EMPLOYMENT TRIBUNALS

Claimant: **Dr A Roy**

Respondent: **Calderdale and Huddersfield NHS Foundation Trust**

Heard at: **Leeds** **On: 20-23 February 2023**

Before: **Employment Judge Maidment**
Members: **Mr W Roberts**
Mr G Corbett

Representation
Claimant: **Mr H Menon, Counsel**
Respondent: **Mr F Sutcliffe, Solicitor**

RESERVED JUDGMENT

The claimant's complaints of unfair dismissal and disability discrimination fail and are dismissed.

REASONS

Issues

1. The claimant was employed by the respondent as a speciality doctor, but was dismissed on the grounds of capability (performance).

2. The claimant brings a complaint of ordinary unfair dismissal. As well as general considerations of reasonableness applicable in capability cases, the claimant points to a number of specific factors which he says rendered his dismissal unfair. These include: restricting him to working at foundation level despite a GMC assessment that he could work at ST2 level; failing to allow the claimant to work at ST4-6 levels to show his capability at those levels; not giving him more time/extending his improvement plan given his mental health; not taking into account his state of mental health; not transferring him to the Calderdale Royal Hospital; not changing his educational and clinical supervisor given a breakdown in relationships; not taking account of the claimant's length of service and failing to consider the

claimant for a lower level post, including outside emergency medicine and such as ST2/3 level posts in minor injuries, the acute admissions unit or clinical decision unit.

3. The claimant also brings complaints of disability discrimination. The respondent accepts that at all material times the claimant was a disabled person by reason of suffering from the mental health impairments of stress, anxiety and depression. It does not accept that it had, however, the requisite knowledge to be liable in the claims that the claimant is pursuing.

4. Those claims are, firstly, one of discrimination arising from disability where the unfavourable treatment asserted is a failure to extend the timescale within which he was required to reach the required standard and, then, his dismissal. The something arising from disability is said to be the claimant's inability to reach the required level in the respondent's timescale and his inability to operate at ST5-6 levels. If the claimant surmounts those hurdles, the respondent seeks to justify the unfavourable treatment with reference to the purported legitimate aims of maintaining patient safety, efficient emergency medicine working and reducing the burden on consultants and colleagues of providing extraordinary and unsustainable support to the claimant.

5. The claimant also brings a complaint alleging that the respondent has failed to comply with a duty to make reasonable adjustments. The provision, criterion or practice relied upon is the requirement of relevant employees to undergo a clinical supervision and improvement plan in a required period. It is said that, as a reasonable adjustment, the claimant ought to have been transferred to the Calderdale Royal Hospital and/or have had a change of clinical supervisor.

Evidence

6. The tribunal had before it an agreed bundle of documents numbering 929 pages. It was also helpfully provided with an agreed and detailed chronology in a case where essentially there is significant agreement as to the facts. Also of assistance to the tribunal were a cast list and glossary of terms used.

7. Having identified the issues with the parties, the tribunal took time to privately read into the witness statements exchanged between the parties and relevant documentation. The tribunal heard evidence firstly, on behalf of the respondent, from Helen Barker, operations director for reconfiguration, Dr Mark Davies, consultant in emergency medicine and former clinical director of emergency medicine and Suzanne Dunkley, executive director of workforce and organisational development. The tribunal was also provided with a signed written statement from a barrister, Carlo Breen, who had chaired the claimant's capability appeal hearing, but no reliance was placed upon it. The tribunal finally heard from the claimant himself.

8. Having considered all relevant evidence, the tribunal makes the factual findings set out below.

Facts

9. The claimant commenced employment with the respondent on 5 August 2009 as a speciality doctor in emergency medicine, level ST4-6 (a reference to the specialty trainee levels which ran from 1 to 7), at Calderdale Royal Hospital. He was born in 1964.

10. The respondent accepts that the claimant was at all material times a disabled person by reason of the mental health impairments of stress, anxiety and depression. The claimant has produced a letter from his GP dated 15 June 2022 which lists a number of consultations leading up to that diagnosis and commencement of treatment. It was said that "eventually" in a consultation of 14 November 2020 (in fact 24 November), the claimant's condition amounted to clinically significant anxiety and depression for which treatment was prescribed. From that date the claimant commenced taking sertraline for mixed anxiety and depression. He had a further consultation when the continuance of that medication was confirmed and, at a consultation on 8 December 2020, the claimant was reported to be feeling "very low" with a reference to him receiving occupational counselling. In terms of chronology, the diagnosis came after the claimant had been told that there would be no PPA/NCAS assessment of his clinical abilities (see below) and sometime before the capability hearing on 15 July 2021 after which the claimant was dismissed. The claimant agreed that he did not disclose his actual specific diagnosis at the capability meeting or subsequent appeal.

11. In terms of the preceding medical history, the claimant saw the respondent's occupational health service on 28 May 2013 regarding a physical impairment and problems working night shifts. The claimant was taken off nightshifts in May 2013. The claimant attended occupational health further on 24 March 2014 who considered it would be counter-productive for him to return to nightshift working given an improvement in his condition. The claimant agreed that not working night shifts was then made a permanent adjustment. The claimant told the tribunal that he also stopped working weekend shifts (the busiest shifts of the week) from January 2016. Thereafter, whilst the claimant did not always work standard hours of 9am to 5pm (mainly as result of being told to seek to shadow his clinical supervisor, Dr Birkinshaw), the claimant accepted that he did not ever work later than 10pm.

12. In the claimant's witness statement evidence, he referred to starting to suffer from stress and anxiety from mid-2015 which got worse by mid-2016. However, there was no record of him raising such impairments with his GP from May 2015. His GP notes referred to an appointment on 2 August 2018 and, against the standard reference to depression screening, it was recorded: "no concerns indicated".

13. The claimant said that he made Dr Verma aware of his stress and anxiety in May 2016. Dr Verma indeed wrote to the claimant on 1 June 2016 confirming the outcome of a meeting and saying that the claimant had indicated that he was experiencing stress and had asked about the support available through occupational health. The context was of the claimant saying he was stressed at a meeting relating to his capability and the

claimant agreed that Dr Verma reasonably did not understand the claimant to be saying that he had a condition relating to stress.

14. According to the claimant's job description, clinical duties included taking a lead role in the management of acutely ill or traumatised patients. The qualities of leadership required as head of an accident team were stressed and it was anticipated that those qualities would be gradually learned through a process of supervision of more junior doctors and involvement in their education. The claimant was expected to utilise appropriately the available senior staff for advice i.e. the emergency medicine consultants. At his level, the claimant was expected to manage the emergency department in the absence of a consultant.

15. In May 2010, concerns were raised about the claimant's clinical ability, working relations with nursing staff and pace of work. There were suggestions that nursing staff had lost confidence in him. On 17 June 2011, concerns were raised about his poor management of 2 acute cases. Concerns were then raised about his management of paediatric cases in April 2014. The claimant was offered time on paediatrics to broaden his experience.

16. On 2 September 2014, a meeting took place between the claimant, Dr Cox and Mr Mohammed. They discussed concerns raised by a variety of colleagues, nursing and medical, junior and senior, about the claimant's attitude, behaviour, professional knowledge and skills, efficiency and the quality of his paediatric referrals. The claimant agreed to look at doing a professional development plan to be signed off by one of the consultants.

17. On 7 September 2014, Jenny Chambers, a senior nurse, emailed Dr Mark Davies, consultant in emergency medicine and clinical director, with concerns regarding how the claimant dealt with critically ill patients, saying that other nurses were saying that they did not feel confident or safe with the claimant in resus and that he did not listen to them when they raised their concerns or queries.

18. On 25 September 2014, the claimant initiated a meeting with Dr Paul Jarvis, consultant, to discuss the feedback he had received from Dr Cox and Mr Mohammed. The claimant said that he felt that a lot of the criticism directed at him could be attributed to a difference of opinion, but did acknowledge that he needed to improve the timeliness of his decision-making and the calibre of information/advice he gave to junior staff. He acknowledged that these issues had probably undermined his credibility with nursing staff. Dr Jarvis agreed to act as the claimant's educational supervisor to assist with these issues.

19. On 3 December 2014, Dr Jarvis noted that the claimant had not followed up on that meeting by arranging further sessions as had been agreed.

20. On 7 January 2015, Dr Davies wrote to the claimant stating that evidence received from numerous sources led him to believe that the claimant's current performance fell short of that of a competent experienced speciality doctor in emergency medicine. A 3 month retraining programme was arranged to commence on 26 January 2015. The claimant would not be

rostered on the clinical rota, but would work in a supervised supernumerary role where his key aim would be to undergo workplace-based assessments and supervised practice. He was advised that if he failed to engage or did not meet the required standards, then formal capability procedures would be invoked. The claimant agreed that at no stage thereafter did he ever suffer a reduction in pay or removal of out of hours payments.

21. By this time Dr Paul Jarvis was operating as the claimant's clinical and educational supervisor. Whilst the claimant maintained that he was not aware of Dr Jarvis operating then as his educational supervisor, Dr Jarvis certainly signed himself off as such in correspondence. Ordinarily, only those employed in training grades (beneath the claimant) would have an educational supervisor. Dr Davies subsequently became the claimant's educational supervisor until July 2021.

22. The claimant met with Dr Davies on 27 January 2015. The claimant expressed himself to be unhappy with the content of Dr Davies' letter and suggested that concerns expressed were inaccurate. Dr Davies expressed his own disquiet at this response, given that there were a number of concerns from a number of sources. Dr Davies said that the desire of the emergency medicine consultant team was to support and retrain the claimant to the level required. If that was not achieved, it might result in the claimant losing his job. The claimant welcomed then, he said, the opportunity for retraining and accepted the terms of the letter of 7 January.

23. On 5 May 2015, Dr Jarvis conducted a 3 month review of the claimant's retraining programme, concluding that he had engaged with it and received good feedback from supervisors. A 360° feedback from senior medical and nursing staff was awaited.

24. On 22 May 2015, Dr Davies wrote to the claimant after a review of progress the previous week. He confirmed that the next step would be for the claimant to move back onto the rota where his performance would be monitored and reviewed again in 3 or 4 months time. Following that period of retraining, he expected the claimant's performance to be maintained at the level expected of a middle grade doctor in emergency medicine. Should that not be the case and his performance be found to be below the expected level, formal competency procedures would be undertaken. Dr Davies said that he was conscious of some of the previous issues being a breakdown in communication between the claimant and some of the senior nursing staff at Calderdale Royal Hospital. A move to Huddersfield Royal Infirmary would mitigate against this. The claimant accordingly commenced working on the rota there. The claimant did not want to move from the Calderdale Hospital in Halifax, but accepted Dr Davies' decision.

25. The claimant and Dr Jarvis met on 22 July to review the 360° feedback received. This was described as mainly acceptable, but that the claimant appeared to have lost the confidence of the nursing and junior staff. The issue seemed to be around his team leadership, the quality of advice given to juniors and the clarity of his planning of patient care. That lack of confidence was echoed across the emergency medicine consultants. The claimant acknowledged that he needed to listen to the senior nurses more and that these were areas for development.

26. On 1 October 2015, Dr Jarvis collated consultant feedback on the claimant which included criticism that he was disorganised, indecisive, gave poor advice to juniors, lacked insight, had no focus and didn't listen. The claimant was also, nevertheless, described as pleasant and polite. The claimant told the tribunal that he accepted the criticisms of the departmental consultants. He agreed that there were a number of consistent and recurring themes in issues of performance raised about him, but said these arose from the moment he started work at Huddersfield.

27. An Extended Supervised Learning Event ("ESLE") took place in October 2015 which involved an extended observation and assessment of the claimant. The conclusion was that the claimant was struggling with his own clinical abilities and needed to start again with training. During the assessment, he had given an excessive dose of a drug to a patient.

28. On 9 December 2015, Dr Davies wrote to the claimant setting out concerns about clinical performance in 2 cases and referring to the case observed during the ESLE. He expressed the view that the claimant's decision-making had fallen below the standards expected and was a significant risk to patient safety. He instructed the claimant to discuss all his cases with a clinical emergency department consultant, not to work weekend shifts, not to advise junior doctors but refer them on for advice and not undertake any locum work outside the respondent. Dr Davies said that he would discuss the concerns with Dr Birkenhead, medical director. The claimant told the tribunal that he found it difficult to talk to Dr Davies because of a "fear factor" around him. He said that he would avoid Dr Davies. He did not dispute the content of the discussion, but said that he had been on his break and eating when he was approached by Dr Davies. He believed that Dr Davies had prejudged the outcome.

29. The claimant responded on 16 December setting out his view of the cases and saying that he thought that he had made all the right decisions in the ESLE case. He wanted to see the ESLE report. The claimant did say that he fully appreciated the help and support he had received from Dr Davies which he admitted had been during a stressful time for him. He said that it was difficult for him to tell junior doctors to refer to someone else when they asked him for help.

30. Dr Davies replied on 21 December 2015 saying that he had spoken to the ESLE reviewers who said that they had given immediate verbal feedback to the claimant on the cases observed. In any event, he attached the ESLE reports.

31. Before the tribunal, the claimant maintained that he did provide an explanation in respect of the cases he was criticised for, but accepted that he had made mistakes in both.

32. On 23 February 2016, Dr Birkenhead appointed Dr Verma, a consultant and divisional director, as case manager in respect of the claimant under the respondent's Procedures for Handling Concerns regarding Medical and Dental Staff Conduct and Capability. The tribunal has been referred to sections in that policy recognising that health problems can have an impact on clinical performance and that reasonable adjustments would be considered in line with the Equality Act. Where there was an incident that

pointed to a problem with the practitioner's health, the incident might need to be investigated to determine a health problem. Dr Verma wrote to the claimant on 25 April 2016 referring to concerns about the claimant's ability in relation to knowledge and management of patients and leadership and delegation, as well as the limited success of support measures put in place. He confirmed that he had discussed the concerns with the National Clinical Assessment Service ("NCAS") and was considering a remediation plan or NCAS assessment for the claimant. He wished to meet with him.

33. On 3 May 2016, Dr Davies met with the claimant to question him about the claimant having undertaken locum work outside the respondent despite the written instruction not to do so. The claimant admitted doing some locum work at Rotherham Hospital. He had not informed them or the agency through which he gained the work of concerns about his performance at the respondent. Dr Davies advised the claimant that he had acted against a direct written instruction and his behaviour posed a risk to patient safety. Dr Davies said that he intended to discuss the issues with Dr Birkenhead and that this may result in a referral to the GMC. The claimant told the tribunal that he had not taken in the specific direction regarding locum work at his meeting with Dr Davies or when he received the letter confirming the restrictions. The GMC had ultimately agreed that he had not acted dishonestly. Also, he thought that the restriction did not apply to working outside the respondent as a locum. He conceded in cross-examination that he could see the possibility of people thinking he was not reliable in the light of this breach.

34. On 9 May 2016, Dr Verma wrote to the claimant arranging a formal meeting to discuss his breach of instructions by undertaking locum work. That meeting took place on 12 May 2016 with an outcome letter provided dated 1 June 2016. The claimant was accompanied by Dr Lord of the Medical Defence Union. The claimant said that he was prepared to agree a remediation plan. The claimant had not yet informed the agency that he was unavailable for locum work, despite telling Dr Davies that he would do so. The claimant told the tribunal that he wished to discuss the issue with Dr Verma first. Dr Verma confirmed that he would refer the matter to the GMC. The claimant explained that he was experiencing stress and confirmed that he had been in touch with occupational health. Dr Verma advised him to speak to his GP in addition.

35. On 22 June 2016, Dr Birkenhead wrote to the GMC explaining the respondent's concerns about the claimant, the involvement of NCAS and remediation steps being considered. He made a referral in respect of the claimant undertaking locum work in contravention of a direct instruction and of failing to inform the agency of his position. On 28 September 2016 it was confirmed to the GMC that NCAS would not be conducting an assessment, but that a remediation plan was being produced.

36. Dr Davies became the claimant's educational supervisor from March 2017 to March 2021 and Dr Birkinshaw, emergency medicine consultant, undertook the role of the claimant's clinical supervisor over the same period.

37. The GMC proceeded to conduct their own assessment of the claimant under its fitness to practice rules and the assessment team's report was sent to Dr Birkenhead on 15 September 2017. The assessment team's

unanimous opinion was that the standard of the claimant's professional performance was deficient. The claimant was fit to practice only on a limited basis and there was a recommendation that he work at a more appropriate level such as junior specialty doctor equivalent to ST1/2 The assessment team found cause for concern in respect of the claimant's clinical management and working with colleagues. His record keeping and relationships with patients were assessed as acceptable.

38. The Medical Practitioners Tribunal Service issued interim orders to the claimant dated 3 October 2017 imposing conditions on the claimant for a period of 12 months for the protection of the public and because there may be a risk to patient safety. Conditions included that he must only work as a speciality doctor in emergency medicine at the respondent, not above a level of ST2 and that he must be closely supervised. Those orders were confirmed by the GMC to Dr Birkenhead on 12 October 2017. The letter stressed that these were interim orders and there were no findings against the claimant. There was a continuing investigation.

39. When put to Dr Davies that the GMC had put a ceiling on the claimant working at level ST2, whereas he had placed greater restrictions on the claimant (representing, because of the claimant's need to refer each patient to a more senior doctor, the foundation level FY1 for someone straight out of medical school), he said that the GMC did not assess the claimant's insight. Dr Davies main concern was that the claimant believed he was in fact operating at ST4 level or higher. A competent ST2 level doctor knew that they were working at that level and knew that they were not at ST4 level. The claimant didn't know what he didn't know. Dr Davies said that he assessed the level of appropriate restrictions to be placed on the claimant 2 years before the GMC's own assessment. Dr Davies rejected in cross-examination the suggestion that as soon as he had placed the initial restrictions on the claimant, the claimant was on the way out. He responded that the respondent was of the opinion that the claimant was a risk to patients, but that did not mean they wanted him out and they did all they could to support him – a huge investment to get him to the level they felt he needed to be at. The tribunal accepts that there is evidence of such an investment and a significant level of patience on the respondent's part.

40. On 5 January 2018, the claimant was asked by the GMC to agree to a series of undertakings about his practice. It was recorded that his fitness to practice was currently impaired. It was recorded that he had indicated that he was prepared to accept undertakings and that these were felt sufficient to protect patients and maintain public confidence. They included designing a personal development plan to address deficiencies in patient assessment, maintaining professional performance, clinical management, working with colleagues, handover and prescribing. They included also having an educational supervisor, only working at ST1/2 level in emergency medicine and getting advance approval before working as a locum. He would also be required to undertake an assessment of performance by the GMC.

41. On 30 January 2018, Dr Birkenhead wrote to Dr Lord regarding sharing a draft NCAS Back on Track action plan with the claimant. He referred to having given consideration to the claimant's request to be based at Calderdale hospital, but that the request could not be accommodated as the claimant's clinical supervisor was based at Huddersfield.

42. On 8 March 2018, the GMC informed Dr Birkenhead that the claimant had accepted the schedule of undertakings which came into effect on 19 February 2018.

43. Also, on 8 March 2018, Dr Verma wrote to the claimant summarising a discussion with him and Dr Lord on 6 March where the claimant agreed to a NCAS Back on Track action plan to be implemented from 12 March 2018. The claimant accepted in cross- examination that the intention of the plan was to remediate his clinical practice. The plan was to be completed over 9 months, although the claimant accepted that in his case he was given 11 months, he said because of some absences from work. He agreed that it was tailored to the GMC assessment of him and that it provided that the overall time allotted would not be extended. The plan provided that a failure to progress might result in the case being considered by a formal panel in accordance with the respondent's capability procedures. The claimant said that the plan assumed he would be working at ST2 level.

44. When put to the claimant that the restrictions imposed by Dr Davies on his practice did not stop him from demonstrating higher-level reasoning, the claimant said that that is what he kept demonstrating, but it was not appreciated by Dr Davies and the restrictions were not removed. Others believed he could work at ST1/2 level. It was put to the claimant that the periodic ACATs (a type of observation of a doctor) and ESLEs the claimant undertook were an opportunity to show that he could work at his contracted ST4 level, he did not disagree, but said that foundation level doctors and those at ST1/2 never did ESLEs. That was put to the claimant to be an example of him being able to show that he could operate at a higher level. The claimant's response that he was only doing the technical part of any ESLE and given that there was still a requirement for him to discuss patients with consultants, it was construed that he was only managing to see a fewer number of patients. It was put to him that Dr Davies position was that he was working at ST1/2 level, but supervised as an FY1 doctor. He was nevertheless able to demonstrate competency at ST4 level.

45. A review meeting of that action plan took place on 14 June with an outcome provided on 27 June. The claimant had reported that he was pleased with his progress and his confidence was building. He acknowledged the support he was receiving from his mentor, Dr Lockey and his coach, Mr Prasadu. Dr Verma said that the feedback he had received was that the claimant was engaging in the process. The claimant said he was apprehensive about making mistakes and was taking more time than normal with cases and overdoing things. Lack of documentation was discussed and a failure to prescribe antibiotics to a patient on discharge which led to the patient's subsequent return to the emergency department. The claimant it was noted had failed his Advanced Paediatric Life Support and Dr Davies reported that the course director had described serious concerns about the claimant's lack of knowledge, skills and team working. Whilst workplace-based assessments had been completed, there were repeat learning points suggesting that the claimant was not putting learning into practice. The claimant was reminded not to advise junior colleagues and to direct them to others for advice. In one case he had advised a junior colleague which had led to a missed neck injury. The conclusion was that the claimant had achieved or partially achieved the actions and milestones for the first 3

months, had demonstrated an increased theoretical knowledge, but needed to transfer the theory into practice. Dr Roy was to undertake 1 ESLE per week over the next 6 weeks.

46. The plan was further reviewed at a meeting with Dr Verma and Dr Davies on 9 August 2018 the outcome of which was confirmed by letter of 13 September. Dr Verma reminded the claimant that the programme was 9 months long and at the end the claimant had to be signed off as performing at the level required to continue in his position as a middle grade doctor in the department. The claimant confirmed that he understood this and the implications if he failed to achieve the required standard. Clinical supervisor reports suggested good knowledge on the claimant's part, but that this was not borne out in clinical practice. The claimant was lacking organisation or an ability to multitask. A number of significant learning points been identified in the 3 ESLEs undertaken by the claimant in the past 3 months. These included poor history taking, the claimant rarely engaging the patient in consultation, repeating the same questions and appearing not to listen to the answers, not communicating management plans to the nurse in charge and slow decision-making. It was said that the claimant was working at the level of a junior trainee ST1/2. Dr Verma advised the claimant that his rate of progress was concerning and that he needed to be at level ST4-6 to remain in a middle grade doctor post in the department. The plan was to meet again in October and by then the claimant was to have completed another 3 ESLEs. Failure to progress, it was said, might lead to a formal capability panel.

47. Mr Prasadu completed a coaching report on 1 November saying that the claimant engaged with the process and his impression was of someone who took the process very seriously and did his best to comply with the requirements of the plan. Mr Prasadu described providing assistance with the claimant's personal psychological development, including stress and anxiety management, assertiveness and communication strategies.

48. A further progress review meeting took place on 1 November 2018 with Dr Verma and Dr Davies. Dr Lord attended by phone. It was noted that the claimant demonstrated good theoretical knowledge and good relations with patients and staff. Observations of interactions with patients (ACATs) and the ESLEs continued however to demonstrate a failure to convert clinical knowledge and skills into practice. There was a consistent failure to take a structured history and examination in a way which demonstrated appropriate clinical reasoning. Clinical decision-making was slow and inconsistent. Dr Verma's view was that they were at month 7 of a 9 month programme and the claimant was no further on than the month 3 stage at best. The claimant told the tribunal that this did not come as a surprise. Dr Verma queried whether the claimant could achieve all the milestones in the last 2 months of the plan. The claimant said that he would probably need more time, but Dr Verma said that there was no more time. If the standards were not achievable there would be a capability panel process. When invited to comment, Dr Lord, present as the claimant's representative, described the situation as difficult and that the claimant needed to hear it, as he himself was worried for the claimant. Could the claimant manage the department, he questioned. Dr Lord saw the capability process could lead to the claimant's dismissal. Dr Lord queried whether there was anything else that the claimant could pull out of the hat in the next 2 months, which

was something he said that the claimant needed to do. He described the claimant as having focused on the theoretical, but that he needed to focus on application. The claimant recognised that he needed to show a turnaround in 2 months.

49. When asked by Dr Verma if the claimant needed anything else from the respondent, the claimant said that he wanted to transfer back to work at Calderdale Royal Hospital. Dr Davies said he was concerned that he had been there originally and had come to Huddersfield for a fresh start. Dr Davies said that changing the claimant's clinical supervisor would be detrimental unless the claimant had concerns about Dr Birkinshaw. The claimant said he had concerns, not about Dr Birkinshaw's ability, but about interpersonal relationships. The claimant said that he did not get inspiration from him. Dr Verma noted that Dr Birkinshaw had been the claimant's supervisor for 7 months and this had been the first time the claimant had raised such issues. After further discussion, the claimant said that he could continue with Dr Birkinshaw. The claimant said that the respondent had helped him a lot.

50. The claimant's evidence is that during 2017/2018 he lost confidence which started to affect his mental health causing him to question his every ability and knowledge. He agreed that he did not mention this to Dr Davies or Dr Verma. He was fearful of speaking to Dr Davies and, whilst he could have spoken to Dr Verma, he said that he feared he would pass the information on to Dr Davies. When put to him that this meant that the respondent had no knowledge of his mental health condition he confirmed: "initially, yes". He said that he had discussed his mental health with his representative, Dr Lord but asked him not to pass the information on. The claimant said that it was very difficult for him due to feelings of embarrassment and fear.

51. A final review meeting took place on 11 February 2019. It was noted that the claimant had been out of the country on 3 occasions since November because of family illness which had disrupted his efforts, but he thought he had made progress. He thought he had hit the milestones to perform at ST5/6 and run the department independently. Dr Davies could not see examples from ACATs or ESLEs of an improvement in the application of clinical knowledge. The claimant had undertaken none of those assessments since November. The conclusion was that there had been no significant progress such that the next step was to discuss the case with the Medical Director to decide whether there should be a formal hearing to consider capability. The claimant told the tribunal that Dr Birkinshaw ceased providing the claimant with a designated period out of his consultant's hours of 4 hours per week to enable the claimant to discuss his clinical practice and which had endured during the period of the plan. Dr Lord asked if more time could be given to the claimant to show an improvement, but Dr Davies queried what would be different and was not sure if there was anything they could do differently. He said nothing on the assessment showed there to have been an improvement, asking the claimant to comment. The claimant replied that he couldn't think of anything.

52. The successor to NCAS, NHS Resolution - Practitioner Performance Advice ("PPA") wrote to Dr Verma on 23 May 2019 following a conversation with him on 9 May. He had contacted them to discuss concerns about the claimant. Their letter referred to the last advice being the implementation of

a local remediation process. Dr Verma had informed PPA that this had been completed, but that the claimant had failed to achieve the expected standard. Despite engaging well with the process, he had not shown that he could work independently at ST4/5 level. He had a good knowledge base, but could not apply it adequately in clinical settings. The option of referring the claimant to PPA for a clinical assessment was discussed. Dr Verma had been unsure that it would offer any more information than they already had, but had said that he would raise it with his medical director.

53. HR emailed the claimant on 6 June 2019 with an updated remediation plan to be discussed at a meeting on 18 June. It was said that Dr Verma would feed back to him discussions he had with the medical director and with PPA.

54. PPA wrote to Dr Verma further on 17 June with further information regarding what was required in any referral for a clinical assessment. Dr Verma was encouraged to ensure that the claimant had support from OH during this "difficult time".

55. The claimant met with Dr Verma and Dr Davies accompanied by Dr Lord on 18 June 2019 to discuss the possibility of a PPA clinical assessment. On 16 July the claimant was provided with documentation for him to review and complete for a PPA referral. On 4 October 2019 the referral application and supporting documentation was sent to PPA.

56. On 18 October the PPA Consideration Group responded with the recommendation that an assessment of the claimant should not be offered. They did not consider that an assessment would add to what was already known as there had already been the GMC assessment in 2015 which led to the development of an action plan to address its findings. The claimant, it was said, had failed to achieve the milestones in that plan and had failed to improve his practice to the required level from when concerns were first identified in 2010. On 1 November, the claimant requested a reconsideration of that recommendation. The PPA responded on 6 December saying that their recommendation remained that a clinical assessment should not be offered. It was stated: "The Group took into account the history of prior assessment by the GMC and the 3 action plans for remediation which have been carried out. One of these was drafted by our service and would be very similar to anything likely to arise post a clinical assessment given that the nature of the concerns have provided consistent themes over nearly a decade, particularly with regard to communication and clinical management. The Group considered that an assessment was unlikely to add appreciably to what is already known about the concerns."

57. On 13 March 2020 a case report detailing the concerns about the claimant's capability was compiled by Dr Davies and Ms Robinson, HR business partner and sent to the claimant.

58. The claimant sent his comments on that report on 6 April.

59. On 9 June, Dr Birkenhead wrote to the respondent's chief executive stating that the claimant had not made the necessary progress through his remediation programme as developed with NCAS and had therefore not demonstrated the required competence to allow him to function as a middle grade doctor in accident and emergency medicine. He recorded that they

had agreed that it was now necessary to institute formal Maintaining High Professional Standards (MHPS) proceedings on the grounds of capability. On 10 June Dr Birkenhead appointed Dr Verma as the Case Manager under those procedures. He wrote to the claimant on 29 June informing him that an investigation into his capability was to be undertaken by Dr Rebecca Isles, consultant in emergency medicine and Mrs Leigh-Anne Hardwick, HR business partner. Allegations were set out as follows: you have failed to achieve the competency set out in the NCAS Practitioner Action Plan of June 2018; you are not capable of working independently at the expected standard of ST4-6 level; there are no further reasonable steps that you all the respondent can take to enable you to achieve that standard; you do not have confidence of specialty consultants or nursing colleagues and you do not have insight into your position. The terms of reference for the investigation were to establish the facts about the claimant's practice and progress, what concerns remained and whether any further reasonable steps would enable the claimant to achieve the required ST4-6 standard.

60. Dr Isles and Mrs Hardwick wrote to the claimant on 11 September regarding the scheduling of a meeting with the claimant. They also said that Dr Verma had asked them to investigate 2 incidents reported to the GMC in March 2020 by Dr Davies. These related to the claimant's treatment on 22 October 2019 of an elderly patient taking rivaroxaban and of his treatment of a man in his 50s presenting with chest pain on 20 February 2020.

61. An investigation meeting took place with the claimant, accompanied by Dr Lord, on 22 September 2020. The questioning included the aforementioned incidents. Interviews with emergency department consultants and nursing staff took place from August – November 2020.

62. On 9 October 2020, Dr Davies submitted to the investigators details of further incidents involving the claimant in the preceding days.

63. The investigation report was completed in November 2020 and sent to the claimant on 14 January 2021. The claimant was asked to respond with any comments on the factual content which Dr Verma said he would consider when determining the next steps. He said that that might include a referral to a formal capability meeting. If the claimant did not respond, he would consider the report and make a decision without his input. He appreciated that it had been a difficult time for the claimant and reiterated an offer of health and well-being support. The claimant responded by email of 27 January which referred briefly to the shadowing work he had undertaken.

64. Dr Verma wrote to the claimant on 17 February. He went through the history of the monitoring of the claimant's performance and said that he had decided that there were serious concerns about the claimant's capability which should be considered by a capability panel. The allegations against the claimant and which would be considered by the panel were repeated.

65. The claimant undertook a routine educational supervision meeting with Dr Davies on 17 March 2021. The claimant described himself as having returned refreshed from a period of annual leave having recently been feeling down, partly as a result of the situation he found himself in, but also due to a flareup of a physical health condition. He said that he had received support, particularly from the psychologist, Mr Prasadu. He said that the

issues were now both under control and he had no ongoing health concerns. He felt that he was in a good place to move forward. The claimant said that he remained keen to move to Calderdale Royal Hospital as he felt that would be a new beginning and improve his confidence. Dr Davies said that he would raise that with Dr Verma as case manager. There was discussion about the need for a new clinical supervisor given that Dr Birkinshaw had left the respondent. Dr Davies then raised that he had been informed that the claimant had raised concerns about his own interactions with the claimant and questioned whether the claimant was happy for him to continue as his educational supervisor. The claimant said that he would have to consider that question further before making a decision. On 22 March 2021 the claimant emailed Dr Davies saying that he had decided that he needed a change in educational supervisor continuing: "I'm sorry to have to take the decision, but I think that is the best way forward for me. Thanks a lot for helping me over these difficult times."

66. On 15 April 2021 an Employment Adviser at the BMA contacted the respondent on behalf of the claimant who had been in touch regarding a breakdown in his relationship with Dr Davies and attaching a bullying and harassment complaint regarding Dr Davies. It was said in the email that it had come to the point where the claimant's mental health had suffered considerably. A meeting took place on 26 May 2021 involving the claimant and the BMA about that complaint. During the interview undertaken with the claimant he was asked if he was getting support was mental health from occupational health. The claimant replied: "I am taking medicines now – has gone too far." A report was produced of the concerns to be considered.

67. On 10 June 2021, Dr Verma sent to the claimant documentation about concerns which had occurred since 13 March 2020 in anticipation of a capability hearing on 15 July 2021.

68. The claimant submitted a statement in his defence. He referred to having been put under extreme pressure by Dr Davies and subjected to inappropriate behaviour by him. He believed that he was put under extra pressure to make him make more mistakes and this resulted in him losing all confidence while seeing patients. He described calling occupational health on one of those occasions in 2016, which resulted in a discussion with the clinical psychologist, Mr Prasadu. He said that he had been meeting with Mr Prasadu up until last year but felt he could not tell anyone except him about his problems and requested anonymity. He said that his GP was also aware of his condition, but they decided to keep away from medication until he had to start it late the previous year.

69. The capability panel met on 15 July 2021. It consisted of Mr G Boothby, director of finance, Helen Barker, chief operating officer and Dr Smith medical director from Bradford Teaching Hospitals Trust. The panel was assisted by Dr Wass as an external consultant in emergency medicine employed at the Mid Yorkshire Trust. Dr Verma and Ms Robinson attended to present the management case. The claimant was accompanied again by Dr Lord.

70. The panel had an 893 page bundle of documents before them. The claimant's position was that he was able to work at ST4 level, but that Dr Davies had prevented him from doing so. On questioning, the claimant said

that he did not know why he was required to work at a lower level, but then conceded that it was because of patient safety concerns

71. Amongst many other things, the panel considered the aforementioned specific cases raised as examples of failures in the claimant's clinical practice. One case involved a patient with a bleed in the head who was taking an anticoagulant, rivaroxaban, which increased the risk of bleeding. The claimant was said not to have considered reversing the coagulant himself and then not reversing it when told to by Dr Isles. Dr Davies had spoken to Dr Isles at that time. When asked to explain the matter at the subsequent appeal hearing, Dr Davies referred only to the aspect of a failure to follow instructions. He agreed that his explanation was not explicit. Dr Davies agreed that in Dr Isles' summary of the allegations on 14 September 2020, she identified only the other aspect i.e. the claimant's own failure to reverse the anticoagulant. It was noted that when Dr Isles questioned the claimant, she did not challenge him when he did not refer to himself as not having complied with an instruction from her to reverse the anticoagulant. Dr Davies said that the claimant would never have been taken to a capability hearing just because he did not hear an instruction. It would be expected that someone of the claimant's knowledge would reverse the anticoagulant himself.

72. Another incident related to a CT scan in September 2019 on a 106 year old patient. The criticism here was that the claimant asked for a CT scan to be carried out on the patient's head but not on her neck as well. It was raised with Dr Davies in cross-examination that the claimant's account differed from that of Dr Mapatuna. Dr Davies said that he had checked the clinical notes and had seen that a request was first made for a scan of the head only and then, only subsequently, for the head and neck. He considered that this record confirmed Dr Mapatuna's account.

73. A third incident raised involved the interpretation of an ECG scan. Dr Davies explained that he had been involved in this incident himself. He had seen a patient who had returned a blood test which suggested a significantly raised heart rate. On the computer it looked like the patient was still in the waiting room. This caused him to go to the emergency department to see if the patient was receiving the appropriate care. At that point, the patient was by then in the resus area. Dr Garside told Dr Davies that he had identified abnormalities based on the ECG and had initiated tests. The claimant had initially seen the patient and had interpreted the patient as having exhibited a normal ECG result. The claimant had told Dr Davies that the ECG result was the same as a previous one. Dr Davies had shown him the previous scan, but the claimant had not been able to recognise differences that were evident to Dr Davies. Dr Davies believed that the claimant had misinterpreted the scan. He said that the claimant's account of this incident had changed during the internal capability process. Before the tribunal, the claimant did not accept what Dr Davies was saying, but accepted that he had been mistaken as to which ECG scan he had been looking at.

74. Dr Davies also referred, in the context of the claimant allegedly discharging patients without consultant approval, to a 16 year old with palpitations who the claimant had diagnosed as having a sore throat but without recording any record of a discussion regarding palpitations. Dr Davies discussed the patient with the claimant who he believed couldn't explain why the issue of

palpitations had not been discussed with the patient. The claimant said that the patient had not mentioned palpitations Dr Davies view was that the patient had to be recalled in circumstances where palpitations were mentioned on the patient referral and where an ECG had been carried out.

75. Dr Davies told the panel that he didn't believe that the claimant could be employed in a different post or at a different level because his lack of insight placed patients at risk.

76. The claimant was informed by letter of 23 July 2021 of the decision to terminate his employment on notice, which he would not be required to work. The panel found each of the aforementioned allegations proven except for the allegation relating to not having the confidence of speciality consultants or nursing colleagues which was found to be partially proven. By letter of 6 August 2021 the claimant was given a more detailed explanation of the panel's findings.

77. The panel concluded that the claimant had failed to achieve the competencies set out in the NCAS action plan of June 2018 which had been agreed with him. He was aware at all times of the consequences of failing to meet the required standards. It had heard no compelling argument that the reason for him failing to achieve competencies related to the site he was working at or the perception of colleagues. The evidence conclusively established that he had failed to achieve the competencies. The panel concluded that the claimant was not capable of working independently at the expected standard of ST4-6 level. It accepted that examples have been given of poor clinical practice. It considered that the claimant had sufficient opportunity to show that he was capable of working at a higher level, but had failed to do so. The best objective evidence was from the GMC assessment which indicated that the claimant was able to practice only at level ST1/2. None of the separate assessments and training plans the claimant had been put through had identified further support which would enable the claimant to achieve the required standard. There was evidence of comprehensive support provided to the claimant over a period of 10 years. The panel did not believe that the claimant had insight into his own position. It had not heard any action the claimant believed he could take to remedy the performance issues. Many errors discussed at the hearing had been dismissed by him as not being his fault, but the assessments of Dr Davies and Dr Birkinshaw were preferred. The perception gap demonstrated in the claimant's 360° feedback was described as unusual. Ms Barker in cross-examination conceded that there were only modest differences in some feedback she was taken to between the claimant's assessment of himself and how others regarded him. She said that the feedback was a factor only and not the reason for the claimant's dismissal. The tribunal accepts that evidence. The panel took the advice of the independent expert assisting it. Whilst considering alternatives to dismissal, the panel was clear that the claimant failed to attain competency standards required for over 10 years despite intensive support. It considered that the only appropriate option was to terminate the claimant's employment on the grounds of capability. Ms Barker described the claimant as not being a safe independent practitioner in circumstances where patient safety is paramount. She considered that he could not remain working, even at his current junior level, without endangering patients or imposing an unsustainable supervisory burden on colleagues. The claimant could not be

relied on to follow instructions in the future and, again, had no insight into his failings.

78. The claimant appealed that decision by letter of 25 August 2021. Arrangements were made for his appeal, which took place on 18 and 21 January 2022 after the claimant's employment had terminated on 23 October 2021. The appeal was heard by a panel consisting of Mr Carlo Breen, a barrister, Ms Karen Heaton, non-executive director and Dr John Adams, medical director of Leeds Teaching Hospitals. An external adviser to the panel from Leeds Teaching Hospitals also attended, Mr Bush, medical director and emergency medicine consultant.. The panel received HR advice from the director of workforce, Suzanne Dunkley. Dr Verma and Ms Robinson again presented the management case. The claimant was again accompanied by Dr Lord.

79. When Dr Davies was interviewed, Dr Adams asked him if he had been aware if the claimant was seeking help with mental health. Dr Davies' position was that he was aware that the claimant had been seeing Mr Prasadu for psychology counselling through occupational health, but not that the claimant had any mental health problems. He said that the claimant had only ever told him that he found the process, i.e. the capability process, stressful. He could understand that, which was why the claimant was seeing Mr Prasadu as part of a course of coaching during the remediation.

80. Dr Adams also asked the claimant about him having help from occupational health, querying whether the claimant explained to anyone else how mental health issues were impacting his performance. The claimant described being advised to talk to Mr Prasadu as a clinical psychologist when he became restricted in his practice. He attended appointments with him. He referred to speaking to his GP sometime in 2017, but had resisted taking medication. The claimant did not address the question as to how his health impacted his performance. Mr Breen asked the claimant why he thought he was regarded as not able to function at a higher level. The claimant said that when he started working at Huddersfield he was getting more anxious and the imposition of restrictions was a big blow. When asked on what basis he was saying that the capability panel had not considered his mental health issues, the claimant said that he was not sure whether they actually gave enough thought to those factors "which could have resulted in my work ability and my efficiency". He confirmed that he had not presented any psychiatric evidence to the capability panel.

81. During the appeal, when questioned by the claimant, Dr Davies said that he thought that the claimant's decision-making was probably at ST1 or ST2 level, but that the claimant's own opinion of himself was that he was working as a ST4. He said that it was that which made it unsafe for the claimant to work as an ST1. The claimant countered by saying that he was talking about having to work at FY1 level, with which Dr Davies is recorded as agreeing. Dr Davies explained to this tribunal that the claimant was being paid as a speciality doctor. He was functioning at ST1/2 level, but supervised at FY1 level.

82. An FY1, he told the tribunal, has to discuss virtually every patient with a senior doctor or consultant before they can discharge them or make a plan. They are straight out of medical school and acted, he said, essentially as

information gatherers. At FY2 a doctor will start to make decisions but will still seek a lot of advice. An ST1 level doctor will make more advanced decisions, but is still junior and would ask for help in around half of his cases. ST2 level doctors spent a period gaining different competencies outside of emergency medicine. At ST3, the aim is to consolidate knowledge and expand decision-making. Such doctors see many of the patients on their own, but still go for help. At ST4, the doctor works for the vast majority of his time independently, but can still get support from a consultant at home and can also supervise and support more junior doctors. By being supervised at FY1 level, this did not mean that the claimant could not perform at a higher level. When going to a consultant with every issue he was in a position to be able to evidence that his decision-making level was significantly higher than FY1. Dr Davies' view was that the claimant was able to show higher level practice, but the FY1 level of supervision had to be in place because patient safety was otherwise at risk.

83. A FY1 doctor would typically come with information and ask what to do. An ST1 would have the basis of a plan and could explain the rationale for that in part, but part of his reasoning was likely to be that they were acting in a particular way because that was always what one did. At ST3 level and above, the doctor started to think of other elements in a case which might not be immediately obvious. Just because the claimant was supervised at FY1 level did not mean that he did not have the scope to come up with an insightful plan.

84. It was put to Dr Davies that at the first capability hearing, Dr Umakanthan had given evidence that what the claimant was doing was working at FY1 level. He was referred to a similar comment in Dr Isles' investigation report of November 2020. Dr Davies said again that that was the level of supervision. The level a doctor at was whatever the level of expertise he actually demonstrated.

85. When put to Dr Davies that at the capability hearing Dr Saquib had said that he could not judge the claimant's ST4 level competencies because of the level at which the claimant had been working, Dr Davies said that there were 2 elements of the work of an ST4 doctor. The first was the ability to make clinical decisions at that level. The second element was to supervise junior doctors and manage the department. ST4 level was the level where you could be the senior doctor left in charge of the department. However, a doctor had to have the clinical decision making ability before he could supervise others in their clinical decisions. Dr Davies agreed that the restrictions did stop the claimant from carrying out supervisory functions. Essentially, the respondent couldn't trust him to supervise others because they couldn't trust his own decisions with patients.

86. By letter of 4 February 2022 the claimant was informed that the decision to terminate his employment was upheld. In its conclusions, the panel referred to the claimant's mental health issue. It noted that, when presenting his case, he suggested that there had been no support with his mental health. The panel had, however, seen evidence of support including psychological support. The claimant also completed the respondent's health and well-being risk assessment which led to the offer of support from occupational health.

87. The panel believed that the sanction of dismissal was reasonable and appropriate on the evidence. There had been a fair and reasonable investigation. It was satisfied that fault had been shown in the claimant in the examples of poor clinical practice relied on. Mr Bush, as external medical adviser, had reviewed the cases and was satisfied that criticism of the claimant's practice was fair and justified.

88. Issues have arisen regarding the claimant's relationship with Dr Davies and Dr Davies behaviour towards him. Indeed, at the appeal hearing he referred to Dr Davies as shouting at him and of telling him not to come into the hospital. Dr Davies denied to the panel shouting at the claimant. The claimant in evidence before this tribunal referred to having been sent home by Dr Davies, but conceded this was a single occasion when there was an issue regarding the claimant possibly having Covid.

89. The claimant, as noted already, said that he was fearful of Dr Davies. Dr Davies did not accept that they had a fractious relationship. Dr Davies did not do regular clinical work in the latter period, but they did chat briefly when they saw each other. During 2019/2020 he just did one shift per week in the emergency department and then mostly on a Monday evening. The claimant's position is that Dr Davies had rebuked him in the middle of the Department with a raised voice and that he had been rude and angry, with a red face. Dr Davies said he could not recall such an incident at all. He said that there are a number of times that he had to speak to the claimant as his clinical director and be assertive and direct because issues of patient safety were involved. He apologised if that had been interpreted as him being angry. They were also, during the period when the claimant was under a capability process, still having pleasant conversations and he said that his tenor was always supportive with an emphasis on patient safety. However, at times he did have to give specific instructions. Dr Davies did not accept that the claimant had been put under extreme pressure to cause the claimant more stress so that he would make more mistakes. He said that his role was to challenge doctors if they made inappropriate decisions to help them develop. After virtually every conversation he had with the claimant, the claimant had said that he appreciated it and thanked him for support.

90. Dr Davies said that when a handover took place at the change of a shift, all the doctors got together and patients were presented by junior doctors. Dr Davies and, he said, all other consultants use this as an opportunity to teach and to better understand people's decision-making. In a case where a doctor had significant learning to undertake there would inevitably be a need for more questions of that doctor, because his decision-making might be more open to question.

Applicable law

91. In the Equality Act 2010 discrimination arising from disability is defined in Section 15 which provides:-

> *"(1) A person (A) discriminates against a disabled person (B) if –*
> *A treats B unfavourably because of something arising in consequence of B's disability, and*

A cannot show that treatment is a proportionate means of achieving a legitimate aim.

92. The tribunal must determine whether the reason for any unfavourable treatment was something arising in consequence of the claimant's disability – this involves an objective question in respect of whether "the something" arises from the disability which is not dependent on the thought processes of the alleged discriminator. Lack of knowledge that a known disability caused the "something" in response to which the employer subjected the employee to unfavourable treatment provides the employer with no defence – see **City of York Council v Grosset 2018 ICR 1492 CA**.

93. Any unfavourable treatment must be shown by the claimant to be as a result of something arising in consequence of the claimant's disability, not the claimant's disability itself. The EHRC Code at paragraph 5.9 states that the consequences of a disability "include anything which is the result, effect or outcome of a disabled person's disability". It has been held that tribunals might enquire as to causation as a two-stage process, albeit in either order. The first is that the disability had the consequence of "something". The second is that the claimant was treated unfavourably because of that "something". In **Pnaiser v NHS England 2016 IRLR 170 EAT** it was said that the tribunal should focus on the reason in the mind of the alleged discriminator, possibly requiring examination of the conscious or unconscious for process of that person, but keep in mind that the actual motive in acting as the discriminator did is irrelevant.

94. Disability needs only be an effective cause of unfavourable treatment - see **Hall v Chief Constable of West Yorkshire Police 2015 IRLR 893**. The claimant need only establish some kind of connection between his or her disability and the unfavourable treatment. On the other hand, any connection that is not an operative causal influence on the mind of the discriminator will not be sufficient to satisfy the test of causation. If an employee's disability-related absence, for instance, merely provided the circumstances in which the employer identified a genuine non-discriminatory reason for dismissal, then the requisite causative link between the unfavourable treatment and the disability would be lacking. The authorities are clear that a claimant can succeed even where there is more than one reason for the unfavourable treatment. As per Simler J in the Pnaiser case: "The "something" that causes the unfavourable treatment need not be the main or sole reason, but must have at least a significant (more than trivial) influence on the unfavourable treatment, and so amount to an effective reason or cause for it". Further, there may be more than one link in a chain of consequences.

95. The duty to make reasonable adjustments arises under Section 20 of the 2010 Equality Act which provides as follows (with a "relevant matter" including a disabled person's employment and A being the party subject to the duty):-

"(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.

96. The tribunal must identify the provision, criterion or practice applied, the non-disabled comparators and the nature and extent of the substantial disadvantage suffered by the claimant. 'Substantial' in this context means more than minor or trivial.

97. The case of **Wilcox –v- Birmingham Cab Services Ltd EAT/0293/10/DM** clarifies that for an employer to be under a duty to make reasonable adjustments it must know (actually or constructively) both firstly that the employee is disabled and secondly that he is disadvantaged by the disability in the way anticipated by the statutory provisions.

98. Otherwise in terms of reasonable adjustments, there are a significant number of factors to which regard must be had which, as well as the employer's size and resources, will include the extent to which the taking the step would prevent the effect in relation to which the duty is imposed. It is unlikely to be reasonable for an employer to have to make an adjustment involving little benefit to a disabled person.

99. In the case of **The Royal Bank of Scotland –v- Ashton UKEAT/0542/09** Langstaff J made it clear that the predecessor disability legislation, when it deals with reasonable adjustments, is concerned with outcomes not with assessing whether those outcomes have been reached by a particular process, or whether that process is reasonable or unreasonable. The focus is to be upon the practical result of the measures which can be taken. Reference was made to Elias J in the case of **Spence –v- Intype Libra Ltd UKEAT/0617/06** where he said: *"The duty is not an end in itself but is intended to shield the employee from the substantial disadvantage that would otherwise arise. The carrying out of an assessment or the obtaining of a medical report does not of itself mitigate, prevent or shield the employee from anything. It will make the employer better informed as to what steps, if any, will have that effect, but of itself it achieves nothing."* Pursuant, however, to **Leeds Teaching Hospital NHS Trust v Foster UKEAT/0552/10**, there only needs to be a prospect that the adjustment would alleviate the substantial disadvantage, not a 'good' or 'real' prospect.

100. If the duty arises, it is to take such steps as is reasonable in all the circumstances of the case for the respondent to have to take in order to prevent the PCP creating the substantial disadvantage for the claimant. This is an objective test, where the tribunal can indeed substitute its own view of reasonableness for that of the employer. It is also possible for an employer to fulfil its duty without even realising that it is subject to it or that the steps it is taking are the application of a reasonable adjustment at all.

101. In a claim of ordinary unfair dismissal, it is for the employer to show the reason for dismissal and that it was a potentially fair reason. One such potentially fair reason for dismissal is a reason related to capability pursuant to Section 98(2)(a). This is the reason relied upon by the respondent. The tribunal refers to **Alidair Ltd v Taylor 1978 ICR 445** – it is sufficient that the employer honestly believes on reasonable grounds that the employee is incapable. If the Respondent shows a potentially fair reason for dismissal, the Tribunal shall determine whether dismissal was fair or unfair in accordance with Section 98(4) of the Employment Rights Act 1996 ("ERA"), which provides:-

> *" [Where] the employer has fulfilled the requirements of subsection (1), the determination of the question whether the dismissal is fair or unfair (having regard to the reason shown by the employer) –*
> *depends upon whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee, and*
> *shall be determined in accordance with equity and the substantial merits of the case".*

102. Classically in cases of performance related capability a tribunal will consider whether an employee was aware of the risk of dismissal and was given a reasonable opportunity to show and improvement and with reasonable support. Were any alternative employment opportunities or changes to the employee's role reasonably considered? The tribunal has to determine whether the employer's decision to dismiss the employee fell within a band of reasonable responses that a reasonable employer in these circumstances might have adopted. It is recognised that this test applies both to the decision to dismiss and to the procedure by which that decision is reached.

103. A dismissal, however, may be unfair if there has been a breach of procedure which the tribunal considers as sufficient to render the decision to dismiss unreasonable. The tribunal must have regard to the ACAS Code of Practice on Disciplinary and Grievance Procedures 2015.

104. If there is such a defect sufficient to render dismissal unfair, the Tribunal must then, pursuant to the case of **Polkey v A E Dayton Services Ltd [1998] ICR 142** determine whether and, if so, to what degree of likelihood the employee would still have dismissed in any event had a proper procedure been followed. If there was a 100% chance that the employee would have been dismissed fairly in any event had a fair procedure been followed, then such reduction may be made to any compensatory award. The principle established in the case of **Polkey** applies widely and beyond purely procedural defects.

105. In addition, the Tribunal shall reduce any compensation to the extent it is just and equitable to do so with reference to any blameworthy conduct of the Claimant and its contribution to his dismissal – ERA Section 123(6).

106. Under Section 122(2) of the ERA any basic award may also be reduced when it is just and equitable to do so on the ground of any conduct on the employee's part that occurred prior to the dismissal.

107. Applying those principles to the facts as found, the tribunal reaches the conclusions set out below.

Conclusions

108. The tribunal considers firstly the claimant's complaint of discrimination arising from disability. The claimant was diagnosed with mixed anxiety and depression on 24 November 2020 (his medical records confirm that to be the date rather than the date referred to in his GP letter of 15 June 2022). From then, he commenced taking antidepressant medication. Whilst that is the date of diagnosis, it is more likely than not that the claimant had been suffering from such mental health impairments for some time previously building up to that GP appointment. Nevertheless, the tribunal was not determining any alternative date for disability status to have arisen and Mr Menon confirmed that he was not asking the tribunal to do so.

109. However, the claimant had not suggested to the respondent over a significant period, the possibility of any mental health impairment. The claimant's own evidence is that he chose not to disclose his condition out of fear and embarrassment. Whilst there was an obvious recognition by the respondent that the assessment and capability process the claimant was undergoing, for indeed some years, would be stressful to him and indications by the claimant that it did cause him stress, on the claimant's own account he does not suggest that this was sufficient to suggest to the respondent that he was suffering from any mental health impairment.

110. Mr Prasadu's coaching report of 1 November 2018 is not suggestive of any condition. It is suggestive of the claimant being assisted through an unavoidably stressful process by a number of psychological coaching strategies.

111. The BMA wrote to the respondent on the claimant's behalf on 15 April 2021 raising complaints of bullying and harassment and referring to the claimant's mental health having suffered considerably. That too is not suggestive of the claimant suffering from any condition or specific mental health impairment. It is a rather general statement that the claimant was very likely to have been affected by the aforementioned processes.

112. However, when interviewed about his complaints on 26 May 2021 and when asked if he was getting support for his mental health, the claimant referred to taking medication and of the situation having gone too far. The claimant then presented his written defence statement for consideration at the capability hearing which took place on 15 July 2021. In that, the claimant referred to having lost confidence and having sought the assistance of occupational health from 2016. He said that he had benefited from Mr Prasadu's assistance since then until the previous year. He explained why he had not told anyone about his problems. He described his GP as being aware of "my condition", but that they had decided to keep the claimant off medication until late in the previous year.

113. The tribunal concludes that the respondent was on notice as to the claimant's status as a disabled person from 26 May 2021. At that point they were aware of the claimant having been prescribed medication for his mental health. The respondent could reasonably be expected to know then that the claimant was a disabled person. An enquiry of the claimant's GP would at that stage have disclosed a diagnosis of a clinical impairment. It would have been a reasonable step, in the context of imputed knowledge of a disability, to seek such medical opinion or at the very least to make a specific referral of the claimant to occupational health to gain a better understanding of the claimant's health issue.

114. In terms of unfavourable treatment, the claimant then relies on the respondent's failure to extend the timescale within which it required the claimant to reach required standards. Whilst time could have been extended at the point of dismissal, this claim relates more to the action plan and assessment process which preceded the capability hearing. The respondent did not have knowledge of the claimant's disability status at that earlier stage. In any event, the suggestion of the claimant having been given a lack of opportunity to show an improvement is misconceived in circumstances where the formal action plan endured for 11 rather than the originally specified 9 months and where there the claimant then continued working under supervision for a further couple of years before the capability hearing.

115. The dismissal of the claimant was, however, clearly an act of unfavourable treatment. The claimant's dismissal was, the tribunal finds, by reason of the respondent's belief that the claimant was not capable of fulfilling his duties efficiently and in a manner which ensured patient safety. No alternative or "hidden" reason for the termination of the claimant's employment has been seriously suggested. There is a significant body of evidence that there were genuine concerns regarding the claimant's clinical practice coming from a significant number of people he had worked with, from junior to senior level and certainly beyond those who were managing the assessment and performance processes.

116. The key question is whether the claimant's performance issues - his inability to reach the required level within the respondent's timescale and to operate as a doctor at ST4/5 level arose from his mental health impairment. That is a matter for the tribunal's determination. The claimant is somewhat uncomfortably having to take two contradictory positions in these proceedings. On the one hand, he maintains that he was a competent doctor capable of performing at the level at which he was employed. On the other hand (and certainly in the context of this disability discrimination complaint), he maintains that his inability to operate at the required level arose from his disability.

117. The tribunal has no evidential basis before it from which it can conclude a linkage between the claimant's mental health impairments and his performance. It is effectively asserted on the claimant's behalf that the tribunal should take judicial notice of employees with mental health impairments struggling to perform duties to the required standard. Whilst the tribunal must not adopt an approach which defies common sense, that proposition goes too far. The tribunal has before it very little evidence of the claimant's mental health impairments and how they affected him. The tribunal has had sight of the disability impact statement which the claimant produced earlier in these proceedings. He gave no evidence to the tribunal with specific regard to that. The claimant in that statement referred to the effects in the workplace as him being slow, making repeated checks for fear of making mistakes, worsening self-confidence and drowsiness.

118. However, the claimant was performance managed and ultimately dismissed arising out of an inability to put his clinical knowledge into practice and to make reliable clinical prognoses. Performance concerns were wide-ranging, but also encompassed poor communication, an unwillingness to follow instructions and a lack of insight, including an unwillingness to be open to criticisms of his performance. The claimant maintains that his mental health was suffering from June 2015 and had got progressively worse with the onset of symptoms of depression from mid-2016. That is not borne out by his medical records. On 2 August 2018 his GP recorded that there were no concerns of depression indicated. There was no earlier reference to a mental health impairment.

119. The claimant's performance issues significantly predated that period and indeed endured consistently from 2010. Against that background and a lack of medical evidence, the tribunal concludes that the claimant's capability issues and his inability to reach the required level of performance did not arise from his disability. It is suggested on the claimant's behalf that inevitably his performance will have deteriorated with the onset of his mental health impairments, but there is no evidence again of such deterioration. Again, as early as 7 January 2015, the respondent was seeking to put in place a retraining programme and was moving the claimant to a supernumerary role where his practice would require substantial supervision. He was warned at that stage that if he did not meet the required standards, then formal capability procedures would be invoked. The

evidence is of the claimant failing to meet the standards expected of a doctor of his seniority prior to the onset of any mental health impairment and of his clinical performance in the period from 2015 – 2021 being entirely reflective of the respondent's assessment of him already in the period from him joining the respondent in 2009.

120. The claimant's complaint of discrimination arising from disability must fail at this stage.

121. The claimant then brings complaint alleging a failure to comply with a duty to make reasonable adjustments. It is accepted that the respondent required employees to undergo clinical supervision and an improvement plan in a required period. However, for the reasons already explained in the context of the discrimination arising from disability complaint, the tribunal cannot conclude that the claimant was disadvantaged as a disabled person in being able to meet the required standards within a required period. The evidence is that the claimant was simply not able to work at the level expected of him which had indeed resulted in initiation of restrictions on his practice as early as January 2015.

122. Had the claimant been able to show such disadvantage, the tribunal in any event does not consider that the changes put forward by the claimant would have been reasonable. A transfer to Calderdale Royal Hospital would not have alleviated any disadvantage. The claimant would have been required to undertake similar work and similar performance concerns would have arisen. The claimant was only moved away from that hospital in the first place because of concerns regarding his capability and a breakdown in relationships with, in particular, nursing staff at that site. Again, a change in clinical supervisor would have made no difference to the claimant's ability to complete an improvement plan. Whilst the claimant cites relationship issues, Dr Davies made genuine and reasonable assessments of the claimant's capability which anyone in his position would have. It is noteworthy that his direct interaction with the claimant's clinical practice was relatively minor and that other consultants were often raising their own adverse experience of the claimant with him requiring him to react as would any clinical supervisor or clinical director. The tribunal does not conclude that the claimant's relationship with Dr Davies was causative of his performance issues. Again, they predate Dr Davies acting as his educational supervisor. There is no evidence from the claimant of adverse treatment of him by Dr Birkinshaw, other than a remark made to the GMC of which he had not been aware. The reality is that the claimant was regarded by the whole body of consultants as a polite and likeable doctor, but sadly one on whose clinical judgement they could not rely.

123. In the context of a complaint of a failure to make reasonable adjustments, the tribunal would note that the claimant had been allowed an extremely long period of time to show improvement in his clinical practice. His days and hours of work were the most conducive as possible in terms of relieving

pressure on him. He was proactively and constructively supervised. He was given the benefit of designated consultant time at significant cost to the respondent for personal one-to-one advice and guidance. His pay was preserved for years at a level way beyond that at which he was working.

124. The complaint alleging a failure to make reasonable adjustments must fail.

125. The tribunal turns then to the complaint of ordinary unfair dismissal. Again, the respondent has been found to have held a genuine belief in the claimant's lack of capability. That was certainly on reasonable grounds. There was an opinion across all of the emergency department consultants that the claimant showed poor clinical judgement and was unable to function at the level at which he was employed. The respondent's view in his lack of capability was arrived at then only after a very lengthy and in-depth assessment of his abilities as described above.

126. The respondent also had the GMC assessment that the claimant could not operate at his contracted level as well as the evidence of his inability to reach the standards set in the NCAS action plan. The NCAS successor body was clear that there would be no benefit in a further assessment of the claimant. That would have produced a similar conclusion that the claimant was incapable of acting at his contracted level. Effectively, everything had been done which could facilitate the claimant demonstrating an improvement.

127. The respondent had gathered through an investigative process and from contemporaneous records, relevant information about the claimant's practice. In cross-examination of the respondent's witnesses, time was spent in exposing anomalies and possible avenues a further investigation into 3 specific examples which had been raised by the respondent of poor clinical practice. Some criticisms of the respondent were justified. However, an over minute analysis of the evidence behind those individual examples (and how the capability and appeal panels viewed them) obscures from the totality of the evidence that the claimant was reasonably viewed as not capable of performing at his contracted level. The claimant was not dismissed, for example, for misconduct arising out of 3 individual instances. These were examples only and, whilst the respondent in any event acted reasonably in ultimately determining that the claimant was at fault to some degree in these, looking at the totality of the claimant's performance over 10 years and the management of it over a period of in excess of 6 years, the tribunal considers that the conclusion which the respondent reached was reasonable in all the circumstances.

128. The tribunal addresses the particular criticisms made by the claimant. Whilst the claimant was restricted to working at a lower level than the GMC assessment, that restriction imposed by Dr Davies predated the GMC's

implementation of restrictions. The restriction he imposed was reasonable in all the circumstances, where he had an overarching concern for patient safety which necessitated, reasonably, for him a greater level of supervision of the claimant's clinical practice. He was in a better position to assess the claimant than the GMC given his greater depth and length of knowledge of his practice. He was clearly genuinely concerned that the claimant did not possess insight into his own practice, a lack of insight which in Dr Davies' reasonable opinion made him a potential risk to patients. Regardless of that level of restriction and the degree of supervision the claimant had to work under, the tribunal accepts that the claimant did have an ability to show improvements in his clinical practice and that he was capable of operating at a higher level. The evidence is that he simply did not show that reliable higher level of decision-making which could have persuaded the respondent that he was able to work independently. The claimant was in a position where he could and would have been allowed to do more if he had shown an improvement during the course of the action plan.

129. The claimant was indeed still able to show that he was working, in the technical sense, at ST4-6 level by the patient plans he devised and his demonstration of clinical judgement. He was not able to carry out all the functions of his role, as his role involved the sole management of the department in the absence of consultants and supervision of more junior doctors. However, it was reasonable to expect someone to be able to show that their own clinical practice was at a sufficient level before they could be allowed (and effectively trusted) with guiding and passing judgement on the clinical practice of others.

130. The criticism that the claimant ought to have been given more time and an extended improvement plan, given his mental health issues, is unfounded in the context of the amount of time allowed to the claimant to show an improvement and the degree of support provided. There is no evidence of any additional supportive measures which might have led to an improvement in performance.

131. The dismissal is said to be then unfair because of the respondent's failure to properly take into account the claimant's mental health. The tribunal can imagine a situation where an employee or an employee's circumstances indicated that a lack of performance arose from ill-health and where an employer, to act reasonably, would have had to have referred the employee for a medical opinion and have considered how the employee could be assisted in terms of improving their health as well as changes to any improvement plan to further assist them. However, that is not the circumstances of the claimant's case. In circumstances where the claimant's ill-health was reasonably not considered to be causative of the claimant's performance failings by the capability and capability appeal panels, it was not unreasonable for it not to have changed its course and have looked deeper into the claimant's health issues. The panels were aware and understood that the claimant had been struggling, but reasonably concluded that he had been provided with a reasonable level of

support through coaching and the allocation of specific resources to help the claimant in his practice.

132. As already addressed, a transfer of the claimant to Calderdale Royal Hospital would not have been reasonable in that the respondent reasonably concluded that the same issues would arise.

133. That also applies in the claimant's assertion that his educational supervisor and clinical supervisor should have been changed given a breakdown in relationships. The claimant had raised allegations of bullying by Dr Davies, but in accordance with an informal process. The tribunal is unable to conclude on the evidence before it that bullying occurred at the hands of Dr Davies in the way the claimant alleges so as to that a failure to remove him as educational supervisor should render dismissal unfair. Changes were in fact made to the management of the claimant in the later stages of his employment.

134. The respondent did not believe that the claimant's length of service ought to be a mitigating factor, but reasonably so. The claimant's length of experience at a senior doctor level was not suggestive of an individual who had a lack of experience. The failings reasonably found by the respondent to exist in the claimant's clinical practice could reasonably not be treated differently on the basis that the claimant had long service with the respondent.

135. The issue of alternative employment was considered, particularly by the appeal panel. The capability issues as found did reasonably cause a breakdown in the trust necessary for the respondent to continue to employ the claimant in any capacity. Moving the claimant to a level outside his expertise was not something which the respondent unreasonably failed to consider. It was not unreasonable for the respondent not to consider the claimant working as an FY1 in circumstances where the evidence had shown a lack of progression which would ordinarily be expected in someone in that role to enable the removal or reduction of supervision. The claimant was certainly not suggesting a low level post and not one at the level of salary which such post would ordinarily attract.

136. The claimant does not suggest that there were any failings of a purely procedural nature in the capability that capability appeal processes. Indeed, these were extremely detailed considerations of the claimant's capability where the claimant was represented, had a full opportunity to state his case and to put questions to those who were suggesting that the claimant's practice was deficient. He was provided with full explanations for the decisions of both panels.

137. Dismissal of the claimant in the aforementioned circumstances was certainly within a band of reasonable responses. For the claimant to operate at his contracted level, the respondent had to be able to have trust that he could operate safely without significant supervision. The claimant's role was not one where the respondent could reasonably be expected to allow for a degree of leeway or tolerance of inadequate practice or potentially mistakes. The potential consequences as regards, in particular, patient safety were too great. The claimant's own representative in the process did not believe that the assessment period of the claimant's performance ought to be extended or that the plan ought to be removed. He was clearly hoping that the claimant would realise the serious situation he was in, which Dr Lord himself considered was likely to result in the termination of his employment. The respondent had not rushed to judgement and had given the claimant every conceivable opportunity to show that he could operate at the required level.

138. For the sake of completeness, had the claimant been able, in his complaint of discrimination arising from disability, to show the necessary linkage between his capability issues and his mental health impairment, the tribunal would have considered his dismissal to have been a proportionate step in pursuit of a legitimate aim. The respondent did certainly have the legitimate aims of safeguarding patients, ensuring an efficient emergency medicine department and reducing the burden on the claimant's consultants and other colleagues of providing what was indeed an extraordinary level of support which it regarded as unsustainable indefinitely. Dismissal of course is the ultimate sanction, but the tribunal does not consider any lesser sanction to have been appropriate to achieve the respondent's aim in the context of the claimant's failings and lack of insight. Again, the decision to terminate employment must be proportionate in circumstances where the respondent had assessed the claimant over a period of many years whilst allowing him to continue working on full pay and where the claimant had not improved to the required level despite significant support in terms of both time and cost.

Employment Judge Maidment

Date 9 March 2023