Reserved Judgment

Case Nos: 2408421/2021
2408422/2021
2408423/2021
2408424/2021
& 2408425/2021

EMPLOYMENT TRIBUNALS

Claimant: Mr L Olayode (1)

Mr O Azeez (2)

Mr A Adenekan (3)

Mr P Idama (4)

Ms M Nguetsop (5)

Respondent: Pennine Care NHS Foundation Trust

HELD AT: Manchester **ON:** 22, 23, 24, 25, 26, 29 & 30 January 2024, chambers day on 13 March and 24 April 2024.

BEFORE: Employment Judge Johnson

MEMBERS: Ms A Berkeley-Hill

Mr J Flynn

REPRESENTATION:

Claimant: Mr N Caiden (counsel)

Miss Armaghan (paralegal from Royal College of Nursing, instructing)

Respondent: Miss J Connolly (counsel)

Mr P Spencer (instructing solicitor)
Miss V Kerley (trainee solicitor)

JUDGMENT

The judgment of the Tribunal is that:

(1) The first claimant's complaint of race discrimination under section 13 Equality Act 2010 is not well founded, which means it is unsuccessful.

(2) The first claimant's complaint of harassment under section 26 Equality Act 2010 is not well founded, which means it is unsuccessful.

(3) The second claimant's complaint of race discrimination under section 13 Equality Act 2010 is not well founded, which means it is unsuccessful.

(4) The second claimant's complaint of harassment under section 26 Equality Act 2010 is not well founded, which means it is unsuccessful.

(5) The third claimant's complaint of race discrimination under section 13 Equality Act 2010 is not well founded, which means it is unsuccessful.

(6) The third claimant's complaint of harassment under section 26 Equality Act 2010 is not well founded, which means it is unsuccessful.

(7) The fourth claimant's complaint of race discrimination under section 13 Equality Act 2010 is not well founded, which means it is unsuccessful.

(8) The fourth claimant's complaint of harassment under section 26 Equality Act 2010 is not well founded, which means it is unsuccessful.

(9) The fifth claimant's complaint of race discrimination under section 13 Equality Act 2010 is not well founded, which means it is unsuccessful.

(10) The fifth claimant's complaint of harassment under section 26 Equality Act 2010 is not well founded, which means it is unsuccessful.

REASONS

Introduction

1. These proceedings arise from decisions made by the respondent in relation to an incident involving the five claimants and a patient on 1 March 2021. The incident took place at the respondent's mental health unit in Rochdale.

2. They involve safeguarding related measures brought against the claimants restricting their ability to work. There was also disciplinary action (in case of first claimant) and a referral to the Nursing and Midwifery Council (NMC) in respect of the first and second claimants by the respondent.

3. The relevant patient (Patient A) had been sectioned under the Mental Health Heath Act 1983 and held at the respondent's psychiatric unit. On the night shift of 28 February/1 March 2021, he became dysregulated and aggressive. The claimants and other members of staff responded by seeking to place him in an on site Seclusion room. However, before this took place, Patient A became more aggressive. Following a review by management, there were concerns that inappropriate techniques were used and procedure not correctly followed.

4. The claimants who are all black believe that they were treated more harshly than comparable white members of staff by the respondent and this amounts to race discrimination.

5. They presented claim forms to the Tribunal on 13 July 2021 following periods of early conciliation. The respondent presented a response resisting the claims on 13 August 2021.

6. Following case management before Judge Allen, a list of issues was agreed involving allegations in the alternative of direct discrimination and/or harassment on grounds of race.

Issues

7. The agreed list of issues provided by the parties at the PHCM before Judge Allen on 28 January 2022 involved all of the claimants relying upon complaints of direct discrimination contrary to section 13 Equality Act 2010 (EQA), and harassment contrary to section 26 EQA. Both complaints related to the claimants' race, which is black and minority

ethnic (BAME). They compare themselves with named and hypothetical comparators.

8. The issues are provided below, (see pp100-102 of the bundle):

1. The treatment allegedly suffered by the claimants is said to amount to either:

1.1 direct race discrimination, as defined in sections 9 and 13(1) of the Equality Act 2010, contrary to section 39(2)(d) of that Act (section 41(1)(b) or (d) in relation to Mr Azeez); or

1.2 racial harassment, as defined by sections 9 and 26(1) of the Equality Act 2010, contrary to section 40(1)(a) of that Act (section 41(2) in relation to Mr Azeez).

2. The claimants all describe themselves as BAME (Black Asian Minority Ethnic) and for the purposes of section 9 of the Equality Act 2010 rely upon their race as being "non-white", accordingly making any relevant comparator a "white" staff member whose circumstances were not materially different.

Direct race discrimination

3. Whether, as defined by section 13(1) of the Equality Act 2010, the respondent directly discriminated against the claimants because of his/her race, having regard to the following:

3.1 Did the respondent treat the first, second, third, fourth or fifth claimant less favourably;

3.2 If so, was this because of his/her non-white race?

4. As regards to paragraph 3(1) above, the less favourable treatment suffered was the following action taken by the respondent as against the claimants who were on shift 28 February 2021/1 March 2021 (night shift) when a patient allegedly attacked staff members and the alleged restraint taken in response, namely:

4.1 For Mr Olayode, employed as a Band 5 staff nurse at the material time:

4.1.1 On or around 1 March 2021 suspending him from duty following his involvement in the incident;

4.1.2 Soon after referring him to the Nursing and Midwifery Council for fitness to practice;

4.1.3 The content of the above referral which in particular failed to mention that the patient had assaulted a member of staff prior to the restraint; (Bundle Page: 101)

4.1.4 The failings in the management case, that led to the disciplinary hearing panel on or around 20 September 2021 dismissing the case, with such failings being (1) failure to interview corroborative witnesses (such as the night manager and doctors involved), (2) failing to take into account that the patient had been deteriorating for three days and known risk of self harm and targeting BAME staff, (3) failing to allow him to view the CCTV footage.

4.2 For Mr Azeez, an agency worker who is a Mental Health Registered Nurse at the material time:

4.2.1 On or around 1 March 2021 being precluded from any further shifts;

4.2.2 Soon after referring him to the Nursing and Midwifery Council for fitness to practice;

4.2.3 The content of the above referral which in particular failed to mention that the patient had assaulted a member of staff prior to the restraint.

4.3 For Mr Adenekan (nursing assistant), Mr Idama (health care assistant) and Ms Nguetsop (health care assistant), all of whom were bank workers of the respondent undertaking bank work when the incident occurred:

4.3.1 On or around 1 March 2021 being precluded from any further bank shifts at Prospect Place (but not at other sites of the respondent) pending completion of learning points from the incident.

5. The relevant comparators for the purposes of the claims are:

5.1 For Mr Adenekan, Mr Idama and Ms Nguetsop, the three nursing assistants set out in paragraph 6 of the Grounds of Resistance (namely Rebecca Meredith, Maria Redfearn, Margaret 'Meg' McGonagle and who are permanent members of staff employed by the respondent);

5.2 For Mr Olayode and Mr Azeez, the two other people involved in the restraint (Maria Redfearn and Meg McGonagle);

5.3 Or (for all claimants) a hypothetical comparator, that someone who is "white" meeting section 23(1) of the Equality Act 2010.

<u>Harassment related to race</u>

6. Whether, as defined by section 26(1) of the Equality Act 2010, the respondent harassed the claimants on the grounds of race, having regard to the following:

6.1 Has the claimant shown that he/she has been subjected by the respondent to unwanted conduct? The conduct relied upon is all of the matters set out as alleged less favourable treatment in the issues for the claim of direct race discrimination above;

6.2 If so, was such related to the relevant protected characteristic of race;

6.3 If so, did such unwanted conduct have as its (a) purpose or (b) effect, violating the claimant's dignity, or creating an intimidating, hostile, degrading, humiliating, or offensive environment for the claimant (for (b), taking into account the perception of the claimant, the other circumstances of the case, and whether it was reasonable for the conduct to have that effect)?

Evidence used.

Witnesses

9. The claimants were each called as witnesses and had produced written witness statements. Each was called to give evidence under oath and they were as follows (with the day of the hearing when they gave their evidence included in brackets):

a) Mr L Olayode (first claimant) – Band 5 Registered Mental Health Nurse employed by respondent. (Day 2).

b) Mr O Azeez (second claimant) – Registered Mental Health Nurse engaged by the respondent through an external agency. (Day 3).

c) Mr A Adenekan (third claimant) – Nursing Assistant and engaged by respondent by its internal 'Bank' system (Day 3).

d) Ms M Nguetsop (fifth claimant) – Nursing Assistant engaged through Bank (Day 3).

e) Mr P Idama (fourth claimant) - Nursing Assistant engaged through Bank (Day 4).

10. The respondent called the following witnesses:

a) Ms S Preedy - (at the time, Network Director of Nursing and Quality – now the Trust's Chief Operating Officer).

b) Ms M Greaves - (at the time, Clinical Services Manger – now Head of Patient Safety and Clinical Effectiveness).

c) Ms N Rutter (Unit Manager at Hurst Place and investigating officer into first claimant's disciplinary process).

11. The Tribunal were also referred to the evidence of Ms J Beech, (HR Business Partner). She had provided a signed witness statement but was not called by the respondent and the claimants accepted her evidence.

CCTV footage

12. A key element of the available documentary evidence used during the final hearing was taken from relevant available CCTV footage of the locations at the respondent's Prospect Place ward. This was where the incident on 28 February/1 March 2021 took place. The Tribunal encountered some difficulties with accessing this evidence at the beginning of the hearing. Mr Spencer (solicitor instructed by the respondent) worked hard on Day 1 to provide the Tribunal with several versions of the relevant footage. This consisted of numerous versions of mp4 files of the 5 CCTV cameras for the night shift of 28 February/1 March 2021.

13. All the CCTV footage was provided without sound and it is understood that most CCTV cameras record silent film without any audio recording taking place.

14. The videos show the following views of the Prospect Place location where the incident took place at around 00:05 to 00:20 on 1 March 2021, (the timings are approximate but give an indication as to how each camera *links* to each other in terms of the timeline and the events in question):

a) CCTV camera 1. This covered the corridor outside the Lounge at Prospect Place with the lounge doors on right hand side (at 00:05 to 00:06 on 1 March 2021). It showed Patient A doing 'laps' along the corridor and passing staff whose numbers increased as the video progressed and who lined the corridor in front of camera 1. Following several laps by Patient A and increasingly provocative actions by him towards staff, he passed them for the final time and appeared to aim a punch at the first claimant, (Mr Olayode). By this time, the first claimant and second claimant (Mr Azeez), were present as well as other members of staff. Following Patient A

throwing the punch, the second and first claimant chased Patient A, followed by other members of staff.

b) CCTV camera 2. This covered the corridor outside the lounge facing in the opposite direction to camera 1 with lounge doors on left hand side (at 00:05 to 00:06 on 1 March 2021). It included footage of Patient A being chased by members of staff including the second and first claimants, (following his punch aimed at first claimant). Within moments of the chase beginning, Patient A appears to be pushed by the second claimant causing him to fall through the double doors into the lounge. He was then dragged to his feet by the first and second claimant and pulled out of the lounge backwards.

c) CCTV camera 3. This covered the view from the lounge looking towards doors in the corridor which can be seen on cameras 1 and 2, (at 00:05 to 00:06 on 1 March 2021). It shows Patient A making a number of laps along the corridor outside the lounge, with him then falling through the lounge door followed by the second and first claimants following the punching incident (as shown on cameras 1 and 2). He is then dragged back out of the lounge and onto his feet. The second claimant was observed to fall onto Patient A as they came through the doors.

d) CCTV camera 4. This covered the corridor outside the Seclusion area, (at 00:06 to 00:07 on 1 March 2021). It shows Patient A being moved into this space by the first and second claimants and towards the wall facing camera 4. They appear to restrain him while the Seclusion room was vacated so he could be placed in it. His legs appear to be spread apart during this particular attempt at restraining him.

e) CCTV camera 5. This was the final film extract and camera 5 covered the Seclusion area immediately outside the Seclusion room (at 00:07 to 00:20 on 1 March 2021). There is some fluctuation in the staff visible during this segment, but the five claimants are present as well as other members of staff. At any one time while Patient A is present, he is attended by 9 or 10 staff members. Patient A is laid on his back immediately outside the Seclusion room door while it is being prepared for him. His legs are held apart and up in the air, with his arms being held as well. His head is supported and held in a way which appears to have the purpose of preventing him from knocking it back onto the floor. A cushion is eventually inserted below his head and during this period, Patient A is resisting the attempts made by staff to restrain him.

Camera 5 shows the first claimant holding one arm, the second claimant the other, the fourth claimant holding the Patient A's head. A still photograph taken from this film could be found on pages 936 and 937 of

the hearing bundle. It had been annotated and helpfully identified the staff members who could be seen.

Two white female members of staff Meg McGonagle and Maria Redfearn are holding the right leg and a black male member of staff known as Taiwo is holding Patient A's left leg. The third claimant (Mr Adenekan), appears in the background but largely remains observing the restraint, as does the fifth claimant, (Ms Nguetsop).

Rebecca Meredith holds the door to the Seclusion room and at the visible instruction of the first claimant on this film, throws a number of cardboard boxes and bowls used as toilet facilities around the claimant's head and into the room.

Once Patient A was placed in the Seclusion room, there was a tussle regarding a sheet which had been placed by a member of staff onto the mattress, but which staff then decided to remove. Patient A resisted its removal which added to the difficulties already encountered in this incident by staff.

The Tribunal noted that there was limited space available to restrain Patient A once he was on the floor in the Seclusion area. Several members of staff remained around the scene of the restraint, doing little more than observing. The Tribunal noted that the most senior member of staff was the first claimant but as he was directly involved in the restraint, he had limited opportunity to direct his colleagues.

15. Having observed the five films, the Tribunal notes that once the initial punch was thrown by Patient A, followed by the push, there was a visible level of anxiety amongst the staff and a lack of coordination in resolving the matter as quickly as possible. Numerous staff remained present and while this may have been the correct number where a violent incident might be likely, it was difficult to see from the CCTV footage whether or not they were engaging with Patient A. However, once the punch and the chase took place, de-escalation appeared to be no longer possible. Patient A was in a heightened and dysregulated state and his placement in the Seclusion room was inevitable. How this placement was carried out by staff became a key issue in the decisions which were subsequently made by the respondent towards the five claimants and other relevant staff members.

Paper documents

16. There was also a hearing bundle of more than 1000 pages. It contained the usual procedural documentation including claim forms, response, and case management orders. Additionally, policies and procedures were

provided, as well as correspondence between management, the claimants, and their union representatives, also investigation reports and internal meetings and disciplinary steps taken.

17. Some supplemental documents were also provided at the beginning of day, and these were added to the bundle with the agreement of Mr Caiden on behalf of the claimants. They primarily concerned spreadsheets showing the claimant's recorded work for the respondent during the period immediately following 1 March 2021.

18. On day 3, Miss Connolly provided some additional documentation which was added to the bundle with the agreement of Mr Caiden with page numbers 1013 and 1014. This evidence was disclosed late because one of the respondent's witnesses having heard the first claimant's evidence on day 1, had recalled she had a notebook in her attic at home and retrieved the relevant pages so that they could be disclosed the next day.

Findings of fact

The respondent (Pennine Care NHS Trust)

19. The respondent is an NHS Trust (the Trust), operating in a number of locations predominantly in the N.E. Greater Manchester area. They operate a site in Rochdale which includes the treatment of mental health patients. This case primarily relates to an incident which took place at the Prospect Place unit which was understood to consist of low secure mental health patients who had been sectioned under the Mental Health Act 1983.

20. The CCTV evidence revealed a location which has several shared areas including a lounge, corridors around an outside quadrangle style area where patients can smoke and a number of other rooms and offices for patients and staff.

21. There is also a Seclusion room which consists of a lockable door opening into the corridor where patients who become dysregulated and at risk of harming themselves or others, may be placed until their dysregulated episode subsides and they are no longer at risk of harming themselves or others. The room is spartan to reduce the risk of furniture or fittings being used by the dysregulated patient to self harm themselves. The Tribunal noted that there was a basic mattress and cardboard containers to be used in place of toilet facilities. In the case of Patient A, the bed sheets were removed due to an 'on the spot' (often called a *dynamic*) risk assessment that he could use them as ligatures for the purposes of self harm.

22. Staffing on each ward consisted of staff working one of two shifts with a night shift (which is the relevant shift in this case), beginning at 7:30pm and ending at 7:30am. The Tribunal were informed that in Prospect Place, typically 15 patients would be accommodated at any one time. Staffing consisted of a registered nurse for each ward and who was the nurse in charge. There would also be several nursing assistants working. Some staff were working in substantive roles and others were supplied through the NHS Bank or an outside agency. In this case, the first claimant (Mr Olayode) was employed as a Band 5 registered nurse the second claimant (Mr Azeez) was an agency registered nurse, with the third (Mr Adenekan), fourth (Mr Idama) and fifth claimants (Ms Nguetsop), being Bank supplied nursing assistants. It is understood that Bank staff work for the NHS but are not permanent employees working for a particular Trust location or department. Instead, they make themselves available for shifts which are offered to workers on the Bank.

23. The Tribunal noted that most staff working the night shift on 28 February/1 March 2021 were non-white, (approximately 75%). However, the Tribunal was not provided with specific data relating to the overall diversity and ethnic composition of staff at Prospect Place or indeed, whether fewer staff were allocated for night shifts than compared with the day time shifts.

24. As a large NHS Trust, Pennine has access to significant HR Policies and Procedures as well as HR resources staff and legal support. While it was understood that there may have been staffing issues regarding the levels of permanent HR staffing being available at the relevant time, Ms Greaves gave evidence that agency workers had been engaged to cover gaps within the existing staffing structure.

25. The Tribunal was aware that the relevant time in this case was the period from February to November 2021 and this was a period where Covid was still an issue in England and Wales. This meant more activities took place remotely and not face to face. Moreover, mask wearing remained a mandatory activity, especially in medical facilities. However, the nature of Prospect Place and its patients meant that inevitably, it was more difficult to strictly adhere to social distancing. This was especially the case as many patients would struggle to follow these expectations due to their various conditions. However, it is understandable that Covid might have had an impact upon the way some members of staff reacted (or failed to react) when closer contact with patients was required.

The claimants

26. The claimants held a variety of nursing roles and were engaged under various contractual relationships. A previous summary of each one is provided below:

a) First claimant (Mr L Olayode).
b) Second claimant (Mr O Azeez)
c) Third claimant (Mr A Adenekan)
d) Fourth claimant (Mr P Idama)
e) Fifth claimant (Ms M Nguetsop)

27. Mr Olayode was a Band 5 staff nurse (Rehabilitation and High Support) and his post involved dealing with patients who could have a history of violence and aggression. His job description (pp173 to 178) expected him to maintain accurate and written records of nursing interventions. It explained that his role involved dealing with often stressful and unpredictable environments with patients displaying challenging behaviour, who could at times be verbally or physically hostile. He was expected to contribute to the maintenance of a safe and secure therapeutic environment, regularly coordinating with others and making autonomous decisions when the Unit manager was not available. He was also responsible for teaching and supervising nursing assistants.

28. In terms of managing risk, the job description required Mr Olayode to contribute to the control of risk and report immediately using the Trust's incident reporting system. It provided that he should report:

'…*any incident, accident or near miss involving patients, service users, carers, staff, contractors or members of the public.'*

29. The Trust had developed a *Violence Reduction Policy: Positive and Proactive Interventions*, (known as the PMVA policy). The author was Chris Heath (described in the report as Violence Reduction & CEST Manager), who was involved in reviewing the incident of 1 March 2021, (pp706 to 756). Mr Olayode had received this training prior to the incident taking place, although his most recent update had taken place the week before remotely, due to Covid restrictions on 18 to 19 February 2021.

30. The Tribunal heard his evidence relating to the deployment of manual restraint techniques and he confirmed that amongst other things, manual restraint should be avoided if possible. However, the PMVA cautioned that if restraint was utilised, any position deployed could cause serious risks and prolonged restraint should be avoided. Moreover, staff should avoid:

'*…taking service users to the floor where possible and support their descent…if the manual standing restraint becomes unstable and begins to collapse'.*

If a traumatic fall had taken place, staff are required to carry out a falls risk assessment '…*as a priority'.* When a restraint did take place, there was an emphasis within the PMVA on supporting the patient's head and avoiding pressure to neck, thorax, abdomen, back or pelvic area, (p731).

31. In summary, Mr Olayode accepted that he was familiar with the PMVA policy and knew how things should be done. However, he accepted that some of the techniques used in restraining Patient A on 1 March 2021 *'…were not appropriate due to the situation and conditions of the incident'.*

Patient A

32. The claim involved an incident concerning a patient whose name was quite properly anonymised and who was known as Patient A. He was a white, male patient, aged 39 at the relevant date and who had a history of misuse of drugs and alcohol. The Trust Approved Risk Assessment (known as TARA) Review Form, (pp205-207) provided a useful summary of his background. The Tribunal noted that Mr Olayode was the author of the TARA form, and he completed it on 25 October 2020, with a further update on 24 December 2020. Patient A had a long history of self harm, including suicidal attempts. He was recorded as having a history of violence and had previously assaulted staff. He had also begun to experience intrusive paranoid/delusional thoughts which resulted in him believing staff and patients were gesturing towards him and calling him a paedophile or pervert. He also attempted to strangle a member of staff on 30 April 2020 because of this paranoia and made allegations while in a psychotic relapse at around the same time, alleging that he had been raped by *'Nigerian staff'.*

33. The Tribunal accepts that Patient A was a troubled individual and would be difficult to manage when he was having psychotic relapses. This was aggravated by his inability to self regulate his use of drugs and alcohol and going 'AWOL', presumably in search of alcohol or drugs. This meant that when he was readmitted to Prospect Place, he would often be experiencing a relapse. Mr Olayode was generous in saying that Patient A could be *'friendly'* and *'lovely'* to deal with when well. However, inevitably the admissions to Prospect Place would often arise from relapses when his mental state was poor.

34. Although the TARA does reference Patient A making allegations towards Nigerian members of staff. When he completed his report of the incident

to which this case relates, Mr Olayode made no specific reference concerning a tendency by Patient A to make racist comments nor that he had been racist during the incident on 1 March 2021. It was noted that he first referred to *'derogatory racist comments'* in his witness statement used in these proceedings.

Evening of 28 February and 1 March 2021

35. The claimants began their night shift at around 7:30pm. There was a shift handover between Mr Olayode and the day shift nurse in charge.

36. It is not necessary to discuss in detail what happened in relation to the incident because that has already been referred to above in the Tribunal's review of the CCTV evidence provided in this case in the *Evidence used* section above. Essentially, it involved Patient A suffering a relapse in his behaviour and then becoming dysregulated. A decision had already been proposed by Mr Olayode given the concerns regarding this behaviour and which he believed had been deteriorating over several days. However, once Patient A became aggressive towards staff in the corridor, an immediate move to Seclusion took place.

37. In accordance with Trust procedure, once Patient A was locked in the Seclusion room, Mr Olayode called Doctor Salaheen. He was not able to enter the room given Patient A's agitated state and visually examined him through the Seclusion room window, (p211). In the Medical Review documents dated 1 March 2021 and timed at 4am, no reported physical health concerns were recorded. He provided a brief summary of why the seclusion had taken place and why it was necessary for it to continue. The examination took place while Mr Olayode was still on shift, but while it reported Patient A punching a member of staff, no record was made of him falling, the subsequent drag to his feet or the difficulties experienced in the restraint, (p236).

38. A Wound Assessment document was produced later that day by another member of staff, and it was determined that no attendance at Accident and Emergency was required. Recorded on this document was an indication of minor wounds involving a graze to the head and slight bruising to the front and back on the right hand side of the upper body. Patient A had reported some pain to his ribs, (pp208-209).

39. As the nurse in charge, Mr Olayode completed an Incident Details form which recorded the incident which led to him being punched by Patient A. However, his recollection appeared to be at odds with what could be seen on CCTV 1, 2 and 3, suggesting that Patient A was:

'…in the process of assaulting Staff Nurse LO [Mr Olayode] again, however patient [A] was immediately placed in hand hold (in accordance with the trust policy) due to [Patient A's] incompliance and aggressive presentation during this manoeuvre propelled the staff nurse LO the patient [A] and other Staff nurse [Mr Azeez] from recovery.' (p897-8).

The Tribunal acknowledged Mr Olayode was completing a form from the perspective of someone who was directly involved in the incident and was not reflecting at the time with the benefit of the CCTV camera footage. However, no mention was made of Mr Azeez and Mr Olayode chasing Patient A down the corridor before he fell into the lounge or the way in which he was brought back to his feet afterwards. Brief mention was made of 2 minor injuries to Mr Olayode and Mr Azeez as members of staff, but in the section describing '*Patient Further Details/Injury Details',* the words *'No Injury'* was added, (pp897-8).

40. The claimants' shift ended at 7:45am with a handover taking the final 15 minutes. A handover document for 1 March 2021 referred to Patient A and the incident during the previous night. However, no mention was made of Mr Olayode as nurse in charge attending the meeting and it is likely that this was a document used for the next shift handover that evening. Patient A however, remained in seclusion and it was noted that he was '*In middle of change to meds',* (p273-275).

What happened next?

41. Mike Liffen, who was the Band 7 nurse ward manager and Mr Olayode's line manager provided an update to a number of managers in an email at 11:16 on 1 March 2021. He provided an update for the patients on the ward and noted that Patient A had deteriorated due to his change in medication, (p276). Mr Liffen reviewed the CCTV footage of the incident involving Patient A and the completed Incident Report.

42. Melanie Greaves explained that she had been notified of the incident on 1 March 2021 when she arrived on duty at 8am. She was told about what had happened by security, but she was of the view that Mr Liffen had not raised any concerns about the incident. However, when security gave her access to the CCTV footage, she was concerned about the way staff had managed the restraint of Patient A and also the apparent lack of concern on Mr Liffen's part following his review of the available evidence.

43. Ms Greaves decided to speak to Patient A, while a doctor examined him as a result of breathing issues being experienced. She heard him complain of sore ribs and she saw bruising and asked the charge nurse on duty (whom she believed was Lucy Shenton), to complete a 'body map' of Patient A. This document included a diagram of a human body

so that areas of injury could be visibly marked. Reference was made to a graze to the head and bruising on front and back of the upper torso on right hand side, (pp208-9). Ms Greaves also asked Chris Heath who was an expert on PMVA techniques to view the CCTV footage and provide an opinion of the handling of the incident by staff.

44. She was also concerned that as Mr Azeez was an agency worker, there was a lack of clarity regarding the level of previous restraint training that he had undertaken. While it appeared surprising that this information was not readily available to Ms Greaves, it was not clear whether it had been sought from the agency supplying Mr Azeez at the point when he began working with the Trust, or whether it simply could not be easily obtained from the Trust's personnel team. Ms Greaves sent an email to Your World Recruitment Group ('YWRG'), who were the agency concerned on 1 March 2021 and requested details of the training that Mr Azeez had received in relation to restraint scenarios, (p942). A PMVA certificate was provided by the agency on the following day (p941).

45. Mr Heath sent two detailed emails on 4 March 2021 at 09:48 and 17:12, with a review of the timed stages of the CCTV footage and at appropriate points, providing 'Observation/Reflection Points'. We felt that Mr Heath's interpretation of the footage was broadly consistent with ours. His evaluation of the events, however, was important given his experience of restraint techniques, (pp281-4). He noted that in terms of Patient A's behaviour:

    '…there appears to be more focus on attempts at BAME staff.'

    He also added that:

    'You may also want to consider AZ's [Mr Azeez] possible perception about being targeted racially having had an attempted punch at himself and observing another to follow BAME colleague.'

    Mr Heath acknowledged that the footage did not include any sound but was concerned that Patient A had been very provocative towards the non white members of staff. He speculated whether this may have added to the aggravation felt by Mr Azeez, which resulted in the chase beginning and the resultant push through the doors into the Lounge.

46. He was of the view that the pushing of Patient A from behind/side by Mr Azeez was not justifiable under the PMVA and was not consistent with any recognisable physical intervention technique. Indeed, he asked,

    'are there any interventions aimed at supporting staff around this if [a focus on BAME by Patient A] is a known trigger/escalation sign[?]'.

Mr Heath also referred to Patient A being dragged up onto his feet following the fall and expressed concern that this could cause a shoulder injury.

47. His second email considered the footage on CCTV 4 and 5. He began by noting that the way in which Mr Olayode and Mr Azeez held Patient A as observed on CCTV 4 could be described as a standing restraint. This was known by staff as an attempt to *'cap'* legs, which could cause a risk of trips and falls, especially as only two people were holding his arms, (as was the case with Patient A). His observation at this point was that there was a lack of planning and organisation and that the many other staff in the area where not being supervised or engaged.

48. He then observed Patient A on CCTV 5 falling backwards onto the ground, with inappropriate holds taking place, including too many staff holding his legs. His observation of the footage concludes by noting Patient A being carried into the Seclusion room using a lifting technique which was not approved. His emphasis in the conclusion to his email was that staff should be asked to view the footage and consider '…*what went well, what didn't go so well and what they would do differently.' (p281-284).*

49. Mr Heath's emails were referred to during the hearing on many occasions. They were helpful documents in that they carefully considered the footage of the incident on the CCTV cameras accompanied by his experienced view as to how a restraint should be properly carried out. He remarked upon the need for all staff present to play an effective part and that it can be possible for too many staff to be deployed. He was not overly judgmental as to what had happened, but there were clearly concerns that the nurse in the charge was unable to properly direct staff as he was heavily involved in the actual restraint. He also observed a *'general disorganisation of the restrictive intervention by all staff is a concern and isn't just down to training'.*

50. In relation to Mr Azeez, he acknowledged that some PMVA training details had been provided by the agency as described above, but *'insufficient for mental health work'.* He added that,

    '…I do not know of any recommended or approved intervention they would teach involving pushing a fleeing service user.' (p282).

    A few days later 9 March 2021, Ms Greaves acknowledged receipt of Mr Azeez's training details from his agency and informed them that the Trust could not offer any further shifts as an NMC referral was being completed. She made no reference to the insufficient training. The

Tribunal understands that Mr Azeez has not returned to work with the Trust and now works as a nurse in Oxford.

51. The Tribunal understood that Mr Azeez was in charge of another ward at Prospect Place and had come to assist Mr Olayode and his colleagues. However, he was also insufficiently qualified for that ward based upon his training record at the time. He was registered and in a more senior position to everyone else present, other than Mr Olayode.

52. He was also an agency worker who was supplied to the Trust by an external employment agency and who would be expected to supply a worker who was suitable and trained for the job being filled. For whatever reason, the agency appears to have failed to ensure that Mr Azeez was sufficiently qualified for the particular challenges faced by a nurse in this mental health unit. This can include very dysregulated patients who lack insight and who can struggle to behave appropriately in social situations. This could mean (as was the case with Patient A), that they could be at times provocative, aggressive and use inappropriate language relating to individual's protected characteristics. This could involve racist, sexist, and homophobic language amongst other things and this could be very uncomfortable and unpleasant for members of staff.

53. However, Mr Azeez was responsible as a nurse to ensure he had the correct training and once problems arose, it was reasonable for the Trust to refuse to allocate further sessions until it was satisfied, he had obtained the appropriate qualifications and competence. In the meantime, as he was not employed, there was no suspension and no investigation relating to a disciplinary process. An email exchange between YWRG and Ms Greaves during 1 March and 9 March 2021, considered the restraint training which Mr Azeez had received previously. However, although a PMVA certificate was provided, it was inadequate to work in Prospect Place and Ms Greaves informed Ms K Mataj of YWRG on 9 March 2021, that *'We will not be giving any further shifts for our Trust'. (pp939-942).*

54. The Trust did ask the agency YWRG to ask Mr Azeez to write a statement of the incident. In the YWRG's email of 11 March 2021, they explained to Mr Azeez the concerns raised by the Trust relating to the incident and their concerns regarding his role in the restraint technique. The Trust informed them that the CCTV had been viewed, a referral to NMC was appropriate and also the Police would need to be alerted. The concerns regarded Mr Azeez's suitability to work in that setting and Sarah Drane at YWRG explained in her email to Mr Azeez dated 11 March 2021, (pp354-5\), that:

'as you are aware, you are restricted from working at Pennine Care NHS Foundation Trust and an NMC and safeguarding referral has been completed. Due to the safeguarding nature of the incident, as an agency, we are unable to offer you further placements pending the outcome of the investigation.

55. Mr Azeez was also regulated by the NMC and once the safeguarding concerns were identified, the Trust was under an obligation to refer the matter to the nursing regulator when a matter of concern about patient safety or the wider Healthcare system was identified. The contents of each referral were broadly similar in relation to Mr Olayode and Mr Azeez and will be considered below. But for the avoidance of doubt, the Tribunal accepts that Mr Azeez was a nurse and in a senior role on that shift. He appeared to overreact by chasing Patient A following a punch being thrown and the fall that subsequently happened only took place because of Mr Azeez's reaction. Mr Olayode was also involved in this incident and chased Patient A as well.

56. The Tribunal did note from the CCTV that Mr Azeez appeared to lose control and chased Patient A, which gave rise to the subsequent fall and the escalation of the situation. The Trust had reasonable grounds for behaving the way that it did in this instance and an unfortunate consequence for Mr Azeez was that as an agency worker (and without the required training), it was impossible for him to continue receiving work from the Trust. He could not of course be suspended on full pay unlike his nursing colleague Mr Olayode.

57. Mr Liffen was also referred to the NMC at the same time as Mr Olayode and Mr Azeez. The Trust raised concerns in his suspension letter about his failure *to take appropriate leadership of the situation* following his consideration of the CCTV footage.

<u>The suspension of Mr Olayode</u>

58. Mr Olayode was suspended shortly after the incident on 1 March 2021. Mr Olayode initially claimed in his witness statement that on or around 1 March 2021, he was suspended from duty following his involvement in the restraining incident of Patient A. During his cross examination he revised this date, saying that had been suspended by Amanda Slater by telephone a few days after the incident but denied that it took place on 8 March 2021, (which was the day that Mr Liffen was suspended). However, once he was shown the two suspension letters both dated 8 March 2021 and both referring to a meeting the same day, he confirmed that 8 March 2021 was the date of the suspension, (pp295-7 and 289-91). Accordingly, he was suspended a week after the incident took place.

59. The suspension letters were very similar but were tailored to deal with the specific allegations made against each nurse and the different roles they played in relation to the incident. In the case of Mr Olayode, four allegations were made against him and were summarised:

    a) Carrying out inappropriate PMVA techniques when he was the nurse in charge.

    b) Failing to report potential injuries and seek an appropriate medical review of the patient and instigate physical health monitoring.

    c) Completing an incident report form inaccurately.

    d) Failing to observe the NMC Code of Conduct. This would be accompanied by a referral to the NMC.

    The letter also provided the usual information that is provided to an employee when being suspended and referred to the Conduct and Disciplinary Policy.

The referral of Mr Olayode to the Nursing and Midwifery Council (NMC)

60. The three referrals to the NMC were by Sarah Preedy. Mr Liffen was the first notification to be made on 8 March 2021 (pp318 to 334), followed by Mr Olayode on 9 March 2021 (pp301 to 318) and finally Mr Azeez on 11 March 2021 (pp335 to 349).

61. The forms consisted of several pages and required Ms Preedy to indicate the reason for the referral, the person involved, what they allegedly did, whether they remained employed and why concerns have been raised.

62. In the case of Mr Olayode, Ms Preedy indicated it was a concern about patient safety, followed by several paragraphs explaining the incident on 1 March 2021, that inappropriate restraint techniques had been used, insufficient follow up care and failing to properly report and detail the incident. Effectively, it was a repetition of the allegations contained in the suspension letter. It was confirmed that he remained suspended and the reasons for holding the concerns. However, the section seeking details of the incident in question downplayed the aggressive behaviour of Patient A when he attempted to punch Mr Olayode, instead referring to him seeking to ‘tap’ staff members as he was running around.

63. Mr Olayode alleged that the content of the NMC referral and in particular the Trust failed to mention that Patient A had assaulted a member of staff prior to the restraint. Ms Preedy had an opportunity to view the CCTV

footage on 4 March 2021 and the Tribunal felt that she failed to provide a proper context of Patient A's behaviour and the challenging behaviour that was presented. While it was suggested by her that she only saw tapping taking place and that she set out the context, the Tribunal finds that she failed to properly consider Patient A's behaviour and explain to the NMC that he was behaving in an aggressive and threatening way. This was subsequently rectified by her when the NMC requested further clarification of the timeline, albeit in relation to the referrals involving Mr Azeez and Mr Liffen, (pp1009 to 1012).

64. We did find it surprising that Ms Preedy omitted to include reference to violent behaviour on the part of Patient A. It was a relevant background matter because it served to explain what triggered the behaviours of Mr Azeez and Mr Olayode giving rise to the chase of Patient A and his subsequent fall. However, what was interesting was that Ms Preedy was very certain when giving her evidence during the hearing that she observed *'tapping'* rather than something more violent. She was adamant that she had viewed the entirety of the CCTV footage on 4 March 2021.

65. In contrast, the Tribunal were of the unanimous view that Patient A attempted to punch Mr Olayode. As we have already mentioned, Mr Heath also observed that Patient A *'…raised his hand to attempt to punch L [Olayode].'* He also mentioned that Patient A raised his hand towards Mr Azeez, but the latter was able to block him with his own arms up, (p281). On balance, while the Tribunal recognises that individuals may see different things when viewing the incident on CCTV, Patient A clearly behaves in an aggressive way. Regardless of the appropriateness of the reaction of the two nurses, Ms Preedy's evaluation seems to be surprising, given Mr Heath's earlier comments.

Outcome of NMC.

66. The NMC produced a report into its investigation of Mr Olayode in a letter dated 21 April 2022, (p928-930). Their headline conclusion was that *'We've decided not to investigate a concern about your fitness to practise.'* Reasons for the decision were provided separately, (p931-935). In terms of the question of whether there was an inappropriate restraint, the NMC concluded as follows:

"From their review of the CCTV footage our nursing advisor noted that 'this was a particularly challenging restraint for all involved. It is worth noting that what is taught about physical restraint in a simulated classroom environment can be very different to a real live restraint where there is likely to be fear and anxiety for everyone involved. In a physical restraint there is the added risk and fear that a patient can cause

significant harm to themselves or the staff. It is also not clear what the approved Trust approved techniques are, therefore is no comparison can be drawn, (sic). There is no identifiable evidence that the force used by nurse Olayode was disproportionate to the situation'."

67. Significantly, they go on to record the findings of the disciplinary panel of the Trust within the disciplinary outcome letter:

'Further to considering the information presented, the chair of the panel was of the view that management did not take into account the significant patient factors. RC [Patient A] had been deteriorating for 3 days with a known risk of significant harm to health care staff and a targeting of BAME staff. The CCTV showed that this was a reactive restraint application rather than a planned co-ordinated one'.

68. To conclude, the decision was that *'…Our clinical advisor stated that in their opinion this restraint was managed in the best way possible given the volatility of the situation and the potential imminent risk from the patient's behaviour.'* Accordingly, the NMC concluded that the restraint was not inappropriate.

69. In terms of the allegation that there was a failure by Mr Olayode to ensure patient safety through observation and assessment, the nursing advisor had informed the NMC:

'that whist the patient was agitated, it would not have been appropriate for the door to be opened in order to complete physical observation, the patient would have had to be restrained to have vital observations completed which would have been disproportionate. By the observing staff, doctor and nurses engaging and the observing the patient via the panel they would have been able to establish that the patient was physically well and breathing. There is no evidence that the patient suffered an adverse reaction during this period in seclusion.'

70. In terms of the allegation that there was a failure in record keeping and incident reporting concerns, the NMC concluded that:

'We consider that if there were omissions in the record there is no evidence to suggest that these were dishonest or that they were sufficiently significant or important to amount to a regulatory concern.'

71. Mr Azeez received a similar letter from the NMC on 29 October 2021, (pp921-3). Unlike Mr Olayode, the NMC did not need to wait until the outcome of a disciplinary investigation, but they reached the same conclusions albeit with less detail. Of relevance is the following section:

'Our clinical advisor noted that physical restraints are never dignified and there is no guarantee a restraint will go to plan. Our clinical advisor noted that Mr Azeez's account is that he assisted with the physical restraint of the patient and that during the restraint there was no risk to the patient as he was being observed throughout.

We have not seen any evidence to indicate that the patient suffered harm.

Our clinical advisor's assessment of the information we received was that the restraint was managed in the best possible way given the volatility of the situation and the potentially imminent risk of harm posed by the patient's behaviour'. (pp924-7).

72. Ms Preedy disagreed with the decision of the NMC and that is a view to which she was entitled to reach. However, the Tribunal felt that the NMC recognised the difficulties experienced with Patient A and the challenges that this caused Mr Olayode and Mr Azeez given the background information that the NMC were able to consider. The Tribunal does not criticise the Trust's management for making the NMC referral as it was clearly an incident which aroused safeguarding concerns.

<u>The management of the disciplinary process relating to Mr Olayode</u>

73. Meanwhile, Ms Greaves who was initially nominated in the suspension letter as investigating officer in the disciplinary process, was removed at her request. This was because her previous involvement in the matter prevented her from being regarded as an independent investigator. Instead, Natalie Rutter (who was the Unit Manager at Hurst Place which was another mental health facility) was appointed to investigate Mr Olayode. She began her investigation on 15 March 2021 and reviewed part of the CCTV footage on 9 April 2021, with the remainder on 23 April 2021. During this investigation, Ms Rutter was supported by Michelle Simpson who was a HR officer.

74. In addition to Mr Olayode, Ms Rutter interviewed a number of witnesses and who were as follows (and with their role/race included):

    a) Margaret McGonagle (27/05/2021) – permanent employed nursing assistant who was present during the restraint, (white comparator for nursing assistant claimants).
    b) Alexandra Ukepbor (27/05/2021) – permanent registered nurse who was briefly present during the restraint but did not assist her colleagues, (black)

c) Rebecca Meredith (27/05/2021) – permanent employed nursing assistant who was present during the restraint, (white comparator for nursing assistant claimants).
d) Patrick Idama (28/05/2021) – bank nursing assistant who was present during the restraint and the 4th claimant, (black).
e) Adeola Adenekan (28/05/2021) – bank nursing assistant who was present during the restraint and the 3rd claimant, (black).
f) Taiwo Odunsi (28/05/2021) – bank nursing assistant who was present during the restraint, (black).
g) Marie Redfearn (06/2021) – permanent employed nursing assistant who was present during the restraint, (white comparator for nursing assistant claimants).
h) Oluwaseyi Saheed Azeez (06 & 1/7/2021) – agency registered nurse who was present during the restraint and the second claimant, (black).

75. These individuals were present at least for part of the time when the restraint took place. Mr Olayode, however, was critical of Ms Rutter in that she failed to interview other corroborative witnesses such as the night manager and doctors involved. Considering the allegations made within the suspension letter, issues relating to reporting and the completion of records of the incident may have made these witnesses relevant to the investigation. However, there was no suggestion that Mr Olayode was asserting that they were aware of conversations or documents or that they were present when the restraint took place. The Tribunal struggled to see how relevant they would have been and Ms Rutter spent a great deal of time interviewing the witnesses who observed the incident involving the restraint.

76. The disciplinary investigation report was produced by Ms Rutter on (pp629-667) on 6 September 2021. She explained the evidence that she had gathered during the investigation including 'Memory Capture' documents which were broadly contemporaneous notes of the incident produced by the witnesses and these were followed by more formal interviews as described above.

77. Ms Rutter recognised in her conclusions that Patient A was *'highly agitated and was acting in a way which caused emotions of stress and fear to the staff on shift during the incident.'* (p665). She mentioned that he had been deteriorating due to a change in mediation and that he had a *'history of assaultive behaviour'.* Ms Rutter was quite clear in the risks posed by Patient A at the time, although she does not make any reference to his behaviour being potentially targeted towards BAME employees. Her view was that the incident could have been handled better had guidance on PMVA training been followed and '*there was clear leadership.'* She noted that Mr Olayode had completed PMVA

training and was in a position of leadership and given that she was the investigating officer, curiously stated *'The allegation is therefore upheld'.*

78. However, the Tribunal recognised that when read with the recommendations, she was asking that the case be referred to a disciplinary hearing which could include dismissal as a sanction, (pp665-7). The language, however, was clumsy and unfortunate. Significantly, she concluded that *'As the Nurse in Charge, you failed to report potential injuries and seek appropriate medical review of the patient.'*

79. With the investigation completed, the matter proceeded to a disciplinary hearing on 20 September 2021. The hearing was before a panel chaired by Matt Welsh who was Network Director for Quality, Nursing & AHPs for the South Division (Stockport and Tameside) and was therefore appointed from outside of the respondent Trust. A decision letter was produced and sent to Mr Olayode on 20 September 2021, (pp690-8). The allegations in the suspension letter were repeated and it was recorded that Mr Olayode's Royal College of Nursing (RCN) representative had expressed concerns at the beginning of the disciplinary hearing that the investigation report made reference to allegations being 'upheld' and the panel confirmed that this was a decision for them to reach and not Ms Rutter.

80. The Tribunal felt that the way in which the investigation was carried out by Ms Rutter was unsatisfactory. She should have offered Mr Olayode an opportunity to review the available CCTV evidence before his interview. She also failed to fully explain the context relating to the incident involving Patient A and explain in the way that Mr Heath and the NMC had done, the extremely challenging behaviour being faced at the time. This was particularly important given that Mr Heath had suggested the nurses' race and BAME staff more generally could have been factor in how Patient A behaved. Section 6.3 of her investigation report 'Summary of CCTV – Chris Heath' was surprisingly brief and given his recognised specialism in restraint techniques no analysis takes place of what he says and how that might inform the questions put to the witnesses and the conclusions that she reached. She was on notice that race may have been relevant to the incident and yet it was something she did not explore as part of the investigation. She did interview the witnesses who were present when the incident took place. While we did not think that it was necessary to interview the night managers and doctors who reviewed Patient A following the incident, we were concerned that Ms Rutter failed to give due consideration of Mr Olayode's request that such interviews take place.

81. The outcome letter of the disciplinary hearing dated 20 September 2021 is also very critical of Ms Rutter's investigation report and the way in

which she conducted the investigation, particularly in her failure to Mr Olayode to review the CCTV evidence at an early stage. They went as far as to say, (p690-8):

'In my view it was not objective for the investigation to rely solely on your [Mr Olayode] your memory of the events and not to give you the opportunity to see the CCTV which was heavily relied upon by management and had been viewed three times by them before they met with you.'

82. The disciplinary panel rejected all of the allegations made against Mr Olayode and taking into account the available evidence before the Tribunal, it was reasonable for them to reach this decision.

Mr Adenekan (nursing assistant), Mr Idama (health care assistant) and Ms Nguestop (health care assistant)

83. These three claimants alleged that they were precluded on or around 1 March 2021, from taking any further Bank shifts at Prospect Place, until they had completed learning points in an action plan devised by Pennine.

84. Justine Beach who was a HR Business Partner at the time emailed Trevor Lewin, Melanie Greaves and others in 16 March 2021 noting that Sarah Preedy had expressed concern that the bank staff present at the incident needed action plans before they could be offered further work, (p365).

85. These three claimants were in the meantime allowed to work shifts on other Pennine wards where PMVA restraint techniques would not be required.

86. The Tribunal accepts that these steps taken by management were reasonable given the nature of what had happened at the incident involving Patient A. However, while this was a reasonable decision, there was an unacceptable lengthy delay in the required training place which occurred because the three claimants were bank staff and did not have an appointed line manager. Ms Greaves accepted in her evidence that was unreasonable and apologised for delay which arose as it clearly placed the three claimants in an uncertain position even if they were able to and did work elsewhere in the meantime. It is to Ms Greaves' credit that she took ownership of this problem and arranged for the necessary training to take place.

87. These three claimants compare themselves with Maria Redfearn, Rebecca Meredith and Margaret McGonagle who were also nursing assistants and who were all white. It is important to note however, that

the three comparators can be distinguished from the three nursing assistant claimants in that they were employed on a permanent contract and had direct line managers in place who were responsible for conducting the training required by Ms Beach.

Law

The Direct race discrimination claim

Race

88. This is defined by section 9 Equality Act 2010 (EQA). Under section 9(1), race includes:

a) Colour;
b) Nationality;
c) Ethnic or national origins.

89. Section 9(2) EQA provides that reference to a person who has a particular protected characteristic is a reference to a person of a particular racial group. A reference to persons who share a protected characteristic is a reference to persons of the same racial group.

Direct discrimination

90. Section 13(1) EQA explains that direct discrimination occurs when A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.

91. Direct discrimination as defined by section 13 EQA, require a person's treatment to be compared with that of a comparator. Section 23(1) requires that on a comparison of cases for the purposes of a direct discrimination complaint under section 13, there must be no material difference between the circumstances relating to each case.

92. Section 23(1) of the EQA provides that in relation to section 13, when considering the circumstances of a comparator, there must be no material difference between the circumstances of the claimant and their identified comparator.

Harassment related to race

93. Harassment is defined by section 26(1) EQA:

(1) A person (A) harasses another (B) if—

(a) A engages in unwanted conduct related to a relevant protected characteristic, and

(b) the conduct has the purpose or effect of—

(i) violating B's dignity, or
(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

94. Ms Connolly referred to section 212(1) EQA and explained that conduct which amounts to harassment cannot be direct discrimination because it does not constitute a detriment. The term *related to* however, was broader than the term *because of* (as required in direct discrimination).

Burden of proof

95. Section 136 EQA provides the basic principles to be followed in all EQA claims when establishing the burden of proof, (subject to guidance provided by a significant volume of case law):

(1) This section applies to any proceedings relating to a contravention of this Act.
(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.
(3) But subsection (2) does not apply if A shows that A did not contravene the provision.
(4) The reference to a contravention of this Act includes a reference to a breach of an equality clause or rule.
(5) This section does not apply to proceedings for an offence under this Act.
(6) A reference to the court includes a reference to—
(a) an employment tribunal;
…

Case law

96. Both Mr Caidon and Ms Connolly made reference to a number of cases, codes and guidance relating to the statutory provisions in their submissions. They are summarised below.

Definition of race

97. Referring to the claimant's asserted race as being non-White, he noted that race can be defined in the negative, *Orphanos v Queen Mary College* [1985] IRLR 249 (HL) at [17]-[18] (identified racial group was non-British).

98. Statutory Code of Practice at [2.48]-[2.49].

99. *R v Rogers [*2007] UKHL 8; [2007] 2 AC 62 The dicta of Lady Hale in at [10] and [13] where she expressed caution in requiring fine distinctions when considering race.

Tribunal's approach to direct discrimination

100. *Shamoon v Chief Constable of Royal Ulster Constabulary [*2003] UKHL 11; [2003] IRLR 285 - although the direct discrimination test is often described in its two stages (namely (i) less favourable treatment and (ii) reason why is the protected characteristic) it is not always necessary nor desirable to adopt this approach in every case and sometimes the issues will need to be taken together and tribunals will simply need to decide if the treatment was because of the protected characteristic – i.e. the *'reason why'* ([8] and [11]).

101. *Nagarajan v London Regional Transport* [1999] UKHL 36, [2000] 1 AC 501, 513B, *Igen v Wong* [2005] ICR 931 and *Villalba v Merrill Lynch and Co Inc* [2007] ICR 469, EAT – these cases were referenced by Miss Connolly being case law relation to the *'because of'* question and the importance of race being a significant factor in the mind of the decision maker in that it had a more a than trivial influence role in the treatment complained of.

102. *Amnesty International v Ahmed* [2009] IRLR 884, EAT [32], [34] - once the alleged treatment has been found but is not overtly or inherently because of race, the Tribunal must enquire into the mental processes (both conscious and unconscious), of the relevant decision makers.

Tribunal's approach to facts in Equality Act 2010 cases and drawing inferences

103. Talbot v Costain Oil, Gas & Process Ltd and ors UKEAT/0283/16/LA at [15]-[16] Mr Caiden referred to this case which summarised the relevant principles from case law as to the proper approach for Tribunals to take in discrimination cases:

a) It is very unusual to find direct evidence of discrimination.
b) The Tribunal's decision will normally depend upon what inference it is proper to draw from all the relevant surrounding circumstances including the conduct of the alleged discriminator before/after the unfavourable treatment in question.
c) It is essential that the Tribunal makes findings about any primary facts which are in issue so that it can take them into account as part of the relevant circumstances.
d) The Tribunal's assessment of the parties and their witnesses when they give evidence forms an important part of the process of inference.

e) Assessing the evidence of the alleged discriminator when giving an explanation for any treatment involves an assessment not only of credibility but also reliability.
f) The Tribunal must have regard to the totality of the relevant circumstances and give proper consideration to the factors which point towards discrimination when deciding inferences.
g) If it is necessary to resort to the burden of proof, section 136 shifts the burden to the respondent where it is proper to draw an inference of discrimination in the absence of any other explanation.

104. *Kowalewska-Zietek v Lancashire Teaching Hospitals NHS Foundation Trust* UKEAT/0269/15/JOJ at [48] - Langstaff J noted that where a defence of unreasonable but not discriminatory, mistakes or lapses of judgment is raised, the Tribunal should exercise careful scrutiny and may be required to consider how others have been treated as one might expect equal problems to have been faced by others in genuine 'mistake' or 'error' cases.

Tribunal's approach to the burden of proof

105. *Igen v Wong* [2005] ICR 931 – which provided guidance on the burden of proof in discrimination cases in relation to the 'discriminatory element' and specifically the Revised Barton Guidance (at [76] and Annex of that judgment). The Tribunal will not repeat it here, but counsel provided the detailed guidance within their written submissions.

106. *Madrassy v Nomura International plc* [2007] IRLR 258 - considered *Igen.* In particular, that something more than the bare facts of difference of treatment are required to place the Tribunal in a position where it could conclude on balance of probabilities, the respondent had committed an act of discrimination.

107. *Commissioner of the Police of the Metropolis and anor v Osinaike* EAT 0373/09 - an illustration of drawing inferences and the *'something more'* principle.

108. *Bahl v The Law Society* [2003] IRLR 640, EAT - while an employer may have behaved in an unreasonable or unfair way, if the Tribunal believes they show no actual discrimination, normally no basis will exist for an inference to be drawn of unlawful discrimination. Indeed, if the employer is unable to persuade the Tribunal that they had genuine reasons behind the unreasonable treatment, there may be other non discriminatory reasons may be derived from the Tribunal's own findings of fact based upon the evidence heard.

109. *Hewage v Grampian Health Board* [2012] ICR 1054 - careful attention is required where there is room for doubt as to facts.

110. *Field v Steve Pye and Co and others* EA-2021-000357-LA [37] & [41] – where HHJ Tayler expressed caution concerning the need to deal with the available evidence which could realistically suggest discrimination before moving onto the second stage of the burden of proof test.

111. *B v A* [2010] IRLR 400 at [12] – the use of a hypothetical comparator to show less favourable treatment when applying the modified burden of proof established in *Shamoon* (above).

112. *Network Rail Infrastructure Limited v Griffith -Henry* [2006] IRLR 865 at [18] – there is no requirement under section 136 EQA for there to be positive evidence of the treatment being because of the protected characteristic or related to where the complaint is harassment.

113. *Raj v Capita Business Services Limited* [2019] IRLR 1057 at [53]-[54] – in harassment cases the modified burden of proof applies to the issue of whether the unwanted conduct is related to the protected characteristic.

114. *Efobi v Royal Mail* [2021] UKSC 33 – confirms the approach to burden of proof described in *Igen.*

115. *Veolia Environmental Services UK v Gumbs* [2014] EqLR 364 at [57] and *Dattani v Chief Constable of West Mercia* [2005] IRLR 327 at [44]) – where an explanation for the alleged treatment that is found to be untruthful or inconsistent may be something more that leads to a *prima facie* case.

116. *O'Neill v Governors of St Thomas More Roman Catholic Upper School* [1996] IRLR 372 (EAT); *Nagarajan v London Regional Transport* [1999] IRLR 572 (HL); and *O'Donoghue v Redcar and Cleveland Borough Council* [2001] EWCA Civ 701; [2001] IRLR 615 - when determining if the protected characteristic, caused the less favourable treatment, it is sufficient for it to have been a cause (it does not need to be the sole or predominant cause). Mr Caiden reminded the Tribunal that the Statutory Code of Practice codifies this approach at [3.11] – *'The characteristic needs to be a cause of the less favourable treatment but does not need to be the only or even the main cause*'.

Case law relating to harassment.

117. *Richmond Pharmacology v Dhaliwal* [2009] IRLR 336 (EAT) at [10]-[16], (updated in *Pemberton v Inwood* [2018] EWCA Civ 564 at [88] by

Underhill LJ) - guidance concerning the approach to be taken in harassment, (although the steps can overlap:

a) Did the Respondent engage in 'unwanted conduct'?
b) Did the 'unwanted' conduct have either the purpose or effect of (i) 'violating B's dignity' or (ii) 'creating an intimidating, hostile, degrading, humiliating or offensive environment'? In approaching this question, the Tribunal must consider (by reason of s.26(4) EQA) whether putative victim perceives themselves to have suffered the effect in question (the subjective question), whether it was reasonable for the conduct to be regarded as having that effect (the objective question), and of course all circumstances of the case.
c) Was this 'related to' the applicable protected characteristic.

118. *Driskel v Peninsula Business Services Ltd* [2000] IRLR 151 (EAT) at [3]-[4] - The Tribunal needs to have regard to the totality of the material and where there have been multiple alleged incidents of harassment, the Tribunal should have regard to the cumulative effects.

119. *Tees Esk and Wear Valleys NHS Foundation Trust v Aslam* [2020] IRLR 495 [20], [24]-[25] – which applied the interpretation in the Statutory Code of Practice at [5.9]-[5.10] of the phrase '*related to'* has a broad meaning.

Discussion

Introduction

120. The Tribunal reminded itself of the list of issues and noted that:

a) direct race discrimination was defined by section 9 and 13 EQA contrary to section 39(2)(d) EQA in relation to Mr Olayode, Mr Adenekan, Mr Idama & Mr Nguestsop & section 41(1)(b) or (d) in relation to Mr Azeez.

b) Racial harassment is defined by sections 9 and 26 of EQA contrary to section 40(1)(a) of EQA to Mr Olayode, Mr Adenekan, Mr Idama & Mr Nguestsop /section 41(2) in relation to Mr Azeez.

121. In relation to their race, all 5 claimants describe themselves as Black and Minority Ethnic ('BAME') and for the purposes of section 9 EQA, describe their race as being 'non-white'. Comparators are accordingly 'white' members of staff whose circumstances were not materially different to each relevant claimant whose allegations are being considered in this case. It was very clear who was white and who was non white and this has been identified in the findings of fact above as relevant.

Direct discrimination

Less favourable treatment under section 13(1) EQA

Mr Olayode (first claimant)

122. In terms of the treatment complained of by Mr Olayode, he asserted in the list of issues he was informed on or around 1 March 2021 that he was suspended from duty following his involvement in the incident involving Patient A on 1 March 2021. Having heard his evidence during the hearing and having considered the available documentation within the bundle, we determined that the actual suspension took place on 8 March 2021 and this was by letter. This related to the Patient A incident and other than the incorrect date provided, this allegation of treatment took place as alleged.

123. The second allegation of direct race discrimination relates to the referral by the Trust to the NMC concerning his potential fitness to practice. This clearly happened as alleged.

124. The third allegation of direct race discrimination involves the alleged failure on the part of Ms Preedy when completing the NMC referral and where she failed to identify that Patient A had assaulted Mr Olayode. This is correct and she did not even refer to the incident beginning following a 'tap' which was her interpretation of the CCTV evidence. She only referred to Patient A's conduct when the NMC pressed her for additional information and therefore in terms of the initial referral, the treatment happened as alleged. Her referral was admittedly basic in terms of content, but Ms Preedy argued that this was the format that she used for each of the three referrals including Mr Liffen.

125. The fourth allegation of treatment made by Mr Olayode was that there were failings in the management of the disciplinary hearing panel on or around 20 September 2021. The Tribunal understood that he meant the actual investigation carried out by Ms Rutter rather than the actual disciplinary hearing. This is because the specific failures detailed in the list of issues included a failure to interview corroborative witnesses, taking into account that the patient had been deteriorating for three days and was a known risk for self-harm and targeted BAME staff as well as failing to allow Mr Olayode to view the CCTV footage.

126. The Tribunal found that Ms Rutter had conducted the disciplinary investigation poorly. While we understood that the additional witnesses identified by Mr Olayode such as the night manager and doctors did not need to be interviewed for the purposes of the investigation, it was her

failure to demonstrate that she had adequately considered the relevance of this request which was demonstrably poor.

127. Ms Rutter also demonstrated a lack of insight and curiosity as an independent investigator. She failed to explore the background to Patient A before the incident took place, even though she had already been put on notice of these matters in Chris Heath's report. This was unfortunate, especially as Mr Heath had raised concern that Patient A may have targeted BAME staff. Finally, there was a failure to allow Mr Olayode to view the CCTV footage at the beginning of the investigation and before he was interviewed on the 5 May 2021. The CCTV footage was an important resource available to management as soon as the incident took place and it appeared she had not viewed the full footage herself before commencing the investigation.

128. This treatment was certainly different to the white comparators the claimants had named in these proceedings and who were identified as Ms Redfearn, Ms Meredith, and Ms McGonagle. They were not suspended following the incident, they were not referred to the NMC and they were not subject to a disciplinary investigation.

129. While this might be the case however, the Tribunal noted that these comparators were not employed by the Trust as nurses but as nursing assistants. Their actions were considered by management following the incident but considering their subordinate role they were required to undergo training rather than be subject to formal disciplinary or regulatory processes. The Tribunal does not accept that they can be considered appropriate comparators in relation to the complaints of direct discrimination for the purpose of Mr Olayode's claim as their circumstances were materially different to his.

130. In the alternative, Mr Olayode and all his fellow claimants requested that the Tribunal should consider hypothetical comparators who were white. In the case of Mr Olayode, this would involve a hypothetical white nurse who was involved in the restraining of Patient A, both in relation to the corridor episode and the subsequent chain of events relating to Patient A's seclusion.

131. In terms of the reason why Mr Olayode was suspended on 8 March 2021, the Tribunal accepted that the Trust were aware that he was the senior nurse on duty when Patient A was restrained and was carrying out inappropriate PMVA techniques. The Tribunal accepts that in an environment where a patient's human rights can be limited, where inappropriate restraints can result in personal injury and can impact upon their dignity, the Trust had to ensure that appropriate safeguarding measures were deployed. This was a case where extensive CCTV

footage was available and when viewed showed real concern that inappropriate behaviour and restraints had taken place on the part of Mr Olayode and Mr Azeez.

132. This was not an incident where appropriate restraint techniques had been used and this was not disputed by Mr Olayode. From a basic safeguarding perspective, it was necessary for his employer to prevent him from working shifts until they could be satisfied that he fully understood how he should respond in a future situation involving a dysregulated patient.

133. Additionally, it is these reasons which made a reference to the NMC essential and until this process was concluded, the suspension would need to remain in place. It also needed to remain in place until the disciplinary investigation concluded.

134. The Tribunal noted that Mr Liffen was Mr Olayode's white line manager and a more senior nurse who was not directly involved in the incident. He was also suspended as part of a disciplinary process and subject to an NMC referral relating to his failure to take the Patient A incident sufficiently seriously. Mr Liffen was given a 6 month warning in relation to his disciplinary action by the Trust as the allegations in the disciplinary process against him were partly upheld. In contrast all allegations against Mr Olayode were dismissed.

135. Ms Preedy as we have already described above, failed to make any reference to Patient A having previously assaulted Mr Olayode in her initial NMC submission. This was something which she did in relation to all 3 NMC referrals, including that of Mr Liffen. While Mr Liffen was not a direct comparator, he was subject to an NMC referral arising from the same incident and where his referral was treated in the same way as his black colleagues. On balance there simply nothing further available which could persuade the Tribunal that Ms Preedy behaved in a way which amounted to less favourable treatment of Mr Olayode on grounds of race.

136. Finally, Ms Rutter has been subject to considerable criticism by the Tribunal in the way that she conducted the investigation in relation to Mr Olayode. The alleged treatment involving her investigation is accepted in terms of failing to consider the interview of the additional witnesses requested by him and also failing to let him see the relevant CCTV evidence at a sufficiently early stage. Moreover, she was so focused upon the alleged behaviour under investigation, that she failed to explore the necessary context including the behaviour of Patient A.

137. Ms Rutter was questioned about whether she was she was negatively influenced by Mr Olayode being non white and in reply said, *'I was influenced by the way I felt the patient had been treated…there was neglecting care of the patient and should have been more patient focused'.* Ms Berkeley-Hill asked her about Mr Heath's concerns that Patient A may have been targeting BAME employees. Ms Rutter said that *'it was one way of looking at things, but could have been looked at differently because they were males as well'.*

138. This allegation caused the Tribunal a great deal of discussion and we were particularly concerned about whether there was subconscious bias on the part of Ms Rutter in terms of Mr Olayode's race concerning her failure to take account of Patient A's potential for targeting BAME staff. However, we accepted unanimously that her decisions concerning witnesses and CCTV footage were not because of his race, but simply involved her failure to apply herself to the investigation process as explained above. The Tribunal felt that the underlying reason was an issue of capability and confidence and an absolute focus on the mechanics of the restraint rather than considering the surrounding factors which led to it happening, which was what the NMC were able to do.

139. An additional factor which we found persuasive when considering the possibility of subconscious discrimination was that although Mr Olayode's complaint asserted race discrimination, this was not something that he raised in his original report following the event and during the investigation. Mr Azeez similarly failed to raise race at these stages as well. Had they done so, Ms Rutter would have been faced with contributory factors which would have required her to consider.

140. Ms Rutter considered Mr Heath's report of the 4 March 2021 (p282) where he expressed concerns about Patient A targeting BAME staff and in her investigation report she confirmed reading this document at 6.3. However, she does not make any reference to its contents at all and this was a significant failing on her part as part of a fair investigation it is necessary for the investigating manager to demonstrate that they have fully considered available relevant evidence and information to ensure a complete background to the matter is considered.

141. Ultimately however, we found that this failure arose not from Ms Rutter's unconscious bias, but a lack of competence in her appointed role as an independent and impartial investigator.

142. Consequently, the allegations of direct discrimination do not succeed in relation to Mr Olayode.

143. Nonetheless, the Tribunal is concerned that Mr Heath produced a reflective and helpful report which identified potential problems arising from patients who may target members of staff in relation to visible protected characteristics and the additional emotional and psychological load that this could place upon those members of staff. His views are certainly something that a reasonable employer should take into account, especially given that NHS Trusts rely upon a very diverse workforce and who encounter patients who lack the capacity or insight to treat people with respect, regardless of their personal characteristics.

Mr Azeez

144. Mr Azeez's first allegation of direct discrimination is that or around 1 March 2021 he was precluded from any further shifts. The Tribunal accepted that this happened because of the email sent from Ms Greaves to YWRG on 9 March 2021. That this was only reached once enquiries had been made concerning his training concerning restraint techniques and whether they were sufficient to allow him to work as a nurse at a secure mental health setting of the nature of Prospect Place.

145. These steps arose from his status as an agency worker and considered the limited control that the Trust had over Mr Azeez as he was not an employee.

146. Like Mr Olayode, the named comparators were not appropriate given that they were nursing assistants and they were also employed by the Trust.

147. Considering the alleged treatment when compared with a hypothetical comparator the Tribunal was nothing to suggest that the decision to refuse further shifts was because he was BAME. This treatment arose solely from his agency worker status and his insufficient training and once the Trust declined to engage his, any further problems in finding alternative work were matters between Mr Azeez and his agency.

148. An NMC referral took place soon afterwards and this is the second allegation of treatment happening on 11 March 2021. The content of the NMC referral failed to mention that Patient A had assaulted members of staff prior to the restraint. These allegations of treatment happened as alleged and repeat the same allegations of treatment made by Mr Olayode above. There is no further evidence which would persuade us to vary our findings made above in relation to Mr Olayode and consequently, these allegations of direct race discrimination cannot succeed.

Mr Adenekan, Mr Idama and Ms Nguetsop

149. These three nursing assistants were precluded from working any further bank shifts at Prospect Place shortly after the incident in question took place.

150. To some extent, the three named white comparators do bear a great deal of similarity to these three claimants as has been already described above. They were nursing assistants who were present when the incident with Patient A took place but they did not find themselves prevented from continuing to work in their roles at Prospect Place. It is understandable that these three claimants felt that they were treated less favourably than the named comparators.

151. While this might be the case, any less favourable treatment arose not from the claimants' race as BAME workers. They were not engaged as employees at Prospect Place, but as Bank nursing assistants. We have already explained that this affected them being able to receive the necessary training which once taken would quickly allow them to return to this work area. The reason was that they did not have line managers who could conduct the training. This was not a problem for the identified comparators because their line manager could allow them to return under supervision and provide the necessary remedial training without delay.

152. We did consider the question of hypothetical comparators in relation to these claimants' direct race discrimination complaints. During the hearing, the Tribunal was referred to a black permanent nursing assistant Alexandra Upkebor who was wrongly identified by security when they viewed the CCTV footage. Before this mistake was identified by management, she was going to be subject to supervision and training like the three white comparators. Because management later recognised that she was not present when the incident took place with Patient A, it persuaded the Tribiunal that the decisions made in relation to nursing assistants were consistent regardless of their race. This means that any difference would relate to whether they were permanent employees or Bank workers.

153. Accordingly, these complaints of direct race discrimination are unsuccessful.

Harassment (section 26 EQA)

154. Ms Connolly submitted that in this case, she did not believe the different approach for direct discrimination (because of a protected characteristic) and for harassment (related to a protected characteristic) was significant when determining the allegations. This was because it involved decisions alleged to have been made by the respondent which

were either materially influenced by the claimants being non white, or they were not.

155. This was a case where the allegations of direct discrimination treatment were pleaded in the alternative as allegations of harassment unwanted conduct.

156. We did note that the findings that we made in relation to these allegations in our consideration of the direct discrimination complaints above, would also apply to the consideration of the complaints of harassment.

157. What we did need to consider, was whether the conduct had the purpose or effect of violating each claimant's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. This involves us considering whether each claimant felt that they had suffered the effect in question and whether it was reasonable for the conduct as having that effect, considering all of the circumstances in this case.

158. We would then need to consider whether this related to their race.

Mr Olayode

159. It was not clear whether Mr Olayode felt that the decision to discipline him, to refer him to the NMC and Ms Pready's failure to refer to Patient A's previous conduct in relation to each element identified in section 26(1)(b). However, in relation to each of these allegations, we did not accept that in all the circumstances it was reasonable for that conduct to have that effect. As we have already discussed in this judgment, these were reasonable and proportionate steps for the Trust and its management to take and a reasonable employee would understand that the safeguarding duty to vulnerable service users was paramount, even allowing for the challenging behaviour that took place.

160. Context was important and we accepted that Ms Preedy applied a particular focus to referral to the NMC which was consistent with each of the 3 individuals concerned, regardless of race. The context was ultimately something which was addressed within processes and this affected the way in which they were resolved. An added issue here was that Mr Olayode did not assert that the incident with Patient A was related to race in the days and weeks following it taking place. Ms Preedy would have been well advised to provide information given by Mr Heath regarding his concerns about Patient A and underlying tendencies within him. But her way of completing referrals was quite narrow, but we were persuaded that this was not related to race (whether consciously or

unconsciously), but to the methodology that she applied when making NMC referrals.

161. Insofar as Ms Rutter's conduct was concerned, we did feel that it was important that we consider this allegation separately from the others because of the concerns we had about her handling of the disciplinary investigation. We did accept that there were failings on her part and that on balance, failures of this nature, while not having the purpose of creating an intimidating or hostile environment to Mr Olayode, they did have the effect of creating such an environment. She had a duty as investigating officer to adopt a fair process which considered all the issues. While she had right to make decisions as to what avenues were appropriate to investigate and which ones were not appropriate, she did not give the impression of having a closed mind and did not seek to manage Mr Olayode's expectations and concerns.

162. Was this unwanted conduct which had the effect of creating an intimidating or hostile environment related to Mr Olayode's race? We are aware that we needed to apply a wider consideration than compared with our consideration of direct discrimination above. However, despite our criticisms of Ms Rutter, we were unable to conclude that on balance there was evidence of a conscious or unconscious bias concerning the way in which she managed the process as alleged and that this conduct could be considered as relating to Mr Olayode's race. He had not been complaining about race from an early stage. Despite Mr Heath's comments regarding Patient A, we were not persuaded that Ms Rutter was placed in a position where she was expected to consider race in this incident and where she closed her mind to the question of race.

Mr Azeez

163. It is not necessary to consider in any detail the allegations of harassment relating to Mr Azeez as his complaints largely reflect those made by Mr Olayode above, other than that he was an agency worker, whereas Mr Olayode was employed.

164. The way in which he was precluded from working shifts was not conduct that could be considered as having the purpose or effect of creating an intimidating, hostile etc environment to Mr Azeez. The Tribunal were satisfied that the Trust handled to carry out the processes which they did and that this related to safeguarding and the requirement to have appropriately qualified nurses working on duty. The decision was not carried out in a high handed or hasty way, but following the incident on 1 March 2021, the nature of what was observed on the CCTV, required his removal from duties. Once his agency confirmed

shortcomings in his training, he could not be allocated further shifts until it had been completed.

165. There may be failings on the part of the Trust as to how it carries out vetting of those nursing staff, but it is not a matter which directly affects the issues under consideration. The NHS undoubtedly relies upon a great many external agencies and the increasing awareness of safeguarding and training requirements can create an additional pressure to all involved. However, health professionals also have a duty to ensure that they have the necessary training and accreditation and it was a combination of what happened on 1 March 2021 with Patient A and the subsequent discovery of shortcomings in Mr Azeez's level of training which gave rise to the alleged conduct and which was not related to his race.

166. There is no need to explore further the allegations relating to the NMC as they repeat what has been alleged by Mr Olayode above. We would refer to our decision in relation to his case in this regard and for the avoidance of doubt, do not accept that the conduct related to Mr Azeez's race.

Mr Adenekan, Mr Idama, Ms Nguetsop

167. Finally, these three claimants repeat their allegation in relation to direct race discrimination in their harassment complaint.

168. Again, it is not necessary to consider this matter in any real detail and all we would say is that we did not accept that the alleged unwanted conduct of precluding them from further bank shifts at Prospect Place had the purpose or effect of creating an intimidating, hostile etc, environment for them.

169. All of the nursing assistants who were present at the incident with Patient A on 1 March 2021, were required to undergo supervision and training. This reflected their more junior role than compared with the nurses involved who were expected to lead, have greater knowledge and who were referred to the NMC. However, any reasonable person would conclude that were inappropriate management of a patient had taken place, however challenging they might be, there would be a need for those involved to be subject to additional support. This is what happened here.

170. While harassment complaints do not involve consideration of treatment in relation to comparators, we did note that the way in which the conduct impacted upon these three claimants, was because of their bank status and there lack of line managers who could quickly react and provide the

necessary supervision and training. Others who were employed within Prospect Place had ready access to such manages and suffered less inconvenience than their bank colleagues.

171. It may be the case that NHS workers from BAME backgrounds may be found in greater numbers in the bank and agency sector than those who have permanent contracts in particular departments and in relation to particular shifts. The Tribunal was not provided with such data and in any event for the purposes of the complaint of harassment under consideration in this case, we were unable to conclude that the conduct complained of related to the claimants' race. We concluded that the conduct was solely because of the three claimants' bank status. While the Trust and the NHS more widely might consider it appropriate to explore how such scenarios could be avoided in the future, it must be the case that appropriate supervision and training must be allowed to take place before affected workers can return to their previous duties.

Conclusion

1. Accordingly, the decision of the Tribunal is that the following judgment must be made in relation to the claimants:

   a) The first claimant Mr Olayode's complaint of direct discrimination is not well founded, which means it is unsuccessful.

   b) The first claimant Mr Olayode's complaint of harassment is not well founded, which means it is unsuccessful.

   c) The second claimant Mr Azeez's complaint of direct discrimination is not well founded, which means it is unsuccessful.

   d) The second claimant Mr Azeez's complaint of harassment is not well founded, which means it is unsuccessful.

   e) The third claimant Mr Adenekan's complaint pf direct discrimination is not well founded, which means it is unsuccessful.

   f) The third claimant Mr Adenekan's complaint of harassment is not well founded, which means it is unsuccessful.

   g) The fourth claimant Mr Idama's complaint of direct discrimination is not well founded, which means it is unsuccessful.

   h) The fourth claimant Mr Idama's complaint of harassment is not well founded, which means it is unsuccessful.

i) The fifth claimant Ms Nguetsop's complaint of direct discrimination is not well founded, which means it is unsuccessful.

j) The fifth claimant Ms Nguetsop's complaint of harassment is not well founded, which means it is unsuccessful.

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Employment Judge Johnson

Date: 26 April 2024

JUDGMENT SENT TO THE PARTIES ON

29 April 2024

FOR THE TRIBUNAL OFFICE

Notes

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