Confidential Containment Brief

Prepared for [Firm — redacted] · Date prepared [redacted] · Confidential to instructed partnership and named advisers.

Validity window — kill switch. *Market and regulatory data correct as of* **[date redacted]**. *Regulatory thresholds, mandatory-reporting positions, clinical capacity and clinic ownership change.* **This brief expires as a basis for action ninety days from the date above.** *Beyond that window, verify every element with named adviser before acting; the brief is a snapshot of a moving regulatory environment, and the date is the kill switch the firm should rely on.*

Confidentiality. *This brief was written for a single firm. It is not for redistribution outside the firm's instructed advisers and partnership. The information about the affected party described here is held only in the writer's possession and is destroyed at delivery.*

How to use this brief

This document provides the clinical and regulatory facts required for an options paper. It is designed to be absorbed into the firm's privileged legal work product by instructed counsel. It is not itself legal advice and is not subject to legal professional privilege; the firm's General Counsel or instructed counsel should review it and determine its internal status.

Executive summary

The firm has described an Equity Partner ("the Partner") in [redacted] practice group, alcohol pattern visible to junior staff and one client-facing colleague over approximately the last six months, no regulator notification considered to date, no occupational health instruction made, and a partnership decision pending in the [near-term redacted] window.

This brief recommends, in order of operational priority:

1. **Pause the partnership decision.** The decision should not be taken on the current information set. The firm needs an OH report, instructed employment counsel, and a clinical assessment before any conduct-track decision is taken on this Partner.
2. **Instruct occupational health within five working days,** through the firm's existing OH retainer, with a referral question scoped to fitness-to-practise rather than fitness-for-work in the narrow employment sense. The two questions are different and the firm's standard OH referral form does not by default ask the right one.
3. **Open the regulatory question with instructed counsel, not internally.** The SRA mandatory-reporting threshold on this fact pattern is not yet engaged on the information presented; it may engage on the OH report's findings. The firm should not notify on a verbal threshold; it should notify, if at all, on a written, dated, sourced position.

The brief is deliberately not doing any of the following: instructing the firm to notify the SRA or instructing it not to; naming a residential clinic for the Partner; replacing the firm's instructed employment counsel; offering a view on the Partner's equity position. Each of these is the firm's decision, taken on instructed advice, against the framing this brief provides.

The firm has approximately [redacted] working days before the partnership decision currently scheduled. The sequence below fits within that window.

How this brief was made

The reconciliation logic

Three duties pull on this firm at once. They are usually handled by three different sets of advisers, each speaking their own language, none of whom can see the whole problem.

- **Regulatory duty.** The firm has a mandatory-reporting obligation to the SRA under the Code of Conduct, triggered by specific written thresholds. The threshold is not "the partner is drinking." It is more particular than that, and it is published.
- **Disciplinary duty.** The firm has a partnership-conduct procedure and an employment-law-bounded set of options for managing the Partner's role, hours, client portfolio and equity position. These options are framed by ACAS guidance, the Equality Act 2010 (alcohol dependence is sometimes a disability under the Act, sometimes not — turns on clinical evidence the firm does not yet have), and the firm's own LLP deed.
- **Clinical duty of care.** The firm owes the Partner a duty of care under common law and under its OH retainer's standard scope. That duty does not vanish because the Partner is senior. It often expands.

These three duties can pull together. They can also pull apart — most acutely when the disciplinary clock starts to run before the clinical track has opened, which is the most common failure mode on partner-track alcohol matters.

Criteria used in this specific reconciliation, in order of weight

1. **Avoid an irreversible move on the current information set.** A partnership decision taken on the information the firm currently has is exposed in three directions: regulatory (premature notification or premature non-notification), disciplinary (Equality Act 2010 risk if alcohol dependence is later established and the firm has acted without OH input), and reputational (the partnership made a senior decision without instructed advice on a matter involving a regulated profession).
2. **Open all three tracks in parallel within five working days.** The cost of opening all three tracks late is materially higher than the cost of opening any one of them now. Sequencing them — OH first, then regulator, then disciplinary — produces a documented gap that is itself a source of risk.
3. **Hold the Partner's role steady during the assessment window.** Suspension on full pay is on the table, but it is not the obvious move on this fact pattern; it has its own regulatory and disciplinary signal. Quiet portfolio adjustment, with the Partner's knowledge, is the more conservative posture for the first 14 days.

What this brief is not doing

- Not legal advice. The firm should instruct employment counsel; this brief is the framing the counsel works against.
- Not clinical advice. The OH provider and any private clinical assessor instructed by the firm are the clinical voice; this brief frames the questions they should be asked.
- Not HR advice. The firm's HR function is downstream of the partnership's decision-making here, not upstream of it.
- Not crisis comms. The matter is not, on the information presented, a crisis-comms matter. If it becomes one, that is a different product and a different adviser.

The regulatory position

The relevant regulator

The Partner is regulated by the **Solicitors Regulation Authority** under the SRA Standards and Regulations. The published mandatory-reporting positions sit in the SRA Code of Conduct for Solicitors, RELs and RFLs (Section 7), the Code of Conduct for Firms (Section 3), and SRA enforcement guidance on health, capacity and serious misconduct.

The operative test

The firm should treat as the operative test the SRA's published position on **serious breach** reporting (Code of Conduct for Firms, paragraph 3.9 on the version current at the date of this brief), read alongside SRA enforcement guidance on health and capacity matters. The threshold is not "the firm is concerned about the Partner's drinking." It is whether the firm has reason to believe a serious breach has occurred or is occurring, with health and capacity treated as a distinct head of consideration that may require notification on its own terms.

Sourced: SRA Standards and Regulations (current version as at date of brief), SRA enforcement guidance "Reporting concerns about a solicitor", SRA position statement on health issues affecting a solicitor's ability to practise. Citations dated and verifiable on the SRA website at the date of this brief.

Questions the firm needs answered internally before any notification decision

1. Does the firm have evidence, in writing, of a serious breach of the SRA Standards by the Partner? If yes, identify the breach and the evidence.

2. Does the firm have evidence the Partner's capacity to practise has been compromised on a specific matter? Client-facing impact is the test; visible-to-junior-staff is not the test.

3. Has any client raised a concern? Has any matter on the Partner's caseload required a reissue, a write-off, an apology, or a regulatory disclosure on the matter file?

4. Is there a complaint to the firm — internal or external — on the Partner's conduct that has not yet been actioned?

5. Has the Partner's own self-reporting position changed? An admission to a partnership colleague, however informal, is itself a data point on the timeline.

The firm should not answer these questions in committee. They are answered by the Senior Partner or General Counsel, in writing, against the firm file, with instructed counsel reviewing the answers before any notification decision is taken.

The firm's options

Option	Posture	Risk to the firm
Notify now	Notification on the information presented, before OH or instructed counsel input.	High. The notification on the current evidence base is unlikely to be sustainable as a serious breach notification and may itself signal a process failure. Premature notification on a partner-track matter is a regulator-relations problem in its own right. **May also trigger a Reportable Event under the firm's Professional Indemnity policy prematurely, with consequences for the next renewal cycle that are disproportionate to the underlying matter.**
Notify after OH report	Wait for the occupational health report. Notify on the report's findings if they engage the threshold.	Moderate. This is the procedurally orthodox sequence and is the route most firms take in this posture. The risk is the OH report is non-committal or returns slowly, leaving the firm with a longer notification gap than is comfortable.

Option	Posture	Risk to the firm
Hold pending clinical assessment	Commission a private clinical assessment in addition to OH, before notification.	Low to moderate. Adds clinical evidence to the notification file. Adds time and a small additional cost. Best fit where the firm anticipates the matter may engage health-and-capacity reporting rather than serious-breach reporting.
Not notifiable on this fact pattern	The firm concludes, on instructed counsel, that the threshold is not engaged.	The risk profile depends entirely on the strength of the contemporaneous file recording the reasoning. The decision to not notify is a decision; it is recorded as one.

No instruction to notify or not notify. The brief frames; the firm decides, on instructed counsel.

The disciplinary position

The employment-law-bounded options

The Partner is an Equity Partner under the firm's LLP deed. The deed is the operative document; what follows is the framing inside which the deed operates.

Option	Legal posture	Practical risk
Suspension on full pay, pending OH	Available under most LLP deeds with a suspension provision. Equality Act 2010 risk if alcohol dependence is later established as a disability under the Act and suspension is found to have been without reasonable adjustment.	High signal — to the Partner, the partnership and the regulator if notification is later made. Suspension is not the obvious move on this fact pattern.
Sickness absence (self-certified, then OH-certified)	The Partner self-certifies; OH then certifies fitness to return. Routine, low-signal, gives the firm time.	Requires the Partner's cooperation. If the Partner declines to self-certify, this option closes. The firm cannot assign it.
Performance management	Available where there is a documented performance issue. The firm should not use performance management as a vehicle for a health matter; doing so is itself an Equality Act 2010 risk.	High. Wrong tool for this posture. Cited here only to be ruled out.
Partnership-conduct procedure	Available under the LLP deed if the firm's deed has one. Slow, formal, file-creating.	Engages the regulator pathway in a way the disciplinary track alone does not. Should not be opened until OH and instructed counsel have framed the matter.
Quiet portfolio adjustment	Informal. The Partner's caseload is reviewed and adjusted in conversation, with the Partner's knowledge, on a clinical-prudence framing rather than a disciplinary one.	Lowest signal. Highest dependence on the Partner's cooperation and on the partnership's discipline in not letting the adjustment leak as a disciplinary signal.
Leave of absence	Available under most LLP deeds. Can be presented as a sabbatical with the Partner's agreement.	Mid-signal. Useful where the assessment window is longer than four weeks. Records a gap on the Partner's professional file the firm and the Partner need to be willing to live with.
Negotiated departure / partnership exit	Available. Should not be on the table during the assessment window.	The Equality Act 2010 risk on a departure negotiated under duress before OH input is the single highest disciplinary risk on this matter.

The interaction with the clinical track

The disciplinary clock often must pause when the clinical track opens. The firm needs to know **when** (typically when OH is instructed, not when OH reports), **why** (because the Equality Act 2010 risk profile changes the moment the firm has reason to believe alcohol dependence may engage as a disability), and **on whose authority** (the Senior Partner or General Counsel, on instructed counsel, recorded in writing).

The conversation with the affected party

- **Who:** Senior Partner and one other equity-track Partner, in person. Not HR. Not three people. The General Counsel is in the building, available, but is not in the room for the first conversation.
- **Where:** A private room outside the firm's main floors. Not the Senior Partner's office. Not a client room.
- **When:** Within five working days of this brief's delivery. Not on a Friday afternoon. Not after a partnership meeting.
- **Record:** Contemporaneous file note, written within the same day, on the firm file. Not an email to the Partner. Not a HR system entry.
- **What is named:** The pattern the firm has noticed. The OH instruction the firm proposes. The framing — health and capacity, not conduct, on the information currently held. The Partner's right to representation under the LLP deed.
- **What is not named:** Notification to the SRA. Suspension. Equity position. Any clinic by name. The £49 bot. Any product on this network.

The clinical position

What the firm's existing OH retainer can and cannot deliver

The firm's existing OH retainer (assumed to be a major national OH provider on a standard corporate retainer) can deliver a fitness-to-practise opinion within ten to fifteen working days, on a written referral from the Senior Partner or General Counsel. The standard OH referral form does not by default ask the right question on alcohol matters; the firm should re-scope the referral to ask, in terms:

1. Is the Partner currently fit to practise as a regulated solicitor?
2. Is there clinical evidence of alcohol dependence within the meaning relevant to the Equality Act 2010?
3. What clinical follow-up does OH recommend? (Specialist assessment, residential treatment, outpatient programme, watchful waiting with review.)
4. What workplace adjustments, if any, does OH recommend?

The standard retainer does not, on most contracts, deliver an addiction-specialist consultant assessment. That is a separate instruction.

Whether private clinical assessment is warranted

On the fact pattern presented — Equity Partner, six-month visible pattern, no acute medical episode reported, no client-facing impact recorded on a matter file — a private addiction-specialist consultant assessment is **warranted in addition to OH**, not in place of it. The consultant's report is the document that gives the firm a defensible Equality Act 2010 position, gives instructed counsel the clinical evidence base for the regulatory question, and gives the Partner a route into treatment that the OH retainer alone is unlikely to produce on its own.

The instruction should be made by the firm, not by the Partner, with the Partner's consent. Self-instruction by the Partner is more common and more comfortable but produces a clinical record the firm cannot rely on for its own decisions.

Whether residential treatment is on the table

On the information presented, residential treatment is **possibly indicated, not certainly indicated**. The consultant assessment is the document that resolves that question. The firm should expect the assessment to recommend one of:

- A 28-day residential admission at a UK clinic with addiction-medicine consultant cover, price band £15,000–£40,000 depending on the unit, with five to seven days of medically supervised detoxification at the start of the admission.
- A structured outpatient programme over twelve weeks, lower cost, with the Partner working through the programme alongside an adjusted caseload.
- A specialist day-programme, in central London, three days per week, over six to eight weeks.
- Watchful waiting with a defined review point at four weeks, in cases where the consultant judges the picture does not yet warrant active treatment.

The firm should plan for the residential option as the case the firm needs to be ready to fund, even if the consultant ultimately recommends a less intensive route. The reverse-planning case (firm assumed outpatient, consultant recommended residential, firm scrambled) is the common failure mode.

Cross-link

If the firm is funding a residential admission and wants an independent shortlist of UK clinics chosen against the affected party's specific clinical and operational picture (medical detox profile, regulator footprint, geography, budget band), the £149 **Clinic Compare Brief** at partner.guide/clinic-compare is the cold-state comparison product. It is the implementation phase to this brief's strategic phase. No discount, no bundle; the two products answer different operational questions.

The reconciliation

The three tracks, side by side, on the assessment window the firm has.

Day / week	Regulatory track	Disciplinary track	Clinical track
Day 1–5	General Counsel reviews SRA reporting threshold against current evidence base. Internally documented. No notification.	Senior Partner has the conversation with the Partner. Quiet portfolio adjustment proposed. LLP deed reviewed by instructed counsel.	OH instructed by Senior Partner with re-scoped referral. Private addiction-specialist consultant identified and instructed.
Week 2	Holding posture. Reporting decision deferred pending OH and consultant input.	Portfolio adjustment in place. Disciplinary clock not running.	OH appointment held. Consultant appointment held or scheduled.
Week 3	Holding posture. Instructed counsel begins drafting the notification position paper for either outcome.	Disciplinary clock remains paused. Partner's caseload reviewed weekly by Senior Partner, on the file.	OH report delivered. Consultant assessment held; report drafting.
Week 4	Notification decision taken by Senior Partner / General Counsel on instructed counsel's advice, against the OH and consultant evidence base. Written, dated, sourced.	Disciplinary track resumes — or does not — on the regulatory and clinical position. Treatment plan integrated with the partnership's role-management decision.	Consultant report delivered. Treatment plan agreed with the Partner.

Named hand-offs

The firm runs the matter through four named hands, in order:

1. **General Counsel instructs employment counsel.** Instruction is in writing, scoped to the LLP deed, the Equality Act 2010 position, and the regulatory question.
2. **Senior Partner instructs OH.** Instruction is in writing, scoped to fitness-to-practise rather than fitness-for-work, with the four questions in the previous section above.
3. **General Counsel instructs the addiction-specialist consultant.** Instruction is in writing, with the Partner's written consent, with the consultant's report addressed to the General Counsel rather than to the Partner.
4. **Senior Partner has the conversation with the Partner.** Internal. Recorded on the firm file.

No fifth adviser at this stage. Crisis-comms is not instructed; the matter is not, on the information presented, a crisis-comms matter. If the matter becomes one — which it may — that is a separate decision taken at the partnership level on instructed counsel.

The next 30 days

A practical sequence. Six numbered moves. Each is short. Each has an owner, a definition of done, a definition of failure, and a fallback if the Partner does not engage.

1. The conversation with the Partner

Owner: Senior Partner. **Done:** held within five working days of this brief, recorded on the firm file the same day, with portfolio adjustment agreed in principle. **Failure:** the conversation is delegated to HR, held in the wrong room, recorded only by email, or held without a portfolio adjustment proposal in hand. **Fallback if the Partner refuses to engage:** the conversation is recorded as held; the OH instruction proceeds; the LLP deed's non-cooperation provisions are reviewed by instructed counsel.

2. The OH instruction

Owner: Senior Partner or General Counsel, jointly. **Done:** re-scoped referral submitted within five working days, OH appointment held within fifteen working days, OH report delivered within twenty working days. **Failure:** standard referral form used (wrong question), OH appointment scheduled beyond the window, report not chased. **Fallback:** if OH cannot deliver within the window, the consultant assessment is brought forward to fill the evidence gap.

3. The consultant assessment

Owner: General Counsel. **Done:** instructed within ten working days, assessment held within twenty working days, report within twenty-five. **Failure:** instruction is made by the Partner rather than by the firm (produces a clinical record the firm cannot rely on for its own decisions). **Fallback:** if the Partner declines consent for a firm-instructed assessment, the matter returns to OH only and the regulatory position paper is drafted on the narrower evidence base.

4. The instructed counsel position paper

Owner: General Counsel, drafted by instructed counsel. **Done:** position paper held in draft by the end of week three, ready for the partnership decision in week four. **Failure:** position paper drafts the regulatory question only and leaves the disciplinary and Equality Act 2010 framing to a separate adviser. **Fallback:** if employment counsel declines to draft the regulatory framing, a second instruction is made to a regulatory specialist; the two papers are then reconciled before the partnership decision.

5. The notification decision

Owner: Senior Partner / General Counsel jointly, on instructed counsel. **Done:** decision taken in week four, in writing, dated, sourced to the OH report, the consultant report, and the position paper. **Failure:** decision taken in committee, by majority vote, without a written reasoning paper. **Fallback:** if the evidence base is non-committal, the firm holds the notification position with a defined review trigger (a further matter, a further OH report, a change in the Partner's pattern), recorded in writing.

6. The treatment integration

Owner: Senior Partner, with the Partner. **Done:** treatment plan agreed by end of week four, with role-management implications worked through. **Failure:** treatment plan agreed without role-management implications worked through, leaving the partnership to handle the role question reactively. **Fallback:** if the Partner declines treatment, the role-management decision proceeds on the regulatory and disciplinary evidence base; the Partner's refusal is itself a documented data point.

What the firm should not do

Six anti-patterns, named plainly. Each is a failure mode this brief has seen on partner-track alcohol matters in firms of this profile.

Do not commission an OH report without a re-scoped referral.
The standard form asks the wrong question on alcohol matters and produces a non-committal report that closes off rather than opens up the next decision.

Do not allow HR to manage this without partnership oversight.
The partnership is the appropriate level of authority for a matter involving an Equity Partner. HR is operational support; HR is not the decision-maker on this file.

Do not treat the EAP referral as a substitute for clinical assessment.
EAP is short-term, low-intensity, and produces no clinical record the firm can rely on for its decisions. EAP referral is appropriate alongside the clinical track, not in place of it.

Do not negotiate the Partner's equity position while the Partner is acutely intoxicated, in withdrawal, or under the immediate impact of a partnership confrontation.
The Equality Act 2010 exposure on a negotiation conducted under duress is the single highest disciplinary risk on this file.

Do not notify the regulator on a verbal threshold.
Notify, if at all, on a written, dated, sourced position, against the OH report, the consultant report, and instructed counsel's position paper. Pre-notification consultations with the SRA are available where the firm is uncertain on threshold; that route exists and is used.

Do not let the partnership decision currently scheduled run on the existing information set.
Move it. The partnership has the authority to do so. The risk of moving the decision is meaningfully lower than the risk of taking it on the current evidence base.

Author, sources, no money in the system

Author

Written by **James Roberts**, named, signed, dated. Independent author. Sober since 1 June 2020 after Delamere. Operates the partner.guide network (sober.guide, partner.guide, theirdrinking.guide, lovedone.guide, discharge.guide, relapse.guide). No employer, no panel, no retainer.

Sources

Every external citation in this brief is listed below with a date verifiable at the date of brief delivery. The brief makes no anonymous claims. Sources are categorised in the sample for redaction; the live brief cites line, page and date.

- Solicitors Regulation Authority — SRA Standards and Regulations, current version (made by the SRA Board on 16 December 2024). Code of Conduct for Solicitors, RELs and RFLs (Section 7). Code of Conduct for Firms (Section 3: Cooperation and accountability, paragraph 3.9). *Verified against sra.org.uk on 29 April 2026.*
- SRA enforcement guidance — "Reporting concerns about a solicitor"; SRA position statement on health issues affecting a solicitor's ability to practise.
- Equality Act 2010, sections 6 and 13, with reference to the EHRC Employment Statutory Code of Practice on alcohol dependence as a disability.
- ACAS Code of Practice on Disciplinary and Grievance Procedures (current version).
- Royal College of Psychiatrists — clinical position on alcohol dependence, assessment and treatment pathways.
- NICE Clinical Guideline CG115 — Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. *Active. Last reviewed 19 July 2019; minor links update March 2025; verified 29 April 2026.*
- The firm's LLP deed (referenced; not reproduced).

Independence statement

No clinic named or referenced in the brief, no EAP, no insurer, no broker, no law firm and no consultant has paid this network for inclusion or recommendation. The £295 paid by the firm is the only money in the system. The Annual Transparency Post audits all refused offers; first post December 2026, then annually. Public location: partner.guide/editorial-standards#transparency.

Crisis routes

If the affected party presents acute risk of suicide, acute alcohol withdrawal (seizure, hallucination, severe tremor with autonomic instability), or other medical emergency, the firm's first calls are: **999** (medical emergency); **111** (urgent but non-emergency clinical advice, NHS); **Samaritans 116 123** (24/7 listening line). The firm's instructed clinical adviser is the second call. This brief is not a crisis-management instrument; the brief's five-day delivery window assumes the matter is not, at the date of instruction, in an acute clinical phase.

End of sample brief. Real briefs name the firm, the affected party's role precisely, the regulator, the operative threshold, the OH provider, and every cited source by line, page and date. The price for a real Containment Brief is **£295**. Application form at **partner.guide/employers**.