EMPLOYMENT TRIBUNALS

Claimant: X

Respondent: [1] The Chief Constable of Gwent Police
[2] Susan Barlow

Heard at: Cardiff **On:** 24th-28th November 2025

Before: Employment Judge H J Randall
Ms S Hurds
Mr A McLean

REPRESENTATION:

Claimant: Mrs L Mankau
Respondent: Mr S Naughton

JUDGMENT

The unanimous judgment of the Tribunal is as follows:

1. All claims against the Second Respondent are dismissed upon withdrawal by the Claimant under Rule 51.

Direct discrimination

2. The complaint of direct disability discrimination is well-founded and succeeds.

Indirect discrimination

3. The complaint of indirect disability discrimination is not well-founded and is dismissed.

Harassment

4. The complaint of harassment related to disability is well-founded and succeeds.

Unfavourable treatment because of something arising in consequence of disability

5. The complaint of unfavourable treatment because of something arising in consequence of disability is well-founded and succeeds.

Remedy

6. The Tribunal makes the following recommendations:

    a. That the Respondent shall, in consultation with the officer concerned, conduct a formal, written risk assessment prior to taking any action in respect of any officer whom they have been informed has been diagnosed with HIV;

    b. That the Respondent shall, within 6 months, consult with the Claimant or an organization or charity with specialist HIV knowledge prior to implementation of the HIV policy that is currently in the process of being ratified; and

    c. Within the next 12 months the Respondent will provide training on HIV to:

        i. frontline officers and their supervisors; and

        ii. occupational health.

The training package must be reviewed/ endorsed by an organization or charity with specialist HIV knowledge, and must form part of training for all new recruits going forwards.

7. The Respondent shall pay the claimant the following sums:

   a. Compensation for injury to feelings (comprising £35,200 injury to feelings and £5,000 aggravated damages):

   £40,200

   b. Interest on compensation for injury to feelings calculated in accordance with the Employment Tribunals (Interest on Awards in Discrimination Cases) Regulations 1996 (comprising interest on injury to feelings from 19th November 2024, and on aggravated damages from 21st October 2025):

   £2,927.08

REASONS

Introduction

1. This judgment and reasons is drafted in accordance with the reporting restrictions issued under Rule 49(3)(b) that the identity of the Claimant should not be disclosed to the public in any documents entered on the Register.
2. The Tribunal announced its unanimous decision at the end of the hearing, giving oral reasons. The Claimant requested written reasons at that stage.

Hearing

3. For health reasons related to travel to the tribunal venue, witness for the Respondent Sue Barlow appeared via cvp. The rest of the hearing was held in person.
4. In the course of the hearing, we heard evidence from the Claimant, and from Susan Barlow, Dr Stephen Williams, and Inspector Y for the Respondent. We also considered unchallenged witness statements from Kerry Jones and Louise Morris for the Respondent. We were provided with a 217 page agreed bundle, which was supplemented by agreement in the course of the hearing by a 7 page additional bundle.

The Claims

5. The Claimant brings claims of direct disability discrimination, discrimination arising from disability, indirect disability discrimination, and harassment related to disability.
6. The disability relied upon in respect of all claims is HIV. The Respondent does not dispute either disability or knowledge.

Findings of fact

7. The majority of evidence in this case is agreed, and the following summary of facts should be taken as agreed evidence unless stated otherwise.

HIV

8. Human immunodeficiency virus (HIV) is a virus which attacks the immune system and weakens the body's ability to fight infections. There is no cure for HIV, but treatment can keep the virus under control and the immune system healthy. Treatment with anti-retrovirals does not merely alleviate symptoms but it restores and maintains the immune system and can mean that levels of viral load and CD4 in an individual reach un-transmittible and un-detectable levels.

9. There are common misconceptions amongst the general population about HIV and its transmission. It can *only* be transmitted through shared bodily fluids. It *cannot* be passed on through kissing or touching, biting, coughing or spitting, breathing the same air, or using the same drinking vessels or eating utensils. At the point at which viral load becomes untransmissible, HIV cannot be transmitted even through shared bodily fluids.

10. There is also, regrettably, stigma attached to HIV, stemming from historical misconceptions. This stigma remains, both in respect of people who have HIV, and the way in which it is transmitted, despite ongoing public health campaigns to irradicate the stigma and encourage testing.

Facts of this case

11. The Claimant was (for the purposes of the Equality Act 2010) employed by the Respondent at all relevant times.

12. At the start of the time to which these claims relate, the Claimant was on a classroom-based training course, run by the Respondent, until 22nd November 2024. He was then scheduled on annual leave from 23rd to 28th November 2024.

13. On 4th November 2024, the Claimant received a phone call informing him that he had been diagnosed with HIV. At the time he was on a classroom-based training course, run by the Respondent. The Claimant was understandably overcome with emotion and immediately told two colleagues who were present in the building with him. The Claimant chose to complete the afternoon's training and left the building at around 4pm.

14. The Claimant at this stage was feeling extremely upset and decided to attend the Respondent's Occupational Health Department as this wasn't far from where the training course was being held. It is not usual for officers/staff to attend without an appointment, however the Claimant was seen by a nurse, Kerry Jones, relatively quickly.

15. The notes of that meeting [pg. 97] include reference to Ms Jones' suggestion that the Claimant *"take time off to process his diagnosis"* and that he is *"currently on a 3 week course which is legislation related not driving"*. In her unchallenged witness statement, Ms Jones detailed that her concerns regarding the Claimant continuing his role were that *"he was so distressed, I would have been concerned about his driving the high-performance police vehicles at high speed"*. This is in accordance with the Claimant's evidence that the immediate response he received from Occupational Health on disclosing his diagnosis was consideration of restricted duties, and that at that stage the concerns raised were surrounding his ability to drive in light of his response to the diagnosis.

16. The following day, 5th November 2024, the Claimant attended an NHS appointment with Stuart Attridge (HIV Clinical Nurse Specialist) to have a blood and urine sample taken, to make sure he had no other underlying health conditions and to find out his viral load and CD4 count. The Claimant's unchallenged evidence was that in the course of that appointment, he asked if he would need to be placed on restricted duties until the levels of virus were un-detectable and un-transmittable. He states that Stuart Attridge reassured him that he did not need to be removed from his front-line duties and placed on restricted duties, and that he could continue his role as normal (the Claimant accepted in evidence that this was ultimately a decision for the Respondent). In the course of the appointment with Stuart Attridge, the Claimant was also provided with education surrounding HIV, his treatment plan, future options, and alternative medication.

17. On the same day, another member of the Respondent's Occupational Health department, Susan Barlow, telephoned the Claimant in Ms Jones' absence (Ms Jones being on annual leave).

18. Mrs Barlow's notes of that telephone call [pg. 97] include *"Advised we would need to arrange a consultation, possibly in a month when blood results are available. [The Claimant] appeared guarded which is understandable but reassured that we are here to support him. He does not feel he requires any support at the moment but assured we have a duty of care and need to be updated about his condition.*

Appointment to be scheduled for 9th December, before he returns to operational duty." Following cross examination, it was agreed evidence that in the course of that call, Mrs Barlow informed the Claimant that he would be placed on restricted duties until the Respondent knew his viral load and CD4 count.

19. The Claimant's evidence was that he could not understand why the Respondent was considering placing him on restricted duties when an NHS specialist was advising this was not necessary, and that he felt angry as a result.

20. The Claimant's unchallenged evidence was that he informed his line manager of his diagnosis that afternoon, and that they decided together that he would continue his duties as normal, unless he was feeling unwell or tired because of his medication or diagnosis. If the latter eventuality arose, he would be kept at the station or doubled crewed (accompanied by another colleague on shift).

21. The Respondent chose not to call the Claimant's line manager to give evidence. We heard conflicting evidence as to the reason for this; all of it hearsay, and we do not place reliance on any of it. Ultimately, it was within the Respondent's power to call her to give evidence had it chosen to do so.

22. On the 19th November 2024, the Claimant attended a further NHS appointment with Stuart Attridge. In the course of this appointment, the Claimant was told that his viral load was 5870 and his CD4 was 480. Mr Attridge advised that the Claimant's HIV levels would be non-detectable and non-transmittible within a few months and that the NHS were not worried about his results.

23. The Claimant attended Occupational Health the same day and Mrs Barlow rearranged other appointments in order to see him. In the course of that meeting the Claimant provided his viral load and CD4 results, and it is agreed that Mrs Barlow expressed the view that these were above the levels they "should" be.

24. The Claimant's case is that in the course of this meeting, Mrs Barlow asked him a number of questions regarding sexual health, namely:

    (a) "*Do you have a partner?"*

    (b) *"Do they know about your diagnosis?"*

(c) *"If you are having sex, are you using a condom?"*

25. Mrs Barlow's evidence in this regard has been inconsistent. In the Grounds of Resistance [pg. 58], it is stated *"the Second Respondent admits that she asked the questions listed at a) and b), but did not use the word condom at c), instead using the word protection."* In her witness statement at paragraph 16, Mrs Barlow stated *"We routinely ask anyone who has a suspected or diagnosed blood borne virus if they have a partner and if so, would recommend they use protection until they are safe and are given the all clear. In the Claimant's case, this would be if their viral load was undetectable. I do not recall asking if his partner was aware of his diagnosis. I did say if he was sexually active, he should use protection until his levels are undetectable."* In cross examination as to what was said in the course of the appointment, Mrs Barlow stated that the Grounds of Resistance were incorrect, and that she did not remember asking the Claimant if he had a partner. This is in contrast to Mrs Barlow's own notes of the meeting [pg. 108] which include *"does not have a current partner"* which information she would not have known had she not asked the question as alleged by the Claimant.

26. We prefer the evidence of the Claimant as to what was said in the meeting. In contrast with Mrs Barlow, his evidence was consistent both through the pleadings and his witness statement. In addition, his evidence of what was asked of him by Mrs Barlow was consistent with his actions following that meeting, to which we shall now turn.

27. The Claimant's evidence was that he was shocked by Mrs Barlow's line of questioning and thought it was wholly inappropriate. He could not understand why he was being asked questions by an Occupational Health nurse about his sexual relationships when this had no bearing on his role as a police officer, particularly when that person knew that he was being treated by a specialist clinic.

28. As a result of this, on the same day, the Claimant's unchallenged evidence was that he spoke with his Police Federation Representative to express how unhappy he was with Mrs Barlow's line of questioning. It is agreed evidence that his Police

Federation Representative spoke with Mrs Barlow on 27th November 2024 and indicated that the Claimant did not want to have any further contact with her.

29. We accept Mrs Barlow's evidence that she considered it necessary to provide the Claimant with advice as to the practicing of safe sex, despite her *"find[ing] it hard to believe that [her] colleagues in the sexual health clinic did not advise him on practicing safe sex until his levels were undetectable"*.

30. However, we find that there is a difference between being given advice and being asked questions. Being given unsolicited advice may be unwelcome or thought to be unnecessary, but it is not intrusive. Being asked questions about sexual behavior in any context is highly intrusive. Being asked questions about sexual behavior in the context of an HIV diagnosis is not only intrusive but also feeds into the stigma surrounding contraction of HIV.

31. On 19th November 2024, Mrs Barlow emailed the Claimant to inform him that a referral must be submitted to HR by his line manager and that this could be referred to as *"a condition affecting [his] immune system"*. The Claimant did not want to do this and informed his line manager that he wanted no further dealings with Occupational Health as every interaction so far had left him feeling ashamed, disgusted, and angry with the way he was being treated.

32. We do not find that the Claimant ever explicitly refused permission for Occupational Health to contact his treating clinicians, rather this was inferred by Mrs Barlow. Had the Claimant explicitly refused such permission we find it would have been noted in the Occupational Health notes, and it is not.

33. It is agreed that the Claimant did not attend a scheduled appointment with Mrs Barlow on 9th December 2024.

34. On 11th December 2024, Mrs Barlow spoke with Dr Williams, Force Medical Advisor, in relation to the Claimant. Dr Williams' evidence is that Mrs Barlow told him that the Claimant had not been on restricted duties because he had been on a classroom course. Mrs Barlow's evidence was that to her knowledge, the Claimant had returned to front line duties on 28th November 2024, nearly 2 weeks

previously. Dr Williams' evidence was that Mrs Barlow wanted to place the Claimant on restricted duties until his viral load was at an un-transmittible level, and that he agreed with her course of action but suggested she take advice from Professor Diana Kloss, an expert in employment and occupational health law.

35. We have seen screenshots of a LinkedIn conversation between Mrs Barlow and Diana Kloss, provided as a 7 page additional bundle in the course of the hearing. In her initial questions, Mrs Barlow writes *"this individual is a front line officer who will be dealing with serious injuries in the course of his work… both myself and our OHP feel we need to restrict his duties until we have further information which will enable [us] to know if he is infectious or the virus is undetectable. What is the legal stance on us taking action until we know he is safe please?"* In the course of a long and detailed response, Professor Kloss states:

    (a) *"Public interest justifies OH in taking any action necessary to assess the risk of transmission and how to control it";*

    (b) *"I imagine the risks of transmission arising from police activities are vanishingly small… there is a case where the court found that there was no danger of HIV transmission through biting or scratching";*

    (c) *"Assuming there is no likelihood of sexual transmission I would have thought the risk was small";*

    (d) *"HIV positive healthcare workers are now permitted to perform exposure prone procedures on patients if their viral load is low enough and they are regularly monitored. Does a PC perform similar activities?"*

36. Mrs Barlow's response, over an hour later, includes *"there is a possibility he may [find] his hands within a body cavity without being able to visualise them"*, to which Professor Kloss responds *"I think the problem arises if he can cut or prick himself when his hands are in the body cavity so that there is a bleed back (like a surgeon). Is that a possibility? I advise you first consult with an HIV expert physician in confidence about possible risks (without identifying the officer)"* and then suggests such an expert.

37. Mrs Barlow's evidence was that she reached the decision to restrict the Claimant from front line duties, and communicated that to the Claimant's line manager on 13th December 2024.

38. Her evidence was that she did not follow Professor Kloss's advice in consulting with an HIV expert physician because she *"didn't have time"*. This perceived urgency on Mrs Barlow's part was entirely of her own making. She had known of the Claimant's diagnosis since 5th November, and known that he was on front line duties from 28th November. We do not accept that there was insufficient time for her to consult with an HIV expert had she chosen to do so.

39. Mrs Barlow states that in reaching her decision, she took into account a Public Health England document entitled *"Emergency Healthcare Workers, Exposure Prone Procedures (EPPs) and the Exposure Prone Environment; Advice from the United Kingdom Advisory Panel for Healthcare Workers Infected with Bloodborne Viruses (UKAP)"* (hereafter "the EPP advice"). When asked by the Tribunal when she had read this she responded *"all the time"* and when asked when she had read it after 5th November 2024, that she couldn't remember.

40. The parts of the document we find to be relevant to this case are as follows:

    (a) *The definition of EPPs given above embraces a wide range of procedures, in which there may be very different levels of risk of bleed-back. A risk-based categorisation of clinical procedures has been developed, including procedures where there is negligible risk of bleed-back (non-EPP) and three categories of EPPs with increasing risk of bleed-back.*

    (b) *The definitions and examples of categories 1, 2 and 3 are:*

        i. Category 1 - Procedures where the hands and fingertips of the worker are usually visible and outside the body most of the time and the possibility of injury to the worker's gloved hands from sharp instruments and/or tissues is slight. This means that the risk of the HCW bleeding into a patient's open tissues should be remote.

ii. *Category 2 - Procedures where the fingertips may not be visible at all times but injury to the worker's gloved hands from sharp instruments and/or tissues are unlikely. If injury occurs it is likely to be noticed and acted upon quickly to avoid the HCW's blood contaminating a patient's open tissues.*

iii. *Category 3 - Procedures where the fingertips are out of sight for a significant part of the procedure, or during certain critical stages, and in which there is a distinct risk of injury to the worker's gloved hands from sharp instruments and/or tissues. In such circumstances it is possible that exposure of the patient's open tissues to the HCW's blood may go unnoticed or would not be noticed immediately.*

iv. *Non-exposure prone procedures - Non-EPPs are those where the hands and fingertips of the worker are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the worker's gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone provided routine infection prevention and control procedures are adhered to at all times.*

41. The document goes on to classify emergency healthcare workers in terms of the likelihood they will carry out EPPs:

(a) *Class A – Likely to undertake EPPs and work in exposure prone environment, including clinicians and critical care providers;*

(b) *Class B – Unlikely to undertake EPPs but likely to work in exposure prone environments, including front line paramedics and technicians;*

(c) *Class C – Unlikely to undertake EPPs and unlikely to work in exposure prone environments, including emergency care practitioners, emergency care assistants, and others undertaking primary care roles;*

(d) *Class D – Will not undertake EPPs or work in exposure prone environments as part of defined role but may incidentally render basic first aid.*

42. The table continues recommend EPP restrictions:

(a) *Class A – EPP clearance needed for advanced practitioners carrying out invasive procedures in major trauma and medical staff working outside an NHS occupational health scheme;*

(b) *Class B – No restrictions if appropriate PPE worn (PPE examples within the document including armoured gloves);*

(c) *Class C – No restriction as EPPs unlikely to be performed;*

(d) *Class D – EPP clearance not needed.*

43. In her evidence, Mrs Barlow indicated she hadn't considered which class the Claimant's role fell into. We find this astonishing in the context of her claim that she had taken the EPP advice document into account in her decision to restrict the Claimant from front line duties.

44. Mrs Barlow accepted in evidence that she did not consult with the Claimant's line manager as to the likelihood of him carrying out an EPP, or what steps might be feasible to manage this risk in the context of his role.

45. On the basis of the evidence before us, we consider that the Claimant's role would have fallen into Class D, given the evidence we have heard that his role might have required him to carry out basic first aid, and that this was the extent of his training. Under the advice document this would not have required EPP clearance. Even if his role were to be categorised two classes above, as Class B, the advice recommended no restrictions if appropriate PPE was worn.

46. Mrs Barlow gave evidence that in reaching her decision she did not consider any less restrictive treatment, for example double crewing, or the provision of suitable PPE. She never produced a full written risk assessment.

47. On 13th December 2024, the Claimant received a WhatsApp message from his line manager, asking if she could come and see him at home, to which he agreed. In

the course of that meeting, he was informed of the Respondent's decision to restrict him from front line duties until he was un-detectable and un-transmissible. The Claimant was shocked and upset. He immediately questioned the decision with his line manager on the basis that the risk posed before he was un-detectable and un-transmissible was not present *"unless I had unprotected sex with someone or I bleed into someone through vein to vein and the chances of either of them happening is slim to none."*

48. The following morning the Claimant sent a WhatsApp message to his line manager *"Hardly slept last night. I can't believe they have done this to me!! Every time I'm moving forward with it, they just pull the carpet from underneath me. They aren't thinking about me, helping and supporting… At what point am I going to allow someone to drink my blood from the vein or start rubbing an open wound into someone else's open wound. Or have unprotected sex with a member of the public. It's barbaric what they've done. They've isolated me and just making me feel like a walking disease."* In his witness statement the Claimant describes *"It felt as though they did not know what to do in situations where an officer had been diagnosed with HIV, so panicked and made the decision to restrict me. It felt like this was feeding into the stigma that surrounds HIV."*

49. The Claimant was due to work on Sunday 15th December but was unable to work his shift as a result of the restriction.

50. On the morning of Monday 16th December, the Claimant attended the sexual health clinic. This was the first time it had been open since he was told he was placed on restricted duties. He spoke with Stuart Attridge and was told that his most recent blood results revealed his viral load was at an un-transmittible level.

51. Stuart Attridge wrote a letter [pg. 114] to the Respondent's Occupational Health Department the same day, confirming that the Claimant's viral load is undetectable, and raising concern as to the Claimant's treatment by the department and the stigmatizing nature of its response. He attached advice on tackling HIV stigma.

52. The Claimant attended Occupational Health immediately on leaving the clinic and spoke with Mrs Barlow. In the course of that meeting he questioned the decision to place him on restricted duties in light of there being no risk of transmission in absence of vein to vein transmission or engagement in unprotected sex.

53. The Claimant raised concerns with the way he had been treated following his revealing his HIV diagnosis to the Occupational Health department. He asked whether a policy could be written so that another officer in his position would not be treated in the same way. The Claimant provided Mrs Barlow with a copy of a policy from West Yorkshire Police on the treatment of officers and staff with HIV which includes a statement of the duties of the force to treat officers and staff members affected by HIV with dignity and respect throughout their career, and the responsibilities of individuals affected, line managers, and occupational health. Notably there is no requirement on individuals affected to disclose their diagnosis, unless there is a situation where a colleague or member of the public has been contaminated by blood or bodily fluid, and then to seek advice and support.

54. We find that Mrs Barlow's immediate response to being asked about a policy for the treatment of officers and staff with HIV was that she *"couldn't write a policy for everything"*, but that she thereafter backtracked somewhat and said she didn't have time before Christmas but would look at it in the new year.

55. In the course of the meeting with Mrs Barlow, the Claimant provided evidence that his viral levels were un-detectable and un-transmittible, and Mrs Barlow thereafter agreed to lift the restrictions. Following this meeting the Claimant returned to full duties.

HIV training/policies

56. Mrs Barlow's evidence was that her clinical training in respect of HIV had been undertaken when working as a ward nurse "about 20 years ago", and that her general knowledge was updated through CPD every 3 years. She stated she is aware of the changes with HIV, but "less specifically because this was covered within blood borne viruses generally".

57. Mrs Barlow accepted in evidence that she had received no specific guidance on the treatment of (in the sense of interaction with) officers with HIV.

58. In the course of his evidence, Dr Williams denied that his knowledge of the transmissibility of HIV was out of date. However, in his witness statement at paragraph 4 he stated *"we had a patient who was HIV positive, and we did not know his viral load. So, at this stage, we did not know if his HIV was transmittible or not."* We find this wording inconsistent with a claim of up to date knowledge of the transmissibility of HIV. HIV is transmittible only through bodily fluids, so whilst no-one knew at that stage whether it would be transmittible by those means, it was known that it was transmissible *only* through those means, and not transmissible in the course of every day interactions. Dr Williams accepted, when asked how things should have been handled better by the OH department, that this would include "taking into account up to date information". In light of all this we find that Dr Williams' knowledge was out of date.

59. Dr Williams accepted that he had not considered the EPP guidance in advising Mrs Barlow, and that if he had read this he may have advised differently. In the course of his evidence, on being asked of the risk posed by the Claimant's role, Dr Williams responded *"I don't know how you calculate risk to be honest"*. We consider this to be astonishing in respect of a Force Medical Advisor, providing advice to an Occupational Health department.

60. At the time to which these claims refer, the Respondent had no policy as to the treatment of police officers or police staff members affected by the HIV virus. In the course of her evidence Mrs Barlow stated that a policy has now been drafted, although this is not mentioned in her witness statement, and no such draft was included in the bundle. The reason given in evidence was that it had not yet been "ratified".

61. It is agreed evidence that the Respondent had no policy requiring an officer or staff member to inform the Respondent of a diagnosis of HIV. In her evidence Mrs Barlow claimed that there was a "moral duty" on an officer to disclose such diagnosis. We find this language to be problematic (to which we shall return), but

in any event, had the Respondent considered it necessary for its officers and staff to inform it of such a diagnosis, it could have produced guidance/policy regarding the same and did not.

62. It is agreed evidence that the Respondent had no written policy requiring an officer diagnosed with HIV to be placed on restricted duties.

Claimant's duties

63. The Claimant's unchallenged evidence was that in over six years as an operational police officer he has never had to put his hands in a body cavity. Mrs Barlow's evidence was that he was not trained to do so.

Stigma

64. In the course of her evidence, Mrs Barlow stated in answer to a question about whether it was necessary for her to give advice on sexual health *"It was necessary, it was my duty of care to protect him, and to protect his colleagues and members of the public from an officer whose viral load remains detectable"*. We found the phrasing of this answer to be troubling, containing as it did mention of protecting colleagues and members of the public *from* the Claimant. The use of such language reduces a person affected by HIV to the virus. We find this indicative of the stigma attached to HIV.

65. Mrs Barlow also claimed that the Claimant was under a *"moral duty"* to inform the Respondent of his diagnosis, in absence of any policy or legal requirement. This language is troubling as it feeds into the stigma that there is some moral or value based judgment associated with the virus. We again find Mrs Barlow's use of such language indicative of the stigma attached to HIV.

66. In his witness statement, Dr Williams sought to draw an analogy between HIV and tuberculosis. Tuberculosis is transmitted readily through the air, when an infected person coughs, sneezes, or speaks. HIV is transmitted only through bodily fluids. Analogy with a virus entirely unrelated in its transmission is unhelpful to say the least. We find that the analogy perpetuates misunderstanding as to the transmissibility of HIV, which in turn perpetuates stigma surrounding it.

Restriction of duties

67. We find that the decision to restrict the Claimant from all front line duties was made in the absence of proper consideration of the realities of the transmissibility of HIV and the real risk of transmission posed by the Claimant's role. It was also made in the absence of proper consideration of measures short of removing the Claimant completely from front line duties.

Law

Direct discrimination

68. Section 13 EqA, provides:

"*A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others...*". Section 23 EqA further provides "*On comparison of cases for the purposes of section 13… there must be no material difference between the circumstances relating to each case.*"

69. Counsel for the Claimant has invited our attention to the case of *Nagarajan v London Regional Transport* [1999] ICR 877, in which Lord Nicholls, when giving Judgment in an appeal in a race discrimination case under the Race Relations Act 1976, stated:

"Thus, in every case it is necessary to enquire why the complainant received less favourable treatment. This is the crucial question. Was it on grounds of race? Or was it for some other reason, for instance, because the complainant was not so well qualified for the job? Save in obvious cases, answering the crucial question will call for some consideration of the mental processes of the alleged discriminator."

"'a variety of phrases, with different shades of meaning, have been used to explain how the legislation applies in such cases: discrimination requires that racial grounds were a cause, the activating cause, a substantial and effective

cause, a substantial reason, an important factor. No one phrase is obviously preferable to all others, although in the application of this legislation legalistic phrases, as well as subtle distinctions, are better avoided so far as possible. If racial grounds… had a significant influence on the outcome, discrimination is made out'

70. Counsel for the Claimant has also referred to the case of *R(E) v Governing Body of JFS* [2010] IRLR 136, in which Baroness Hale referred to the case of *Nagarajan* and further provided:

"The distinction between the two types of "why" question is plain enough: one is what has caused the treatment in question and one is its motive or purpose. The former is important and the latter is not."

Discrimination arising from Disability – Equality Act 2010 s15

71. Section 15 EqA 2010 provides:

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

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

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

72. In considering whether treatment is a proportionate means of achieving a legitimate aim, we remind ourselves from the case law on the subject of the need to consider:

(a) Whether the objective of the measure is sufficiently important to justify the limitation of a protected right;

(b) Whether the measure is rationally connected to the objective;

(c) Whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective;

(d) Whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to

the extent that the measure will contribute to its achievement, the former outweighs the latter.

Indirect Disability Discrimination – Equality Act 2010 s13(1)

73. Section 19 of the EqA 2010 provides:

"(1) A *person (A) discriminates against another (B) if, A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.*

(2) For the purpose of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if

(a) A applies, or would apply, it to persons with whom B does not share the characteristic

(b) It puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share,

(c) it puts, or would put, B at that disadvantage; and

(d) A cannot show it to be a proportionate means of achieving a legitimate aim."

Harassment related to Disability – Equality Act 2010 s21(1)

74. Section 26 of the EqA provides:

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

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

(b) the conduct has the purpose of effect of

(i) violating B's dignity; or

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

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

(a) the perception of B;

(b) the other circumstances of the case; and

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

Analysis and conclusions

Direct Disability Discrimination – Equality Act 2010 s 13(1)

75. The less favourable treatment relied upon by the Claimant is his placement on restricted duties from 13th December 2024, until he provided evidence that his viral load was at an untransmissible level on 16th December 2024. It is admitted by the Respondent that this was done; it is denied that this was less favourable treatment.

76. It is argued by the Respondent that in considering whether this treatment was "less favourable", we should adopt a hypothetical comparator with a hypothetical blood borne virus without stigma, in circumstances which include that the comparator:

    (a) Had ceased contact with occupational health in mid-November 2024;

    (b) Refused to agree to a management referral to occupational health;

    (c) Had cancelled a meeting on 9th December 2024; and

    (d) Had insisted on confidentiality.

77. We find the suggestion of the hypothetical comparator with a hypothetical blood borne virus without stigma to be helpful, as it removes the complication that the only blood borne viruses cited to us in evidence being Hepatitis B and C, each of which bears its own levels of stigma, and which would in any event be a physical impairment for the purposes of the definition of disability. However, we find the list of circumstances we are invited to consider to pose complications:

    (a) Firstly, we have found that Mrs Barlow informed the Claimant that she intended to place him on restricted duties until the Respondent knew his

viral load and CD4 count in the course of the telephone call on 5th November 2024. This predates any of the circumstances sought to be relied upon by the Respondent; and

(b) Secondly, we have found that the reason that the reason the Claimant withdrew from full engagement with the Respondent's Occupational Health team was due to the Respondent's treatment of him and/or his perception thereof in light of the stigma attached to HIV. He could not understand and felt angry with the indication on 5th November 2024 that the Respondent intended to place him on restricted duties when an NHS specialist had indicated to him that this was unnecessary. He felt shocked and unhappy with Mrs Barlow's line of questioning on 19th November 2024 relating to his sexual health. Both these events have to be viewed in light of the misconception and stigma surrounding the transmission of HIV. A hypothetical comparator with a blood borne virus without stigma would not necessarily have responded in the same way, and therefore would not necessarily have withdrawn from engagement with occupational health.

78. For this reason, we find the most helpful comparator to be a hypothetical individual with a hypothetical blood borne virus without stigma, in the same circumstances as the Claimant on 5th November 2024, this being the date on which we have found the decision to place the Claimant on restricted duties was made (albeit that it was not implemented until a much later date).

79. We therefore consider what Mrs Barlow would have done if presented with an individual with a hypothetical blood borne virus, without stigma. We consider in those circumstances, and in the absence of a policy as to the treatment of a person with that virus, she would have:

(a) Asked the comparator what advice he had been given by his treating clinicians as to any adjustments necessary to his working conditions;

(b) Considered that advice;

(c) If necessary conducted research into the virus and its transmissibility;

(d) If necessary, carried out a full written risk assessment, taking into account:

i. the circumstances in which the virus could be transmitted,

ii. the likelihood of those circumstances arising in the comparator's role, and

iii. what steps could be taken to prevent those circumstances from arising.

80. By contrast, in the Claimant's case, Mrs Barlow's immediate response was to inform him, on 5th November 2024, that he would need to be placed on restricted duties. She did not ask for or take into account the advice of his treating specialist clinicians. She did not carry out a full written risk assessment as to the circumstances in which HIV could be transmitted, the likelihood of those circumstances arising in the Claimant's role, or the steps which could be taken to prevent those circumstances from arising.

81. We find that the reason Mrs Barlow eventually placed the Claimant on restricted duties on13th December was because the Claimant had HIV as opposed to some other blood borne virus without stigma. She reached that decision on 5th November 2024, communicating it to the Claimant the same day, and everything she did from that point onwards was to reinforce her original decision as opposed to objectively assessing the real risks involved. In assessing this, we have focused on what caused the treatment and not its motive or purpose. We do not find that Mrs Barlow intended to discriminate against the Claimant because of his HIV positive status, but such status was nevertheless the reason why she placed him on restricted duties.

82. Counsel for the Claimant has contended that was can do away with any comparator, on the basis that the treatment complained of was *"a knee-jerk reaction not based in reality, but based upon stereotypical assumptions of the risk posed to the public by the Claimant's HIV status"*, and that it is therefore "*inherently directly discriminatory"*. We have found the use of a hypothetical comparator of assistance as set out already, but if we are wrong about that, we agree with the

Claimant's submissions; that Mrs Barlow's decision was a reaction to the Claimant's HIV status, and was therefore inherently directly discriminatory.

Indirect Disability Discrimination – Equality Act 2010 s13(1)

83. We have found that the reason the Claimant was placed on restricted duties was specifically because of his HIV status, and not because of any policy or practice of placing officers with blood borne viruses on restricted duties. In those circumstances, the Claimant rightly concedes that there was no PCP and therefore the claim of indirect disability discrimination fails.

Discrimination arising from Disability – Equality Act 2010 s15

84. It is conceded by the Respondent that placing the Claimant on restricted duties constituted unfavourable treatment, and that the treatment was because of something arising from his disability.

85. The question we really need to consider in these circumstances is whether the treatment was a proportionate means of achieving a legitimate aim.

86. In answering this question, we consider first the Respondent's aim. This was framed in the Grounds of Resistance [para 43] as *"to ensure the safety of all officers and members of the public"*, and in the list of issues amended in the course of the hearing as *"to completely remove the risk of HIV transmission to colleagues and members of the public"*. In assessing whether this was a legitimate aim, we have found it necessary to consider the level of risk posed in circumstances where no restrictions were placed on the Claimant's role. HIV, we repeat, is transmissible only through bodily fluids. The *only* circumstances the Respondent has been able to identify of there being a risk to members of the public in the circumstances of an officer in the Claimant's role having HIV is if he attended the scene of an accident, to find a casualty with a bodily cavity, which required <u>him</u> (as opposed to any other police officer or health care worker present at the scene) to put his hands inside the cavity, such that he could not see his hands, was then himself cut, and bled

into the casualty's open wound. The Claimant's evidence was that in over six years of policing he has never had to do this. Mrs Barlow's evidence was that he was not trained to do this. The EPP guidance considers it unlikely for anyone but clinicians and critical care practitioners to undertake EPPs.

87. For these reasons we find that we agree with Professor Kloss, in considering that the likelihood of risk of HIV transmission from the Claimant to members of the public to be "vanishingly small". The risk to his colleagues was even more remote, the only circumstances identified by the Respondent being if both the Claimant and a colleague had their hands in a body cavity, with their hands out of sight, were both cut, and their wounds came into contact.

88. In circumstances where an identified risk is so slight, we question the legitimacy of the Respondent's aim to completely irradicate such risk.

89. However, whether the aim was legitimate or not, we find the treatment of the Claimant in completely restricting him from all front line duties until his viral load was un-transmissible, was out of all proportion with the level of risk. In the course of evidence, we heard a number of less restrictive measures which would have irradicated the risk. Not one of these was considered by the Respondent before the restriction from all front line duties was imposed.

90. In balancing the needs of the Claimant and the Respondent we take into account the level of risk (which we have found to be incredibly small), and the level of impact of the treatment.

91. The Respondent has argued that the treatment was not very serious, on the basis it was only for a few days and only resulted in the missing of one shift. We disagree. The treatment involved a complete exclusion of the Claimant from carrying out his role because of his HIV positive status and unfounded fears surrounding transmission of the virus. It was treatment which isolated and separated him from colleagues, effectively shunning him. It made him feel, in his own words, like "a walking disease". It perpetuated misconception as to the transmissibility of the virus. It stigmatised him, and perpetuated the stigma surrounding HIV.

92. In balancing the needs of the Respondent and Claimant we fall entirely on the side of the Claimant and find that the Respondent's placing of him on restricted duties was discrimination arising from disability.

Harassment related to Disability – Equality Act 2010 s21(1)

93. We have found that in the course of the meeting with the Claimant on 19th November 2024, Susan Barlow asked the following questions:

    (a) "*Do you have a partner?"*

    (b) *"Do they know about your diagnosis?"*

    (c) *"If you are having sex, are you using a condom?"*

94. We have found that this was undoubtedly unwanted conduct, it upsetting and angering the Claimant to the point he informed his Police Federation Representative that he wanted no further contact with Susan Barlow.

95. We find also that the conduct undoubtedly related to the Claimant's disability, Mrs Barlow's evidence being that she asked the questions because of his HIV status.

96. We turn then to the purpose and effect of the questions.

97. We do not find that Mrs Barlow's purpose in asking the questions was to violate the Claimant's dignity or to create an intimidating, hostile, degrading, humiliating or offensive environment for him. Her purpose, we accept, was to provide information as to prevention of transmission of the virus.

98. However, we have to look at both what was said and the context of that. The questions asked by Mrs Barlow were, as we have found, highly intrusive, particularly in the context of an HIV diagnosis They were asked in circumstances when Mrs Barlow knew that the Claimant was under the care of a sexual health clinic and HIV specialist advisers. In some contexts, it is necessary for questions about sexual behavior to be asked. We do not consider that it was necessary for such questions to be asked in the context of an occupational health appointment. Should she have considered it necessary to do so, Mrs Barlow could have simply

provided advice as to the use of barrier protection. We find that there was no need for Mrs Barlow to enquire into the Claimant's sex life to be able to provide this advice; the advice remained the same regardless of the answers. We find that the asking of those questions had the effect of violating the Claimant's dignity and creating a degrading and humiliating environment for him.

Remedy

Injury to feelings

99. We have reminded ourselves of the general principles that underly awards for injury to feelings:

    (a) awards for injury to feelings are designed to compensate the injured party fully but not to punish the guilty party

    (b) an award should not be inflated by feelings of indignation at the guilty party's conduct

    (c) tribunals should bear in mind the need for public respect for the level of the awards made

100. We have considered not just the bands but the guidance provided by the Vento case; per Lord Justice Mummery, injury to feelings encompasses *'subjective feelings of upset, frustration, worry, anxiety, mental distress, fear, grief, anguish, humiliation, unhappiness, stress, depression and so on'*.

101. We have also considered the guidance on injury to feelings awards given by the EAT in the recent case of *Eddie Stobart Ltd v Graham 2025 EAT 14*: *"The frequency and duration of the claimant's exposure to the discriminatory conduct are not the only measures that could support an inference of injury. Relevant considerations include:*

    (a) *whether the discrimination was 'overt'. Overt discrimination is more likely to cause distress and humiliation;*

(b) *the existence of ridicule or exposure. Discrimination played out in front of colleagues or for others to see might well cause greater harm; and*

(c) *whether the discrimination reflects or exposes an asymmetry of power, influence and information. In some cases, that could be manifested in exclusion that causes isolation."*

102. We have also considered the effect of the treatment not just at the time it took place, but any ongoing effect.

103. In considering the impact of the discrimination on the Claimant, the R argues we should essentially "offset" against the injury to feelings that the C's diagnosis would have caused him in any event. We agree with the need to focus on the injury to feelings caused by the discrimination itself, but we take into account the effect the discrimination had on the Claimant coming to terms with his diagnosis:

(a) When the Claimant was told of his diagnosis on 4th Nov, he was understandably upset and worried.

(b) He was then reassured by the specialist HIV nurse advisor he saw the following morning. This reassurance was almost immediately undermined by the Respondent telling him that afternoon that he would need to be placed on restricted duties.

(c) The Claimant was further reassured by his specialist HIV nurse on 19th Nov that his levels would soon be un-detectable and un-transmittible. This was again undermined by the Respondent that same day telling him his levels not what should be, that he would need to be placed on restricted duties, and then subjecting him to the harassment we have found as pleaded.

(d) The Respondent failed to carry out any adequate risk assessment of the real risk posed in the course of the Claimant's role before placing him on restricted duties, leaving him feeling like "a walking disease" and that his employer (acting through health care professionals who should have known better) was feeding into the stigma that surrounds HIV.

104. We have taken into account the Claimant's written and oral evidence, and consider that in *absence* of the Respondent's discrimination, the Claimant would have been quickly reassured by his NHS specialists, and dealt robustly with the news of his diagnosis. The Claimant's response to his diagnosis was to continue to work, to take advise from specialists, and to draw reassurance from that advice. We find that he has been measured throughout his bringing of these proceedings, his written evidence, and his evidence to the tribunal.

105. We find that all of the injury to feelings detailed by the Claimant in his witness statement, and found by us in our findings of fact, were caused by the Respondent's discrimination. Those acts, as we have found, perpetuated the stigma surrounding HIV, and the fear induced in the Claimant that he would be stigmatized as a result of his diagnosis.

106. In terms of the finding of Harassment, we find that this:

    (a) Caused upset, humiliation and anger that intimate questions were being unnecessarily asked of the Claimant; and

    (b) We have found the questions asked perpetuated stigma surrounding transmission of HIV.

107. We find that the Respondent's actions in restricting the Claimant from duties had a number of effects:

    (a) It perpetuated the Claimant's fears of misconception and stigma surrounding the transmission of HIV;

    (b) It induced frustration that the risks of transmission were not being properly assessed;

    (c) It induced worry and anxiety that the restriction would lead to colleagues asking questions as to the reason for his restriction;

    (d) It actualised that fear, the Claimant's unchallenged evidence being that colleagues asked why he had been placed on restricted duties – (para 69 of witness statement); and

(e) It perpetuated stigma and misconception surrounding HIV.

108. We also note that throughout these proceedings, the Respondent has failed to apologize to the Claimant, all of the witness statements from members of the Occupational Health team joining forces to justify the actions taken, actions which we have found to have been discriminatory on a number of grounds.

109. In all those circumstances, we find that we agree with the Claimant that the injury caused to his feelings by the Respondent's actions falls at the top of the middle band.

110. It is agreed that in respect of claims presented after 6th April 2024 and before 6 April 2025 (as in this case), the middle of the "Vento bands" is £11,700 to £35,200.

111. We consider an award of **£35,200** to be appropriate in this case.

Aggravated damages

112. A claim for aggravated damages is made on the basis of the Respondent's conduct in the course of these proceedings in disclosing the Claimant's diagnosis to Inspector Y, in order for him to provide evidence in the case.

113. Aggravated damages can be awarded only on the basis that the aggravating features have increased the impact of the discriminatory act on the claimant and thus the injury to his feelings. The basis for awards of this nature are divided into three potential headings:

(a) Where the act is done in an exceptionally upsetting way;

(b) Motive; and

(c) Subsequent conduct.

114. It is the last of these upon which the Claimant relies.

115. The cases of *Bungay & Anor v Saini & Ors* UKEAT/0331/10 and *Zaiwalla & Co v Walia* [2002] UKEAT/451/00 found that subsequent conduct includes conducting the trial in an unnecessarily oppressive manner.

116. We consider then whether the Respondent's disclosure of the Claimant's diagnosis to Inspector Y was unnecessary and/or oppressive.

117. Firstly, as to necessity, we do not find that it was necessary for the Respondent to call Inspector Y as a witness. The Claimant's immediate line manager at the time of the complaints knew of the Claimant's diagnosis, and is still in her role. She was in a position to give the evidence given by Inspector Y. It was within the Respondent's power to have called the Claimant's line manager to give evidence had it chosen to, which would have negated the need to disclose the Claimant's diagnosis to Inspector Y.

118. Secondly, as to whether the action was oppressive, we have considered the definition of oppressive to be "inflicting harsh or authoritarian treatment"; the definition of authoritarian to be "enforcing strict obedience to authority at the expense of personal freedom."

119. In informing Inspector Y of the Claimant's diagnosis, the Respondent did something which it knew he did not want. He had made it clear to his employers from the outset that he wished to keep his diagnosis private.

120. Disclosure not only breached the Claimant's clear wishes, it perpetuated his feeling of loss of control over sensitive, stigmatized information being released to others, with the risk that the Claimant would be treated with stigma as a result.

121. Had it chosen to, the Respondent could have written to the Claimant in the course of proceedings, informed him of its wish to call Inspector Y as a witness (and the need in those circumstances to inform the Inspector of the Claimant's diagnosis), and asked for the Claimant's views/consent. The Respondent chose not to. Instead, the first the Claimant knew of his diagnosis being revealed to his superior officer was at the point of exchange of witness statements. We heard unchallenged evidence that the Claimant was left feeling *"gutted", "angry*", and *"like a part of my*

private life has been taken from me". Inspector Y gave evidence that in a subsequent meeting between himself and the Claimant it was awkward for both of them and that the Claimant was visibly upset.

122. For the Respondent, in its position of power, having knowledge of the Claimant's diagnosis, to reveal that diagnosis to a member of its organization without the Claimant's knowledge or consent, we find was oppressive, and that it acted to damage the trust and confidence an employee should be able to have in his employer.

123. We have considered the aggravation of this action to the injury to feelings award already made, and consider a further award of **£5,000** to be appropriate.

Interest

124. We make an award of interest at a rate of 8%, accruing from day to day. In respect of injury to feelings, this is calculated from 19th November 2024 (the date of the first act of discrimination), and in respect of the aggravated damages this is calculated from 21st October 2025 (the date of the exchange of witness statements).

Approved by:
Employment Judge H J Randall
28th November 2025

Judgment sent to the parties on:

18 December 2025
For the Tribunal:

Katie Dickson