EMPLOYMENT TRIBUNALS

Claimant: **Miss OJ Kirkpatrick**

Respondent: **Dartford and Gravesham NHS Trust**

Heard at: **London South** **On: Thursday, 21 September 2017**
Friday, 22 September 2017

Before: **Regional Employment Judge Hildebrand**

Representation

Claimant: **In Person**

Respondent: **Mrs H Winstone, Counsel**
Miss D Sikorska, Solicitor

RESERVED JUDGMENT

The Judgment of the Tribunal is that that Claimant's claim of unfair dismissal fails and it is therefore dismissed.

REASONS

The Claim

1. By a claim presented to the Tribunal on 20 December 2016 the Claimant claimed that she had been unfairly dismissed from her post as Mortuary Technician with the Respondent for whom she had worked since July 1993 until her dismissal in September 2016. In a manuscript attachment the Claimant set out a chronology of events. She had been suspended, she said, on the word of a trainee. She considered the Respondent's disciplinary action was pre-planned and she was set up to fail. She said she had been told to train a trainee when it was not her job. She considered it had taken the investigating officer 4 weeks to come to a decision. At the time of the incident of the loss of a fetus was reported she

was on suspension and consequently she had not been identified as being present at the Trust. This had been recorded after she had been suspended. In the disciplinary hearing she challenged the suggestion that an audit of the mortuary had been conducted the previous year. She said the dates recorded on the Datix incident report about the missing fetus were incorrect. She challenged the trainee's statement. She said the Bereavement Office evidence was incorrect. She contended everything had been done on probability without evidence. The conclusion of the disciplinary was that she was to be sacked. The Claimant was called a liar and it was alleged that she knew about the baby going missing.

The Response

2. The claim was resisted by the Respondent. It was stated that the Claimant had been employed since 2005 as a Band 4 Mortuary Technician and had been acting up as a Band 5 Anatomical Pathology Technician until she became a substantive Band 5 with effect from 18 May 2015. The Respondent explained that an audit of mortuary equipment had been undertaken by the trainee at the request of the pathology quality manager. The finding of the audit had identified failings in cleansing and decontamination. The Claimant was suspended and during the course of the investigation into the failings in cleansing and decontamination further concerns were identified regarding the body of a 20 week old fetus which had gone missing from the mortuary and poor record keeping. An investigation had been undertaken. A disciplinary hearing had taken place and charges had been put to the Claimant. The disciplinary hearing took place on 19 September 2016 and the allegations were upheld and a decision reached to terminate the Claimant's employment summarily for gross misconduct. The Claimant had appealed and at her request the appeal had been dealt with in her absence.

The Evidence

3. The Tribunal heard evidence from the Claimant and on the Respondent's side from Ms Deborah McAllion, Head of Midwifery, Mr Michael Brand who dealt with the investigation, Ms Karen Costelloe, who conducted the disciplinary hearing and Mr Gerard Sammon who heard the appeal.

4. I received written statements for those witnesses and they gave oral testimony which was offered for cross-examination. I also received a bundle of documents running to some 860 pages, only a small proportion which was referred to in the hearing. In the course of preparing this reserved judgment I have had the opportunity to consider further the contents of the bundle. This was a hearing where the Claimant appeared in person. She offered little by a way of cross-examination of the Respondent's witnesses and it was necessary to request that she put the key elements of her case to those witnesses at my direction. At my request the Claimant identified the basis upon which she challenged the fairness of the dismissal. There were two elements to the challenge. One is that there was a conspiracy on the part of others to bring her

employment to an end. The other aspect was that the sanction of dismissal was unduly harsh.

The Issues

5. The Respondent's representative helpfully prepared some submissions which were provided at the beginning of the hearing. The set out issues for determination which were discussed with the Claimant and which are uncontroversial. They are as follows:-

    1) What was the reason for the dismissal? The Respondent says gross misconduct and the Claimant appears to say it was pre-planned. The Claimant denied the allegations made and found proved against her.

    2) If the Respondent establishes the reason as being gross misconduct, a potentially fair reason, the Tribunal moves to the test in section 98(4) of the Employment Rights Act 1996, namely whether the Respondent acted reasonably in treating the reason shown as sufficient to justify dismissal. The Respondent referred to the case of ***British Home Stores Ltd v Burchell [1980] ICR 303*** and the test in three stages which following clarification of the neutral burden of proof by statute is stated:

        i. Did the Respondent have a reasonable belief that the Claimant had committed an act of gross misconduct?

        ii. Was that belief based on a reasonable investigation and

        iii. Was dismissal within a range of reasonable responses open to a reasonable employer?

The Findings of Fact

Background

6. I made the following findings of fact. The Claimant begun her employment with the Respondent as a trainee Anatomical Technician on 19 July 1993 and had achieved the grade of Band 5 Anatomical Pathology Technician at the time of her dismissal.

7. A curious feature of the history of the Claimant's employment was her extreme reluctance to take annual leave despite considerable pressure on the part of the Respondent, understandably concerned in relation to her welfare as a lone worker. The Respondent requested that she should take the annual leave to which was entitled. The Claimant appears to have steadfastly declined. Following observations in a Human Tissue Authority report on the mortuary where the Claimant was working in July 2015 the Respondent responded to concerns about lone working by recruiting a trainee to work with the Claimant. The transferee commenced

employment in October 2015 but the Claimant was obstructive in relation to his training and the Respondent began disciplinary action in the form of investigation on 23 November 2015 in relation to inappropriate remarks by the Claimant and her unprofessional and dismissive behaviour towards the trainee.

8. The trainee referred to as "JP" in the hearing brought a grievance against the Claimant on 22 January 2016 alleging bullying and harassment against her. The trainee had to be relocated to work in the pathology laboratory pending resolution of the issues between him and the Claimant. The Claimant attended a disciplinary hearing with the Pathology General Manager on 18 March 2016 and was issued a first written warning to last for 6 months and informed that she must work with JP and train him. The Claimant appealed that decision. Later that month on 29 April JP's grievances against the Claimant were partially upheld. It was found that the Claimant had failed to train him and had refused to show him the training programme developed for him. The outcome was a recommendation that the Claimant should begin training JP as soon as possible and that there should be mediation between then concurrent with his return to the mortuary. The Claimant's appeal against her first written warning was rejected on 15 May 2016.

The Suspension of the Claimant

9. On 17 June JP attended to conduct an audit of the cleaning of mortuary equipment by reference to a statement of practice written by the Claimant. He was instructed to this by the Quality Manager for Pathology, Emma Clenshaw. The Claimant had commenced the cleaning work before JP began work preventing him from observing the totality of the procedure. The claimant did not admit him to the room where she was working and he was only permitted to observe her from the doorway of the room. His observation found the Claimant to be using Fairy Liquid to wash used post-mortem equipment rather than the chemical disinfectant Virusolve which was specified in the standard operating practice. Following this report from JP Mr Michael Brand, Senior Governance Manager was asked to investigate and the Claimant was suspended to await the outcome of the investigation on 22 June 2016.

10. The following day the Respondent identified that a fetus was missing from the mortuary. There was no evidence of this fetus being admitted to the mortuary in the register other than a name plate on a mortuary fridge.

The First Investigation Meeting

11. The Claimant attended her first investigation meeting on 5 July 2016. This was directed to the issue of cleaning equipment. The claimant was present with her union representative. She confirmed she was aware of the SOP for cleaning of equipment. She had written it. She was aware of the process and that Virusolve was involved. She said that she had cleaned the equipment before JP arrived by soaking it in Virusolve and leaving it to

air dry as prescribed. When JP arrived he did not check what stage she was at and that is why the audit showed non compliance. She accepted she had not checked the expiry date for the Virusolve. The Claimant accepted that the equipment had not been taken to the Sterile Services Unit for decontamination by autoclaving. She accepted the last time equipment had been sent was 29 November 2014. The Claimant accepted this part of the procedure had not been followed but stated that autoclaving was not required after every post-mortem. The important part was the use of Virusolve. Having considered the SOP I find it clear that the process envisaged is for equipment to be cleaned and then treated with Virusolve. There is no provision for treating with Virusolve and then washing with washing up liquid. Further the procedure specifies daily autoclaving and sets out how the equipment is to be prepared for transit and to where it is to be taken. The intermittent autoclaving suggested by the claimant is without foundation in the procedure. Indeed the procedure identifies the importance of the receipt from the SSU indicating that it is to be kept for 7 years,

12. In the investigatory meeting the Claimant denied falsification of cleaning record sheets by photocopying completed sheets with the date left blank. The Claimant disputed that there was a failure to clean the mortuary table and gullies. She contended a post-mortem had occurred after her suspension. The Claimant said she had little management support for the last three years during which she had been a lone worker. She was asked informally at the end of that meeting about the missing fetus but denied knowledge. The Respondent consequently decided that Michael Brand should commence an investigation into the whereabouts of the fetus.

13. On 23 July 2016 the Claimant was informed by letter than new allegations would be added to the existing investigation. These included failure to escalate the disappearance of the fetus, failure to ensure that the documentation was completed regarding the storage of bodies and failure to escalate when documents fell short of required standards. The final charge was failure to follow reasonable management instructions to communicate in an effective and professional way towards the trainee, JP.

The Second Investigation Meeting

14. A further investigation meeting took place with the Claimant on 2 August 2016 in relation to the missing fetus. The Claimant attended with a companion. The Claimant denied knowledge of the missing fetus and that Jan Fowden, the Bereavement Officer, had spoken to her about it. She accepted that she was responsible for completion of the mortuary register and that there has been three occasions when the register should have been completed in relation to this fetus and it had not. She said she knew how to escalate issues such as this but had not done so because she had no knowledge of it. She could offer no explanation why three fetuses in the mortuary did not have corresponding entries in the register. She cited lone working as an explanation for gaps in the register, and a resulting 48

hour delay in completion of the register. This delay was said to have caused the gaps evident in the register at the time of her suspension.

15. The Claimant also reacted in the investigatory meeting to the failure to communicate with the trainee. She said this was because her relationship with him was not good. She said she had shown him processes and spoken to him in a professional manner. She had only worked with him for one week before her suspension.

The Investigation Report

16. On 31 August 2016 Michael Brand completed his investigation report and decided that there was a disciplinary case to answer.

17. Mr Brand's report runs to some 7 pages and has 36 appendices. In relation to the cleaning allegations the report found that the standard operating procedure required cleaning of equipment and decontamination to maintain a safe working environment. Instruments were to be cleaned and sprayed with Virusolve, the specified proprietary disinfectant, and left to air dry. The audit by JP found cleansing only with Fairy Liquid. There was no evidence of sterilisation. The Claimant stated that she soaked the instruments in Virusolve and then washed them with a detergent, Fairy Liquid, and left them to air dry. The investigation established that the Virusolve in the mortuary was all out of date, and some of it was 4 years out of date. It was established that Virusolve had not been ordered since before 1 April 2012. The Claimant had demonstrated that she was aware of the procedure for ordering. Manufacturer's guidance with regard to Virusolve required that it be disposed off when past its "use by date." Disinfectant properties were not guaranteed for the product after that date.

18. The second allegation related to failure to follow decontamination processes from mortuary equipment that could have put at risk the health and safety of the Claimant and others. The investigation identified that sterilisation records showed that no equipment had been sent from the mortuary for sterilisation since 29 November 2014. The standard operating procedure written by the Claimant stated that instruments were to be placed in the carrying tray and to be adequately and appropriately cleaned prior to transfer to the SSU for decontamination. The Claimant confirmed that she had authored and approved the standard operating procedure. Independent advice received in the investigation suggested that although sterilisation is not mandatory it is recommended and that sterilisation at least weekly would be the minimum required to maintain the safety of staff.

19. In relation to the third allegation relating to the failure to escalate that the baby had gone missing, investigation found that a baby had been delivered stillborn in February 2016. Records of Carillon indicated that a job was completed and the baby delivered to the mortuary at 7:47 on 15 February 2016. The Claimant entered the mortuary at 7.45 that morning. The mortuary booking in form was not completed. This is the

responsibility of the porter who completed that transfer. The Claimant was responsible for the correct completion of the records for the recently deceased received into the mortuary including completion of the mortuary register. The mortuary register was not completed for this baby. There was no indication in the mortuary that the baby had ever been in the mortuary apart from the handwritten name on a fridge door. The parents signed consent forms agreeing to a post-mortem for the baby but did not wish to be involved or informed about the funeral arrangements. The Respondent normally waits three months before arranging the funeral to allow for the possibility that the parents may on reflection review that decision. On 17 February 2016 the baby was sent for post-mortem at St. Thomas' Hospital by commercial funeral directors contracted to the Respondent. The standard operating procedure written by the Claimant makes it clear that before the deceased is released a three point patient identification check must be carried out by the funeral director and mortuary staff to ensure the correct patient is identified. This should include surname, forename and date of birth. The Claimant suggested that the undertaker should have completed the mortuary register on this occasion. That is contrary to the standard procedure.

20. On 1 March 2016 St. Thomas' Hospital sent notification by fax to the Bereavement Office that the post-mortem had been carried out and the body was ready for collection. The same undertakers who had taken the body to St. Thomas' Hospital brought it back to the mortuary. The baby arrived on 2 March 2016. The Respondent then followed their planned delay of three months before the baby went for funeral in the event that the parents reflected and changed their mind about involvement.

21. In June the decision was taken for the baby to go for a sensitive funeral and this was scheduled for 21 June 2016. The maternity bereavement midwife directed this in a form signed on 13 June 2016. The Bereavement Officer contacted the Claimant in the mortuary some time between 13 and 16 June to arrange for this baby and others to go for a sensitive funeral in June. The relevant paperwork was provided. The Claimant could not locate the body of the baby and the Bereavement Officer accepted that the baby should go for funeral in July to allow time for the fetus to be located.

22. The Claimant disputes that she was aware of the fact this baby was missing and she was also unaware that this baby was intended for a sensitive funeral in June. She challenged the Bereavement Officer's recollection and said the Bereavement Officer could be forgetful. The Bereavement Officer's version of events is supported by a statement from JP who recalled that he overheard a telephone conversation where the Claimant said she could not find the body. A complete audit of all other fetal remains in the mortuary failed to locate the body. The mortuary register was not completed for the baby and there was no indication in the mortuary that the baby had ever been in the mortuary apart from the handwritten name on the fridge door. The internal analysis undertaken by the Respondent concluded that the baby had probably been sent for an

earlier sensitive funeral in error. No escalation of the possibility of a missing baby was undertaken until after the Claimant was suspended.

23. The fourth allegation was that the Claimant failed to ensure all documentation was completed regarding the storage of bodies and of failure to follow escalation procedures when documentation fell short of required standards. The investigation concluded that it was clear that documentation was not completed for the baby as indicated. Further, an audit undertaken suggested that 5 cases were not recorded in the mortuary register. The Claimant disputed this in the investigation and suggested that three would have been entered in the register but were awaiting further details. The Claimant accepted in the investigation that she was aware of issues with regards to fetal remains and had previously asked for a separate register for these babies. This was the subject of cross-examination in the Tribunal on the basis that there was no reason for treating these remains as different from other remains and the same register should have been used in all cases. The claimant could not explain why a separate register was needed.

24. The investigation made clear that completion of mortuary registers is a professional responsibility of the Claimant as referred to in her job description. Failure to complete the register made it impossible to track the baby.

25. Allegation five related to failure to follow reasonable management instructions to communicate with the trainee JP and failure to train. The investigation found that the Claimant and JP did not have a good working relationship and the Claimant was not speaking to him. The Claimant was informed by the General Manager of Pathology to act professionally around JP at all times. The Claimant contended that JP had returned to work with her without mediation having been undertaken. The investigation suggested that JP should have return to work and mediation should have taken place thereafter, not before he returned to work as suggested by the Claimant. The way in which the Claimant dealt with the attempt to undertake an audit suggests that the working relationship remained very unsatisfactory.

26. Mr Brand's conclusion was that the Claimant had failed to follow standard operating procedures in relation to cleaning disinfecting and maintaining mortuary equipment. She had used out of date disinfectant. She had failed to follow the decontamination process involving sterilisation. She had failed to escalate the fact that the baby had gone missing and failed to ensure that all documentation was completed regarding storage of fetal bodies. He was unable to find evidence to support the allegation that the Claimant had failed to follow reasonable management instructions to communicate in an effective and professional way towards the trainee due to the very short time span the two worked together.

The Disciplinary Hearing

27. On 7 September 2016 the Respondent wrote to the Claimant informing her of the allegations being taken to disciplinary level. She was provided with a copy of the investigation report and appendices and invited to a disciplinary hearing on 19 September 2016. The letter of invitation advised the Claimant that the allegations could constitute gross misconduct. And dismissal was a possible outcome.

28. The Claimant responded on 19 September 2017. She questioned how other matters could be added to the suspension. She concluded by stating she had worked without support for 3 ½ years. She said this was a breach of Health and Safety Act and the there had been no duty of care from the Trust. She set out areas where she disputed the investigation report.

29. The Claimant attended the disciplinary hearing with Mr Brian Easeman a workplace colleague employed by Carillion. The disciplinary hearing was chaired by Mrs Karen Costelloe, General Manager of Surgical Services with expert advice from Mr Gary Winson, Mortuary Manager at Southampton, and HR support. There are manuscript notes of this meeting, although they are difficult to read. They are found at pages 677 to 694 of the bundle. It is clear that the Claimant was given an opportunity to raise the challenges she had indicated in her letter before the meeting.

The Disciplinary Outcome

30. The outcome letter dated 23 September 2016 sets out the charges faced by the Claimant. It then summarises the management case. It then deals with the five allegations made. It records Mr Brand's summarising the investigation report and clarifying that the Claimant admitted that she failed to follow the standard operating practices and regulations referred to in allegations 1 and 2. In relation to allegations 3 and 4 it recorded that the Claimant had failed to escalate the absence of the baby. The Claimant denied responsibility for the baby despite of being three opportunities for her to complete the mortuary register. There was no paperwork or audit trial for this baby and it had not been possible to locate the baby. This was a failure to follow the admission the deceased and completion of mortuary registers SOPs [p.706].

31. The letter recorded the Claimant claimed the baby had been checked out to the undertakers but here was no paperwork to support this suggestion. The undertakers could not obtain access to the mortuary without the technician allowing them in and the Claimant must have been aware of the body the funeral directors were collecting.

32. A reference was made in the outcome to the allegation that others had used her swipe card to access the mortuary. It is not clear how this is relevant to the issues in dispute in this case.

33. The findings of the disciplinary hearing on allegation 1 were that the Claimant had admitted her failure to check that the Virusolve was in date and she had failed to follow the SOP for cleaning equipment. A small amount of Virusolve had been used over time, none having been ordered since 2012, four years before this process. The disciplinary hearing had doubts whether it was used at all on a regular basis. It was a cause of increased risk to the Claimant and others.

34. Failure to follow the decontamination process identified in allegation 2 was also found proved and the letter stated that it was a serious concern allowing risk of infection to colleagues, porters and the deceased.

35. In relation to allegation 3 regarding the missing baby the conclusion of Ms Costelloe was that she believed that the Claimant knew the baby had gone missing. Calls had been made to her and she had admitted at the time of the calls that the baby could not be found. The Claimant was aware of the escalation process but did not use it. Three occasions when documentation and identification checks should have been conducted were missed and at none of these did the Claimant escalate concerns.

36. In relation to allegation 4 the finding was that the Claimant failed to complete documentation for the baby who went missing and for others. It was a key element of her role which should at all times have taken priority. The conclusion was slap-dash approach to the identification checks completed, particularly having regard to the requirements the Claimant explained in the disciplinary hearing.

37. Finally, in relation to allegation 5, although the investigation considered the evidence was limited, having heard directly from the trainee technician Ms Costelloe concluded that given repeated concerns about lone working status expressed by the Claimant she would have expected a more positive response to being allocated a new trainee and for her to act in a professional way. JP had not been provided with adequate support during the audit or during his time in the mortuary at a time when the Claimant claimed she desperately required support.

38. Ms Costelloe took into account previous disciplinary issues, mitigation and the seriousness of the actions. She considered there was a breach of the implied term of trust and confidence. She considered that the Claimant's action amounted to gross misconduct and warranted summary dismissal.

The Internal Appeal against Dismissal

39. The Claimant appealed by letter dated 7 October 2016. She made reference to the General Manager Shelly Wilson coming out of the meeting room and going back in before the meeting started. She considered allegation 5 could not be upheld as the investigation report had not supported it. She queried how it could be said to have been established that the baby went missing while the Claimant was working

before her suspension. She did not accept that there was proof that she was unprofessional towards the trainee. She said that JP's evidence in cross-examination had not supported what was recorded. She found the same two people kept coming up in all the previous and present allegations.

40. Finally in relation to the missing baby she said the incident date on the Datix report was when she was not in the Trust but under suspension. She strongly denied a slap-dash approach to identification checks.

41. The bundle contained the management statement for the appeal hearing. The appeal hearing was listed for 10 November 2016. The Claimant indicated she did not wish to attend any further meetings.

The Appeal Outcome

42. The appeal panel met on 10 November. The Chair was Mr Gerrard Sammon Director of Strategy and Planning and Deputy Chief Executive. The other member was Mr Andy Brown, Director of Human Resources. The dismissing officer presented the management case. The appeal outcome letter is dated 21 November 2016. The appeal panel dealt comprehensively and in great detail with the points raised by the Claimant. The presence of Shelley Wilson in the room prior to the hearing was explained. She had collected the expert witness and escorted him to the hearing room. The basis of suspension was explained. Some aspects of the appeal were not clearly understood in the absence of the Claimant, particularly in relation to her suggestion that terms of reference should be expanded. The appeal panel found that the disciplinary hearing was entitled to uphold allegation 5 notwithstanding the view of investigating officer that there was insufficient evidence.

43. Dealing with the Claimant's conspiracy allegation the appeal panel concluded that the dismissing officer made her decision to dismiss from the evidence of a range of individuals, including the evidence of the Claimant, and did not place undue weight on the evidence on any particular individual. In relation to the Datix incident the panel agreed that the date of the Datix was the date of the incident report not the date that it occurred.

44. Mr Sammon provided a detailed analysis of the allegations against the Trust disciplinary policy and found that each of allegations 1 to 4 was alone gross misconduct sufficient to justify dismissal. He did not find allegation 5 to amount to gross misconduct. He termed this allegation misconduct and indicated he would have issued a lesser sanction had it been the only finding.

45. Those are the relevant findings of fact.

The Submissions of the Parties

The Claimant's submission

46. In the closing submission the Claimant referred to the reference she said the Respondent had made to the Disclosure and Barring Service. She queried why the Respondent had made allegations to that body. I explained that that this was outside my jurisdiction and not part of the case. The Claimant indicated she did not wish to make any further submission having set out her position in the evidence.

The Respondent's submission

47. The Respondent relied on the submissions in writing already given at the outset of the case. The Respondent's position had not changed. The Respondent submitted that allegations 1 to 4 warranted dismissal on their own. It was difficult to fathom the case made by the Claimant from the Claim Form. The allegation of a conspiracy was fanciful. The trainee could not have overheard something about which he knew nothing. The fact that the removal form was not available and there was no documentary evidence regarding the missing fetus corroborates the Respondent's position. The test for the Respondent was to find misconduct on the balance of probabilities. Reference was made to the case of ***Burchell***. The representative referred to the dismissal letter at page 695. The Claimant had been represented by a Trade Union representative. She had questioned the witnesses. The belief of the decision makers and the investigation undertaken were within the band of reasonable responses. The Respondent had taken an almost forensic approach to the evidence. The investigation report was found at page 645 with 36 appendices. This showed that the Virusolve was out of date and ineffective and the Claimant had changed her story in relation to washing up.

48. It was submitted that there were cases of misconduct where no lesser sanction than dismissal would be appropriate even with 23 years service. Ms Costelloe gave consideration to other sanctions. A lesser sanction might have been permissible if the Claimant had accepted that the baby was missing, but she did not. There were concerns regarding her trust worthiness. The Claimant insisted that she had done nothing wrong and asserted that she did not know that the Virusolve was out of date. The response of the Respondent was reasonable.

49. In the event that unfair dismissal was found there were issues of contribution and **Polkey**. The Claimant admitted to a large portion of the matters upon which dismissal was based in relation to charges 1 and 2 that was contributory culpable conduct.

50. Issues of **Polkey** would also arise. The Claimant had raised concerns in the procedure. These were all addressed and had not been raised further in the Tribunal. The Claimant had been kept up to date during her

suspension. It took three months from her suspension to dismissal. The Respondent was careful and thorough. This was said to be a fair dismissal.

51. The Claimant was offered an opportunity to respond. She stated that she considered that if she had support for last three and half years this might not have happened.

52. The Respondent's written submission produced at the beginning of the hearing referred to the relevant legal principles. In particular reference was made to reasonable belief in gross misconduct based on a reasonable investigation and a consideration whether dismissal was within the range of reasonable responses. The Respondent then set out a précis of the facts in the case. In conclusion the submissions stated that the Respondent was faced with an experienced senior professional whose behaviour appeared trenchant. It was unsurprising that the decision was taken to dismiss. The Claimant had failed to demonstrate any insight into her actions and was not apologetic. A mistake with a lost baby could have been forgiven but the evidence was that the Claimant knew of this and failed to admit it.

53. In summary the Respondent stated the investigation was detailed and thorough forming the basis of a reasonable belief in the mind of the dismissing officer. Suspension took place on 22 June 2016 and the disciplinary hearing was on 19 September 2016. Given the seriousness of the allegations this was not an unduly long period of time. The case involved allegations in relation to public health issues. Suspension was reviewed every two weeks and extended as permitted within the disciplinary procedure. Dismissal was within the range of reasonable responses. The Respondent submitted that the Claimant would have been dismissed in any event if the procedure was found to be unfair and that the Claimant contributed by very high degree to her dismissal.

The Law

54. The right not be unfairly dismissed is conferred by section 94 of the Employment Rights Act 1996 ("The 1996 Act"). Section 98 provides by subsection 1 that it is for the employer to show the reason and if more than one the principal reason for the dismissal and that it is either a reason falling within subsection 2 or some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held. One of the potentially fair reasons in subsection 2 is conduct. That is the reason relied on by the Respondent in this case. Although the Claimant has sought to challenge that reason by alleging a conspiracy she has not sought to set up any other reason by a way of a positive case and accordingly conduct is the relevant reason for the purposes of this case. Subsection 4 provides that where the employer has shown the reason the determination of the question whether the dismissal is fair or unfair depends on whether in the circumstances including the size and administrative resources of the employer's undertaking the employer

acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee. The subsection provides that the determination shall be in accordance with equity and the substantial merits of the case.

55. The Respondent's representative set out in the submissions what is knows as the ***Burchell*** test although statutory amendment has rendered that term an anachronism. As can be seen from the passages paraphrased above once the reason, about which there is no dispute in this case, is known there is no burden of proof in relation to the test set out in subsection 4. The analysis derived from ***Burchell*** creates a test based on 3 elements. All three elements are to be considered by the Tribunal in the context of identifying whether the Respondent's actions are within the band of reasonable responses. The first of the three elements is to determine whether the Respondent had a reasonable belief that the Claimant had committed an act of gross misconduct. The second element is whether that belief was based upon such investigation as a reasonable employer would undertake. The third element is to determine whether dismissal was within the range of reasonable responses to the circumstances found.

Conclusion

56. A significant barrier to any independent appreciation of the case put forward by the Claimant is the absence of any clear statement of that case. One element of the case appears to be that because an incident was reported in relation to the loss of the fetus after the suspension of the Claimant, the Claimant contended that the fetus had gone missing at a time when she was not responsible for the mortuary and therefore it was an inappropriate ground for disciplinary action. She further disputed the fifth charge in which it was said that she was unprofessional towards the trainee on the grounds that the investigation had found insufficient evidence to proceed with that. It was consequently on the Claimant's case improper for the chair of the disciplinary hearing to proceed with this element. The Claimant contended that everything was based on probability and there was no actual evidence against her. The Claimant contended in her claim form that the action against her was pre-planned and that she was set up to fail.

57. In the course of the Claimant's cross-examination of Mr Michael Brand, Investigating Officer I was concerned to establish that she had put her case to the Respondent's witnesses and asked her to clarify the case. She explained that she alleged a conspiracy between the Pathology General Manager, Shelley Wilson, Emma Clenshaw the Pathology Quality Manager and Karen Hines, Pathology Office Manager from the 2015 grievance taken against the Claimant who had together conspired to dismiss her. Mr Brand said it had not been put to him in his investigation that those three individuals had conspired. He recorded that the Claimant had expressed concern about management input. The Claimant had not said that the management of the mortuary were trying to remove her. Mr Brand drew attention to the fact that at the investigation meeting on 2 August 2016 the Claimant had not raised an allegation of a conspiracy or

ill will towards the Claimant by others. He drew attention to the fact that the Claimant had received and approved the notes of the meeting which were found at pages 609-611 of the bundle.

58. It is thus extremely difficult to focus on the Claimant's case which in itself is a bald allegation of a conspiracy without any specifics. The alleged conspirators were as far as I am aware named for the first time in the Claimant's answer to my question.

59. By contrast on the Respondent's side the background is clear. The Claimant had worked for a long period of time alone and the Respondent had demonstrated concerns in relation to that and in relation to her failure to take annual leave. An attempt to introduce a trainee had been met with distrust by the Claimant and had led to a grievance on the part of the trainee. The Claimant had declined to engage with the training of the trainee. After the grievance had been resolved attempts to re-introduce the trainee to the mortuary had been thwarted by the Claimant and the trainee had not been able to complete an audit of the Claimant undertaking her own standard operating procedure in relation to cleaning equipment used in the mortuary. The first and second charges arose from this unfortunate conflict.

60. Aside however from the conflict underlying that introduction of a new staff member the difficulty for the Claimant is that the investigation revealed that the Claimant had wholly failed to undertake appropriate cleaning of equipment for some considerable time. Stocks of the necessary chemical were out of date and were not being used. The Claimant was not following her own procedure and equipment had not been sent for sterilisation as clearly required in the setting of the mortuary and set out in the SOP.

61. The Claimant's response to these charges gave the Respondent no confidence that she understood the seriousness of her obligations and the danger of cross-contamination, infection and worse to which she was exposing herself and others. Those two elements alone would, as made clear by the appeal officer in an extremely detailed report, have justified summary dismissal. The requirement for compliance with instructions and procedures and confidence in a belief in the underlying ethos of the work were all the more important with an individual who was frequently working alone.

62. Turning to the third and fourth charges upon which the dismissal is based, without relying on the conversation overheard by the trainee JP, it is clear from other sources of information that the fetus which should have been present in the mortuary for a sensitive funeral in June 2016 was missing.

63. Significant external corroboration demonstrates movement into the mortuary, out of the mortuary for post-mortem, and return to the mortuary. It is difficult to see how the Claimant in her role can avoid responsibility for

such a wholesale failure of record keeping. The Respondent indicated that a mistake in this context alone would not have resulted in dismissal.

64. The Claimant had in addition failed to demonstrate any urgency in escalating the problem when she became aware of it and in the course of the disciplinary investigation and hearing appears to deny knowledge of it. She sought to argue that the deficiency took place after her suspension. In the Respondent's view her positions was untenable.

65. The disciplinary procedure utilised was full and thorough and dealt in detail with these aspects at the hearing and subsequently on appeal. The only challenge or substance made by the Claimant relates to the fact that her swipe card was used after her suspension. While on a number of grounds that is undesirable it does not go to the heart of the significant and serious allegations found proved by the Respondent against the Claimant.

66. Accordingly, I find that the Respondent as a result of a thorough investigation formed at the disciplinary hearing a belief in the misconduct of the Claimant in respect of the four charges identified. Since the Respondent did not seek to argue that the fifth charge would in itself have merited dismissal I have removed it from consideration in this judgment.

67. The Respondent's decision makers at the disciplinary and appeal stages clearly had a reasonable and honest belief in the conduct alleged. There is no real challenge to the investigation undertaken by the Respondent which on any view is an impressive piece of work. There is no valid procedural challenge. The final consideration is therefore the sanction imposed.

68. The Claimant relies on 23 years of employment, during the latter part of which for a significant period she bore sole responsibility for the mortuary. That mitigation must be placed in context. The Claimant's actions in relation to seeking assistance as a lone worker but frustrating the assistance eventually provided does not stand scrutiny. When the Claimant was supplied with a trainee she disputed that she was able to train. Rather than make the best from a practical point of view by offering the trainee an opportunity to carry out the practices she had herself written the Claimant obstructed his audit of those procedures, which he had been instructed to undertake, and failed to comply with her own procedures. The Claimant was apparently incapable of recognising the seriousness of this failure which has consequences in a number of directions both in relation to hygiene, cross-contamination, possible affect on legal proceedings, and so on. The Claimant's responsibility extended to the record keeping for the mortuary. When a major deficiency in record keeping was identified the Claimant denied the failings that had clearly taken place and showed no recognition of the deficiencies in the slap-dash procedures which she had herself adopted. Her procedures fell far short of her own standard operating procedures and indeed any expectation which could reasonably be held of the record keeping required in a public mortuary.

69. As a consequence of the serious failures the Respondent decided that dismissal was the appropriate sanction. That decision in my judgment falls entirely within a range of reasonable responses. The acts described in Charges 1 to 4 clearly fall within the contractual definition of gross misconduct. The Respondent did not rely solely on that terminological conclusion but considered carefully in relation to the misconduct identified whether dismissal was the appropriate sanction. The Claimant's length of service and commitment to the Respondent was taken into account. The decision taken and the conclusion reached fall within the range of reasonable responses. The dismissal was for conduct, a potentially fair reason. The Respondent formed a reasonable and honest belief in the misconduct alleged. The belief was formed after such investigation as a reasonable employer would undertake. Dismissal was within the range of sanctions open to a reasonable employer for the conduct identified.

70. I therefore find the dismissal was fair and the Claimant's case fails.

Regional Employment Judge Hildebrand

27 October 2017