



# EMPLOYMENT TRIBUNALS

**Claimant:** Mrs K Luker

**Respondent:** South Tyneside and Sunderland NHS Foundation Trust

## RESERVED JUDGMENT

**Heard at:** Newcastle Employment Tribunal

**On:** 23<sup>rd</sup>, 24<sup>th</sup>, 25<sup>th</sup> August 2022  
(deliberations 25<sup>th</sup> August and 15 September 2022)

**Before:** Employment Judge Sweeney

**Members:** David Dorman-Smith  
Stephen Carter

### **Representation:**

For the Claimant: Paul Sangha, counsel  
For the Respondent: Colin McDevitt, counsel

The unanimous Judgment of the Tribunal is as follows:

- 1. The complaint of disability discrimination by way of failure to make reasonable adjustment is well founded and succeeds.**
- 2. The complaint of unfavourable treatment because of something arising in consequence of disability is dismissed upon withdrawal.**

# REASONS

## The Claimant's claims

1. By a Claim Form presented on **28 November 2019**, the Claimant brought a claim of disability discrimination.
2. The case was due to be heard at the Newcastle Employment Tribunal on **01 March 2021**. However, the Final Hearing was postponed by order of Employment Judge Green on what was to be the first day of the hearing. Judge Green summarised the issues (**page 67.32**). The proceedings were ultimately relisted to be heard in August 2022.

## The Final Hearing

3. At the outset of the hearing, the final list of issues were agreed. Mr Sangha had not been provided with a copy of Mr Henshall's email, in which he had set out the issues. Once this was provided, it was agreed that there was only a slight variation to the issues as summarised by Judge Green and no objection was taken. Mr McDevitt said that he would reflect on one point while the Tribunal completed its reading of the witness statements. The parties then left the Tribunal to read. Upon returning, Mr McDevitt withdrew the complaint of disability discrimination contrary to section 15 Equality Act 2010.
4. The Claimant gave evidence on her own behalf. She had intended to call another witness, Doctor Richard Cooper, who proposed to give evidence remotely by CVP. However, Dr Cooper had since left the UK to reside in New Zealand. The Tribunal was not alerted to this until fairly late in the day. It is necessary for a foreign state to confirm their agreement to a person giving oral evidence from their territory. Unfortunately, as the state of New Zealand had not consented to the giving of evidence by the time of this Hearing, that meant that Dr Cooper was unable to give oral evidence. Mr McDevitt said that, in the circumstances, he would not call him but invited the Tribunal to read his written statement and to give what weight to it that the Tribunal considered appropriate, recognising that he was not present to be challenged on it.
5. The Respondent called the following witnesses:
  - a) Mark Roberts, Senior Estates Officer
  - b) Janice Clayton, Senior Radiology Sister
  - c) Laura Berry, Directorate Manager for Diagnostic Imaging
  - d) Julie Mills, Matron for Clinical support

- e) Kay Stidolph, Directorate Manager for Urgent and Emergency Care
6. The parties had prepared a large bundle of documents consisting of:
- a) A joint hearing bundle of 504 pages;
  - b) A supplementary bundle of 518 pages.

**The issues**

7. The issues, both disputed and not disputed were as follows:
- 7.1. Was the Claimant, at all material times, a disabled person within the meaning of section 6 Equality Act 2010? [This was not in dispute]
  - 7.2. Did the Respondent know that the Claimant was a disabled person? [This was not in dispute]
  - 7.3. Did the Respondent apply the following PCP: “the wearing of protective lead while procedures that create radiation are in progress” [not in dispute]
  - 7.4. Did the Respondent put the Claimant to a substantial disadvantage? [not in dispute]
  - 7.5. Did the Respondent know that the PCP was likely to put the Claimant to the substantial disadvantage? [not in dispute]
  - 7.6. Was the Respondent under a duty to take such steps as were reasonable to avoid the substantial disadvantage to the Claimant caused by the PCP? The proposed steps were:
    - a) That the Respondent provide light lead aprons for her to wear for short periods;
    - b) That the Respondent rotate her radiology duties with other members of the cardiology nursing team;
    - c) That, while the x-ray tube is emitting radiation for Fluoroscopy/CT imaging, she be permitted to monitor the patient from behind the fixed static lead screening shield in the room;
    - d) That the Respondent address (by decreasing) the temperature in the room.

[The essential dispute was whether it was reasonable to make any of these adjustments]

### Findings of fact

8. The Tribunal heard a considerable amount of evidence. It is not our function to set out every piece of evidence or to make findings on every issue or dispute. We do not propose to resolve every dispute of fact between the parties, only those which we have considered to be necessary for the purposes of determining the complaints. The Tribunal was assisted in this case by an agreed statement of facts, which are at **pages 67.1 to 67.3** of the bundle.
9. Having considered all the evidence before it (written and oral) and the submissions made by the representatives on behalf of the parties, the Tribunal finds the following key facts.
10. The Claimant was employed by the Respondent from **06 July 2009** until her retirement on **09 June 2019** as a Band 6 Senior Registered Nurse. For most of her employment, her employer was South Tyneside NHS Foundation Trust. However, with effect from **01 April 2019** that Trust merged with another Trust, City Hospitals Sunderland NHS Foundation Trust. She suffers from chronic urticaria, which in days gone by was, and is still sometimes today, referred to as 'hives'. Since first developing the condition in January 2019, she has tried to keep it under control with the use of mild steroid cream and over the counter antihistamine. However, the condition can be triggered and/or exacerbated by stress. Despite her best efforts, the rash gradually got worse, to the extent that well-meaning staff would comment on it, which made the Claimant feel very self-conscious. Over a period of time, the rash spread to her back, chest and stomach. It was painful, resulting in broken skin and the constant itching was adversely affecting her sleep, making her tired and easily irritable.
11. It is agreed that the Claimant's physical impairment constitutes a disability within the meaning of section 6 Equality Act 2010. It is also agreed that the Claimant was disabled during the material period relevant to her claim in these proceedings.

### The Respondent

12. As indicated above, South Tyneside and Sunderland NHS Foundation Trust was created **on 01 April 2019**, following the merger of City Hospitals Sunderland NHS Foundation Trust ('Sunderland') and South Tyneside NHS Foundation Trust ('South Tyneside').

### The nature of the Claimant's work

13. The Claimant was employed as a band 6 Senior Registered Nurse, based in the radiology department at South Tyneside District Hospital, where she worked as part of a 3-person team. She reported to the Senior Radiology Sister, Janice Clayton. She had 10 years' experience of working in radiology. She had

extended her role to undertake Hysterosalpingogram Investigations ('HSGs'). She was also one of two members of staff training to implant loop recorders – a small cardiology monitoring device placed in the subcutaneous tissue of the chest area.

14. The radiology department at South Tyneside carried out a wide range of work. In the main, it carried out interventional radiology which involves image guided techniques using guidewires and catheters to carry out procedures as an alternative to surgery. The procedures include oesophageal and biliary stents, inserting vascular ports and carrying out biopsies and drainage procedures. The department also carried out cardiology procedures, such as insertion of pacemakers and diagnostic coronary angiography. The procedures which the department carries out may be planned or unplanned or emergency.
15. The Claimant's job description is at **pages 68-76**. She was required to work in a multidisciplinary team within the radiology department. Being in a multidisciplinary team means that the Claimant worked alongside radiologists, cardiologists, radiographers, radiography assistants, cardio technicians and other nurses. One of those with whom the Claimant worked was Dr Richard Cooper, a Consultant Radiologist, and former Clinical Lead for South Tyneside. Dr Robert's involvement in Interventional Radiology was limited to arthrography.
16. The Claimant's duties included assisting "radiologist/cardiologist with a wide range of specialised clinical procedures for example, peripheral angioplasty/plasty/stenting and diagnostic coronary angiography. The duties also involved carrying out pre-procedural assessment of patients attending for interventional procedures. As to working conditions, her work was primarily to be in radiation-controlled areas, requiring her to wear PPE such as gloves/aprons for most of each working day. The approximate weight of a standard lead apron was 4 kilograms [**page 75**].
17. A large part of the role of a radiology nurse is to assist the radiologists during procedures. Procedures are carried out in rooms, in which there will, in most cases, be two nurses present (along with other medical staff). Within the radiology department there were 3 rooms of particular relevance to these proceedings, where the Claimant worked as a radiology nurse assisting with various procedures:
  - a) Room 5, or the 'fluoroscopy room'. Fluoroscopy is a screening or imaging procedure enabling medical professionals to see, in real-time, movements inside the body. It passes x-rays through the body and uses a contrast dye to enhance the images. Within room 5 procedures such as to coronary angiograms, pacemaker fitting and radiological intervention work are undertaken

- b) Room 6, where other procedures related to HSGs and occasionally endoscopy and bowel stents are undertaken. These procedures involve the use of x-rays.
  - c) CT room, where CT scans and CT guided biopsies are undertaken. A CT (Computed Tomography) scan uses x rays to make detailed images of the body.
18. Most of the the Claimant's work was in the fluoroscopy room, or room 5. That was the case for the team generally.
19. The role of a Radiology Nurse entails a number of activities. However, there were two aspects of the Claimant's activities (which made up of most of the work) relevant to these proceedings:
- a) The activities of a Scrub Nurse
  - b) The activities of Circulating Nurse
20. A good understanding of the respective roles was available to us not only from the evidence of the Claimant and Mrs Clayton, but from the RCN/RCR guidelines on **pages 344-345** of the bundle. The scrub nurse scrubs up prior to any procedure beginning. This means that she, or he, must disinfect her hands and forearms and put on a sterile gown. She must also put on her PPE, which has, in South Tyneside Radiology department, always involved nurses wearing a lead apron. In addition to lead aprons, there was a mobile lead screen at South Tyneside [**page 493** of the supplementary bundle]. The X-Ray local rules for south Tyneside hospital and Sunderland hospital theatres allows for the use of mobile lead screens instead of a lead apron, as appropriate PPE during certain circumstances set out on that page.
21. The scrub nurse assists the radiologist set up and tend to the instruments trolley which will be used during the procedure. She will prepare sterile instruments and equipment. She then assists during the procedure, keeping an accurate account of catheters, wires and blades collected during the procedure. She will anticipate the needs of the clinical radiologist by observing the progress of the procedure.
22. The circulating nurse's role is to monitor and look after the patient and ensure that any additional equipment that may be required by the scrub nurse is made available. The circulating nurse is not scrubbed
23. By the very nature of the work, the procedures involve the emission of radiation or x rays. Therefore, to mitigate against the exposure to radiation, staff are required to wear PPE. In particular, the nurses were required to wear protective lead aprons.

24. South Tyneside had local rules in place. They were referred to as Local Rules for Radiation Safety in Diagnostic Radiology. The most recently revised rules during the period which concerned us, were in the supplementary bundle, **pages 1 to 35**. The Rules were prepared to satisfy the Ionising Radiations Regulations 1999, to assist those working with radiation to protect themselves and others from hazards associated with working with radiation. The Rules designate 'Controlled Areas'. A Controlled Area was each X-ray room containing fixed X-ray equipment, except that part in each room shielded by the control cubicle, the boundary of which is indicated by a line on the floor. In CT the boundary was the internal door to the control cubicle. Appendix 2 of that document lists those persons with special responsibility in radiation protection for South Tyneside. One of those listed is the Radiation Protection Supervisor ('RPS') who in this case was Fiona Kirkpatrick [**page 14**]. On page 18, the Controlled Area is defined by walls and doors to each room excluding protected areas behind consoles [**page 18 and 20**]. Lead aprons, and thyroid collars/glasses if available, must be worn by all staff remaining within the controlled area [**page 19**].
25. There is an area within each room which is shielded by a fixed or static lead shield or separate cubicle (in the case of the CT Room). Within these shielded areas, are monitors and screens used to monitor the patient. What shows on each screen will vary according to who is using it. For example, in room 5 whenever a cardio technician is working there, he or she always sits in the shielded area behind the protective screen. The area where the procedure takes place is visible to those behind the protective screen via a large glass panel.
26. We were shown some photographs of room 5 [for example, **pages 148-150**] which, alongside the witness evidence, gave us a good understanding of the geography of the room. The distance from where the patient lies to the protective screen is about six feet. On the other side of the screen is a desk, about 2 feet deep. Therefore, if standing behind the protective screen and desk, the distance between nurse and patient would be about 8 feet.
27. This issue was the most contentious issue in these proceedings. The Claimant's position was that, when the radiologist was due to activate a dose of radiation, she should be able to withdraw from the controlled area and retreat to a position behind the protective screen. From that position, she would be able to continue to monitor and observe the patient by viewing the patient through the large glass panel and by observing the data on the monitors. If she were permitted to do this, she would not need to wear a lead apron at all while operating as circulating nurse, or, would only need to wear one if the procedure necessitated her being in close physical contact with the patient – for example, when the procedure was the fitting of oesophageal stents, where she would need to keep the patient's airways open. On these occasions, it was her case

that she could wear the light lead apron. However, on most occasions, as a circulating nurse, she would be able to dispense with the need for a lead apron. This is because it is only during the emission of radiation that she must wear a lead apron and only then if she remains in the controlled area. The Respondent's position was that she was required, at all times, to remain near the patient to perform the role of circulating nurse and that she would be unable to act in the best interests of the patient if she retreated behind the protective screen when radiation was being emitted. This, argued the Respondent, was because she would not be able to provide appropriate nursing support to the patient during the procedure.

28. With specific reference to room 5 (fluoroscopy) rule 4 states that: '*whenever possible, staff must absent themselves from the Controlled Area before x-rays are generated*'. [page 21]. The same applies to the CT room [rule 6, page 22]. If it is necessary for a person to remain in the examination room during scanning, they must wear a 0.35mm lead equivalent apron and 0.5mm lead equivalent thyroid collar [rules 7 and 2, page 23].
29. There were different types of lead apron available within the Trust. There was a one-piece apron and thyroid collar, or there was a two-part apron, consisting of a skirt plus a top and a thyroid collar. Those were the only two made available in the radiology department. These were referred to in these proceedings as the standard apron, which were 0.35mm thick. However, there was also a lighter lead apron, which was both thinner and lighter in weight but which offered the same protection against radiation. This was referred to in these proceedings as the lighter lead apron. However, these were not made available in the radiology department albeit some were used in other parts of South Tyneside.
30. The amount of time the Claimant was required to wear the lead apron differed according to which nursing activity she was undertaking. When acting as scrub nurse, she was required to put the lead apron on earlier than when acting as circulating nurse, prior to the medical procedure that was to be undertaken and prior to scrubbing up. When acting as circulating nurse, she was able to put the lead apron on in the 'procedure room' and just before the procedure started. When acting as scrub nurse, she wore the apron for longer periods.
31. Irrespective of which role she was undertaking, the practice is and was that, at the time radiation is emitted, all those involved in the procedure stepped back, away from the patient, to a safer distance. They did not leave the controlled area but they did step back a few feet. Therefore, at this stage, they were a few feet away. The Claimant positioned herself further back than the radiologist and scrub nurse. She normally positioned herself so that her back was up against a cupboard. Therefore, she stepped back about 4 feet from the patient. During this period of radiation emission her view was generally obscured by the others in the room (scrub nurse, consultant and radiologist). However, that was never



an issue as the greater part of any monitoring tended to be by way of keeping an eye on the data on the monitors.

32. The X-Ray Local Rules from December 2019 for the now merged Trust [pages 295.3 to 295.36] advise staff on three key concepts: DISTANCE, SHIELDING and TIME. In order to minimise the radiation dose they must:
- a) Increase distance as radiation dose falls quickly if you stand back;
  - b) Use shielding to block radiation, example being structural walls, protective screens,
  - c) Minimise time: if possible they should leave the area during the radiation exposure
33. This was the case whether involved in mobile radiography, static fluoroscopy, interventional radiography or CT scans. On page 295.25, the rules say that each fluoroscopy room is temporarily defined as a 'radiation-controlled area' when the x-ray equipment is switched on and a yellow 'controlled area' warning light is illuminated at each entrance. It is defined by the walls, floor and ceiling of the room but excludes the area behind the control screen and where the lead equivalent aprons are stored. A person may remain in the Radiation Controlled Area during a procedure only if:
- a) Their role is considered essential to the procedure,
  - b) They are wearing a dosimetry badge and
  - c) They are wearing a PPE (a lead apron) as detailed in section 3 – for those working within 1.5 metres during radiation exposure this was to be a minimum of 0.35mm lead equivalent apron and thyroid collar.
34. If the Claimant was able to step behind the protective screen during radiation activation, then while carrying out her duties as a circulating nurse she would not have to wear a lead apron at all. The cardio-technician carries out his/her duties behind the protective screen without the use of a lead apron. If the cardio-technician was required to assist in an emergency (for example, a patient had a cardiac arrest) the radiation would be stopped immediately, and he/she would rush to the patient from behind the protective screen to provide the patient with expert assistance.
35. The Claimant had undertaken some monitoring of patients from behind the protective screen. She had acted as circulating nurse during three angiograms, assisting Dr Hall.
36. In her evidence, Mrs Clayton accepted that, in general, there was no need for the circulating nurse to have close contact with patients. She accepted this when taken to **page 128** of the supplementary bundle. This was an extract from a weighty document prepared by the International Atomic Energy Agency

(IAEA) called 'Radiation Protection and Safety in Medical Uses of Ionizing Radiation'. At paragraph 3.66 it stated:

*"In general, there should be no need for occupationally exposed staff to hold, or have close contact with, patients during a radiological procedure. If such holding or contact is indeed necessary, then the person to be used in that role should be considered a carer or comforter of the patient, and should be afforded the appropriate radiation protection described in paras 3.247 – 3.251."*

37. However, if a particular patient wanted or needed the contact or support, her view was that the nurse should provide this support. She referred to paragraph 3.79 of the IAEA document [page 131], which states:

*"Image guided interventional procedures, performed either in fluoroscopy rooms or dedicated interventional rooms, tend to be complex and are performed on patients who can be very ill or have a life-threatening condition. As a consequence, more staff will be needed in the room to attend to the patients' individual medical needs (e.g. interventionists, anaesthetists, medical radiation technologists, nurses and other specialists). Not only will more staff be exposed during interventional procedures, but they may also be standing close to the patient, where does rates from radiation scattered by the patient are high."*

38. The reference in that paragraph to nurses does not specify any particular nurse, such as a scrub nurse or a circulating nurse. All this document does, we find, is to inform those working in this sphere of activity that there may be a need for some people to be close to a patient depending on the patient and the procedure, but as a general rule, there should be no need for occupational staff to have close contact during the radiological procedure.

39. In practical times, on most occasions, the Claimant – and others – stepped back, away from the patient (in the Claimant's case a distance of some 3-4 feet away) during radiation activation. The only time she would not step back was where the procedure itself required close contact, for example, during an airways procedure (oesophageal stent). That is one of those occasions when it had to be accepted that the radiation exposure risk was greater.

### **RCN/RCR Guidelines**

40. A large part of the radiology nurse's role, then, involved being present during the procedure, in the controlled area. The Royal College of Nursing (RCN) and Royal College of Radiologists (RCR) issued Guidelines for nursing care in interventional radiology. Those were found at **pages 329 to 347** of the bundle. In the Foreword it states that:

*"The provision of appropriate nursing support in a department of clinical radiology is a vital component in the provision of patient care. This document*

*outlines the issues, sets out models for nursing staff and describes the role of the interventional radiology nurse in the management of patients who are undergoing interventional radiology treatment. This document and its recommendations are designed to help in your discussions within your trust with regard to setting appropriate levels of nursing support for departments...The HCA (Healthcare Assistant) will, after suitable training, be able to fulfil some of the functions that were previously the domain of registered nurses.”*

41. At page 332, the Guideline went on to say:

*“It is vital to ensure that patients are safe within the department of clinical radiology, and to ensure that adequate and safe monitoring of the patient occurs before, during and after interventional procedures. This should be recognised as a key risk management issue for the trust.”*

42. Most procedures are carried out with conscious patients, who may often receive a small amount of sedation. The role is akin to that of a theatre nurse with additional responsibility of caring for a conscious patient. When acting as circulating nurse, this will involve monitoring of pulse, blood pressure, electrocardiogram (ECG) and oxygen saturation. The guidelines say that during the procedure, the circulating nurse or HCA should remain in the procedure room throughout.

#### **Temperature issues in room 5**

43. An issue in the proceedings was whether the Respondent could make an adjustment contended for by the Claimant – that adjustment being to lower the temperature in room 5. In its Grounds of Resistance dated **13 January 2020**, the Respondent, at paragraph 7.4 [page 31 of the bundle] said that it arranged for the issue of the temperature in room 5 to be looked into, that temperature gauges had been added to the room and that it has ‘undertaken other modifications’ to address the issue. It added that *‘the temperature remained an issue and that discussions were ongoing to try to identify a sustainable solution (if at all possible)’*. For this reason, the Respondent pleaded in paragraph 16.3 that it was not reasonable for it to take the suggested step of addressing (in effect, lowering) the temperature in room 5.

44. There was undoubtedly an issue with the temperature in room 5. It is important to monitor the temperature, not only for staff reasons, but due to the storage of temperature sensitive drugs. The staff who worked there complained that it was too hot. This complaint about the temperature was nothing new to the Respondent. Laura Berry, Directorate Manager for Diagnostic Imaging, was made aware of the issue in 2018. Although the issue affected all staff, it became a particular issue for the Claimant after she developed urticaria.

45. In the context of discussing her skin condition, the Claimant expressed her concern about the temperature and its effect on her condition at her return to work interview on **25 April 2019**. She asked for the temperature to be reduced [page 163-164]. Mrs Clayton recorded that the estates department would be asked to review the temperature again. On **30 May 2019**, her colleague Rachel Oliver, also concerned about the temperature, submitted an online risk management incident form, known as a Datix. This is a form, used by the Respondent, for the investigation of incidents at work. She noted that the temperature of the room was showing as 23.8 to 23.9 degrees and that 'due to lead aprons and machinery the temperature continues to rise and is becoming intolerable for most staff.
46. Temperature of the room was monitored daily by a thermometer. Estates believed the thermometer to be inaccurate and a replacement was purchased. However, the temperature remained too high for staff to work comfortably, owing to the fact that they were required to wear PPE. In addition, the machines and equipment generated heat throughout the day with the temperature rising with prolonged use of the equipment and with the presence of staff in the room.
47. Mark Roberts is a Senior Estates Officer for South Tyneside. He was called by the Respondent as its witness on the attempts to resolve the issues with the temperature in room 5. His involvement followed the submission of the Datix incident form by Ms Oliver (paragraph 4 of his witness statement).
48. Room 5 is one of a number of rooms in the radiology department for which heat is provided by a ventilation plant. This pumps air into the room and also extracts air. There is one temperature sensor which controls the temperature of the rooms supplied by the plant. If the temperature setting for the plant is adjusted, all rooms supplied by it will be heated, or cooled to the same specified temperature. The system did not allow for control of each room individually.
49. In his witness statement, Mr Roberts explained that he arranged for the temperature in the room to be monitored. On **11 October 2019**, his team also checked the airflow to the room and checked the ducting. They wished to understand whether there was some issue with air flow, which might have impacted on room temperature. They installed temperature loggers to monitor temperature. They turned the temperature down but received complaints that it was too cold in other rooms. Mr Roberts extended the run period of the ventilation plant to lower the air supply. However, he was unable to make any inroads.
50. Mr Roberts' team investigated the plant but apart from finding a flexible duct that had come away from the grill, found nothing in particular that seemed to be making the room too hot for staff. The replacement of the grill made no significant difference. In his oral evidence, Mr Roberts said that they are now (in 2022) running at a reduced temperature and at a level where they are no

longer getting complaints from those in other rooms. However, they have only managed to reduce the temperature by 1 degree, to a temperature he said of 21 or 22 degrees, which is similar to what it had been when the Datix was first lodged. This was done simply by lowering the temperature. On **05 December 2019**, he emailed Kevin Fleetham and Melanie Byers [page 242]. He advised that the temperatures they were recording did not seem excessive but the staff were still uncomfortable. He added that *'the more staff in the room the hotter it becomes (consultants and scrub nurse also wear scrub gowns over their lead aprons).'*

51. In cross examination, Mr Roberts accepted that steps could be taken to reduce the temperature in room 5 and then increase it in other rooms. He referred to fitting trimmer or heater batteries, which fits into the duct work. He explained in very basic terms how air comes in and crosses the battery – installed in the ducts leading to other rooms - which raises the temperature in those other rooms. That may be an over-simplistic and perhaps not entirely accurate description of the system. However, the point is, that there was something that could be done to maintain higher temperatures in other rooms, while reducing the temperature in room 5. However, to do that in all the other rooms would be a substantial exercise, requiring further investigation and assessment. Mr Roberts would need to investigate what the electrical infrastructure was, what kilowatt heat could be provided, whether there was any risk of overloading the system and the feasibility of fitting batteries in the duct work, which might be inconvenient and in respect of which there would be a financial cost. No such assessment as to the feasibility or cost was carried out.
52. Rather, the estates team continued to monitor the temperature in room 5 and were still doing so at the date of Mr Roberts' witness statement, which was November 2020. The last time he checked the temperature it was an average of 22 degrees. This was on **26 October 2020**. In paragraph 9, he said: *"The next step if the temperature of 22 degrees is not considered acceptable by the Radiology Department would be individual room control which would have a significant capital investment required and would therefore need to be actioned by the Radiology Department using the Trust's capital request procedures."*
53. Thus, by **October 2020**, and as far as we can see from the evidence, as of the date the Claimant left the Trust, the Respondent had not resolved the issue with temperature in room 5, despite a Datix Incident Report having been raised in **May 2019**.
54. Mr Roberts agreed with Mr McDevitt that it was not 'beyond the wit of man' to reduce the temperature in one room, saying that 'anything is possible'. In his witness statements, the Respondent advanced no positive evidence of the cost of introducing individual room control for room 5. Nor did it advance any positive evidence of the cost of fitting the trimmer/heater batteries to which Mr Roberts referred only in answers from the Tribunal. In answer to a question of Mr

Roberts from the Tribunal, he explained that the Trust had recently installed a separate air handling unit in the CT scan room. He thought this was from capital investment and while not sure precisely, believed the whole cost of the work done in that room to be in the region of £380,000 – that was for the whole works. As for the air handling unit, and the work to install it, he estimated this cost to be in the region of about £120,000. The installation of the air handling unit was only undertaken because they had replaced the CT scanner. We were not told anything about budgets, available capital or other funding that was or might be available to the Respondent for the purposes of either installing an individual air handling unit in room 5 or fitting duct mounted heater/trimmer batteries, or the cost of undertaking that work. We can only surmise that these things would have been costly, but without any evidence as to the cost and the impact of the cost on budgets or as to the availability of funds, the Tribunal could not say whether this was affordable or not. The totality of what the Respondent had done in response to the temperature concerns in room 5 was to monitor temperatures and replace a thermometer and a grill.

### **Occupational health and other medical advice, from March 2019**

55. On **25 March 2019**, Occupational Health (Lisa Dawson, senior nurse) wrote to Karen Green, matron to advise that the Claimant suffered from a skin condition and that she may require some adjustments to her role on a short-term basis to allow her to remain at work. The wearing of the lead apron was mentioned. It was thought that, as the Claimant wore the lead apron for long periods of time during the day, this generated heat on her body which in turn caused irritation and discomfort. Occupational health suggested that management look at adjustments to her role/alternative duties in the short term to help prevent any exacerbation of her allergy, if possible, to give her duties that do not require the wearing of the lead apron for long periods of time (**page 161**).
56. As an interim measure, the Claimant's colleague, Rachel Oliver, agreed to work as scrub nurse and it was agreed that the Claimant would act as circulating nurse. This would allow her to remove her lead apron in between the arrival of patients. Fiona Kirkpatrick, Lead Radiographer and Radiation Protection Supervisor, whom the Claimant approached for some advice, suggested to the Claimant that she obtain an alternative apron from theatres. That apron was a lighter lead apron (or lead equivalent). A lighter lead apron is what it says it is: it is 'lighter'. That is, it is lighter than the apron that was used within the radiology department.
57. The Claimant did obtain a lighter lead apron. She arranged this herself by borrowing it from a theatre, as they were not readily available in the radiology department. She used it for one session to get a feel for it and to try and gauge if it was easier on her back. It felt lighter for sure. However, she was not able to measure its success from that single session as her back had been particularly bad at the time. This one usage of the lighter apron has on occasion been

referred to by the Respondent as a 'trial'. However, it was not a trial in any meaningful sense of the word. There was no measurement or monitoring of its use and effects on the Claimant over any period of time. She simply tried it for a session and concluded that it certainly felt lighter on her body. She could only use it for one session because she had to return it to the theatre from which she borrowed it.

58. Between **25 March 2019** and **08 April 2019**, the Claimant worked in such a way as to minimise the amount of time wearing leads (as stated above, she acted as circulating nurse). Mrs Clayton was on leave either for all or at least for a part of this time. To the extent that duties were adjusted in that period, this was arranged personally between the Claimant and her colleague, Rachel Oliver.
59. On **08 April 2019**, as a result of the pain caused by her skin condition, the Claimant commenced a period of sick leave. She had an appointment with her dermatologist on **10 April 2019**, following which she commenced a more intense treatment. She was seen by Doctor Fiona Ewart, Specialty Doctor. Dr Ewart advised that the lead apron which she wears at work seems to have exacerbated her rash to an extent. This can only be a reference to the lead apron that the Claimant had always worn – i.e. the only apron available to her, being the heavier apron. We do not find this to be a reference to all lead aprons. There was no indication that Dr Ewart was aware of the availability of lighter lead aprons. She was to see the Claimant again in 6 weeks' time. Dr Ewart updated the Claimant's general practice in a later dated **11 May 2019** (**page 123-124**).
60. On **25 April 2019**, the Claimant returned to work. She had a return-to-work interview with Mrs Clayton (**pages 162-164**). Following this she was supported by Mrs Clayton in doing amended duties. These were short term adjustments, in line with occupational health's advice of **25 March 2019**. This support involved some rotation of duties away from room 5, continuing to undertake the role of circulating nurse rather than scrub nurse (thus minimising the amount of time she had to wear a lead apron) and undertaking pre-assessment of patients. Mrs Clayton also arranged for the Respondent's Estates department to investigate the cause of the hot temperature of the Fluoroscopy room, following a discussion with the Claimant that the heat in the room aggravated her condition.
61. The Claimant was seen again at the dermatology clinic on **22 May 2019**, again by Dr Ewart. She updated the Claimant's GP in a letter dated **23 May 2019** (**page 125-126**). Dr Ewart observed that the rash has recurred and seems to be related to possibly the pressure effect of her lead apron and that sweat may also be a contributing factor. The doctor wondered about whether the episodes are being precipitated by the pressure effect of her lead apron at work. Although it is not referred to in that letter, the Claimant accepts that she was advised not

to wear lead aprons. When the Claimant said that she was required to wear lead aprons at work, Dr Ewart said that she could always get another job. We find that, as she said in oral evidence, during this visit to the dermatology clinic, the Claimant mentioned the possibility of wearing a lighter lead apron and was told to raise that with occupational health.

62. After the visit to Dr Ewart, also on **22 May 2019**, the Claimant told her line manager, Mrs Clayton, that she had been diagnosed with the condition urticaria and that she could no longer wear a lead apron as the condition was exacerbated by heat and pressure. Mrs Clayton agreed that she and Rachel Oliver would carry out all work which required the use of a lead apron and in the meantime the Claimant would continue to focus on alternative duties, including more nursing administration. Mrs Clayton referred the Claimant to Occupational Health.

63. On **07 June 2019**, the Claimant attended a further assessment with Lisa Dawson. She was accompanied to that meeting by Fiona Kirkpatrick. The Claimant informed occupational health that she had been advised at the recent visit to the dermatology clinic not to wear the lead apron. Ms Dawson's report, dated **10 June 2019** and found at **page 171-172** of the bundle stated that:

- a) It is likely that the Claimant's condition would fall within the ambit of the Equality Act;
- b) The Claimant was not fit for her full-time role but that she would be fit to work in an amended role with reasonable adjustments to support her. This was with a view to supporting her to remain at work in her department.
- c) There should be discussions between management, the Claimant and HR to look at all options to support the Claimant in her work area with reasonable adjustments;
- d) All options regarding adjustments should be considered before going down the route of redeployment;
- e) Adjustments may be required in the longer term;
- f) A discussion had taken place between occupational health and the Claimant as to whether lighter lead aprons could be used for short periods to prevent exacerbation of the skin condition;
- g) A work life balance stress risk assessment would be advised at the earliest convenience;
- h) Action plans are put in place to support the Claimant where required.



64. As set out above, occupational health referred in this letter to light lead aprons because the Claimant raised it with OH as had been suggested to her by Dr Ewart. Having done so, Lisa Dawson said to the Claimant that if she was happy to try it for a short time to see if her skin settled, she should and then go from there. We find that Ms Dawson must have considered it worthwhile on the basis that she considered that the wearing of lighter leads, either alone, or in conjunction with other adjustments, had a prospect of preventing exacerbation of the Claimant's condition. Mrs Clayton received that report on or about **10 June 2019**.

65. Jumping ahead in time, and out of sequence for now, there was a further occupational health report dated **06 March 2020** from Dr Ndovela (**page 318-319**). The advice largely repeated advice which had been given the previous year by Lisa Dawson and Stephanie Doughty. The Claimant was assessed as fit to do her work with the suggested adjustments and modifications previously suggested. Dr Ndovela advised that, in the event that the recommended adjustments were not effective in minimising the symptoms for the Claimant, then medical redeployment could be considered.

#### **Meeting of 11 July 2019**

66. On **11 July 2019**, the Claimant, accompanied by her trade union representative, Jane Hamilton, met with her line manager, Janice Clayton and an HR representative, Colleen McNicholas. The meeting was to discuss the occupational health report of **10 June 2019**. The Claimant had attempted to speak to Mrs Clayton about the report before the planned meeting but Mrs Clayton declined, saying that she should wait until the meeting where there would be an HR officer present.

67. At the meeting, the Claimant offered suggestions of adjustments as follows:

- a) That the Respondent provide light lead aprons for her to wear for short periods;
- b) That the Respondent rotate her radiology duties with other members of the cardiology nursing team;
- c) That, while the x-ray tube is emitting radiation for Fluoroscopy/CT imaging, she be permitted to monitor the patient from behind the fixed static lead screening shield in the room;
- d) That the Respondent address (by decreasing) the temperature in the room.

68. The Claimant also informed Ms Clayton that she had discussed the proposed adjustments to her role with colleagues, including Consultant Radiologists,

Consultant Cardiologists, Radiographers and Nurses and they were all prepared to support those adjustments by way of a 3-month trial and then further assess the situation. A list of those individuals is on **page 180** of the bundle.

69. As regards the wearing of a light lead apron, the Claimant's position was that when acting as circulating nurse, she would not need to wear a lead apron if she could stand behind the protective screen during radiation emission. There may be occasions when she may have to wear a light lead apron, for example in those cases when she had to be beside the patient, for example to keep the patient's airways open during an oesophageal stent procedure (which were relatively few). She would wear the light lead apron when acting as scrub nurse. The objective, from her perspective, was to minimise the occasions when she had to wear leads. This was also the case in respect of rotating some duties with cardiology nurses.
70. The Claimant accepted in evidence that her proposed adjustments were discussed at that meeting but she says that only redeployment was offered. She says that she perceived Mrs Clayton to be unwilling to explore the Claimant's suggestions, and that she and HR were prepared to proceed only on the basis that redeployment was really the only option for the Claimant. Unfortunately (and, given the presence of an HR representative and the importance of the meeting we would add, surprisingly), there were no notes of this meeting. It appears that the Claimant's trade union representative made no notes either. We would expect an organisation of the size and resources of the Respondent, especially when
71. When discussing the proposal that the Claimant monitor patients while standing behind the static screen, Mrs Clayton said *'that is not the way we do things'*. She accepts that she said this but there is a dispute between the Claimant and Mrs Clayton as to what she meant by that. The Claimant understood her to mean that she was not going to change the routine way in which they worked, that she was reluctant to change anything. Mrs Clayton says that she meant only that standing behind the screen was not their practice.
72. It is, we find, a bit of both. It was indeed not the practice of the radiology department that the circulating nurse would stand behind the static screen during radiation emission and then approach the patient after the radiation was emitted. To that extent, what Mrs Clayton said was right. However, we also find that the phrase was designed to convey to the Claimant that Mrs Clayton would not change the practice. Through experience and maturity, people learn to pick up on the messages and signals imparted by the use of language, especially when they have known and worked alongside each other for many years. It was clear to the Claimant that Mrs Clayton was, in effect, saying to her 'that is not the way we do things' and that it 'will not be' the way we do things. In other words, Mrs Clayton was shutting her mind to change.

73. Not only did the Claimant perceive this to be Mrs Clayton's position, we find as a fact that it was her position. Mrs Clayton held a firm view at that meeting that none of the proposed adjustments could be accommodated. It is a view from which she has not since deviated. Mrs Clayton makes no secret of this. She holds to that view, not out of any sort of animus or ill-will towards the Claimant. We have no doubt that Mrs Clayton saw herself as a friend of the Claimant's (at least when at work) and was supportive of her. Her mindset was based on her genuinely held desire to do the best for her patients. It was her views on the quality of nursing care, the high standards to which she subscribed that led her very quickly to conclude that monitoring patients from behind a screen was not acceptable practice. In short, Mrs Clayton's view is that to make the suggested adjustment [paragraph (c) above] would compromise on the quality of nursing care that her team delivers to patients. We find that her view was that the patients come first and, regrettable though it may be for the Claimant, the only real option for the Claimant was to be redeployed. If there was a conflict between the Claimant's needs and Mrs Clayton's view of what the patients needed, the patients came first. Coming first, we find, meant that the Claimant's proposed adjustment (c) would never be accepted – or even trialled - by Mrs Clayton.

74. Therefore, while she was quite prepared to discuss the Claimant's suggestions with her at the meeting on **11 July 2019**, it was with a view to explaining to her why they would not be accommodated. She was not willing to trial any of the suggested adjustments. Neither Mrs Clayton nor HR came up with any suggestions of their own, other than redeployment.

75. We infer that this was the view of Mrs Clayton from the following:

75.1. She was not prepared to countenance any trial period of the use of light lead aprons. This was because of the genuine belief of Mrs Clayton (and accepted by HR) that to permit the Claimant to wear even a lighter apron would be to go against medical advice.

75.2. She was not prepared to countenance any trial period involving the Claimant standing behind the static screen to monitor patients. This was because Ms Clayton genuinely believed that patients who would be monitored from behind a screen when the Claimant was acting as circulating nurse would receive a lower level of nursing care than when she or the other nurse, Rachel Oliver, were acting in that capacity and this was not acceptable to her;

75.3. She was not prepared to discuss the proposed adjustments with any of those listed on **page 180**. We accept that most of those are not nurses, and none is a cardiology nurse, but as Mrs Clayton accepted in evidence, they would have had a valuable contribution to make to the

discussion as they are all professionals who work in the same department. She did not speak to them because of her belief that the monitoring of patients from behind a static screen meant a lower level of nursing care and that only experienced radiology nurses could make that assessment.

- 75.4. She said to the Claimant '*that is not the way we do things*', thereby conveying her view that no change would be made to the way they do things with regards to monitoring patients.
- 75.5. In an email dated **12 June 2019 (page 173)**, Julie Mills, Matron Clinical Support says: "*I would think (Janice can clarify) that it would be impossible to work in either site in radiology if unable to wear the lead apron particularly as a Senior Nurse*". Nowhere did Mrs Clayton disagree with that at the time.
- 75.6. In evidence, when asked about whether she was of the same view as Julie Mills, Mrs Clayton said '*she had never heard of a radiology nurse who does not wear a lead apron, so would guess 'yes'*'. We infer from this that Mrs Clayton had in mind the usual, heavier, lead-apron that radiology nurses had traditionally worn in her department, as that was the only style apron that they used in the department.
76. Following the **11 July** meeting, on **15 July 2019**, Laura Berry was doing a walk around in the radiology department when she saw the Claimant. The Claimant broke down in tears when Ms Berry asked her how she was doing. She explained to Ms Berry that she had been to a sickness review meeting recently and that redeployment to another role had been discussed. This was a reference to the meeting of **11 July**. Ms Berry said that, if they had suggested redeployment at that meeting, she was sure that they would have carried out all the necessary assessments before suggesting this. Ms Berry explained how the redeployment process would work. She was explaining the process. She did not convey to the Claimant that any decision had been made on redeployment – Ms Berry was not in a position to know this one way or the other as she had not been involved in the previous discussions.
77. The same day, **15 July 2019**, the Claimant wrote to Ms McNicholas to record her concerns about the meeting (**page 180 – 181**). In the letter, she referred to the fact that she worked in a multidisciplinary team and named those with whom she had spoken to ask if they were willing to trial the proposals suggested in the occupational health report. She said that they had all agreed to trial them for a limited period of three months and that they were happy to speak to management about the proposals if they so wished. One of those on the list was Dr Cooper, Consultant Lead Radiologist. Neither Mrs Clayton nor anyone from HR or wider management spoke to anyone on that list. Mrs Clayton's rationale for not doing so (as she explained to the Tribunal) was firstly, that no-

one on the list was a cardiology nurse and therefore would not know the role of the cardiology nurse and secondly, that she did not know what might have been said to anyone and therefore would not have wished to breach the Claimant's confidentiality by speaking to them about her health and needs. The latter could easily be overcome by checking with the claimant that she was happy for her to speak to them about those things (which she clearly was) and the former seems to us as a rather 'purist' and unnecessarily restrictive approach to the exercise. The fact that those on the list were not radiology nurses may be so, but to say that they do not know the role cannot be right. They may not undertake the role but they would (as Mrs Clayton accepted in evidence) be able to contribute something worthwhile to the debate about whether the Claimant could undertake her nursing roles, with the suggested adjustments, in a way which would not harm patients.

78. We are satisfied that the Claimant spoke, as she says she did, to each of those on the list, about wearing light lead aprons and monitoring patients from behind the screen while the x-ray tube was emitting radiation for Fluoroscopy/CT Imaging. Indeed, although he was not present to be challenged, Dr Cooper speaks of this in his witness statement. Ordinarily, a witness statement that is not challenged in evidence is given little weight. However, it is not a rule that no weight be given to such statements. Appropriate weight can be given to statements which are unchallenged and unsworn, especially if they are supported by other evidence. There is no suggestion that the Claimant did not have the support of those on the list on **page 180**. The Respondent had every opportunity to speak to any of them, as it was invited to at the time and declined. Dr Cooper's statement is actually uncontroversial. We accept what is said in that statement.
79. Therefore, a body of professionals as listed on the Claimant's letter were willing to trial alternative methods of work (light lead aprons and monitoring from behind the screen) and to review after the trial. The Claimant was clear in that she wished the Respondent to undertake a trial of these working methods and that, if at the end of the trial, it could be seen that patient care had been compromised, she would seek redeployment.
80. At this juncture, it is relevant to set out our finding that a proposal to alter the well-established procedures of monitoring CT scan patients had been made in the past. We were not given the date this happened or the identity of the person who introduced the proposal. However, it was not in dispute that prior to the Claimant developing her skin condition, a proposal had been made that, when radiation was being emitted, the radiology nurses could leave the patient and monitor him/her from the monitoring control room (the equivalent of the fixed static screen in room 5). Mrs Clayton spoke to the Claimant and Ms Oliver about this at the time. She said that this was something they could do, if they wished. However, all three decided not to, on the basis that – as dedicated nurses – they would stay by their patient's side (or nearby them at the very least). Other

professionals (radiographers, etc..) monitored from within the monitoring room, but not, they decided, nurses.

81. It is also relevant to set out our finding that, more recently, the claimant herself had acted as circulating nurse on three angiograms in room 5 and monitored her patient safely from behind the protective screen (see paragraph 35 above). She also nursed on a biopsy with Dr Hall, monitoring the patient from the shielded control room of the CT scan room. When monitoring the angiogram patients from behind the protective area, she was able to see the patient clearly through the glass. Indeed, she had a better view than when she monitored the patient by standing with her back against the cupboard (as described in paragraph 31 above). She was also able to monitor the patient's progress on monitors located behind the protective screen.
82. It is also relevant to state our finding that the Claimant was aware of a consultant in Sunderland whose practice was to move to a position behind the screen during radiation emission.
83. From these facts (and in particular the finding that the radiology nurses considering monitoring CT patients from the control room and from the finding that the Claimant had monitored some angiograms and a biopsy from behind the screen) suggests that the RCN reference to remaining in the procedure room (however that is defined) is set in stone. Indeed, we infer that that particular guideline – even assuming the Respondent to be right as to the boundaries of the procedure room – is not set in stone. It is, as the name suggests, only a guideline in any event.

### **The Claimant's grievance**

84. On **16 July 2019**, the Claimant commenced a period of sick leave from which she never returned to work. On **22 July 2019**, she submitted a formal grievance. This was investigated by Kay Stidolph, Associate Directorate Manager for Urgent and Emergency Care. Ms Stidolph interviewed a number of people, including Fiona Kirkpatrick, the RPS. The notes of that interview are at **pages 230.12 to 230.22** of the bundle. Ms Kirkpatrick advised Ms Stidolph that lighter lead aprons provided a suitable level of protection in relation to the job that she was doing, certainly for shorter procedures (such as HSG procedures) and that she was not sure about longer periods where she may be scrubbed for a procedure. Ms Kirkpatrick also was of the opinion that the Claimant could monitor patients from behind the protective screen, as it probably was not necessary to have a circulating nurse standing next to the patient during irradiation.
85. There was an occasion when a patient required an urgent pace-maker fitting. The Claimant said she could monitor the patient from behind the screen during irradiation. Ms Kirkpatrick contacted Dr Jachuk to check if he was comfortable

with this and for him to do the procedure with only him scrubbed (and that the Claimant would sterile prepared the trolley for him in advance). She understood that Dr Jachuk was comfortable with this.

86. There were quite a few consultants who wore light lead aprons [page 230.21]. In cross examination, Mrs Clayton accepted that it was reasonable to trial the wearing of light lead aprons and that she could have done it sooner than it was decided on (on the outcome of the Claimant's grievance) if the Claimant had medical clearance to wear a light lead apron.
87. There was a further occupational health assessment on **20 August 2019**, again with Lisa Dawson. In her report of the same date, Ms Dawson repeated the advice that she had previously provided. She added: "I would only advise redeployment when the reasonable adjustments have been tried." She also expressed the opinion, that until there was some discussion and plan regarding how the Claimant could be supported with reasonable adjustments, she did not feel the Claimant would be in a position to return to work. Ms Dawson was of the view that the current situation was having a marked impact on the Claimant's emotional wellbeing. We find that this was indeed the case. The Respondent's inactivity with regards to the proposed adjustments, and its failure even to engage with other professionals, as the Claimant had asked, had set the Claimant back and was causing her anxiety and upset.
88. On **27 November 2019**, Ms Stidolph wrote to the Claimant with the outcome of her grievance (page 286). It can be summarised as follows:
- (a) The adjustment that the Claimant stand behind the static screen to monitor patients could not be supported as it was felt that this would impact on the high level of care currently being given by Mrs Clayton's service;
  - (b) The purchase of a light lead apron could be financed, so that a 3 month trial of its use could be undertaken to gauge the impact on the service, subject to approval from the Claimant's Consultant Dermatologist or GP that wearing the apron would not be detrimental to the Claimant;
  - (c) There was no suggestion that JC had disclosed any information to other members in Radiology about the Claimant leaving the service, or being redeployed.
89. On **10 December 2019**, some two weeks after Ms Stidolph's grievance outcome, letter the Claimant's GP confirmed that the Claimant could trial light lead aprons [page 292]. The Claimant appealed the grievance outcome on **10 December 2019**. However, that appeal was never heard.
90. In Ms Stidolph's witness statement at paragraph 10 she says that it would have been 'difficult to accommodate' the Claimant's suggestion of standing behind

the static screen to monitor patients while the radiation procedure is under way. That view is based almost entirely on Mrs Clayton's explanation that one of the roles of the radiology nurse involves providing emotional and clinical support, ensuring the patient is comfortable, being able to closely observe the patient, offering support to the patient and keeping them informed during a procedure. It was Mrs Clayton's view that part of the role could not be carried out effectively behind a static screen. Mrs Clayton was concerned that, by implementing that adjustment, it would dilute the level of care given to patients. Ms Stidolph had no experience of working in radiology. However, she accepted Mrs Clayton's explanation that, to permit monitoring of a patient from behind the protective screen, would allow a difference in treatment between patients.

91. Ms Siddolph did not deal with the issue of rotating the Claimant's radiology duties with other members of the cardiology nursing team. That was, we find, because it was not central to the Claimant's grievance. Nevertheless, it was a proposed adjustment to her duties, in respect of which no investigation or assessment was undertaken.

#### **Rotation of duties with cardiology nurses**

92. Ms Stidolph did not say anything in the grievance outcome letter about the other adjustments that the Claimant had asked for, namely rotation of duties and the temperature reduction in room 5. In her evidence, she said that the temperature was being looked at by 'Works'. As for the rotation with cardiology nurses, she said that it would be difficult to do this because there are different directorates or services involved.
93. The Claimant is an experienced radiology nurse. Cardiology nurses do not necessarily have the skills to undertake that specialist nursing role. The Respondent did not suggest that they could not acquire the skills, only that they would require training. In cross examination, the Claimant accepted Mr Sangha's proposition that it would take considerable time and effort. She added that this is not to say that it should not be done. Precisely what that training involved, or how long it would take we were not told. No-one on behalf of the Respondent expanded on the type of training, the amount of it, or the duration of it. As far as Ms Stidolph knew, no-one from the Respondent looked at the feasibility of rotating duties. She would not have expected that to be an avenue to be explored if there was no agreement between the two directorates.
94. Cardiology nurses were, in fact, deployed from time to time in radiology, to cover sickness absences or to cover annual leave. Ms Stidolph accepted that this was the case. However, she added that this was okay in the short term but in the longer term, it would mean having to look at a change of roles. She did not look into this because she did not think it reasonable.



95. In Ms Mills' evidence, she accepted that a cardiology nurse was competent to undertake the role of circulating nurse under a nurse in charge. However, she added that such a nurse would not be competent (without further training) to be a radiology nurse. We accept that some training would be required but were not in a position to determine how much was required, owing to the absence of any evidence to that effect. However, when acting as a circulating nurse, there would be another radiology nurse present: either Mrs Clayton, or Rachel Oliver – or the claimant - acting as scrub nurse, as was the case when cardiology nurses had previously used to help out during periods of annual leave and sickness absence.
96. Cardiology nurses were available to assist with two morning planned lists per week. This was not in dispute. We accept that it would be more difficult to deploy cardiology nurses to assist with unplanned cases, including emergency cases but this is not what was being sought.

### **March 2021: Zero Gravity Radiation Protection System**

97. The Claimant first presented her Claim Form in these proceedings on **28 November 2019**. It was listed for a three-day final hearing commencing on **01 March 2021**. That hearing, before EJ Green and members, did not go ahead and it was converted to a case management preliminary hearing. At the hearing, the Claimant made an application to add documents to the hearing bundle, referring to a 'Zero Gravity suspended radiation protection system'. This was the first time this system had been referred to in the proceedings and it had never been mentioned by the Claimant since developing urticaria. Therefore, the preliminary hearing, the Claimant, through her counsel, was raising for the first time a new suggested adjustment for the purposes of her complaint of failure to make reasonable adjustments.
98. This suggested adjustment was added to the issues in the case and in due course, the Respondent obtained supplemental witness statements from Laura Berry and from Mrs Clayton. The Claimant also served a supplemental witness statement.
99. The Zero Gravity Protection System is a suspended radiation protection system which provides weightless radiation protection. There are two versions of the system available: a ceiling mounted system and a floor based system.
100. The Claimant first heard about such a thing as a zero gravity system back in about **2017**. At the time of these proceedings, she only had a vague recollection of it and recalled that she looked it up on Youtube. She did so out of curiosity, simply because she had an interest in things that came up in discussion and work. However, she thought no more about it. She next came to hear about in about **May 2019** when it had been mentioned, in passing, by a cardiologist, Doctor Nasser. He too had apparently seen a reference to it and

looked it up on line. The Claimant never mentioned the existence of the system or that it could be considered for her to anyone in management, or to anyone who might be responsible for putting in place reasonable adjustments in the workplace. Had Dr Nasser not mentioned it, and had it not come up in passing conversation back in **2017** she accepted that she would never have known of its existence. She did not mention it prior to **March 2021** (which was to be the first day of the final hearing) because it was, she acknowledged, an expensive piece of equipment. However, we also find that she did not mention it because it was not widely known about and it was not at the forefront of her mind. She raised it at the hearing in **March 2021** because, in the consideration that is given to issues during the course of litigation, it came to the fore as being yet another option.

101. Janice Clayton had not heard of this system prior to it being mentioned at the hearing in **March 2021**. Fiona Kirkpatrick, the RPS, had never mentioned it to anyone and it was not something that had been mentioned to or raised by occupational health. Laura Berry, Directorate Manager for Diagnostic Imaging, had not heard of this system prior to it being raised at the hearing in **March 2021** either. However, after it had been raised she undertook some research into it. She made enquires about the system with the company that markets it in the UK, namely Biotronik. There is no dispute that the system is expensive. The cost of one unit was in the region of £80,000. It was unclear whether the Claimant would require one, two or three units. Even if one unit, the cost was substantial and would come out of capital spend. As explained by Ms Berry in her second witness statement, the cost and maintenance cost would have to be approved and this would take some time, if approved at all. She also spoke to colleagues and to the Estates department to get an understanding of how the equipment could physically be accommodated at either South Tyneside or Sunderland.

102. As of **10 March 2021**, on the evidence we have seen, there were no ceiling mounted systems anywhere in the UK. The only known floor mounted version had been purchased in Eastbourne [page 479].

103. If the Claimant was able to stand behind a protective screen, while acting as circulating nurse (for all procedures save perhaps for those smaller number of cases where she may have to keep airways open) then she would not require a zero gravity protection system. It may be something, however, that she could use as a scrub nurse, or if she was not permitted to monitor from behind the protective screen, when acting as circulating nurse and if not wearing light lead aprons.

104. We heard much evidence about floor space, dimensions of the systems, the sweep of the equipment, the limited amount of room space. Whatever the precise dimensions, we find that to install either a ceiling mounted system or use the mobile floor system would have introduced a significant piece of

equipment into an already busy room and it would have presented logistical difficulties for the Respondent. We are not saying that those logistical difficulties would be insurmountable, but they would have presented real practical difficulties and as such, from the point of realising the existence of such equipment, it would have taken some time in order to understand the equipment, inspect it, purchase it and fit it into room 5.

105. We were not told when the Claimant gave notice of her retirement, or indeed of the precise date of her retirement. All that we were told was that she retired in June 2021 following notice. It is reasonable to infer that she gave at least 4 weeks' notice (the minimum required under her contract of employment). Therefore, notice must have been given on **30 May 2021** at the latest, although it could have been earlier, on **01 May 2021** even before.

106. The Claimant remained on sick leave up to her retirement.

### Relevant law

#### Sections 20-21 Equality Act 2010: failure to make reasonable adjustments

107. The duty is set out thus:

- (1) 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.
- (2) The second requirement is a requirement, where a physical feature 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.
- (3) In relation to the second requirement, a reference in this section or an applicable Schedule to avoiding a substantial disadvantage includes a reference to—
  - (a) removing the physical feature in question,
  - (b) altering it, or
  - (c) providing a reasonable means of avoiding it.
- (4) A reference in this section, section 21 or 22 or an applicable Schedule (apart from paragraphs 2 to 4 of Schedule 4) to a physical feature is a reference to—

- (a) a feature arising from the design or construction of a building,
- (b) a feature of an approach to, exit from or access to a building,
- (c) a fixture or fitting, or furniture, furnishings, materials, equipment or other chattels, in or on premises, or
- (d) any other physical element or quality.

108. Paragraph 20 of Schedule 8 of the Act provides:

(1) A is not subject to a duty to make reasonable adjustments if A does not know, and could not reasonably be expected to know—

(a) ....

(b) [in any case referred to in Part 2 of this Schedule] that an interested disabled person has a disability and is likely to be placed at the disadvantage referred to in the first, second or third requirement.

109. The focus of section 20 EqA is on affirmative action: **General Dynamics Information Technology Ltd v Carranza** [2015] I.C.R. 169, EAT, para 32. It is imperative to correctly identify the ‘PCP’. Without doing this, it is not possible to determine whether it has put the disabled person at a substantial disadvantage or what adjustments are required. The question that has to be asked is whether the PCP put the disabled person at a substantial disadvantage compared with a non-disabled person. In the case of **Ishola v Transport for London** [2020] IRLR 368, the Court of Appeal observed that the words ‘provision, criterion or practice’ are not terms of art, but are ordinary English words. They are broad and overlapping, and in light of the object of the legislation, not to be narrowly construed or unjustifiably limited in their application. The function of the PCP in a reasonable adjustment context is to identify what it is about the employer’s management of the employee or its operation that causes substantial disadvantage to the disabled employee. In context, and having regard to the function and purpose of the PCP in the 2010 Act, all three words carry the connotation of a state of affairs indicating how similar cases are generally treated or how a similar case would be treated if it occurred again (see Simler LJ @ para 38).

110. The employer must take such steps as it is reasonable to take to avoid the disadvantage (section 20(3)). It is well established that ‘steps’ are not merely the mental processes, such as the making of an assessment but involve the practical actions which are to be taken to avoid the disadvantage: **General Dynamics Information Technology Ltd v Carranza**, @ para 35.

111. Any modification of, or qualification to, the PCP in question which would or might remove the substantial disadvantage caused by the PCP is capable of amounting to a relevant step under section 20(3). There is no requirement that the adjustment must have a good prospect of removing the disadvantage. It is enough if a tribunal finds there would have been a prospect of the disadvantage

being alleviated: **Leeds Teaching Hospital NHS Trust v Foster** EAT 0552/10. The only question is whether it was reasonable for it to be taken.

112. The duty to comply with the reasonable adjustments requirement under section 20 begins as soon as the employer can take reasonable steps to avoid the relevant disadvantage: **Abertawe Bro Morgannwg University Local Health Board v Morgan** 2018 ICR 1194, CA.

113. The PCP, or the relevant physical feature, must put the employee to a comparative substantial disadvantage. As to comparators, in **Fareham College Corporation v Walters** [2009] IRLR 991, the EAT (Cox J) said:

*“in many cases the facts will speak for themselves and the identity of the non-disabled comparators will be clearly discernible from the provision, criterion or practice found to be in play”.*

### **Knowledge of disability and disadvantage**

114. In considering whether the employer can be said to be subject to a duty to make reasonable adjustments, the Tribunal must consider the knowledge of the Respondent. The law is clearly articulated in **Department of Work and Pensions v Alam** [2010] IRLR 283. The employer is not under a duty to make reasonable adjustments if it did not know or could not reasonably have known:

- a. That the employee was a disabled person, and
- b. That he was likely to be placed at a substantial disadvantage by the relevant PCP

### **Burden of proof**

115. Section 136 Equality Act 2010 provides that:

- (2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred;
- (3) But subsection (2) does not apply if A shows that A did not contravene the provision

116. Section 136 EqA, otherwise known as the burden of proof provision, lays down a two-stage process for determining whether the burden shifts to the employer. However, it is not obligatory for Employment Tribunals to apply that process. Whether there is a need to resort to the burden of proof provision will vary in every given case. Where there is room for doubt as to the facts necessary to establish discrimination, the burden of proof provision will have a role to play. However, where the tribunal is in a position to make positive findings on the evidence one way or the other, there is little to be gained by

otherwise reverting to the provision: **Hewage v Grampian Health Board** [2012] I.C.R. 1054.

117. In cases where the tribunal is not in a position to make positive findings, s136(2) means that if there are facts from which the tribunal could properly conclude, in the absence of any other explanation, that A had failed to make reasonable adjustments or harassed B, it must so conclude unless A satisfies it otherwise. In considering whether it could properly so conclude, the tribunal must consider all the evidence, not just that adduced by the Claimant but also that of the Respondent. That is the first stage, which is often referred to as the 'prima facie' case. The second stage is only reached if there is a prima facie case. At this stage, it is for A to show that he did not breach the statutory provision in question. Therefore, the Tribunal must carefully consider A's explanation for the conduct or treatment in question: **Madarassy v Nomura International plc** [2007] I.C.R. 867, CA; **Igen Ltd v Wong** [2005] I.C.R. 931, CA.

118. In the case of **Project Management Institute v Latif** [2007] IRLR 579, the EAT considered the application of section 136 in the context of reasonable adjustments. The burden does not shift at all in respect of the 'PCP' or 'substantial disadvantage'. Those are aspects of the complaint and issues of fact which a Claimant must establish in every case. The reversal of the burden comes into play on the issue of adjustments. By the time a case comes before a tribunal there must be some indication of what adjustments it is alleged should have been made. The burden is reversed once a potentially reasonable adjustment is identified. It is for the Claimant to identify not only that the duty to make reasonable adjustments has arisen but that there are facts from which it could reasonably be inferred, absent an explanation, that it has been breached. Therefore, there must be evidence of some apparently reasonable adjustment that would have avoided the comparative substantial disadvantage occasioned by the PCP. At the very least it is important for the Respondent to understand the broad nature of the adjustment proposed and be given sufficient detail to enable it to engage with the question of whether it could reasonably be achieved or not.

### **Submissions**

119. Counsel for the respondent, Mr Sangha prepared written submissions which he developed in oral submissions. Mr McDevitt made oral submissions. We have paid careful attention to those submissions. We mean no discourtesy to counsel by not setting out those submissions in these already lengthy reasons.

### **Discussion and conclusions**

120. We propose setting out our conclusions based on the issues.....

## PCP

121. Both counsel were agreed that the only real issue between the parties was whether the adjustments were reasonable (see paragraph 1 of Mr Sangha's submissions). Nevertheless, we shall record here the conclusions on PCP, substantial disadvantage and knowledge.

122. There was a single PCP in this case: the wearing of protective lead while procedures that create radiation are in progress. The reference to protective lead is to the protective lead apron that the Claimant had always worn when carrying out her duties when in the three rooms in question (i.e. the heavier lead apron). If it were otherwise, there would be no sense in suggesting the adjustment of a 'light' lead apron.

### **Substantial disadvantage**

123. It was not in dispute that this requirement to wear protective lead put the Claimant to a substantial disadvantage from about **February 2019**. We conclude that the prolonged wearing of the lead apron while carrying out the role of scrub nurse and circulating nurse exacerbated the Claimant's skin condition meaning that she would be unable to undertake her role as a radiology nurse. Logically, this in turn exposed her to the risk of sickness absence, to redeployment away from her chosen role and, in the event of no redeployment opportunities being available, also to the risk of dismissal on ill health grounds. Although the Respondent did not dispute substantial disadvantage, we conclude in any event that she was put to a disadvantage and that the disadvantage was substantial.

### **Knowledge of disability and that the Claimant was likely to be placed at the substantial disadvantage by the PCP**

124. There is no dispute that the Respondent was aware that Claimant was disabled and that the requirement to wear protective lead aprons put the Claimant at the disadvantage and we so conclude in any event.

### **Duty to make reasonable adjustments**

125. Given the above, the Respondent was, therefore, under a duty to take such steps as it was reasonable to have to take to avoid the disadvantage. While still employed the Claimant had suggested the following steps:

- a) That the Respondent provide light lead aprons for her to wear for short periods;
- b) That the Respondent rotate her radiology duties with other members of the cardiology nursing team;

- c) That, while the x-ray tube is emitting radiation for Fluoroscopy/CT imaging, she be permitted to monitor the patient from behind the fixed static lead screening shield in the room;
- d) That the Respondent address (by decreasing) the temperature in the room.

126. By the time we got to the Final Hearing (**by 21 March 2021**) the Claimant had suggested a fifth adjustment that would have avoided the disadvantage (Zero Gravity protection system).

### **Adjustments**

127. The essential question then is whether there was a step or a combination of steps which it was reasonable for the Respondent to take to avoid the substantial disadvantage occasioned by the PCP. An employer may consider that it has done a lot to help and encourage a disabled employee, as in this case and that it should not, in such circumstances, be criticised for acting unreasonably. We have found and recognise that the Respondent did a lot for the Claimant and in many respects acted reasonably: responding to her immediate concerns, providing her with short-term adjustments, covering the scrub nurse role, assuring her of the redeployment process. Our task, however, is to consider whether the Respondent acted reasonably in a general sense but to consider there was a step or steps which it was reasonable to take that might have had a prospect of avoiding the disadvantage to the disabled employee occasioned by the application of the PCP.

128. The Claimant has, in our judgement, identified apparently reasonable adjustments (as she is required by **Latif**) and in those circumstances, the Respondent must satisfy the Tribunal that it was not reasonable to make the proposed adjustment.

### **Light Lead Aprons**

129. What operates against the Respondent in relation to this particular adjustment is that, in **November 2019**, it decided that this was something it could reasonably put in place – at least for a trial period. It was the Respondent's case that it could not have provided the Claimant with a lighter lead apron earlier because to have done so would have gone against medical advice. This so-called medical advice was the advice that the Claimant had conveyed to Mrs Clayton on **22 May 2019**, following her appointment with Dr Ewart, i.e. that she should not wear a lead apron.

130. However, there was no written medical advice to that effect. We do not doubt for one moment that Dr Ewart said to the Claimant that she should not



wear lead aprons. After all, that is what the Claimant conveyed to Mrs Clayton. However, what we do not know is what Dr Ewart meant by this? For example:

- 130.1. Whether she meant that the Claimant should not wear **any** lead apron, heavy or light?
  - 130.2. Whether she know that there was such a thing as a light lead apron or a lead equivalent apron?
  - 130.3. Whether she meant that the Claimant should not wear a lead apron ever again or until further assessment after her more intense treatment had been monitored?
131. We were not alone in not knowing the answers to those questions. Neither the Claimant nor the Respondent knew them. The dermatologist letters are, in our judgement and assessment, very far from giving any considered opinion on the matter. On **page 124**, Dr Ewart says under the heading 'comments': "*....lead apron.....seems to have exacerbated*". On **page 125**, she says: "*...seems to be related to possibly the pressure effect of her lead apron.*" That is the extent of anything in writing from the dermatologist regarding the lead apron and the impact on the Claimant's condition.
132. We are not satisfied that what the Respondent refers to as medical advice not to wear lead aprons was in fact advice to that effect. Further, even if it could be so described, it was far from clear and any reasonable employer – and in particular, this employer – would and should have asked for a more definitive position. This was especially so in the face of occupational health advice that a trial of a lighter lead apron should be trialled.
133. It was the pressure effect of the heavier apron and the associated generation of heat that exercised the mind of Dr Ewart. Had someone explained to the dermatologist that there was a light lead apron, which was not so heavy and would therefore create less pressure on the body, and possibly generate less heat, it is more likely than not that Dr Ewart would have said 'give it a go', much as the occupational health physicians and nurses said. We can conceive of no reason why she would not say this, especially bearing in mind our finding that she said that the Claimant should discuss the matter with the occupational health physician. Therefore, to say that it would have gone against medical advice does not truly reflect the facts. There was medical advice from occupational health to the effect that the Respondent should try lighter lead aprons. That was advice in writing on **10 June 2019**.
134. Had the Respondent put even this adjustment in place when the Claimant suggested it, this in itself would have had a prospect of removing the substantial disadvantage to the Claimant. That prospect, we infer, is not a fanciful one – otherwise it is highly unlikely that occupational health or the

Claimant's GP would have sanctioned a trial, as he/she did within two weeks of Ms Stidolph's grievance outcome.

135. Therefore, we conclude that, following receipt of the Occupational Health report on **10 June 2019**, it would have been reasonable for the Respondent to have sought clarity from Dr Ewart upon seeing the suggestion of a trial of light lead aprons. That could have been done, with the Claimant's agreement, in advance of the meeting which eventually took place on **11 July 2019**. Certainly it could and should reasonably have been done immediately upon conclusion of the **11 July 2019** meeting. It was not, we conclude, because of Mrs Clayton's fixed view of the way in which radiology nurses should work and the focus of that meeting, was as the Claimant suggested, on redeploying her into another role.

136. In the face of the Claimant's request to trial light leads and in light of occupational health advice to trial light leads, and in the absence of any written advice from the dermatologist, and in light of our finding that the reference to not wearing leads was to the lead apron traditionally worn in the radiology department, the Respondent has not satisfied us that it was unreasonable to obtain and permit the Claimant to trial a light lead apron from **11 July 2019**. Indeed, we are entirely satisfied that it would have been reasonable to have taken this step. However, it is not simply that step that was being suggested. We must not look at this proposed adjustment in isolation. The Claimant put it forward as one of a combination of adjustments, all of which would have had a greater prospect of removing the disadvantage.

### **Monitoring from behind static screen / from the control room**

137. We infer from our finding in paragraphs 79- that no one within that body of medical professionals considered that the proposed adjustments were unsafe for patients or not practical to implement, without trial. They were willing to trial them so that they could be properly assessed. However, as we have found, that was something that Mrs Clayton was not prepared to do. In the ultimate analysis, we find that it was not down to a concern about patient safety on her part but to a genuinely held desire to give patients the best possible nursing care and support, which in her opinion required the circulating nurse to be present in the 'procedure area' (and not behind the lead screen) at all times. We respect her opinion, as a dedicated and experienced radiology nurse. However, it must be weighed against the opinion of the Claimant, who is also a dedicated and experienced nurse. It must also be looked at in the context of the views of other medical professionals, whose interest is always the safety and interests of their patients. All of those individuals were willing to trial both the wearing of light lead aprons and the monitoring of patients behind screens. Further, the evidence of the Claimant was that she had safely monitored angiograms and biopsies. This was not disputed. There was also the evidence of the offer to permit monitoring of CT patients from the monitoring room. We

made findings of fact on these matters all of which are relevant to this question of whether it was reasonable to permit a trial as requested by the Claimant. Bearing in mind that the burden is on the Respondent, we conclude that it has not satisfied us that it was not a reasonable step to take.

138. The Respondent's case was that it was not just Mrs Clayton's opinion that it was not reasonable to allow the Claimant to monitor from behind the screen (or even to trial modification of procedure). It refers to the Royal College of Nursing guidelines and emphasises that these guidelines focus on interventional procedures. Their case was that it was a requirement of the Royal College of Nursing that the Circulating Nurse remain in the procedure room with the patient at all times and that it could not modify this requirement. This led to a dispute between the parties (at least during this hearing) as to what was meant by the 'procedure room', or more precisely, the boundaries of the 'procedure room'. We were referred to **page 295.7** (South Tyneside Local Rules For the Safe Use of X rays) and **page 345** of the Guidelines for Nursing Care in Interventional Radiology (RCN/RCR). On **page 345**, it says that '*during the procedure the circulating nurse or HCA/AP should, among other things, remain in the procedure room throughout*'.
139. The Respondent argued that the procedure room was the area excluding the area behind the static lead screen. The Claimant argued that the procedure room was the whole of the room including the area behind the lead screen. She maintained that she could safely monitor patients, during the period of radiation emission, while standing behind the fixed screen. The Respondent argued that to do so, would be in contravention of the RCN/RCR Guidelines (**page 345**).
140. We do not find **page 295.7** to be of much assistance in resolving this dispute as to where the procedure room starts and ends. This is because the document refers to the Radiation Controlled Area (and not the procedure room). That area, it says, is defined by the ceilings and walls of the room but excludes the space behind the lead screen. However, that is talking about the RCA, not the procedure room. It makes more sense to us that the procedure room consists of the whole area including that area behind the screen, as that is the room where all activity takes place, whether in front of or behind the screen. However, the Respondent was adamant that the procedure room excluded the space behind the protective screen. The parties were at odds in their reading and interpretation of the guidelines in that respect. In the event, we do not think it matters what the answer to this dispute is. The RCN document is a guideline document. If it is in the guidelines, and if it is reasonable to have to modify even a well-established guideline procedure to accommodate a disabled person, then the guidelines can be changed – if, we emphasise, it is reasonable to do so. That is so, whatever the correct interpretation of the 'procedure room'.
141. The Respondent contended that the Claimant could not adequately monitor patients from behind the protective screen because she could not see

the patient clearly enough (and thus pick up on change in skin tone, distress etc). However, we found that on the occasions the Claimant did monitor from behind the static screen she could see perfectly clearly, and in fact had a better view. The Respondent also argued that it could not reasonably permit a trial of behind screen monitoring because of the risk of emergency situations arising. If an emergency arose, the patient would be at risk by her being located behind the protective screen due to the time it would take her to react to an emergency situation. Referring back to our findings in paragraphs 35 and 81 above, although no emergency situation arose on those occasions when the Claimant was monitoring from behind the screen, had one arisen we conclude that one or more of the professionals in the room would immediately indicate that there was a problem and the radiation would be stopped, thereby enabling those behind the screen to enter the area. That this would happen was not disputed. However, the Respondent argued that the distance the Claimant would have to travel to get from behind the screen to the patient was such that the patient would be at risk in an emergency situation.

142. We were not persuaded of this on the evidence. We are talking of a distance of approximately 8 feet, compared to a distance (compared to where the claimant ordinarily stood during radiation emission, which was about 4 feet, owing to the fact that during the radiation phase, all concerned would step back from the patient). Yet the cardio-technician remained behind the protective screen at all times – as we have found in paragraphs 25 and 34. If a patient were to suffer a cardiac arrest, the cardio-technician would leave the protective area to attend to the patient, having to travel the same distance as the nurse. Unlike the cardiac technician, in the Claimant's case, this monitoring from behind the screen, would only be during the emission of radiation. Before and after that phase of the procedure, the Claimant would remain outside the protective area, in the vicinity of the patient – as she did during those occasions referred to in paragraph 81 of our findings. There was no concern expressed about the cardio-technician not being able to respond quickly enough to an emergency situation. Any issue that arose, a nurse or doctor or technician would speak up, the radiation would be stopped and those in attendance would tend to the patient. It must be noted that these are emergency cases. Most cases go without incident and the Claimant is never the only one in the room and therefore never the only one to have to respond to an emergency. There were the smaller number of occasions when the Claimant was required to be in unavoidable close physical contact with a patient during the procedure was when they were inserting an oesophageal stent. But this is a risk she was always exposed to prior to developing her skin condition. It was a radiation risk. The risk to an exacerbation of her skin condition on those occasions could be addressed by the wearing of a light lead apron: thus, an example of combining adjustments.

143. We would add that, although it did not feature prominently in the case, there was available to the Respondent a mobile lead screen. If the Respondent

had concerns about the Claimant being too far away from the patient if standing behind the fixed static screen, it could reasonably have investigated whether she could effectively carry out those monitoring duties from behind a mobile screen. However, it did not consider this. Mrs Clayton was concerned that by permitting the Claimant to monitor from behind a protective screen was to dilute the quality of care that radiology nurses provided. Respectful as we are of her considerable experience and dedication as a nurse, we do not agree that there is sufficient evidence before us to enable us to conclude this. The Claimant, too, is a highly experienced and dedicated nurse and we are entirely satisfied that she would not have contemplated anything that would put any of her patients in danger or would have engaged in any practice that undermined the quality of care on offer. It may well be that by monitoring patients in fluoroscopy by standing behind the screen she would have been doing it differently to Mrs Clayton and Ms Oliver but that is not to say that this 'difference' equates to lower standards or to standards that put any patient at risk.

144. The Respondent suggested that it did not assist the Claimant's argument that the radiology nurses had been offered the opportunity to monitor CT scan patients from the monitoring room because they agreed not to do it. However, this agreement by the Claimant to carry on as they always had, was at a time when the Claimant did not have the skin condition and before she was disabled. Whilst not the practice that had been adopted in the department, the very fact that the offer was put to them was, we infer, an indication that it was considered to have been an acceptable nursing practice, and not an unsafe one. The Claimants were given a free choice whether to adopt the practice of monitoring from the control room. There was no suggestion that, had the Claimant taken the offer up, that it would have been rejected.

145. The question for us is, during the period of time when the Claimant was a disabled person within the Equality Act 2010, was it reasonable to have taken this step so as to avoid the substantial disadvantage above? We are satisfied that it would have been reasonable to take the step for the reasons above. The burden, we emphasise, is on the Respondent (applying the case of Lafit). They have not satisfied us that it was a step which it was not reasonable to take. This is particularly so, as it was a trial period that was requested. By the time the Respondent agreed to trial the use of light lead aprons, the Claimant was suffering from anxiety and stress due to her perception of being met with resistance from management.

146. Taking this adjustment in isolation, it would have reduced the length of time the Claimant was required to wear a lead apron (light or heavy). She could dispense with any apron when working as circulating nurse. There may be some occasions when she would need to wear a light lead apron as circulating nurse, for example during oesophageal stents. Alternatively, if that was not an option – assuming it was a planned procedure required a circulating nurse to hold the patient's airways, that could have been accommodated by rotation of

duties (which we address below). Alternatively, she could act as scrub nurse on those procedures. The Claimant could wear the light lead apron when acting as scrub nurse. The combination of these steps would reduce the amount of time she was wearing leads. Therefore, had the Respondent taken this step of permitting her to monitor from behind the protective screens, especially when combined with the other two adjustments, it would have had a prospect of avoiding the disadvantage to the Claimant and enabling her to continue to work as a radiology nurse.

### **Reduction of temperature in room 5**

147. We can take this proposed adjustment briefly. We repeat that the burden is on the Respondent to show that it was not reasonable to take the proposed step. We have found as a fact that all that the Respondent did with regards to room 5 was to monitor the temperature and replace a defective grill (paragraph 54 above). The Respondent called Mr Roberts to give evidence but no positive evidence on the feasibility or cost involved in putting measures in place to reduce the temperature in room 5. Mr Roberts accepted that it could be done but that it would be costly and disruptive. We do not know what the cost would be. The approximate costings which he gave us in evidence were in relation to the work recently undertaken in the CT room (not room 5) and were off the top of his head. When asked about the feasibility of reducing the temperature with trimmer or heater batteries, he could not give any costs.

148. Put simply, the Respondent having accepted that it was not 'beyond the wit of man' to reduce the temperature in one room while not making it too cold for staff in other rooms, and recognising that the system as is currently in place is one integral, linked system, nevertheless, the Respondent has not satisfied us that it was not reasonable to reduce the temperature. Had the Respondent done more than simply monitor the temperature, or adduced evidence of the costs and level of disruption associated with putting some measure in place along the lines of those suggested in evidence and referred to in our findings, then the outcome may well have been different. However, in the circumstances, we conclude that the respondent failed to show that the proposed step of reducing the temperature in room 5 was a step which it was not reasonable to have to take to avoid the substantial disadvantage to the Claimant.

149. Had it taken the step, when combined with the other two adjustments, it would have had a prospect of avoiding the disadvantage to the Claimant and enabling her to return to work as a radiology nurse and a prospect of removing the substantial disadvantage.

### **Rotation of duties**

150. We reach a similar conclusion with respect to the rotation of duties. The Claimant was not seeking a wholesale rotation of duties on any particular level.

The request was that some duties could be rotated. She wanted the Respondent to see what could be rotated. Referring back to our findings in paragraph 97, there were two morning planned sessions a week. The Respondent gave evidence about the 'difficulty' of arranging for cardiology nurses to rotate with a radiology nurse. We do not suggest that it is not difficult, but 'difficulty' is not the test. The difficulty of putting a proposed arrangement in place is undoubtedly a factor, but not an answer to the question of whether it is reasonable to make an adjustment. The main 'difficulty' apparently was that the cardiology nurses are in a different directorate/department and that the radiology department cannot simply take nurses from one directorate. However, that is unlikely to be insurmountable. It is certainly not, in itself, an answer to a complaint of failure to make the adjustment in this case. Moreover, the Respondent did not inquire about the feasibility of rotating cardiology nurses. That was because the position adopted by the Respondent from the outset was that it could not be done.

151. From our findings, we could see that the Respondent had, in fact, used cardiology nurses to back fill sickness and annual leave. Therefore, we infer that there must have been some arrangements between the directorates, to enable this to happen.

152. The Respondent suggested that there would potentially need to be changes to terms and conditions of employment (for example salary). We did not understand why this should be so as nurses are paid according to their band. There was insufficient evidence before us to show that this was anything other than a 'possibility' and it was put no higher than this. Mr Sangha submitted that there would be a need for changes to job descriptions. We do not consider that this would have been insurmountable. No one was suggesting imposing changes to anyone's work or terms. The Respondent could have made inquiries to see if any cardiology nurses were interested in rotation. There would be added benefits, not just for the Claimant, but for those other nurses, in expanding their skill base. Further, what was suggested was that this be trialled. Had the Respondent asked, it may very well have found willing nurses, keen to expand their skills and to rotate for some planned sessions. There was ample scope, in our judgement, for sitting down and explaining the benefits all round. This is not a case where the Respondent came to tribunal with evidence that it asked cardiology nurses but could not get any to agree; or that it had discussed the issue with the cardiology directorate who explained that they could not spare any cardiology nurses.

153. The Respondent suggested that there would have to be training before a cardiology nurse could work in radiology. Mr Sangha submitted that there would have to be significant training. That may be so, but the Respondent did not give any evidence of what training was required, how long it would take or why a cardiology nurse could not be expected to get up to speed fairly quickly, especially given that they used such nurses to backfill leave and sickness. We

infer that the Respondent would only deploy cardiology nurses to backfill in cases of annual leave or sickness if it were safe to do so and that the nurses had sufficient competence to enable them to step in.

154. Nor is it an answer to say that the cardiology nurses would not be competent to act as a fully experienced radiology nurse. There is no reason why they have to – although in due course they might well become one. A There would always be another nurse present – and the other nurse would be a radiology nurse.

155. Mr Sangha submitted that the Claimant would not necessarily have all the skills to enable her to work in cardiology. But there was no skills analysis done, at least no evidence of any such analysis was put forward. It may be that experienced nurses have intuitive and deeply held knowledge about what is required to enable a radiology nurse to get up to speed as a cardiology nurse and vice versa. However, as a tribunal of fact, whilst recognising and respecting that expertise, we are unable to accept that statement without more. In a case where there is an apparently reasonable adjustment which, particularly when implemented alongside other adjustments, would have a prospect of avoiding a substantial disadvantage to a disabled employee, the burden is on the Respondent to show that it was not reasonable to have to take the step. We were confronted with evidence that cardiology had been used in radiology and an experienced radiology nurse who professed to have the skills required for certainly some aspects of cardiology nursing.

156. Therefore, in respect of this proposed adjustment, the Respondent might have satisfied us that the proposed adjustment was an unreasonable step had it adduced in evidence what training was required, the what practical difficulties, if any, lay in the way of facilitating that training and so on. However, the evidence it gave was insufficient to satisfy us of this. Again, we come back to what the Claimant was seeking: a trial of these adjustments, in combination. It may well have been that one or other of them might have been considered unworkable after such a trial. It may well be that the Claimant might have agreed to this, or even to redeployment. All was dependent on whether the adjustments were going to help. However, the Respondent did not even try. At the very least, it could have asked any cardiology nurses whether they were willing to rotate and from there look at what planned shifts were manageable.

157. Had it introduced some rotation, even only a couple of shifts, combined with the other steps the Claimant was asking for and which we have concluded it was reasonable to take, this too would have had the prospect of avoiding the disadvantage to the Claimant by the application of the PCP.

### **Zero Gravity protection system**



158. We did not agree that it was reasonable to expect the Respondent to have purchased and introduced into the working environment a zero-gravity protection system. The Respondent has satisfied us that it was not reasonable to have to take this step. We refer back to our findings from paragraph 98 – 107. From those findings, we conclude that within the Trust, zero-gravity protection systems were not widely known about. There was little knowledge in the Trust. To the extent that it was suggested that the Respondent ought to have been aware of it before it was raised, we reject this. Indeed, from our findings, there was little knowledge of the systems being more widely, as demonstrated by the evidence that there extremely few hospitals in the UK where they were used. By the time this system came to the knowledge of the Respondent, and more importantly, those whose responsibility it was to implement adjustments, the timescales, the cost and the logistical difficulties involved in obtaining and installing such equipment were such that it was unreasonable to expect the Respondent to do this given the short period of time from March to May 2021 when the Claimant had decided to retire. In any event, the Claimant was on sick leave during this time and was not at work to take advantage of it, even during the short period of time left before her retirement. We agree with Mr Sangha's submission in paragraph 94 of his written submissions.

159. Further, had the Respondent taken the steps which we have found it was reasonable for it to have taken, it would have been unnecessary to consider a zero gravity protection system. The Claimant accepted as much herself, when in cross-examination she accepted that it was a very expensive piece of equipment and did not put it forward as an option because of the other options, which she considered were reasonably feasible and which would have obviated the need for such expensive equipment.

### **Combination of proposed adjustments**

160. In paragraph 47 of Mr Sangha's written submissions, he suggests that it was clear that the Claimant's continued work in the department was not dependent upon one adjustment (such as light lead aprons). We are not sure that he is right about that. The authorities make clear that the question for the Tribunal (indeed for the employer) is whether, by making the adjustment, there is a prospect of avoiding the disadvantage. We have concluded that there was a prospect of avoiding the disadvantage caused by the application of the PCP by making the adjustment through use of the light lead apron alone. This assessment is not something that is capable of precise, scientific analysis. It is more impressionistic, based on a qualitative assessment of the evidence and inference from that evidence. We have inferred from the advice given by occupational health regarding the trialling of light lead aprons that there was more than a fanciful prospect of this alleviating the pressure and heat on the Claimant's skin. There was a prospect of avoiding the disadvantage to the Claimant.

161. However, whether one adjustment would have been enough or not is largely academic. That is because of our conclusion that, by a combination of some or all of the adjustments (light leads and permission to monitor from behind the screen or one or both of those alongside rotation of some duties and a reduction of temperature in room 5) there was a real prospect of avoiding the disadvantage to the Claimant.

162. In summary then, the Claimant was put to a substantial disadvantage by the application of the agreed PCP. The Respondent was under a duty to take such steps as it was reasonable to have to take to avoid the disadvantage. It would have been reasonable to make the adjustment which it was agreed to make following completion of the grievance by mid-July 2021. It would also have been reasonable to make the adjustment of trialling the monitoring of patients from behind the static screen and rotate some duties with other nurses in cardiology. It would have been reasonable to have made adjustments to the room temperature by mid-late July 2019 (allowing some three months from the date the Claimant requested it to be addressed).

163. The Respondent failed to make these adjustments and failed in its duty to make reasonable adjustments. The complaint under section 20-21 Equality Act 2010 succeeds.

### **Remedy**

164. In light of our conclusions a remedy hearing will be necessary, at which the Tribunal will consider the Claimant's claim for financial losses and injury to feelings. However, we would encourage the parties to attempt to resolve matters without the need for a such a hearing.

165. To give the parties an opportunity to resolve matters at this stage, no directions will be issued for a period of 21 days from the date on which this judgment is sent to the parties. The parties must then write to say whether a remedy hearing is necessary and, if so, what directions they seek (or have agreed) in respect of that hearing.

**Employment Judge Sweeney**

26 September 2022