Case number: 1805348/2022

EMPLOYMENT TRIBUNALS

Claimant: **Mrs L Denton**

Respondent: **Tees Esk and Wear Valleys NHS Foundation Trust**

Heard at: **Leeds**

On: **19-21 April and 19-20 July 2023**

Before: **Employment Judge Maidment (sitting alone)**

Representation
Claimant: **Mr J Jackson, Counsel**
Respondent: **Ms N Twine, Counsel**

RESERVED JUDGMENT

The claimant's claims of unfair dismissal and seeking damages for breach of contract fail and are dismissed.

REASONS

Issues

1. The claimant was employed by the respondent as a nurse and was dismissed, purportedly on the grounds of misconduct in the way she had handled a patient. She brings a complaint of ordinary unfair dismissal and separately one seeking damages for breach of contract referable to her period of notice.

Evidence

2. The tribunal had before it an agreed bundle of documents numbering 493 pages. Having identified the issues with the parties, the tribunal took time to privately read into the witness statements exchanged between the parties and relevant documentation. On the afternoon of Day 1, it heard, on behalf the respondent, from Mr Andrew Brace, ward manager, followed by Ms Karen Harrison, investigation officer, Nicky Scott, associate director of nursing, Chris Williams the respondent's lead for pharmacy services and strategic lead for medicines management, Mr Dominic Gardner, care group

director of operations and transformation and Mr Stephen Davison, nurse consultant in positive and safe care. The tribunal was unable to conclude all witness evidence by the end of the 3 days for which this case was originally listed. At the resumed hearing, it then heard from the claimant, followed by Ms Nicole Greenwood, regional officer of the Royal College of Nursing, who gave her evidence by CVP videoconferencing. On the second day of the resumed hearing, the tribunal received from both parties their written submissions and commenced deliberations having heard supplementary oral submissions from respective counsel.

3. Having considered all relevant evidence, the tribunal makes the factual findings set out below.

Facts

4. The claimant was employed by the respondent as a band 5 registered nurse, working on an acute male mental health ward, the Danby Ward, in a hospital in Scarborough. The claimant had commenced employment with the respondent in September 2016. She had an unblemished disciplinary record and was regarded by colleagues and the ward manager, Drew Brace, as a caring and dedicated member of staff.

5. Patient A was admitted to the ward on 5 November 2021 because his current placement had broken down and a new placement did not accept admissions at the weekend. He was due to be transferred on Monday 8 November but remained there until 10 November. However, the new placement was found to be unsuitable and Patient A was returned to the Danby Ward around midnight on 13 November.

6. Patient A was an adult male with autism and subclinical epileptiform disorder. He suffered from acute learning difficulties. He might become anxious which could result in physical aggression. At a previous placement, he had broken a carer’s collarbone and, whilst with the respondent, he had forced staff to retreat into a kitchen to ensure their safety.

7. The safety summary in place for Patient A, dated 13 November 2021, referred to a risk of retaliation from others when his behaviour escalated and a lack of awareness as to how his behaviours might affect others. He was unaware of dangers. He had been used to 1 to 1 support at all times and 2 to 1 support during the day from 11 September 2021. He had exhibited sexually inappropriate behaviours at a placement. Whilst on the Danby Ward, he had been noted to be verbally abusive, to spit at staff, throw objects and to kick and damage items.

8. The report noted that the environment on the Danby Ward was wrong for his needs, which could not be properly met there due to the high level of care required. Patient A exhibited behaviours which were of a similar nature to that of typical patients on the Danby ward, but with a different medical

reason for his behaviour. Mr Brace agreed that staff were more used to dealing with patients with mental illnesses, rather than learning disabilities. He accepted that it might take longer to communicate with a person with learning difficulties and require different techniques to be used to de-escalate a situation. Staff were trained to deal with disruptive behaviours, but were not specifically trained in handling those with learning disabilities. The claimant helpfully described some of the adult mental health patients as being men of few words, but more actions. In contrast, Patient A would talk non-stop. He couldn't, however, understand things and be reasoned with, for example, regarding the number of drinks he should have during the day or the time he was to get up. He had a mental age of 4½ years. The claimant asked the tribunal to imagine a 4½ year old child in a ward with adult men. Patient A was not capable of appreciating the risks around him.

9. On the other hand, from time to time, the ward did take patients with acquired brain injuries and patients known to be violent. The claimant accepted that there was always a mix of patients and each one had different triggers and individual care plans.

10. The claimant said and Mr Brace accepted that a low stimulus environment on the ward could not always be guaranteed, along with the staff to patient ratio. He accepted that ideally Patient A would not have been admitted to the ward and was to remain there only for so long as necessary. It was not unusual for a patient with learning difficulties to be placed in an acute mental health ward when there was no alternative available, but, again, it was not an ideal environment.

11. It was noted in the report that Patient A needed a consistent approach and for his Positive Behaviour Support plan "(PBS plan") to be followed. The claimant's PBS plan referred to him not coping well with sudden changes to his care arrangements and to change being a trigger for his autism. Mr Brace accepted that the claimant's arrival at the ward late in the night on 13 November 2021 could have been a trigger. Patient A needed a consistent team that knew him well and was able to focus on him. It was advised to create a low stimulus environment around Patient A if he appeared to be unhappy with noise or being in busy communal areas. This might involve closing curtains, putting meditation music on or encouraging others to leave the environment. There was an encouragement to start an activity within Patient A's view - if he at first appeared dismissive, he might eventually join in. When disruptive, there was encouragement to give Patient A space and time, step back and observe him.

12. It is noted that the claimant met with the respondent's Freedom to Speak Up Guardian on 26 October 2021 to report a patient safety concern due to the Danby ward being critically understaffed. Mr Brace was unaware of that. Whilst accepting that understaffing was a regular occurrence within the NHS, he did not believe that the staffing at the Danby ward had ever been critically low. The claimant raised on 16 November, shortly after the incident

with Patient A, concerns about where staff were situated, but without any reference to concerns about Patient A. The claimant said that she thought that it was sufficient to include her concerns in his patient record.

13. The Danby ward was typically staffed by two nurses and three healthcare assistants. There were also 3 members of management present during daytime hours on weekdays. On a Saturday there would be 2 nurses and 3 healthcare assistants present, with a duty nurse coordinator on the hospital site with oversight for the Danby ward and 2 other wards. Other healthcare teams were also based on the hospital site. That was the level of staffing on Saturday 13 November. The only male member of staff on the ward was LC. Those staff were responsible for 13 patients. Mr Brace agreed that this was challenging and, even more so, if there was a patient such as Patient A who needed 1 to 1 or 2 to 1 care. There was a possibility, in the case of a major incident, to trigger an alarm with the expectation that up to 3 members of nursing staff might come over from one of the other wards. That, however, depended upon availability. 2 of the staff on the neighbouring ward were pregnant at this time.

14. The respondent issued and operated in accordance with Guidelines for the Use of Physical Restraint on which staff were ("PAT") trained. The guidelines provided that staff were expected to only use physical holds which were approved and taught during their training. Staff were to adopt a graded response. Techniques available were put into a number of different categories. A restricted escort involved any restrictive hold where an individual is moved from one area to another regardless of the level of hold. A standing restraint was where a patient was restrained in a standing position. A seated restraint was where the patient was held in a seated position. A supine restraint was when a patient was held on their back and a prone restraint when in a chest down position. All taught techniques required patients to bear their own weight at all times and none of the approved techniques were to be utilised in the moving and handling of patients.

15. The respondent's witnesses all rejected any confusion in the policy suggesting, on one reading, that any restraint whilst the patient was walking was contrary to policy. The policy said that someone could be moved, but that none of the restraints could be used in moving and handling patients. Mr Brace ultimately accepted some confusion in the wording, but was clear that moving a patient under restraint was part of a permitted restricted escort. Staff were trained on this he said - they were taught how to use a restraint when moving a patient. He felt it was quite clear from the policy and training that when a patient was moving/being moved they must be weight bearing - able to walk and they may have to be taken under some form of restraint. He accepted that walking a patient under restraint could be more unsafe to staff than a patient on the ground. He said that if a patient did try to kick out at staff or go limp, then best practice was to guide the patient down to the floor. The tribunal does not accept that there was in

practice a confusion amongst staff because of the policy wording – there was a separate moving and handling policy relating to routine handling of patients in providing care for them. It was never part of the claimant's case that she handled Patient A in a particular way arising out of any such confusion.

16. Mr Brace expressed the view that, given that there was no scope for moving patients within the guidelines if they did not bear their own weight, in such cases, staff had then to wait for the patient to get up. If the patient was unwilling, staff were to continue to make an assessment of the situation. In circumstances where there was an imminent threat to the patient from others, the concentration would be on restraining the attacker. The potential victim being then moved to seclusion was said to go against everything the respondent practised in terms of not putting someone into exclusion because of it being an easier option.

17. The claimant told the tribunal that it was not her case that she had had insufficient training on handling patients, whether as a result of more truncated refresher training due to the coronavirus pandemic or otherwise. She accepted that clinicians of all disciplines undertook the same training. She understood the importance of PBS plans, that restraining a patient was a last resort to be used only when other methods failed, that the least restrictive restraints possible were to be deployed, only those approved as part of the PAT training, that the patient's dignity was to be maintained so far as possible and that de-escalation techniques were to be continued during any restraint. The claimant was clear that her knowledge arose primarily out of the training she had received rather than from reading any guidelines – she had not previously considered whether the restraints taught all involved a patient bearing their own weight. She had not read the policy though she accepted that it was her responsibility to familiarise herself with it.

18. An incident occurred on 13 November 2021 which involved Patient A being placed in involuntary seclusion.

19. Mr Brace had been informed about the seclusion on his return to work on Monday 15 November by Emma Cory, the duty nurse coordinator who had described it as a difficult episode, which the staff had managed well. Mr Brace completed a 72 hour rapid review on 18 November regarding the admission of Patient A and his subsequent seclusion. The tribunal notes that the seclusion area on the Danby ward was closed but a permission had been given for its use, if necessary, in the case of Patient A.

20. Mr Brace noted that the Danby ward provided limited support specific to Patient A's needs. The environment, having heightened Patient A's agitation, resulted in physical aggression leading to Patient A being placed in seclusion.

21. On 22 November, the claimant contacted Mr Brace and advised that she was not fit to work due to work-related stress. The following day he messaged her asking how she was and she replied: “It’s all just got stupid at work”. The claimant was signed off as unfit to work for 2 weeks.

22. On 24 November, Mr Brace received a message from the claimant stating she wanted to “whistle blow herself”. She was worried about the incident on 13 November and wanted Mr Brace to review CCTV footage and carry out an investigation. He tried to reassure her as he did not want her worrying about work. He said that he would review the CCTV, but that he could not believe that she would intentionally put anyone at risk. He got the impression from the claimant that she felt the use of seclusion for a patient with learning difficulties was wrong and that she was concerned about the management of Patient A going forward. He thought that he was being asked to view the CCTV footage to observe the presentation of the patient which had resulted in the use of seclusion.

23. On 27 November, the claimant contacted Mr Brace again saying that she felt uncomfortable about returning to work until the seclusion incident had been properly investigated. Mr Brace said that he would have a look at the footage next week saying: “But the bottom line on this is that the patient is safe and so are the staff. We deal with difficult situations on the ward and have to make quick judgements that are not always right. I believe that you would have never of done anything that would have intentionally put anyone at risk and that’s what’s important. Please don’t beat yourself up about this.” Mr Brace said that he wrote this without knowing the context which subsequently emerged.

24. Mr Brace did not think to prioritise the matter because he believed it had been handled well by the claimant. He felt she was being overly critical of herself. The claimant had not indicated that she had any concerns about the way in which Patient A was moved to seclusion, but rather his behaviour in the lead up to the decision to place him in seclusion. He did not, until later, review separate “Paris notes” completed by the claimant which described Patient A as being “slid to seclusion on his bottom” until 2 December. Mr Brace, in cross-examination said that, having subsequently seen the CCTV footage, it was more accurate to describe Patient A as having been “dragged” rather than “slid”.

25. At a leadership meeting on that day, Mr Brace raised concerns about the claimant’s well-being. The view of the team was that the claimant was suffering from distress and most likely being over critical regarding what had happened. There was no concern at this time that she had put Patient A’s health at risk. It was agreed that Mr Brace would view the CCTV footage.

26. He viewed the footage that afternoon. Mr Brace described himself as shocked to see the use of a dragging technique in moving Patient A. He also felt that Patient A was clearly identifying that he wanted to be left.

27. The tribunal has been shown footage from 2 separate cameras. The footage shows that, shortly after 3pm on 13 November, Patient A walked into a corridor on the ward. He was being supported by the claimant and a colleague, JS. A further staff member, CW, was also in attendance. The claimant then went to the floor and shortly after they were all joined by a male colleague, LC. Patient A started to hit out at staff when they moved closer to him. He moved so that he was sat with his back against the wall. At this point, the claimant tried to grab his arm, but Patient A resisted. LC moved forward to take the patient's left arm and JS took his right arm. The claimant then moved in front of Patient A and took hold of his left ankle. She then started pulling/dragging him down the corridor by his ankle/foot.

28. The tribunal notes that this occurred within in a short space of time (it was around 50 seconds from patient A going to ground and him being moved) and without any evidence of any form of communication by the claimant to her colleagues or Patient A, albeit there is no sound on the footage.

29. Patient A was then pulled/dragged along the floor, around a corner and through a set of doors into the seclusion room. Whilst being moved, only Patient A's bottom was on the floor. The moving of Patient A lasted around 25 seconds.

30. Mr Brace's immediate conclusion, on viewing the CCTV, was that the manoeuvre adopted by the claimant was not an appropriate way to move a patient. It was not a known technique, was undignified and placed, he felt, Patient A at risk. He reported what he had seen to the modern matron who advised that he reported it to the locality manager and head of service. Mr Brace was instructed to complete a second 72 hour review. In this, he described how he had had no initial concerns, with the focus of the initial view being on the placement of Patient A on the ward. He recorded that he had not been aware of the improper use of restraint. He recorded that, prior to seclusion, Patient A had placed himself on the floor and was transported to seclusion on the floor with the use of inappropriate handling techniques i.e. in arm holds on the floor which was against the Use of Physical Restraint Techniques policy. He recorded that the claimant, as the staff nurse on duty and in charge, had contacted him reporting a concern regarding the incident and had requested for it to be reviewed.

31. Mr Brace accepted, before the tribunal, that the claimant had been in a difficult situation. He did not think that she had intended to harm Patient A. His own view was that a member of nursing staff should never drag a patient and that such an incident was always going to end in an investigation and an employee dismissed due to gross misconduct. He had never known such

behaviour in all the time he had been a nurse. His view was that the use of any form of movement of a patient who was not bearing his own weight could only be if there was an imminent risk to life and that was not the case in Patient A's situation. Mr Brace accepted that he had not viewed other footage which might have shown what had occurred prior to the incident. He did not personally feel that he needed to have seen more footage to reach a view.

32. The tribunal has also heard from Mr Davison, who is the respondent's expert in safe restraint techniques and is involved in devising relevant training. He was not, however, involved by the respondent until after the claimant's appeal and prior to the appeal outcome being issued. He had been aware of a concern, but had not previously viewed the CCTV.

33. Mr Brace showed the CCTV footage to Ms Nicky Scott, then Locality Manager. She prepared a preliminary assessment which was submitted to a preliminary assessment group, including a representative from HR. Ms Scott held a video meeting with the claimant, who was accompanied by her RCN union representative, on 11 February 2021. Ms Scott explained that the claimant was being placed on non-patient facing duties as an alternative to suspension regarding the incident on 13 November, that the allegation was serious and would be formally investigated. If proven, it would amount to a breach of the respondent's policies and could result in her dismissal for gross misconduct.

34. Karen Harrison is employed by the respondent to carry out investigations. She was appointed to investigate an incident of alleged inappropriate handling of Patient A by the claimant. She reviewed the CCTV footage, the Paris case notes, Patient A's PBS plan and initial statements of LC, CW, JS and Mr Brace. JS referred to another patient being prevented from attacking Patient A – she referred to Patient A being "threatened literally just before the restraint." She interviewed the claimant on 25 February 2022. The claimant was accompanied by her union representative. The claimant was upset when viewing the CCTV footage. She said that she had had no recollection of taking hold of the patient's leg in that manner.

35. Ms Harrison produced then a report on 10 March setting out her findings. She was aware that the claimant had switched on her bodycam before the incident, but unfortunately no viewable recording had been made due to a technical issue. The tribunal accepts that no recording was ever available, in the absence of any evidence to the contrary She agreed that the claimant's actions in turning on the camera showed transparency on her part. She did not agree, when put in cross-examination, that it would have been relevant to see earlier and different camera footage if it had shown another patient seeking to attack Patient A. Ms Harrison explained that her inquiry was about unsuitable handling and it would not have been appropriate, if Patient A had been under attack, to move him in this manner. Witnesses had said that Patient A had been under attack – they were all

saying, said Ms Harrison, that the attack had happened "just previously" – there was, therefore, no need to view CCTV footage to come to that conclusion. For her, Patient A being under attack was part of the context, but not a rationale for the claimant moving Patient A as she did. This had not been the claimant's rationale at the time for how she moved Patient A.

36. The tribunal notes, at this stage, that there was inconsistent evidence as to why additional CCTV footage was not disclosed to the claimant. It would have been available for around 2 months after the incident, but was then automatically deleted.

37. Ms Harrison noted that Patient A was in a very confused state when admitted to the Danby ward. The claimant had told her that she had familiarised herself with his PBS plan. She noted that the claimant had recorded in the Paris notes that Patient A was shouting loudly, banging doors, spitting at staff, hitting them and throwing objects, as well as biting his own hand, swearing and being hostile. On viewing the CCTV footage, she considered that the claimant appeared to be trying to encourage Patient A to go to seclusion and JS had confirmed that the claimant had offered him time in his bedroom. She noted that they had Patient A in approved arm holds before the claimant moved in front of him and took hold of his left ankle. She noted that the claimant's explanation for her doing so was that JS and LC were at risk of injury. It had been the intention of JS and LC to place Patient A in approved arm holds and walk him into the seclusion room. JS, LC and CW stated that they were surprised at the claimant's actions, but said that there was no time for them to react. CW stated that she was uncomfortable with what was happening - she followed her colleagues, but made a conscious decision not to put her hands on Patient A. The claimant had confirmed that she had made the decision to take hold of Patient A's foot "on the spot" and that the other members of staff would have been unaware that she was going to take this action. She did not communicate her decision to her colleagues or Patient A in advance.

38. Ms Harrison noted the respondent's guidelines stating that physical restraint should be recognised as a last resort to be considered only when all other practical means of managing a situation, such as de-escalation, distraction or consented medication administration, had failed. She noted further that a patient's well-being and dignity should be maintained and that the patient should bear their own weight at all times. The claimant, she reported, had not considered that the guidelines applied to the situation because the plan was not to restrain Patient A to place him in seclusion. The claimant also said that the procedure was written for people with acute mental health impairments and not people with learning disabilities in an unsuitable environment.

39. Ms Harrison accepted in cross-examination that she should have interviewed Mr Davison about PAT training. She believed that he had been

involved when the matter was referred at an early stage to Ms Scott, but could not give any detail.

40. Ann Marshall, deputy director of nursing, decided on receipt of the report that there was a disciplinary case to answer and Chris Williams, the respondent's lead for pharmacy services, was appointed to conduct a disciplinary hearing. Whilst others attended, as part of a panel, in an advisory capacity, he was the sole decision maker.

41. He wrote to the claimant on 13 April inviting her to a video hearing on 3 May. He explained that he would be accompanied by Ms Ahmed of HR and Ms Weddle, nursing adviser. Ms Harrison would also attend to present the management statement of case. The claimant made a request to record the hearing which was denied due to lack of approval from Information Governance to record video hearings at that point in time. Only brief notes were taken of the hearing and were provided to the claimant subsequently, only as part of the tribunal disclosure process.

42. During the hearing, there was a review of the CCTV footage and the claimant was given an opportunity to explain what had happened. She said that the plan was to move Patient A as quickly as possible and as gently as possible. She wanted to get him into the seclusion room, because it was a less stimulating environment. She was also concerned that Patient A had upset another patient who had tried to attack him. When Patient A went to the floor, the claimant had initially stood back to give him space. Ms Weddle observed that there were 3 members of staff present with Patient A sitting on the floor, his back to the wall, such that there was no immediate threat to the safety of anyone present. The claimant argued that a threat could arise in an instant.

43. The claimant explained that she had not activated an alarm because more people attending the scene would not have helped the situation. Patient A had told CW to go away and lashed out at her. This caused CW to step away out of reach and it was at that point which the claimant decided she needed to get Patient A into seclusion as quickly as possible. The claimant said that Patient A was deprived of sleep and she needed to move him immediately out of the overstimulating environment.

44. When asked why she used this particular method to move Patient A, the claimant said that she was aiming to get him from point A to point B as safely as possible. She accepted, however, that the action had been undignified and ungainly. The panel noted that Patient A's right leg was sticking out to the side with a risk of it colliding with the walls or doors. The claimant accepted that Patient A could have been hurt and the pressure placed on his arms and shoulders was not appropriate. The claimant said that this is why she had asked for the placement of Patient A on the ward to be investigated, but she had been shocked that the focus of the investigation

was on her actions rather than the placement itself. Mr Williams told the tribunal that this gave him the impression that the claimant did not understand that she had done anything wrong.

45. JS gave evidence to the panel. She explained that Patient A's behaviour had been difficult and was escalating. They were trying to de-escalate the situation, but he was becoming more agitated. His behaviour was causing upset to other patients. Another patient tried to attack him. Whilst they knew seclusion was an option for Patient A, that was not the intention at that moment. JS confirmed that the decision to try arm holds had been verbalised to Patient A in advance. JS and LC had held his arms with the purpose of preventing him from assaulting staff rather than to move him to seclusion. When the claimant had taken Patient A's foot and started moving him towards seclusion, JS was unable to let go of his arm because he could have fallen backwards and caused injury to himself and members of staff. JS said that none of the staff had been trained in learning difficulties or autism and that they had not worked with anyone with those complex needs. She also stated there should have been more staff present who could have helped

46. Mr Williams was of the view that there were enough staff working there at the time and there was an option, which had not been taken, to call the duty nurse coordinator. Mr Williams noted that some of the staff were not PAT trained. The claimant raised that none of the staff had received Non-Abusive Psychological and Physical Intervention (NAPPI) training. He told the tribunal that this form of training had not been approved by the respondent.

47. The panel then heard from LC who said that, in his view, the ward was not suitable for Patient A and that he had not been trained to deal with patients with learning difficulties. He was up to date with PAT training. LC said that, at the time, the action taken had felt necessary, but, on reflection, he had concerns about what had happened.

48. CW when interviewed described the action as "restraint", but that it had not been planned or communicated. She felt uncomfortable with what had happened. On reflection, she felt the patient should have been walked to seclusion using appropriate handling methods. She said that following the incident, people involved appeared upset by what had happened.

49. Ms Weddle asked the claimant about her request that the incident be investigated and what specifically she wanted to be investigated. The claimant said that she wanted the whole thing to be investigated. She acknowledged that the way in which Patient A had been moved to seclusion was not ideal, but that he should not have been admitted onto the ward in the first place. She believed that there should have been a recognition that it had been inappropriate having Patient A on the ward and she was shocked to find that her conduct was the only subject of the investigation.

50. The claimant was further questioned as to why it was felt necessary at that moment to quickly get Patient A into seclusion. The claimant said it was not the first time that he had put himself on the floor and another patient had threatened to assault him. The claimant said that "in a moment of madness" she picked up his leg. She felt it was the safest option to move him to seclusion at that time.

51. The claimant provided a number of statements from colleagues in support of her. The panel, however, felt that there seemed to be a misconception evident within them that the claimant was being punished for alerting the respondent to her conduct.

52. The hearing was adjourned and reconvened on 4 May. Mr Williams told the claimant that the outcome was her dismissal. The decision was confirmed in writing on 10 May 2022. He took into account that Patient A was not typical of the patients usually cared for on the ward. It was recognised that this would have created challenges and was not ideal. However, this was not the first time that an admission of that type of patient had been made to the ward. Caring for Patient A had been difficult. However, a PBS plan had been provided for him and the claimant had a good understanding of many aspects of the plan. She had completed PAT training and refresher training during her employment. She should have understood how to safely use restraints and how to apply the PBS plan and support people in distress. The act of moving Patient A to seclusion had taken approximately 25 seconds in which time there was ample opportunity for the claimant to reflect upon the inappropriateness of her actions and stop the manhandling of Patient A. Mr Williams found that the claimant had endangered Patient A's physical health and safety and he was likely to have been traumatised by the process of being dragged along the floor on his bottom against his will. The duty nurse coordinator was on site, but had not been called on for support. Also, immediately prior to the incident, Patient A did not appear to be in danger and was not posing a threat to others. The claimant had instigated the mishandling by taking hold of Patient A's leg. There was no communication to her colleagues - JS and LC had no option but to move with the claimant. If they had let go of him, that would have put him at risk of physical injury. The claimant's actions were in breach of guidelines.

53. Mr Williams noted that in the claimant's statement, which she read out at the hearing, she expressed remorse, but Mr Williams did not feel he had seen any evidence of that at the hearing. She repeatedly demonstrated to him that she did not understand the seriousness of her actions and he was not reassured that she had genuine remorse or took responsibility for her conduct. He was not, therefore, reassured that there would not be repetition of this behaviour in the future.

54. Mr Williams said in cross-examination that he felt that the claimant was dismissive of the options such as using the alarm for calling the nurse

coordinator. If the claimant had been concerned about another patient attacking Patient A, there was no indication of any consideration of ringing the alarm or calling for the duty nurse coordinator. Whilst, to her credit, she took responsibility for the decision making rather than seeking to place it on other staff working that day, she did not say at any point that grabbing hold of the patient's leg was wrong and she would not do it again. She was more upset that the focus of the enquiry was on this part of the process and the seriousness of the claimant's actions over a period of just 25 seconds. Whilst there was an expression of remorse in the statement she read out, he did not feel that it was expressed during the hearing. He did not accept that it was more difficult to get across one's feelings in a video hearing. He accepted that the claimant was clearly upset during the hearing. He accepted that it was plain that the incident had affected her greatly. However, anyone within a disciplinary situation would feel a significant emotional response and it would be common to be upset. Mr Williams said that he appreciated that raising systemic issues was not inconsistent with the claimant being individually remorseful for her own actions. He had given the claimant credit for having brought the incident to Mr Brace's attention in the first place

55. Mr Williams said that he had taken into account the character references. He did not dispute that the claimant had not gone out of her way to harm patient A - that was not her intention. However, that did not mean that her actions were not deliberate. He considered that the training and experience provided and possessed by the claimant should have allowed her to understand that it was not appropriate to drag someone across the floor for a protracted period of time.

56. Mr Williams did not believe that, after the disciplinary process, the claimant was better placed to understand the inappropriateness of her actions and with further training could be retained in her employment. He said that others involved in incident clearly recognised from their own training that the claimant's actions were inappropriate. When it was put that the statements of the witnesses to the incident differed from one to another, Mr Williams' view was that no one was saying that the way in which the patient was moved was appropriate. He accepted, however, that the claimant had not stated that she had done the right thing. Nevertheless, he was not sure that this would not happen again.

57. Mr Williams had not considered it necessary to obtain any further information from Mr Davison. He felt the nursing adviser sitting with him, Ms Weddle, was able to give relevant advice.

58. Mr Williams' decision was that the inappropriate physical intervention was so serious as to amount to gross misconduct. The most appropriate course of action would have been to continue engaging with Patient A and use techniques to de-escalate the situation for as long as was required. Alternatively Patient A could have been supported to his feet using

approved arm holds as the claimant's colleagues were doing at the time she took hold of his leg. The appropriate sanction was dismissal without notice. The claimant was given the right of appeal.

59. Mr Williams was taken, in cross-examination, to the outcome letter and omissions within it. He said that despite no reference to it, he had given the claimant credit for her transparency in turning on the body cam. He was aware of and considered her clean disciplinary record. He appreciated the differences between communicating with someone with poor mental health and someone with a reduced mental age. He understood that communication with the latter was likely to take longer. He understood that Patient A was not typical. He understood that the environment he was placed in was not optimal. Patient A, he recognised, disliked change and needed a consistent team. He had been used to 1 to 1 or 2 to 1 care. There was a need to create a low stimulus environment. He rejected the proposition that he had downplayed those differences. He also maintained that he took into account all mitigating factors. It would have been useful if the claimant had received specific training regarding handling those with learning difficulties. He believed that the claimant was up-to-date with her training, but it would have been something to be considered if she hadn't been. He appreciated that, during the coronavirus pandemic, training had not been as extensive as would ordinarily be the case. Mr Williams noted that the claimant was saying that the incident she was faced with was not something which had been covered in training in any event. He was aware that there was no technique for moving someone who was on the ground and refusing to comply. The tribunal accepts Mr Williams' evidence as to those matters in his mind and considered in determining the disciplinary sanction. It is unsurprising that not everything considered was noted in the outcome letter, particularly those matters which were no considered ultimately to be material to his decision making

60. Mr Williams had considered but rejected any consideration of an alternative role for the claimant.

61. When suggested that Patient A would still have to be moved in circumstances of imminent threat, Mr Williams said that he knew that the patient was not under such threat. He believed that you could see from the CCTV footage that there wasn't an imminent threat of attack. There was no one else on the video and no indication from those around the patient that anyone else was in the vicinity. They were all clearly focused, he said, on Patient A. None of the staff had described that, if they had not moved the patient in the next minute, there would have been a threat. He was not dismissing that there had not been a threat towards Patient A in the lounge, but he disputed that what had occurred there represented an imminent threat which would cause the claimant to move Patient A as if there was an imminent threat to his life. There might have been an imminent threat of attack in the lounge, but in the corridor, with 4 employees standing around Patient A, the risk had changed. He described how a different reaction might

have been justifiable if there was another patient looming over Patient A and the only way to get him away from a punch or a knife attack was to drag him. That was not, however, what was happening. Patient A was on the floor with the staff around him. There was no patient creating a threat at that time.

62. Mr Williams accepted that there was no direct evidence of Patient A being traumatised by what had happened and no evidence of physical harm of which he was aware. He agreed that his comment regarding being traumatised was an assumption.

63. The claimant notified the respondent of an intention to appeal on 13 May 2022 and Ms Greenwood of the RCN provided grounds of the appeal on 23 August.

64. The appeal took place on 24 October 2022 chaired by Mr Dominic Gardner, care group director of operations and transformation. The panel also included Elspeth Devanney, group director of nursing and quality. The claimant was accompanied by her union representative. Ms Harrison attended to present the CCTV footage and answer questions about the investigation and Mr Williams to explain his case for dismissal. LC and JS were available to attend as witnesses, but were not asked to attend in circumstances where nobody had specific questions for them.

65. Ms Harrison was asked why she did not consider the appropriateness of the seclusion and whether there was a threat to Patient A. Mr Williams explained that the decision to move Patient A into seclusion was not within the remit of the investigation. Mr Williams observed that if there had been a threat to Patient A in the form of another patient, that individual was then in the lounge area and separated from Patient A by a set of doors – the tribunal appreciates that the doors leading to the corridor where Patient A was sat were open. Mr Williams continued that there were no other patients visible on the CCTV footage and the panel had been satisfied that there had been no immediate threat to Patient A. The claimant was concerned about the lack of CCTV footage available. The panel was told that it had not been considered to be proportionate to watch all of the CCTV from the shift. Mr Gardner had no reason to doubt this had been a challenging shift and that Patient A was displaying challenging behaviours. It was noted that the claimant had turned on her body cam, before the incident, but the recording had not worked. The CCTV footage for the rest of the shift had not by this point in any event been retained. The claimant said that she had not completed a Datix incident report following Patient A's seclusion, because she did not consider that she had done anything wrong by grabbing Patient A by the ankle.

66. The appeal panel did not believe that there was an immediate risk as the patients were in a separate area. Ms Devanney questioned whether the

attempts to de-escalate the situation had been adequate as the CCTV footage showed Patient A sat on the floor for only around 1 minute before he was taken away. The claimant said that the situation had been going on for hours by that point. The claimant confirmed that she did feel her action was an appropriate attempt to de-escalate the situation and that she should have done it earlier. Her view was that 1 minute was adequate time for her to attempt to de-escalate the situation. The panel did not agree.

67. The claimant said that she had asked for the CCTV footage to be reviewed as a patient with learning difficulties should not be placed in seclusion. The first time she knew that she had acted inappropriately, however, was when Ms Harrison told her it was not okay to move a patient if they were not able to bear their own weight. The claimant said she accepted responsibility for her actions. She queried whether Patient A should have been allowed to reach the level of distress he did and whether that ought to have been investigated. The claimant said that her training was up to date, but the guidance did not apply as this was not a case of restraining a patient, but of moving him from one point to another. The HR representative advising the panel asked how the claimant could convince them that this would not happen again. The claimant responded that, going forwards, a patient with learning difficulties should not be on the ward and, if they were, they would not be in the same level of crisis. Mr Gardner told the tribunal that this did not reassure him that the claimant would not act in the same way.

68. At the conclusion of the hearing, Ms Greenwood said that the investigation had not been balanced, as weight was not given to evidence which supported the claimant, namely the CCTV footage of the rest of the shift, the fact that the claimant had reported the incident, the failure to consider how seclusion should have been used and the fact that Patient A was an atypical patient and staff had not been trained to deal with patients with learning difficulties.

69. Mr Gardner wrote to the claimant on 31 October dismissing her appeal. The specific allegation against the claimant had been that she had inappropriately handled a patient. It was that allegation which needed to be and was investigated. There was no reason to widen the scope. The claimant's view was that she should not be punished, because she had inadvertently brought the matter to the respondent's attention. The panel disagreed.

70. The head of nursing for North Yorkshire had conducted a further review and found no link between the concerns the claimant had raised and disciplinary action taken against her.

71. Stephen Davison, nurse consultant in positive and safe care, had also been asked on 28 October 2022 by Ms Devanney to review the CCTV footage – after the hearing and before the outcome letter. Part of his role was to

arrange for the provision of training to staff in patient handling. He supported the director of nursing in fulfilling her legal responsibility under the Use of Force Act for people in mental health units. He concluded that the techniques used to transfer Patient A could have put him at significant risk of injury. He was placed at risk of burns. By holding one of his ankles, the claimant also put herself at significant risk as Patient A could have kicked her in the face. He could see no evidence that any attempts were made to use the taught techniques. He explained that training provides staff with the skills to move a distressed patient to a standing position safely and it is only once this has been achieved that the patient should be assisted to walk. If that cannot be achieved, then staff stay where they are until there is a change in behaviour which will allow a safe transfer. He thought it would have been helpful if staff had, from a safe distance, come down to Patient A's eyelevel. Standing over him at such close distance would have likely exacerbated the issue. From the CCTV footage, it was not clear to him what de-escalation or diversion strategies had been used. Mr Davison had not spoken to the claimant nor seen the witness statement of others.

72. Mr Davison explained to the tribunal that the guidelines already referred to were those relevant for patients in distress or non-compliant. They were not the same as the more general guidelines regarding manual handling of patients. The guidelines represented a component part of the information and techniques to help nurses respond to incidents. A separate policy sat alongside it regarding Supporting Behaviours that Challenge. There were other policies on different types of restrictions, including the use of tranquilisers. He said that staff were expected to use the techniques set out in the guidelines and not go beyond them. Restraint techniques could be used to move patients including arm holds. Effectively a standing restraint involved one employee on each of the patient's arms. This became a restricted escort when the patient started to move. It was the same hold, but for a different purpose. However, the patient bore their own weight at all times. Mr Davison accepted in cross-examination that a natural reading of the guidelines suggested inconsistency with a restricted escort and arm holding. However, restricted escorts and how to conduct them was covered in training. None of these techniques were used for lifting a patient. The suggested inconsistency was not something that had ever been raised by anyone in the respondent's internal reviews. He believed that every healthcare professional understood what the guidelines meant. The tribunal has made a finding on this point already.

73. Mr Davison recognised that situations would occur which could challenge the applicability of the guidelines. However, the techniques needed to be carried out as taught, as that was the safest way for the respondent's patients. When staff were taught, they did look at the legal considerations involved and the concept of reasonable force. Staff were required to conduct a continual appraisal of a situation of risk which was not always static. He recognised that nurses needed to make rapid clinical decisions. A patient should never be moved if that was not necessary. A patient could not be moved on the ground. He agreed that moving someone on their feet

could make it easier for a patient to attack staff, but said that risk was significantly reduced if the patient was in an arm hold and the training given to staff on the appropriate position to stand in mitigated against such risks. If there was a decision to seclude a patient, there was still a need to consider the safety of doing so and a duty to transfer the patient safely. He recognised that this could be a long process involving a patient sitting down before a situation could be de-escalated and the patient then voluntarily standing.

74. Mr Davison was asked in cross-examination what ought to be done if there was an imminent threat to one patient from another. In such circumstances, there would be a need to consider how to deal with both patients. In a difficult situation, there might be a need to call for the assistance of others, but he would expect any nurse to seek advice. He conceded that sometimes it might not be possible to have the luxury of waiting. The test, in terms of departure from trained techniques, would be whether there was genuine imminent risk to life. The bar was as high as that. If you did not use the right restraints, you could break limbs or cause dislocations and it was a significant matter to put a patient at such a risk. There might be such a level of risk which required a move of one patient away from another outside of the guidelines. Mr Davison recognised that that could occur, but it would usually be a situation where the ward called the police first. A major consideration would be the issue of how to deal with the aggressor. Seclusion was about a patient who was an immediate risk to those around him. The patient who was threatening violence more clearly met the threshold for seclusion. In the example of a fire, Mr Davison said that an imminent risk to life could clearly be demonstrated and removing a patient from the area would fall into the category of treatment that was legally proportionate and necessary. However, they would still have to use the least restrictive means and the question came back again to whether there was a clearly defined imminent risk.

75. Mr Davison confirmed that a process of de-escalation could go on for a number of hours. The situations could be challenging and complex and become part of a wider operational discussion included in terms of staff resources. On the basis of the CCTV footage, he did not feel that there had ever been a need to move Patient A. If there had been a need, the reasonable expectation would have been to seek to attempt to use an arm hold and restricted escort.

76. Mr Davison described the PAT training on handling techniques to involve a 5 day introductory course with a 3 day annual refresher. He agreed that the length of annual updates had been reduced during the coronavirus pandemic. His evidence was that respondent was one of the few trusts which had kept on providing this training during the pandemic.

77. The panel rejected the claimant's argument that she did not believe the dismissal was a possible outcome because the disciplinary hearing had not

been recorded. The potential outcome was made clear in earlier correspondence.

78. The appeal panel did not notify the claimant of the advice sought and received from Mr Davison. The panel regarded Mr Davison as confirming what it already knew and providing a useful further opinion, but nothing which impacted on or caused it to review its reasoning.

79. The appeal panel agreed with the disciplinary panel's conclusion that there was no risk of attack immediately before the incident. They were satisfied that there were no other patients in the immediate vicinity immediately before the incident. There had been ample opportunity to give Patient A time and space while continuing to engage with him and give thought as to how to deal with the situation. They were not persuaded that there was an urgent need to take action at that moment. They acknowledged that Patient A's admission to the Danby ward was not ideal, but this was not unusual. It was the claimant's responsibility, as the nurse in charge, to ensure that all patients were treated with dignity and respect. That had not happened. The panel was satisfied that Mr Williams had been aware that he could issue a sanction less than dismissal. The claimant's handling of Patient A could have resulted in an injury to him and to the claimant's colleagues. The panel considered that her actions amounted to ill-treatment or physical abuse of a patient. They noted that, when the claimant was asked regarding how she would react in the future, her initial response was that she would ensure that there were no learning disabled patients on the ward. However, this would not be within the claimant's power to prevent. Only then the claimant had backtracked and said that she would escalate the matter to a more senior member of staff. The panel did not consider that she consistently conveyed a recognition of her actions being wrong and placing Patient A at risk. The panel was unconvinced that she understood that what she had done was wrong. The claimant said at the appeal that she was deeply sorry for picking up patient A's leg. However, in the overall context of the hearing, Mr Gardner was not reassured how the claimant might act in the future or that an alternative sanction would safeguard patients. Safeguarding patients was paramount and it was believed that the claimant's actions amounted to a significant breach of her duty of care. The panel did not feel that the claimant could be reinstated and issued with a final written warning as this was not appropriate given the gravity of her conduct and her lack of insight into the seriousness of her actions. The panel was confident that the disciplinary panel had made the correct decision.

80. In evidence to the tribunal the claimant said that the PBS plan was not fit for purpose in the Danby ward setting and ought to have been adapted to the facilities there. The staff, including herself, had been trying to de-escalate Patient A all day long, but there were constant fluctuations in his mood.

81. Patient B had attacked Patient A in the lounge. Patient A had been moved out of the lounge, because of the threat Patient B posed. Patient B was a

large and strong adult male who, the claimant thought, was capable of clearing a lot of ground quickly. He had followed them out of the lounge area and she had de-escalated him and asked him to stay where he was. She accepted that the steps she had taken to de-escalate Patient B had reduced the level of threat. However, she considered that her success in doing so might be short-lived. They had no way of knowing what Patient B was going to do. He had stopped following them, but the imminent threat was still there. It was more dangerous to have shut the doors through to the corridor, as she was concerned that Patient B could burst through them and knock Patient A with the doors.

82. This attack had occurred up to 60 seconds prior to Patient A placing himself on the floor, having been escorted from that area. The claimant agreed that at the time they were seeking to persuade Patient A to get up off the floor, Patient B was not in the corridor. She knew that he wasn't due to her positioning and was able to see that he was not there. However, she did not consider that made him any less of a threat.

83. She said that, when she attempted to take hold of Patient A's right arm, she realised how heavy he was and that the two healthcare assistants at each side of him would not be able to raise him to an upright position. It was at that point, she said, that she immediately took hold of his ankle and started to move him. She believed there to be a direct and imminent threat to him, so it was appropriate to remove him from the immediate risk.

84. She described doing so as the worst moment of her career - it was a moment of madness, but one which could just as well be described as a lightbulb moment. She responded "in a moment" to provide the best possible outcome. As she was pulling Patient A by his ankle, she was looking at him and talking to him. She accepted that this manner of movement was undignified for him. She accepted that the way he was moved was likely to have caused some distress to him. However, she took the decision to override his choice in his own best interests, to get him to a place of safety.

85. The claimant described having had her own experience of where a colleague had nearly died as a result of a patient attack, saying that had a bearing on how she thought she needed to act to keep Patient A safe. She denied that there was any loss of patience, saying that they were "designed" to go 13 hours without losing patience. She didn't like to think what the outcome could have been if Patient B had attacked Patient A. She did not want to explain why a patient had died, just because she had thought that she had sufficient time to de-escalate a situation. If there had been attack by Patient B, she would have put herself between him and Patient A, which is what all the staff would have done unless they had frozen, which had indeed been an issue with some of them in the past. One of those in attendance had frozen when sexually assaulted by a patient and another had a metal plate in their face due to a patient incident. Another member of

staff in the area, EC, who the claimant accepted could not have added any useful information as part of the investigation, had just been moved onto the ward on that day and was very frightened there. The claimant described her as spending most of the time “hiding”, having been hurt by Patient A at some point during the day.

86. The claimant accepted that she did not release her hold on patient A, for instance, once they had moved him round the corner. She said that they were transporting him to seclusion and with every step they got closer to that goal and away from the threat. She did not think Patient A was being hurt, so he was unsure what a change in approach would have achieved. The situation would have been different if one of her colleagues had been losing their grip on Patient A or if Patient A had said that he would stand up.

87. She agreed that she shouldn’t have handled Patient A as she did. It was not something she said that she had wanted to do. She said that she had not been specifically told in training never to move a non-weight bearing patient. The technique she had used to move Patient A was not something she had intended to do (in advance of the move).

88. The claimant said she reported the incident, not because she knew that she had handled Patient A in an incorrect manner. She had put someone into seclusion who was there for around 22 hours. She was instrumental in that and was upset by the situation. She was upset by the stress of what had happened to Patient A and management not investigating how such a situation had been allowed to develop. She didn’t think she had done anything wrong, but the way Patient A was treated was undignified and no one with a learning disability should be put in seclusion. She had switched her body cam on and wouldn’t have been recording the incident if she felt she was doing anything wrong. She believed that she had responded to a threat which she believed to be imminent, but still felt that the situation was so bad that there ought to be an investigation. She was seeking a solution to avoid such circumstances arising again.

89. She felt that the respondent needed to have conducted a wider investigation into how she had been faced with the dilemma involving Patient A and how that could have been avoided. She wanted to be shown a way in which she could have dealt with the situation better. Those who had judged her were making assumptions without having reviewed all available CCTV footage.

Applicable law

90. In a claim of unfair dismissal, it is for the employer to show the reason for dismissal and that it was a potentially fair reason. One such potentially fair reason for dismissal is a reason related to conduct under Section 98(2)(b) of the Employment Rights Act 1996 (“ERA”). This is the reason relied upon by the respondent.

91. If the respondent shows a potentially fair reason for dismissal, the tribunal shall determine whether dismissal was fair or unfair in accordance with Section 98(4) of the ERA, which provides:-

    " [Where] the employer has fulfilled the requirements of subsection (1), the determination of the question whether the dismissal is fair or unfair (having regard to the reason shown by the employer) –

    (a) depends upon whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee, and

    (b) shall be determined in accordance with equity and the substantial merits of the case".

92. Classically in cases of misconduct a tribunal will determine whether the employer genuinely believed in the employee's guilt of misconduct and whether it had reasonable grounds after reasonable investigation for such belief. The burden of proof is neutral in this regard. The tribunal agrees with Mr Jackson, that more will be expected of a reasonable employer where the allegations of misconduct and the consequences for the employee are particularly serious, for example, potentially career ending.

93. The tribunal must not substitute its own view as to what sanction it would have imposed in particular circumstances. The tribunal has to determine whether the employer's decision to dismiss the employee fell within a band of reasonable responses that a reasonable employer in these circumstances might have adopted. It is recognised that this test applies both to the decision to dismiss and to the procedure by which that decision is reached.

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

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

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

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

98. In a claim for wrongful dismissal, the tribunal must conclude for itself whether the employee was guilty of gross misconduct or a repudiatory breach of contract entitling the employer to dismiss the employee without notice.

99. Applying the aforementioned legal principles to the facts as found, the tribunal reaches the conclusions set out below.

Conclusions

100. The claimant accepts that the respondent had a genuine belief that she was guilty of misconduct and that this was the reason for her dismissal. No improper or hidden motivation has been raised.

101. Criticisms are made of the respondent's investigation. Perhaps the key criticism is that the respondent took too narrow an approach, concentrating on the CCTV footage from the moment Patient A took himself to the floor in the corridor to when he arrived in the seclusion room less than 2 minutes later. The footage viewed did show the entirety of the incident of handling for which the claimant was dismissed. The claimant was of the view that her actions could only be understood, however, if there was a greater consideration of the events of early of the day and the wider context. The respondent accepted that Patient A was agitated, an atypical patient and uncooperative. It accepted that Patient A had been attacked by patient B in the lounge area just prior to him being moved into the corridor, where he took himself to the floor. The respondent was not considering whether the claimant was reasonable in determining that the seclusion of Patient A was required. That decision was not criticised. Ms Harrison, in cross-examination did accept that with hindsight footage of the earlier attack was relevant and perhaps she should have requested it. Mr Williams did not consider, at the stage of the dismissal decision, that viewing wider CCTV evidence would have added anything to his enquiry. Patient A had been removed from the lounge and he did not consider there to be an imminent threat.

102. The claimant's case was not that Patient B had left the lounge area and was bearing down upon her and her colleagues as she sought to move Patient A. That was not what her colleagues said when interviewed – there was a threat before moving Patient A, but no one was saying that an attack was imminent in the sense of it being in progress. Clearly, the situation was

unclear and unpredictable, but the respondent was reasonable in considering only the CCTV evidence it did on the basis that any additional footage would have confirmed what it was willing to accept from the witnesses to the incident in any event. It is certainly not the claimant's case now that, if CCTV footage had been viewed of the corridor, Patient B would have been seen. That was not her position during the internal process. At most, there would have been evidence of the claimant calming Patient B down in the doorway leading on to the corridor from the lounge, up to and around 1 minute before Patient A was moved in his seated position to the seclusion room. For the respondent to have concluded that Patient A was in serious and imminent risk of his life or serious harm, as would have been, in its view, required to depart from restraint protocols, Patient B would have to have been at or approaching patient A.

103. Viewing additional footage, it was reasonably concluded, would also have added nothing to the respondent already accepting that de-escalation had been attempted all day with Patient A. The respondent accepted that to be the context around the incident. It could nevertheless reasonably conclude that Patient A taking himself to the floor was a further incident, which required addressing through the de-escalation techniques known to be capable of having some effect on Patient A's behaviours. There was no suggestion that Patient A had been continually agitated in the sense of de-escalation having had no effect at all, even if only briefly. For the respondent, each new occurrence reasonably required its own de-escalation strategy. The tribunal appreciates the level of patience required of staff in this task, but this is the environment in which the respondent reasonably believed that such steps were appropriate in terms of its duty of care to patients with mental impairments.

104. It has been suggested, on the claimant's behalf, that a further member of staff who came onto the scene, EC, could have been spoken to as part of the investigation. The claimant accepts now that she could have added nothing material beyond providing further information the respondent already had regarding the unsettled nature of Patient A. Evidence from the doctor who attended Patient A after the incident would have been immaterial in circumstances where the respondent's considerations were not dependent upon whether Patient A had suffered any physical harm.

105. It is suggested that the seeking of Mr Davison's opinion after the appeal hearing is indicative of the need for his opinion to have been sought at a much earlier stage and, in particular, before the decision to dismiss was taken. Ms Harrison, when cross-examined, accepted that a PAT trainer could and should have been interviewed, but Mr Williams made his decision together with Ms Weddle present as a nursing adviser. He reasonably believed that he had the benefit of any relevant input from people qualified to give it. The involvement of Mr Davison might be regarded as helpful, but a failure to involve him did not make the investigation an unreasonable one.

106. Were there then reasonable grounds for a belief that the claimant was guilty of misconduct? Mr Williams clearly came to his decision after a careful and repeated viewing of the CCTV footage which showed the claimant pulling Patient A by his ankle on his bottom along a corridor for a period of around 25 seconds. This occurred after a period of around 50 seconds during which Patient A was sat on the floor, which Mr Williams reasonably viewed as a relatively brief period of time in which to seek to de-escalate Patient A and apply strategies to persuade him to cooperate in his move to seclusion.

107. CW had said she was uncomfortable with the methods of restraint applied and how Patient A was moved. She was surprised when the claimant lifted Patient A's leg. Her evidence was that Patient A should have been moved by using an approved technique. LC had reported taking hold of Patient A's left arm with the intention of walking him to seclusion and effectively had no choice but to retain Patient A in hold when the claimant commenced moving him in case of potential injury. JS, who took Patient A's right arm, had said it had never been her intention to physically move Patient A. She was taken by surprise and again felt like she could not let go in case the patient fell.

108. The context was of a patient who had been unsettled and who was atypical when compared to the ordinary patient on the Danby ward with mental health impairments. Nevertheless, a detailed PBS plan was in place which effectively warned staff regarding Patient A's behaviour and provided for various de-escalation strategies.

109. The claimant was an experienced nurse and the lead nurse on duty, who had made and implemented the decision to move Patient A on his bottom. She had received training on safe forms of restraint. It was not said to Mr Williams that the claimant had considered the written procedures and found them to be confusing. He reasonably concluded that the claimant should have known this form of movement to be outside the respondent's protocols. Mr Williams could and did reasonably conclude that Patient A could have suffered physical injury by this method of moving him, as well as the potential for distress. There was no argument but that moving him in this way was undignified.

110. His conclusion regarding the imminence of any threat from Patient B or otherwise was reasonable. There had been a past threat and Patient B was not himself under any form of restraint which would have prevented him entering the corridor. He had not, however, on any evidence entered the corridor to place himself in the immediate vicinity. In such circumstances, Mr Williams reasonably concluded that there was time and space for further attempts at de-escalation and that the type of circumstance of imminent danger which would have justified such a significant departure from established methods of restraint was simply not there. He reasonably concluded that if the patient was under attack, the appropriate immediate

consideration would be to take action to prevent the threat the aggressor posed.

111. Mr Gardner on appeal reached a similar conclusion. Before doing so it was confirmed to him by Mr Davison that, in his view, further de-escalation should have been attempted which could in such circumstances be protracted and, absent a threat to life to a patient, the patient should not have been moved as he had.

112. The claimant obviously saw the nature of the threat differently and came to a different judgement, but it was not unreasonable for the respondent to conclude that in doing so she misjudged the situation, which caused her to move Patient A in an impermissible manner. This was with full appreciation of situations constantly changing and the need for staff to make a dynamic assessment of risk. It was reasonably concluded that the level of risk had changed when Patient A was moved into the corridor. The evidence of the other members of staff present was not of any ongoing attack. JS reported that the aggression towards patient A was literally just before Patient A was moved, but no one referred to a currently persisting threat (rather than the possibility of a threat, for instance) at the point Patient A was moved.

113. Many of the criticisms levelled at the respondent's decision makers are perhaps more accurately characterised as criticisms of how the misconduct was evaluated in terms of appropriate sanction.

114. Before addressing the outcome of dismissal, the tribunal considers the criticisms levelled at the procedure adopted by the respondent. It was not unreasonable not to record the disciplinary hearing. The claimant was aware in advance that it would not be recorded and was represented by a trade union official who could take their own notes. The claimant's suggestion that the reference to a lack of recording effectively lulled her into a false sense of security, in that she did not therefore believe the respondent could be considering the termination of her employment, is unsustainable given that that level of sanction was expressly anticipated in the disciplinary invitation.

115. Fuller notes should reasonably have been taken and provided to the claimant, certainly in advance of her appeal hearing. There is no evidence, however, that the claimant was disadvantaged or unclear in her recollection of what had been discussed. Ms Greenwood might have taken her own notes to assist the claimant. Notes were not requested from the respondent.

116. The dismissal outcome letter has been criticised for omissions within it, but anyone receiving that letter was reasonably able to understand the reason for the dismissal and also the sanction of dismissal.

117. It can be problematical for further evidence to be taken prior to a decision and without the claimant being aware of it and being able to challenge the new evidence. That is said to be the case in the appeal panel seeking Mr Davison's opinion after the hearing, but before providing its outcome. However, in all the circumstances, this did not prejudice the claimant. The tribunal agrees that the panel was seeking a further opinion and check on their own interpretation of what they had seen and Mr Davison's opinion simply affirmed their view of the inappropriateness of how Patient A was moved without any material change in evidence relied upon.

118. The obvious delay in concluding the appeal is insufficient to render dismissal unfair.

119. Turning to the issue of sanction and its reasonableness, the tribunal has accepted that Mr Williams was mindful of the claimant's clean disciplinary record and length of service and other matters of mitigation, despite not all of his points of consideration being set out in the dismissal outcome letter.

120. The respondent, as a healthcare provider, obviously has an overriding duty to maintain the safety of its patients. A failure to act with due regard to such duty was reasonably a serious concern for the respondent. That was in circumstances again where the respondent had reasonably concluded that Patient A was not, but for the claimant's actions, in serious and imminent danger. In circumstances where the respondent could reasonably reach such a conclusion, it was weighed up by Mr Williams that the claimant had acted outside the protocols on which she had been trained, had not taken steps to sufficiently de-escalate Patient A at the point he was sitting on the floor and had acted prematurely in subjecting Patient A to an undignified and inevitably potentially stressful and physically risky manoeuvre.

121. He had reasonable grounds for considering a lack of sufficient recognition in the claimant of the inappropriateness of her actions which was not suggestive of the claimant having sufficient insight into her actions. The claimant did question why her conduct was the sole issue for investigation when the circumstances of A's admission and behaviour were reasonably not regarded as a justification or excuse for inappropriate handling. The claimant making the respondent aware of the situation did not reasonably prevent the respondent from seeking to address the issue of potential misconduct with her or again reasonably necessitate a reduction of sanction.

122. Mr Williams appreciated and factored in that Patient A was atypical and challenging. He appreciated that the claimant had not acted with the intention of causing harm. He was aware that she had shown a level of

transparency and had not sought to put blame on her colleagues. He was aware of her clean disciplinary record and how others thought of her. The claimant had made a judgement as to how appropriately to deal with a situation. It was reasonably open to Mr Williams not to apply a lesser sanction due to the claimant's length of service and previous good record. It was not unreasonable for him to conclude that the method of handling of Patient A exhibited conduct so serious as to override those considerations. Dismissal, in all the circumstances of this case, fell within a band of reasonable responses.

123. The claimant was fairly dismissed and her claim of unfair dismissal must fail.

124. Turning to the question of wrongful dismissal, it is then for the tribunal to be satisfied on the balance of probabilities that the claimant was guilty of gross misconduct or to put it another way conduct sufficiently serious to be repudiatory of her contract of employment. Such conclusion is finely balanced. Whilst the claimant was dismissed for reason of conduct (and it is correct that the action she took was deliberate/wilful rather than accidental), the circumstances here are far removed from a nurse who deliberately abuses or mistreats a patient.

125. Albeit, significantly, before he saw the CCTV footage, Mr Brace had told the claimant: "But the bottom line on this is that the patient is safe and so are the staff. We deal with difficult situations on the ward and have to make quick judgements that are not always right. I believe that you would have never of done anything that would have intentionally put anyone at risk and that's what's important. Please don't beat yourself up about this."

126. The claimant had indeed made her own dynamic calculation of risk in a fast-moving situation and where she genuinely considered there to be a potential of a further altercation with a patient, if Patient A was not swiftly moved to seclusion. Had Patient B been bearing down upon Patient A, dismissal may well have been outside the band of reasonable responses. She saw, on her evidence to the tribunal, the worst case scenario and acted swiftly to avoid that.

127. However, the claimant's account has shifted in emphasis up to this hearing and what she says now is difficult to straightforwardly accept as at the core of her rationale at the time. On the evidence, the tribunal cannot conclude the imminence of risk of serious harm to Patient A existed at the moment the claimant made her judgement to handle Patient A in what she knew was an inappropriate manner, which was undignified and carried its own obvious risks to the safety of Patient A.

128. The tribunal has sympathy for the claimant's position. She is clearly a caring individual, who strongly advocated for the best interests of the

patients on the Danby ward. The tribunal can only speculate as to the reason for what it considers to have been, on the facts, a pre-emptory and excessive reaction. Certainly, this was a stressful environment requiring unusual levels of patience which many would struggle to exhibit. Objectively, this one moment should not result in an irredeemable loss of career. Whilst the claimant's insight might have been lacking at times during the internal process or difficult for her to express, that does not mean that she now could no longer be relied upon in a caring role.

129. However, sadly, the tribunal must conclude that, on the facts, the way in which she moved Patient A on this one occasion, and with due weight being given to her own duty of care and level of responsibilities on the Danby ward, amounted to a fundamental breach of contract such as to allow the respondent to terminate her employment without notice.

Employment Judge Maidment

Date 28 July 2023

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