# Independent Investigation Report

## Review of Five Complaints of

## Alleged Procedural Impropriety, Bullying and Harassment

## Worcestershire Health and Care NHS Trust

Conducted By
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tamarix people

- Executive & Leadership Coaching
- Organisational Development & Diagnostics
- Workplace Investigation & Conflict Resolution

The report reviews 5 complaints raised by former staff about their employment with the former Worcestershire Health organisations* and Worcestershire Health and Care NHS Trust

*Former organisations include: Worcestershire Mental Health Partnership NHS Trust and Worcestershire Primary Care Trust

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## 1. Executive Summary

### Introduction

1.1. The investigation was commissioned by the NHS Trust Development Authority (TDA) following representations by a group of complainants about the management and conduct of their individual employment cases by the Worcestershire Health and Care NHS Trust (WHCT) and the predecessor organisations to that Trust.

1.2. The Investigator was asked to complete an independent review of six cases that had been identified to the TDA where the individuals concerned alleged that there had been either some impropriety in the conduct of their case or that their case reflected bullying and harassment by managers employed at the Trust or its predecessor organisations.

1.3. One of the complainants withdrew their case at the commencement of the Investigation; only five cases were therefore considered.

1.4. Three of the cases concerned the former Worcestershire Mental Health Partnership NHS Trust and one the former Worcestershire Primary Care NHS Trust (PCT) (also known as NHS Worcestershire); these cases cover the period 2009/11. The fifth case concerns WHCT and relates to 2014/15.

1.5. The Investigator was asked to review each case and to consider if collectively, the management and HR processes surrounding the five cases indicated any common themes and specifically if bullying and harassment by managers of the organisations concerned was a common feature of the cases.

1.6. Alongside this the Investigator was asked to consider the effectiveness of the relevant organisation's processes and procedures for managing grievances and enabling staff to raise concerns in each of the five cases and if appropriate to identify any lessons to be learnt so that these could be shared with WHCT.

1.7. The full Report sets out the conclusions of the review of the five cases, and provides overarching conclusions about shared themes and findings that emerge from the consideration of those cases.

### Methodology

1.8. An independent and experienced investigator conducted the Investigation who has significant experience as a human resources professional including conducting similar reviews as well as senior leadership experience in the public sector.

1.9. A clear methodology was employed to assess the evidence against the relevant policies and procedures applicable to each case and key lines of enquiry following the specific the complaints made by the individuals concerned, set against the terms of reference for the Investigation.

1.10. A detailed desktop review was completed of each individual case.

1.11. The desktop review included an examination of the various documents concerning investigations and HR processes, audio recordings of hearings and witness statements, a review of transcripts, investigation reports, associated personnel records and various policies and emails.

1.12. In addition, each complainant was interviewed and allowed to submit any documentation they considered appropriate. Where possible witnesses were interviewed when there was an apparent conflict that could not be resolved from the documentary evidence base available.

1.13. In some cases it was not possible to access a witness because they had left the Trust.

1.14. In these cases, and where necessary, the Investigator used their judgement assessing the evidence objectively and applying the test of the balance of probabilities, by which it is meant assessing whether something is/was more likely than not.

**Key Themes**

1.15. The review identified 10 key themes. These are set out in detail in the body of the Report and for the executive summary the headings are provided below:

1) Take Consistent Reasonable Action across all staff.
2) Ensure that Investigations Establish Key Facts.
3) Maintain Objectivity and Impartiality.
4) Set out Allegations Clearly and Specifically.
5) Intervene in a Timely Manner.
6) Manage with the Employee in Mind.
7) HR As Guardians of Fair and Reasonable Process.
8) Maintain Transparency and Good Governance in Investigations.
9) Be Open to Correcting Procedural Errors.
10) Keep a Fair and Balanced Perspective.

**Conclusions**

1.16. A significant conclusion however, notwithstanding the above themes, is that there is insufficient evidence to support the overarching suggestion by the complainants that these cases are exemplars of a systemic problem of abuse of staff by managers at the organisations concerned.

1.17. In one of the WMHPT cases (Case B in the Report) there is evidence of considerable support to an employee in the management of their sickness absence, which was possibly above and beyond the minimal statutory duties and policy considerations that could have been applied in the circumstances.

1.18. in one other case (Case C in the Report), the concurrent disciplinary case (on which there was some mutual dependency of case C, and more significant disciplinary charges), showed that the managers (who would have also been responsible for hearing case C) demonstrated a constructive and lenient consideration of the issues.

1.19. The PCT case shows a considerable delay in tackling an emergent workplace concern however, that at a very late stage when a senior manager became involved, a balanced and fair approach in seeking to resolve issues between two employees and in seeking to enable an employee to return to work in a supported way to resume their career.

1.20. The remaining two cases fall short for disparate reasons; one (Case A), because of the quality of the investigation (which in itself was complex and restricted because of concurrent litigation); and the other (Case E), because of the ill judged approach of the commissioning manager to the investigation.

1.21. Similarly, the evidence does not support the broad allegation by complainants that these cases show that managers singled out individuals because (allegedly) they are considered awkward, or because the manager or organisation had something to hide/wanted a scapegoat.

1.22. This appears to be a particular interpretation of the cases which on the balance of probabilities is likely to have arisen because in some cases, the complainants were not in full possession of all the relevant facts which, for rational reasons of confidentiality and wider responsibilities to other parties involved in the cases concerned, was not available to them.

1.23. There is, however, evidence that historically the predecessor organisations to WHCT could seemingly be insensitive or reluctant to respond to concerns raised in some of the cases reviewed which staff side says is no longer the case. However, this is a possibly causal factor for some of the concerns within the cases reviewed.

1.24. The review found some inconsistency in the general standards and approaches of internal investigating officers and arrangements for commissioning investigations and conducting hearings, with the reported training of investigation officers being provided from variable sources. Investigation reports were of variable standards with some excellent examples and others weaker.

1.25. There was also some inconsistency in the role adopted by HR advisers with some showing a strong independent advisory role and others more passive or at times drawn into overly supporting the investigating officer (albeit for rational reasons at the time).

1.26. The cases show that the individuals involved, have struggled to come to terms with their experiences as a consequence, which is understandable because they did not feel

that at the time their concerns were heard and conflict with an employer is always an emotionally distressing experience, whatever the circumstances.

1.27. It may have been helpful if more care had been taken by the predecessor organisations in particular to ensure through effective case management, that the experience and timeliness of the relevant procedures in each case was kept under objective review, and if less daunting language and processes could have been used either to resolve issues at an earlier less formal stage, or to clearly explain the issues of concern.

1.28. There is some evidence that the actions of some individuals or others acting on their behalf has played a part in the development of their cases at the time and, there is evidence that others involved in their cases have subsequently (or in some cases at the time), been equally distressed by the continued representations of partial aspects of the cases which they consider has not given balance to the full issues.

1.29. It is hoped that as a result of the Independent Investigation and publication of the Report on the outcomes of that review, together with the anticipated commitment of WHCT to follow up on the various recommendations in the Report that it will provide an opportunity for closure and for all to move forward.

**Overarching Recommendations**

1.30. The following recommendations have been brought forward as wider supporting recommendations, to underpin the findings of the individual case reviews and the key themes identified.

1.31. The intent of the recommendations is to encourage the further development of the positive culture that is reported to be emerging in WHCT, and to support learning from the case review.

1.33. It is recommended that in addition to the individual recommendations for each case WHCT should:

i. Review the cadre of internal investigating officers to ensure that all have the relevant competencies to undertake internal investigations and that there is sufficient depth and breadth to avoid any potential or legitimately alleged conflicts of interest.

ii. Refresh the training of investigation officers and develop or commission jointly with staff side a new training programme which ensures that all are accredited internally and are operating from a standard framework which is consistent with WHCT's new values and disciplinary policies and procedures.

iii. Review and clarify the arrangement for disciplinary and associated HR case management to ensure that there is regular monitoring of progress of individual cases and that employees are not “lost” in the processes.

iv. Consider with staff side how, in addition to measuring the number of disciplinary cases etc. they and the Trust may reasonably assess the qualitative experience of the management of such cases.

v. Review with staff side if it is entirely necessary to record all interviews in employment processes and if the style and content of associated correspondence can be improved so that it is both compliant with any necessary legal advice and drafted in a manner that is less daunting.

vi. Continue the review of employment policies in partnership with staff side.

vii. Ensure that managers at all levels are provided with refreshed training and guidance to ensure that actions and behaviours align with the revised employment policies and WHCT’s value base.

viii. Ensure that HR continues, and is supported and encouraged, to challenge appropriately, where they consider investigations may potentially be handled by informal resolution rather than formal procedures.

## 2. Background to Investigation and Methodology

### Introduction

2.1. The investigation was commissioned by the NHS Trust Development Authority (TDA) following representations by a group of complainants about the management and conduct of their individual employment cases by the Worcestershire Health and Care NHS Trust (WHCT) and the predecessor organisations to that Trust

2.2. The Investigator was asked to complete an independent review of six cases that had been identified to the TDA where the individuals concerned alleged that there had been either some impropriety in the conduct of their case or that their case reflected bullying and harassment by managers employed at the Trust or its predecessor organisations.

2.3. Six cases were originally agreed with the TDA as eligible for the review. One complainant withdrew in August 2015 immediately prior to the commencement of the Investigation and only five cases were therefore reviewed by the Investigation.

2.4. Three of the cases concerned the former Worcestershire Mental Health Partnership NHS Trust (WMHPT) and one the former Worcestershire Primary Care NHS Trust (PCT) (also known as NHS Worcestershire); these cases covered the period 2009/11. The fifth case concerned WHCT and relates to 2014/15.

2.5. The investigation was commissioned at the end of July 2015 and concluded at the end of November 2015.

### Background to the Trust

2.6. WHCT was established on 1 July 2011. It manages the vast majority of the services that were previously the responsibility of Worcestershire Primary Care NHS Trust's Provider Arm, and the mental health services that were previously responsibility of Worcestershire Mental Health Partnership NHS Trust.

2.7. The Trust serves a population of approximately 560,000 across an area of approximately 500 square miles, with a relatively high proportion of residents' aged 65 and above. Major urban areas include the towns of Worcester, Bromsgrove, Kidderminster, Redditch, Evesham, and Malvern.

2.8. The three Clinical Commissioning Groups in Worcestershire commission the majority of the Trust's services.

### Terms of Reference

2.9. The terms of reference asked the Investigator to consider the management and HR processes surrounding the five cases allocated in order to identify if there were common themes that underpinned the five cases.

2.10 The investigator was asked to identify if bullying and harassment by managers of the Trust was a common feature of those cases.

2.11. The investigator was also asked to consider the effectiveness of the processes and procedures for managing grievances and enabling staff to raise concerns in each of the five cases in order to identify any lessons that could be learnt and shared with WHCT.

2.12. It was clearly specified in the terms of reference that the Investigation should not re-open any of the previous investigations that had been completed under the relevant organisation's procedures and that the focus of the review was the handling and management of the five cases identified.

2.13. The terms of reference also specified that a detailed desktop examination of the five cases should be undertaken alongside documentation submitted by the five complainants and any other relevant documentation that the Investigator considered relevant to the core purpose of the Investigation.

2.14. The terms of reference required that the Investigation Report should be a summary of the enquiries made and show relevant findings and recommendations about what further actions should be considered.

2.15. It was also stated that the TDA intended to make the report publically available and that the Report should not name or identify individuals.

**Methodology**

2.16. Carole Taylor-Brown, an accredited experienced independent investigator, who had no prior connection with the health system or any individuals referenced in the five cases to be considered was appointed to undertake the Investigation.

2.17. At the commencement of the Investigation in late July 2015, the TDA hosted a meeting with the five complainants, some of their representatives, together with the Investigator to set the context for the Investigation.

2.18. The TDA sought consent from each of the individuals to release a summary report that had previously been lodged with the TDA to the Investigator. For four cases, a representative of those individuals prepared this summary; the fifth complainant submitted a separate summary document.

2.19. These summaries were used to form the basis for individual interviews, which were conducted with each complainant (accompanied by a representative) in August 2015, when each complainant was invited to give an individual account of their case and concerns and to submit any further relevant documents to the Investigator.

2.20. The Investigator asked WHCT to provide the full documentation of each of the five cases including any relevant policies and procedures to enable the detailed desktop analysis.

2.21. There were some delays in accessing the information from WHCT because of the historical nature of the cases and in some cases because third party consent was required to access some case material.

2.22. A detailed desktop analysis was completed of the documentation for each case including a review of witness transcripts, audiotapes, disciplinary and associated hearings, relevant policies, procedures, emails and other documents.

2.23. Whilst every attempt was made by WHCT to retrieve some of the historical information requested, not every item single document could be traced, however the core material was made available.

2.24. The Investigator is satisfied that for the purpose of the Investigation, they have seen sufficient information in relation to each case to reach a fair and balanced judgement on the issues that they have been asked to consider.

2.25. In areas where there was a conflict or uncertainty about the evidence reviewed, witnesses were interviewed; again having regard to the historical nature of the majority of the cases and the potential for a lack of reliability in recall given the passage of time, this was kept to a minimal level.

2.26. Where resolution of conflicts of evidence was not possible due to the unavailability of documents or because the relevant individual had left the employ of the Trust, the Investigator used their best judgement, applied objectively, against the test of the balance of probabilities. This means that having considered all the evidence, the Investigator reached a conclusion that something is or was, more likely than not.

2.27. All interviewees seen by the Investigator including the complainants were given a summary note of their interview and all agreed those notes with the Investigator. Some individuals submitted additional documents in support of their statements that were received and considered by the Investigator.

2.28. In areas where the working draft Report identified a likelihood of a potential criticism of an individual and in accordance with the terms of reference, that individual was given an opportunity to comment before the Report was finalised

2.29. Every reasonable effort has been made to protect the identity of individuals discussed within this Report. It is evident however for reasons outside the control of the Investigator, that it may be possible that some individuals may still be identifiable because others have publically shared some aspects of the individual cases, including particular details given during internal investigations conducted by the relevant organisation.

**Acknowledgements and Declarations**

2.30. The Report has been prepared solely for the use of the NHS TDA and WHCT. Details may be made available to other NHS bodies including NHS England or specified external agencies for example external auditors. Otherwise the Report should not be quoted or referred to in whole or part without prior consent. No responsibility to any third

party is accepted as the Report has not been prepared and is not intended for any other purpose.

2.31. The Investigator would like to thank all participants for their co-operation and openness in the course of this Investigation. Particular thanks are extended to Louise Collins at the TDA who assisted with the administration of the Investigation.

2.32. The Investigator confirms that they had no previous direct or indirect professional connection with WHCT or its predecessor organisations or with any of the individuals interviewed as part of the Investigation.

## 3. Introduction to Case Reviews

3.1. Each of the five cases has been subject to a detailed desktop review to consider the management and HR processes surrounding the individual case, and through this to identify any common themes that underpinned the cases including if bullying and harassment by managers was a common feature.

3.2. For the avoidance of doubt it was not intended that this review would re-open the individual cases and given the historical nature and extent of documentation available, witnesses have only been interviewed where there has been a need to clarify conflicting evidence.

3.3. In introducing each of the case reviews it is relevant to stress that the detailed desktop analysis has involved a review of documents, including witness statements, transcripts and audio recordings of interviews and or hearings.

3.4. Access to some aspects of the evidence has required consent from third parties in accordance with the Data Protection Act 1998. Reasonably, in these circumstances, some of the third parties have expressed concerns about the use of the information in any public report and sought assurance in this regard.

3.5. It has been agreed by the TDA that this Report would manage material sensitively and would protect anonymity.

3.6. The case reviews that follow in sections 4 – 8 of the Report have, therefore, been presented to provide a summary timeline and overview of the case along with evidence to support key findings and conclusions.

3.7. The individuals have been anonymised and to further protect third parties, dates have been given in the month and year only.

3.8. Individual complainants have subject to their agreement, been given the opportunity to have a more detailed explanation pertinent to their case, subject to their agreement that the fuller explanation was not for publication for the reasons set out in paragraph 3.5 and 3.6. above.

## 4. Case A: Worcestershire Mental Health Partnership NHS Trust: 2009/10

### Context

4.1. This case concerns a staff nurse (referred to as A in this Report) who was dismissed from the predecessor Worcestershire Mental Health Partnership NHS Trust (WMHPT) in April 2010 following a disciplinary investigation.

4.2. The summary timeline and circumstances of the case are as follows:

*October 2009*

1) A was responsible for managing a shift on an inpatient ward in late October; there had been some previous issues concerning a patient and their carer on earlier shifts that A was made aware of when they commenced their shift. During the shift in question, the patient who had been highlighted to A by their colleagues, self harmed and was subsequently released from the ward by A without proper authorisation.

2) A contacted their line managers about the incident during the shift, neither of those managers raised any concerns at that time about the incident or A's handling of the matter, although one gave specific advice about obtaining authorisation for the patient to leave the ward which A failed to do.

3) Neither of the managers contacted appeared to have been concerned about the incident reported to them by A. One did not follow up on the advice they gave A when they took over the ward from A later the same evening. The other manager showed no concern when informed by A during the shift in question, that A had not allowed the carer onto the ward and had asked a more junior colleague to deal with the carer at the ward entrance.

4) When the incident was reported through the clinical incident reporting system by A the following week, the same manager rated the incident as minor, although anticipated in that report that the incident may generate a subsequent complaint.

*November 2009*

5) The anticipated letter complaint was received by the Trust a few weeks later (10 days after the date shown on the letter). The complaint covered a number of issues about the patient's care over the course of their inpatient stay, including a specific incident when the patient sustained a self-harm injury whilst A was the staff nurse in charge of the ward.

6) The complaint was investigated in accordance with the Trust's complaints procedures following which it was escalated to a senior manager because of the issues identified in the complaint and, the inconsistencies between the complainant's account and that of the staff concerned.

7) It was determined by the senior manager that a number of actions needed to be taken including the commissioning a disciplinary investigation in regard to the actions of A and one of their junior colleagues when the incident took place.

*December 2009 - February 2010*

8) The disciplinary investigation was initiated in December 2009 when A was suspended. Interviews of the key witnesses took place over January and February 2010.

*March 2010*

9) In mid-March 2010, the investigating officer reported their findings to the senior manager who had commissioned the report. The senior manager determined a disciplinary hearing was appropriate for A and their junior colleague (Case B).

10) At the same time the senior manager agreed with the investigating officer's recommendations that the actions of one of the line managers concerned should be dealt with through a supervisory route and agreed that for the other manager the concerns identified should be taken forward as part of a wider programme of action concerning that individual at that time.

11) One other individual mentioned in the wider investigation and complaint was dealt with under the Trust's capability procedures.

*April 2010*

12) A attended a disciplinary hearing in April 2010 which determined that A should be dismissed and that A should be referred to the Nursing and Midwifery Council (NMC) for consideration of their fitness to practice.

May/June 2010

13) A appealed against the dismissal decision. The Trust sought to make arrangements for the appeals hearing after establishing with A details of their representative who was a Full Time Trade Union Officer (FTO).

14) The Trust attempted to agree dates for the appeal hearing with the FTO and after waiting for a reasonable period for a response that was not forthcoming, set a date in September 2010. This date was subsequently amended at the Trade Union's request to October 2010.

*October 2010*

15) The hearing took place in early October 2010 when the decision of the disciplinary hearing was upheld.

16) Subsequent to the appeal, A submitted a claim to the Employment Tribunals Service.

*February 2011*

17) A withdrew their Employment Tribunal application after taking legal advice and following receipt of a costs warning notice from the Trust's solicitors.

*February 2012*

18) The NMC subsequently investigated and considered the Trust's referral of A against their criteria for a registrant's fitness to practice.

19) In February the NMC advised A and the Trust that there was no case to answer as regards A's fitness to practice.

**Summary of Concerns**

4.3. A considers that in the management and conduct of their case there was a failure by the Trust and/or managers to:

a) Ensure an appropriate response to the incident leading to the complaint and that line managers did not accept their responsibility in the management of the matter in the subsequent investigation.

b) Adhere to the proper management of the complaints procedures and to instigate a safeguarding referral.

c) Comply with Trust disciplinary procedures including failing to manage conflicts of interests for some key individuals involved in the investigation and that there was a lack of impartiality in the conduct of the investigation and hearings.

d) Deal consistently and equitably with managers and staff in the conduct of the investigation and that there was a general failure in the duty of care for A during the case.

The concerns have been considered against the evidence base and reported below.

**Line Managers Response**

4.4. There is limited evidence that A's line managers showed any significant concern about the incident or took any remedial action immediately after the incident to support or reprimand A, or to investigate the wider issues surrounding this patient until a complaint was received a few weeks later.

4.5. These managerial failings were identified as part of the Trust's wider investigation and for which actions were identified and implemented in respect of the managers concerned.

4.6. These were not matters that A or their representatives brought forward as a concern during the course of their disciplinary case.

**Management of Complaint**

4.7. The complaint was properly investigated in accordance with the complaints procedures by the Trust's PAL's team although seemingly at the local ward level there was some loss of control of the number of copies of the complaints letter retained by staff who were asked to complete statements.

4.8. This was not a concern that A or their representatives brought forward during the course of their disciplinary case.

## Safeguarding

4.9. There is no evidence that any individual, including A, considered at any time that the patient's case should be referred as a potential safeguarding issue under the Trust's Adult Safeguarding Policy.

4.10. The criteria set out in the Adult Safeguarding Policy suggests that the patient should have been referred for a safeguarding review. The criteria indicates that this should have happened when the patient re-presented to the ward the day following the incident on A's shift, or failing that, when the clinical incident report was completed, or when the complaint was received and investigated or when the disciplinary investigation was commissioned.

4.11. Wider evidence suggests that at that time, such incidents were in general, more likely to be investigated and reported as a clinical incident on the inpatient ward (as happened in this case) and not reported as safeguarding incident.

4.12. This is in contrast with the current position, which the Investigator was advised would normally see such matters, escalated as standard practice. The current WHCT disciplinary procedures give greater prominence and focus to consideration of a safeguarding matter in the conduct of an investigation.

4.13. The lack of safeguarding referral was not a concern that A or their representatives brought forward during the course of their disciplinary case. It is also a matter for which A as a clinician as well as others (managers and clinicians) would also have had a responsibility to raise under the Trust's Adult Safeguarding Policy.

## Administrative Failings in the Management of the Case

4.14. At an administrative level, there was a failure to properly monitor the suspension period for A, and a delay in issuing a copy of the disciplinary procedures to A. This was not compliant with the Trust's Disciplinary Procedures however A was supported at all stages by a trade union representative who would have been familiar with the terms of the disciplinary process and able to advocate on A's behalf.

4.15. In context, allowing for the impact of the Christmas period and the unavoidable rescheduling of a second interview with A due to the availability of their representative, the investigation was completed in a reasonable time frame.

4.16. A substantive delay in the conduct of this case arose in the organisation of the appeals panel. This rested largely with the availability of A's representative and also the concurrent issues of planning the hearing over the peak summer holiday period.

4.17. The management of the suspension and delay in the issue of the disciplinary procedures were issues that A's FTO highlighted at A's appeal panel and which were acknowledged by the Trust as administrative failings.

4.18. None of the administrative issues appears to have had a material impact on the conduct of the investigation.

4.19. The delays in the management of the disciplinary case could undoubtedly have added to A's emotional distress at the time however given that two significant delays were as a result of the lack of availability of A's representatives it is difficult to conclude that the Trust was culpable.

**Potential Conflicts of Interest**

4.20. There is no evidence to support any suggestion that the senior manager responsible for commissioning the investigation was conflicted in their role.

4.21. The evidence shows that the premise for this allegation was based on unfounded speculation and gossip that was circulating in the Trust at that time. This gossip was a matter of concern for the senior manager concerned and their managers, however, no action was taken by the Trust because the perpetrators of the rumour mongering could not be readily identified.

4.22. The investigating officer met the criteria set out in the disciplinary procedures for appointment to that role however, they had previously managed the staff concerned in the incident (up until 2001/2) although they had no involvement in the ward of A's management at the time of the investigation.

4.23. In general terms this should have not have presented any conflict of interest and it would not be unusual for managers to investigate areas that they previously managed (provided that they met the general terms set out in the disciplinary procedures). This was not a concern that A or their representatives raised at the time of their investigation.

4.24. A (and B) have subsequently suggested that this familiarity was a potential conflict of interest for the investigating officer concerned. On balance however the evidence suggests that this concern is primarily related to the manner with which the investigation was conducted and which is discussed further below.

**Conduct of Investigation**

4.25. The evidence shows that the investigating officer did not maintain sufficient impartiality throughout the investigation, partly because they undermined this by meeting with the line manager of some witnesses immediately prior to interviewing those witnesses, and also because in the disciplinary interview with the same line manager invited speculation in a conversational manner, about the employees on the ward in question.

4.26. Further, the evidence shows that they did not test sufficiently some of the evidence of the line manager robustly, and specifically when the line manager made unsubstantiated allegations and statements to the disadvantage of A.

4.27. The transcripts show that the investigating officer used leading questions and reframing of responses as a predominate interview style and in one interview in particular, seemingly pressured a witness in regard to their account of events. On the balance of probabilities, this might reasonably be concluded to have resulted in unreliable evidence from that witness.

4.28. There is no evidence that suggests this was a malicious action by the investigating officer, who reports a particularly complex investigation.

4.29. The investigating officer also says that by virtue of their professional background they are inclined to reframe issues to help understanding particularly when dealing with difficult interviews and that they did not consider that this was inappropriate in the investigation. It should be noted that neither witnesses nor their representatives raised concerns during the course of those interviews.

4.30. The investigating officer also says that in their mind, there was an unusual coincidence in the detail and specific adjectives used in the accounts offered by A and two other key witnesses and, that in consequence, they felt this had to be tested robustly against the complaint. The HR adviser in attendance at the interviews concerned also supports this position.

4.31. The evidence further shows that the investigating officer did not on balance, explore the evidence base sufficiently and equitably. In part because they did not interview all of the potential relevant witnesses and, did not appear to test the managers' and complainants' evidence with the same rigour that they applied to the staff evidence. It also appears on balance, that they gave more weight to the complainant's evidence than to the staff accounts including in relation to some contentious photographic evidence submitted by the complainant.

4.32. The investigating officer says there were some restrictions, which applied to examining in detail the complainant's evidence because of the concurrent litigation process and that they sought to verify the evidence but had to do so through the complainant's legal representative.

4.33. The investigating officer accepts they did not test some aspects of the line manager's evidence because in one case concerning authorisation of mental health patients' leave, they had knowledge of the general email to which the manager was referring.

4.34. They also acknowledge that they did not look at the clinical incident report signed off by the manager and did not interview two other potential witnesses; one because they did not appear to be present during the incident and the other because the Trust's Policy at that time did not extend to include witness statements from other patients; in addition to which they did not consider that the other patient could reliably comment on the self harm injuries sustained by the patient involved in the incident.

4.35. There is no evidence to show that at the initial disciplinary hearing that the above issues were raised as concerns by A or their representative however they were highlighted to the appeals panel as material concerns by A's FTO and were also reflected as matters of concern in the external review of the case by the NMC.

4.36. There are also some areas of the investigation where the record keeping of the investigating officer is not fully complete and relates to areas where they have not fully accounted for or recorded conclusions or judgements they have reached.

4.37. This includes the documentary trail for the actions to be taken against managers, however, this Investigation was able to establish sufficient evidence to assure that there was an agreed course of action for the managers that was taken forward by the Trust.

**Disciplinary Hearing and Appeals Panel**

4.38. The evidence shows that there were some potential opportunities at both the disciplinary hearing and the appeals panel for some of the above issues to have been examined and tested more robustly (at the disciplinary hearing) or potentially corrected (at the appeals panel).

4.39. The disciplinary hearing did not fully test or challenge the investigating officer's report nor did it critically examine some of the evidence offered in the hearing. This was particularly so when a line manager submitted some verbal unsubstantiated evidence.

4.40. It is possible that on the balance of probabilities, the hearing missed two potential opportunities during the course of receiving witness evidence to open up the issues concerning the line managers' response to the incident. The Chair of the hearing does not accept that this is a valid judgment by the Investigator.

4.41. The Chair of the hearing also failed to intervene in a timely way, to stop leading questions by the investigating officer and that evidence given in response to leading questions led to a statement by the witness of unsubstantiated evidence.

4.42. The Chair did subsequently caution the investigating officer on the use of leading questions but this was after the witness had left and the Chair did not in the course of the hearing, give any direction as to the weight to be given to the evidence given in response to leading questions.

4.43. The appeals panel did not fully explore or accept some of the issues highlighted by A's FTO as regards the substantive matters of equity and balance in the conduct of the investigation.

4.44. It appears from the final comments of the appeals panel, that a greater focus was given to the administrative concerns over the equity issues raised; on the balance of probabilities, it is likely that the lack of a written submission by the FTO to support those concerns, was unhelpful.

## Duty of Care

4.45. There is limited evidence at all stages of this case that consideration was given to the experience of A during and immediately after the incident in question and during the management of the case overall.

4.46. In particular, having regard to the reported concerns of other staff about some aspects of the complainant's alleged behaviour, there is limited attention to the impact of this on A and their feelings of intimidation.

4.47. There was some recognition verbally by the investigating officer that the information given to A when they took over the shift may have impacted adversely upon A and raised A's concerns about dealing directly with the carer, but when the investigating officer did so they also suggested that other more junior colleagues had not felt intimidated.

4.48. There is no evidence that the wider investigation provided evidence of the effect of the alleged behaviour by the complainant on staff in general or A in particular.

4.49. A's FTO raised the alleged behaviour of the complainant and A's feelings of intimidation as part of mitigation but did not identify the matter as directly linked to the Bullying and Harassment Policy or suggest that managers had been remiss in their support in this regard.

4.50. There is no evidence that A or their representatives raised any concerns as regards the Trust's duty of care.

## Raising Concerns

4.51. A and their representatives raised a number of concerns about the conduct of their case formally through the disciplinary procedures and specifically at the appeals panel.

4.52. There was no claim by A to this Investigation or any evidence to suggest that this was impeded in anyway by the Trust, although the case was escalated to the Employment Tribunals Service (ET).

4.53. A says they withdrew their ET claim as a result of legal advice which suggested that they were unlikely to succeed and also because they had become emotionally fragile after losing their job and income.

4.54. A also reports feeling intimidated by the cost warning letter from the Trust's solicitors, which although a fairly standard practice for respondents when contesting claims, was not a matter about which they had been forewarned by their representatives.

4.55. A says in any event the most pressing issue for A at this time, was the NMC referral which they and their Trade Union considered to be unduly harsh and punitive on the part of the Trust; in the event, this was not supported by the NMC which in their investigation, identified some flaws in Trust's internal investigation.

## Bullying and Harassment

4.56. There is no evidence to support a claim that the conduct of the disciplinary investigation or the associated hearings was indicative of any particular malice by any individual or group of individuals towards A personally.

4.57. Equally it is difficult to evidence that in itself the management and conduct of the case shows particular actions by an individual, including the investigating officer, that would have been in breach of the Trust's Bullying and Harassment Policy.

4.58. There is, however, some wider contextual evidence that suggests that the case may provide support for allegations made about the wider corporate culture in respect of the management and conduct of disciplinary investigations and associated HR processes at that time in this Trust, which has been reported to the Investigation and is discussed more fully in Section 9 of this Report.

## Conclusions

4.59. The overall conclusion of this Investigation is that the management and conduct of this case falls short when set against the key policies of WMHPT that were applicable at the time and, specifically the disciplinary procedures and adult safeguarding policy.

4.60. The disciplinary investigation was not well balanced; in some areas the investigating officer lost impartiality and did not equitably weight and examine all the evidence and did not fully account in their report for some of their judgements and decisions.

4.61. On the balance of probabilities it is likely that the strong presentation of the evidence by the manager and the concurrent litigation had a detrimental impact of the ability of A to secure a fair and balanced consideration of their case.

## Recommendations

4.62. Having regard to the imbalance of the original investigation that this review of the case has identified, and the consequent detrimental impact that this had on A's career it is recommended that:

i. WHCT formally and directly apologises to A for the conduct and management of their disciplinary investigation by the predecessor WMHPT in 2010.

ii. WHCT engages with A (subject to their agreement) to explore what options might be possible to support a mutually acceptable arrangement to facilitate a return to practice and resumption of their career as a registered mental health nurse.

## 5. Case B: Worcestershire Mental Health Partnership NHS Trust 2009/10

### Context

5.1. This case concerns a Healthcare Assistant (referred to as B in this Report) who was dismissed from the predecessor WMHPT in March 2010 in accordance with the Trust's sickness management procedures.

5.2. B was managed formally under the Trust's sickness absence procedures from 2008 until their dismissal. B was a colleague of staff nurse A (discussed above) and was in 2009/10 subject to a concurrent disciplinary concerning the same incident which led to A's disciplinary investigation.

5.3. The summary timeline and circumstances of the case are as follows:

*January/July 2008*

1) As a consequence of their poor attendance levels B was subject to regular review; local targets were set for sustained attendance coupled with supportive interventions.

2) The management interventions included referral of B to occupational health that identified that B had an underlying medical condition and recommended some workplace adjustments. The manager implemented these locally.

3) Occupational health also offered some therapeutic interventions to support B with their condition and suggested that B should consider reduced hours or alternative employment, which although offered by the manager was declined by B.

4) In June 2008, because of falling attendance levels, B was referred to a first formal review of their attendance levels.

5) The formal review determined that as B had shown some improvement in their attendance during the summer of 2008 that no further action would be taken but reserved the right to escalate the matter to a second formal review if B's attendance levels deteriorated below the target level set by their manager.

*January/September 2009*

6) In 2009 B's attendance showed deterioration against the target levels set and after meeting with B, the new line manager, (who had continued to support the previous manager's interventions and responded to further requests by B for adjustments in their working pattern), made a further referral to occupational health.

*October/November 2009*

7) In early October 2009, after meeting again with B, the line manager escalated B's attendance issues to a second formal hearing as provided by the outcome of the previous hearing in 2008; the arrangements for the meeting were passed to the HR administration team to organise.

8) In late October 2009 B was involved in the incident concerning A set out in the previous section of this Report. B was also party to the complaints investigation that followed.

*December 2009*

9) In December 2009 B was suspended pending a disciplinary investigation into issues arising from the incident on the ward when staff nurse A was in charge of the ward and in which B was the subject to an aspect of the complaint.

February/March 2010

10) In early February 2010 the second formal hearing into B's attendance levels was held and determined to refer B's case to the final stage of the sickness procedure known as a dismissal decision hearing.

11) The dismissal decision hearing was conducted in mid-March 2010, when B was dismissed for persistent poor attendance over a four-year period. B was offered the right of appeal against the decision but did not do so.

12) Subsequent to their dismissal, B was notified by the Trust that the disciplinary investigation had been concluded and that as a result it had been determined that if B had still been in employment, the matter would proceed to a disciplinary hearing.

13) A letter to this effect was placed on B's personal file.

**Summary of Concerns**

5.4. B considers that in the management and conduct of their case there was a failure by the Trust and/or managers to:

a) Correctly adhere to the Trust's sickness procedures and alleges that HR advisers and a line manager manipulated this procedure to secure B's dismissal in advance of their and A's disciplinary hearing.

b) Act reasonably having regard to B's medical condition and the relevant legislation.

c) Comply with Trust disciplinary procedures in the management of B's disciplinary investigation.

d) Exercise a duty of care towards B.

**Management of Sickness Absence**

5.5. A review of the full case history of B's sickness absence management shows that occupational health identified to B's managers that B had an underlying medical condition that may result in some periods of short-term absences.

5.6. Occupational health suggested some workplace adjustments that they felt may reduce the frequency of these absences and further supported this with some therapeutic interventions. They also suggested that B might find it more helpful to reduce their working hours or to consider alternative employment.

5.7. There is a clear audit trail which shows that managers responded to these recommendations and implemented reasonable adjustments to B's working patterns and arrangements to accommodate the reported underlying medical condition and, continued to do so throughout the period 2008/9.

5.8. The records also show that B declined the offer of reduced hours or alternative employment made by a line manager and did not make full use of the therapeutic interventions that were offered by the Trust.

5.9. There is also evidence in the sickness records that a significant proportion of B's absences from work were not related to the reported underlying medical condition (which B accepts to be the case and particularly so in 2009).

5.10. Two managers managed B over the period 2008 – 2009 and both independently determined that B's attendance levels had not substantially improved notwithstanding the various adjustments and flexibilities afforded. Both concluded that B's attendance record was not conducive to the operational needs of the ward and escalated their concerns to formal hearings in line with the sickness absence policy.

5.11. The decision to escalate B's attendance issues in October 2009 to a second formal hearing was taken by the line manager and HR adviser two months prior to any suggestion of a disciplinary investigation in relation to B.

5.12. The evidence shows that this decision also followed a further referral to occupational health, further local adjustments requested by B's GP and a discussion with B about the underlying contributory factors.

5.13. There was a substantial delay in arranging the second hearing, for which there is no single obvious explanation although there appear to be a number of contributory factors.

5.14. The most important of these concerned B's scheduled appointment with their medical consultant whose advice was material to the further consideration of B's attendance issues. The outcome of the appointment was not known until the end of November 2009.

5.15. More or less at the same time as this matter was clarified, the complaints investigation concerning the incident on the ward which occurred in late October 2009 commenced and both B and the line manager became involved in the complaint and disciplinary investigations over the period late November 2009 - January 2010.

5.16. HR have confirmed that although neither the disciplinary or sickness management process was reliant on the other it would have been challenging for the HR administration team to secure all the necessary independent staff for the second formal sickness hearing

given the impact of the Christmas holiday period; however, there is no evidence to show that this was definitely the case.

5.17. There is no evidence to support that the line manager concerned or HR advisers/administrators manipulated the timing of the second formal meeting and on the balance of probabilities, it is more likely that the arrangements for the meeting were delayed as a consequence of the combined factors set out above

5.18. The second formal hearing held in early February 2010 determined that B's case should be referred to the final stage dismissal decision hearing because it was considered by that hearing that there was no assurance that B could maintain a reasonable attendance level, notwithstanding the workplace adjustments that had been put in place over a period of time.

5.19. The dismissal decision hearing was organised for mid-March and the evidence shows that this hearing explored very carefully B's ability to give assurance that they could sustain a regular pattern of attendance at work. A trade union representative supported B at the hearing; it was acknowledged by that representative that the Trust had been supportive and agreed that other circumstances outside the underlying medical condition had impacted on B's attendance during 2009.

5.20. The hearing concluded that the evidence showed that although there had been a number of adjustments and flexibilities in B's working arrangements. B's persistent poor attendance over a four-year period had not improved. The hearing therefore determined that B should be dismissed with notice.

5.21. The decision was appropriately conveyed to B who was also advised of their right of appeal but did not do so.

**Consideration of the Medical Condition**

5.22. The evidence shows that in managing B's case the Trust showed considerable support and responsiveness with a range of reasonable adjustments to respond to B's underlying medical condition, which at the time was not specifically covered by the Disability Discrimination Act 1995 (DDA).

5.23. The condition is covered in the Equality Act 2010 although that came into effect seven months after B had been dismissed.

**Disciplinary Investigation**

5.24. B's disciplinary investigation was run concurrent with A's and would have been subject to the same evidence base as A, however, because the case did not proceed to a hearing, B was not supplied with a disciplinary report and supporting evidence by the Trust. The majority of B's representations to this Investigation rely on their knowledge and access to A's documents and case.

5.25. For this reason the focus of this case review has been directed to the particular issues concerning B rather than the wider issues concerning the disciplinary investigation that have already been addressed in the consideration of A's case.

**Administrative Issues**

5.26. At an administrative level, there was a failure to properly monitor the suspension period for B. This was not compliant with the Trust's Disciplinary Procedures.

5.27. In addition it appears that the senior manager allocated to meet with B to advise of their suspension, did not do so and delegated this to another person. This was unknown to the Trust and was not an issue that B raised as a concern during the course of their disciplinary investigation.

5.28. There is no evidence to suggest that either matter had a material impact on the course of the investigation although it is evident that the delegation of the suspension meeting caused some avoidable distress to B at that time.

**Contact Restrictions**

5.29. During B's suspension (and in common with A), the Trust placed restrictions on B having contact with Trust colleagues except for specified individuals unless B had prior approval from a senior manager. This became a matter of contention when it was identified during the course of the investigation that B had maintained social contact with a colleague who was a key witness to the disciplinary investigation.

5.30. As a consequence the investigating officer and an HR adviser considered that B had contravened the terms of their suspension, which both B and their representative challenged with the HR adviser unsuccessfully when it was raised with them.

5.31. The commissioning officer for the disciplinary investigation, acting on the advice of HR, issued a further allegation against B, which alleged that because of the contact, that B had had with another witness they had breached their terms of suspension.

5.32. The Trust's disciplinary procedures at that time, provided that a suspended employee may be subject to such conditions that the Trust may impose and that suspended employees would be asked not to contact colleagues at work. The procedures also acknowledged that the Trust could not prevent any social contact between colleagues outside work whilst on suspension.

5.33. There is no express statement in B's letter of suspension issued at the commencement of the investigation, which prohibited social contact.

5.34. The advice given by HR adviser on this matter to both the investigating officer and commissioning officer at that time was incorrect and the fourth allegation issued by the Trust that B had breached the terms of their suspension was therefore, also incorrect.

**Disciplinary Interview**

5.35. The evidence shows that B's disciplinary investigation interview which was conducted by the same investigating officer as A, was consistent in style to that discussed in A's case review; there is some evidence of the use of leading questions and reframing.

5.36. The investigating officer also introduced an unrelated and unsubstantiated allegation (highlighted by the line manager to the investigating officer) that was not directly related to the case they were investigating.

5.37. There is no evidence that B or their representative challenged the conduct of the interview at the time and the transcript and audio recording shows that B was robust and challenging in some of their responses and questions to the investigating officer.

**Duty of Care**

5.38. The evidence shows that little attention was given to the impact of the dual process of the sickness management process and the disciplinary process on B and there was some "heavy-handedness" around the interpretation of the contact restrictions during the suspension period. There was also a failure to ensure that the suspension meeting was handled sensitively as intended by the commissioning officer.

5.39. The suspension letter provided B with options for support including occupational health and support from line managers although there is little evidence to show that the line manager provided this to any degree.

5.40. There is no evidence that B or their representatives raised any concerns as regards the Trust's duty of care during either the sickness management or disciplinary processes.

**Raising Concerns**

5.41. The evidence shows that B and their representative both raised concerns about the contact restrictions when this was raised with them and that their representations were unreasonably and incorrectly overridden.

5.42. It is likely on the balance of probabilities that the subsequent allegation would have been challenged again at a disciplinary hearing had this taken place (although there is no reference to this allegation in the overall investigation report produced by the investigating officer).

5.43. It is also likely, on the balance of probabilities, that had the allegation been challenged at a disciplinary hearing, that given the provisions in the disciplinary policy on this matter, the allegation would have been dismissed.

## Bullying and Harassment

5.44. There is no evidence to support a claim that the conduct of the sickness management process was indicative of any particular malice by any individual or group of individuals towards B personally.

5.45. The evidence shows a consistently supportive approach towards B in regard to their attendance and this was maintained over a lengthy period of time by line managers and was compliant with the relevant statutory provisions in place at the time.

5.46. There is no evidence within the disciplinary investigation that would support a claim under the Trust's Bullying and Harassment policy, although it is clear that B found the experience of the suspension to be stressful.

## Conclusions

5.47. The overall conclusion of this Investigation is that the management and conduct of B's sickness management absence was compliant with the Trust's sickness absence policy and demonstrated a reasonable and fair approach by the Trust in working supportively with B on this matter over an extended period of time.

5.48. There is no evidence to show that any individual manipulated the sickness absence management policy in any way. It is significantly important to note that B was under active management in regard to their attendance from 2008 and that the decision to escalate to a second stage two hearing commenced two months prior to any disciplinary issues concerning B emerging.

5.49. The evidence shows that the decision was entirely related to B's poor attendance over a period of time.

5.50. There was a delay in organising the second formal sickness hearing (for which there are reasonable and plausible explanations), however, it logically follows from the evidence, that had the matter been attended to earlier, that B's employment with the Trust would have been terminated at an earlier date.

5.51. In regards to the disciplinary procedures, it is evident that there were some minor administrative failings in the management of B's disciplinary investigation. However, overall these were not material to the conduct of the investigation.

5.52. The interpretation of the contact restriction was incorrect and if this had been the intention of the Trust (although it is difficult to consider it a reasonable or enforceable matter) it should have explicitly stated this in the suspension letter and set out the rationale for that restriction.

5.53. In relation to the disciplinary case itself, having regard to the allegations and the evidence base, it is likely on the balance of probabilities, that B's disciplinary case, had it proceeded, was likely to have resulted in a lesser disciplinary sanction that dismissal.

**Recommendations**

5.54. Having regard to the impact of the alleged issues concerning the initial suspension meeting, and the incorrect interpretation of the suspension contact restrictions, it is recommended that:

i. WHCT formally and directly apologises to B for the handling of this aspect of their disciplinary investigation by the predecessor WMHPT in 2010.

## 6. Case C: Worcestershire Mental Health Partnership NHS Trust 2011

### Context

6.1. This case concerns a Registered Community Mental Health Nurse (referred to as C in this Report) who retired from the WHCT in December 2011 when they also signed a Compromise Agreement with the Trust. At the time C, was also a recognised trade union representative.

6.2. The summary timeline and circumstances of the case are as follows:

*February/March 2011*

1) In February 2011 it was identified that due to an oversight by a colleague, (identified as colleague+ in this Report), two patients had not received their regular medication. C was asked to visit one of the patients concerned and administer the medication whilst another staff member dealt with the other patient.

2) When C accessed the relevant patient's clinical records they identified that colleague+ had failed to enter their visit to the patient in January 2011, although colleague+ had entered the medication details on the separate medicines record.

3) C did not complete their contemporary entry for their February 2011 visit in the patient's clinical records, and decided to make colleague+ aware of the omission in the clinical records regarding colleague+'s January 2011 visit. C felt was important that colleague+ should be given a chance to make their entry and that this would also maintain the chronology of the records.

4) Although colleague+ was on annual leave, C telephoned them at home and encouraged them to return to the office to complete the January 2011 entry that they had failed to record on the patient's clinical records.

5) Before doing so C discussed colleague+'s omission with a senior nurse and a more junior colleague and made them aware of their intention to contact colleague+ and encourage them to return to put the missed entry into the patient's clinical records.

6) At the same time C also asked if the manager of the team (who C knew was aware of the other oversights by colleague+ regarding the missed routine medications for the two patients) was aware of the clinical records omission when it was established that the senior nurse had not yet shared this information with the manager concerned.

7) One of the colleagues that C discussed the issue with was a senior nurse; this senior nurse had spoken with colleague+ about the missed medications earlier in the day, when they had told colleague+ that they should not access the clinical records of the patients' concerned.

8) The senior nurse did not share their earlier instruction to colleague+ with C at this time (or subsequently).

9) C made two telephone calls to encourage colleague+ to return and make their entry in the clinical records.

10) In one of the calls, C suggested that if as colleague+ indicated, they felt uncomfortable or embarrassed about returning again to the office that day, C would lend them their key to the building so they could return when the building was less likely to be occupied. C subsequently drove to colleague+'s house and loaned them their key to the building.

11) Colleague+ did not make C aware of the earlier instruction from the senior nurse not to access the relevant patients' clinical records at any time in their conversations.

12) Colleague+ attended the office building later that evening and made an entry in the patient's clinical records, which they dated as if it had been made in January 2011. They also set out in their entry that the plan was for C to cover the next medication.

13) The following morning the senior nurse reviewed the patient's notes and identified that the entry had been made by colleague+. The senior nurse had an angry confrontation about the matter with C in which both seemingly became distressed. During the discussion between them, C suggested (in panic) that colleague+ should return and remove the offending page in the records and rewrite the entry; both dismissed this suggestion.

14) Seemingly neither noticed in this discussion that colleague+ had backdated the entry they had made in the clinical records to the month previous (January 2011).

15) In the meantime, C completed their entry in the clinical record underneath the entry made by colleague+ to show that they had visited the patient in February 2011 and stated that they were not aware of the plan shown in the entry above.

16) The following day C advised their line manager that they had not been aware of the plan now shown in the patient's clinical records. The senior nurse also had a discussion with the line manager about the matter when both identified the entry made by colleague+ had been backdated to January 2011.

17) As a result of the identification of the backdated entry, the manager escalated the matter as a serious concern to senior managers and subsequently had a terse exchange with C about the matter. Later that day C telephoned the manager to confirm their involvement in the matter.

18) The following week when colleague+ concerned returned to work they were advised that they were to be moved to a supervised ward based post pending the outcome of disciplinary investigation into the matters concerning their medication omissions and the alleged fraudulent entry they had made into the patient's clinical records.

19) In the same week C followed up their earlier conversation with their manager, by providing an unsolicited written statement in which they recounted their involvement in the matter and said that they were shocked when their manager had spoken to them about the matter and did not know what to say. (see 17 above).

20) C accepted in that statement that their individual actions in the matter were wrong and in contravention of the Trust Policy on documentation and that they were aware that clinical notes should not be recorded retrospectively.

21) C also stated that it was difficult to meet all the statutory demands without forgetting something and that they did not consider the entry in the records to be contentious because colleague+ had signed the medicines card contemporaneously.

22) C also stated their actions in the matter were as a result of their concern for and a desire to support a friend and that their judgement was clouded at the time because of their own anxiety about work pressures and their knowledge of how misdemeanours were treated by the Trust.

23) During the initial stages of the disciplinary investigation for colleague+, witnesses (including colleague+) suggested to the investigating officer that C had pressured colleague+ to return to make the entry, which colleague+ said was against their will, although they believed it was well intentioned on C's part.

24) As a result following the interviews, (March 2011) it was determined by the commissioning manager for colleague+'s investigation that C's role should be investigated as a separate disciplinary case. In discussion with the HR adviser and investigating officer it was agreed that C should also be transferred to an alternative work location in a supervised post during the investigation.

25) A senior line manager who was responsible for C's work area (but not directly involved in the investigation) met with C and advised C of the allegations and of the intended transfer to alternative employment for the duration of the investigation. At the end of the meeting the manager handed a letter setting out the allegations in writing to C.

26) C was extremely shocked and distressed by the decision and was subsequently signed off sick by their GP.

*May/June 2011*

27) In May, C was sufficiently well enough to attend their disciplinary interviews and along with their FTO sought further clarity on content, detail and authors of the allegations made against C.

28) At the same time C submitted a set of grievances in which they highlighted a number of concerns and indicated that they considered that the Trust's disciplinary procedures were hostile towards them.

29) The HR adviser supporting the case initially declined consideration of C's grievances as they considered these to be matters of mitigation against the disciplinary charges.

30) After continued representations by C's representative the HR adviser agreed the grievance matters could be considered informally under the Trust's Grievance Procedures by a senior manager independent to the disciplinary investigation and C's immediate work area.

31) In June 2011, C returned to work in a supervised post on an inpatient ward (as per their disciplinary investigation's requirements) when they also lodged a further grievance against the senior nurse who had reported colleague+'s medication omissions to the manager.

32) Although C was in a temporary supervised role on the ward the ward sister agreed that after training C could undertake some qualified nurse roles including the drug round.

*July/August 2011*

33) In early July, C and their representative were notified of the identity authors of the allegations against C and as a result made immediate representations that the investigating officer was conflicted.

34) Three HR advisers' considered the representations (seemingly) separately but did not accept they were valid and held that there was no conflict for the investigating officer.

35) In July 2011, C attended a meeting with the senior manager nominated to consider their grievances. After meeting with C, the manager provided a written response in which they addressed some of the issues raised by C whilst identifying other matters that could not be resolved at that stage because of the concurrent disciplinary processes this included the separate grievance against the senior nurse

36) C escalated their concerns as a formal grievance in accordance with the grievance procedures.

37) In August 2011, C's FTO believed that as a result of on-going representations they were making about C's case, that the disciplinary investigation against C might be dropped or restarted with a new investigator; they advised C verbally via their spouse, of that understanding.

*September/October 2011*

38) In September 2011, C concluded as a result of a communication from the HR team, that their disciplinary case was not going to be dropped. C became concerned that they may be dismissed and considered that this might put their pension options at risk and in particular, their option to opt for early retirement by virtue of their mental health officer status.

39) C decided to opt to retire from their post in December 2011 when they could access their pension and submitted their resignation to this effect to their line manager. C also asked their FTO to negotiate with the Trust a proposal to achieve resolution of some aspects of their grievances in return for the removal of the implication of gross misconduct in their disciplinary charges.

40) In October 2011 C received notification of their impending disciplinary hearing whilst parallel discussions continued between the Trust and C's FTO about C's proposal to resolve some of their grievances and disciplinary matters .

41) In late October 2011, and as a result of the discussions with C's FTO, the Trust issued a draft Compromise Agreement via C's FTO for discussion with C.

42) Whilst awaiting the outcome of those discussions, the Trust indicated they would hold the date for the planned disciplinary hearing as pending.

*November/December 2011*

43) In November 2011 C attended colleague+'s disciplinary hearing as a witness.

44) On the day following the hearing, the ward sister and matron of the inpatient ward where C was working, advised C that on the instruction of a senior manager, C could no longer undertake unsupervised duties. C felt this was a hostile action towards them and most likely a consequence of their experience at the disciplinary hearing the previous day.

45) C was signed off sick by their GP and did not return to work at the Trust.

46) In late November 2011 after receiving independent legal advice (funded by the Trust), C signed the Compromise Agreement, which nullified their grievances against the Trust and the Trust's disciplinary action against C.

47) C subsequently retired in December 2011 with their pension benefits.

**Summary of Concerns**

6.3. C considers that in the management and conduct of their case was fundamentally flawed and alleges that:

a) Their disciplinary investigation was unwarranted and the allegations were inappropriate and unfounded.

b) Some witnesses to the disciplinary investigation colluded to give a conflicting or spurious accounts of events to the detriment of C and in order to ensure they themselves were not implicated.

c) The investigating officer was conflicted, lacked impartiality and attempted to disguise this in their investigation report.

d) The Chair and Management Representatives of the disciplinary hearing which C attended as a management witness, acted inappropriately and in an aggressive and in a bullying manner towards C and that this resulted in a hostile action against them the following day.

e) The Trust through its managers and HR staff was hostile towards C and that as a result it was unlikely that would have experienced a fair impartial hearing if they had proceeded to a disciplinary hearing.

f) A senior HR manager pressured C into signing the Compromise Agreement and HR advisers lacked impartiality, and acted inappropriately in regard to the investigation and C's grievances.

g) There was a general lack of duty of care towards C by managers and the Trust in the management of their case.

**Rationale for Disciplinary Investigation**

6.4. The initial evidence gathered in February and March 2011 as a result of the disciplinary investigation into colleague+'s actions, shows that colleague+ implied in their interview, that C had played a significant role in influencing them to attend the office out of their normal working hours.

6.5. Colleague+ also suggested this had been against their will even if well intended by C. Colleague+'s evidence also implied, but did not state, that C's encouragement may have influenced them to date the entry as January 2011. This appears to have been because colleague+ considered at that time that C had suggested that they should make a contemporary entry in the records (which C consistently denied and stated they had used the word chronological).

6.6. The evidence also shows that at this stage in the investigation both the investigating officer and the HR officer asked some leading questions in the interview with colleague+, and at one stage in the interview suggested adjectives to describe the power of the interaction between C and colleague+.

6.7. Both the investigating officer and the HR adviser say this exchange was in the context of wider comments made by colleague+ at the interview about C, which suggested to them that C had been vigorous in the manner of their encouragement of colleague+ to act and, that the colleague+ considered that C could be passionate about issues.

6.8. They also say they did not intend to lead the witness, but to clarify, as it was difficult to gauge, what was meant by colleague+'s statements given the level of distress they showed at the interview.

6.9. The evidence shows that overall the investigating officer's interviewing style was generally open and measured; there is no evidence that they had a predominate style of asking leading questions.

6.10. WHCT has nonetheless, already acknowledged and apologised for what they described as the unfortunate impact of the particular exchange in this interview in a letter to C in May 2013. They also accepted in that letter, that it was regrettable that the use of the word coerced was used in one of the allegations against C.

6.11. Other witness statements taken at this stage in the investigation, also suggested witnesses overheard part of the discussions between C and colleague+ and, that those witnesses held the view, that that there was some pressure exerted by C to encourage colleague+ to return to the office and make an entry in the patient's clinical records.

6.12. There was also some reference in those witness statements, to C's passionate nature and, that C had sought to ensure that the manager was unaware of colleague+'s clinical records omission before C contacted colleague+.

6.13. Other significant evidence held by the investigating officer at this stage of the investigation included the written statement that C had provided to their manager a few weeks earlier admitting their role in the matter. (See paragraph 6.2:19-22 above).

6.14. Overall, the weight of evidence available at this stage of the investigation, shows that there were grounds for the Trust initiate a disciplinary investigation to establish more clearly the role and influence of C in the course of events.

**The Allegations**

6.15. After completing the witness interviews the investigating officer and HR adviser discussed the situation the evidence they had established with the commissioning officer for colleague+'s investigation; this was on the same day as the witness interviews.

6.16 It was agreed in a telephone discussion that given the concerns that the early evidence raised, C should be moved to an alternative work base pending a disciplinary investigation.

6.17. The HR adviser, with input from the investigating officer, drafted the letter setting out the allegations against C. This was passed to a senior manager (not the commissioning manager) to sign off; this manager met with C to inform them of the allegations later that same day.

6.18. The letter in question contained three disciplinary allegations against C. Two of the allegations did not set out the details of the alleged infringement and were presented as statements of fact (which C themselves had confirmed and volunteered).

6.19. One incorrectly suggested that C had made a suggestion to colleagues (about tearing a page out of the notes) rather than a single colleague. This was a matter on which C made representations and it was subsequently corrected by the Trust when they issued the notification of a disciplinary hearing in October 2011 to C and their representative.

6.20. This particular allegation was also the consequence of a reported heated conversation between C and the senior nurse, in which the senior nurse admitted to being very angry and, also indicated that the comment by C had been out of character and probably as the result of the panic and stress of the moment.

6.21. The third allegation described C's interaction with colleague+, as coercion and suggested that clinical records had been altered. C and their FTO contested this allegation; C refuted that they had applied force when encouraging colleague+ to return who they said had wanted to do so and, contended that no records had been altered because colleague+ had made a new entry in the clinical record concerned.

6.22. None of the three allegations were coherently aligned with those made against colleague+ and whose disciplinary investigation had led to the charges.

6.23. A further fourth disciplinary charge of trust and confidence was added to the allegations against C in October 2011.There was neither context to this allegation in the letter nor any reference to the same in C's disciplinary investigation report.

6.24. C and their representatives consistently challenged the allegations and sought to establish the specific infringements to which two of the allegations related but did not receive any substantive response from the Trust to their representations.

**Alleged Collusion in Witness Evidence**

6.25. There is no evidence to support an allegation that the investigating officer colluded with witnesses, however, there is some evidence that at times, the investigating officer was encouraging of and potentially empathetic towards distressed witnesses, which the investigating officer accepts.

6.26. There is some evidence that on some occasions the investigating officer used leading questions in interviews, however, this is not a predominate style in the investigatory interviews conducted by this investigating officer, who says that they only used this style on occasions, to check understanding.

6.27. There are some areas of the witness evidence that there was speculation in some witness statements as regards C's intent and, particularly so at the second interviews conducted by the investigating officer. These interviews occurred three to four months after the event itself.

6.28. In one such interview a witness suggested that C might have intended colleague+ to backdate their entry, however the witness acknowledged that this was a hindsight reflection on their part. The investigating officer confirms that they did not challenge this statement by the witness at the time; because it was clearly speculation and that they disregarded this evidence in their final report.

6.29. A review of the final report confirms that the investigating officer did not reference this evidence.

6.30. There is some conflict and hearsay in the accounts of two witnesses in regard to C's actions to ascertain the manager's awareness of the clinical records omission by colleague+. This is not given significance by the investigating officer in their final report and one of the witnesses concerned acknowledged that it was hearsay.

6.31. C's own evidence shows that the manager's awareness of the omission was a matter that they had discussed with one of the two witnesses above, whilst C strongly disputed the account of the other witness.

6.32. No disciplinary charges were brought against C as regards collusion with colleague+ about the backdating of the entry made by colleague+ in the patient's clinical records, however the evidence shows that this emerged as a concern during colleague+'s disciplinary hearing. It is relevant to note, there was a lack of clarity particularly given that in their second interview, colleague+ said that they now considered that when C had contacted them in February 2009 about the matter, C had used the word chronological rather than contemporaneous which was contrary to their statement in their first interview.

6.33. The issue of potential collusion between C and colleague+ was clarified only when colleague+ confirmed to their disciplinary hearing, that C had not instructed or advised them what to write in the patient's clinical records. Colleague+ also clarified at the same time, that they had not wanted to go to the building and had done so only because of C's insistence on maintaining the chronology of the records and this had created confusion in

their mind. They also said that this had been a factor in their decision to backdate the entry in the records. Colleague+ confirmed that they knew how to make a correct backdated entry and that they knew their action in making the January 2011 entry in the patient's records at this time was wrong.

6.34. The final investigation report of C's case does not transparently expose the failure by the senior nurse and colleague+ to inform C of the instruction given to colleague+ by the senior nurse, that colleague+ should not access the relevant patient's clinical records.

6.35. The senior nurse acknowledged this failure on their part and also stated that with hindsight they should have been more assertive with C on the matter.

6.36. The investigating officer accepts that on reflection they could have added more weight to this aspect in their final investigation report.

6.37. It is likely, however, that on the balance of probabilities, this is an issue that would have become more transparent had C's case progressed to a disciplinary hearing, because it would have been a matter that the FTO could have represented strongly given the evidence available.

6.38. Taken as a whole having regard to the full records of the concurrent investigations, there is evidence that the investigating officer took reasonable steps to establish the evidence base for the investigation and sought to corroborate and check conflicting evidence whilst disregarding hearsay and or speculation.

**Alleged Conflict and lack of Impartiality of the Investigating Officer**

6.39. There is no dispute of fact that C and their FTO made repeated requests to ask that the Trust notify them of the identity of the authors of the allegations against C. This was not provided until August 2011 when they were informed that the investigating officer and HR adviser supporting C's case had been involved in drafting the allegations.

6.40. C and their FTO immediately made representations that this together with the wording of the allegations, suggested that a conclusion had been reached at the start of the investigation by the investigating officer and it could not reasonably be held that the investigating officer was impartial in their investigation.

6.41. Several HR advisers were subsequently involved in considering these representations and each concluded that there was no breach of impartiality.

6.42. The rationale offered by the HR team, was that the investigating officer met the criteria set out in the disciplinary procedures and that it was logical that the same officer should investigate the allegations against C alongside their investigation of colleague+ as the issues were mutually dependent.

6.43. The Trust has already accepted (in May 2013) during correspondence with C, that with hindsight, they considered it might not have been wise to extend the investigating officer's role to include investigation of C, given their earlier involvement with colleague+'s investigation.

6.44. The investigating officer also confirms they raised the issue of potential conflict at the outset of C's investigation and was advised by HR that this was not an issue.

6.45. The investigating officer's report on C's case has minor some factual errors concerning dates, which C considers are a further example of the investigating officer's lack of impartiality, and alleges these are an attempt by the investigating officer to disguise this.

6.46. In the investigation report the incorrect date is shown for commencement of the investigation and the incorrect date is shown against C's transfer to another ward in two places. However, the report shows the correct date for notification to C of the allegations against them and that date directly conflicts the dates shown in the report for the commencement of the investigation and C's transfer to the ward.

6.47. The investigating officer accepts that there are some minor errors in the dates in their report, which they cannot explain other than to say to it was most likely due to a mix up with dates connected with the aligned investigation into colleague+.

6.48. The investigating officer says that they undertook the investigation in an earnest and honest manner and with reference to HR advice and there was no attempt on their part to mislead or disguise anything in their report.

6.49. The minor errors are clearly evident in the investigation report and as such would have easily been subject to challenge and correction either in advance of or at a disciplinary hearing. Whilst they were not material to the substance of the investigation report they were understandably a concern to C.

**Treatment of C as a Witness**

6.50. The transcript of C's witness evidence session at the disciplinary hearing in November 2011 shows that C experienced a fairly long and at times detailed examination of certain aspects of their evidence.

6.51. A review of the audio recording of the interview shows no evidence that any manager significantly raised their voice, shouted or acted inappropriately at any stage in C's evidence session.

6.52. It shows, however, that in comparison to other witness sessions at the hearing, that C's session appears to have been tense for both parties and particularly so, around the points concerning medical records administration.

6.53. There is evidence that one manager was particularly concerned by C's response to their questions as regards the legal standing of clinical notes and, used a firm clear tone and when speaking to C on this matter. This is more audible in comparison to the rest of the hearing where the same manager has a soft quiet tone, but it does not support the allegation by C that the manager concerned shouted at them.

6.54. In February 2013 WHCT wrote to C and acknowledged that this manager had demonstrated some persistence in their questioning of C at the hearing. WHCT wrote

again in May 2013 to acknowledge that the manager's questioning could be perceived as uncompromising and apologised for any upset this may have caused C.

6.55. The hearing evidence also shows that the two managers with professional nursing backgrounds, who questioned B, both held concerns as regards C's apparent lack of understanding of medical records administration. A particular concern was C's explanation of contemporaneous and chronological record keeping.

6.56. Some tension also seems to have arisen during C's evidence when the hearing sought to establish what degree of collusion, if any, had taken place between C and colleague+ as regards what was to be written in the notes. Again this again seemingly, primarily related to C's apparent lack of understanding of medical notes administration.

6.57. In their evidence C was critical of the Trust in regard to its documentation policies and training as regards medical records administration; C suggested that staff had not been properly trained in how to make late entries in clinical records. Other witnesses including colleague+ did not support C's view on this.

6.58. The full audio recording of the hearing confirms that the hearing adopted a reasonable and consistent approach to gaining an understanding of all witnesses' knowledge of medical records administration.

6.59 There is no evidence at any stage of hearing of inappropriate behaviour by the members of the hearing towards any witness, including C, who was themselves at times challenging and firm in their responses, whilst understandably defensive in the circumstances.

**Events Post the Hearing**

6.60. Both the managers responsible for questioning C about medical records administration say that at the end of the hearing they held a shared and significant concern about C's apparent lack of awareness of medical records administration.

6.61. This concern was discussed with the other members of the hearings panel and it was agreed that an appropriate senior manager should discuss this matter with C. No formal action was agreed between the panel, other than that HR would need to take this forward with the relevant senior manager.

6.62. The following day C reported for work on the ward where they had been working since June 2011, when they were told they would need to revert to supervised duties. This meant that they could not undertake various duties including drug rounds that they had been allowed to do since joining the ward.

6.63. The evidence shows that in a discussion completely unconnected to the disciplinary process, the ward sister and matron had reported C's involvement in qualified nurse duties on the ward to the senior manager responsible for the ward.

6.64. The senior manager was concerned because as C was supernumerary and temporary, C could not be counted and used as a core member of the qualified ward

staffing level; the senior manager instructed that the ward should not use C to cover the qualified staffing duties and that this should cease immediately.

6.65. The senior manager concerned had no connection to or knowledge of the disciplinary case concerning C or that of their colleague.

6.66. The ward manager and matron were asked by the senior manager to apologise and explain the situation to C. It seems that the explanation was insufficient; C concluded the decision was part of the wider hostility they felt the Trust was exhibiting towards them and, was particularly likely to have been related to the witness evidence they had given at colleague+'s hearing the previous day.

6.67. C was devastated and was signed off on sickness absence by their GP; C did not return to work at the Trust.

**Alleged Hostility by Trust towards C and Relationship with HR**

6.69. The evidence shows that C considered the Trust to be hostile towards them in the disciplinary process at an early stage in their case and lodged this complaint as part of their grievances in May 2011.

6.70. It would seem on the balance of probabilities, that C's relationship with the Trust was severely damaged when they were removed from their normal duties and faced with allegations of potential gross misconduct about their contributory role in colleague+'s actions.

6.71. Two principal issues appear to have been particularly significant; the nature of the allegations made against C and the wider concerns that C held about the Trust and its approach to staff facing disciplinary matters at that time.

6.72. The correspondence and exchanges between C and the Trust from May 2011 onward also suggest that C viewed that the disciplinary action as damaging their trust and confidence in the Trust as an employer and, it is evident that the escalation to a formal disciplinary investigation caused C considerable distress.

6.73. There is some evidence in the transcripts and other communications between C, and the HR adviser involved in C's case, that indicate that the relationship between the two of them became increasingly strained during June - August 2011 and at times, the exchanges appear to be mutually antagonistic in manner.

6.74. The evidence shows that the HR adviser who initially dealt with C's case was overwhelmed and stressed by C's approach during the case, and as a result C's case was reallocated to other HR colleagues.

6.75. C contends that given the issues put to them and the initial resistance of the HR adviser concerned to considering their grievances, or explaining the allegations, they were understandably defensive and challenging.

6.76. The records show that C's case was passed in succession to two other HR advisers and was ultimately overseen by a senior HR manager who became more active around August/September 2011 as a result of discussions they were having with C's FTO.

6.77. This involvement included a discussion with the FTO about the alleged impartiality of the investigating officer. It seems that as a consequence of this discussion that C's FTO believed this would result in either a cessation of the investigation or that the investigation would be re-commissioned and a new investigator allocated.

6.78. The FTO concerned made a telephone call to this effect to C's spouse. However the subsequent communications from the HR department confirmed that this was not the case and that the investigation and planning for a hearing was continuing.

6.79. In May 2013, WHCT clarified to C, that there had never been any intention to halt the disciplinary proceedings against C by the WMHPT as a result of this discussion.

6.80. There is some wider evidence, which suggests that at this time, communications between HR and the trade unions, was not as open or as constructive as might have been ideal, and this may, on the balance of probabilities, give some explanation to this apparent misunderstanding. (See: Section 9).

6.81. It is difficult to identify any specific actions or evidence that would suggest that the Trust was knowingly hostile towards C, although it is apparent that C interpreted the cumulative experience of their case to be so and seemingly formed the view that they would not experience a fair and reasonable hearing of their case.

**Compromise Agreement**

6.82. The evidence shows that the Compromise Agreement was offered to C via their FTO as a consequence of C's request for their FTO to negotiate with the Trust a proposal to achieve resolution of some aspects of their grievances in return for the removal of the implication of gross misconduct in their disciplinary charges.

6.83. The draft Compromise Agreement was sent in late October 2011 to C's FTO and was supported by a letter which set out that the Compromise Agreement was being offered in response to concerns that the FTO had expressed on behalf of C in regard to their forthcoming combined disciplinary and grievance hearing planned for mid-December 2011.

6.84. The letter also indicated that the dates for the disciplinary and grievance hearings would be held as pending and that the Trust would wait to hear from the FTO after they had discussed the matter with C.

6.85. C has confirmed that they discussed the matter with their FTO and that they were provided with independent legal advice on the terms of the Compromise Agreement and subsequently signed the Compromise Agreement in late November 2011.

6.86. C claims that they took this action largely because of their perception of the hostility of the Trust towards them and that they felt to do otherwise, might result in a loss of their pension options. C says another factor was that their spouse was seriously ill at this time.

6.87. C also alleges that the legal advice they received about the Compromise Agreement was limited and not overly helpful.

6.88. The quality of the legal advice is not a matter for which the Trust can be held culpable and overall the evidence shows that C was supported by their trade union at this time that would have held primary responsibility for supporting C on this matter.

6.89. There is no evidence to support the allegation that the Trust or any of its officers placed C under any pressure to sign the Compromise Agreement and on the balance of probabilities, a major influence appears to have been C's view of the Trust's hostility towards them and the personal concerns for them at home at that time.

6.90. In March 2013, two years after the Compromise Agreement had been signed; C raised concerns with the Trust about the Compromise Agreement and sought release from the legal agreement, which the Trust declined.

**Duty of Care**

6.91. C has raised a number of concerns about the Trust's duty of care most of which have been discussed in the sections above; a concern about the initial handling of the meeting with C when a senior manager notified them of their disciplinary allegations is discussed below.

6.92. C alleges the manager in this meeting was unsupportive and that, the meeting was called without warning when the manager did not afford them the opportunity to respond to the allegations put to them. C also alleges that at the end of their meeting the manager did not check if they were fit to drive home.

6.93. There is no evidence that the manager concerned was actively involved in consideration of the issues or allegations or that the manager played an active role at any subsequent stage in the disciplinary process. It was unusual, in these circumstances, that this manager signed the letter confirming the allegations against C, which should normally have been signed by the commissioning manager.

6.94. There is no evidence that C had any forewarning of the meeting and the meeting appears to have been arranged quite quickly following the completion of the witness interviews and discussion with the commissioning officer earlier on the same day.

6.95. As C was a trade union representative the disciplinary procedures required that any action other than suspension should first be discussed with the Head of HR and the representative's FTO.

6.96. There is evidence that the Trust contacted C's trade union office, however, no FTO was available to attend the meeting that evening, an email was sent to the trade union to advise them of the impending investigation into C.

6.97. C was redeployed which the disciplinary procedure provides as a reasonable and primary alternative to suspension and therefore this action did not require the FTO/HR discussion set out in the disciplinary procedures.

6.98. The manager who met with C, was acting on HR advice and as part of that ensured that a neutral party (a ward manager) was present at the meeting to act as a witness and provide support to C as necessary.

6.99. The Trust considered that this was a sensitive approach, as they did not think that C would like a peer trade union representative to attend the meeting. There is no evidence that C was invited to comment on this decision.

6.100. The manager reports that they explained in as sensitive a way as possible to C the allegations against them and what support would be available to C during the investigation. They also say that after the meeting they contacted C's line manager to ensure that they maintained contact with C asked them to reaffirm to C their right of access to occupational health services for counselling etc.

6.101. The letter setting out the allegations to C placed restrictions on C having contact with colleagues in their work team, however, this was not written in such a way that it was entirely consistent with the restriction clause set out in the disciplinary procedures.

6.102. C asserts that they should have been given the right to respond to the allegations at this meeting with the manager as provided in the disciplinary procedures.

6.103. A review of the disciplinary procedures shows that in the section stating the guiding principles, that employees will be informed of the basis of any issues against them and that they will be given the opportunity to put their case before a decision is made. Put into context of the whole document this appears to relate to a hearing following an investigation rather than when allegations first emerge

6.104. Another concern raised by C is the lack of support they received after their meeting with the manager advising of the allegations against C.

6.105. There is some evidence to show that there was some early confusion about C's preferred method of contact immediately after this meeting; it appears that C's FTO contacted the Trust and asked that C's line manager should not contact C at this time.

6.106. Evidence shows that contact with the line manager appears to have been reinstated after a direct discussion between HR, C and their FTO in May 2011 when C also accessed some occupational health counselling support, which they reported they found helpful at the time.

**Raising Concerns**

6.107. As the previous sections show, C and their representatives raised concerns about the allegations and probity of the investigation from May 2011 onwards, when C also submitted grievances some of which concerned their investigation directly and others of which were more general in nature.

6.108. It appears that they had little success in influencing the Trust's responses to those concerns save for the initial consideration of the grievances lodged by C.

6.109. The initial rationale for the resistance to accepting C's grievance has been explored in paragraph 6.2 - 30.

6.110. A review of the disciplinary procedures shows that at that time, where an employee raised a grievance during a disciplinary investigation that the disciplinary process could be temporarily suspended to deal with the grievance. It also states that in the case where the grievance and disciplinary case are related it is for the Business Unit Lead (in C's case this was the commissioning manager) in discussion with the employee's representative and HR to consider whether it is appropriate to deal with both matters concurrently.

6.111. The evidence suggests that this was not handled correctly by the Trust at all stages. Initially the evidence suggests that HR handled this matter and then resolved the matter in discussion with C's FTO.

6.112. Further, after C had lodged a formal grievance the commissioning manager confirmed that the matter was to be dealt with concurrently although C's FTO maintained this was not their understanding of the discussions with HR.

6.113. Eventually the issue was overtaken by the Compromise Agreement; this difference of view was never fully resolved.

**Bullying and Harassment**

6.114. There is no evidence to support a claim that the conduct of the disciplinary investigation or the associated hearings was indicative of any particular malice by any individual or group of individuals towards C personally.

6.115. Equally it is difficult to evidence that, in itself the management and conduct of the case shows particular actions by an individual that would have been in breach of the Trust's Bullying and Harassment Policy

6.116. There is, however, some wider contextual evidence that suggests that the case may provide support for an alleged corporate culture in the management and conduct of disciplinary investigations and associated HR processes at that time in WMHPT, which is discussed more in Section 9 of this Report.

**Conclusions**

6.117. The overall conclusion of this Investigation is that the Trust had reasonable grounds to initiate a disciplinary investigation to consider the role and influence of C in relation to colleague+'s alleged falsification of a patient's clinical record.

6.118. There was sufficient evidence during the disciplinary investigation to suggest that C had played an influential role in encouraging the actions of their colleague.

6.119. The early evidence also suggested that C might have been implicitly involved in advising the colleague about the dating of the entry and it is apparent from the overall evidence of both C's investigation and the disciplinary investigation report for colleague+, that it only became clear that this was not the case after colleague+ gave evidence at their disciplinary hearing in November 2011.

6.120. C's decision to delay their contemporary entry to record of their visit in February 2011 in the patient's clinical records, whilst also encouraging colleague+ to return to make the missed January 2011 entry chronologically, could only have resulted in disturbing the true contemporary clinical record of that patient. It is apparent from the evidence that C did not consider that this was a significant issue given that colleague+ had made a contemporary entry of their visit on the medicines card. This was not a view that the Trust or its managers shared.

6.121. This appears to have been the nub of the issue that caused some concern when C gave evidence to colleague+'s disciplinary hearing and when the hearing concluded that C did not seem to appreciate the significance of the alleged fraudulent entry made by colleague+; in consequence the hearing concluded that this appeared to show some apparent lack of knowledge by C of medical records administration.

6.122. There are, however, no grounds to support C's allegations of inappropriate conduct by managers at the hearing; nonetheless it is accepted that it was a stressful experience for C, in which they are likely to have felt very isolated because of the broken relationship with the Trust at that time. WHCT have already apologised to about the manager's questioning of C in this hearing.

6.123. The disciplinary allegations put to C were poorly drafted and lacked specificity and were matters on which the Trust had persistent representations at the time. It would have been reasonable to respond to those concerns at the time having regard to the Trust's disciplinary procedures and the ACAS Code of Practice on Disciplinary and Grievance matters. WHCT has apologised, in part, in regard to this issue on behalf of WMHPT.

6.124. On balance, it seems that the allegations and the arrangements for the meeting with C on the same day, were somewhat precipitous and may, on the balance of probabilities, have been handled in a more considered and sensitive manner to have ensured better alignment with the existing allegations against C's colleague+. This may also have enabled better support for C at the meeting when the Trust informed C of the allegations against them.

6.125. Similarly, whilst in normal circumstances it would have been reasonable for the Trust to commission the same investigating officer for the concurrent and mutually dependent investigations, this was not astute because the investigating officer had played a part in drafting the allegations against C.

6.126. This decision led to reasonable representations by C and their FTO, that this had the potential for a lack of impartiality in the investigation. There is no evidence to suggest this was the case, however, the Trust could have shown more sensitivity and

responsiveness at the time, by re-commissioning the investigation through a newly appointed investigating officer.

6.127. There is no obvious rationale for the delay in releasing the details of the authors of the allegations against C and the delay in doing so only served to heighten C's concerns.

6.128. Overall, however, the investigation conducted into C's case was a reasonable investigation and although there were some minor factual date errors, on balance the investigating officer appears to have honestly represented their consideration of issues, indicating the witness evidence they had used to support their conclusions.

6.129. Nonetheless, more attention and transparency could have been given in the investigation report to the role of the senior nurse in failing to assertively restrain C in their actions and for failing to advise of C of their earlier instruction to C's colleague+ not to access the records. Similarly colleague+ should have made C aware of this instruction and did not do so.

6.130. There are also some other procedural issues in the management of C's case that could have been more attentively and sensitively managed. These include the expression of the contact restrictions and the management and responsiveness to C's grievances.

6.131. Whilst these are seemingly perceived by C in their representations to this Investigation, to be vindictive actions by individual managers against C and to which they attribute motives, the factual evidence does not support this and on the balance of probabilities is more likely to have been (as discussed in section 9 of this report) a manifestation of an alleged culture that was evident in employee relations in WMHPT at the time.

6.132. In part, it also seems that C's perception of the cultural environment in the Trust, appears to have contributed to the deep distress of C, but this was also as a result of the inadequacies of the allegations against them and the lack of responsiveness to reasonable representations about their case.

6.133. It also seems, that on the balance of probabilities, that another factor may have been C's own feelings of guilt and fears, that their well-intended actions to support a friend had placed both their friend and themselves at risk of serious disciplinary sanctions.

6.134. For C seemingly, this created a perceived hostile response from the Trust, which C felt was disproportionate to the issues and, in seeking to defend their position, their fear and concern for themselves and their friend, may have exhibited as confrontational and was on the balance of probabilities, contributory to the deteriorating relationship between C and the Trust.

6.135. Whilst it is unfortunate that neither C, their representatives nor the Trust were able to break this cycle, the significant responsibility for the failing to do so has to rest with the Trust as the employer and, particularly so, because there is no evidence that a senior leader took responsibility to retrieve the situation before the relationship of trust and confidence between C and the Trust was destroyed irretrievably.

6.136. Whilst is clear that there was no relationship between the decision by a senior manager to revert C to a supervised role, and C's attendance at their colleague+'s hearing, this action had an unintended catastrophic impact on C, as it served to compound C's concerns and belief of the Trust's hostile intentions towards them.

6.137. This was however, an unfortunate coincidence of circumstance rather than a conspiracy, and is indicative of the apparent lack of case management and oversight of individual employee cases at that time.

6.138. There is no evidence to support C's allegation that they were placed under duress by the Trust to sign a Compromise Agreement, although because of the broken relationship it is reasonable to conclude that C may have felt, given their views of their relationship with the Trust, that this was their only option at that time.

6.139. Against this however, whatever the views of C about the Trust at that time, given the outcome of colleague+'s disciplinary case, it is unlikely that on the balance of probabilities, that C, who in terms, was facing weaker and lesser disciplinary charges, would have been dismissed.

6.140. This would have been a matter for C's advisers to have discussed and assessed with C at that time.

**Recommendations**

6.141. Given the issues that the review of the case has identified and the continued distress that this matter continues to cause C it is recommended that:

i. Noting that WHCT has apologised for a number of areas it may be appropriate for WHCT to give further consideration to issuing an acknowledgement and final apology for the additional issues that have been identified in this Report directly to C for the conduct and management of their disciplinary investigation by the predecessor WMHPT and the associated distress this has caused C.

## 7. Case D: Worcestershire Primary Care NHS Trust 2009/2011

### Context

7.1. This case concerns a Specialist Public Health Nurse (referred to as D in this Report) who retired from Worcestershire Primary Care NHS Trust (PCT) In October 2011.

7.2. The summary timeline and circumstances of the case are as follows:

*November/December 2009*

1) In November 2009, D's line manager raised some informal concerns with D primarily in regard to D's interactions with colleagues and a client. At the end of the discussion the manager concerned placed D on an informal capability process and agreed to look into the matters they had raised with D in more detail.

2) In the meantime D initiated their own investigation into the matters raised with them and established that the allegations were unfounded. They shared this outcome with their manager.

3) During November/December 2009 both parties met and exchanged correspondence regarding the matter and in mid-December the manager wrote to conclude their mutual discussions.

4) D did not agree that this letter reflected the outcome of their discussions and in late December 2009 contacted their trade union for advice.

5) A meeting between D, their trade union representative, the manager and a HR representative was arranged for February 2010.

*January /February 2010*

6) In January 2010 and as a result of long-term staff absences the manager reviewed the teams' caseload and revised the team's priorities. As part of this review they increased D's caseload and set new priorities for D. D considered this to be a substantial and unreasonable adjustment by their manager and alleges their manager singled them out against others for an increased caseload.

7) D raised concerns about their caseload with the service manager who suggested a meeting to discuss the matter further.

8) In late February 2010 the planned meeting with D, D's manager D's trade union representative and HR, took place (see 5 above) to discuss the issues from 2009; the manager wrote to confirm the outcome shortly after. There was no discussion of the caseload issue at the meeting.

*April/May 2010*

9) In April 2010 following representations from D, D's trade union representative wrote to HR to indicate that D was not satisfied that their manager had accurately recorded the outcome of the meeting between them in February and that they had not adequately followed up on the actions agreed at the meeting between them.

10) In May 2010 in the absence of a response from HR, D contacted HR and subsequent to this their trade union representative because they understood that HR was not intending to respond to the representations made as they considered this to be the manager's responsibility.

11) D indicated to both HR and their trade union representative that they wanted to raise a grievance to get matters satisfactorily resolved. There is no record of a grievance being raised at this time.

*June/July 2010*

12) In June 2010, D met with the service manager as planned, (see 7 above) to discuss their concerns about their caseload and relationship with their manager when it was agreed that a meeting would be arranged with the service manager involving the manager and D to seek to resolve matters between them.

13) In late June/early July 2010, matters between D and their manager began to escalate around the caseload matter and tension between them increased.

14) In mid July 2010 the manager identified a concern in regard aspects of D's clinical records keeping and placed D on informal capability procedures; D agreed an action plan to meet the identified development needs.

15) Shortly after this meeting the manager identified a specific incident in regard to D's clinical records, which they considered was sufficiently serious for them to escalate to their service manager.

16) Around the same time the manager acting on the advice of other senior managers sent D home from work when they attended the office in their own time to catch up on their caseload prior to the summer break.

17) Shortly after this incident, D met with the service manager as planned following their meeting in June 2010, to discuss their caseload and relationship with their manager; however, the service manager amended the purpose of the meeting to discuss the emergent concerns about clinical record keeping by D.

18) The service manager prepared notes of the meeting, and passed these to their manager (identified as senior manager* in this Report). The notes were not shared with D at this time although they were able to comment on them at a later stage through the disciplinary process discussed below.

19) In late July 2010 senior manager* met with D and advised that they were commissioning a disciplinary investigation into matters relating to D's clinical record keeping and a concurrent bullying and harassment investigation by another independent person into D's concerns.

20) They also indicated that D should not attend their normal work base or access their clinical records during the investigation and that arrangements would be made to transfer D temporarily to another work base on their return to work after the summer school holidays.

*August/September 2010*

21) D submitted their formal bullying and harassment complaint as requested by the senior manager* in early August 2010.

22) A few days later D sent a humorous card to a colleague at home (seemingly at the expense of an unidentified manager) and wrote some comments in it about how they were responding to their current situation. The colleague brought the card to work and shared it with D's manager who was distressed by the card.

23) Another management colleague was shown the card who also considered the card to be inappropriate and contacted D and had an angry exchange with D, which D found to be distressing.

24) In late August, shortly before their expected return to work after the summer holiday break, D reported sick.

*September/October 2010*

25) In September 2010 the disciplinary investigation into D's alleged clinical record keeping failures began. D attended three interviews due to the volume of evidence they wished to present and did so with occupational health consent and the support of their trade union representative.

26) The bullying and harassment investigation also commenced in September 2010; the investigation was specifically excluded from considering issues being addressed in the disciplinary investigation.

*February 2011*

27) In February 2011 senior manager* received the outcome of the disciplinary investigation. The investigation concluded that whilst there was some issues relating to D's record keeping the specific incident, which had led to the disciplinary investigation, could not be clearly attributed to D.

28) The bullying and harassment investigation also submitted their report in February 2011 and this identified some issues for the manager and the service manager in regards to their handling of matters and for D in regard to their openness to legitimate management challenge. The investigation did not support the allegation of bullying by the manager or that HR and the service manager had corporate complicity in the matter.

29) Senior manager* communicated the outcome of the disciplinary investigation to D in which they indicated that the report highlighted some competency issues which required an action plan to support D's return to work. D responded expressing concern at the brevity of the letter and raised various other matters about their views of the matter and their manager's behaviour towards them and other matters concerning the service manager. They handed the letter to senior manager* when they met with them in March.

*March/April 2011*

30) In early March 2011, senior manager* met with D and their trade union representative to discuss the outcome of the disciplinary investigation. D raised a number

of complaints about the disciplinary process and outcome. Senior manager* subsequently wrote to D to confirm the meeting between them and to advise that if D wished, they could raise a grievance about the disciplinary investigation with HR.

31) In the same letter senior manager* confirmed the arrangements for feeding back to other individuals involved in the disciplinary investigation and that with D's agreement they would be issuing the outcome of the bullying and harassment investigation in writing; senior manager* also indicated that when D was well enough they wanted to discuss arrangements for D's return to work.

32) In late March senior manager* wrote to D and issued summary of the bullying and harassment investigation. In the letter senior manager* indicated that their conclusion from the investigation was that there was no case to answer for the manager and that D's other allegations against the service manager and HR were also unfounded.

33) Senior manager*also indicated the relationship between D and their manager was irretrievably broken and that if D was dissatisfied with the process of the investigation but not the content of the investigation's findings, that that D could raise a grievance.

34) A few days later D wrote a strongly worded letter to the senior manager* rejecting the validity of the outcome of the investigation which they considered had been selective in the interpretation of the bullying and harassment policy and had failed to address the caseload issue and some other issues associated with the matters investigated in the disciplinary case.

35) D also raised their concerns about their interactions with another manager over the birthday card they sent in August 2010, (see 22 and 23 above) and they indicated intended to take matters further.

*April/May 2011*

36) In April 2011, D raised a formal grievance in regard to the incidents that had occurred between themselves and their manager since 2009 including the outcome of the bullying and harassment and the matter concerning the birthday card. A grievance panel was organised for May 2011.

37) In early May 2011 senior manager* contacted D concerning some alleged inappropriate texts sent by D which was followed up in writing by the senior manager*. D responded with a strongly worded letter, which they subsequently apologised for in writing a few days later. Senior manager* accepted the apology and wrote a few days later to positively reinforce the need for support to D and their desire to enable and support a positive return to work for D.

38) In late May 2011, D's representative approached the PCT to request that the alleged client complaint of November 2009 was investigated and that D was supported with a graduated return to work and allocated appropriate caseload.

39) This was agreed by the PCT and another independent very senior manager looked into the issue of the alleged client complaint of November 2009.

*June/July 2011*

40) Following the investigation, the very senior manager advised that senior manager* should write to confirm to D that there was no evidence of a client complaint in 2009; they also recommended that it would be appropriate to place D under the management of a different team leader and to support D's return to work and the identified training issues for D and asked that this should be detailed in a letter to D. They also recommended that D should accept this as a conclusion of their grievances.

41) Senior manager* arranged to meet with D with their trade union representative at the end of June 2011. D prepared a document setting out their terms for a return to be discussed at the meeting.

42) Along with a number of other issues D stated that they expected to return to their original work base and that their line manager should be moved elsewhere. They also stated that in the document that they had no intention of compromising on the terms set out in the document.

43) In early July 2011 senior manager* wrote to D (as suggested by the very senior manager), to confirm that the alleged complaint by a client in November 2009 had not been proven and that there was no substantiated evidence that a written complaint had been made. Senior manager* accepted in that letter that the matter should have been concluded at its initial stage and apologised for the delay in resolving matters and for the distress this may have caused D.

44) Senior manager* also indicated that they would act on the other points raised by senior manager's report in regard to learning points for the managers and confirmed that on the basis of the discussion with D this brought to a conclusion the outstanding grievance and that they would now be moving onto discussing a successful phased return to work.

45) Senior manager* wrote a separate letter to D proposing that as the relationship between D and their manager was broken, that D move to an alternative work base where there was a full team compliment and a appropriate caseload that D could be supported by a new manager and training. The proposed location was approximately 25 miles from D's home location.

46) Senior manager* noted that D indicated they disagreed with the proposal to relocate which they emphasised was not a disciplinary sanction and was offered with the intent of creating a fresh start in a new supportive environment for D. Senior manager* indicated that all PCT employees could reasonably asked to change their base of work and that this included D's team.

47) D responded to the two letters promptly and acknowledged the apology and conclusion of the November 2009 matter and indicated their intention to return to work. D set out again their rationale for their objection to move to another place of work. The senior manager* responded to indicate that they felt it was appropriate for D rather than the manager to move.

*August/September/October 2011*

48) In August senior manager* wrote again to D to restate that it had been agreed by all parties including D and their trade union representative that is was untenable for D and their manager to work together. They also highlighted that in some of the communications that D had sent since the matters had ben resolved it was evident that D's was still "raw" about some of the issues and that the PCT t had to consider both D's health and well being and the best interests of running an efficient service.

49) D then wrote to HR to seek to reinstate their grievances concerning the previous caseload allocation and that the bullying and harassment investigation had not been conducted appropriately. HR responded and explained why they had understood that the formal grievance had been withdrawn and also reaffirmed that the PCT was now working and committed to securing a return to work for D in an effective way

50) D responded a few days later to say that they had never agreed that the caseload matters would be dismissed and raised that this was a relevant factor in the bullying and harassment case that had not been attended to.

51) In September 2011 D wrote to senior manager* to say that they were about to exhaust their sick pay and in consequence were being forced by virtue of the actions of the PCT to consider early retirement however stated that this was not a letter of resignation. Senior manager* invited D to meet with them and HR in mid-October 2011.

52) After this meeting with Senior Manager* D handed their letter of resignation, to Senior Manager* in which they restated their view of events and that they felt had been left with no option but to resign.

53) A senior HR manager acknowledged D's resignation letter; D responded to restate their view that the PCT had driven them from their post because of the PCT's intransigent approach to their grievances and concerns.

**Summary of Concerns**

7.3. In summary D's concerns and allegations are that:

a) Their disciplinary investigation was unwarranted and the allegations in this and a previous informal disciplinary/capability matter were unfounded and as a result of bullying by their line manager.

b) The bullying and harassment investigation conducted by the PCT into their concerns did not give full consideration to the issues that they raised in that case and that, the outcome of the investigation resulted in an unfair outcome for them.

c) HR advisers lacked impartiality, and acted inappropriately in regard to the investigations and D's concerns.

d) That the Trust has failed to learn from or act on the issues identified in the various investigations.

e) That the issues have impacted adversely on D's wellbeing and reputation and resulted in them seeking early retirement with reduced benefits.

**Disciplinary and Bullying and Harassment Investigations**

7.4. Both investigations were initiated by senior manager* when the two issues concerning the alleged disciplinary infringement and the alleged issues concerning D's manager and their relationship with D.

7.5. It seems that in order to resolve issues that senior manager* determined to commission two investigations concurrently; one to consider the manager's allegations and the other D's allegations of unreasonable treatment by that manager.

7.6. The disciplinary investigation established that the particular incident which initiated the manager's concerns could not be attributed to D whilst also acknowledging that D had some development needs that had been identified as part of the related informal capability issues initiated by the same manager.

7.7. The disciplinary investigation also identified that there were a number of wider issues concerning working practices at the clinic concerned regarding lines of accountability and responsibility; deficiencies in the audit trails of important documentation and that all of the issues were exacerbated by long term sickness amongst staff based at the clinic.

7.8. The disciplinary investigation report shows a balanced and reasonable consideration of the evidence and the highlighted the weaknesses in the system and D's clinical record keeping and concluded that the wider issues raised by D's manager about D's clinical record keeping would have in any event have been dealt with by the agreed capability action plan discussed between D and their manager.

7.9. The disciplinary report is well balanced and addresses the issues that it was asked to consider in a fair and well-considered manner. It shows that wider issues were explored and set out as well as the particular matters of concern that the manager had raised.

7.10. D was initially advised of the outcome by telephone which was followed up in writing by senior manager* when they were invited to a meeting to discuss the investigation outcome along with their trade union representative a few weeks later.

7.11. The bullying and harassment investigation is also well balanced against the issues that it was asked to address. The investigator considered that the actions of the manager and the service manager showed a need for development of both and that their joint actions towards D had been insensitive and on one occasion thoughtless.

7.12. The investigator also suggested that D could usefully reflect upon their openness and response to legitimate management challenge and noted the breakdown in the relationship between them and their line manager. (D does not accept that there were legitimate management challenges due to the lack of timeliness by their manager).

7.13. The investigator did not consider however that within the remit of the issues they had been asked to consider, that the evidence substantiated bullying when considered against the PCT's Bullying and Harassment Policy, whilst also acknowledging that D's complaint was not vexatious.

7.14. The investigator noted the breakdown in the relationship between D and their manager and concluded both had a responsibility for how this had developed and concluded that it had irretrievably broken down.

7.15. As a consequence of their findings the investigator recommended development and training for D's manager and their immediate senior manager along with the use of an external facilitator to support D in reflecting on their own behaviour in the matter and enable D to develop alternative strategies for the future.

7.16. Both the investigations give a fair and balanced assessment of the issues and recognised that it was no longer feasible for D and the manager to work together.

**Role of HR Advisers**

7.17. There is no evidence to suggest that HR advisers acted inappropriately with regard to D's case, however there is some evidence identified in the bullying and harassment investigation, that D's manager was inclined to attribute responsibilities for their actions to HR.

7.18. The bullying and harassment investigation concluded that this was an example of the manager's development needs and gave rise to D considering that matters were being handled more formally than was the case.

**Bullying and Harassment**

7.19. D's case was investigated by the PCT for issues of bullying and harassment and the outcome is discussed above. Some additional comment is included in the conclusions of this Report below.

**Raising Concerns**

7.20. Overall the evidence shows that this case was beleaguered by a lack of responsiveness and action to resolve the concerns raised by D at a local level. This in part reflects the fractured relationship between D and their manager but also the failure by the service manager who was aware of the issues in January 2010, to grip the emergent situation between the two individuals at an early stage.

7.21. The first substantive management intervention appears to have taken place in July 2010 when senior manager* initiated the concurrent investigations to consider the issues that had emerged between the two individuals.

7.22. There is a clear audit trail that shows that senior manager* was open to receiving and responding to a formal grievance submission from D and it was not until April 2011 that D raised a formal grievance.

7.23. The evidence shows that the PCT responded reasonably and promptly to a subsequent proposal and negotiated position by D's representative, to enable for D to withdraw the grievance, which after the PCT responded D subsequently sought to reopen.

7.24. On balance, given the involvement of the trade union representative in negotiating and agreeing the withdrawal and the PCT response it does not seem unreasonable that the PCT declined to do so.

**Conclusions**

7.25. The overall conclusion of this Investigation is that during the course of 2009/10 there was a significant breakdown in the relationship between D and their manager for which both carry some responsibility and which neither appeared to able to resolve between.

7.26. Matters were allowed to drift and develop between them in an unhealthy way, without a timely intervention by a senior manager, even although D raised these issues with a service manager in January 2010. It is unreasonable that having done so, it took nearly five months for a meeting to be held to consider the concerns and then a further month for action to be taken, by which time it was too late.

7.27. The intervention by senior manager* in July 2010 was a reasonable attempt (albeit at a very late stage), to try to understand the issues between D and their manager and on the balance of probabilities, appears to have been intended to be a way of objectively and equitably establishing the substance of the issues between them.

7.28. The full documentation of the bullying and harassment investigation (which was supported by a very experienced and senior HR professional) shows that this it was a reasonable and fair investigation. It balanced very carefully the evidence, offered well-reasoned findings and sought to pragmatically suggest an equitable way forward from a very poor situation that had emerged between two individuals.

7.29. It may have been helpful however, had the bullying and harassment investigation been asked to consider the outcome of the disciplinary investigation as an additional matter before finalising their report. On the balance of probabilities, had this been done, it is likely that this may have led to the conclusion that the manager's actions in seeking the disciplinary case against D may have been viewed as a breach of the Trust's Bullying and Harassment Policy.

7.30. However, given the issues concerning D's own contributions to the failing relationship established in that investigation, it is likely on the balance of probabilities, that even if this had happened, that the course of action proposed in report, would have remained unchanged.

7.31. The proposal to move D rather than the manager, to an alternative location was also seemingly a well considered and a pragmatic supportive intervention.

7.32. The findings of the disciplinary investigation highlighted that the clinic where D was originally located, had poor working practices and systems and had reduced levels of staffing as a result of long-term sickness.

7.33. The report also identified that D had some development needs as regards their clinical records standards and would require support and development to achieve the necessary standard and D had maintained that the workload they had been allocated was unfair. Given the on-going pressures as a result of the sickness issues in the team at D's original work base it was unlikely that an appropriate workload for D would have been achievable at that location at that time.

7.34. There is clear evidence that the PCT wanted to support D constructively to return to work and actively sought to do so. It would have been irresponsible had they returned D to work at their original work base, because even if the manager had been moved, there was no possibility that D could have been allocated a caseload that could accommodate the identified development and training needs.

7.35. It is also apparent from the evidence, that the impact of the breakdown of the relationship between D and their manager, had affected other staff at the clinic and this may, on the balance of probabilities, have created a less that conducive working environment for a supported return to work. D themselves, also indicated that they anticipated some difficulties if they were to return to the same clinic, although considered these could be overcome.

7.36. It is also evident, that whilst D felt under understandable stress over this period, that at times, their response to some of the issues identified, demonstrated an uncompromising and inflexible approach and particularly so when the PCT sought to facilitate their return to work in 2011 to an alternative work base. (It should be noted that D does not accept this conclusion by the Investigator).

**Recommendations**

7.37. Having regard to the impact of the delay in sorting this situation initially, and the issues that emerged in the investigations arising from this case, it is recommended that:

i. WHCT formally and directly reinforce the earlier apology by senior manager* to D for the unacceptable delays in the initial handling of the issues concerning their concerns by the managers at the predecessor Worcestershire Primary Care NHS Trust.

ii. WHCT in partnership with staff side assure the Board that the actions recommended for the PCT and its managers in the bullying and harassment investigations (reported in 2011) have been fully implemented and taken into

practice at the work area concerned, by which it is meant that the Trust assures with staff side, that there has been no reoccurrence of the issues identified in the bullying and harassment investigation.

## 8. Case E: Worcestershire Health and Care NHS Trust– 2014/15

### Context

8.1 This case concerns a Secretary/Administration Assistant (referred to as E in this Report) who retired from WHCT in January 2015.

8.2. The summary timeline and circumstances of the case are as follows:

*August/September 2014*

1) In August 2014 E, along with other staff at a community hospital, attended a meeting held by a senior manager (referenced as senior manager^ in the Report). In the meeting an on-going patient complaint was discussed along with some personnel and management changes at the community hospital.

2) At that meeting senior manager^ drew attention to the need for staff to observe confidentiality about matters discussed in the meeting and that indicated that a failure to do so might result in disciplinary action. The meeting was also reminded of the Trust's policy on confidentiality.

3) Two days later a senior official of the League of Friends of the Community Hospital (LFCH) attended the community hospital and in the course a conversation with a ward sister, mentioned their concern at the impending management changes at the community hospital.

4) The ward sister discussed the matter with E, who advised they had emailed another official of the LFCH in a routine email on another matter, when they had mentioned the changes. E told the ward manager who had only recently joined the community hospital, that it was normal practice to let LFCH know such things and that they did not think they had done anything wrong.

5) The ward sister indicated E should not continue to make such communications and that such communications should come from managers and said that they intended to raise the matter with senior managers.

6) The ward sister raised the issue with the operational manager and senior manager^. Senior manager^ requested that the ward sister submit a written statement giving their account of the conversations, as it was agreed that E's actions may warrant formal disciplinary investigation, as it might be a breach of the Trust's Confidentiality Policy.

7) The ward sister provided the statement a few weeks later. In late September senior manager^ commissioned a disciplinary investigation into an alleged breach of confidentiality by E.

8) In August E had submitted notice of their intention to retire in December 2014 which following a discussion with the ward sister, which they subsequently sought to rescind and amend to 31 March 2015.

9) There was an initial delay in responding to this request from E and in September 2014 the operational manager discussed the matter with E when they agreed to accept the amended date proposed by E. At the same time they informed E of the impending disciplinary investigation commissioned by senior manager^.

10) The operational manager also advised E that if E were to amend the date of their retirement again the Pensions Agency would need three months notice in order to ensure there was no delay in releasing E's pension.

11) Senior manager^ wrote to E a few days later to set out the allegation; the letter stated that if the allegation was founded it may potentially constitute gross misconduct. It went on to say that although suspension was not considered appropriate at that time there would be some restrictions on E in regard to communications during the investigation.

*October 2014*

12) In October 2014 E submitted a further (and final) letter of resignation to the operational manager in which they indicated they intended to retire at the end of January 2015. This was accepted by the Trust and passed to the Pensions NHS in order to organise E's pension on their retirement.

*November 2014*

13) In early November E was interviewed as part of the disciplinary investigation; the investigating officer did not have a copy of the email in which the alleged breach of confidentiality had occurred. The email was provided by E and read out by the HR adviser at the interview in order that it was recorded in the interview notes. The investigating officer also took a copy of the email for their investigation records.

14) As a consequence of E's interview and sight of the email, the investigating officer and the HR adviser involved in the case, concluded that there was no case for E to answer and proceeded to close down the investigation.

*December 2014*

15) In early December 2014 the investigating officer produced their report in which they concluded that whilst E had communicated with the LFCH this had been in the context of established custom and practice at the community hospital and, that this did not therefore constitute a breach of confidentiality by E.

16) The investigating officer recommended that guidance should be given by managers to all staff at the community hospital about what information could be shared with LFCH.

17) In mid December senior manager^ wrote to E to confirm the outcome of the disciplinary investigation and that no formal disciplinary action was to be taken. In the same letter senior manager^ indicated that there were a number of recommendations following from the investigation some of which concerned E and arranged a meeting for early January 2015.

*January 2015*

18) In early January 2015, E together with a representative, met with senior manager^ and HR as requested. The meeting was difficult between them and during the meeting senior manager^ raised a further allegation that E had breached confidentiality on another matter a few days previously. The meeting ended with issues unresolved between them.

19) In mid January 2015, senior manager^ wrote to E to summarise the meeting they had together.

20) E retired from the Trust as planned at the end of January 2015.

**Summary of Concerns**

8.3. E has previously raised some concerns about the case being reviewed in this investigation and also mentioned other historical concerns about their employment with the Trust that are not directly within the scope of this Investigation.

8.4. There is also a link to a patient complaint that is a separate matter and outside the scope of this Investigation.

8.5. In summary E's concerns and allegations are that:

a) The disciplinary investigation in 2014 was unwarranted and the allegations were based on inaccurate information.

b) The investigating officer lacked impartiality and did not fully inform themselves of all the relevant facts before the investigation and their report lacked key evidence.

c) That senior manager^ did not behave in a way that suggested they accepted the outcome of the investigation and conducted themselves in a bullying manner towards E at the feedback meeting when they raised another allegation against E.

d) The Trust has allowed an improper account of the disciplinary investigation to emerge at the community hospital and has taken no responsibility to address this and allowed the rumouring to damage E's local reputation and in consequence cause them considerable personal distress.

**Disciplinary Investigation**

8.6. The evidence shows that when the investigation was commissioned it was based on an incomplete and inaccurate account of the events.

8.7. The ward sister's statement did not reflect that E had advised them that they had written to a different member of LFCH and did not include the email containing the alleged breach of confidentiality.

8.8. There is also no evidence that any action was taken by the ward sister, the operational manager or senior manager^ to verify the established custom and practice at the community hospital before a formal disciplinary investigation was commissioned.

8.9. Senior manager^ says that they had a conversation with an official of LFCH who had expressed some concerns that they had not been communicated formally on the matter by a manager.

8.10. The issue of custom and practice was identified to the ward sister before the formal disciplinary investigation commenced, when another established senior member of the nursing workforce, supported E's position on the established custom and practice of such communications at the community hospital.

8.11. Senior manager^, who commissioned the investigation, says that they did so in consultation with the ward sister, operational manager and HR and, took it forward because it was held in that discussion, that E's actions may have been a breach of the Trust's Confidentiality Policy.

8.12. They also say that matters concerning the management arrangements at the community hospital should not have been communicated by E to the LFCH because it was made clear to staff that Trust information should not be communicated to third parties and that this included organisations such as LFCH.

8.13. Senior manager^ says that HR did not indicate that the email was essential for the investigation to commence, whilst HR says that senior manager^ was clear and insistent when the matter was discussed with them, that a disciplinary investigation was appropriate.

8.14. The allegations that were made against E which were in a letter signed by senior manager^ and specifically refer to the breach of information occurring after a confidential staff meeting in August 2014, although senior manager^ contends that the investigation was not as a result of any specific instruction given at that meeting.

8.15. The investigation commissioned by senior manager^ shows that the significant emphasis was given to examining what was said at the August 2014 meeting by the senior manager^ about confidentiality boundaries that applied to staff.

8.16. The investigation concluded that there was not a consistent understanding of whether senior manager^ had intended their comments on confidentiality to apply to the whole meeting or to just the patient complaint that was discussed.

8.17. The investigation also confirmed that there was established custom and practice of sharing information with LFCH and that communication by E did not constitute a breach of confidentiality or fall outside of the code of conduct for employees.

8.18. The investigation made a single and overarching recommendation that all staff at the community hospital should be given guidance on what information should be given to the LFCH. There was no specific recommendation or recommendations concerning E.

8.19. The investigation also concluded that the matter concerning E's communication could have been dealt with informally.

**Role of the Investigating Officer**

8.20. There is no evidence to suggest that the investigating officer lacked impartiality in the investigation and the report reflects a reasonable balance of the facts and information gained, and dismisses the allegations against E.

8.21. The investigating officer was not in possession of the relevant email sent by E when they commenced the investigation although they had made enquiries of IT to supply this, which resulted in E accessing the document and bringing it to their disciplinary interview.

8.22. This was at the very early stages of the investigation and once the investigating officer received the email and with the benefit of the other evidence gained in the interviews conducted on the same day as E's, the investigating officer quickly determined that there was no case to answer and proceeded to close their investigation.

8.23. It is of some concern given that this was a relatively straightforward investigation that the email, a significant piece of evidence, was subsequently lost by the investigating officer. It was very fortunate that it had been read out at E's interview and recorded in that transcript.

**Follow Up From Disciplinary Investigation**

8.24. When senior manager^ wrote in mid December to E to confirm the outcome of the disciplinary investigation and that no formal disciplinary action was to be taken, they also indicated in that letter that there were a number of recommendations following from the investigation some of which concerned E.

8.25. The investigation report had one overarching recommendation and made no specific recommendations concerning E.

8.26. In the planned feedback meeting, which took place in early January 2015 to discuss the outcome of the investigation there, is no dispute of fact that the meeting was difficult and fractious. However, each party each holds a differing view about the behaviour of the other and the meeting seemingly ended on a bad note between senior manager^ and E.

8.27. The start of the meeting was delayed which senior manager^ says they do not recall, although another party to the meeting considers may have been the case. E contends there was no explanation for the delay or an apology about this when the meeting commenced. E agrees, however, that they were angry when the meeting started because of the delay and became even more so when senior manager^ opened the meeting by reading out the unfounded allegation against them, which E says had caused them considerable distress over the previous five months since it was first raised.

8.28. E says that senior manager^ was aggressive in tone, which senior manager^ disputes and says that they did not raise their voice but may have used a challenging tone at times in the face of the hostility shown by E towards them.

8.29. E says they raised concerns about the length of time that the investigation had taken which senior manager^ did not accept and felt that the timescale had been reasonable.

8.30. E also complains that senior manager^ had not read the alleged offending email before they commissioned the investigation or at any time thereafter. Senior manager^ confirmed this was the case. E says they became even angrier when it became apparent in the meeting that the email had been lost by the investigating officer and could not be found as they considered this reflected the haste and lack of care that had been given to a matter and that had caused them so much distress immediately prior to their retirement.

8.31. E agrees that in the meeting with senior manager^ they raised a range of historical issues concerning their employment on which senior manager^ directed E to the Trust' grievances procedures.

8.32. A third party in the meeting, says that neither party handled the meeting particularly well and that the tenor of the meeting deteriorated very quickly which was not helped by the cramped environment in the room.

8.33. The third party also confirmed that during the discussion senior manager^ introduced an additional allegation when the substance of the disagreement about what information should be shared with LFCH in particular, emerged between E and senior manager^; this was towards the latter part of the meeting.

8.34. There is little evidence to substantiate the alleged complaint that underpins this further allegation by senior manager^ and no firm detail was provided by the Trust to the Investigation to support this allegation.

8.35. It is agreed by HR and senior manager^ that this allegation was discussed verbally between them immediately prior to the meeting with E, and they agreed at that time that it would be appropriate to seek E's comments on the alleged complaint as part of the meeting.

8.36. The HR adviser concerned indicated that with hindsight, given the tenor of the meeting that developed between senior manager^ and E, this was not a particularly wise thing to do at that time.

8.37. In mid January 2015, senior manager^ wrote to E to summarise the meeting and gave details of how E could raise a grievance about the other issues they had raised.

8.38. They also stated that they had found E's behaviour at the meeting to be hostile and inappropriate and indicated that similar action would result in further action against E, whilst also confirming that E's requests for additional information from HR would not be met.

8.39. Senior manager^ was aware at the time they wrote this letter of E's impending retirement.

**Raising Concerns and Bullying and Harassment**

8.40. Given the conclusions that follow in this Report below these areas have not been covered in the same way as the previous cases. There is also on-going communication between the Trust and E about related matters.

8.41. There also appears to be an important backdrop to this case concerning a patient complaint and related concerns about breaches of confidentiality at the community hospital concerned.

8.42. Whilst this may be an additional context for the conduct of E's case it is not a matter that is within scope of this investigation; however for the purpose of this Investigation E denies any such involvement in these matters.

**Conclusions**

8.43. The overall conclusion of this Investigation is that a formal disciplinary investigation of this issue was ill-judged and demonstrated a "heavy-handed" approach to a matter that should have been dealt with and resolved locally by the ward manager and or operational manager.

8.44. As a result, the escalation to a formal disciplinary process, E was faced unnecessary and avoidable distress and in the small community of colleagues and associates, to some avoidable reputational damage in the twilight of their career.

8.45. An initial exploration of the historical communication arrangements at the community hospital would have identified the established custom and practice of communications with the LFCH and, in turn enabled managers to set out clearly for staff including E, what communications would be acceptable in the future. It would also have provided an opportunity to communicate the same to LFCH.

8.46. It was unreasonable in the absence of these basic enquiries to initiate a formal disciplinary investigation and even more so given the failure of the managers to review and inform them of the content of the alleged breach contained in the email that E had sent.

8.47. The representations by senior manager^ that this was a decision taken in consultation with others and in particular HR, does not absolve them of their personal responsibility for the commission of the investigation and, on the balance of the evidence given to the Investigation, it seems that they were particularly influential in that decision and, ultimately, they were responsible for signing off the commission.

8.48. It also appears, on the balance of probabilities, that senior manager^ may have been conflicted in the role of commissioning officer for this disciplinary investigation,

because the substance of the allegation against E and the investigation that followed, struck at the heart of an instruction and boundary that they felt they had given to staff at the community hospital in the meeting of August 2014.

8.49. The internal investigation report did not support that the instruction had applied to the whole meeting, however senior manager^ maintained that this was the case to this Investigation.

8.50. Senior manager's^ approach to the handling the subsequent feedback meeting also appears to be unduly "heavy-handed". The letter inviting E to the meeting sent by senior manager^ inaccurately suggests that the investigation led to a number of recommendations some of which concerned E. This was not the case; with only one recommendation in the report, which was general to all staff; no specific recommendations were made in the investigation report in regard to E.

8.51. The meeting that took place was also less than helpful for both parties. The findings of the report, (which had taken nearly five months for a relatively simple issue to be resolved), meant that E could reasonably have expected the meeting to have resulted in a full apology alongside a rationale explanation of why the action and had been initiated.

8.52. This could have been supported by a constructive explanation of what was to be put into place in future, to ensure that staff were made aware of the new standards of confidentiality to apply to communications with LFCH.

8.53. It is apparent that the poor quality of the meeting between the two parties was mutually attributable, given the apparent delay in starting the meeting and the anxiety that a prolonged and unfounded disciplinary investigation would have promoted in any employee, some leeway should have been given for E's response and anger in the meeting and particularly so when they became aware that senior manager^ had not read or seen the email leading to the investigation.

8.54. In the context of what had proved to be a contentious and difficult meeting it was unwise and unnecessarily provocative of senior manager^ to introduce at the end of the meeting, a further allegation against E, even if this had been their original intention. Ideally this could have been picked up if necessary, at a more appropriate time when matters were calmer, noting that E had only two more weeks to service with the Trust.

8.55. The subsequent letter issued by senior manager^ which confirmed the meeting outcome also appears unnecessarily provocative and heavy-handed and particularly so given that E was in the last two weeks of their employment with the Trust.

8.56. Put in the context of the January 2015 meeting itself, the communications about that meeting and the manner of the commission of the preceding disciplinary investigation which was found to be unfounded and a matter for local resolution, it was reasonable for E to consider that senior manager^ was acting unreasonably and in a potentially oppressive way towards them.

8.57. This could have resulted in a reasonable and formal complaint by E against the senior manager^ under the Trust's Bullying and Harassment Policy.

**Recommendations**

8.58. Given the impact of the handling of this case and the distress caused to E it is recommended that:

i. WHCT formally and directly apologise to E for the conduct and management of this case and the evident distress that this has caused them and, in so doing acknowledge that the case should not have been brought.

ii. WHCT ensure (with E's consent and agreement on the content) that staff at the relevant community hospital are made aware of the outcome of E's case review and that action is taken to stop any further reputational damage in this regard to E.

iii. WHCT reviews the manner in which this case was initiated and subsequently managed to determine any appropriate internal actions or development need for the management staff involved.

## 9. Overarching Themes and Conclusions

This section of the Report identifies the emergent themes, conclusions and recommendations from the review of the five cases.

### Context

9.1. It difficult to have confidence, that four historical cases which are now some five to six years ago, and one relatively contemporary case, set in the context of an organisation employing nearly 4000 staff, provide a reliable indicator of the current climate and approach in WHCT. Together, however, and particularly so in the more historical cases, they form part of the inherited legacy for WHCT and provide a useful insight into underlying corporate memory.

9.2. It was refreshing to hear that staff side (the recognised employee representatives of the current workforce) and WHCT (managers who were interviewed in the Investigation), both acknowledged that WHCT had inherited some difficult and complex employee relation issues from their predecessor organisations. Both parties also considered they had moved forward from the substance of those issues and that the current workplace culture was more constructive and balanced.

9.3. There was a suggestion from both staff side and managers, that some of the issues in these cases may have been driven by the manner in which predecessor organisations conducted staff relations and a suggestion that the alleged culture had impacted on the conduct and management of associated employment policies at the time.

9.4. It was reported to this Investigation, to have been particularly evident in the former WMHPT where it was alleged, that there was a particularly difficult culture and relationship between WMHPT and staff side, which had encroached on related HR policies and procedures. As a result, it is alleged, that this translated into some “heavy-handedness” in the manner that employment decisions were taken or managed, which it has been suggested, was to the detriment of some employees.

9.5. Some, but not all of the issues that have been raised collectively in this Investigation by the complainants seem to sit within this general assessment and description of the culture of that organisation at that time.

9.6. The staff side account of the legacy culture also alleged that the relationship between FTOs and the former WMHPT was almost broken and, that at the time there was little confidence in the overall leadership of the HR department. This, it is alleged, led to some fractious and unproductive discussions and, reportedly, at one stage, almost led to a universal withdrawal and vote of no confidence by all FTOs on the conduct of certain aspects of HR matters.

9.7. The staff side give a persuasive account of the significant shift in these matters as a result of the current leadership in WHCT as the successor organisation and, their comments about the culture and approach are generally very positive.

9.8. It appears that staff side hold a genuine belief that since the new Trust and leadership team have become established, that there has been a marked improvement in the general management culture and approach to employment issues. They say this is characterised by the leadership team and HR working constructively and respectfully with staff side as partners.

9.9. In evidencing this, the staff side referred to quantitative evidence within the workforce performance data that shows evidence of a reducing number of disciplinary cases (and which is reviewed regularly at Board level through a Committee and the staff side in its meetings); the partnership approach to revising employment policies, which they say has seen some important simplifications and an improved balance in the management approach including for example, a fast track disciplinary process for more simple misconduct issues.

9.10. The staff side also offered qualitative evidence, for example, their experience of the open and positive response of the current Chief Executive to any areas of concern (and say that this is also mirrored in the senior leadership team), and pointed to the fact that whereas the FTOs were constantly at loggerheads with the former WMHPT, they were now infrequent visitors to WHCT.

9.11. The staff side were, however, also realistic and cautious about how embedded the new culture was across the whole organisation. They considered this is still work in progress and noted that occasionally some examples of the old alleged “heavy-handed” approach emerged in certain pockets of the organisation.

9.12. The staff side felt that occasionally some middle managers (particularly those from the predecessor WMHPT) could default and resort to a procedural and “heavy-handed” approach rather than seeking local resolution and discussion. However, they described this as having decreasing frequency and far more isolated than had previously been the case in WMHPT.

9.13. The staff side also observed that there is still a significant amount of work to do in reviewing and ensuring that employment policies are consistent with the new WHCT ethos and values and as part of this fit with recognised health sector best practice. They considered that the refreshed and refocused HR team, which now works very constructively with the staff side, was also a significant catalyst for this on-going change programme.

9.14. The staff side also say that they do not consider that there is any evidence, in their experience, to suggest that there is within the WHCT grounds to suggest there is a systemic problem of abuse by managers of staff or, that there is a wider culture within WHCT, either overtly or discreetly, that suggests selective bullying by managers. Staff side nonetheless also recognised that within a large organisation of 4000 or so that such issues may emerge from time to time.

9.15. There was considerable confidence expressed by staff side about the ability to raise concerns on behalf of employees and, although the staff side said they did not have any managers or areas within WHCAT which gave particular concern, they could and had, raised any such concerns about individual managers with the Chief Executive and found that this resulted in a prompt, fair and constructive response.

9.16. These are reassuring comments that reflect a growing confidence in the new leadership and organisational culture of WHCT, however, which such strong and powerful memories of the legacy culture and examples such as Case E, it is important that WHCT is alert to the potential for that confidence to be undermined and continues to embed the new values and behaviours expected at all levels in WHCT.

**Key Themes**

9.17. Having given consideration to the five cases, ten core themes have emerged and yet equally may also seem the most obvious in any employment process, however, because of the findings of the case review they are set out below:

1) **Ensure Consistent Reasonable Action**: In taking action, ensure that all parties regardless of seniority are treated fairly, consistently and reasonably, having regard to the circumstances of the issue and that decisions are properly recorded in the investigation documents.

2) **Establish Key Facts**: Before embarking on an investigation, check the key facts and explore the option of local resolution or alternative approaches before launching a formal disciplinary investigation.

3) **Maintain Objectivity and Impartiality**: Check with an open mind, and from the perspective of all parties' concerned, potential conflicts of interest or where objectivity may potentially be open to challenge.

4) **Set out Allegations Clearly and Specifically**: Ensure allegations set out the alleged wrongdoing clearly, simply and specifically in order that the employee can respond appropriately and, where cases are aligned or mutually dependent ensure consistent alignment in the allegations as appropriate.

5) **Intervene in a Timely Manner**: Ensure prompt attention to issues and seek to resolve these at an early stage informally if possible, particularly where employees are raising concerns about working relationships.

6) **Manage with the Employee in** Mind: Manage the cases proactively and with consideration of the impact on the employee at the centre of the issue; keep a track of progress and an objective overview at an HR and managerial level of how matters are emerging and progressing for the employee.

7) **HR as Guardians of Fair and Reasonable Process**: HR should take a strong role in ensuring consideration of the experience for the employee and should

challenge constructively and where appropriate, the need for and conduct of investigations.

8) **Transparency and Good Governance**: Ensure that clear written audit trails are maintained for decisions or judgements in employment matters and record all decisions and discussions concerned with investigations within the investigatory records.

9) **Openness to Correcting Procedural Errors**: Maintain a responsive and open mind to considering representations that a procedure may have been misinterpreted or applied unduly harshly, and ensure that hearing/appeals panel examine these aspects carefully to ensure a balanced objective decision.

10) **Balance and Perspective**: Consider if formal process is necessary and review the processes used to ensure that they are not unduly legalistic or put forward in a daunting manner, which is unnecessarily threatening for the employee concerned.

**Overarching Conclusions**

9.18. A significant conclusion however, notwithstanding the above themes, is that there is insufficient evidence to support the overarching suggestion by the complainants that these cases are exemplars of a systemic problem of abuse of staff by managers at the organisations concerned.

9.19. In one of the WMHPT cases (Case B in the Report) there is evidence of considerable support to an employee in the management of their sickness absence, which was possibly above and beyond the minimal statutory duties and policy considerations that could have been applied in the circumstances.

9.20. In one other case (Case C in the Report), the concurrent disciplinary case (on which there was some mutual dependency of case C, and more significant disciplinary charges), showed that the managers (who would have also been responsible for hearing case C) demonstrated a constructive and lenient consideration of the issues.

9.21. The PCT case shows a considerable delay in tackling an emergent workplace concern however, that at a very late stage when a senior manager became involved, a balanced and fair approach in seeking to resolve issues between two employees and in seeking to enable an employee to return to work in a supported way to resume their career.

9.22. The remaining two cases fall short for disparate reasons; one (Case A), because of the quality of the investigation (which in itself was complex and restricted because of concurrent litigation); and the other (Case E), because of the ill judged approach of the commissioning manager to the investigation.

9.23. Similarly, the evidence does not support the broad allegation by complainants that these cases show that managers singled out individuals because (allegedly) they are

considered awkward, or because the manager or organisation had something to hide/wanted a scapegoat.

9.24. This appears to be a particular interpretation of the cases which on the balance of probabilities, is likely to have arisen because in some cases, the complainants were not in full possession of all the relevant facts which, for rational reasons of confidentiality and wider responsibilities to other parties involved in the cases concerned, was not available to them.

9.25. There is, however, some suggestion that historically WMHPT, could seemingly be insensitive or reluctant to respond to concerns raised in some of the cases reviewed (which staff side says is no longer the casein WHCT). However, this is possibly a causal factor for some of the concerns within the cases reviewed.

9.26. The review found some inconsistency in the general standards and approaches of internal investigating officers and arrangements for commissioning investigations and conducting hearings, with the reported training of investigation officers being provided from variable sources. Investigation reports were also of variable standards with some excellent examples and others considerably weaker.

9.27. There was also some inconsistency in the role adopted by HR advisers with some showing a strong independent advisory role and others more passive or at times drawn into overly supporting the investigating officer (albeit for rational reasons at the time).

9.28. The cases show that the individuals involved, have struggled to come to terms with their experiences as a consequence, which is understandable because they did not feel that at the time their concerns were heard and conflict with an employer is always an emotionally distressing experience, whatever the circumstances.

9.29. It may have been helpful if more care had been taken by the predecessor organisations in particular, to ensure through effective case management, that the experience and timeliness of the relevant procedures in each case was kept under objective review, and if less daunting language and processes could have been used either to resolve issues at an earlier less formal stage, or to clearly explain the issues of concern.

9.30. There is some evidence that the actions of some individuals or others acting on their behalf has played a part in the development of their cases at the time and, there is evidence that others involved in their cases have subsequently (or in some cases at the time), been equally distressed by the continued representations of partial aspects of the cases which they consider has not given balance to the full issues.

9.31. It is hoped that as a result of the Independent Investigation and publication of the Report on the outcomes of that review, together with the anticipated commitment of WHCT to follow up on the various recommendations in the Report that it will provide an opportunity for closure and for all to move forward.

**Overarching Recommendations**

9.32. The following recommendations have been brought forward as wider supporting recommendations, to underpin the findings of the individual case reviews and the key themes identified.

9.33. The intent of the recommendations in this Report is to encourage the further development of the positive culture that is reported to be emerging in WHCT and to support learning from the case review.

9.34. It is recommended that in addition to the individual recommendations for each case, WHCT should:

i. Review the cadre of internal investigating officers to ensure that all have the relevant competencies to undertake internal investigations and that there is sufficient depth and breadth to avoid any potential or legitimately alleged conflicts of interest.

ii. Refresh the training of investigation officers and develop or commission jointly with staff side a new training programme which ensures that all are accredited internally and are operating from a standard framework which is consistent with WHCT's new values and disciplinary policies and procedures.

iii. Review and clarify the arrangement for disciplinary and associated HR case management to ensure that there is regular monitoring of progress of individual cases and that employees are not "lost" in the processes.

iv. Consider with staff side how, in addition to measuring the number of disciplinary cases etc. they and the Trust may reasonably assess the qualitative experience of the management of such cases.

v. Review with staff side if it is entirely necessary to record all interviews in employment processes and if the style and content of associated correspondence can be improved so that it is both compliant with any necessary legal advice and drafted in a manner that is less daunting.

vi. Continue the review of employment policies in partnership with staff side.

vii. Ensure that managers at all levels are provided with refreshed training and guidance to ensure that actions and behaviours align with the revised employment policies and WHCT's value base.

viii. Ensure that HR continues and, is supported and encouraged, to challenge appropriately, where they consider investigations may potentially be handled by informal resolution rather than formal procedures.

## Appendix A - Terms of Reference

### 1. Background

a. The NHS Trust Development Authority (TDA) received an initial complaint regarding Worcestershire Mental Health NHS Trust complaining about flawed HR processes and an organisational culture of bullying and harassment. Further complainants have now approached the TDA, including a former employee of Worcestershire Primary Care Trust (provider function). The Mental Health Trust ceased to exist in July 2011 and the PCT in April 2012; the successor body for provider services is Worcestershire Health and Care NHS Trust (The Trust).

b. The TDA has appointed an external investigator to review the circumstances surrounding the departure of the five members of staff who have complained to the Trust and/or the TDA.

c. The Trust, the complainants and the investigator will be consulted on these terms of reference.

### 2. Scope

a. For the avoidance of doubt, the investigation is not re-opening any previous investigations under the Trust's Disciplinary or Grievance Policies. It is a review of the handling, by the Trust, of the five cases identified.

b. No further cases will be recognised within the scope of the review once it has been commissioned.

### 3. Purpose

a. The overall purpose of the investigation and review is to examine the management and HR processes surrounding the five cases identified to the TDA in order to identify if there are common themes that underpin the five cases and particularly with a view to identifying if bullying and harassment by managers of the Trust is a common feature of these cases.

b. As part of this the review the investigator will also consider the effectiveness of Trust's processes and procedures for managing grievances and enabling staff to raise concerns (relevant to the five cases) in order to identify any lessons to be learnt.

### 4. Evidence to be Considered

a. The investigation should include a detailed desktop examination of the five cases. The Investigator will be provided with any relevant background and access to relevant information and documentation for the purpose of this investigation and will liaise with the Trust's Company Secretary in connection with obtaining information.

b. Consent will be obtained from all five complainants in advance of a request for documentary disclosure from the Trust.

c. The investigator may request additional information from Trust staff as appropriate; Trust staff should treat these requests for additional information as if they emanate directly from the Trust Board. Any problematic issues with information requests should be referred back to the TDA for resolution

d. The investigator will also consider documentation submitted by the five complainants and any other relevant documentation that she considers relevant to the investigation.

e. The investigator will reserve the right to look into Trust processes around HR and staff support and staff welfare as appropriate.

5. **Witnesses to be Interviewed**

a. The investigator will interview the five complainants to understand the specific nature of their complaints.

b. The investigator will also meet with members of the Trust and other third parties that she determines as relevant to the review of the five cases

c. Any person interviewed as part of this investigation, may be accompanied by another individual for the purpose of informal support if they so wish.

d. The interviews and meetings undertaken as part of this investigation will be conducted in private and will be regarded as confidential to all parties interviewed; however interviewees will be made aware that any information they give in the course of their interview may be included in the final report which is to be published by the TDA on completion of the investigation.

6. **Conduct of the Investigation**

a. The Investigation shall be conducted in a manner which seems appropriate to the Investigator, at all times acting in accordance with the principles of fairness and respecting the dignity and other rights of all those involved in the process, including those against whom any allegations have been made.

b. A note-taker will be supplied by the TDA to accompany the investigator to the interviews. Consent will be sought from individuals to enable the use of a digital recorder to support the note-taker. Interviewees will be asked to agree the content of any note from the meeting as a correct record with those who participated in it. Where requested copies of the digital recording will be supplied to the interviewees otherwise these will be destroyed once a note has been agreed.

c. The investigator will be asked to complete the report in a timely fashion having regard to the availability of witnesses and requested evidence and the need to

consult with individuals in regard to any adverse findings of fact or recommendations of disciplinary action against any individual(s).

7. **Role of TDA**

   a. The TDA will appoint an independent reviewer with no prior knowledge of the Trust or the Local Health Economy.

   b. The independent reviewer will have the appropriate credentials to conduct a detailed review of historic HR processes.

   c. The TDA will appoint a case manager as a point of liaison with the Independent Investigator, the complainants and the Trust as required.

8. **Reporting and Publication**

   a. The Investigator shall produce a report setting out:

      - A summary of the enquiries that have been made
      - Relevant findings
      - Recommendations about what further actions should be considered

   b. Where it is proposed that the report will make adverse findings of fact or recommend the consideration of disciplinary action against a person or persons, the Investigator shall ensure that that person has had an opportunity to comment on that proposed finding or recommendation before finally reporting the matter.

   c. The Independent investigator will deliver a copy of the final report to the TDA Chief Executive Officer.

   d. The TDA will consider the report to determine their next steps.

   e. The TDA will receive the investigation documentation on completion of the report as they may be required for a subsequent process.

   f. The TDA will then publish the report together with their response. The report will not name or identify individuals.

***29 July 2015***

## Appendix B - Objections to the findings from Complainants A, B & C

The NHS Trust Development Authority has received some objections from Complainants A, B, and C to some of the findings by the independent investigator with respect to their particular cases referred to in the report.