EMPLOYMENT TRIBUNALS

Claimant: Mr Steven Miles

Respondent: Greater Manchester Mental Health NHS Foundation Trust

Heard at: Manchester (remote public hearing via CVP)

On: 26 and 27 April 2021

Before: Judge Brian Doyle

Representation
Claimant: Ms Jane Lee, friend
Respondent: Ms Jade Ferguson, counsel

JUDGMENT

The claim is not well-founded and it is dismissed.

REASONS

1. These are the written reasons for the oral decision in outline delivered on 27 April 2021 at the conclusion of the final hearing of Mr Steven Miles's claim. That decision was recorded in a judgment signed by the judge on 27 April 2021 and sent to the parties on 29 April 2021. The written reasons are provided following a timely application made by the claimant after the hearing on 30 April 2021 in accordance with rule 62 of the Employment Tribunals Rules of Procedure 2013.

2. The judge apologises for not being able to provide the written reasons sooner due to the pressures of the present caseload of the Tribunal and an earlier electronic draft of the written reasons being deleted accidently and being incapable of recovery, requiring the draft to be re-written.

The claim and the issues

3. Acas early conciliation commenced on 26 February 2020 and concluded on 9 April 2020. The ET1 claim form was presented on 6 May 2020. It contains a single complaint of unfair dismissal. The ET3 response form contains grounds of resistance dated 6 June 2021.

4. Because standard case management orders were issued, the claim was not the subject of a case management hearing. A formal list of issues had not been settled. Nevertheless, at the commencement of the hearing, with the parties' agreement, the Tribunal identified the issues that appeared to arise from the claim and the response as follows.

5. (1) Was the decision to dismiss the claimant taken at the correct level and with the correct authority? (2) Was the severity of the incident for which the claimant was dismissed correctly graded? (3) Was there a procedural irregularity in the refusal to permit witness evidence at the appeal hearing? (4) Was the dismissal decision based upon an incorrect understanding of the claimant's conduct? (5) Was there a failure to apply NHS guidelines ("Just Culture") to the question of whether the claimant had committed misconduct? (6) Was the claimant's previous record taken into account? (7) Was dismissal a proportionate sanction even though the claimant was already the subject of a final written warning? (8) Were environmental factors (including workload demands and lack of clinical supervision) not taken into account properly or sufficiently?

6. The claim also appears to suggest a concern that the claimant's mitigation was not properly accounted for; the investigation did not capture the evidence properly; the claimant was the victim of a new emphasis on the security of confidential information; and he was not treated consistently with other employees.

The final hearing

7. The final hearing was conducted over 2 days on 26-27 April 2021 as a remote public hearing, with all participants taking part via the Cloud Video Platform (CVP).

8. At the commencement of the hearing the Tribunal dealt satisfactorily and without further implications with two issues of evidence: the late provision of the claimant's witness statement and two missing documents.

The evidence

9. The respondent's evidence is derived from the evidence of Joanne Wright (Team Manager) and Ana Sanderson (Service Manager). Joanne Wright carried out the investigation that led to a disciplinary hearing conducted by Ana Sanderson. The Tribunal did not hear or have witness evidence from the manager who conducted the appeal hearing, Andrew Maloney (or Adam Young, who was with him at that hearing). An account of that hearing was given by Ana Sanderson, who was present at it.

10. The claimant gave evidence in his own behalf. He also called evidence from Claire Miller (Care Co-ordinator), Jane Lee (Unison shop steward), Dr John Mulligan (Clinical Psychologist) and Rosaleen Dyer (Physical Health Nurse).

11. Ana Sanderson was recalled in order to deal with matters that arose from the claimant's witnesses' evidence.

12. The main bundle of documentary evidence comprised 544 pages. References to the bundle appear in square brackets below.

Assessment of the evidence

13. The claimant gave his evidence honestly and candidly. He did not attempt to embellish his evidence, or to deflect from the seriousness of the matters that led to his dismissal, although understandably his evidence was also a vehicle for putting his arguments to the Tribunal.

14. As was apparent from the evidence of Jane Lee (his representative at the Tribunal hearing, although not in the internal procedures), the dismissal of the claimant took place against the background of a collective dispute about "environmental factors" in this workplace, largely but not exclusively concerned with workload, caseload and professional practice. Jane Lee's evidence was led by that context and in the final analysis was not helpful in deciding the matter of which this Tribunal was seized: the fairness of the claimant's dismissal. Her evidence was supported by that of Claire Miller. Similarly, Dr Mulligan's evidence was instructive as to what clinical supervision might have brought to the table and as to the claimant's well-regarded professional reputation, but did not advance the resolution by this Tribunal of the legal dispute between the individual claimant and the respondent, namely, whether he was unfairly dismissed. Rosaleen Dyer provided helpful evidence on the policy and practice of administration of medication.

15. The respondent's witnesses, Joanne Wright and Ana Sanderson, were impressive witnesses, who gave a measured and detailed account of the disciplinary process in which they were engaged with the claimant. Their evidence focussed on the questions that any Tribunal must answer in an unfair dismissal complaint. Their evidence was consistent within and between themselves, without any suggestion that it lacked independent reflection or that they had collaborated to produce an account favourable to the respondent. As is often most significant, their evidence accorded with and was corroborated by the quite comprehensive documentary evidence. Their evidence was compelling and persuasive, such that the Tribunal has had no hesitation in drawing its findings of fact in the main from their accounts.

16. Reference in the findings of fact is made to two colleagues of the claimant – Emma Gyles and Louise Malkin. The Tribunal has not heard evidence from either employee. It wishes to emphasise that it makes no findings of fact that are intended to be critical of them or to infer any suggestion that their actions are open to negative assessment.

Findings of fact

17. The claimant was employed within the respondent's Early Intervention Service (EIS) as a Care Co-ordinator/Community Psychiatric Nurse (CPN). EIS is a secondary mental health service based in the community, supporting individuals aged 14-65 years who are identified as having experienced a first episode of psychosis. This is done through the allocation of a Care Coordinator who undertakes responsibility for coordinating their care.

18. Steven Miles was a Band 6 Care Coordinator/CPN. He was employed by the respondent between 1 September 2013 until 6 December 2019.

19. In September 2019 Joanne Wright became his line manager. This was following the organisational change from the Trust acquiring Manchester Mental Manchester Mental Health and Social Care and part of the model was a divisional creation of community services to North, Central and South and Trafford divisions. Manchester Early Intervention Service was operationalised into three teams in September 2019 – North, South and Central Division.

20. In February 2019, Ana Sanderson was asked by HR to chair a formal disciplinary hearing involving Steven Miles. At the time, she was not aware of the incident in question. Steven Miles had already been suspended from his duties [73-74]. The allegation against Steven Miles was that he left a service user's personal and confidential data on his doorstep (more accurately, outside his house) to be picked up when he had set off to the airport to go on holiday.

21. By letter dated 18 February 2019, Steven Miles was invited to attend a disciplinary meeting [101-102]. He was reminded of his right to be accompanied at the meeting. He was also provided with a copy of the Investigation Report in advance [55-99].

22. On 19 February 2019 Ana Sanderson was provided with a copy of the Investigation Report together with a copy of the RDASH Disciplinary Policy by the HR Manager, Joanne Smith. Steven Miles had transferred to the Trust from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH), which was why that policy applied to him [339-370]. In advance of the hearing, she reviewed the investigation report, read the RDASH Disciplinary Policy and made a note of the questions she wanted to ask in the hearing. Given the serious nature of the alleged conduct, Steven Miles was advised in the invitation letter that the allegations against him could be construed as gross misconduct. As such, a possible outcome of the hearing was that he might be summarily dismissed from his employment with the Trust.

23. On 14 March 2019, Ana Sanderson attended the disciplinary hearing as the hearing manager. Joanne Smith was also in attendance to provide HR support and advice. Dan Cottam, who was the Team Manager at the time, presented the investigation report and his findings, with the support of Julia Cairns, HR Advisor. Steven Miles was accompanied by his union representative, Ben Jackson. The minutes of this meeting can be found at [126-143].

24. The evidence at the hearing was that on 7 August 2018, Steven Miles worked half a day. He was going on holiday later that day. He was due to leave his house at 4.30pm to go to the airport. He realised that he still had depot cards and the service users involved would require medication while he was away. The depot cards contain personal details of the service users, including their name, date of birth, NHS number, address and details of their medication, dosage and any allergies. Steven Miles explained that he did not have time to drive back to work with the depot cards and so he had arranged with his colleague, Emma Gyles, to collect them from his home. He did not agree a time for her to collect them and he did not inform her that he needed to leave home at 4.30pm.

25. At the time he needed to leave, his colleague had not yet been to collect the depot cards. He took the decision to place the depot cards in a bag and leave them underneath a bush to the side of his front door. He texted his colleague to advise her of this and he then left for the airport. He noticed some missed calls from his colleague and a text stating she could not find the depot cards. He rang his neighbour, who advised that they had taken the bag in. He then instructed his neighbour to put the bag back outside (in what was an unsecure place). The bag containing the depot cards was then collected by another colleague. From the investigation report, Ana Sanderson noted that Steven Miles admitted to the allegation and he did so again at the disciplinary hearing.

26. As Steven Miles had admitted to the conduct, which Ana Sanderson believed constituted gross misconduct, a possible outcome of the hearing was dismissal. Steven Miles had left three depot cards which contained personal and sensitive information in a place that could be accessed by the public, and he had done so twice. He was able to articulate his understanding of information governance and had attended training in relation to this prior to the incident. He failed to escalate the situation to his line manager or consider other options. His actions put the reputation of the Trust at risk as well as the risk of loss of confidence in its trustworthiness by the service users. This also placed the Trust at risk of a fine.

27. Steven Miles provided mitigation, namely that he was in stressful situation having to arrange his family getting to the airport. Ana Sanderson did not accept that preparing to go on holiday mitigated his actions. This would have been a pre-planned arrangement and he ought to have planned his working arrangements in advance. She also did not accept that his wish not to burden colleagues was mitigation. However, at the disciplinary hearing Steven Miles was remorseful and realised these decisions were wrong and he explained that he had reflected on his conduct.

28. Given the reassurance Steven Miles provided to her that he understood the importance of confidentiality, that he had reflected and learnt from this, and that this would not be repeated, Ana Sanderson decided to issue him with a final written warning rather than dismiss him, having deliberated and taken advice from HR. She confirmed at the hearing that the final written warning would remain live on his file for 12 months from the date of the hearing. She emphasised to him that she would not expect there to be a repeat of such conduct given his reflection and assurance. She explained to him that should there be a repeat of breaching confidentiality, disciplinary action up to and including summary dismissal could be taken against him.

29. This outcome was delivered to Steven Miles by letter dated 8 April 2019. He was reminded of his right to appeal this outcome. He did not appeal. Ana Sanderson was aware that Steven Miles's suspension would then be lifted and upon his return to work he would be required to undertake the Information Governance training again, which he did.

30. On the morning of 5 September 2019, Joanne Wright was approached by Steven Miles in the Central Team EIS Office at Chorlton House to ask if he could discuss an urgent matter. Steven informed her that he had received a

telephone call from his service user (AD) who was very angry as he was concerned he had been given the wrong depot medication during their last contact on the 29 August 2019. A depot injection is a slow-release form of antipsychotic medication. It is the same medication as the antipsychotic that comes in tablet or liquid form, but it is given as an injection in a liquid that releases it slowly, so it lasts a lot longer.

31. Steven Miles explained that the day before he was due to give this service user his depot he was at Hexagon Tower and had gone to the medicines cupboard to get the depot medication out for the following day. It was then when he discovered that he had not re-ordered this service user's medication the last time he had given him his depot. The claimant confirmed that he had forgotten because he had been about to go on annual leave. In light of this, he therefore asked a colleague, Louise Malkin, if he could take a box of depot medication that had been prescribed for one of her service users (MLM), who has the exact same prescribed medication. Steven Miles explained that Louise had agreed to this.

32. The claimant reported that he administered the depot to AD without incident and left the empty box that had contained the depot with the service user, with the intention that they would destroy it. The box had a sticker on it, containing the personal data of the other service user (MLM) whose medication Steven had taken. On looking at the label on the empty box, AD saw that it contained another individual's name. AD therefore assumed that Steven Miles had given him the wrong depot, causing him distress. The claimant explained that he had attempted to explain and reassure the service user that they had taken the correct medication, but the service user remained angry and upset.

33. Joanne Wright requested Steven Miles to complete an incident report via Datix. All incidents (including near misses) must be reported using the Trust's reporting electronic system, called Datix, which provides a systematic process enabling incidents to be reported and then investigated. She confirmed that she would need to discuss this with Dan Cottam, who was the EIS Service Manager at the time. She also needed to take immediate steps to speak with the relevant service users and explain how this incident had occurred and to reassure AD that he had been given the correct medication.

34. She spoke to AD and confirmed what had happened and noted that management were investigating the incident internally. AD was still very upset and was on the verge of raising a complaint, but he was content in the knowledge that the Trust would be dealing with this internally. She also spoke with MLM, as she had to inform her that her personal details had been shared with another service user by mistake. It was important that she was honest with her about the breach of confidentiality and to reassure her that this was being investigated internally to avoid this happening again. The service user was also given the opportunity to make a formal complaint if she so wished. This was a duty of candour meeting.

35. Within EIS, one of the fundamental aspects of the job is building trust with the service users and maintaining consistency. A service user needs to trust the Care Co-ordinator to give them an injection. If a relationship breaks down the potential consequences can have a negative impact on the delivery of care. A

service user may lose trust and disengage with the service and then decide not to take their medication. These are people with serious mental health issues, and if something goes wrong with their care, or if they feel that something has gone wrong, it can be extremely unsettling for their mental health. Patient safety and their trust and confidence in the service has to remain paramount to the work EIS does.

36. This incident generated a Datix report [185-188]. When Joanne Wright reported this to Dan Cottam, he noted that Steven Miles already had a live final written warning on his file for a similar incident involving a breach of confidentiality. Dan Cottam advised that she undertake a formal disciplinary investigation due to the mishandling of sensitive clinical data. She was appointed as the Investigation Officer around the first week of September 2019. Dan Cottam informed HR and it was agreed that Steven Miles would be placed on suspension from face-to-face contact with clients. Given the risk to service users in light of the breach of confidentiality, it was felt that suspension from patient-facing duties was appropriate. She confirmed this to Steven Miles by letter dated 11 September 2019 [195-196]. Steven Miles remained office-based and engaged in triage and completing paperwork for his caseload, while Joanne Wright undertook the investigation.

37. Joanne Wright understood her role as the Investigation Officer was to establish the facts and present any evidence in relation to the allegation against Steven Miles in accordance with the Disciplinary Policy [339-370]. She was required to produce an Investigation Report outlining the facts and to make a recommendation on how to progress. She finalised the lnvestigation Report on 2 October 2019 [173-203]. In preparing the report and in conducting her investigation, she held investigation meetings with Steven Miles; held an investigation meeting with Louise Malkin; reviewed the training that Steven Miles had undertaken; and considered all of the evidence gathered, including Steven Miles's mitigation evidence.

38. By letter dated 20 September 2019, Steven Miles was invited to attend a disciplinary investigation meeting to take place on 27 September 2019 [197-200]. This confirmed the allegation against him, which was that on 29 August 2019 he left a medication box with a printed pharmacy label on it containing a service user’s personal information, in the home of another service user, in breach of a service user's confidentiality.

39. On 27 September 2019, Steven Miles attended the disciplinary investigation meeting. Joanne Wright was in attendance at the meeting. She was supported by Katie Robb (HR Advisor). At the meeting, Steven Miles was reminded of his right to representation, but he opted to continue without a representative. Joanne Wright explained that this was a fact-finding meeting for the purposes of conducting a thorough investigation. Minutes of this meeting were taken [197-200].

40. Steven Miles admitted the conduct again. He confirmed that he was aware that it was an issue, that it amounted to a breach of confidentiality and that it was inappropriate. He confirmed that the day prior to the incident, he was planning his next working day as he wanted to avoid having to return to Hexagon Tower as he was travelling by bicycle and had a number of visits scheduled. During

the meeting on 27 September 2019, Steven Miles was unsure if this was a day or two days before he was due to give the service user his depot. He explained that when he went to the medicines cabinet in Hexagon Tower he discovered that he did not have a depot in stock and that he must have forgotten to order the depot as he had been going on annual leave the next day. He confirmed that he had agreed with Louise Malkin that he would take her service user's medication and he had offered to reorder a depot for her. He confirmed that he had never engaged in this practice of borrowing medication before. That day, he had taken the depot home with him. He confirmed that on 29 August 2019 he had attended the service user's home and administered the depot without any issues. He had asked the service user to dispose of the packaging and the empty box and had forgotten that the empty box contained a sticker on it with the other services user's personal details.

41. Joanne Wright asked Steven Miles if there were any mitigating circumstances. Steven Miles reported that he had a lot to think about as he had two ward rounds on the day of the incident which he was worried about as both of the in-patients at the time were homeless and there was a lot of pressure to find accommodation for them. Joanne Wright took into consideration that Steven Miles was worried about his workload at the time the incident occurred. He stated that usually the shortest period for ordering depots is a day or two in advance of a scheduled appointment, but that he would normally re-order as soon as he had administered the last depot. He confirmed that he was aware that there is an alternative way of getting the depot medication, which is to take the service user's depot card to Lloyds Pharmacy, who would issue the depot. When asked why he did not do this, he stated it was too late to do so. Lloyds Pharmacy's opening hours are 8.30am to 6.00pm Monday to Friday.

42. As part of her investigation, Joanne Wright also spoke to Louise Malkin to seek her version of events. She spoke to her on 9 September 2019 and then again on 1 October 2019 to ask her some supplementary questions regarding the date when Steven Miles had asked to borrow the medication. Louise Malkin could not remember when this was.

43. Following the initial investigation meeting with Steven Miles, Joanne Wright wanted to make sure that the timeline of the incident was correct. She was still unclear about when he had realised that he had not ordered AD's medication. She met with Steven Miles again on 15 October 2019 to look at his diary with him. It became clear that Steven Miles had actually realised this on 27 August 2019 and would therefore have had time to arrange medication from Lloyds Pharmacy the day prior to his meeting with AD.

44. Joanne Wright noted that Steven Miles had undertaken all of the relevant training and had completed his Information Governance training again on his return from suspension in March 2019 (which addresses standards of confidentiality). When working within the NHS, all employees are made aware that information governance, and, in particular, protecting patients' confidential information, is paramount. All staff have responsibility to abide by their legal, professional, ethical and contractual responsibilities for information governance-related issues. Through the Trust's policies and mandatory training, staff are made aware of their individual responsibilities. Joanne Wright therefore considered that Steven Miles was aware of his duties and

responsibilities, but that he had not shown the due care and attention required when handling personal data.

45. Having considered the evidence, including the mitigation evidence, Joanne Wright considered that there was evidence of a serious breach of a service user's confidentiality which affected two service users. The conclusion of her investigation report was that the matter was serious and there was a prima facie case for the employee to answer, which warranted a formal disciplinary hearing being convened to consider the case further. She took advice from HR throughout the process and also discussed the conclusions of her report. Joanne Wright attended the disciplinary hearing on 6 December 2019. She presented the investigation report at the hearing. Steven Miles had an opportunity to comment on the contents of the report. He did not challenge the investigation or the report.

46. The second disciplinary hearing was conducted by Ana Sanderson. In advance of the disciplinary hearing, she was provided with a copy of the Investigation Report, together with all appendices [173-203]. She noted that the allegation was that on 29 August 2019 Steven Miles failed to keep a service user's personal data secure when he left a medication box in a service user's home with a printed pharmacy label on it containing another service user's personal information, breaching confidentiality. It was clear from the investigation report and his statement of case that Steven Miles admitted to the alleged conduct and confirmed that the findings of the investigation report were accurate.

47. Steven Miles attended the disciplinary hearing on 6 December 2019. He was accompanied by Karen Buckley, Unison Staff Side Representative. Jamie Brown, HR Manager, was also in attendance to provide support with the process. As already noted, Joanne Wright, the Investigating Manager, attended the meeting to present the investigation report and she was supported by Katie Robb, HR Advisor.

48. The Trust has been unable to recover the minutes of the disciplinary hearing.

49. Ana Sanderson's evidence, which the Tribunal accepts, is that in the hearing Steven Miles was given the opportunity to raise questions, put forward evidence and challenge any aspects of the report. Ana Sanderson challenged some aspects of his mitigation and this is set out in the outcome letter. The mitigation was that he was under pressure with his workload at the time, due to the fact he did not have access to a car and had started to ride a bicycle at work. He explained that his geographical patch of service users did not match his base, which was Hexagon Tower at the time. The service was moving to a three-team model from a two-team model, the staff alignment process had already been completed and he was moving his base from Hexagon Tower to Chorlton House. The final step required to complete this transition was the re-allocation of a number of service users to the team members working specifically in the area that they live in. This specific process commenced on 5 July 2019 and concluded on 30 August 2019. He explained that he had a number of care documents to update to enable the transfer of his service users and his caseload was 25, which was higher than was recommended.

50. Ana Sanderson considered this mitigation evidence. She noted that his caseload was above expected levels in the Early Intervention Service (EIS). He had also reported that he was retaining a number of these service users. She understood that he was not required to update care documents for 25 service users by the end of August 2019. She clarified this within the hearing. Furthermore, he had not escalated his concerns about task management to his line manager, from whom it was reasonable to expect support. This was despite him presenting a similar mitigating factor in his first hearing. Ana Sanderson accepted that at times pressures for staff can fluctuate and become more acute, but there were supportive mechanisms in place to ensure that their impact was mitigated – for example, managerial supervision, and real-time escalation for support by staff through their line manager. In light of this, she did not consider his workload to be excessive and so she did not accept this as adequate mitigation.

51. Steven Miles also noted that he had not had clinical supervision again until recently. Clinical supervision is a non-directive confidential forum within which a clinician can reflect on their practice and consider actions which may support them to improve/adapt their practice based on their reflections. Ana Sanderson did not find that Steven Miles had presented in his statement of case (or in response to questioning within the second hearing) about how resuming clinical supervision would mitigate the risk of any further repetition. There had now been two incidents, despite a final written warning and evidence that the reflection he communicated in the initial hearing had not translated to changes in practice: for example, escalation to line manager for support to help with task prioritisation.

52. Steven Miles also suggested that he did not wish to burden colleagues by asking for them to undertake tasks for him: for example, collecting medications ordered from pharmacy. This was similar to the mitigation he had raised for the first disciplinary hearing, where he suggested he did not want to burden his colleagues, explaining how this impacted on his ability to manage his time and organise his workload. In the first disciplinary hearing, Ana Sanderson had explained to Steven Miles why this was not an appropriate excuse and it would have been entirely reasonable to seek support from his line manager at the very least in order to ensure that his role was manageable. She was concerned that despite her expressly advising him about this in March 2019, he had not learnt from this or adapted his practice. At no point during the disciplinary hearing did he suggest that he was unable to speak to his line manager if he was struggling, and he acknowledged that he could have asked for support from his line manager, for example, with collecting medications from the pharmacy.

53. With this incident, Ana Sanderson was particularly concerned that Steven Miles's lack of care and attention had impacted on two service users. This situation had arisen because he had borrowed a colleague's supply of medication for their service user, as he had not ordered a supply for his own service user in time and did not follow the correct procedure of checking the identity on the prescription box. She did consider that him borrowing another service user's medication was not a supported practice within the Trust's Medicines Policy about safe administration of prescriptions. However, this was not her immediate concern in this case. She accepted that, while this was not

best practice, this practice had occurred. The fact that he borrowed the medication did not form part of her decision-making.

54. Ana Sanderson was concerned that Steven Miles had not followed the Trust's guidelines in relation to the safe administration of medications. This was on the basis that if he had checked the prescription box prior to administering the prescription, he ought to have noticed that this was another individual's name. If so, this should have reminded him not to leave the box containing another person's details on it with the service user. She was concerned that he did not realise this when administering the depot injection to the service user.

55. Given the already live final written warning on Steven Miles's file in relation to a serious information governance breach earlier in 2019, Ana Sanderson felt that it would have been reasonable to expect that he would act in line with expectations and policies as set out within the sanction. She was not satisfied that he had recognised the seriousness of the earlier incident. In her view, it is imperative that with an employer and employee relationship there is trust and confidence between the parties. Steven Miles had previously assured her that no further conduct of this nature would happen. Within a few months of this assurance, he had committed a further breach of confidentiality. In Ana Sanderson's opinion, a disciplinary process should be a fair corrective process. When proportionate sanctions are given, it is intended that they provide an employee with an opportunity to improve their conduct or address concerns. She was not satisfied that he had improved since his previous warning, given the clear breach of patient confidentiality again.

56. Ana Sanderson took a break at the end of the disciplinary hearing to deliberate on her decision and to take support from and to discuss this in detail with Jamie Brown. Having considered the evidence, the mitigation put forward by Steven Miles and his previous employment record, she felt that his conduct constituted gross misconduct. Prior to delivering the outcome to him, she made a note of the outcome of her deliberation [212-213]. This document assisted her with delivering this outcome to him in the meeting. It ensured she communicated her decision and rationale. She was mindful of the impact of this decision on him. She did consider whether a final written warning or dismissal with notice would be appropriate. However, given the previous final written warning for a similar and serious conduct, Ana Sanderson decided to dismiss Steven Miles from his role, with immediate effect. She resumed the disciplinary hearing and confirmed this decision to him.

57. This outcome was confirmed to Steven Miles by letter dated 16 December 2019 [214-215]. Within this letter Ana Sanderson also advised him that, given the Trust's professional obligations, she had to make a referral to the Nursing and Midwifery Council (NMC). This letter reminded Steven Miles of his right to appeal the outcome.

58. On 18 December 2019, Ana Sanderson received a text message from Steven Miles in which he requested that she reconsider her decision to refer him to the NMC and, if she did so, he would not appeal the outcome of the disciplinary hearing. She considered this text message to be wholly inappropriate. It further concerned her that he did not appreciate the obligations and duties of the profession as set out in the NMC Code of Conduct. She considered the

suggestion in the text message to be improper and she did not respond to it. She did subsequently make a referral to the NMC [273-276].

59. Steven Miles appealed the outcome. Ana Sanderson was therefore required to present her management response to this [220-228]. She attended the appeal hearing on 4 May 2020 to present this response. Andrew Maloney (Director of HR & Deputy CEO) chaired the appeal, alongside Adam Young, Associate Director. Andrew Maloney was supported by Nicola Wilkinson, Head of HR. Steven Miles was accompanied at the appeal meeting by a union representative.

60. As part of his appeal against dismissal Steven Miles suggested that Ana Sanderson did not have the relevant authority under the policy to dismiss him. This was discussed with HR at the time she was deliberating her decision. It was confirmed that she had the relevant delegated authority to make this decision. The RDASH Disciplinary Policy expressly provides for delegated authority [332-333 and 330]. The Tribunal agrees. Andrew Maloney asked Ana Sanderson about this at the appeal hearing. He did not uphold any contention from Steven Miles that Ana Sanderson did not have the authority to arrive at the sanction she did.

61. As part of his appeal, Steven Miles also stated that the disciplinary sanction was based on the false understanding that his behaviour was inconsistent with the Medicine Management Policy. This is not the case. Ana Sanderson reflected this fact within her management response. She noted that the standard operational procedure for the process of administration of medicines states that “the prescription for each item should be read accurately, check the label on the container with the prescription and that the medication in the container reflects the label and prescription. Check the label corresponds to the correct patient if it has been individually labelled.” The reference to this was simply to demonstrate that if he had administered the medication in line with this policy, he should have noted at that point that this box contained another service user’s personal details, which should have reinforced the importance of taking this box away with him.

62. As part of his Tribunal claim, Steven Miles has suggested that the appeal panel refused to hear from two witnesses, on the basis that they should have presented their evidence at the disciplinary hearing. He has alleged that he was informed that it would be unwise to bring witnesses to the original hearing. He was not advised of this by Ana Sanderson. He was given the opportunity to bring witnesses to the hearing. It is part of the Trust’s processes to inform employees of this in advance of a formal disciplinary hearing. Similarly, the Disciplinary Policy clearly states that “if the employee wishes to call any witnesses at the hearing, they should make arrangements for their attendance, and inform the Trust” [351]. At the disciplinary hearing, Steven Miles did not suggest that he had been stopped from bringing a witness to the hearing. Furthermore, Ana Sanderson did consider the character references he provided when considering the outcome.

63. Steven Miles has also suggested that Ana Sanderson failed to implement “Just Culture” guidelines. This recognises that human error can occur sometimes due to systemic factors and staff are supported to freely admit and learn from

errors, without fear of sanction. Investigations arising seek to understand why an error has occurred and take necessary actions considering any learning found. It does not preclude that staff can be held to account if, on investigation, there is evidence of negligence or misconduct. The latter are defined within Disciplinary Policies, which are underpinned by principles of proportionality and fairness.

64. Ana Sanderson noted that no systemic or organisational learning arose from either investigation nor was this presented by Steven Miles in his statement of case in either hearing. Within the first disciplinary hearing, he identified his own specific learning and responsibilities to take action to prevent circumstances arising where errors could occur and that he accepted responsibility to address this. Ana Sanderson found that gross misconduct had occurred. A sanction she could have applied was one of dismissal. However, she applied what she regarded as a proportionate sanction of a final written warning to give Steven Miles an opportunity to improve, in light of the personal responsibility he took. He accepted this decision and he did not appeal it.

65. At the second disciplinary hearing, misconduct was found. In line with "Just Culture" principles and the RDASH disciplinary policy, Steven Miles was again held to account. Given the seriousness of the substantiated allegation (breach of confidentiality and distress caused to service users); a live sanction; repetition of breach of confidentiality despite explicit communicated expectations about maintaining confidentiality; and the requirement to escalate for support in task prioritisation, Ana Sanderson found that there was a loss of trust between the Trust and Steven Miles. She therefore felt that there was no other justifiable sanction other than dismissal.

66. The appeal hearing was a review rather than a re-hearing. Andrew Maloney, the appeal manager, held that a fair and reasonable process had been applied. While he determined that in his opinion this conduct did not actually amount to gross misconduct – and therefore Steven Miles was paid for his notice period – the decision to dismiss Steven Miles was upheld.

Submissions

67. Both parties made oral submissions at the conclusion of the evidence. The Tribunal has recorded those submissions in its notes of proceedings.

Relevant legal principles

68. The relevant legal principles in a complaint of unfair dismissal by reason of conduct are well-known, but bear summarising here.

69. The headline principles are: (1) What was the reason for the dismissal falling within the Employment Rights Act 1996 (ERA 1996) section 94(1) and (2)? (2) Was the dismissal for that reason fair and reasonable in the terms of section 98(4)? (3) Did the dismissal result from a fair procedure? (4) How did the Acas code of practice apply?

70. The question is whether the respondent acted reasonably and not whether the claimant suffered unfairness or injustice. The test is an objective one. It is not

for the Tribunal to step into the respondent's shoes or to substitute its judgment for that of management or by promoting what it might have done in these circumstances in place of what the respondent actually did. The test focuses upon how a reasonable employer might or would have behaved in these circumstances. That test is predicated on the range of reasonable responses available to a reasonable employer in similar circumstances. The Tribunal takes care not to adopt a "substitution mindset".

71. See *British Leyland (UK) Ltd v Swift* [1981] IRLR 91 CA; *Iceland Frozen Foods v Jones* [1982] IRLR 439 EAT; *Foley v Post Office, HSBC v Madden* [2000] IRLR 827 CA.

72. The test is based upon the set of facts or beliefs known to the employer at the time of the dismissal. Account is also to be taken of the size and administrative resources of the employer: section 98(4).

73. The importance of a fair procedure is underlined by the decision in *Polkey v AE Dayton Services Ltd* [1987] IRLR 503 HL. The *Polkey* principle emphasises the importance of a fair procedure involving a reasonable investigation and a fair hearing. The Acas code of practice also stresses the staged approach to a decision to dismiss, involving an investigation; informing the employee; inviting the employee to a meeting; affording the employee a right to be accompanied; making a decision; and extending an opportunity to appeal.

74. In a conduct dismissal, the well-known guidance in *BHS Ltd v Burchell* [1978] IRLR 379 EAT is to be accounted for. Did the employer have a genuine belief that the employee had misconducted himself? Was that genuine belief based upon reasonable grounds? Did it follow upon a reasonable investigation? Has the employer accounted for any mitigation? Has the employee's record and length of service been considered? Has the employee been treated consistently with other employees (in similar situations)? Is dismissal a proportionate sanction?

Discussion and conclusion

75. It is for the respondent to establish the reason for the dismissal of the claimant (ERA 1996 section 98(1) and (2)). The claimant does not dispute that the reason for his dismissal was a conduct reason – a breach of the respondent's information governance rules.

76. The Tribunal has no jurisdiction to revisit the 2018 breach, when the claimant left on his doorstep confidential information relating to three service users, for which the claimant was disciplined with a final written warning. It is, of course, relevant to the 2019 breach. The claimant accepted that the 2018 breach was a serious matter. He did not appeal either the disciplinary finding or the disciplinary sanction. At that time there was an opportunity for discussion and reflection. The claimant had received relevant training and that was renewed. He offered in mitigation his workload, but he accepted that there were steps that he could take to moderate the effects of his caseload.

77. Yet some few months later there was a second breach of the information governance rules, despite the earlier final written warning. When he left

confidential information relating to one service user in the house of another service user, it does not appear that he had learnt the lessons of the previous breach that he had undertaken to learn. He committed a second breach knowing that a repetition of such conduct would almost certainly result in his dismissal. The mitigation he offered did not differ materially from the mitigation he had already rehearsed at the time of the first offence. He did not demonstrate any of the moderating steps that had been discussed and agreed with him only a few months earlier had been followed. It is correct that he was distracted by the demands of his work, but those are the pressures under which all employees work and are expected to handle professionally. There was nothing surprising or unexpected about the circumstances in which the second breach occurred and nothing that the claimant could not have avoided had he taken the steps he had agreed to take as part of the debriefing from the 2018 breach.

78. The evidence suggests that Ana Sanderson weighed the claimant's plea of mitigation in the balance. Nevertheless, she could not ignore the previous reassurances the claimant had given her only a few months earlier. He had not availed himself of the opportunity of clinical supervision (which was for the claimant to seek rather than for the respondent to provide or arrange) nor had he sought the support of his line management.

79. The Tribunal accepts that it was reasonable in terms of section 98(4) for the respondent to dismiss the claimant only a few months after he had admitted a similar breach and had received a final written warning. It is not for this Tribunal to substitute its view (for example, by suggesting that the first offence warranted a first written warning and the second offence a final written warning), even if, as the appeals manager (Andrew Maloney) considered that the second offence did not amount to gross misconduct and warranted dismissal with notice rather than summary dismissal. The respondent's management acted within the range of reasonable responses available to it in these circumstances.

80. It is correct that the respondent was pressing a policy and practice of ensuring that the rules of confidentiality were abided by and that service users could be confident that their personal information and their confidentiality would be protected. There were wider reputational and regulatory risks for the respondent. The respondent's approach comfortably fell within the band of reasonable responses.

81. The claimant's position was that mutual trust and confidence in him had not been lost because when he was suspended at the investigatory stage he was allowed to work in triage. The respondent is right to respond that this is office-based work and presented no risk to a further breach of confidential information.

82. The Tribunal can detect no objectionable breaches of procedure or procedural failings. The only matter that might merit analysis was the refusal to admit new witness evidence at the appeal stage. The appeal was not a fresh hearing. It was a review of Ana Sanderson's disciplinary hearing. It was not an invitation or opportunity to present new evidence that had in any event been available at the time of the disciplinary hearing. That evidence – which in any event did not serve to suggest that there had been no misconduct, but which sought to place

the claimant's breach in a wider context – should have been brought at the disciplinary hearing.

83. Turning back finally to the issues that the Tribunal identified at the commencement of the final hearing. The decision to dismiss the claimant was taken at the correct level and with the correct authority. The severity of the incident for which the claimant was dismissed was correctly graded. There was no procedural irregularity in the refusal to permit witness evidence at the appeal hearing. The dismissal decision was based upon a correct understanding of the claimant's conduct. There was not a failure to apply NHS guidelines ("Just Culture") to the question of whether the claimant had committed misconduct. The claimant's previous record was taken into account Dismissal was a proportionate sanction even though (and not least because) the claimant was already the subject of a final written warning. Environmental factors (including workload demands and lack of clinical supervision) were taken into account properly or sufficiently. The claimant's mitigation was properly accounted for. The investigation did capture the evidence properly. The claimant was not the victim of a new emphasis on the security of confidential information. He was treated consistently with other employees.

Disposal

84. In summary, applying the test of fairness in section 98(4) to the respondent's reason for dismissal (conduct in the terms of section 98(2)) the claimant was fairly dismissed. His complaint of unfair dismissal is not well-founded. The claim is dismissed.

Judge Brian Doyle
Date: 4 July 2021

WRITTEN REASONS SENT TO THE PARTIES ON
28 July 2021

FOR THE TRIBUNAL OFFICE