EMPLOYMENT TRIBUNALS

Claimant: **Mrs M Lawan**

Respondent: **The Rotherham NHS Foundation Trust**

Heard at: **Leeds** **On: 24 – 27 February 2020**

Before: **Employment Judge Maidment**
Members: **Ms H Brown**
Mr G Corbett

Representation
Claimant: **Mr B Williams, Counsel**
Respondent: **Mrs R Levene, Counsel**

JUDGMENT having been sent to the parties on 28 February 2020 and written reasons having been requested by the Claimant in accordance with Rule 62(3) of the Employment Tribunals Rules of Procedure 2013, the following reasons are provided:

REASONS

Issues

1. The Claimant complains of ordinary unfair dismissal and that her dismissal was an act of direct race discrimination. The Claimant identifies herself as black African (of Nigerian descent) in terms of her colour/ethnicity. The Respondent's position is that the Claimant, a staff nurse, was dismissed for a reason relating to conduct arising out of her failure on 15 March 2018 to escalate an acute MI reading on an ECG test to a specialist heart failure nurse.

2. Amongst other things, the Claimant maintains that there was lack of consistency in that a colleague, Ms Taylor, had done the same thing the previous day and yet had not been disciplined. She also criticises the conduct of the disciplinary hearing, maintains that the panel which heard her appeal was improperly constituted and that, in any event, that panel decided that the disciplinary hearing had not been thoroughly conducted.

Evidence

3. The Tribunal had before it an agreed bundle of documents numbering in excess of 500 pages.

4. Having briefly reconfirmed the issues with the parties, the Tribunal took some time to read into the witness statements exchanged between the parties and relevant documentation. This meant that when each witness came to give their evidence, they could do so by simply confirming the contents of their statements and then, subject to brief supplementary questions, be open to be cross-examined.

5. On behalf of the Respondent, the Tribunal firstly heard from Mr Mark Hill, Head of Nursing – Medicine and Mr Paul Ferrie, Deputy Director of Workforce. The Tribunal then heard from 2 witnesses called on behalf of the Claimant, Lynda Storey and Susan Biggins, both nurses. The claimant then finally gave her own evidence.

6. Having considered all relevant evidence, the Tribunal makes the factual findings set out below.

Facts

7. The Claimant commenced employment with the Respondent on 7 April 2003 as a staff nurse. The Claimant is black of Nigerian origin and a British citizen. She previously worked in cardiology research as a specialist nurse practitioner in the heart failure department. However, following a, for the Claimant, contentious redundancy exercise she was redeployed from this band 6 hospital position to a more junior band 5 staff nurse position in the heart failure team working in the community.

8. The Claimant's job description referred to supporting the more senior specialist heart nurses and required her to refer people to other practitioners when needs and risks were beyond her own scope of practice. She had to liaise with the multiple disciplinary team and communicate, sometimes complex and sensitive information, with people in an appropriate manner. In terms of patient care, the first aspect of the role identified was to assess, plan, implement and evaluate the physical, social and psychological condition of the cardiac patient and provide required interventions. She was to undertake duties with reference to the NMC Code of Professional Conduct and the Respondent's own protocols.

9. One of the Claimant's duties was to visit patients in the community to assess their health, which often included undertaking ECGs. Katie Taylor and Sarah Briggs had, as heart failure specialist nurses, line management responsibility for the Claimant in her day-to-day tasks.

10. The Claimant was completing a round of patient visits on 15 March 2018. At 2pm on that day Ms Taylor logged an incident involving the Claimant in the Respondent's electronic reporting system for patient concerns, known as Datix. She noted that the Claimant had visited a patient to complete an ECG which showed significant changes consistent with 'possible acute MI' – that indeed was the notification displayed on the ECG print-out. This meant essentially that the patient might have had or be having a heart attack. Ms Taylor went on that no further action was taken by the Claimant and the ECG print-out was seen by Ms Taylor on the Claimant's desk around four hours after she had completed the ECG. This had resulted in Ms Taylor calling the patient, who was currently chest pain free but had been having episodes of chest pain from the last 24 – 48 hours, albeit as a diabetic his presentation was, she noted, not always "classic". Ms Taylor recorded that given the "significance of changes" she had put out an emergency call for the patient to be taken to accident and emergency by ambulance to get an urgent medical review. The patient was subsequently discharged with no further action necessary.

11. Ms Taylor further recorded that the non-escalation of an abnormal ECG had been discussed with the Claimant. She further noted: "Abnormal ECG escalation of what to look out for had not been discussed with the staff nurse as she has CCU background and said she reads ECGs. This has now been discussed, the staff nurse assured "the investigator" that this would not happen again. The line manager will give her some written guidance on what ECG results need escalating and what can be handed over later in the day."

12. She noted, however, that the Claimant had still not mentioned the ECG to her 6 hours after the test had been undertaken and had said she was going to refer to it on handover when she got to the office. The Claimant had noted the reading of possible acute MI on the ECG. When asked why she had not escalated it, she had said that she was going to check it against an old ECG but had not done this or passed this over to Ms Taylor. Ms Taylor stated that the: "nurse is not expected to interpret the ECG and we do not rely on the printed diagnosis but this should have warranted a discussion with a senior member of staff ASAP."

13. On 16 March Ms Taylor sent an email to the Claimant stating that she had had to submit a Datix report regarding the non-escalation of the ECG result "as this was a near miss". She said that it highlighted that formal processes regarding interpretation/reading of the print-out diagnosis had not been discussed and she understood that her colleague, Ms Briggs, was planning to provide the Claimant with written guidance about this. She went on that she had closed the Datix report as a "non-harm incident" with the above lessons learnt, concluding that thankfully the patient involved was discharged later with normal troponins.

14. Indeed, written guidance was subsequently produced dealing with the practical procedures relating to and the interpretation of ECGs. This commenced with a statement that, as a nurse with considerable cardiac experience, it is important to use knowledge and also to encourage use of current skills whilst increasing knowledge and new skills. Under the heading of ECG interpretation, it was said that whilst not vital to the post, the nurse should within the scope of her knowledge review the ECG and ensure no acute event. All abnormal ECGs needed, however, to be immediately reported to the referrer or to any clinician within the cardiac team, it then being stated, “if in doubt please report it”.

15. The Datix report was sent to a range of more senior nurses and picked up by Joanne Mangnall, deputy head of nursing (community), as a matter requiring further investigation. She conducted a fact-finding meeting with the Claimant on 19 March at which she asked the Claimant to explain what she had been asked to do with ECGs. She accepted that she had not been told to interpret them and that that was not her decision. When asked if she would be expected to bring results back straight to the office after the visit as a priority, she said that she would do other visits before going back to the hospital. When asked if she had been told what to do if she had any concerns about an ECG she responded: “not anything. Never come across a very poorly patient before on visits though.” The Claimant confirmed that she did not have any medical records with her relating to the patient she had seen 15 March. She had not telephoned Ms Taylor immediately on seeing the ECG result as the patient wasn’t poorly. There were no symptoms and the patient was happy. She confirmed that she had had no instructions about the ECG and that “actions were from own discretion”. The Claimant was told that a formal investigation would be undertaken for the safety of patients and the Claimant and, in the meantime, she would be placed on restricted duties. Ms Mangall wrote to the Claimant on 21 March confirming that the purpose of the earlier meeting had been to discuss a serious allegation regarding the incident on 15 March of failing to escalate the results of the ECG following a patient visit to the appropriate clinician who could interpret the results fully and take the necessary action to ensure patient safety. The Claimant was being moved to a non-clinical role. The Claimant was told that the allegations were so serious that the matter might be referred to a disciplinary hearing as potentially a misconduct or gross misconduct allegation.

16. The Claimant was subsequently invited to an investigation meeting undertaken by Michelle White, community matron, on 25 April. This referred to the allegation of failing to escalate the results of an ECG. The Claimant provided her own typed statement prior to that meeting. In this she gave details about her working day on 15 March and her visit with the relevant patient sometime after 10am. After visiting that patient, she went to another patient’s home and, after that visit, telephoned Ms Taylor to seek permission to pop home to pick up her training folder. She then went to see a further patient before returning back to the hospital. Whilst having lunch she was asked to go and see another patient urgently, which she did. On returning

to the hospital she said that Ms Taylor spoke to her about her concerns with the patient. When asked why she hadn't escalated the matter or phoned while she was at the patient's home, she said that she could have, but the patient looked well with no problems or symptoms and he was not poorly at all during the time of the Claimant's visit. The Claimant said she was shocked to hear the patient was in hospital and queried if he had become poorly after her visit. Ms Taylor had explained that, because of the change recorded in the ECG, they had to call an ambulance to take the patient to hospital. The Claimant apologised and said that her intention was always to work to the best of her ability. She went on to explain that she would definitely escalate any concern about a patient even without anyone telling her to do so. Since starting her current role with the cardiac team she said she had come across a number of patients who needed urgent care and she did pass the information on appropriately. She gave details of some of those patients.

17. When interviewed by Ms White she was asked if she was expected to interpret ECG results. The Claimant replied that if the ECG was abnormal then she would discuss, but as the patient was fine she followed the normal processes. If there had been a problem then she would not have waited but rung immediately. She later said that she was focusing on the patient describing him as well, good and excited and continuing that maybe his excitement was what elevated the ECG reading and that is why it showed acute MI. She was asked what the escalation process was if she suspected a patient was having an acute MI. She said that she would call for an ambulance. She was asked who she would contact if she was unsure whether it was an acute MI and responded that she would ring the person who had asked her to complete the ECG and that she had done this before. She gave an example of doing this when someone told her that they were in pain. When asked what she would have done if she had been aware that the patient had recently suffered from shoulder/chest pain, she said that she would have done things differently and would have taken their blood pressure and telephoned Ms Taylor to discuss.

18. Ms White interviewed Ms Taylor on 1 May. She referred to the Claimant having started with the team in August and by November Ms Taylor having submitted 5 Datix reports in relation to her blood results record-keeping. When asked if she had established that the Claimant was competent to undertake ECGs, she responded that there may have been an assumption made given that she previously worked in the CCU, but that they did discuss competencies with her and there were no concerns raised. There was also reference to an informal action plan being put in place to support the Claimant dated 27 February 2018.

19. As regards the incident on 15 March, she said that the Claimant was only expected to complete the ECG. When asked what her role was in completing the ECG, she responded that she thought the Claimant might have been confused as to whether she was completing an assessment or

a task. She said that although there is some degree of assessment, they wanted to make sure that she could do the task before they moved her onto assessments. She said that given that the ECG stated a possible acute MI, the Claimant was not required or expected to make a clinical decision whether to act or not. She should have contacted somebody about this. Ms Taylor referred to her informal action plan saying that she should escalate concerns, going on that this was the first example of something the Claimant had done that was life-threatening. There was no expectation that the Claimant should diagnose and maybe she was unclear of this.

20. Ms Briggs was also interviewed by Ms White on 2 May. She said that the Claimant had received an induction and had shadowed her quite a lot. When asked if she was aware that the Claimant was competent in undertaking ECGs she responded that she was a CCU nurse and then moved to the research team. As part of this role she had told them that she had done ECGs and was competent in undertaking them. When asked if that was undertaking or interpreting the ECGs, Ms Briggs responded: "undertaking, she could use her knowledge but her role was to perform and report back to us." Ms Briggs went on that she was aware when the Claimant joined the team that she had lots of experience and she told the Claimant that she might feel restrained as the role was task orientated. She said that she made it clear that problems/issues should always be reported back to her. She made similar comments later in the interview including that it was made clear to the Claimant from the beginning that she was to gather information report back, not to assess and examine and that Ms Briggs had explained that she might find that boring taking into account where she had worked previously. She said that expectations in terms of escalation had been imparted to the Claimant and "we kept emphasising this". When asked if she was aware that the Claimant had undertaken any formal ECG training she said that she would have completed the basic training.

21. Ms White completed her investigation report on 3 July 2018. This summarised the investigation meetings. It noted, amongst other things, Ms Briggs as saying that she had discussed ECGs with the Claimant who had confirmed that she was competent in undertaking them and had done so as part of her previous roles. In her conclusion, Ms White said that she believed that the Claimant's actions were a potential breach of the disciplinary procedure and that they could fall within a number of categories of gross misconduct including serious neglect of patients, gross negligence and a serious clinical act or omission which is significantly prejudicial to the service.

22. Mr Mark Hill, Head of Nursing, was asked to chair a disciplinary hearing which was ultimately convened on 7 August. Prior to this, Mr Hill had received and read Ms White's investigation report and its 38 numbered appendices which included notes of the investigatory meetings, the Respondent's policies, the NMC code and information regarding the

Claimant's training and employment record. The Claimant was accompanied by a representative from the Royal College of Nursing.

23. Ms White commenced by presenting the investigation. The Claimant then presented her case calling Ms Taylor and Ms Briggs as witnesses. Ms Briggs said that expectations of the Claimant had been made clear to her on her redeployment and she anticipated the Claimant might have felt as though her wings had been clipped - she was conscious the role would feel less challenging for her.

24. Mr Hill then asked the Claimant a number of questions he had prepared. She said that the patient had informed her that he felt well and that coincided with her own observations. She said that she used her professional judgement and experience to arrive at the decision not to escalate this patient to anyone for further assessment or opinion. She said that the patient was well, excitable and that he was focused on going out later that day. The plan was to hand over as usual and therefore she did not view the patient as requiring urgent care. She planned on raising the matter with Ms Taylor but had been interrupted on her lunch break, when asked to attend the further urgent patient visit. She said that she had not thought to raise the matter when she had spoken to Ms Taylor earlier in the day over the phone about collecting the training folder. When asked how she would do things differently if a similar incident happened again, she said that she would do things differently. When prompted to elaborate she explained that she would do a full assessment, discuss further with the patient and ask about their general health and medical history. Mr Hill noted that her reflection did not include any mention of any sort of escalation.

25. Mr Hill then adjourned to consider his decision. He concluded that the Claimant had received an extensive and robust induction into the role and on 27 February 2018 a formal development plan had been put into place to further support the Claimant. In addition, a daily timetable had been created to support her. He felt that the Claimant had been provided with documentation which clearly laid out the expectations of her in her role and also highlighted when to escalate concerns. More than reasonable support had been provided including regular one-to-ones. He considered the Claimant's job description, which he felt was also clear regarding what was expected of her and that it had been made clear also that the expectations from the role would be for her to undertake ECGs but not to interpret them. He accepted that it had been made clear that escalation of any issues was a key part of her role and it was the responsibility of the more senior specialist nurses to make an assessment and interpret the ECG readings.

26. His conclusion was that the allegations against the Claimant had been made out. Considering potential sanctions, he was concerned that, despite the aforementioned support, he felt that the Claimant did not appear to have any real insight into the concerns. He was not assured that she would escalate similar concerns in the future and this worried him. Given the

support that had been in place at the time of the incident, he felt that there were no other departments which could provide further support to the Claimant. The incident could have resulted in a fatality and he felt that the Claimant presented a risk to patient safety and to the Respondent. In the circumstances he concluded that the Claimant's employment should be terminated.

27. He reconvened the hearing and explained this decision. The Claimant clearly became distressed on hearing this decision. Mr Hill's view of her behaviour was that it was aggressive and threatening, in that she had lent across the table, waved her arms and shouted at Mr Hill and his HR adviser present with him before throwing herself on the floor, kicking off her shoes and, in his words, chanting religious words and charging around the meeting room in a threatening manner.

28. Mr Hill wrote to the Claimant on 14 August 2018 confirming her dismissal and that she had the right of appeal. She appealed by letter of 24 August, submitted by her RCN representative, and an appeal panel was put together chaired by Paul Ferrie, at the time Acting Director of Workforce, and including Helen Dobson as a deputy director and Andrew Brammer as a service director, both of whom had a clinical background. They had received the full pack of documentation which was at the disciplinary hearing. The Claimant was again accompanied by her RCN representative. Mr Hill attended to present the management case. The Claimant's representative suggested that no account had been taken of the Claimant's length of service or alternatives to dismissal. He submitted that the dismissal was disproportionate in that the Claimant had been criticised for causing a delay of 4 – 6 hours by making a poor decision. The Claimant's case was that she did not see the ECG as requiring immediate action, judging this on the patient's presentation. The Claimant said she had apologised. If she had been concerned about the patient she would have called from his home, but he was really well. The Claimant's representative said that the Claimant accepted that she should have rung the ECG in, but at the time the patient's presentation persuaded her otherwise. She had said repeatedly that this would not happen again. Ms Dobson asked the Claimant again to explain why she had not escalated the patient's ECG. It is clear from her questions that the panel did not appreciate that the additional guidance document produced after the event had not been in place at the time of the incident on 15 March 2018.

29. The appeal panel adjourned to consider its decision which was notified to the Claimant in writing on 10 December 2018. They upheld the decision to dismiss. They felt that the Claimant was a very experienced nurse and that the expectations of her role had been made very clear to her. She failed to escalate a very concerning ECG which could have had serious consequences for the patient. Ms Taylor's comments in the Datix were seen as a risk assessment of processes within the service rather than a risk assessment of the Claimant's individual practice. It was felt that the

Claimant had continued to demonstrate a lack of insight into her actions and potential consequences for the patient, continuing to highlight that the patient appeared well. The Claimant clearly could have escalated the ECG but had chosen not to. It was concluded that her actions in failing to escalate the ECG constituted gross negligence and dismissal was justified, a lack of insight giving the Respondent no reassurance that her behaviour would not be repeated. The Claimant's length of service was acknowledged but because of this she was experienced and had received latterly extensive support.

30. The Claimant had had the benefit of an induction where she had shadowed Ms Briggs on her rounds on 2 days and had then been observed carrying out procedures on patients herself by Ms Briggs on a further day. She expressed herself to be happy with her new role. The Claimant had undertaken basic practical skills training in correctly recording and basic interpretation of ECGs on 31 August 2017. Before the Tribunal, the view of Mr Hill was that whilst these were basic competencies, on obtaining an acute MI recording he would expect any professional to contact a specialist and see the need for a further assessment. There was no expectation on the Claimant to interpret this for herself. Whilst the Claimant had not had the more explicit guidance produced after the incident, he observed that the Claimant highlighted herself cases where she had escalated matters. Indeed, she had given examples in the statement she produced prior to her investigatory meeting. In cross examination, Mr Hill agreed that the guidance which referred specifically to ECGs had only come into being after the incident had occurred and conceded therefore he was aware of a gap in the guidance/instructions given to the Claimant. He agreed that if the Claimant had had this document she could have had no excuse for the failure to escalate, but again referred to the fact that without this guidance the Claimant had referred to cases she had escalated. The guidance was a "fail safe". He would still expect any professional to contact a specialist and see the need for further assessment if met with an acute MI reading. At the Claimant's appeal hearing, she said that she had previously performed an ECG on a patient which showed up atrial fibrillation and she had escalated this. However, she did not think that the Respondent wanted her to escalate matters when the patients were well. If the patient had had any symptoms she would have taken over and done her best for the patient. When put to her by Ms Levene that if there was something of concern regarding a patient she knew to escalate the matter she responded: "Exactly. 100%."

31. The Claimant did attend regular one-to-one reviews, albeit the occurrence of all of those listed are not agreed by the Claimant. An agreed working plan was drawn up at a meeting on 11 January 2018 which refers to new patients requiring particular investigations regarding heart rate, blood pressure respiratory rate and ECG. This referred to the Claimant having to give a daily verbal handover late afternoon of all visits undertaken that day to the responsible senior nurse, but that any concerns that could not wait had to be discussed via telephone. The one-to-one meeting of that date referred to the Claimant's role being currently task orientated. A timetable was

discussed to help her manage her daily tasks. This reflected carrying out home visits typically during the morning with a handover to the more senior specialist nurse after the lunch period before completing documentation in Systm 1 for that day's visits and completing other more administrative tasks. The Tribunal has been referred to the Claimant's informal development plan dated 27 February 2018. In the section dealing with handovers under "actions required" was a need to escalate any concerns regarding a patient prior to the arranged hand over time if the patient was "unwell/not as expected". The Claimant understood that requirement of her, but considered that the patient she had seen, from her own observances and assessment, was not in pain and was well enough to be planning to go out. The ECG result was not expected, she agreed, and was abnormal with a message displayed indicating that the patient had had or was having a heart attack. Nevertheless, the Claimant believed that the ECG result did not match the Claimant's actual presentation and that the patient was not showing any adverse symptoms or complaining of any pain such that she concluded that there was no need to make an immediate report or take any immediate action, but simply to log the issue on the system as part of the daily handover. The Claimant agreed that she did not have any patient notes and was unaware if the patient might have any condition such as diabetes which could mask the symptoms ordinarily experienced in an individual suffering from an acute MI.

32. The Claimant before the Tribunal said that if she saw something which caused her concern she would discuss it with one of the senior nurses. However, she should give holistic care. With the patient on 15 March 2018, she saw the changes evidenced by the ECG result but looked at the patient and focused on him. He was well and he was intending to go out. She intended to log her observations and the ECG record on system 1 and report it as part of the ordinary handover process. This was in circumstances where she did not see this patient as exhibiting any problem. The ECG result did not reflect her physical observation of the patient and what the patient was saying himself regarding his lack of pain. When put to her that her former colleagues, Ms Storey and Ms Biggins, had described to the Tribunal an acute MI as being a red flag and that it was a result which would always be followed up, she said that definitely that could be done, but you had to look at the patient and here the patient was saying he was well and in no pain. If she had known the history of the patient, she could have done a complete assessment of him, but that was not something that she was being asked to carry out as part of her role. She agreed that an acute MI indicated that a heart attack was happening or had happened or it was about to happen, but said that readings were not necessarily accurate and she had to look at the patient. If the patient had been in pain she would probably take the initiative herself to get the patient to hospital. When put to her that, given that she did not have all the relevant information regarding the patient's medical history, there was all the more reason to escalate it, she said that she asked if the patient was okay and since he was it was something that she would escalate later. She was going to tell the senior

nurses, but they delayed her by sending her out for another patient visit before she could record the ECG result on system 1. She said that she understood that if something was a problem or urgent she was to tell her superiors. She agreed, however, that in this case she was probably just going to log the matter on system 1 in the normal course of things because she did not see the issue as a problem.

33. Again, she said that at the time she had not seen this is something to escalate immediately and had agreed that in the future, on recording any abnormality, she would tell her senior colleagues but noted that an ECG can display so many different categories of abnormality and she would still look at the patient. She did not accept that the case of the patient on 15 March was a serious matter as she told her colleagues that the ECG result did not reflect the patient's own representation. The patient was very well. She agreed that, if she had been worried, she knew that she had to immediately escalate the matter and would have done that, but the ECG could give her "any reading".

Applicable law

34. In a claim of unfair dismissal, it is for the employer to show the reason for dismissal and that it was a potentially fair reason. One such potentially fair reason for dismissal is a reason related to conduct pursuant to Section 98(2)(b). This is the reason relied upon by the Respondent. If the Respondent shows a potentially fair reason for dismissal, the Tribunal shall determine whether dismissal was fair or unfair in accordance with Section 98(4) of the ERA, which provides:-

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

35. Classically in cases of misconduct a Tribunal will determine whether the employer genuinely believed in the employee's guilt of misconduct and whether it had reasonable grounds after reasonable investigation for such belief. The burden of proof is neutral in this regard. The Tribunal must not substitute its own view as to what decision it would have reached in particular circumstances. The Tribunal has to determine whether the employer's decision to dismiss the employee fell within a band of reasonable responses that a reasonable employer in these circumstances might have adopted. It is recognised that this test applies both to the decision to dismiss and to the procedure by which that decision is reached.

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

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

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

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

40. The Claimant complains of direct race discrimination. In the Equality Act 2010 direct discrimination is defined in Section 13(1) which provides: *"(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."*

41. "Race" is one of the protected characteristics listed in Section 4 and further defined in Section 9 of the 2010 Act so as to include colour, nationality, ethnic or national origins. Section 23 provides that on a comparison of cases for the purpose of Section 13 *"there must be no material difference between the circumstances relating to each case*".

42. The Act deals with the burden of proof at Section 136(2) as follows:-

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

43. In **Igen v Wong [2005] ICR 935** guidance was given on the operation of the burden of proof provisions in the preceding discrimination legislation (particularly on the Tribunal's scope for inferring discrimination) albeit with the caveat that this is not a substitute for the statutory language. The Tribunal also takes note of the case of **Madarassy v Nomura International Plc [2007] ICR 867**.

44. It is permissible for the Tribunal to consider the explanations of the Respondent at the stage of deciding whether a prima facie case is made out (see also **Laing v Manchester CC IRLR 748**). Langstaff J in **Birmingham CC v Millwood 2012 EqLR 910** commented that unaccepted explanations may be sufficient to cause the shifting of the burden of proof. At this second stage the employer must show on the balance of probabilities that the treatment of the Claimant was in no sense whatsoever because of the protected characteristic. At this stage the Tribunal is simply concerned with the reason the employer acted as it did.

45. The Tribunal refers to the case of **Shamoon v The Chief Constable of the Royal Ulster Constabulary [2003] ICR 337** for guidance as to how the Tribunal should apply what is effectively a two stage test. The Supreme Court in **Hewage v Grampian Health Board [2012] UKSC 37** also made clear that it is important not to make too much of the role of the burden of proof provisions. They will require careful attention where there is room for doubt as to the facts necessary to establish discrimination. However, they have nothing to offer where the Tribunal is in a position to make positive findings on the evidence one way or the other.

46. Having applied these legal principles to the facts, the Tribunal reaches the following conclusions.

Conclusions

47. The Tribunal deals firstly with the Claimant's complaint of race discrimination. This is limited to a complaint of less favourable treatment in her dismissal.

48. It was put to Mr Hill that his decision to terminate the Claimant's employment was tainted by consideration of her colour or ethnic origin. He disagreed. The Tribunal can conclude that he was somewhat taken aback by the Claimant's reaction to being informed of his decision to dismiss her. He described her as threatening and there was a suggestion made to him that this was based upon a lack of cultural understanding. There is no denial by the Claimant that she became very upset at this point and Mr Hill explained to the Tribunal exactly how the Claimant had acted which caused him to comment on her behaviour. There is nothing in this which raises an

inference that his earlier decision to terminate her employment was influenced by considerations of race.

49. There is no actual comparator relied upon in this case. There is no evidence that Ms Taylor omitted to do something which she ought to have done with the patient the previous day or that there was anything problematical in her then simply instructing the Claimant to carry out an ECG on that patient. Her involvement with the patient was not of a similar nature to that of the Claimant.

50. Otherwise, the Claimant points to perceived defects in the Respondent's approach to the allegations raised and pursued against her. The Tribunal does not agree that the matter was approached superficially or that the Respondent sought rely on varying reasons for dismissal. There is no evidence that the Claimant was unable to present her case freely at either disciplinary or appeal hearings. The Claimant did not, when she appealed, seek to suggest that Mr Hill had not afforded her an opportunity to state her case. Indeed, the Claimant did not suggest at the time that she believed that she had been treated less favourably because of race.

51. The Respondent's decision-making involved an assessment of the Claimant's dealings with a particular patient, an issue which, by the time of the dismissal decision, had been discussed with the Claimant and others on multiple occasions and at considerable length.

52. There are no facts shown from which the Tribunal could reasonably conclude that the Claimant's dismissal was in any way because of her race. In any event, the Tribunal is completely satisfied with the Respondent's explanation that her dismissal was based purely on its assessment of her treatment of the patient on 15 March 2018.

53. The Claimant's complaint of race discrimination must fail and is dismissed.

54. Turning to the Claimant's complaint of unfair dismissal, the Tribunal accepts that the reason for the Claimant's dismissal was the Claimant's failure to escalate the results of an ECG following a patient visit. Mr Hill believed that this constituted gross misconduct and dismissed the Claimant for that reason. Different labels have been attached or sought to be attached to the Claimant's actions at various stages including by Ms White, Mr Hill and Mr Ferrie. Mr Hill saw this primarily as a serious clinical omission which was significantly prejudicial to the service – an example of potential acts of gross misconduct in the Respondent's disciplinary procedures. He also considered that the Claimant had been negligent in a way which caused a potential risk to patient safety. However the Claimant's actions potentially fitted within the examples of gross misconduct, the reason for dismissal was certainly related to conduct. That is a potentially fair reason for dismissal.

55. Did then the Respondent arrive at its conclusion as to the Claimant's guilt on reasonable grounds after a reasonable investigation?

56. The Tribunal has been concerned with the question as to whether or not the Claimant was reasonably viewed as understanding that she was required to escalate immediately the ECG reading of acute MI for the patient she saw on 15 March 2018.

57. The Tribunal's attention is rightly drawn to a specific guidance note drawn up only after the patient incident which states clearly and expressly that all abnormal ECGs need to be immediately reported and that a report should be made by the nurse if in any doubt. The creation of that guidance after the event, together with the Datix records compiled by Ms Taylor, are said to illustrate the lack of sufficient guidance already in existence and in support of (and as justification for) any lack of knowledge/appreciation on the Claimant's part. Ms Taylor indeed recorded that abnormal ECG escalation had not been discussed with the Claimant given her background in coronary care. Written guidance was therefore to be produced.

58. Ms Taylor was subsequently interviewed. She said that there may have been assumptions made regarding the Claimant's competency to undertake ECGs, although competencies had been discussed with her and there were no concerns. She recognised that there may have been some confusion on the Claimant's part as to whether she was completing an assessment or a task. However, she said that if the Claimant had seen "that ECG" she should have discussed it with someone quickly - something needed to be checked. The Claimant was not required or expected to make a clinical decision whether to act or not, but should have contacted someone about this. The Claimant had not acknowledged the urgency of this particular ECG reading.

59. Ms Briggs, when interviewed, said that she had made it clear to the Claimant that a problem/issue should always be reported back. She was clear that, with this patient, further advice should have been sought immediately. The Claimant was not to assess or examine, but gather information and report back. This was said to have been made clear to her from the beginning of her current role. Ms Briggs said that the Claimant was aware of the expectation of her in terms of escalation and that they had kept emphasising this with her.

60. The Claimant, in the first statement she provided prior to the investigation meeting, said that she would definitely escalate any concern about a patient and had come across a number of patients, who needed urgent care, where she did pass information on appropriately. She gave examples. When Ms White interviewed her, she asked the Claimant about the escalation process including who she would contact if she was unsure whether the patient was having an acute MI. She said that she would ring the person who had asked

her to complete the ECG and that she had done so in the past. She gave an example of doing so when a patient told her that they were in pain. The Claimant described working (as she had previously) in a non-community setting where she had seen an acute MI reading and said that she would show her colleague, repeat the ECG and take bloods.

61. As noted, in the Claimant's very first statement before the investigatory meeting she had given examples of instances where she had escalated concerns. At the appeal hearing she said that when she had come across an ECG reading of atrial fibrillation, she had escalated it. She went on, at that point, that she did not think that the Respondent wanted her to escalate matters when patients were well. She never had any intention of escalating any concern about the relevant patient – indeed, the Claimant had had an obvious opportunity still quite early in the day when she spoke to Ms Taylor over the telephone.

62. That chimes with the Claimant's evidence at the disciplinary and appeal hearing. The evidence before this Tribunal is further illustrative of the similar position she took at those internal hearings. The Claimant knew that problems and concerns about a patient were to be escalated immediately, but she considered herself to be competent and an appropriate person to make her own assessment of whether, essentially, a patient was well or unwell. If, in her judgement, a patient was well, then there would be no need to escalate. If the patient displayed symptoms, then she would. She took, what she described as, a holistic approach which she hoped would benefit the patient, but which relied upon her own assessment of the patient.

63. Otherwise, the Claimant certainly had been signed off in August 2017 as having the necessary skills to record an ECG reading and undertake a basic interpretation of it. She had significant experience, including of nursing in a coronary care unit. She had undergone a practical induction with Ms Briggs. A working plan dated 11 January 2018 made reference to escalation in circumstances of a patient showing obvious signs of being unwell. That was in circumstances where an ECG was one of the investigatory tools listed as required. The Claimant's informal development plan dated 27 February 2018 referred to the need to escalate concerns to a more senior nurse prior to the arranged handover time if the patient was unwell/not as expected.

64. The Claimant accepted in evidence that the ECG reading for the patient on 15 March 2018 was both "abnormal" and "unexpected". Nevertheless, in her view, that patient was not unwell and therefore she felt there was no requirement to escalate - it was not an issue of concern but rather a matter to be logged on the system on her return to the centre and mentioned at the normal afternoon handover time. Her failure to mention the patient during her telephone call with Ms Taylor reflected that view.

65. It is said that until the after the event guidance, there was no document in place which was explicit in respect of the need to escalate ECGs, but on the basis of all the evidence, including from the Claimant herself, Mr Hill could and did reasonably conclude that the Claimant knew or ought to have known that there was an expectation that she would escalate an ECG reading displaying an acute MI.

66. An acute MI reading signified that a person had had or was currently having a heart attack. It was reasonably concluded that this ought to have been recognised by the Claimant as something which rendered a patient unwell or showing a cause for concern. Mr Hill was reasonable in believing that any medical practitioner should have seen this as a red flag, a situation which was potentially threatening to life or certainly might signify damage to a patient's heart. The Claimant's former colleagues who gave evidence agreed that an acute MI reading would require follow-up action.

67. It was not the Respondent's practice for nurses in the Claimant's position to carry patient notes and this was reasonably regarded as a factor which again pointed to an obvious need for there to be an escalation. The Claimant's ability to assess the patient was significantly limited. The Claimant knew that some people, including diabetics (this patient was in fact, unknown to the Claimant, diabetic) do not necessarily exhibit classic symptoms when having a heart attack and in the case of a "silent" MI there might be no discernible pain. Mr Hill noted these considerations.

68. The Claimant asserts that the Respondent's investigation was fundamentally flawed in a way which ought to render dismissal unfair. It is true that Ms Taylor did not recognise there as having been misconduct on the Claimant's part which ought immediately to be elevated as a disciplinary issue. She, however, did log this as a concern on Datix (this was not a method of raising any disciplinary issues) and there was no bar on any of those to whom the concern was escalated reviewing the matter and recognising the Claimant's conduct as an issue of concern which ought to be fully investigated. There was no reason why Mr Hill ought reasonably to have been concerned that the matter was allegedly reopened in circumstances where he had before him evidence of a full subsequent investigation and of certainly sufficient justification for the Claimant to face disciplinary allegations into her conduct. Ms Taylor may have made statements in the Datix report that ECG escalation had not been discussed and that written guidance was required but, through the investigatory and disciplinary process, the Respondent reasonably sought to understand, not least by interviewing Ms Taylor, Ms Briggs and the Claimant herself, what was in place in terms of guidance and what, crucially, the Claimant understood her responsibilities to be.

69. The Tribunal agrees with Ms Levene that it was not reasonably evident to Mr Hill that a particular criticism was being made by the Claimant of the nature of the investigation, but in any event Ms White appeared before Mr

Hill to present her investigation and the Claimant or her representative could have questioned her conduct of the investigation had they thought it to be appropriate.

70. The Tribunal has noted that Ms Taylor referenced more general concerns about the Claimant's performance and that the decision-makers were aware of an informal action plan in place to aid the Claimant's performance. Reference was also made to a pile of ECGs conducted by the Claimant being found in a drawer. The raising of such issues does not, however, in the circumstances illustrate any bad faith. Particularly in Ms Taylor's case, she does not appear to have been seeking to target or criticise the Claimant beyond the Datix report when the issue arose with the patient and she identified further support for the Claimant. Fundamentally, the Tribunal is satisfied that these additional pieces of information, potentially prejudicial to the Claimant, did not form part of the Respondent's decision making at either disciplinary or appeal stage.

71. It might be said that Ms White could have approached her questioning of Ms Taylor more forensically and sought to better understand the statements she had made on the Datix, but the interview with Ms Taylor was a reasonable exploration of Ms Taylor's understanding as to the Claimant's degree of knowledge and how the service worked. She was of course called by the Claimant as a witness at the disciplinary hearing. Ms White ought not to be judged by the standards of a lawyer and the band of reasonable responses test applies to the investigation as well as the decision to dismiss.

72. Mr Williams points out in submissions that when Ms Briggs was interviewed and asked about the procedural document for ECGs, this was with reference to the guidance document which was produced after the event. Mr Hill's understanding of this passage was not explored with him. In evidence Mr Hill was referred to this written guidance and that it was a document which came after the Datix report where it had been stated that written guidance would be provided. He agreed. It was not suggested to him that he was under any misapprehension that the specific ECG guidance predated the incident. He was not referred to his outcome decision which is drafted in a way which seems to rely on this after the event documentation as part of the directions and guidance given to the Claimant which she had acted in breach of. The Tribunal cannot conclude that he was working under a misunderstanding or that he based his decision to dismiss the Claimant upon a belief that she had already been given explicit ECG guidance. Before the Tribunal, Mr Hill accepted that there might have been a gap in the guidance provided which was filled by this document as an effective, to use his words, 'fail safe'.

73. Again, the outcome letter is troublesome, but in terms of evidence before the Tribunal remains unexplained in circumstances where there might have been an explanation other than Mr Hill labouring under a misapprehension, for example that this was not what was meant, that the drafting was

inaccurate/misleading or that this letter did not constitute Mr Hill's own wording or had not been properly reviewed by him. The Tribunal is not seeking to speculate but rather to illustrate its inability to make a finding that Mr Hill based his decision on the Claimant having had guidance which had only been given after the event. The best evidence is that, before the Tribunal, Mr Hill certainly appreciated when the guidance came into being.

74. The situation is somewhat different with the appeal hearing. The Tribunal can and does believe that the panel was operating under a misunderstanding that this document in the pack predated the incident. This is clear from questions asked of the Claimant. The Tribunal appreciates that Mr Hill was at this hearing and does not appear to have sought to correct this. In any event, the Tribunal does not consider such defect to render the dismissal decision unfair.

75. There was nothing inconsistent in Mr Hill concluding that, although the guidance could be improved, the Claimant was aware of what she should do in terms of an acute MI ECG escalation. Whilst Mr Hill accepted in cross examination that there was a potential conflict in the expectations of the Claimant to be read from her job description, which anticipated her assessing patients, that did not render it unreasonable to conclude that a line had been crossed by the Claimant from a legitimate assessment to a situation where the Claimant ought not to have relied on her own assessment, but to have escalated the ECG reading. As a matter of common sense, every nurse will assess patients and that is not contradictory to the Claimant having a lack of autonomy in terms of decision-making.

76. The Tribunal considers that the decision to terminate the Claimant's employment fell within a band of reasonable responses open to a reasonable employer in the circumstances. The Claimant's lack of escalation was reasonably regarded as amounting to a serious clinical omission. It is axiomatic that a serious clinical omission would be significantly prejudicial to the service and the Tribunal does not consider that the Respondent was reasonably required to show actual significant prejudice before reaching the decision to dismiss. It was reasonably concluded to be a life-threatening omission not to escalate for further consideration a patient who may have been having a heart attack. This may have been a one-off occurrence against a lengthy and unblemished period of service, but it was a serious one.

77. It is right to note that the Claimant immediately apologised and had also, in her earlier statement before the investigatory interview and at the disciplinary hearing, said that in the future she would escalate a patient in these circumstances. However, at the disciplinary and appeal hearing the decision-makers were not faced with an individual who was straightforwardly apologetic, who recognised her mistake, who recognised that best practice necessitated escalation, who was comfortable in a nursing

role which was task-based and where she was not expected to take responsibility for patient assessments (obviously, again, every nurse has to assess the patient to some extent). It was not in this context that she was saying that she would not repeat the previous omission. Rather, she sought to defend and justify her actions saying that she had done nothing wrong and indeed had done everything for the benefit of the patient. She had not accepted an ECG reading at face value in circumstances where she could and had made an assessment of her own that the patient was symptom-free, not in pain and that therefore that the ECG reading was unreliable. She had the necessary knowledge and skills to make that assessment and had done so for the benefit of the patient.

78. Mr Hill and Mr Ferrie both saw this as worrying and as displaying a lack of insight on the Claimant's part such as to make them conclude that they could have no further trust in the Claimant in the context of the Claimant holding a role of significant responsibility, lone working in the community and having to make decisions which were genuinely matters potentially of life and death.

79. There was no argument advanced in terms of inconsistency of treatment and, whilst the Tribunal has limited information regarding Ms Taylor's involvement with the patient the previous day, there is no basis for regarding the patient's condition at that stage and the necessary steps to be taken to be at all comparable with the Claimant carrying out an ECG giving an acute MI reading. Ms Taylor appears to have done an assessment of the patient and have asked the Claimant to carry out an ECG for a medication review the next day. Ms Taylor obviously was the person to whom to escalate any problematical ECG reading.

80. There is no evidence that the Respondent acted unfairly in the way it conducted the disciplinary and appeal hearing process. Indeed, the meetings appear to be very full meetings where the Claimant was represented by the RCN and given an opportunity, directly or through her representative, to state her case. There is no evidence of Mr Hill seeking to prevent the Claimant from speaking and no complaint made in that regard by the Claimant's union representative, whether at the hearing or subsequently in her grounds of appeal. There is no argument now pursued that the appeal panel was not properly constituted in accordance with the Respondent's procedures. There is no breach alleged of the ACAS Code on Disciplinary Procedures.

81. The Claimant's complaint of unfair dismissal must therefore fail.

Employment Judge Maidment

Case No: 1811350/2018

Date 20 March 2020