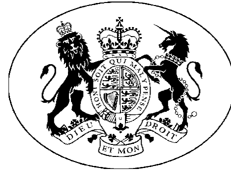

EMPLOYMENT TRIBUNALS

Claimant: Mr C Bessong

Respondent: Pennine Care NHS Foundation Trust

Heard at: Manchester **On:** 30 April – 3 May and in chambers on 4 May 2018

Before: Employment Judge Franey
Mrs A Jarvis
Ms B Hillon

REPRESENTATION:

Claimant: Mr N Caiden, counsel
Respondent: Ms J Connolly, counsel

JUDGMENT

The unanimous judgment of the Tribunal is as follows:

1. The complaint of harassment related to race fails and is dismissed.

2. The complaint of direct race discrimination fails and is dismissed.

3. The complaint of indirect race discrimination succeeds.

REASONS

Introduction

1. This case concerns the steps which an NHS Trust should take to protect its ethnic minority nursing staff from racist abuse and assault by patients on a secure ward for adults with serious mental health issues.

2. The proceedings began with a claim form presented on 16 August 2017. The claimant was employed as a Staff Nurse by the respondent and describes himself as African and black. In the early hours of 7 April 2017 he was subjected to a racially aggravated assault by a patient, "A", who had a history of racist behaviour[1]. The claimant alleged that the respondent had failed to take appropriate steps to protect him, and that this amounted to harassment related to race, direct race discrimination and/or indirect race discrimination.

3. By its response form of 28 September 2017 the respondent resisted all the complaints on their merits. It claimed to have done what it could to protect the claimant, and denied any breach of the Equality Act 2010.

4. At a preliminary hearing on 2 November 2017 permission to amend the claim form was given, the issues were identified, provision made for further particulars and an amended response form, and the final hearing listed to deal with liability only in the first instance. The claimant filed further particulars on 28 November 2017 and the amended response was presented on 5 January 2018. These amendments focussed the harassment and direct race discrimination complaints on five steps which the claimant maintained should have been taken to protect him.

Issues

5. The issues had been identified at the case management hearing but some matters were no longer pursued by the claimant at our hearing. Helpfully the advocates agreed an amended list of issues which was as follows:

<u>**Direct race discrimination**</u>

1. Did the respondent allow the claimant to be exposed to racial abuse from patients in general terms and/or without redress and thereby fail to take adequate steps to counter the threat of racial abuse / aggression posed by patient A which eventuated in the assault on 7 April 2017, in particular by failing to:

- **1.1 increase the numbers of staff on night shift**
- **1.2 provide adequate training to staff to manage violent situations**
- **1.3 increase observations levels in respect of patient A**
- **1.4 redeploy or swap non-white staff from wards with prior incidents of racial abuse or threats with white staff on other wards**
- **1.5 use rewards or punishments more proactively to control behaviour (eg seclusion, and/or being required to stay in bedroom and/or being made to take time out in extra care area and/or cancelling or suspending leave for a significant period of time).**

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[1] In the documents and the hearing the patient was referred to by his initials but to minimise the risk of identification in these reasons we will call him "A" and other patients by "B" etc.

2. **If so, was that treatment "*less favourable treatment*", i.e. did the respondent treat the claimant as alleged less favourably than it treated or would have treated others who were non-African and/or non-black and/or British and/or white? The claimant relies on hypothetical comparators.**

3. **If so was this because of race?**

Indirect race discrimination

4. **Did the respondent have the following PCP(s):**

    4.1 **the practice of staff not always reporting incidents of racial abuse**
    4.2 **tolerating certain levels of abuse against staff by patients and/or**
    4.3 **treating a certain level of abuse by patients towards staff as 'low level' abuse and so not requiring recording/escalation or further action?**

5. **If so, did the respondent apply the PCP(s) to C at any relevant time?**

6. **Did the respondent apply (or would the respondent have applied) the PCP(s) to persons with whom the claimant does not share his race, the claimant's relied upon race being African and/or black and/or non-British and/or non-white?**

7. **Did the PCP put those with whom the claimant shares his characteristic, race, at a particular disadvantage when compared to with persons with whom the claimant does not, namely, they were more likely to be subjected to abuse or subjected to abuse of a particular kind, namely, racial abuse?**

8. **Did the PCP(s) put the claimant at that disadvantage at any relevant time?**

9. **If so has the respondent shown the PCP(s) to be a proportionate means of achieving a legitimate aim, namely, care of patients and the delivery of mental health services in accordance with its contract and the Mental Health Act?**

Harassment related to race

10. **Did the respondent engage in conduct by the inaction set out in paragraph 1 above?**

11. **If so, was that inaction unwanted?**

12. **If so did it relate to race?**

13. **If so, did the conduct have the purpose or effect of violating the claimant's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the claimant (taking into account the claimant's perception, the other circumstances of the case and whether it is reasonable for the conduct to have that effect)?**

Evidence

6. The parties had agreed a bundle of documents running to over 650 pages. A number of documents were added to that bundle by agreement during the hearing. Any reference to page numbers in these reasons is a reference to that bundle unless otherwise indicated.

7. All of the witnesses gave evidence pursuant to a witness statement. The claimant gave evidence himself, and called three former colleagues. They were

Gabriel Fatoki, who worked at the same unit[2] as the claimant from December 2014, Assion Akumah who worked at that unit between June 2009 and April 2014, and Anthony Salmon who had worked at that unit since about 2010.

8. The respondent called three witnesses to give evidence in person. They were Michael Liffen, the Unit Manager of the ward on which the claimant was working at the relevant time, Fiona Christopher the Clinical Services Manager to whom Mr Liffen reported, and Christopher Heath, the Violence Reduction Manager and Core and Essential Skills Training Manager, who gave evidence about training, "punishments" and redeployment.

9. By agreement with the claimant the respondent also relied on two written statements from witnesses who were not called to give evidence in person. They were Sarah Murphy, a manager who investigated the claimant's grievance, and Dario Griffiths, the Manager of a different ward at Prospect Place since March 2013.

Relevant Legal Principles

Council Directive 2043/EC

10. The Equality Act seeks to implement (amongst other measures) the Race Discrimination Directive, Council Directive 2043/EC of 29 June 2000 ("the Directive").

11. Article 7 requires member states to ensure that judicial procedures for the enforcement of obligations under the Directive are available to all persons who consider themselves wronged by failure to apply the principle of equal treatment to them.

12. Article 2 paragraph 2 describes direct and indirect discrimination, and paragraph 3 reads as follows:

> **"Harassment shall be deemed to be discrimination within the meaning of paragraph 1 when an unwanted conduct related to racial or ethnic origin takes place with the purpose or effect of violating the dignity of a person and of creating an intimidating, hostile, degrading, humiliating or offensive environment. In this context, the concept of harassment may be defined in accordance with the national laws and practice of the Member State."**

Equality Act 2010

13. Discrimination against an employee is prohibited by section 39(2) Equality Act 2010:

> **"An employer (A) must not discriminate against an employee of A's (B) –**
>
> **…. (d) by subjecting B to any other detriment."**

14. Harassment during employment is prohibited by section 40(1)(a). By section 212(1) conduct which amounts to harassment does not also amount to a "detriment".

15. The protected characteristic of race is defined by section 9(1) as including colour, nationality or ethnic origins.

[2] The terms "unit" and "ward" were used interchangeably in this case.

16. In interpreting the Act we had regard to the Code of Practice on Employment issued by the Equality and Human Rights Commission ("the Code").

Direct Discrimination

17. The definition of direct discrimination appears in section 13 and so far as material reads as follows:

> **"(1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others".**

18. The concept of treating someone "less favourably" inherently requires some form of comparison, and section 23(1) provides that:

> **"On a comparison of cases for the purposes of section 13 … there must be no material differences between the circumstances relating to each case".**

19. It is well established that where the treatment of which the claimant complains is not overtly because of race, the key question is the "reason why" the decision or action of the respondent was taken. This involves consideration of the mental processes, conscious or subconscious, of the individual(s) responsible: see the decision of the Employment Appeal Tribunal ("EAT") in **Amnesty International v Ahmed [2009] IRLR 884** at paragraphs 31-37 and the authorities there discussed.

Harassment

20. The definition of harassment appears in section 26 which so far as material reads as follows:

> **"(1) A person (A) harasses another (B) if -**
>
> **(a) A engages in unwanted conduct related to a relevant protected characteristic, and**
>
> **(b) the conduct has the purpose or effect of**
>
> **(i) violating B's dignity, or**
>
> **(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B…**
>
> **(4) In deciding whether conduct has the effect referred to sub-section (1)(b), each of the following must be taken into account -**
>
> **(a) the perception of B;**
>
> **(b) the other circumstances of the case;**
>
> **(c) whether it is reasonable for the conduct to have that effect.**
>
> **(5) The relevant protected characteristics are …race".**

21. The phrase "related to" a protected characteristic was originally introduced as an amendment to the Sex Discrimination Act 1975 in 2008 following the decision of the High Court in **Equal Opportunities Commission v Secretary of State for Trade and Industry [2007] ICR 1234.** Burton J decided that the phrase "on the ground of sex" failed properly to implement the formulation in the amended Equal

Treatment Directive (EU/2002/73 EC) which proscribed unwanted conduct "related to" sex. The latter phrase encompassed conduct associated with sex even if not caused by it.

22. One of the cases which Burton J agreed might have amounted to conduct related to sex even though it was not caused by it was **Brumfitt v Ministry of Defence [2005] IRLR 4** in which a male RAF sergeant made offensive and obscene remarks directed at the male and female personnel attending a training course. Burton J in the **EOC** case put it this way (paragraph 11):

> **"Thus the training officer in *Brumfitt* was found, by dint of the generally unpleasant nature of his language and the fact that the audience was of mixed sexes, not to have discriminated against the claimant on grounds of sex. Given that the tribunal decided that the claimant had been exposed to language which was 'offensive and humiliating to her as a woman', it appears likely that she would have succeeded in a claim in respect of unwanted conduct related to her sex."**

Liability for Third Party Harassment

23. The circumstances in which an employer can be liable for harassment of an employee by a third party have varied over time.

24. Prior to there being any separate prohibition on harassment, a hotel was held liable for direct discrimination in the form of racist and sexist jibes made by a guest speaker at a private dinner: **Burton v De Vere Hotels Ltd [1997] ICR 1.** In **Pearce v Governing Body of Mayfield School [2003] ICR 937** the House of Lords disapproved **Burton**. Parliament then made statutory provision for third party liability in 2008, which survived in section 40 of the Equality Act 2010 until its repeal in 2013.

25. In the **EOC** decision, made in early 2007 before the legislation changed, it was accepted by both parties that the formulation "related to" in the Equal Treatment Directive could on appropriate facts make an employer liable for failing to take steps to protect an employee from third party actions (see paragraphs 36 – 40 of Burton J's judgment).

26. In this case three more recent EAT authorities were the focus of the argument.

27. The first was **Conteh v Parking Partners Ltd [2011] ICR 341.** A car park attendant was racially abused by a user employed by her employer's client. She complained that her employer had not done enough to protect her. The case was brought under the Race Relations Act 1976 (as amended) where harassment was prohibited if "on grounds of race". "Unwanted conduct" could include inaction if some action was called for. Such conduct could be regarded as creating the proscribed environment if the inaction made matters worse. Nevertheless, the inaction must itself be on the grounds of race. It was not enough that the third party conduct was on the grounds of race. There had been no finding that the failure to deal properly was on such grounds and the claim failed.

28. The second was **Sheffield City Council v Norouzi [2011] IRLR 897.** A residential social worker was subjected to offensive racial remarks by a child resident at the home. The statutory formulation of harassment was still "on grounds of race". The core allegation was that the local authority had not done enough to protect the claimant from such abuse. The claimant relied on the direct effect of the Directive.

The case had proceeded on the agreed basis that the Directive could on appropriate facts make an employer liable for failing to take steps to protect an employee from third party harassment, as had been agreed in the **EOC** case. On that basis the EAT upheld a finding that the employer was liable for harassment. The tribunal had been sufficiently specific in its findings about what the respondent should have done, and had not simply treated it as automatically liable for the child's actions.

29. The third was **Unite the Union v Nailard [2017] ICR 121[3].** The claimant was employed by a trade union. Elected lay officials subjected her to sexual harassment and she complained to senior employed officials. They took inadequate steps to investigate her complaints. Disciplinary action should have been taken against the perpetrators to protect her. She was transferred against her will (prompting her resignation). One of the issues raised was about the meaning of "related to" in section 26 of the Equality Act 2010 when considering the role of the employed officials. The Employment Tribunal found that their failings were related to sex because the claimant's complaints were of sexual harassment. The EAT reviewed the **EOC** case, **Conteh** and **Norouzi.** It considered that no definite conclusion had been reached in those cases as to whether "related to" could encompass third party liability where it was only the third party's conduct which was related to the protected characteristic. In its view there was still a requirement that the conduct (or inaction) of the employer was associated with the protected characteristic (paragraph 100). The Employment Tribunal had fallen into error, and was overturned, although in remitting the case the EAT recognised that it was possible that a correct application of the test might lead to a finding in favour of the claimant (paragraph 105).

30. The Code as issued in 2011 covered the third party harassment legislation then in force (paragraphs 10.20-10.24). Following the repeal of those provisions, in May 2014 (after **Norouzi** but before **Nailard**) the Equality and Human Rights Commission issued a supplement to the Code to identify developments in the law since the Code was issued in 2011. In relation to harassment by third parties the following appeared:

> **"The provisions addressing harassment by third parties have been repealed. However, whilst this means that usually an employer will not be responsible for discrimination, harassment or victimisation by someone other than their employee or agent (see paragraphs 10.45-10.49), case law indicates that it is possible that they could be found to be legally responsible for failing to take action where they have some degree of control over a situation where there is a continuing course of offensive conduct, but they do not take action to prevent its recurrence even though they are aware of it happening.**
>
> **Example: A woman is employed to work in a hostel for young men aged between 18 and 21. Some of the young men regularly make sexually abusive comments to her and sometimes touch her inappropriately. She has complained to her manager about this many times but he has done nothing to stop it, by, for example, warning the young men that the conduct is unacceptable and that they might be required to leave the hostel if it does not stop. The employer may be legally responsible for the harassment by the young men."**

31. It appears in the light of **Nailard**, however, that this position is not sustainable in so far as it indicates that there may be liability where the employer's conduct/inaction is not itself related to the protected characteristic. The position

[3] The Tribunal decided this case before the judgment of the Court of Appeal was promulgated on 24 May 2018 and it played no part in our deliberations.

appears to be as articulated in **Conteh.** The claimant's success in **Norouzi** was a result of a concession by the respondent about the meaning of the Directive which may have been erroneously made.

Indirect Discrimination

32. Indirect discrimination is rendered unlawful by section 19 of the Act. The relevant parts read as follows:

> **"(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.**
>
> **(2) For the purposes of subsection (1) a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if –**
>
> **(a) A applies, or would apply, it to persons with whom B does not share the characteristic,**
>
> **(b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,**
>
> **(c) it puts, or would put, B at that disadvantage, and**
>
> **(d) A cannot show it to be a proportionate means of achieving a legitimate aim."**

Burden of Proof

33. The burden of proof provision appears in section 136 and provides as follows:

> **"(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 sub-section (2) does not apply if A shows that A did not contravene the provision".**

Relevant Findings of Fact

34. This section of our reasons sets out the broad chronology of events necessary to put our decision into context. In order to convey an accurate impression it will be necessary from time to time to record the actual racist terms used by patients.

Prospect Place

35. The respondent is an NHS Trust providing a range of medical services including mental health services.

36. One of the establishments it operates is Prospect Place, a residential facility for adult men who have a diagnosis of psychotic disorder and who are detained under the Mental Health Act. There are three wards with 15 patients on each.

37. The majority of new patients were admitted to the Engagement and Assessment Ward where staff will seek to assess the patient, optimise his mental state, support him in developing relationships with the team, and help him form individualised care plans. When appropriate the patient will move on to the Recovery and Intervention Ward, and finally the Social Inclusion Ward prior to anticipated discharge. The expected length of stay at Prospect Place is generally two years.

38. There were staffing levels prescribed for each ward. For Engagement and Assessment the day shift consisted of two qualified nurses and three nursing assistants; the night shift of one qualified nurse and two nursing assistants.

Care Plans

39. Each patient had a Care Plan to which professionals from all the different disciplines contributed. It identified a pathway to recovery and discharge. It contained sections about stopping problem behaviours, getting insight, and recovering from drug and alcohol problems. The Care Plan was regularly reviewed.

40. On a day to day basis notes about individual patients were kept on records maintained by the consultant, and on records maintained by the nursing staff. The nursing notes were available to be considered by nursing staff when they came on duty.

41. Each month there was a multidisciplinary clinical team meeting for each patient known as the 'CTM' meeting. Reports for that meeting were prepared by nursing staff, occupational therapists and other professionals. They included a review of any incidents of significance since the previous meeting.

42. In addition there were periodically community team meetings on the ward involving patients and staff. They were a forum for general discussion about life on the ward.

Reducing Restrictive Practices Framework

43. The respondent had a framework policy on reducing restrictive practices at low secure units such as Prospect Place (pages 391-410). The policy said that reducing restrictions on patients was key to reducing violence and producing a positive and safe care experience. It made clear that use of restrictive practices must always be a last resort, and that the degree of the restrictive practise used should be proportionate to the risk and the likelihood of harm. Appendix 4 made clear that a restriction unnecessary for treatment was unlikely to be justified.

Mental Health Act Code of Practice

44. The policy included extracts from the Mental Health Act Code of Practice ("MHA Code"), amongst which were the following:

> **"1.5 Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action.**
>
> **26.21 Leave should not be used punitively. Restrictions associated with such programmes should be reasonable and proportionate to the risks associated with the**

behaviour being addressed and consistent with the guiding principles of the Code (and the Mental Capacity Act (MCA) where it applies). Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a 'reward' or 'privilege' dependent on 'desired' behaviours. …

8.6 Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an individually identified risk; they should be applied for no longer than can be shown to be necessary."

45. Paragraph 26.36 of the MHA Code (page 410a) defined "restrictive interventions" as deliberate acts that restrict a patient's movements, liberty and/or freedom to act independently. They were permitted in order to take immediate control of a dangerous situation, or to end or reduce significantly the danger to the patient or others. The MHA Code stated that restrictive interventions should not be used to punish.

<u>Incident Reporting Policy</u>

46. The respondent had a policy on incident reporting dating from June 2017 which appeared at pages 359-390. It was not suggested that it materially differed from any earlier versions. The aim of the policy was to provide a unified process for reporting and investigating when things go wrong, and to provide support for staff and patients when incidents occur (page 362).

47. An "incident" was defined as follows:

"an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, victors or members of the public."

48. Clause 5 of the policy said that it was the responsibility of all employees to make sure incidents were reported via an electronic system. An example of an incident report form appeared at pages 442-443. The staff member completing the incident report had space to give a description of the incident and to categorise it by reference to the type of incident, the broad cause group, and for two sub-causes to be identified. The cause group categories included assaults to staff, verbal abuse to staff and violence and aggression. The sub-causes which could be identified included racism.

49. Assaults by patients could be reported to the police, whereupon they would be considered by the multi-disciplinary "Managing Vulnerable Offenders Panel" ("MVOP") to inform a decision on whether there would be a criminal prosecution. That was ultimately a matter for the police, not for the respondent.

<u>The Claimant</u>

50. The claimant qualified as a Registered Mental Health Nurse in November 2010 and was employed by the respondent as a Staff Nurse in April 2011. He was deployed to Prospect Place in November 2014 and worked the majority of the time on the Engagement and Assessment Ward. He worked a mixture of day and night shifts, and would almost always be the senior nurse on the shift.

January 2014 Akumah Email

51. On 10 January 2014 Mr Akumah sent an email to his manager Dario Griffiths which was copied to other mangers including Mr Liffen. The email was described as an open letter regarding a racial incident (pages 54a-54b). Mr Akumah was working on the Social Inclusion Ward at Prospect Place at the time. His email expressed doubt that management would tackle racist behaviour because a lot of things had happened in the past. He queried why black nurses were expected to accept racial abuse as “just part of the job”. He referred to some recent incidents and said that the focus had been on the patient with no attention paid to the ones who were subjected to vile abuse. The nurse who was a victim of abuse had been moved but nothing further had been done. He made reference to an investigation which had been done in ill-faith and he invited mangers to create an open and constructively challenging climate encouraging staff to act with integrity.

52. In his oral evidence Mr Akumah confirmed that he regarded moving the victim of racist behaviour as bad practice.

Patient A and Racist Incidents 2015 - March 2016

53. The assault on the claimant on 7 April 2017 was committed by Patient A. He was a white British man in his early 30s. He had experienced mental health problems since the age of 17, having had in-patient treatment in adult acute wards, psychiatric intensive care units, and medium secure units. He had a history of verbal abuse and physical assaults on patients and staff. He sometimes failed to comply with his anti-psychotic medication regime. He misused psychoactive drugs.

54. As part of the investigation of the assault, details were obtained of all the incident reports involving A in the possession of the respondent. These details appeared at pages 242-287. They recorded incidents where racial abuse was accompanied by or followed by a physical assault, as well as incidents which had no racial element. In October 2007 A called a member of staff a “fucking black bastard” and then threw a telephone at the member of staff and sought to punch him (page 245). In August 2007 he barged into a fellow patient and called him a “fucking Paki” (page 247).

55. Those records also showed that in the six months or so prior to his admission to Prospect Place in September 2015, there had been seven reported incidents of racist abuse by A.

- In February 2015 he called a member of staff a “nigger” (page 248). The incident report showed that staff told A his conduct was not acceptable (page 442).

- In March 2015 he called another member of staff the same word and made an offensive hand gesture (page 248). Once again staff told A his conduct was not acceptable (page 444).

- There were two incidents in June 2015 during which he was racially abusive towards staff (pages 256-257).

- In August 2015 there was a further incident of racist abuse of staff (page 264). He called a member of staff a "nigga" and said that he "deserved to be hung with the rest of his family". Verbal de-escalation failed to work on this occasion so A was taken to the Extra Care Area and given medication. The Extra Care Area was a room where staff could take an agitated or aggressive patient and remain with him while he calmed down.

- In September 2015 the claimant abused a black member of staff, calling her a "nigger" and telling her to "go back to her own country" (page 266). The incident report appeared at pages 464-466. That was six days before he was admitted to Prospect Place.

56. After his admission this type of behaviour continued. An incident report was submitted by Nurse Riley on 19 November 2015 (pages 460-463). The incident description was as follows:

> **"During 1:1 session patient A disclosed that on his 33rd birthday (21.4.15) he was going to poke out a staff nurse's eye with a pen. He described himself as a "fucking racist bastard", as a "nigger" [**sic**]. Later in the conversation he retracted and said he was going to "take staff out" then "take myself out", described how he would do this by cutting a main artery in his arm with the intention of dying."**

57. The incident report recorded that the Charge Nurse, Ward Manager and responsible Clinician were informed, and that the risk assessment was to be updated. There was to be a meeting in the next week to discuss the risks that A presented. Staff identified in the threat were to be notified of the threat made and strategies put in place to manage it (page 461).

58. A further incident report form was submitted on 31 December 2015 at pages 467-470. A called a black member of staff a "grassing fucken nigger" and then repeated the insult to the Charge Nurse Shakiel Khan. The response team was called but A continued to threaten to "beat up" Nurse Khan and asked him why he did not go back to his own country. After the response team left the threats continued, and the incident report recorded that a decision was made to move Nurse Khan and another ethnic minority member of staff to a different ward for the rest of the shift. Senior management were informed of the redeployment of the two staff to avoid a further altercation.

59. On 29 February 2016 A assaulted a male Asian patient by punching him in the mouth and causing a serious injury. It was reported to the police but prosecution was not pursued (page 116).

60. On 6 March 2016 Mr Fatoki submitted an incident report about A. He was asked not to wake another patient up with his behaviour and became abusive calling Mr Fatoki a "nigger". He became aggressive towards Mr Fatoki. Mr Fatoki's incident report read as follows:

> **"When I told him that I may be forced to pull my alarm [**to**] help me this further escalated his aggressive behaviour towards me. He started to accuse me that I was going to 'take him out'."**

61. The form recorded that the response team attended and that A apologised twice for his behaviour.

62. In his oral evidence Mr Fatoki told us that the following day Mr Liffen said that if he had been on duty he would have recommended that Mr Fatoki be sacked because he had said he would take the patient out. Mr Fatoki said this was an example of lack of support for black staff in this kind of incident. He said it made him lose all confidence in reporting any further incidents. Mr Liffen denied having said that Mr Fatoki would be sacked or having mentioned any discipline. He said he wanted Mr Fatoki to reflect on the language used, since using the phrase “take you out” could be misinterpreted by a patient like A as meaning “kill you”. From Mr Liffen’s perspective it was a communication issue.

Claimant’s Training April – June 2016

63. In April 2016 the claimant had some training on incident reporting (pages 484-486).

64. The claimant had attended a five day course in July 2014 on the Management of Violence and Aggression (“MVA”). There were two day refresher courses in August 2015 and June 2016.

65. Copies of the presentation slides from MVA training appeared at pages 508-550. The aim was to train staff on how to deal with incidents of violence and aggression by patients. The course covered not only physical assaults but also non-physical assaults by inappropriate words or behaviour causing distress (page 547). It included sections on maintaining a reactionary gap between the aggressor and the staff member, and using verbal communication skills to de-escalate a situation. At page 540 the training slides made clear that all MVA incidents were to be documented not just in the clinical healthcare record and risk assessment, but using the incident report form.

June - July 2016

66. On 11 June 2016 the claimant had a monthly supervision meeting. The note appeared at page 72. The claimant raised concerns about the shortage of staff. He was concerned that there might be an incident as a result.

67. In fact between June and December 2016 there were increased staffing levels at Prospect Place because of a particularly unsettled patient population. The problems included drug use on the unit and there was one patient with a habit of breaking furniture and doors on a regular basis.

68. On 29 July 2016 the risk assessment for A was reviewed (page 578). It recorded that A continued to be verbally threatening and intimidating. He had bitten a patient during a fight. This risk assessment later formed part of the report for the CTM in early September 2016 (pages 574-584).

69. The respondent was subject to inspection by the Care Quality Commission in July 2016. Prospect Place received a rating of “Good” and no reference was made in that report to problems with staffing levels.

August 2016 – Patient A Incidents

70. In August 2016 there were two further incidents involving A.

71. An incident report was submitted by a Student Nurse on 23 August 2016 (pages 471-474). He had called her a "black bitch" and told her to go back to her country. His racist abuse was accompanied by sexist comments. He said he would ensure that it was her first and last time on the unit. The student nurse found that staff on the ward regarded this as "the norm" and she was not advised to fill in an incident report until she returned to her usual ward. The incident report recorded this:

> **"I communicated all of the above to staff on duty only to be informed that this is the "norm", nobody offered me any support or advised me to complete an incident form, after returning to Heathfield House in my vehicle I communicated the above to my colleagues and they encouraged me to incident form the above."**

72. Ms Christopher became involved. She was concerned that the student had been told by staff on A's ward that this was the norm, but had not been able to identify the member of staff in question. She told us that the message had been given to staff that this behaviour by the patient was not acceptable, and the importance of the use of incident report forms was reiterated.

73. In another incident in August 2016 (recorded at page 280) A grabbed hold of a female Nursing Assistant and sought to undo her bra through the back of her top. The entry recorded that the staff team were aware of sexually inappropriate behaviour towards women and were addressing this with this patient and others. Mr Liffen took steps to remind staff to make sure they were not followed into the security cupboard where the assault took place, and reiterated the importance of the reactionary gap.

Patient "B" Incident August 2016

74. The claimant was subjected to racial abuse by a different patient, "B", on 24 August 2016. His incident report form appeared at pages 475-478. The form recorded that the patient had been using his mobile phone to record staff and in accordance with the Care Plan his phone was confiscated. The action to be taken included a review with a responsible clinician and the team, and a briefing of staff to be done by the Charge Nurse.

Patient A CTM September 2016

75. Reports were prepared for the CTM about A on 5 September 2016. The package of documentation appeared between pages 574-584. They recorded incidents of increased hostility and verbal abuse and threats towards staff over the previous months. The incidents on page 576 included racist abuse, sexist abuse and calling a member of staff a "faggot". He had expressed an intention to assault another patient with a knife. There was concern about whether it was appropriate for him to continue at a low secure unit like Prospect Place (page 585).

76. There were similar issues recorded in the CTM paperwork for 5 October 2016 (pages 586-593) and 31 October 2016 (pages 595-603).

Fatoki Assault by Patient C December 2016

77. On 12 December 2016 Mr Fatoki was assaulted by a different patient, "C". It was a racially aggravated assault. He reported it to management and the police. It had a serious effect on him and he was off sick for some time. He was not made aware by managers that the incident had been referred to the MVOP. In due course the police told him that there would be no prosecution. After a protracted period of sick leave he returned to work on a phased basis redeployed to a different unit.

January – March 2017

78. There was a CTM for patient A on 16 January 2017. The report for that meeting appeared at pages 604-611. He signed a "Stopping Problem Behaviours Care Plan" (page 606). His risk assessment was updated (page 607).

79. The claimant had a supervision session with Mr Gregory on 4 February 2017. The note appeared at page 71. The claimant expressed concerns about the ward feeling unsafe, but that was to do with the quality of staff not their numbers.

80. A CTM report on A was prepared for a meeting on 13 March 2017. It appeared at pages 623-635. The incidents recorded since the previous CTM included verbal hostility and aggression but no actual violence. They included sexist and racist abuse. The report recorded (page 627) that A was to be allocated a new named nurse who would be clear in boundaries and could implement those boundaries as a way of controlling his chaotic behaviours and abuse towards others. There was a further reference to the care plan for stopping problem behaviour (p.628). At the CTM meeting itself (page 635) the note recorded the following:

> **"A has not responded well to these new rules** [about finance] **and has been verbally aggressive and hostile towards staff. Nursing staff feel he would benefit from clear guidance around what is acceptable behaviour such as zero tolerance on abuse and threats. This should then be linked in with any leave given."**

81. A meeting to discuss staffing levels was arranged for 22 March 2017 but cancelled because of a patient physical health incident. The second meeting took place on 5 April 2017 at 7:45pm so night staff could attend. Mr Liffen later recorded (page 87) that night staffing was not raised by the staff as one of the agenda items.

6 April 2017

82. On 6 April 2017 the claimant was on night shift due to start at 7:30pm.

83. Earlier that day there was a community meeting of staff and patients at which he was not present. The nurse in charge of the day shift, George Abadaki, was not present at the meeting either. Mr Liffen was present and later approved the note that was issued as a record (page 77). Ms Ndebele was there, as was patient A. Mr Liffen recalled that Nurse Mary Bradshaw was present although her initials did not appear on the list of attendees at page 77.

84. During the meeting patient A asked why it was all black people working on the ward. He also said that he did not like the claimant and that the claimant had a "bad

attitude". Mr Liffen told A that his comments were unacceptable. After the meeting he approached A to ask him to discuss matters one-to-one, but A refused.

85. Mr Liffen did not complete any incident form about this matter and nor did he ensure it was recorded in the note of the meeting. He did not believe that there was a threat to the claimant, not least because A had appeared calm during the meeting.

86. However, the comment was recorded in the nursing notes completed by Nurse Bradshaw at page 108 as follows:

> **"A attended the community meeting. He made racial comments saying 'why is that it's all black people working here?'…"**

87. A spoke to the Dual Diagnosis Nurse in the early evening and she made a note in the nursing notes too (page 108). He had approached her to ask about leave, but then changed the subject. Her note read as follows:

> **"Then changed subject making racist comments about 'too many black staff' and 'hating' black staff. I reflected with A [**that**] this was neither true nor appropriate and reminded him of his good relationship with certain staff who happen to be 'black' skinned. A reflected and agreed."**

88. The claimant had a handover meeting with Nurse Abadaki around 7:30pm. He was told that A had made a racist remark at the community meeting about why it was all black people working on the ward. Nurse Abadaki also made an entry in the handover note for patient A at page 80. The note reflected a standing entry in A's Care Plan:

> **"to go into Extra Care Area if verbally abusive towards staff for period of time out."**

89. It also recorded that he had attended the community meeting and made a racial comment about staff. Neither verbally nor in the handover note did Mr Abadaki inform the claimant that A had specifically mentioned him.

90. The claimant was told of that informally by Ms Ndebele shortly after he started his shift. He was attending to some medication for a patient when she told him in passing that A had mentioned him personally in the community meeting. The claimant was busy and did not ask for further clarification.

7 April 2017 – Patient A's Assault on Claimant

91. Shortly after 1.00 am on 7 April the claimant was violently assaulted by patient A, who threw about eight punches and held a pen as a weapon. The attack was accompanied by racist abuse. The claimant later recalled that the attacks started with A saying:

> **"You fucking black I'm going to stab you now".**

92. The claimant managed to fend A off, used his fob alarm, and the response team attended. A was taken to seclusion. The claimant sustained significant facial swelling and redness and had to go hospital. He began a period of sick leave. The police were contacted and the assault reported.

93. The nursing note at page 109 recorded that A said he had attacked the claimant because he wanted to be moved to a medium secure unit and because he hated black people.

94. An incident report form was completed that night (pages 86-91). It made no mention of the racist element of the assault. Mr Liffen added to it on 10 April at the top of page 87. He recorded that the claimant had been mentioning staffing as an issue but that night staffing had not been raised as an issue at the staffing meeting on 5 April. However, concerns about staffing on night shifts were also recorded at page 89. It was unclear who made that entry.

<u>After the Assault</u>

95. After the incident the claimant called Mr Liffen to ask about the community meeting on 6 April. He was told that Mr Liffen had challenged A but had not thought that there were threats directed at the claimant.

96. A was still in seclusion on 9 April 2017. A nursing note that evening (page 111) recorded that he had shown no remorse regarding the incident and had said he hated the claimant.

97. About a week after the incident he was out of seclusion. Mr Salmon and Mr Liffen were engaged in listening to an interaction between another patient and a doctor. Mr Salmon asked Mr Liffen if he knew how the claimant was following the assault. He did not realise that patient A was standing behind them. A overheard the question and said of the claimant:

> **"[**He**] should be dead. He's a fucking bastard. He shouldn't be in this country."**

98. Mr Liffen did not react to that statement. In cross examination he explained that his first instinct was not to provoke A any further, but that he was also focussed on his primary task of listening to the patient/doctor interaction. He said he intended to approach A later but could not recall if he had actually done so.

99. Immediately after the assault A had been assessed by a medium secure unit but not accepted. He therefore remained on Prospect Place.

100. On 24 April 2017 Mr Liffen sent an email to a number of managers, including Karl Adderley who liaised with the police, about further threats by A. A had said that he intended to stab the claimant and if he saw him in public he would attack him again. There had been further racist remarks.

<u>Grievance 2 May 2017</u>

101. On 2 May 2017 the claimant lodged a grievance (p.122-123). He said there was a normal culture in which staff no longer completed incident forms for hate crimes: they went unpunished and occurred every day. Staff had become resigned to the normalised culture. There had been no follow-up or documentation after the comments made by A in the community meeting. There had been no plan to safeguard the claimant or any black staff that evening. He sought an apology and asked that he not be required to return to work on the Engagement and Assessment Ward.

Concise Investigation Report 11 May 2017

102. There was an investigation triggered by the incident report. On 11 May Mr Liffen completed a "Concise Investigation Report" (pages 113-121). It recorded that the responsible clinician Dr Sturman had reported to the MVOP that he was not at all convinced that the sustained and apparently planned assault with a clear racial motivation was related to A's mental disorder. The report included the following:

> **"Staff possibly becoming complacent around this patient and his threat level, CCTV of the incident does not demonstrate a reactionary gap being maintained and so A is able to grab [**the claimant**] without difficulty.**
>
> **Lack of consequence for racist, verbally and physically aggressive behaviour, other than cessation of leave. Involvement of criminal justice is slow and does not have a conclusion."**

103. The behavioural management plan for A would be amended: it currently said that the police "may be called" if there were future incidents of physical aggression or threats and this would be changed to "will be called".

104. By mid-May the police had taken a decision not to pursue a criminal prosecution against A. Through Mr Adderley the respondent protested at this decision. A was eventually prosecuted and convicted of a racially aggravated assault.

Further Patient A Incidents May 2017

105. In the meantime, during May 2017 there were two further recorded incidents of racism involving A (page 282).

106. In the first he said he was glad there was a white member of staff on shift and was told this was not acceptable. The incident was documented in the patient notes and reported.

107. In the second he was abusive and threatening to a Nursing Assistant, saying he did not like Africans. Staff gave him medication and verbally de-escalated the situation. That incident report had additional information added by the manager as follows:

> **"A consistently voices racist remarks to black staff, he has a Care Plan that addresses this and the** [Extra Care Area] **is used if he becomes aggressive. A is also prone as part of his paranoid illness to misinterpret facial expression. A has assaulted a black member of staff on 07.04.17".**

Grievance Investigation

108. Sarah Murphy was appointed to investigate the claimant's grievance. She interviewed Mr Liffen on 9 June (pages 134-140) and the claimant on 26 June 2017 (pages 144-152). Nine other members of staff were interviewed between 28 June and 1 September (pages 153-221).

109. In the meantime, the claimant returned to work on a phased basis on a different ward in July 2017. He presented his Employment Tribunal claim form on 16 August 2017.

110. Ms Murphy's report into the grievance and the grievance outcome (pages 288 – 316) were provided to the claimant with an outcome letter (pages 317 -323) at the end of September 2017. She had considered the log of incidents involving A derived from the incident reporting system as well as documents from the time of assault. She also had an analysis of the CCTV undertaken by Mr Heath in June 2017 (page 140a-140b).

111. Her conclusions can be summarised as follows:

- The claimant had raised concerns during supervision about staffing levels, but the staffing of the night shift when the incident occurred met current staffing level requirements.

- The incident report made no mention of racial motivation, although the claimant had not been aware that he could use a secondary cause code of "racism".

- Racial abuse was not consistently reported but none of the staff said that they were ever discouraged from reporting such incidents.

- There was evidence that Mr Liffen had actively challenged racial abuse when it occurred.

- The information about the racial comment made by A had been available to the claimant when he started his shift because it was recorded in the nursing notes and the handover document.

112. The recommendations included the following:

- There was to be a survey for staff as part of a plan to address racial abuse experienced by staff.

- Staffing levels should be discussed as a fixed agenda item at staff team meetings.

- There was going to be an away day for Assessment and Engagement which would focus on risk assessment including racial abuse.

- The claimant was to complete a further 5-day MVA course.

- **"A review of the safeguard system should be considered to ensure that all incidents of racial abuse can be captured. Staff should be encouraged to report low levels of racial abuse to ensure that patient Care Plans can be reviewed accordingly."**

113. The claimant appealed against the decision to reject his grievance. The appeal outcome letter of 21 March 2018 appeared at pages 330a-330h. The appeal was not successful. However, two additional recommendations were made:

- Communications with staff about police prosecutions would be improved.
- There would be communications with staff about the responsibility to report incidents of any nature, be they verbal abuse of any kind or assaults.

Submissions

114. At the conclusion of the evidence each advocate helpfully provided the Tribunal with a written submission, which was supplemented by oral submissions. The detail of what was said is contained in those written documents and reference should be made to them as appropriate. What follows is a summary of the broad position taken by each side on the agreed list of issues.

Respondent's Submissions

115. After some initial observations, Ms Connolly began her submissions on the direct discrimination complaint by cautioning against reliance on any factual matters other than the five steps specifically identified by the claimant as alleged shortcomings. It was only those matters on which the Tribunal had full evidence. The less favourable treatment was an alleged unreasonable failure to take any or all of those steps before 6 April 2017. Her submission was that the respondent had taken reasonable steps prior to the assault: these were set out in paragraphs 4.6 and 4.7 of her written submission.

116. As to the specific allegations, staff numbers were in line with reasonable practice and effectively approved by the CQC; patient A was being observed every 15 minutes, significantly more frequently than the baseline of once per hour; the claimant and his colleagues had been trained in managing violent situations, and redeployment would only be considered when there was no other reasonable way of managing the risk on the ward. To redeploy black staff because of racist views or comments by patients would be to reward or to reinforce that behaviour. It was not possible within the clinical framework to take steps for the purpose of punishment as opposed to for therapeutic purposes or to manage clinical risk. Ms Connolly highlighted that in cross-examination the claimant and his witnesses all disavowed the use of the word "punishment" even though it appeared in their witness statements.

117. Further, even if less favourable treatment were established, it was not because of race. Mr Liffen dealt with the matter as he did because of a clinical judgement. He would have taken the same position in an offensive remark about women. A hypothetical comparison did not assist the claimant because the two matters were dealt with in a similar way. Ms Connolly invited us to reject the contention of the claimant that this was an example of less favourable treatment which was inextricably linked to the protected characteristic.

118. In relation to indirect discrimination Ms Connolly submitted that the first PCP had not been proven by the claimant. It was too broad and too vague. It ignored the

fact that staff were required to report such matters under the incident reporting policy, and individual decisions made not to report incidents could not be said to be restricted to racial abuse as opposed to any other kind of abuse. Further, any such PCP was not "applied" to the claimant: he chose not to report himself. Particular disadvantage could not be shown on a group basis because staff were at risk of abuse from patients for any number of reasons, including characteristics protected by the Equality Act and those which were not. The proper definition of the pool for comparison was important. In any event there was no particular risk because even if matters were not recorded through incident reporting, they were recorded in other ways (e.g. nursing notes) which provided protection to staff.

119. The second and third PCPs were not drafted by reference to racial abuse alone and appeared to depend upon a failure to report matters. If a PCP of "doing nothing" was established Ms Connolly accepted it could not be justified. These issues were intertwined with the question of whether the respondent failed to take reasonable steps in relation to the five individual matters identified by the claimant. If the respondent had to act unreasonably for those PCP's to be made out, objective justification would not be relied upon.

120. As for harassment, Ms Connolly accepted that in principle inaction could constitute conduct, but that inaction had to be related to race. That required consideration of the mental processes of those involved. Ms Connolly urged us to reject the contention of the claimant that the Directive meant that mental processes were irrelevant. She relied on the decision of the EAT in **Nailard**, particularly the passage between paragraphs 90-105. In any event, the Directive was not capable of direct effect because it left to Member States the definition of harassment.

Claimant's Submissions

121. After some initial observations, Mr Caiden submitted that the claimant was not constrained by the five matters identified in paragraph 1 of the agreed list of issues: the formulation of that paragraph recognised that the argument was put in general terms and included the lack of redress (i.e. support for the claimant). He accepted, however, that the remedy sought by the claimant related only to the incident on 7 April 2017 even though the culture in place prior to that was at the heart of the case.

122. On the direct discrimination complaint this case was really about the claimant and his colleagues who were not white British. The white British groups suffered no racial abuse, so racial abuse of the claimant amounted to less favourable treatment. That treatment was either inextricably linked to the protected characteristic, or in the alternative, there were facts from which the Tribunal could conclude that race had a material influence on the reason for the treatment. Those matters were set out in detail in paragraph 28 of the written submission. Ultimately Mr Caiden submitted that the evidence showed that there was a view at the respondent that those who were not white British had to expect some level of racial abuse and therefore people did not act when it occurred.

123. As to indirect discrimination, the written submission identified the evidence from which the Tribunal could conclude that the three PCPs were applied. Mr Caiden submitted that if the Tribunal found that the respondent had a policy but that

there was a practice of staff ignoring it (i.e. of not reporting racial abuse through the incident reporting system) this could still be a PCP applied by the respondent. It had been applied by Mr Liffen himself in not reporting the racial comments made by A at the community meeting on 6 April 2017. The particular disadvantage was that the claimant's racial group was more likely to suffer threats, assault, and abuse than those in the White British racial group. The evidential basis for that conclusion was set out in paragraph 37. Once group and individual disadvantage was shown, he submitted that the respondent could not justify any of these PCPs by reference to its legitimate aim because there was no relationship between the two.

124. As to harassment, Mr Caiden argued that there were two routes by which the respondent should be liable in this case. The first was via **Norouzi**. The respondent was an emanation of the state and the claimant could rely on the Directive. The respondent was on notice of the harassment related to race to which the claimant was subjected, but it did not do enough to protect the claimant from A. There was no requirement under the Directive for the inaction of the respondent to be related to race. He rejected Ms Connolly's argument that this interpretation had been rejected by the EAT in **Nailard**: he invited us to prefer **Norouzi** on that point.

125. The second route was based on **Conteh**. The unwanted conduct was inaction which made the work environment worse, and it was related to the claimant's race because there was no evidence that the respondent would have failed to take reasonable steps with equivalent conduct of a sexual nature.

126. Mr Caiden did not accept the proposition that if the claimant succeeded on harassment he could not succeed on discrimination as well: he relied on Article 2 of the directive which made harassment a form of discrimination, meaning that Section 212(1) of the Equality Act 2010 should be disregarded.

Discussion and Conclusions – The Alleged Failings

127. Underlying this case was the proposition that the respondent had allowed the claimant to be exposed to racial abuse from patients in general terms and/or without redress, and had thereby failed to take adequate steps to counter the threat of racial abuse or aggression posed by patient A, resulting in the assault on 7 April 2017. Before addressing the statutory formulation of the different causes of action we considered each of the five steps in turn (issues 1.1 – 1.5).

Increasing Night Shift Staffing

128. The first matter we considered was the allegation that the respondent failed to take adequate steps to increase the numbers of staff on night shift. We considered this both on a general basis and then in relation to the night shift beginning on 6 April 2017.

129. The base staffing level on nights was one qualified nurse and two assistants. As confirmed by the later email from Ms Christopher at page 230, there were provisions for that to be increased when the need arose. That could be on a medium-term basis (as happened between June and December 2016). Equally it could be short term (even a single shift): the charge nurse could seek the agreement of the duty manager to a temporary increase in staff to respond to a specific need.

130. The claimant raised concerns about a shortage of staff in his June 2016 supervision meeting (page 72) although on 4 February 2017 (page 71) the concerns recorded were more about the quality than the number of staff. However, the incident report form itself recorded that there had been concerns raised about staffing levels on night shift (page 87 and page 89). Staff on nights did not feel safe with only three staff on each ward, and had requested staff meetings but none had taken place for a significant period, particularly involving night staff. A meeting had been arranged on 22 March 2017 but was cancelled due to a patient incident; it was rearranged for 5 April 2017 at a time when night staff could attend. Mr Liffen recorded on the incident report that night staffing had not been raised as an agenda item by staff. However, it was unclear why that was not raised by management given what staff had previously said.

131. Those concerns were strongly reiterated during the grievance interviews. Staff talked about there being a "skeleton staff" on nights, or staff being limited in number (page 208). It was also noted that there were a lot of black staff on nights, and that patient A would target black staff. It was clear that staff who worked on nights, particularly the ethnic minority staff, considered that the shift was understaffed.

132. The Tribunal was concerned at the lack of leadership shown by management on this issue. It does appear that management could have been more proactive in discussing and addressing the concerns raised by night staff in the period leading up to the assault on the claimant. However, the NHS does not have unlimited resources and staffing levels are determined not only by the perception of staff but also by clinical need. Despite what his colleagues said during the grievance interviews, overall the claimant had failed to prove facts from which the Tribunal could conclude that there was inadequate staffing on night shifts generally given the arrangements in place for that staffing level to be increased when the need arose.

133. The second question was whether there was a failure to increase night staff on the claimant's shift of 6/7 April 2017 given the comments made by patient A during the community meeting. The Tribunal had to make a finding of fact about what was said by A at the community meeting. The note of the meeting itself at page 77 made no record of any comment, those notes being intended for display in the ward, and the earliest record appeared to be the note made by Nurse Bradshaw at page 108 in the nursing notes. There was some doubt about whether she had been at the meeting as her name did not appear on the list of attendees, but Mr Liffen thought she had been there. We took into account that later that evening A made a comment to the Dual Diagnosis Nurse about hating black staff and we noted what was said in the grievance interviews - including by Mr Liffen at page 137, and by Ms Ndebele at page 167. It was only Ms Ndebele who thought that during the community meeting A had said he hated the claimant, although she said she did not recall exactly. She went on to say that she told the claimant to be careful, but that was not in line with what the claimant said in his witness statement about what Ms Ndebele told him. There was no-one else confirming that A used the word "hate" during the community meeting, although he clearly did use it a little later to the Dual Diagnosis Nurse.

134. Putting these matters together we concluded that in the community meeting A repeatedly questioned why there were so many black staff on night shift and said he had complained about the claimant who had a "bad attitude". We did not find on the

balance of probabilities that he said he "hated" black staff or the claimant individually. Nor did he make any overt threat to assault the claimant or anyone else. A little later, however, he did tell the Dual Diagnosis Nurse that he hated black staff.

135. The question was therefore whether in the light of what was said the respondent failed to take adequate steps to protect the claimant by allocating another member of staff to the night shift that evening. Patient A did not present in an agitated or aroused state at the meeting. He had been in a relatively settled period leading up to early April (as evidenced by the CTM records). Although he had assaulted two patients in the past, there was no history of violence towards staff members since he moved to Prospect Place save for an incident in August 2016 when he threw a cup of juice at the charge nurse (page 277). Ultimately it was a matter of clinical judgment and the Tribunal concluded unanimously that the respondent had not failed to take adequate steps to increase staffing levels on that night shift.

136. Accordingly, the element of the claimant's case which related to staffing levels was not well founded.

<u>Training</u>

137. The next allegation related to the adequacy of staff training in managing violent situations. The claimant attended a 5-day MVA course in July 2014. He attended a two-day refresher course in August 2015 and again in June 2016. There was an extra MVA session in January 2017 and he was due to go on the 5-day course again in June 2017. The MVA topics included maintaining a reactionary gap, verbal de-escalation of incidents, the need to document incidents, and specifically made reference to verbal assaults. There was no suggestion that any other members of staff did not receive comparable training.

138. The claimant was asked in his oral evidence what extra training he felt might be needed and he said he was mainly talking about breakaway techniques. That may have reflected the fact that he was criticised by Mr Heath on the basis of the CCTV evidence for not having maintained a reactionary gap. The claimant did not accept that criticism. However, the Tribunal was satisfied that the respondent had taken steps to provide adequate training of staff to manage violent situations and this element of the claimant's case was not well-founded.

<u>Observation of Patient A</u>

139. The next suggestion was that the respondent acted inadequately in failing to increase observation levels for A. We rejected that. Patient A was already on 15-minute observations rather than the standard one-hourly observations. In the absence of any express threat of violence or any perception of increased clinical risk, the respondent did not fail to take adequate steps when it maintained that observation level. This element of the claimant's case was not well-founded.

<u>Redeployment of Non-White Staff</u>

140. The next suggested inadequacy was a failure to redeploy non-white staff from wards with prior incidents of racial abuse.

141. Page 467 was an incident report from an incident involving patient A on 31 December 2015 when he made aggressive racial comments and threw a packet of crisps at an ethnic minority nurse. A decision was made that evening that the two ethnic minority staff members should be moved to a different ward, but only for the remainder of that shift.

142. It was apparent that whilst moving staff might be an appropriate situation to manage risk as a last resort, it would not be appropriate proactively to move black staff to forestall further incidents on wards where there had been incidents of racial abuse or threats. Mr Akumah acknowledged that it would be wrong to do that, not least because it would reinforce inappropriate behaviour by patients and enable them to influence the ethnicity of the staff appointed to care for them. The failure of the respondent to take this step did not amount to an inadequate response to the situation.

Rewards or Punishments

143. The final of the five expressly pleaded elements of the claimant's case was that the respondent failed adequately to use rewards or punishments more proactively to control behaviour. The examples that the claimant relied upon were all examples of "punishments" rather than of rewards. They were seclusion, requiring the patient to stay in his bedroom, taking the patient to the Extra Care Area, and cancelling or suspending leave for a significant period of time.

144. The MHA Code (e.g. page 410a) made it clear that restrictions could not be imposed on a patient for the purposes of punishment. Any restrictions had to be for a therapeutic purpose or to protect the patient or a member of staff. Those of the claimant's witnesses (including the claimant himself) who used the word "punishment" in their witness statements were at pains in oral evidence to explain that that was not exactly what they meant. The claimant suggested that he meant "repercussions" or "consequences" for racist behaviour. The key issue was whether these measures could be put in place only when there was a therapeutic need or a specific risk to be addressed, as the respondent maintained, or whether, as the claimant maintained, they could be used to control behaviour by making clear to a patient that there would be adverse consequences if there were racist comments or abuse in future.

145. Seclusion, being taken to the Extra Care Area or being required to stay in the bedroom were all examples of restrictive interventions. The MHA Code at page 410a acknowledged that they might be warranted either for clinical reasons to meet the patient's therapeutic needs, or to protect members of staff (or others). The clinical framework did not support the use of such measures as an identified punishment for certain types of behaviour.

146. To that extent, therefore, the criticism by the claimant that the respondent should have used such measures proactively to control such behaviour was not well-founded, whether that behaviour was regarded as a "punishment" or a "consequence".

147. In relation to the cancellation or suspension of leave, the concise investigation report suggested that leave might be lost as a consequence of racist verbal aggression, yet in this case patient A had already had his leave stopped for other reasons (page 118).

148. Accordingly the Tribunal concluded that the claimant had not established that the respondent failed to take adequate steps pro-actively to control behaviour given the clinical framework in which it had to operate.

Incident Reporting

149. Practice in relation to incident reporting did not appear in the five expressly pleaded allegations of inadequate steps. Ms Connolly argued that in considering harassment and direct discrimination the Tribunal was constrained to deal only with those five matters; Mr Caiden argued that the Tribunal could reach conclusions on other steps which should have been taken if they had been properly canvassed in the evidence.

150. We noted that the allegation that the respondent should have ensured that staff always reported incidents of racial abuse formed a central part of the indirect discrimination complaint (issue 4.1). It had been fully addressed in the evidence. The five specific allegations of failings in paragraph 1 of the list of issues were particulars of the more general point. Accordingly we regarded it as fair and just for the Tribunal to take the evidence on that matter into account in relation to harassment and direct discrimination too, rather than be strictly constrained to consider only the five matters.

151. It was clear that the policy was that all incidents of racial abuse should be the subject of an incident report. So much was evident from the MVA training pack at page 540, from the evidence of Mr Heath, and from the definition of an incident at page 363 which included any incident which could have resulted in mental injury. The categories of incident reporting available via menus on the electronic form included “verbal abuse to staff” and a potential sub-cause was “racism”.

152. Equally, it was clear that not every incident of racial abuse was reported using the incident report system. The grievance reached that conclusion (page 318). It was evident from staff interviews that there were more instances of racial abuse than were formally reported. The recommendations included that there be a review and that steps should be taken to ensure that all staff knew they should report such matters.

153. Indeed, Mr Liffen accepted not only that staff were not reporting such matters but also that the comments made by patient A at the community meeting on 6 April 2017 ought to have been the subject of an incident report if the policy were applied strictly.

154. The Tribunal unanimously concluded that a perception had formed amongst many black staff that reporting every single racist incident was pointless. The consequence was that the incident report system fell into disrepute in that respect. We based this not only on what the claimant and his witnesses told us in our hearing, but also on the following references in the documents:

(a) Mr Akoumah's email of 10 January 2014 saying black nurses were expected to accept racial abuse as "just part of the job".

(b) The claimant's comment in his grievance interview that "people are not bothered [about reporting] as nothing comes of it" (page 145).

(c) A comment which Mr Oitomen reported Mr Liffen having made to him (page 189) that management "can't really do anything" when such comments were made.

(d) The reference by Mr Liffen in the investigation report (page 119) to a lack of consequences for such comments.

(e) Mr Liffen's acceptance in the grievance interview (pages 143-139) that racial abuse was not reported enough and there were occasions when "it's not approached enough".

(f) Ms Ukpebor's comment in her grievance interview that "it's just a fact that [racial abuse] keeps going on and on and on…if you are not seeing any changes what's the point?" (page 207).

(g) The student nurse visiting from another unit was told in August 2016 that racist incidents were the norm. No one at patient A's unit told her to fill in an incident report (page 471). She was advised to do so only on return to a different unit.

(h) The claimant had not been aware that racism could be recorded as a secondary sub-cause on an incident report (page 308).

155. Further, we concluded that there were steps which the respondent should have taken to reinforce the message to staff that they should do an incident report after every such incident. The failure to take those steps contributed to the negative perception held by many black staff about the value of incident reporting. The steps which should have been taken included the following:

(a) The message to patients that racist incidents were unacceptable should have been reinforced more vigorously. Mr Liffen explained how patients became aware that such comments were not appropriate. He said that the mutual expectations would be conveyed to the patient as part of the induction by the named nurse when the patient first came to the ward. However, there did not appear to be any further proactive engagement with patients beyond challenging such behaviour when managers became aware of it. There were posters up at times but not consistently available. It was not necessarily a regular topic for discussion at community meetings on the ward, albeit discussed on occasion (page 330b).

(b) The message could have been reinforced to staff not only on a collective level but by way of individual debriefing each time such an incident came to the attention of managers.

(c) The incident reporting system should have been reviewed to ensure that all incidents of racist abuse could be captured and identified as such – as recommended by the grievance outcome (page 318).

(d) Managers should themselves have completed an incident report every time a racist comment was made, whether witnessing it themselves, hearing about it from another person, or reading about it in clinical notes. An approach of that kind would have resulted in an incident report completed by Mr Liffen after the community meeting on 6 April 2017 and by the Dual Diagnosis Nurse later that day after the further comments recorded on page 108[4]. Such an approach would have reinforced the message that such incidents would not be tolerated and that staff would be supported when they happened.

(e) There should have been clear feedback to individuals once they had made an incident report, so that they knew what steps had been taken. Both the claimant and Mr Fatoki (following the assault on him in December 2016) explained in their evidence how they did not know what was happening after they lodged their respective incident reports. The claimant was not involved in the concise investigation report compiled by Mr Liffen, and learned of some matters only through having lodged a grievance himself. Leaving staff uninformed in that way following an incident report contributed to a culture in which it was seen by some as not worth doing. This was recognised (in relation to police prosecutions) in the grievance appeal outcome (page 330g).

(f) There should have been a staff survey to give senior managers a better understanding of the problems faced by staff (as noted in the grievance outcome at page 320).

(g) There should have been a focus on racist abuse in staff training, as recommended in the grievance outcome (page 316).

156. Of course, the failure to take such steps to encourage incident reporting would be immaterial unless it contributed to the claimant's exposure to racial abuse and physical violence from patient A on 7 April 2017. The respondent's case was that the gaps in the incident reporting system were not material because those incidents of racist abuse were recorded in other ways. They would go in the nursing notes and then be fed into the monthly CTM, and thereby form part of the patient risk assessment and any behaviour management plan. Further, the respondent suggested that given the patient population, some level of racist comment was unavoidable.

157. Although we recognised that the absence of an incident report did not mean that racial abuse went unrecorded, we were satisfied unanimously that the failure to create a culture in which all such incidents were formally reported in that way contributed to an environment in which racial abuse from patients was more likely to

[4] It would also have resulted in an incident report after the comment made by patient A to Mr Liffen (paragraph 97 above) about how the claimant should be dead and "shouldn't be in the country", but as this occurred after the assault it was not material.

occur. There was a perception among some staff that it was simply part of the job and had to be tolerated. That made it more likely that patients would not be challenged over racist comments and abuse. At a corporate level the absence of incident reports on every occasion meant that the risk of verbal racist abuse was under-appreciated and therefore not sufficiently prioritised as a risk to be addressed. At ward level the confidence of staff to challenge such behaviour was impaired by the perception that management were not taking the issue as seriously as they should.

158. The approach of the respondent to racist incidents is illustrated by the fact that had the claimant not brought a grievance, matters would have rested with the concise investigation report. The recommendations on page 120 did not address the question of incident reporting. It was only because the claimant raised that issue in his grievance, and because the culture became evident through the interviews of other ethnic minority staff, that the managers eventually recommended (after some five months) that there should be changes to the approach in that respect.

159. Would a practice of universal reporting of racist incidents have made any difference to the situation with which the claimant was confronted on 7 April 2017? On the balance of probabilities, we concluded that it would have done. The evaluation of the remarks made by patient A at the community meeting the previous afternoon by Mr Liffen, and the view taken by the Dual Diagnosis Nurse of the further remarks, would have been different had they been conscious that an incident report form was required. It would have been much more likely that the claimant would have been properly briefed about what had been said at the meeting and that he had been singled out for comment by A. Mr Liffen's conclusion (concise investigation report page 119) that there had been a clear handover to the night team of the racist remarks failed to appreciate that the claimant had not been told in the handover that he had been specifically mentioned by A. The handover document at page 80 made no mention of the claimant personally. This was a significant failing in the information given to the night team.

160. Further, the claimant would have been aware about the comment made to the Dual Diagnosis Nurse about hating black staff. In cross examination the claimant said that if he had been made aware in a formal way (i.e. at the handover meeting rather than simply in passing by Ms Ndebele as he was concentrating on another task) he would have been able to reassess the degree of risk. The impact on him of learning that he had been singled out would have been much greater had it been properly conveyed by management or his peers rather than conveyed in passing by a more junior colleague. A similar point was made by Ms Ukpebor in her interview (page 211) when she said she would like to be told so she could be more careful. It was possible for strategies to be put in place where a specific risk was identified, as illustrated (see paragraph 57 above) by the November 2015 report by Nurse Riley (page 461).

161. In addition, the Tribunal was satisfied that if greater priority had been given to formal reporting of such incidents the approach taken to patient A by Mr Liffen would have been different. Although Mr Liffen responded to the comment made by A during the meeting, he did not insist on a one-to-one meeting afterwards when A refused to have it. Had A been challenged more systematically by managers on each occasion where he made a racist comment, and had he been properly challenged over this

comment, it may well have been less likely that he would have engaged in the racially aggravated assault on the claimant on 7 April 2017.

162. For those reasons the Tribunal was unanimously satisfied that the respondent had failed to take sufficient steps in relation to the proper reporting of racist abuse, and that this contributed significantly to the situation in which staff perceived themselves as unsupported in relation to such matters. A proper approach to this could have made a difference to the exposure of the claimant to the events of 7 April 2017. Whether that failure amounted to a breach of the Equality Act will now be addressed.

Discussion and Conclusions – Harassment – Issues 10-13

163. Having concluded that the respondent had failed to take all reasonable steps to promote formal reporting of racist incidents (the "incident reporting failing") the Tribunal moved to consider the list of issues.

164. We considered it appropriate to address the harassment complaint first, because under Section 212(1) if conduct amounted to unlawful harassment, it would not also amount to a detriment for the purposes of the direct or indirect race discrimination complaint. Mr Caiden acknowledged that this was so, although we recorded above his contention that Section 212(1) failed properly to implement the Directive.

Unwanted Conduct

165. The Tribunal concluded that the incident reporting failing represented conduct by the respondent. Inaction can constitute conduct: see paragraph 30 of **Conteh**.

166. Further, that inaction was plainly unwanted by the claimant (and by those of his black colleagues who gave evidence). The sense that the respondent was failing to take matters as seriously as it should came through strongly in that evidence. Ensuring universal incident reporting of racist abuse would have been welcomed.

Related to race

167. The Tribunal then considered whether the incident reporting failing related to race. It is clear (see **Nailard** paragraph 97) that the words "related to" were intended to effect a change to the previous formulation of "on the grounds of" race. The test is broader than the causation test for direct discrimination where the protected characteristic has to have a material influence on the mental processes of the person taking action or failing to take action.

168. However, equally it would be an error of law (unless Mr Caiden is correct in his contention about the direct effect of the Directive - see below) for the Tribunal to assume that conduct is related to race simply because the actions of the third parties (in this case, the patients) were themselves harassment related to race. That approach would have been permissible under the now-repealed third-party harassment provisions of the Equality Act but they were not in force at the time of this incident.

169. It appeared from **Nailard**, however, that there is still a requirement that the employer's conduct/inaction is itself related to the protected characteristic, as per **Conteh.** The claimant's success in **Norouzi** was a result of a concession by the respondent about the meaning of the Directive (based on the **EOC** case), a concession about which the EAT had its doubts. **Nailard** was the most recent authority and we preferred to follow it rather than the approach agreed by the parties in **Norouzi**. As a result we rejected Mr Caiden's argument that the Directive had direct effect so as to make the respondent liable for racial harassment by patients. We therefore considered whether the incident reporting failure by the respondent could be said to be related to race.

170. It seemed to us that to make that finding would be to distort the meaning of section 26, even recognising that it is a formulation wider than "because of" (or "on the grounds of" as in **Conteh**). We rejected the contention that this was treatment "because of race" (see below). Nevertheless in his written submission Mr Caiden invited us to conclude that "given the scale of the issue and the respondent burying its head in the sand there must have been some relationship with the claimant's race". He based that on a suggestion that such a scale of sexual assaults, touching and language would have been addressed differently. We rejected that argument. It was merely supposition. There was nothing in the respondent's failure to ensure universal reporting of racist incidents which was related to race other than the subject matter of the failure. On that basis the harassment complaint failed.

<u>Proscribed Effect</u>

171. In case we were wrong on that it was convenient to consider issue 13: whether the conduct had the purpose or effect of violating the claimant's dignity or creating the proscribed environment for the claimant. It was not suggested that this was the purpose of the incident report failing. We considered whether it had that effect.

172. Section 26(4) requires the Tribunal in addressing that question to have regard to three matters in particular, being the perception of the claimant, the other circumstances of the case and whether it is reasonable for the conduct to have that effect.

173. The perception of the claimant was that there was no point reporting incidents because "nothing comes from it" (page 145). He said (page 149) that if he was advising a junior member of staff he would make it clear that they could report the incident but nothing would come of it. He had not seen anything done on the ward for someone who was racially abused and targeted (page 150). The failure to ensure that staff always reported racial abuse via the incident reporting system contributed to an environment which the claimant found degrading, humiliating and offensive since he found himself unprotected by management against offensive racial remarks and racial abuse by patients.

174. The other circumstances of the case also supported this. Similar concerns were expressed by other black colleagues in the grievance interviews and in the evidence they gave to our hearing. In his interview (page 200) Mr Rudnicki said that the verbal abuse "became almost part of the job, became normalised". He had earlier said that racial abuse was reported to nursing staff but was under-reported through incident reporting. Ms Ukpebor (page 206) confirmed that she would not

report a racist comment by a patient and that this sort of behaviour had happened for so long it was accepted as part of the job. The nurse Mathew Gregory (page 156) said there was a danger of tolerance building up with a specific nature of the environment on the unit. Mr Gregory went on to say (page 157) that Mr Fatoki had been racially abused every single day and that there was a "possibly high" percentage chance of a black member of staff on the unit being racially abused. Although those sentiments were not expressed by everyone who was interviewed, we were satisfied that those matters showed that the perception held by the claimant was not unique to him.

175. We were also satisfied that it was reasonable for the incident reporting failure to contribute to that effect. Although the racial abuse came from patients, a significant part of the proscribed environment was due to the management reaction to that, of which the incident reporting regime was part.

176. Therefore, we were satisfied unanimously that the incident reporting failure "created" the proscribed environment for the claimant in the sense that it was a significant contributory factor. This complaint would have succeeded had that failure been related to race.

Discussion and Conclusions – Direct Discrimination

177. Did the incident reporting failure amount to less favourable treatment of the claimant because of race than the treatment the respondent would have afforded to white British comparators?

178. Mr Caiden argued in paragraph 27 of his written submissions that this was a case where the less favourable treatment was inextricably linked to the protected characteristic. It was certainly correct that in our case the evidence of racist abuse was always racist abuse against staff who were not white British rather than those that were. However, that practical experience did not mean that the less favourable treatment was inextricably linked to race. There was no basis on which we could infer that a white member of staff suffering racist abuse from a non-white patient would have been treated any more favourably in terms of incident reporting. We therefore concluded that this was a case in which the Tribunal had to consider the mental processes of the relevant managers in order to determine whether race was a material influence, consciously or subconsciously, on the incident reporting failing.

179. Mr Caiden set out in paragraph 28 of his written submission the list of matters which he said supported an inference that race was a cause of the less favourable treatment. Those matters included the fact that the racial abuse was entirely of those in the claimant's racial group of non-white British, the evidence that on occasion individuals were told not to challenge racist abuse, and a recognition by Mr Liffen that on occasions it was not "approached enough". He also suggested that the Tribunal should infer that racist abuse was not treated like other forms of abuse, assuming that all forms of discriminatory abuse were fully reported. We considered all those matters carefully, but we declined to draw the inference that the incident reporting failure was because of race, either consciously or subconsciously. There was no evidence that other forms of verbal abuse (such as sexist abuse, homophobic abuse or abuse not related to a protected characteristic under the Equality Act) were handled any differently. Although racist abuse on the evidence we

heard was particularly prevalent compared to other forms of abuse, and although the victims saw it as amongst the most hurtful and distressing forms of abuse, the fact that the abuse was racial in nature played no part in the mental processes of management contributing to the failure to ensure that it was properly reported on the incident reporting system.

180. Nor did the race of the claimant and his black colleagues have any material influence on the incident reporting failure. Even if the factors identified by Mr Caiden shifted the burden of proof to the respondent, the respondent had shown that a hypothetical white British comparator subjected to racist abuse from a non-white British patient would have found himself in the same position.

181. Accordingly, we concluded that the direct discrimination complaint failed.

Discussion and Conclusions – Indirect Discrimination

182. Finally, the Tribunal turned to the indirect discrimination complaint.

First PCP

183. The first PCP was the practice of staff not always reporting incidents of racial abuse (issue 4.1). Mr Caiden confirmed that this meant reporting by means of incident reports.

184. For reasons set out above the Tribunal found that there was a practice at Prospect Place of staff not always reporting incidents of racial abuse in that way. Ms Connolly suggested that the practice could not be restricted to racial abuse since other forms of verbal abuse were not reported either. We rejected that approach. It is for the claimant to define his PCP and he chose to do so by reference to the nature of the abuse.

185. The question was whether this was a practice "applied" by the respondent or simply a consequence of decisions by individual members of staff not to report incidents formally. The incident reporting failure represented a breach of the respondent's own policies and training. Ms Connolly argued that it could not therefore have been a PCP "applied" by the respondent. There will no doubt be cases where an employer has done all that it can to get staff to report incidents but individual members of staff choose not to do so, perhaps for personal reasons unrelated to anything the employer has done. However, this was not one of those cases. We noted that the Code says in paragraph 4.5 that the PCP "should be construed widely so as to include, for example, any formal or informal policies, rules, practices, arrangements…" The Tribunal was satisfied that the informal practice of staff not universally reporting incidents of racial abuse was at least in part a consequence of the failure by the respondent to take adequate steps to ensure that this was done, and the failure to provide adequate feedback to staff where a report was made. This helped to create a lack of confidence in the incident reporting system. It was used less often as a result. Although the message was conveyed in the MVA training, it was not sufficiently pressed on staff either through global communications or through speaking to staff individually each and every time such an incident occurred. Accordingly the respondent bore some responsibility for the

practice which developed amongst staff and in that sense it "applied" that practice to the claimant and to other members of staff.

186. We also concluded that the PCP was applied at Prospect Place and not more widely (issue 5). The evidence before us showed how the respondent approached matters at Prospect Place but we did not have any detailed evidence about the respondent's other sites. We heard evidence from Mr Akumah of a different approach by managers at other mental health sites. We also noted that the student nurse suffering racist abuse was advised to report it by staff at a different unit, not at Prospect Place (page 471).

187. As for issue 6, the PCP was applied to nursing staff of all races at Prospect Place. It would have been applied to a white British member of staff who was the victim of verbal racist abuse from a patient.

188. Issue 7 was whether the PCP put the non-white British members of staff at a particular disadvantage. Ms Connolly suggested on the basis of **Grundy v. British Airways PLC [2008] IRLR 74** paragraphs 29 and 30 that the appropriate comparative approach was to look at all forms of abuse to all staff, and therefore that non-white staff were not particularly disadvantaged because white staff would be subjected to equivalent levels of abuse about different characteristics.

189. We rejected that argument. The PCP applied was about racial abuse. Given the ethnic profile of the patient population (predominantly white), non-white British members of staff were much more likely to be subjected to racial abuse than the white British staff. The failure to ensure universal incident reporting helped to create an offensive and humiliating environment for non-white staff in which they felt unsupported and racist behaviours by patients became more likely. Accordingly, we concluded that the particular disadvantage to non-white staff was made out.

190. The claimant was put at that disadvantage too (issue 8). We explained in paragraphs 156-161 above our conclusion that the fact that racist abuse was not always reported as an incident report contributed to the lack of appropriate action over the comments made by A on 6 April 2017 at the community meeting and to the Dual Diagnosis Nurse. Had those matters been identified as warranting an incident report management would have ensured a more effective handover of that information to the claimant, and steps taken to deal with the risk of an incident that night.

191. Accordingly, the ingredients of Section 19 were satisfied.

192. Ms Connolly did not seek to justify the application of this PCP.

193. The indirect discrimination complaint succeeded.

Remaining PCPs

194. Given that conclusion it is convenient to deal with the two remaining PCP's briefly.

195. The Tribunal was satisfied that the respondent did not tolerate (in the sense of ignore completely) certain levels of abuse against staff even though not all those matters were reported through the incident reporting system. Entries would be made in the nursing notes and these would feed into the monthly CTM meetings resulting potentially in changes to the risk assessment for the patient, to the Care Plan and possibly in a behavioural management plan. However, what appeared to be missing was any appreciation of the impact upon the staff as employees, other than as a reflection of the clinical care of the patient. That explained the absence of any system of debriefing staff who had been subject to abusive comments to see how they felt about it and whether there was any action they thought could be taken, and the lack (on the evidence before us) of any reflection of this in risk assessments for staff. To that extent the respondent did tolerate certain levels of abuse against staff by patients.

196. As for the third PCP, this was based upon a phrase used in the grievance investigation report (page 314) which said:

> **"staff should be encouraged to report low levels of racial abuse to ensure that patient Care Plans can be reviewed accordingly".**

197. Although this again reflected a concern for patients rather than staff, the phrase "low levels" reflected that for incident reporting purposes physical injuries were treated as higher level incidents than verbal abuse. That might not be a justified approach in all circumstances. The grievance outcome did support the conclusion that the respondent had contributed to a practice of "low levels" of abuse not requiring recording under the incident report system, and to that extent the PCP was being applied.

198. These PCPs were not restricted to racial abuse. There was much greater force in Ms Connolly's submission that group and individual disadvantage could not be shown. Many of the recorded incidents of abuse were not racial in nature. The patients would alight upon any perceived weakness or difference.

199. However, the non-white staff faced not only the risk of being abused because of gender, appearance, sexuality, accent, clothing or other characteristics, but the additional risk of being abused because of race. That would of course be a visible characteristic; sexuality, for example, might not be. We concluded that this greater risk was sufficient to establish group disadvantage, and individual disadvantage for the claimant.

200. As to justification, we concluded that respondents had failed to show that either of these PCPs was a proportionate means of achieving its legitimate aim of care to patients and the delivery of mental health services in accordance with its contract and the Mental Health Act. Tolerating abuse or treating it as low level had no therapeutic value. Clinical concerns for the patient could condition the response once these matters were reported. We accepted Mr Caiden's argument that there was no connection between the aim and these discriminatory PCPs.

201. The indirect discrimination complaint therefore succeeded on these two PCPs as well.

Conclusion

202. For those reasons the Tribunal unanimously concluded that the complaints of harassment related to race and of direct race discrimination failed and were dismissed, but the complaint of indirect race discrimination succeeded.

203. Remedy will be determined at a further hearing in due course. Within 14 days of the date on which this judgment is sent to the parties the parties should supply their dates of availability between 16 July and 31 December 2018 for a remedy hearing with a time estimate of one day.

Employment Judge Franey

20 June 2018

JUDGMENT AND REASONS SENT TO THE PARTIES ON
16 July 2018

FOR THE TRIBUNAL OFFICE

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