EMPLOYMENT TRIBUNALS

Claimant **Respondent**

Mrs S Ahmed-Khaderi **v** **Imperial College Healthcare NHS Trust**

Heard at: London Central (by video) **On**: 11 – 17 May 2021

Before: Employment Judge E Burns
Ms J Grant
Ms D Olulode

Representation

For the Claimant: In person

For the Respondent: Mr Suraj B Sudra, Counsel

JUDGMENT

The unanimous judgment of the Employment Tribunal is that the claimant's allegations of direct race discrimination fail and are therefore dismissed.

REASONS

THE ISSUES

1. This was a claim of direct race discrimination pursuant to section 13 of the Equality Act 2010 arising from the claimant's employment with the respondent. That employment is ongoing. The claim concerns events which took place between October 2018 and 4 November 2019.

2. The issues to be determined had been agreed at a case management hearing held on 29 April 2020 and were as follows:

Jurisdiction

1. Did any act or omission, about which the Claimant complains, occur wholly before 5 August 2019 (that being three months plus a day before the

Claimant contacted ACAS in respect of early conciliation)? If so, such act or omission is, on its face, out of time.

2. *Is it just and equitable for the Tribunal to extend the time limit for any out-of-time complaints?*

Direct Discrimination

3. *Did the Respondent subject the Claimant to the following less favourable treatment:*

a. *Linda Wildridge failing to support the Claimant on her return from maternity leave in October 2018?*

b. *Linda Wildridge unfairly subjecting the Claimant to a disciplinary investigation in October 2018 and making unjustified recommendations as a result of the investigation?*

c. *Linda Wildridge letting the Claimant know that she will be investigated for misconduct on her return to work from maternity leave without informing her what the allegations were until 6th December 2018*

d. *HR's refusal to disclose the outcome of the Claimant's meeting of 1 March 2019 with, Charlotte Mustoe, soon after the meeting.*

e. *The Respondent's failure to amend the Claimant's personnel file to reflect the meeting detailed at paragraph 4(d) (supra).*

f. *In late 2018, Linda Wildridge, not permitting the Claimant to investigate patient mis-reporting errors by, Louise Meaney.*

g. *Failing to address the Claimant's grievance, submitted on 24 January 2019?*

4. *If so, was the Claimant subjected to that less favourable treatment because of her race?*

5. *In particular, was the Claimant treated less favourably than David Johnson, (white male).*

THE HEARING

3. The hearing was a remote hearing, undertaken by video (CVP).

4. The tribunal ensured that members of the public could attend and observe the hearing. This was done via a notice published on Courtserve.net

5. From a technical perspective, there were a few minor connection difficulties from time to time. We monitored these carefully and paused the proceedings when required. The participants were told that it was an offence to record the proceedings.

6. The claimant gave evidence. For the respondent we heard evidence from:

   - Linda Wildridge, former Site Manager of the Blood Sciences Lab, based at the Chelsea and Westminster Hospital, the claimant's line manager
   - Charlotte Mustoe, former Divisional Manager, for North West London Pathology ('NWLP') - the claimant's line manager's manager
   - Nazia Hussain, who took over Ms Mustoe's role on an interim basis from 29 May 2019
   - Alia Ahmed, HR Business Partner for NWLP

7. The tribunal ensured that each of the witnesses, who were all in different locations, had access to the relevant written materials which were unmarked. We were satisfied that none of the witnesses were being coached or assisted by any unseen third party while giving their evidence.

8. There was an agreed trial bundle of 1022 pages, which included some additional documents which were admitted into evidence during the course of the hearing with the agreement of the parties. We read the evidence in the bundle to which we were referred and refer to the page numbers of key documents upon which we have relied.

9. We explained our reasons for various case management decisions carefully as we went along and also our commitment to ensure that the claimant was not legally disadvantaged because she was a litigant in person.

10. On the first day of the hearing, the claimant made an application for witness orders for three additional witnesses:

    - Nhung Ly – Band 7 Senior Biomedical Scientist at the Chelsea and Westminster Hospital
    - David Johnson – Band 8a Blood Transfusion Laboratory manager at St Mary's Hospital
    - Lorry Phelan, ex-Site manager for Blood Sciences at St Mary's Hospital

11. The claimant accepted that she had had knowledge of which witnesses the respondent intended to call since 23 April 2021. Following a discussion about the circumstances in which tribunals order witnesses to give evidence at tribunal hearings and the possible impact on the viability of the present hearing if the orders were granted, the claimant decided to withdraw the application.

FINDINGS OF FACT

Introduction

12. In the view of the tribunal panel, all of the witnesses who gave evidence to the tribunal were credible and honest witnesses. We had no reason to doubt what they told us. In addition, the bundle contained a large number of useful contemporaneous documents, including emails, handwritten investigation notes and written accounts prepared by Nhung Ly's account (616) and David Johnson (585 – 587).

13. Having considered all the evidence, we find the following facts, where necessary, on a balance of probabilities.

14. The parties will note that not all the matters that they told us about are recorded in our findings of fact. That is because we have limited them to points that are relevant to the legal issues.

Background

15. The respondent is an NHS Trust. The Haematology and Blood Transfusion Department provides acute services to the four Hospitals in Charing Cross, Hammersmith, Chelsea and Westminster, and St Mary's run by the respondent trust. Each site has its Blood Transfusion services supplied from a local dedicated laboratory.

16. The claimant is currently employed by the respondent as a Band 8A Blood Transfusion Manager at the Chelsea and Westminster Hospital. In this role she oversees the day to day management of the dedicated Blood Transfusion Laboratory at the Chelsea and Westminster hospital. She is currently on maternity leave.

17. The claimant has held this role since January 2017, but has worked for the respondent since 2 June 2014. As well as working at the Chelsea and Westminster Hospital, she had also worked at St Mary's Hospital. She moved to Chelsea and Westminster for promotion.

18. The claimant has a degree in Bio Medical Science and, at the time of the matters about which she is complaining, she had over 15 years' service in the NHS. Her role is registered with the Health Care Professionals Council and she is subject to certain professional obligations as a result. She is also subject to legal obligations pursuant to the Blood Safety and Quality Regulations 2005.

19. The claimant describes her race as British Pakistani.

20. The claimant's line manager, at the material times for the purposes of this claim, was Linda Wildridge, Site Lead for Blood Sciences at the Chelsea and Westminster Hospital. Ms Wildridge is white. She started managing the claimant in January 2017 and was based at Chelsea and Westminster. Ms Wildridge's equivalent at St Mary's Hospital was Lorry Phelan who is white. The claimant's equivalent at St Mary's Hospital was David Johnson, who is white.

21. Ms Wildridge, and Lorry Phelan reported to Charlotte Mustoe, Band 8C Divisional Manager for Blood Sciences. Ms Mustoe's role covered all aspects of blood sciences for the North West London Pathology service (NWLP) which included the hospitals in the respondent trust, together with other hospitals from two other trusts. Ms Mustoe is white. She was based at Charing Cross Hospital.

22. The claimant's role required her to manage a team of individuals who worked in the blood laboratory. The claimant had good relationships with colleagues throughout her employment and this is reflected in good personal development reviews. She had not been investigated for any potential misconduct or had cause to raise any grievances before October 2018. The respondent's witnesses confirmed that the claimant is bright, conscientious and hardworking.

23. The claimant had a good working relationship with her manager Ms Wildridge during the period from January 2017 to October 2017. They were not close, however, and Ms Wildridge's "hands-off" management style was different to the management style of the claimant's former line manager. Although Ms Wildridge is a qualified Biomedical Scientist, she does not have a background in Blood Transfusion.

24. The claimant was used to having direct conversations with Ms Mustoe, whom she trusted and respected. She felt able to approach Ms Mustoe with concerns.

Policy Framework

25. The claimant's work and that of her colleagues was governed by large number of standard operating procedures (SOPs).

26. There is a robust framework for reporting harmful incidents and near misses involving blood transfusions, both internally within the respondent and externally.

27. The claimant's job description says:

> *"The post holder is responsible for monitoring Clinical Risk and is required to organise the investigations of incidents reported through the Clinical Governance reporting system.*
>
> *The postholder will be expected to liaise effectively with the Operations/Site Manager for Blood Sciences and the Consultant Haematologist with Blood Transfusion responsibility on their site [*known as the clinical lead*].*
>
> *The post holder reports on all matters related to Clinical Governance to the Senior Manager in the Directorate responsible for risk reporting and investigation."*

28. As noted above, the Operations/Site Manager for the claimant was her line manager Linda Wildridge.

29. The clinical lead for Blood Transfusion at Chelsea and Westminster was Dr Francis Matthey, Consultant Haematologist. There was also clinical lead for Blood Transfusion for the whole of NWLP was Dr Fiona Regan.

30. In October 2018, there was temporarily no-one in post in the role of Divisional Haematology and Blood Transfusion Quality Manager. There was a more senior manager in post, however, Helen Hobson who held the title

NWLP Quality and Governance Manager, Band 8C who was based at the Charing Cross Hospital.

31. The procedures which should be followed when reporting different types of incident are found in a number of written policies.

32. Internal reporting (which is done using is governed by the following policies and procedures:

- NWLP Risk Management Procedure (283 – 308)
- Respondent's Pathology Incident Reporting and Escalation SOP (146 – 171)
- Systematic Investigation of Incidents (186 – 194)
- Haematology & Blood Transfusion incident Reporting Procedure
- Entering a Blood Sciences Non-Conformance (BSNC) in QPulse (195 – 210)

33. Online systems are used to make internal reports, one of which is called Datix. The Datix system is a national system. The on-line systems are set up so that there is an automatic cascade of information to relevant senior staff members when an incident is reported.

34. External reporting is via the Serious Adverse Blood Reactions and Events process (SABRE) which is the online system for reporting Serious Adverse Events (SAE's) and Serious Adverse Reactions (SAR's) to the Medicines and Health Care products Regulatory Authority (MHRA). In serious cases, Serious Hazards of Blood Transfusion (SHOT) an additional report has to be completed through a separate tab on the SABRE website. The respondent has a SABRE and SHOT reporting procedure (112 – 129).

35. Section 6 of the SABRE and SHOT reporting procedure states:

"- When an incident occurs, the decision to report to SABRE and SHOT should be taken at the earliest opportunity (ideally within 72 hours) by any member of the transfusion team. The decision should be based on the criteria set out in section 2.2.

- An SAR or SAE should be reported to SABRE at the earliest opportunity. Do not wait for any investigation to be completed."

36. The respondent has a Disciplinary Policy and Procedure (227 – 242), a Grievance Policy and Procedure (255 – 266) and an Appeals Procedure (243).

37. We note that the Disciplinary Policy and Procedure says at section 4.1:

38. "An investigation to establish the facts of a case will be carried out before formal disciplinary action is taken. Under normal circumstances, as soon as the allegation comes to light the manager will meet the person to establish their version of events and determine if the case requires further investigation. People are entitled to seek trade union representation and

advice. Managers shall allow trade union representatives to attend investigation meetings where this does not unreasonably delay the conclusion of an Investigation.

Prior to the commencement of an investigation into alleged misconduct. A pre-investigation checklist will be carried out. This should be between the potential investigator, a senior manager from the division (8C and above), who will have no involvement in the case and with support from ERAS." (228 – 229)

Maternity Leave

39. The claimant took maternity leave from October 2017 to October 2018. During her absence, her role was covered by Louise Meaney who had been seconded to the role from her substantive Band 6 role at St Mary's Hospital. Ms Meaney is white Irish.

40. The claimant was not involved in the recruitment of Ms Meaney as her acting cover. Although they had worked at St Mary's Hospital at the same time as each other for a short period of time, they had not worked together and did not know each other well.

41. The claimant had concerns about Ms Meaney's capacity to cover her role.

42. The claimant was aware that issues had arisen between Ms Meaney and the former site manager at St Mary's Hospital before David Johnson took over the role. Although the claimant could not know the facts of the matter, she believed that David Johnson's predecessor had been performance managing Ms Meany's because of her "*persistent underperformance and shortcuts in her work in Blood Transfusion*." She further believed this had led to Ms Meany raising a grievance against him which ultimately led to the predecessor's retirement because Lorry Phelan had taken Ms Meany's side and protected her.

43. In addition, after Ms Meaney had been offered the role, some information came to light about her which suggested performance issues had arisen in a previous role before she joined the respondent. The recruitment panel decided to proceed with Ms Meaney's appointment, however, as the offer had already been made. The claimant was initially told this information by Ms Wildridge. She then spoke to Ms Mustoe to ask her about it, as she was concerned. Ms Mustoe told her Ms Meaney had previously held a Band 8a role but had been demoted due to performance concerns.

44. During the claimant's maternity leave she visited her team. During the visit some members of her team expressed concerns about some aspects of Ms Meaney's management style and changes that she had made. The claimant rang Ms Mustoe to tell her. Ms Mustoe felt the information was based on gossip and that the claimant should not get involved. She advised the claimant that if she had concerns about clinical risk arising from Ms Meaney's management she should contact Ms Wildridge. The claimant did not do this.

45. During the claimant's visit, Ms Wildridge had also told the claimant that having Ms Meaney was the best thing that had happened to Chelsea and Westminster. Ms Wildridge explained to us that she had said this because she wanted to reassure the claimant that, despite it being a challenging time for various reasons, Ms Meaney had been doing a good job and the claimant would find things to be in good order when she returned. Ms Wildridge and Ms Meaney had a lot in common. The claimant perceived Ms Wildridge's comment as suggesting Ms Wildridge preferred working with Ms Meaney.

Return from Maternity Leave

46. The claimant and Ms Wildridge exchanged emails about the claimant's return from maternity leave in August 2018 (463). The claimant requested that she be allowed to use five Keeping in Touch ("KIT") days at the end of her maternity leave to help support her back into her role. She also requested a written handover document and the chance to work alongside Ms Meaney during her five KIT days.

47. The claimant wanted the KIT days to be in the week commencing 22 October 2018. Ms Wildridge explained in the email exchange that as this was half term week, Ms Meaney would only be available on the Monday and Tuesday of that week. The claimant agreed to this, but requested a written handover document by 19 October 2021. Ms Meaney sent the claimant the written handover document claimant on this date (475).

48. As it transpired, Ms Meaney was only available to have a handover meeting with the claimant on Monday 22 October 2018. However, the claimant was aware that she could contact Ms Meaney at any time after she had returned to her substantive post at St Mary's Hospital. She and Ms Meaney would continue to be employed by the respondent, albeit at different sites.

49. In addition to the handover arrangements with Ms Meaney, Ms Wildridge also organised for the claimant to have various meetings with relevant people who could update her on any changes that had taken place during her maternity leave. The claimant was given protected time to read emails and to catch up with any policy changes. Refresher training was also arranged for the claimant.

50. Ms Wildridge returned to work after her annual leave on Monday 29 October 2019. She briefly welcomed the claimant back on this date, but was unable to meet with her because she became unwell during the course of the working day. This led to her leaving early. Ms Wildridge was away on sick leave until 5 November 2018.

51. Ms Wildridge invited the claimant to attend a one to one meeting on 5 November 2018. As the claimant was having her refresher training that day, the meeting was rearranged for 7 November 2018.

52. The meeting of 7 November 2018 enabled Ms Widlridge and the claimant to have a general discussion. Ms Wildridge asked the claimant if there was any additional support she could provide to her at the meeting. The claimant did not ask for any additional support.

Incident and Initial Reporting

53. In the meantime, an incident had occurred that was brought to the claimant's attention. A member of the Blood Transfusion team working the night shift at the weekend had received a request for cross match of 4 units of blood. This was for a woman in labour undergoing an emergency Caesarean section operation.

54. The clinical details suggested an antibody issue which meant that certain blood should be given. When the blood transfusion staff member checked the lab records, they contradicted what he was being told. The records indicated that the antibody had been reported as "clinically insignificant" and that no samples had been sent to the reference centre.

55. The blood transfusion staff member involved, however, spoke to the midwife concerned who confirmed the patient was carrying an antibody card. He then contacted the reference centre who confirmed the antibody position. The staff member therefore ordered suitable units of blood and there was no patient harm.

56. The blood transfusion worker handed over to the Senior Biomedical Scientist in the morning. This was the Band 7 in the claimant's team, Nhung Ly. Ms Ly undertook an initial investigation into why the patient antibody had not previously been confirmed. This suggested that Ms Meaney had misreported tests of the patient's blood.

57. Ms Ly did not speak to Ms Meaney about the issue directly. Instead, she reported it to the claimant the following morning on 23 October 2018. The statement Ms Ly prepared later, when the incident was being investigated, confirms that Ms Ly suggested to the claimant that a 12 month audit should be carried out to see if there had been any similar misreporting issues.

58. Ms Ly had also been absent on maternity leave at the same time as the claimant, although she had returned earlier in August. Ms Ly later said in her statement that:

"My reasoning was to make sure we haven't misreported any more antibodies as it had been a very stressful year for everyone, some may have been missed/incorrectly reported due to work pressure." (616)

59. The handwritten notes of her meeting with Ms Wildridge on 10 December 2018 suggest that Ms Ly told Ms Wildridge that she knew the lab had been short staffed and workload had been high while she was away. She had also been told by a colleague that antibody reactions had not been sent for confirmation at the Chelsea and Westminster site since Ms Meaney had started (619).

60. The claimant agreed that Ms Ly should undertake a 12 month audit. The results of the audit, which were known by 29 October 2018, identified 4 similar misreporting issues involving Ms Meaney. Ms Ly provided a

spreadsheet to the claimant confirming the outcome of the audit on 30 October 2018 (494).

61. On the 24 October 2018 the claimant raised an internal Blood Science No-conformance report (BSNC) and reported the incident as a Serious Adverse Event to SABRE MHRA. On the 25 October 2018, she raised an internal Datix incident on the Chelsea and Westminster Hospital system (195 – 210).

62. Prior to making the SABRE report, the claimant rang the MHRA for advice as to how she should categorise the incident. The conversation was with Chris Robbie of the MHRA. The claimant also spoke to Chris Robbie about the 12 month audit. We know this because this is what she told Helen Hobson in an email she sent her to her on 30 October 2018 at 10:07 where she stated, "….*I spoke to Chris Robbie and he agreed with my plan of action of going back through the last 12 months of panels reported to see if we had potentially mis-reported or missed key antibodies*" (518).

63. The claimant's report triggered a cascade of emails to go out to all appropriate managers who would need to be alerted to an incident of this nature. This included Ms Wildridge, Ms Mustoe, Ms Phelan and Mr Johnson.

64. The BSNC report required the claimant to risk assess the incident. She initially assessed as follows:

- Likelihood of non-conformance recurring: unlikely to recur – scoring 2
- Potential impact if non-conformance were to recur: moderate – scoring 3

65. The claimant emailed Ms Mustoe about the incident on 25 October 2018, having already submitted the reports. She marked the email "Confidential Information relating to SABRE" and said the following in her email:

"Hi Charlotte

Hope you are ok. I am back this week in work from maternity leave. This week is my KIT week and start officially next week.

L just wanted to raise a concern with yourself about Louise. I know that Lloyd is retiring and they have advertised his job at the moment and not sure who will be interviewing for the position.

I have today reported a Serious Adverse Event to SABRE and spoke to Chris Robbie at MHRA SABRE yesterday. We have found by chance a patient who was pregnant and had been tested elsewhere but reports were on the SPICE system as to the patient having anti-M. We at CWH had samples from this patient 3 times and on 2 of the samples the panels were performed. However, what is concerning and alarming is the way that Louise has reported it saying antibody detected no further action, when in fact we should have performed more internal panels and then sent the sample to NHSBT plus check SPICE. This is in the SOP but Louise did not follow the SOP. It has been reported to me by staff in ST that this was not the isolated

incident of reporting the panel in this way and due to this now I am going to be checking the last 12 months panels particularly focusing on the comment used by Louise and disseminated to staff to also do.

We have been lucky that nothing happened with this patient in getting blood not suitably matched and typed for them.

With this in mind and previous errors and QI's when she was at SMH prior to starting this role I am quite concerned about how she will perform technically if she was to be successful in getting a BT lead role. I have also had a member of CWH staff report to me that they were glad I am back as things had not progressed when they had approached Louise with projects that I had handed over to her prior to going on maternity leave.

I also wonder why may this be the reason why she reduced her handover days to me from 3 to 1 and I only found out when I came in on Monday this week that I only had 1 day handover with her when it was agreed and arranged prior between myself, Linda and Louise. Anyhow I am glad I asked for a written report for handover prior to starting back.

I am sorry if it feels like I am moaning but my conscious compelled me to email you to inform you as I feel if I do report to Linda when she is back next week it will fall on deaf ears.

Hope to speak soon." (503)

66. On 29 October 2018, the claimant contacted Mr Johnson about the incident. This was because Ms Meaney had returned to her substantive role and was being managed by Mr Johnson again. The contact was initially by email and followed up with a phone call. The claimant was aware of the audit results by the time she contacted Mr Johnson. In her email to him she described the audit findings and said:

"*There are a few more but these ones are most alarming for me with someone with many years of experience and having been at BT Ms Meaney level for the past 12 months and intending to go for the vacant position at CXH (hasten to add nothing personal but patient safety is of utmost importance and service users confidence in the person in the BT Ms Meaney position on site).*"

67. It was later alleged that when the claimant spoke to Mr Johnson on 30 October 2018, she advised him to remove Ms Meany from clinical duties when she did not have the authority to do so. We find that the claimant was deliberately careful to say to Mr Johnson that it was up to him and Lorry Phelan to make any decisions about what Ms Meaney should be permitted to do, including whether she should be permitted to continue to work in Blood Transfusion. This is what Mr Johnson told Ms Wildridge when she interviewed him (581). In addition, in his statement Mr Johnson said:

"I believe from an organisational perspective that in speaking to me directly as the BT manager for St Mary's [the claimant] acted in a professional

manner that showed respect for Ms Meaney as her colleague as this was a discreet discussion between two managers that may have been effected by the issues/incidents and / or their outcomes." (587)

68. On 30 October 2018 at 10:07, the claimant emailed Helen Hobson. The main purpose of her email was to ask Helen Hobson whether she should update the internal report with the additional audit findings or create a new internal report. She also described the background to the incident to her. We note that she told Helen Hobson:

"I have already spoken to David as he is one of her line managers at [St Mary's Hospital] and she is still working. I have not told Louise yet but obviously she will (sic) as I will need her to fill in the reflective bit for the BSNC-919 but have not contacted her yet as waiting for your advice to see if we raise others we have found as separate incidents???" (518)

69. At some point following his conversation with the claimant, Mr Johnson informed Lorry Phelan about the incident. According to Ms Mustoe's evidence, Ms Phelan contacted her and complained about the claimant's conduct towards Ms Meaney.

70. Ms Hobson replied on the same day saying:

"Hi Saaba

From your email it would appear that there has been no actual harm to the patients as a result of the admission.

If this is the case then please report the additional cases under the same Datix incident investigation. Please ensure the investigation reviews policies and processes rather than just any individual staff members involved.

Regarding performance issues for staff please escalate this as necessary operational teams (site manager, divisional manager)." (493)

71. The claimant replied saying:

"*Hi Helen*

No harm has come for the patients although there was a potential there. SOP's related have been checked by myself and Nhung my senior BMS and SOP's have correct procedure so they have not been followed (That was the first thing I checked just in case something had changed while I was on matemity leave).

Nothing personal against Louise but was just a concern for me as it is not one case as we are all human and can make mistakes but this is several cases. Yeah sure will pass onto relevant managers for them to decide what they wish to do next." (506)

Investigation

72. On 5 November 2018, Ms Mustoe forwarded the email sent to her by the claimant to Ms Wildridge and Dr Fiona Regan. This was notwithstanding that it was marked confidential and included a negative comment about Ms Wildridge.

73. Ms Mustoe also spoke to Linda Wildridge that day. She sent a further email to Ms Wildridge and Dr Regan later that day saying:

> *"Dear Fiona and Linda,*
> *Please could you read the full email trail below.*
> *Firstly, Fiona, please could you tell me if this is clinically significant and or against any regulatory rules?*
> *Secondly, Linda, please investigate this as a conduct issue. From both Louise and Saaba conduct. I am very concerned about Saaba, she has phoned David at St Marys and told him to take Louise off the bench and stated why. Saaba has also gone to the MHRA without referring to her line manager and or clinical lead." (516-517)*

74. Ms Mustoe told us that in reaching the decision to instructing Ms Wildridge to undertake an investigation she was influenced by the culture in the Blood Transfusion departments. She explained that blood transfusion is a stressful working environment as blood mistakes can kill patients instantly. As a result, blood transfusion experts tend to be highly conscientious and risk adverse, but are often quite highly strung. Also at the respondent, the blood transfusion departments had a gossipy culture and could be territorial. Rather than get drawn into the gossip, she decided it made sense to investigate the matter.

75. Following receipt of the email from Ms Mustoe, Ms Wildridge emailed the respondent's HR team (ERAS) for advice as to the process to be followed This was on 6 November 2018. (516).

76. On 6 November 2018, unaware of the action taken by Ms Mustoe, the claimant emailed Ms Meaney to send her a reflective practice form about the initial incident. This was a requirement of the BSNC procedure (557).

77. On the same date, the claimant updated the on-line reports to say that her investigations showed the SOP had been checked and were in order meaning the incident was a training and competence issue for one person.

78. On 7 November the claimant forwarded the email exchange she had had with Helen Hobson to Ms Mustoe. Ms Mustoe replied to the claimant saying:

> *"Dear Saaba.*
> *I have asked Fiona Regan to discuss this with you as I need assurance there is no risk. I have asked Linda to investigate the conduct of the Lab manager as she is the site manager.*
> *Thank you.*
> *Charlotte"* (506)

Ms Mustoe did not tell the claimant that she has also asked Ms Wildridge to investigate the claimant's conduct.

79. The claimant replied to Ms Mustoe saying she had completed her investigation and sent the post quality incident forms off the previous day. There was a further email exchange between her and Ms Mustoe about Dr Regan's role. The claimant said that she had informed Francis Matthey the previous week as the nominated lead for Blood transfusion for Chelsea and Westminster. She said that he was away on annual leave for two weeks and that she would liaise with him and Fiona and report back with a report in summary. Ms Mustoe replied that Fiona was the clinical lead for N WL and should be the first point of call when there is no immediate issue. The claimant replied to say that she wasn't sure of this, and thanked Ms Mustoe for letting her know. She confirmed she would contact Fiona to discuss (507).

80. Following the email exchanges with Ms Mustoe, the claimant attended the one-to-one meeting that had been arranged with Ms Wildridge referred to above in paragraph 52. The claimant took the information she had collated about the incident and the audit to the meeting with the intention of telling Ms Wildridge all about it. At the meeting Ms Wildridge informed the claimant that she would be scheduling another meeting to discuss the incident. Ms Wildridge did not explain that she had been asked by Ms Mustoe to investigate the claimant's conduct.

81. Later that day, Ms Wildridge sent an investigation meeting invite to the claimant for 9 November 2019. She had not received a reply to her email to ERAS and so drafted the meeting invite herself. It said:

"I am writing to invite you to attend an investigation meeting on Friday 9 November 2018 so that I may discuss the matter with you to establish the facts in relation to your alleged misconduct to determine whether there is a case to answer requiring further investigation."

The invitation advised the claimant that she was entitled to be accompanied to the meeting by a trade union representative or a colleague (510).

82. The claimant was shocked to receive the meeting invite and emailed Ms Wildridge for clarification. When Ms Wildridge did not reply, the claimant attended the meeting and asked for clarification there. Ms Wildridge confirmed that she was conducting an investigation into the claimant's conduct, but did not provide her with any further details. The claimant asked for the meeting to be postponed because she needed time to prepare and to organise union representation.

83. Ms Wildridge told the claimant that she was not to undertake any further investigation into the incidents she had reported.

84. Ms Wildridge had also invited Ms Meaney to an investigation meeting. Her investigation meeting was also postponed. Ms Wildridge did not tell Ms Meaney or the claimant that she was investigating both of them.

Checklist Stage

85. There was then a delay in progressing the investigation. This arose because a new stage, the pre investigation checklist stage, had been introduced in the Respondent's Disciplinary Policy. HR had brought this to Ms Wildridge's attention when she asked for further advice on 12 November 2018 and she emailed the claimant to explain this (985).

86. Pre-investigation checklists were prepared by Ms Wildridge with a senior manager and ERAS support for both the claimant and Ms Meaney. They were completed on 19 November 2018.

87. The allegations contained in the pre-investigation checklist for the claimant were:

"It is alleged Saaba Ahmed Khaderi. Blood Transfusion Lead at Chelsea and Westminster Hospital has failed to

- Escalate an incident appropriately through her line manager and clinical lead
- Ensure that the department undertook a risk assessment regarding an incident which could have impacted on patient safety
- Failed to uphold appropriate professional standards by advising a colleague to remove another colleague from clinical duties when she did not have the authority to do so
- To uphold Trust values" (559)

88. The allegations contained in the pre-investigation checklist for Ms Meaney were:

"It is alleged Louise Meaney did not follow laboratory procedure regarding blood
transfusion samples received from patients with known antibodies.

- *Panels were not reported in the correct way*
- *Samples probably should have been investigated further by testing on a 2nd panel and if not clear sent to the referral centre NHSBT*
- *Compromised patient safety by her action"* (563)

89. The claimant was absent on annual leave from 16 November 2018 to 4 December 2018. Ms Wildridge invited her to intend a pre-investigation meeting on 6 December 2018. At this meeting, Ms Wildridge shared the allegations with the claimant. The meeting was not an opportunity for the claimant to give her versions of events, however. This was arranged for 17 December 2018. The claimant attended the meeting with a companion and produced lengthy written submissions which she gave to Ms Wildridge.

Grievance

90. The claimant found not knowing what the allegations against her were extremely stressful. We believe the account of her distress set out in paragraph 12 of her witness statement is accurate and not embellished.

91. The position was exacerbated as a result of a parallel process involving a flexible working application the claimant had submitted which Ms Wildridge had rejected. The claimant successfully appealed the rejection to Ms Mustoe.

92. The relationship between the claimant and Ms Wildridge was very strained at this time. We note that Ms Wildridge referred the claimant, with her agreement, to occupational health (653). In addition, there was to be a meeting between Ms Wildridge, the claimant and Ms Mustoe on 7 January 2019. As the investigation had not been concluded by this date, the claimant declined to participate. This was in line with legal advice she had received from a friend of the family (654).

93. On 24 January 2019, the claimant submitted a grievance against Ms Wildridge to Ms Mustoe. The grievance was headed "Misapplication of Policy" and was essentially a complaint that the claimant should not have been subjected to an investigation under the disciplinary policy by Ms Wildridge. In particular, she complained that the investigation should not have been initiated before Ms Wildridge had spoken to her about the incident. The claimant stated that she felt the way Ms Wildridge had gone about the process was unfair and that she felt Ms Wildridge had "*something against*" her. The claimant did not allege race discrimination.

94. Ms Mustoe initially attempted to meet the claimant to discuss the grievance, but when this was not possible, they spoke about it on the telephone. Ms Mustoe followed the call up with an email. In that email, sent on 30 January 2021, she said:

My response to your grievance is:

Dear Sabba Your grievance is about an investigation that is still going on and that investigation has been through a pre-investigation checklist and review by senior management within Imperial, in order to assess whether it should be investigated at a formal level.

Therefore, the concerns Sabir has expressed in her grievance will be responded to within the investigation, but ultimately, the investigation has already been assessed to be going down the correct policy and procedure.

If you still feel that the wrong policy has been applied, please could you tell me what policy you think should have been invoked?" (723)

95. The claimant did not reply to Ms Mustoe's email.

96. Ms Mustoe told us that she believed she also told the claimant that if she remained unhappy that that the issues raised in the grievance had not been resolved once the investigation was complete, she could resubmit the grievance. The claimant said she was not told this. As this is not mentioned in the email, we prefer the evidence of the claimant on this point.

97. Ms Mustoe did not share the grievance with Ms Wildridge.

Investigation Outcome

98. As part of her investigations, LW sought information from each of the claimant and Ms Meaney, Ms Ly, Mr Johnson, Dr Regan and Dr Matthey.

99. Dr Francis Matthey's provided his input in an email to LW which said the following:

"In the past I have discussed possible transfusions errors with the lab manager (and clinical issues with the Transfusion Practitioners), although often the issue would have already been reported on Datix and then SABRE or SHOT, either by the Blood Bank Manager or the Transfusion Practitioner depending on the appropriate classification of the issue.

Where there are clinical concerns and I discussed with the relevant person (Lab Manager, Transfusion Practitioners) and agree a plan of action, most particularly in respect of the likelihood of harm (or not the case may be).

I rely on the judgement of the Blood Bank Manager and Transfusion Practitioners to bring such issues to my attention and whether to report it to SABRA / SHOT etc Often the incident would be reported by the Blood Bank Manager or one of the TPs before I become aware of it, which I may do at one of our Hospital Transfusion Team meetings after the incident has been reported.

We don't have a formal SOP about this, though, and I think it would be fair to say that I'm not routinely involved in issues prior to them being reported to SABRE/SHOT unless there is a clinical concern, this being based largely on the judgement of the Blood Bank Manager or the Transfusion Practitioners.

There are other dimensions to this matter that I would be happy to discuss with you." (680)

100. Ms Wildridge did not ask Dr Matthey about his last comment.

101. Ms Wildridge produced investigation reports and completed post-investigation checklists for both investigations. She sent Ms Meaney and the claimant investigation outcome letters on 12 February 2019, but did not share the investigation reports with them. Instead, the decision was taken that Ms Mustoe, as the manager that had commissioned the investigation, would go through the investigation findings with each of them.

102. The outcome of the investigation for Ms Meaney was that there was no case to answer (471). Her outcome letter said:

"I have now completed my investigation. The findings of do not raise sufficient concerns for the case to be heard at a formal disciplinary hearing and as such informal interventions have been recommended:

RECOMMENDATIONS
That you complete reflective practice; for workings on panels to show exclusions and for interpretation. and in the use of better commentary to explain the clinical significance or otherwise." (737)

103. Ms Wildridge's conclusion was that Ms Meaney should have been clearer in her commentary when reporting on blood panels, but that was all. She also identified some gaps in the respondent's SOPs for relevant to reporting on antibodies (710 – 714).

104. The outcome of the investigation for the claimant was not that there was no case to answer, but that the situation should be managed informally and followed up in writing (464).

105. The claimant's outcome letter said:

"I have now completed my investigation. The findings of do not raise sufficient concerns for the case to be heard at a formal disciplinary hearing and as such informal Interventions have been recommended:

RECOMMENDATIONS
That you are counselled and complete reflective practice;
1. To manage all staff in a consistent manner in line with Trust standards and procedures.
2. Receives refresher training in incident reporting, investigation and escalation procedures to ensure issues raised are systematically investigated and reported consistently and fairly." (739).

106. Ms Wildridge provided copies of the outcome letters to HR. This led HR to close the matter on its system.

107. Ms Wildridge's conclusions with regard to the allegations are not fully clear from her investigation report, but she explained them to us in tribunal hearing. They were as follows

***Allegation One - The alleged failure to escalate the incident appropriately through her line manager and clinical lead*.**

107.1 Ms Wildridge concluded that the claimant should not have sought advice from the MHRA without first speaking to the clinical lead. In addition, reporting the incident to the external regulators should have been the last stage of the BSNC process as details of the incident, clinical impact, root cause analysis (RCA) and actions take to address the RCA should have been completed prior to contacting SABRE MHRA to ensure accurate reporting of the incident and to avoiding over reporting.

107.2 She also concluded that as there had been no patient harm, the initial incident was not a Serious Adverse Event and therefore it was arguable whether the incident should have been reported to SABRE MHRA at all.

107.3 In addition, she concluded that the claimant should have spoken to her, as her line manager, before contacting David Johnson.

Allegation Two - The alleged failure to ensure the department undertook a risk assessment regarding an incident which could have impacted on patient safety.

107.4 Ms Wildridge's conclusion, although not set out in the report, was that although the claimant had risk assessed the incident, she should not have done this without reference to the clinical lead.

Allegation Three - The alleged failure to uphold appropriate professional standards by advising a colleague to remove another colleague from clinical duties when she did not have the authority to do so.

107.5 Ms Wildridge's conclusion, although not clearly set out in the report was that the claimant had done this.

Allegation Four - The alleged breach of the Trust's values.

107.6 Ms Wildridge concluded that the claimant had breached the following values:

- ***Expert****:* Ms Wildridge concluded that the claimant had not conducted the investigation correctly. The errors she identified included not conducting a full root cause review and only seeking Ms Meaney's input after the online incident records were completed and closed. This led to the claimant neutralising the incident and investigating a single cause rather than a broader investigation into policies and procedures.

- ***Kind:*** Ms Wildridge concluded the claimant had failed to demonstrate positive and supportive behaviour towards Ms Meaney. In reaching this conclusion, she took into account comments made by the claimant about Ms Meaney potentially applying for a promotion in her emails to Ms Mustoe and Mr Johnson. In addition, Ms Wildridge considered the comment made by the claimant to Ms Mustoe about herself in the email the claimant sent Ms Mustoe dated 25 October 2018 constituted a breach of this value.

- ***Collaborative***: this was breached, in Ms Wildridge's view because the claimant had failed to discuss the incident with her before discussing it with Mr Johnson.

108. We note that Ms Wildridge did not consider that she was unable to investigate the information contained in the claimant's email dated 25 October 2018 by reason of it being marked confidential. She assumed the heading was intended to protect patient information.

Investigation Outcome Meeting with Charlotte Mustoe

109. The claimant was invited by Ms Mustoe to attend a meeting to discuss the investigation outcomes with her on 1 March 2019. No notes have been found of the meeting and Ms Mustoe cannot recollect it happening.

110. The meeting was intended to be held in accordance with section 5 of the respondent's policy (229 – 230). We note that as the meeting was not part of the HR process, there was no requirement to send a copy of the notes to HR. The policy mentions the manager involved taking brief notes of any discussions (paragraph 5.3 on page 229) and the possibility of an letter being placed on the employee's file (paragraph 5.4), but in this case that had been done via the investigation outcome letter.

111. Our finding is that the meeting did take place as the claimant referred to it in a later email dated 7 May 2019 (795).

112. The claimant's mistaken understanding was that the letter she had received from Ms Wildridge was her post investigation summary and that Ms Mustoe would be producing an outcome letter. This is how she described the position to HR later in July (815).

113. We find that in an effort to try to move matters forwards, Ms Mustoe agreed to review the requirement that the claimant should have to undertake refresher Datix training. She asked the claimant to let her know what Datix reports she had made since October 2018 and when she had last been Datix trained in an effort to release her from the obligation to undertake refresher training. This was not progressed, however.

114. Ms Mustoe did not give the claimant a copy of investigation report or have had any in depth discussion with her about its findings at the meeting on 1 March 2019.

115. Incidentally, we note that the claimant's email referred to above also demonstrates that the claimant believed the BSNCs she had submitted in October/November 2018 were still live because the reflective logs she had sent to Ms Meaney had not been returned. (795).

Post Investigation

116. On 13 March 2019, Occupational Health sent a report about the claimant to Ms Wildridge. The claimant had told occupational health that she had taken out a grievance against Ms Wildridge and was awaiting an outcome. This was a reference to the grievance of 24 January 2019. This was the first time, Ms Wildridge had heard about the grievance which led her to ask Ms Mustoe about it.

117. Following exchanges of emails with Ms Wildridge and the claimant, Ms Mustoe suggested referring them to mediation as their line-management relationship had deteriorated to the extent that it was not sustainable. Both eventually agreed to participate and a mediation session took place on 3 July 2019. By this time Ms Mustoe had left, her last working day being 27

May 2019. Ms Mustoe did not clarify the position with regard to the outstanding grievance before leaving.

118. On 22 May 2019 the claimant contacted the Managing Director of NWLP by email (806) saying that concern she had raised about Ms Wildridge had not been appropriately addressed. This led to the Director of HR for NWLP, Dawn Morris, asking the claimant to email the outstanding grievance to her. Ms Morris also arranged for one the HR Business Partners, Ms Ahmed to contact the claimant. The claimant duly emailed her grievance in, but the Ms Morris failed to share it with Ms Ahmed.

119. After she had spoken to the claimant, Ms Ahemd checked the HR system which confirmed:

- the disciplinary investigation had been concluded with Ms Wildridge's letter of 12 February 2019
- there were no notes on the HR system about a meeting on 1 March 2019 with Ms Mustoe
- the system referred to a grievance having being resolved informally

Ms Ahmed confirmed this information to the claimant.

120. In the meantime, the claimant had also asked to meet Ms Mustoe's interim successor Ms Hussain. The claimant explained the background to Ms Hussain. The claimant's key concerns related to her grievance about Ms Wildridge and the outcome of the meeting of 1 March 2019 with Ms Mustoe.

121. Ms Hussain followed up with HR and Ms Wildridge. HR told her that they were not aware of an outstanding grievance. Ms Wildridge explained that she had learned about the grievance from the Occupational Health Report, but was due to attend a mediation session with the claimant. He also told Ms Hussain that they had no record of the meeting with Ms Mustoe on 1 March 2019.

122. Following the mediation of 3 July 2019, the claimant emailed Ms Hussain on 9 July 2019 to say that she had lost all trust in Ms Wildridge and felt that if she was of another ethnic group Ms Wildridge and Ms Mustoe would have gone about things differently (813). She expressed concerns about Ms Wildridge doing her PDR. As it transpired, Ms Wildridge did conduct the claimant's PDR and her summary of the claimant's overall performance was extremely positive (829).

123. On learning at the end of August 2019 that the claimant had decided not to participate in any further mediations, Ms Hussain proactively contacted the claimant to enquire why and whether the medication had successfully resolved the claimant's concerns. The claimant's reply to Ms Hussain on 29 August 2019 led her to believe that the claimant and Ms Wildridge had agreed to put the past behind them and move forward (845).

124. The claimant remained concerned, however, that the on-line reports she had made about the original incidents remained open. She raised this with Ms

Hussain and then to Ms Morris. In her email to Ms Morris, the claimant reiterated that she felt that her grievance of 24 January 2019 "*did not really get dealt with as should have*" and she "*never received a response back to* [it]." The claimant stated that:

"*I essentially feel discriminated against due to my race and colour as I strongly believe if I was not ethnic minority things would have been done differently. This is quite stressful for me and although I have carried on as business as usual the upset that it has caused me niggles away at me in the back of my mind each time I come into work and realise that this particular incident has been shut down effectively but remains open. Essentially who will take the wrap if external inspectors come across this issue?"* (848)

125. This led to Ms Hussain contacting the claimant for a further meeting. Almost immediately following the meeting, which took place on 4 November 2019, Ms Hussain summarised the discussion they had had in an email. Ms Hussain was unable to alter the claimant's personnel file, but did her very best, to reassure the claimant that the records on her file were not adversely affecting her and asked her what she might do to assist her to find closure.

126. The claimant felt that Ms Hussain could not assist her any further and decided to initiate the ACAS early conciliation process that same day. That process was concluded on 19 November 2019 (1) and the claimant presented her claim to the employment tribunal on 2 December 2019 (2).

LAW

Time limits

127. The relevant time-limit is at section 123 Equality Act 2010. According to section 123(1)(a) the tribunal has jurisdiction where a claim is presented within three months of the act to which the complaint relates.

128. By subsection 123(3)(a), conduct extending over a period is to be treated as done at the end of the period.

129. In *Hendricks v Metropolitan Police Commissioner* [2002] EWCA Civ 1686, the Court of Appeal stated that the test to determine whether a complaint was part of an act extending over a period was whether there was an ongoing situation or a continuing state of affairs in which the claimant was treated less favourably. An example is found in the case of *Hale v Brighton and Sussex University Hospitals NHS Trust* UKEAT/0342/17 where it was determined that the respondent's decision to instigate disciplinary proceedings against the claimant created a state of affairs that continued until the conclusion of the disciplinary process.

130. When determining if there was a continuing state of affairs the tribunal will consider what the acts were, the context and who was involved. It is not necessary to take an all-or-nothing approach to continuing acts. The tribunal can decide that some acts should be grouped into a continuing act, while others remain unconnected *(Lyfar v Brighton and Sussex University Hospitals Trust [2006] EWCA Civ 1548).*

131. The normal three-month time limit needs to be adjusted to take into account the early conciliation process and any extensions provided for in section 140B Equality Act.

132. The tribunal may still have jurisdiction even if the claim was presented late if it was presented within such other period as the employment tribunal thinks is just and equitable, as provided for in section 123(1)(b).

133. The tribunal has a wide discretion to extend time on this just and equitable basis. As confirmed by the Court of Appeal in *Adedeji v University Hospitals Birmingham NHS Foundation Trust* [2021] EWCA Civ 23, the best approach is for the tribunal to *assess* all the factors in the particular case which it considers relevant to whether it is just and equitable to extend time. This will include the length of and reasons for the delay, but might, depending on the circumstances, include some or all of the suggested list from the case of *British Coal Corporation v Keeble* [1997] IRLR 36 set out below, as well as other potentially relevant factors:

- The extent to which the cogency of the evidence is likely to be affected by the delay.
- The extent to which the party sued had co-operated with any requests for information.
- The promptness with which the claimant acted once they knew of the possibility of taking action.
- The steps taken by the claimant to obtain appropriate professional advice once they knew of the possibility of taking action

134. It is for the claimant to show that it would be just and equitable to extend time. The exercise of discretion should be the exception, not the rule (*Bexley Community Centre (t/a Leisure Link) v Robertson* [2003] EWCA Civ 576).

Direct Race Discrimination

135. Section 39(2) of the Equality Act 2010 prohibits an employer discriminating against one of its employees by dismissing him or by subjecting the employee to a detriment. This includes direct discrimination because of a protected characteristic as defined in section 13.

136. Race is one of the protected characteristics identified in section 4 of the Equality Act 2010. Section 9(1) of the Equality Act 2010 says race as includes colour, nationality and ethnic or national origins.

137. Section 13 of the Equality Act 2010 provides that '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'.

138. Under section 23(1), where a comparison is made, there must be no material difference between the circumstances relating to each case. It is possible to compare with an actual or hypothetical comparator.

139. In order to find discrimination has occurred, there must be some evidential basis on which we can infer that the claimant's protected characteristic is the cause of the less favourable treatment. We can take into account a number of factors including an examination of circumstantial evidence.

140. We must consider whether the fact that the claimant had the relevant protected characteristic had a significant (or more than trivial) influence on the mind of the decision maker. The influence can be conscious or unconscious. It need not be the main or sole reason, but must have a significant (i.e. not trivial) influence and so amount to an effective reason for the cause of the treatment.

141. In many direct discrimination cases, it is appropriate for a tribunal to consider, first, whether the claimant received less favourable treatment than the appropriate comparator and then, secondly, whether the less favourable treatment was because of race. However, in some cases, for example where there is only a hypothetical comparator, these questions cannot be answered without first considering the 'reason why' the claimant was treated as she was.

142. Section 136 of the Equality Act sets out the relevant burden of proof that must be applied. A two-stage process is followed. Initially it is for the claimant to prove, on the balance of probabilities, primary facts from which we could conclude, in the absence of an adequate explanation from the respondent, that the respondent committed an act of unlawful discrimination.

143. At the second stage, discrimination is presumed to have occurred, unless the respondent can show otherwise. The standard of proof is again on the balance of probabilities. In order to discharge that burden of proof, the respondent must adduce cogent evidence that the treatment was in no sense whatsoever because of the claimant's race. The respondent does not have to show that its conduct was reasonable or sensible for this purpose, merely that its explanation for acting the way that it did was non-discriminatory.

144. Guidelines on the burden of proof were set out by the Court of Appeal in *Igen Ltd* v *Wong [2005] EWCA Civ 142; [2005] IRLR 258* and we have followed those as well as the direction of the court of appeal in the *Madarassy* case. The decision of the Court of Appeal in *Efobi v Royal Mail Group Ltd* [2019] ICR 750 confirms the guidance in these cases applies under the Equality Act 2010.

145. The Court of Appeal in *Madarassy*, states:

'*The bare facts of a difference in status and a difference in treatment only indicate a possibility of discrimination. They are not, without more, sufficient material from which a tribunal 'could conclude' that on the balance of probabilities, the respondent had committed an unlawful act of discrimination*.' (56)

146. It may be appropriate on occasion, for the tribunal to take into account the respondents' explanation for the alleged discrimination in determining whether the claimant has established a prima facie case so as to shift the burden of proof. (*Laing v Manchester City Council and others* [2006] IRLR 748; *Madarassy v Nomura International plc* [2007] IRLR 246, CA.) It may also be appropriate for the tribunal to go straight to the second stage, where for example the respondent assert that it has a non-discriminatory explanation for the alleged discrimination. A claimant is not prejudiced by such an approach since it effectively assumes in his favour that the burden at the first stage has been discharged (*Efobi v Royal Mail Group Ltd* [2019] ICR 750, para 13).

147. The tribunal's focus "*must at all times be the question whether or not they can properly and fairly infer… discrimination*.": *Laing v Manchester City Council*, EAT at paragraph 75.

148. We are required to adopt a flexible approach to the burden of proof provisions. As noted in the cases of *Hewage v GHB* [2012] ICR 1054 and *Martin v Devonshires Solicitors* [2011] ICR 352, they will require careful attention where there is room for doubt as to the facts necessary to establish discrimination. However, they may have little to offer where we in a position to make positive findings on the evidence one way or the other. However, if this approach is adopted it is important that the Tribunal does not fall into the error of looking only for the principal reason for the treatment but properly analyses whether discrimination was to any extent an effective cause of the reason for the treatment.

149. Allegations of discrimination should be looked at as a whole and not simply on the basis of a fragmented approach *Qureshi v London Borough of Newham* [1991] IRLR 264, EAT. We must "*see both the wood and the trees*": *Fraser v University of Leicester* UKEAT/0155/13 at paragraph 79.

ANALYSIS AND CONCLUSIONS

Did the respondent treat the claimant as alleged?

150. We first considered whether each of the allegations occurred as alleged. We have done this in approximate chronological order, rather than follow the numerical order of the allegations.

Allegation 3 a.

151. We do not consider Linda Wildridge failed to support the claimant on her return from maternity leave in October 2018. Ms Wildridge was in touch with the claimant well in advance of her return from maternity leave. She arranged for the claimant to have refresher training in line with the respondent's policy and to have protected time to deal with emails, catch up with policy changes and have handover meetings with a variety of different people.

152. Ms Wildridge also arranged for Ms Meaney to prepare a written handover note which was sent to the claimant in advance of her return to work, as requested by the claimant.

153. Because of the timings, Ms Wildridge was on leave at the time the claimant returned to work and the amount of handover time for which Ms Meaney was available was limited. Given that Ms Meaney was returning to her previous role and would still be available to deal with any queries the claimant had, we do not consider this was insufficient.

154. It was unfortunate that Ms Wildridge also became unwell and was absent due to her illness, but this was not her fault.

155. Finally, Ms Wildridge met with the claimant and asked her if there was anything more she could do to support her. The claimant accepts that she did not ask for anything further as she interpreted this question as relating to business as usual activities rather than her return from maternity leave. We are satisfied, however, that Ms Wildridge intended the question to be broader and it was an invitation to the claimant to tell her if there was anything causing her concern.

Allegation 3 b. part 1

156. The second allegation is in two parts. The first part concerns the decision to initiate a disciplinary investigation into the claimant's conduct in October 2018. It is now not disputed between the parties that the decision to do this was taken by Ms Mustoe and not Ms Wildridge. We do not consider that the decision taken by Ms Mustoe was unfair. She decided that there should be an investigation into the two complaints that she had received: one from the claimant about Ms Meaney and the other from Ms Phelan about the claimant.

157. Ms Mustoe did not make any decisions about how the investigation should be conducted, however. She simply instructed Ms Wildridge to proceed. It is surprising to us that the disciplinary investigation took so long and was so formal. It seems to us that a critical step from the respondent's policy was not followed which was the step set out in paragraph 4.1 of the policy that says:

"Under normal circumstances, as soon as the allegation comes to light the manager will meet the person to establish their version of events and determine if the case requires further investigation."

158. We read the policy as suggesting that this step that should be normally be undertaken to determine if there is a need to undertake a formal investigation requiring pre and post investigation checklists and the preparation of an investigation report. The step was not taken.

159. The formality of the investigation being accused of misconduct caused both Ms Meaney and the claimant distress. We know little about the position of Ms Meaney, but for the claimant, being accused of misconduct when she considered (a) she was fulfilling her legal duty to report a near miss and (b)

doing it in the same way she had always done it was and remains devastating.

160. We can only speculate, from the comfortable position of looking back with hindsight, as to what might have happened if Ms Wildridge had done this. It is possible that she could have met the claimant to determine her version of events and then fed back to Ms Mustoe that she did not consider a formal investigation was appropriate in the circumstances. Similarly, she could have met with Ms Meaney and then fed back that the appropriate route to investigate Ms Meaney's conduct was via the incident reporting route rather than a separate conduct investigation.

161. As it was, Ms Wildridge initiated a more formal investigation, initially using her own precedents for investigation invites. The reason she did this was because of the instruction from Ms Mustoe. She did not interpret that instruction as giving her the discretion to decide whether a formal investigation was required. Although we question whether such a formal investigate was required, we consider her interpretation of the instruction was a reasonable one in the circumstances.

162. Shortly after initiating the investigation, Ms Wildridge was advised by HR that a new stage, that of the pre-investigation check-list needed to be carried out. This meant that there was a review as to whether a formal investigation was appropriate. The review involved a senior manager that was not Ms Mustoe and someone from HR. The outcome of the review was that the formal investigation should proceed.

Allegation 3 c.

163. The devastation the claimant experienced at being accused of misconduct was compounded by the lengthy delay in being told exactly what the allegations against her were.

164. We accept the respondent's explanation for the delay to be genuine, namely it was caused by a combination of the length of time the new checklist process took and the claimant's annual leave which was booked from 16 November 2018 to 4 December 2018.

165. We note that although the claimant was told the four allegations being investigated, she not informed of the specific allegations being considered under the generic heading "Failure to uphold Trust values." It seems to us that this was a flaw in the investigative process.

Allegation 3 f.

166. We find that the claimant was not permitted to continue the investigation she had begun into patient mis-reporting errors she considered had been made by Ms Meaney. Based on the evidence we have seen the claimant's enquiries had not been concluded at the time the investigation was taken out of her hands. The claimant had formed a preliminary conclusion which she recorded on the respondent's system, namely that the errors were the responsibility of Ms Meaney in isolation and not the result of any other

failings. However, she had sent Ms Meaney a reflective practice sheet on 6 November 2018 and not received a response.

167. The claimant understandably felt that being told she could not continue the investigation was a detriment, as conducting an investigation of this nature was within her remit as the Blood Laboratory Manager. However, in the circumstances, preventing the claimant from taking any further action, was a logical consequence of the decision made by Ms Mustoe that Ms Wildridge should be responsible for the ongoing investigations.

Allegation 3 b. part 2

168. The second part of the second allegation concerns the recommendations made by Ms Wildridge following the outcome of her investigation and requires us to consider if they were unjustified.

169. The overall finding of Ms Wildridge was that the investigation did not raise sufficient concerns for the case to be heard at a formal disciplinary hearing but it was appropriate for informal interventions to be recommended. On the post investigation checklist, Ms Wildridge recorded the outcome as the situation should be managed informally with the individual and followed up in writing, rather than there being no case to answer. In contrast, she had found Ms Meaney had no case to answer Ms Meaney.

170. As noted in the section on the section in the facts, we struggled to fully understand the factual findings Ms Wildridge had reached from reading the investigation report alone and had to explore these with her in her evidence to gain this understanding. Overall, to the extent that we are able to evaluate them, we consider the findings to be justified by the evidence. There were three key areas where we consider her investigation was flawed, however.

171. The first of these concerns her conclusion the claimant had failed to escalate the incident appropriately through her line manager and clinical lead and should not have reported it before doing so. We consider that Ms Wildridge failed to take full account of the way in which the claimant was used to working with her clinical lead, Prof Dr Francis Matthey. In particular, it is apparent from his email to her (680) that there was additional information he wished to share. It is disappointing that she did not follow this up.

172. The respondent's policies make it very clear that a report should be made at the earliest opportunity and not later than 72 hours after the incident. In addition, the policies say the report should not await the outcome of the investigation. We understand that the respondent's position is that this is true where the incident is obviously one which meets the reportable criteria, but to avoid over reporting there needs to be internal discussion in less serious cases.

173. It seems to us, that with the benefit of hindsight, there was no need for the SABRE report to be made because the risk was so low. It was possible this would have been established had the claimant had internal discussions before making the report. However, it is not at all clear that the claimant

acted inappropriately in making the report or that she did anything different to what she was used to doing.

174. We are also bemused by her conclusion that the claimant should have spoken to her before speaking to David Johnson, when she was absent and unavailable. She does not suggest how the claimant could have achieved this.

175. Our second key concern is the finding that the claimant had failed to uphold appropriate professional standards by advising a colleague to remove another colleague from clinical duties when she did not have the authority to do so. This allegation concerned what the claimant said to David Johnson when she telephoned him.

176. Our factual finding concerning this allegation is at paragraph 67. We have reached it on the balance of probabilities based on the written accounts form Mr Johnson contained in the bundle. We had to do this because, unlike Ms Wildridge, we did not have any opportunity to ask Mr Johnson the direct question as to what the claimant said to him. It is very disappointing that she did not properly resolve this question and resorted to treating his written account as "indicative". In other words, she inferred an outcome instead of asking the direct question.

177. Our final concern concerns the failure of Ms Wildridge to appreciate that the email the claimant sent to Ms Mustoe was intended to be confidential and that the label confidential did not simply refer to the need to protect patient information. We consider however that the comments that the claimant made about Ms Meaney and Ms Wildridge in the email were unprofessional and were made to a senior manager.

178. Having made the above points, and taken them into account, we consider that the recommendations that Ms Wildridge made were reasonable in the circumstances. We were extremely surprised, however, to learn that the investigation report was never shared with the claimant. We understand that as Ms Mustoe was responsible for commissioning the report, it was deemed that she should be responsible for feeding back the findings. As such, we consider that she should also have been responsible for deciding the recommendations and that this would have been truer to the way the informal resolution section of the respondent's Disciplinary Policy and Procedure is drafted.

179. We find it very difficult to understand how the claimant could have been expected to complete the recommendations made, particularly the reflective practice, when she was not informed what she had not done correctly.

Allegation 3 g.

180. The claimant's grievance was submitted to Ms Mustoe on 24 January 2019. Ms Mustoe replied immediately and effectively replied to the main complaint the claimant was making. That complaint was that there should not be an investigation underway at all. The reply was that the investigation had been through the pre-investigation checklist process and reviewed by senior

management, the outcome of which that it should proceed on the formal basis.

181. Given that this was the position, it was not necessary for Ms Mustoe to share the grievance with Ms Wildridge. Unfortunately, her failure to fully explain the finer nuances to the claimant left the claimant believing that Ms Wildridge would be investigating the grievance.

182. What was required was for Ms Mustoe to clearly explained that the initial decision to conduct the investigation was hers and not that of Ms Wildridge; informed the claimant that her decision had been subsequently reviewed via the checklist process and advised her whether there was any right for an employee to challenge that decision using the grievance procedure. This would have ensured that the claimant fully understood the position.

183. We consider that the respondent did address the claimant's grievance, but failed to properly explain this.

Allegations 3 d. and 3 e.

184. We have considered the final two allegations together as they concern the same matter.

185. Following the outcome of the investigation, our finding is that Ms Mustoe met the claimant on 1 March 2019. The purpose of the meeting was to discuss the findings in the report and the recommendations. However, they did not do this in detail.

186. Ms Mustoe was both sympathetic to the claimant's position and driven by a desire to find a pragmatic solution to her concerns. We infer that she had a solution in mind as a response to the concerns raised by the claimant. That solution was to release the claimant from any obligation to undertake additional refresher training. We consider Ms Mustoe hoped to use the fact that the claimant had had recent training in incident reporting and made other reports since the incident in October as a means to achieving this.

187. We do not infer that Ms Mustoe informed the claimant that she would be issued with a fresh outcome letter, however. This is because the claimant asked about documentation in her later email suggesting that she had not been told what documentation she would receive.

188. The respondent's HR system contained a record that the investigation took place and held the outcome letter, but did not require any further follow up once the outcome letter had been issued. In this case, it was never intended that there would be any check by HR to see if the claimant or Ms Meaney followed the recommendations made by Ms Wildridge. This was understood to be a line management responsibility. There was therefore no refusal by HR to disclose the outcome of the claimant's meeting of 1 March 2019 with Ms Mustoe. HR was not made aware of the outcome and had no record of it and could not therefore have amended the claimant's personnel file to reflect the outcome of the meeting.

189. The claimant continued to be aggrieved and later raised this matter with HR (Ms Ahmed) and Ms Mustoe's interim successor Ms Hussain. Given that there was no record of the meeting neither Ms Ahmed nor Ms Hussain were in a position to grant the claimant what she requested. This was in effect a refusal to amend the claimant's personnel file with the outcome of the meeting.

Was the claimant treated less favourably because of her race?

190. We have found that the treatment complained of under allegations 3a, 3d, 3g did not occur as alleged. The claimant was supported on return from maternity leave, there was no failure to address her grievance of 24 January 2019 and HR did not refuse to disclose the outcome of the meeting held on 1 March 2019. We have therefore not considered whether the claimant's race had anything to with these matters.

191. The claimant does not accuse Ms Ahmed or Ms Hussain of treating her less favourably because of race. They were the decision makers in relation to allegation 3e and therefore this must fall away as an allegation of direct discrimination.

192. In compliance with our duty to see "*both the wood and the trees"* in this case, we have considered each remaining allegation in detail and the overall circumstances. Our conclusion is that the decisions and actions taken in relation to the investigation by Ms Mustoe and Ms Wildridge were not influenced, in any way, by the claimant's race.

193. It is correct that the claimant was almost the only non-white person involved in the issues being investigated. The person who complained about her (Lorry Phelan) was white; the person who she allegedly wronged (Louise Meaney) was white; the person who decided there should be an investigation (Charlotte Mustoe) was white; the person who conducted the investigation (Linda Wildridge) was white and one of the key witnesses (David Johnson) was white. The only other non-white person involved was Nhung Ly who had first reported the concern about Ms Meaney to the claimant.

194. We can appreciate that the claimant felt that she was being singled out unfairly and that Ms Meaney's white colleagues were collaborating to protect her. This feeling was no doubt exacerbated because the claimant was aware that Ms Meaney and Ms Wildridge (who she believed to be the primary decision maker) shared common interests and were very friendly. She also had in the back of her mind, the information she had learned about Ms Meaney's previous performance issues and the comment made by Ms Wildridge praising Ms Meaney. In our view, however, the evidence does not support this contention.

195. We consider that this is a case where the claimant has failed to identify primary facts from which we could conclude, in the absence of an adequate explanation from the respondent, that the respondent committed an act of unlawful discrimination. As confirmed in the case law, there has to be "something more" than a mere difference in race to do this.

196. If we are incorrect, however, and the burden of proof has shifted onto the respondent, we are satisfied that the respondent has adduced cogent evidence that the claimant's treatment was in no sense whatsoever because of the claimant's race. The respondent has been able to explain the reasons for acting the way that it did and demonstrated that they were non-discriminatory.

197. Although the key fact which leads to the possibility of a shift in the burden of proof is the difference in race. There are other facts that are relevant too:

- some of the decision making appears poor (i.e. the decision to conduct such a formal investigation);
- some aspects of the investigation could have been conducted better; and
- timeliness and communication all round needed to be improved.

198. Against this, we consider that it is significant that Ms Meaney was subjected to the same degree of formal investigation as the claimant, although she is not an appropriate comparator for all of the allegations because her circumstances were very different. Although David Johnson held the same position as the claimant, in that he was a Blood transfusion Manager who had made incident reports in his role, we do not consider his circumstances were sufficiently similar to the claimant's position for him to be the correct comparator from a legal perspective. We have therefore considered the claimant's case using a hypothetical comparator.

199. What was unique about the claimant's position when reporting this incident is that she reported a potential failure by someone (Ms Meaney) who did not report to her but worked at a different site and under different line management. She also expressed views, that she intended to be private, to a senior manager about that person which were very critical. These reached the ears of Ms Phelan who, protective of her member of staff, complained. There was no evidence before us that Ms Phelan would not have had the exact same reaction in the same circumstances had Ms Meaney been non-white or the claimant been white.

200. We are mindful of the comments made by Ms Mustoe that the blood transfusion departments were gossipy and, it seems to us, territorial. This is the context in which the comments were made.

201. It was sensible for Ms Mustoe to appoint Ms Wildridge to conduct an investigation and she believed she was being even-handed getting her to investigate both the claimant and Ms Meaney. Ms Wildridge followed the instructions given to her by her line manager in conjunction with HR. Preventing the claimant from continuing her investigation into Ms Meaney was a logical action for the respondent to take, once the investigation by Ms Wildridge had been initiated.

202. There was no evidence before us that suggests that Ms Wildridge would not have made the same investigative errors which we have identified had she been investigating a white employee. Similarly, there is no evidence that Ms

Mustoe's communication around the claimant's grievance or her approach to the meeting of 1 March 2019 would have been any different if the interactions had been with a white employee.

203. Finally, the treatment which the claimant found to be most difficult was the respondent's failure to tell her allegations against her for such a long time. The delay was appalling and distressing. The explanation the respondent has provided, however, demonstrates that it was in no sense whatsoever because of the claimant's race, but caused by the necessity to follow the process it was following. It is significant that the same delay occurred in the case of Ms Meaney.

204. For these reasons, we do no uphold any of the claimant's allegations of race discrimination.

Time Point

205. As we have not upheld any of the claimant's allegations of direct race discrimination. we have not considered the time point.

Employment Judge E Burns
15 July 2021

Sent to the parties on:15th July 2021

For the Tribunals Office