EMPLOYMENT TRIBUNALS

Claimant: Mrs P McCarthy

Respondent: Marie Curie

HELD AT: Manchester **ON:** 31 October to 2 November 2017

BEFORE: Employment Judge Whittaker

REPRESENTATION:

Claimant: Ms J McCarthy, Solicitor
Respondent: Miss N Owens, Counsel
Ms D Costas, Solicitor

JUDGMENT

The judgment of the Tribunal is that:

1. The claimant was unfairly dismissed.

2. It would be appropriate to apply a percentage of 100% Polkey deduction to any compensatory award made in favour of the claimant.

3. It would be appropriate to apply a percentage of 100% reflecting contributory conduct to reduce both the basic and compensatory awards.

REASONS

1. The claimant brought a single complaint of “ordinary” unfair dismissal as confirmed in the Case Management Order of 14 June 2017. A list of the issues to be determined by the Tribunal was also agreed at that Preliminary Hearing and was included in the bundle of documents presented to the Tribunal on 31 October 2017 at pages 69/70.

2. At the beginning of the hearing the Tribunal discussed with the legal representatives of the parties the List of Issues which had been agreed. After that discussion it was agreed that the central and most important issue for the Tribunal to determine was whether or not the respondent had reasonable grounds for concluding that the claimant had been guilty of gross misconduct. It was properly and reasonably conceded on the part of the claimant that if there were reasonable

grounds for concluding that the claimant had been guilty of gross misconduct that summary dismissal was within the band/range of reasonable responses available to the respondent as a reasonable employer. Furthermore, it was agreed with the Tribunal that there was no question of whether the respondent's decision makers had held an honest/genuine belief in the conclusions which they had come to. That was not an issue which needed to be determined by the Tribunal. Representations were made on behalf of the claimant, however, that the investigations and enquiries made by the respondent witnesses did not meet the standard of a reasonable enquiry by a reasonable employer, and that was therefore an issue to be determined by the Tribunal.

3. The claimant gave evidence on oath by reference to a witness statement and was cross examined. The respondent had indicated that they intended to call four witnesses. Even though the reason for dismissal was acknowledged by everyone as being conduct, the respondent still believed that it was appropriate to call the representative of the respondent who carried out the disciplinary investigation. That investigation was carried out by Mrs Finney. She gave evidence on oath by reference to a written witness statement and was cross examined for a relatively brief period of time. The decision to dismiss the claimant was taken by Mrs Whincup, and she also gave evidence on oath by reference to a written witness statement and was cross examined.

4. The claimant appealed against the decision to dismiss her. The appeal was conducted by way of a review and not by way of re-hearing. That was agreed between the parties with the Tribunal. The appeal was conducted by Mrs Thorley. She gave evidence on oath by reference to a written witness statement and was cross examined.

5. The Tribunal was presented with a bundle of documents comprising 1,101 pages. The Tribunal expressed some considerable surprise at the volume of documents which it was presented with. The Tribunal indicated at the outset that if the parties expected the Tribunal to read each and every one of those documents that the time limit afforded to hear the case to a conclusion was likely to be challenging. However, at the outset the legal representatives indicated that it would not be essential for the Tribunal to read all the necessary documents. The Tribunal therefore retired to read each of the four witness statements and to consider the pages referred to in those witness statements. The Tribunal only read those pages but concentrated on the disciplinary investigation interviews, the notes of the disciplinary hearing, the dismissal letter, the letter of appeal lodged by the claimant, the notes of the appeal hearing and the letter sent to the claimant rejecting her appeal. That limitation of the reading process was discussed with the parties' representatives who agreed that it was not necessary for other documents to be considered in advance of oral evidence by the Tribunal, and that other documents which were relevant would be raised in the course of cross examination and could be considered by the Tribunal at that stage rather than as part of any process of pre-reading.

6. The three witnesses for the respondent gave evidence first and the claimant then gave evidence. After hearing the evidence and after considering the documents to which the Tribunal was referred, either in the witness statements or in the course of cross examination and which are specifically referred to below, the Tribunal made the following findings of fact:-

(a) The claimant was employed by the respondent as a Senior Healthcare Assistant from November 1997 until the effective date of termination of her employment on 30 November 2016. It was acknowledged by the respondent and the Tribunal that the claimant had many years' nursing experience and 20 years' experience of employment by the respondent in the same capacity. The role of the claimant with the respondent involved tending to terminally ill patients in their own homes as a "lone-worker". That was the role of the claimant throughout her employment with the respondent.

(b) On 21 May 2016 the claimant was assigned the responsibility of working a night shift in the home of a patient who throughout this judgment will be referred to only as "JB". In her witness statement the claimant acknowledged that JB was terminally ill and was in a bed in his downstairs living room. JB was being supplied constantly with oxygen through a nasal cannula and in order to regulate the temperature of the room there was also a fan to circulate air. Communication with JB was extremely limited. In fact conversation was so limited that there was hardly any exchange between the claimant and JB throughout the length of the nine hour shift from 10.00pm until 7.00am.

(c) JB was suffering from the effects of asbestos and would become breathless even when speaking in short sentences or when becoming engaged in the slightest physical exertion such as moving in bed. It was not disputed that JB was a challenging patient for the respondent. He did not like to be disturbed and demonstrated frustration and even annoyance if he was disturbed. However, the professional responsibilities of the claimant to JB, set against her 20 years' experience of her role with the respondent, required her to recognise and acknowledge the condition of JB and to respond and care for him in a manner which was at all times entirely consistent with her professional responsibilities and the professional standards of the respondent.

(d) The respondent had written guidance expressed as a Code of Conduct for Senior Healthcare Assistants in carrying out their role. A copy of this document appeared at pages 857-914 of the bundle. The Tribunal did not read this document in its entirety and it was not requested to do so. It was referred by the parties to various sections for consideration. The pages included not only the Code of Conduct but also the staff handbook. At page 861 the respondent makes it clear that its employees, including the claimant, are expected to carry a copy of the handbook with them at all times while they are working as a member of Marie Curie's nursing staff. The claimant confirmed that she had a copy of the handbook with her on the night of 21 May 2016. At page 866, clear guidance is given to employees as to what is expected of them during their time that they are visiting patients. Employees are reminded that they should be "alert to the patient's needs at all times". Equally employees are reminded that they must "monitor the patient's condition". So far as note taking is concerned, again at page 866, employees are told that they are "required to make written notes using

a black pen as soon as possible after the event to which they relate". The handbook goes on to say that those notes "must provide accurate, current and concise information concerning the condition of the patient and be written, wherever possible, in terms that the patient and carer can understand". Further guidance is contained within the handbook about documentation and record keeping at pages 870 and 871. A number of important guidelines are issued indicating why "good record-keeping is important". This includes making sure that there is a documented account, not only for patients but also for their families and carers who are trusting employees such as the claimant with vulnerable members of their family who are terminally ill. At page 170 it is confirmed that good record-keeping should "contain key information which at some point may be of vital importance to the patient or next of kin". At page 870 the handbook goes on to say that, "The quality of your record-keeping is also a reflection of the care you have provided. Good record-keeping is a mark of the skilled and safe Healthcare Assistant. While careless or incomplete record-keeping often highlights wider problems with practise".

(e) At page 870, guidance is given by way of reference to a number of factors that contribute to effective record-keeping. Employees are reminded that records should be factual, consistent and accurate. They should be written as soon as possible after an event has occurred, providing current information on the care and condition of the client. They should be accurately dated, timed and signed with the signature printed alongside the first entry. The entries should be chronological. They should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared. The Code of Conduct, duplicated in the bundle but appearing at pages 850-854, reminds employees including the claimant, at page 852, that certain standards of behaviour are required for all Marie Curie employees, including those working at the grade that the claimant worked at. Care is to be provided safely and should reflect high standards of behaviour at all times. The employee is equally reminded that their conduct must maintain the good standing and reputation of Marie Curie Cancer Care and reflect charity policy.

(f) The first time that either the claimant or any representative of the respondent had any concern about the events of 21/22 May 2016 was when the respondent received a telephone call from the daughter of patient JB. A file note of that conversation appeared at page 113 in the bundle. The daughter of JB was very upset and she said that JB had died whilst on the phone to NHS Direct at approximately 7.00-7.30am. She expressed concern that her father had died alone and that the police and ambulance had been called. The claimant's shift at the home of JB under the terms of her contract of employment and shift pattern was due to end at 7.00am. The daughter expressed concern saying that she could not understand why if a Marie Curie nurse was present her father had phoned NHS Direct on telephone number 111. An ambulance had been sent to the home of JB and they had contacted the police. Understandably the daughter wanted to know why her father had needed to call NHS Direct.

(g) The claimant was then contacted by Mrs Finney, one of the witnesses for the respondent, who carried out the investigations. A note of that telephone call appeared in the bundle at page 113. In that telephone call the claimant described JB as being "quite a rude and grumpy gentleman". The claimant told Mrs Finney that as far as she was concerned there was nothing unusual about the time that she had spent at the home of JB. She said that when she left that he "did not appear unwell or any different" to any other part of the shift time that she had spent in his company.

(h) At page 113 Mrs Finney recorded the claimant as saying to her that JB had "asked her to leave at 6.55am". The claimant denied saying this and denied saying that JB had told her that. The Tribunal does not find that JB told the claimant that she should leave at 6.55am. The Tribunal concludes that this was an honest mistake on the part of Mrs Finney in her record-keeping. The Tribunal was not presented with the notes which were taken at the time of the telephone call by Mrs Finney. The Tribunal believes that there may have been some discussion between Mrs Finney and the claimant about the time that she left the home of JB and that somehow that has been translated into suggesting that the claimant had left because JB had instructed her to do so. The timing of that suggested comment at 6.55am is entirely inconsistent with the likely medical condition of JB about which the Tribunal will comment below. The Tribunal therefore does not accept that JB instructed the claimant to leave at 6.55am.

(i) At page 115 it is recorded that Mrs Finney rang JB's daughter back and told her that care had been provided to her father by the claimant and that there was documentation in his notes. Page 115 records JB's daughter as being reassured and that she did not wish to take the matter further. However, the record-keeping of the claimant and the notes which she had/had not made during the course of the time that she had spent with JB were not discussed in any detail with JB's daughter. She was simply reassured by Mrs Finney that there was record-keeping and appears to have been prepared to accept that bold assertion.

(j) During the telephone call between Mrs Finney and the claimant, Mrs Finney asked the claimant to provide a written statement of the events of that night. That written statement appears at pages 116-117. The claimant describes JB as being "quite irritable". She also describes him as being short tempered. She indicates that she had "no concerns" about the condition of JB.

(k) In that statement the claimant said that she "had a conversation with JB at approximately 6.50am". She did not, however, say what that conversation was about or what she said and what JB had said. She confirmed in that statement that the conversation took place before she had then walked to her car to put her bags in the car. However, at page 116 the claimant gives no indications of what was said when she "had a conversation with JB at approximately 6.50am". She is clear that that "conversation" took place before she went to her car.

(l) What the claimant says at page 116 is not consistent with her witness statement at paragraph 15. At page 116 the claimant says that the discussion with JB about whether there was anything that he wanted took place after she returned to the house having put her bags in her car. However, at paragraph 15 of her witness statement the claimant says that this was a conversation which took place before she went out to her car. That is very clear from paragraph 16. At paragraph 15 of her witness statement the claimant says that the only thing that she said to JB after returning from putting her bags in the car was that she was leaving. There was no conversation or discussion with JB. He simply raised his hand with his arm laid flat on the bed. He raised his hand from the wrist by way of simple acknowledgement but did not say anything.

(m) However, at page 1019 when the claimant is aware of the timing of the telephone discussions and telephone calls which had taken place between JB and external agencies, the claimant then changes what she said at page 116 to say that the conversation that she had with JB was not before she went out to her car, which is what she says at page 116, but must in fact have been a conversation which she had after she returned from the car. This is a point of particular significance.

(n) By the date of the document at page 119, which is the claimant's own statement in connection with her appeal against dismissal, the claimant is aware that JB had phoned Careline at 6.46am and had then been engaged in telephone calls and discussions between 6.46am and 6.52am. JB was in a state of sufficient medical distress by 6.46am to have used his Careline alert pendant which was around his neck to alert Careline that he was being sick and was so breathless that he needed medical attention. The claimant was not in the room at the time that JB activated the Careline alert at 6.46am and on her own evidence was not present at any time during the following six minutes, when JB was engaged in telephone calls with external agencies.

(o) At page 1019 the claimant suggests that when she returned from her car, after the six minutes of telephone calls in which JB had been engaged, that “the patient was awake”. The claimant also says at page 1019 that despite the telephone calls that he had been engaged on for the previous six minutes that not only was he awake but that he was able to engage in discussions with the claimant. The claimant says that after she returned from her car, and after JB had participated in the six minutes of telephone calls, that he was able to answer the claimant when she asked him if he needed anything before she left and that JB then was able to say that he did not. In the opinion of the Tribunal this is a significant discrepancy in the evidence of the claimant. In the opinion of the Tribunal the statement at page 1019 is an attempt, perhaps prompted or assisted by the claimant's trade union representative, to “fit” the timescale of the telephone calls with the initial statement of the claimant at page 116. If, as the claimant suggests, at page 116 the discussions with the claimant had taken place at or around 6.45am then in the opinion of the Tribunal it is not reasonable to conclude that having been able, in the words of the

claimant, to participate in a discussion with her at about 6.45am and having been able to assure the claimant that there was nothing that he needed, and being able to do that apparently without difficulty on the evidence of the claimant, that within no more than a minute the patient, JB, was in such a state of medical distress, including describing himself as being sick, that he activated his Careline alert around his neck. In the opinion of the Tribunal those two pieces of evidence cannot reasonably or sensibly sit side by side in a timeline of less than one minute.

(p) When the claimant returned from her car JB had been engaged in telephone calls for six minutes between 6.46am and 6.52am. The claimant had not been present or heard any of those telephone calls. She had not even heard the attempts which had been made by NHS Direct to call JB back when he had unexpectedly ended the telephone calls. It is in the opinion of the Tribunal not reasonable to conclude that JB, after engaging in telephone calls of that nature, was then able to have a conversation with the claimant about whether he needed anything before she left and was then able to say to the claimant that he did not. JB had by then been told that as a result of what he had reported about his medical condition that an ambulance was being sent. It is not at all consistent and it is, in the opinion of the Tribunal, beyond reasonable to suggest that the content of the telephone transcripts is in any way consistent with the patient then having what the claimant suggests was a perfectly normal and standard discussion with her prior to leaving the home of JB.

(q) The conclusion of the Tribunal is that the conversation, before or after the conversations which the claimant alleges she had with JB about asking him whether or not he needed anything before she left and JB allegedly saying that he did not, is a conversation which did not take place either before the claimant went out to her car or afterwards. The Tribunal is further persuaded that this is the case because there are no written notes at all of this conversation in any of the medical records maintained by the claimant. A full copy of those appeared in the bundle at page 229. It was recognised by the claimant during the hearing that in fact there were no relevant notes of anything to do with the care that the claimant had offered JB between 6.00am and 7.00am when she left. Whether when making her witness statements the claimant was simply reporting what she might normally or usually do with patients when she came towards the end of her shift the Tribunal cannot say, but in the opinion of the Tribunal it is an obvious possibility as opposed to being an accurate representation of what actually took place between the claimant and JB between 6.45am and 7.00am on 22 May.

(r) The claimant and other employees of the respondent in her position are required to use an electronic communication system called "Communicare". They are required to log into this system at the beginning of their shift and at the end of the shift. Written instructions about this are included in the staff handbook of the respondent and they appeared at page 865 in the bundle. The instructions are clear. They require the claimant to log in before she arrives at the home of a

patient and "when you leave a patient's house for whatever reason". The claimant is reminded in those written instructions that this is a telephone system that "provides practical support for your safety when you are working as a lone worker". That guidance goes on to say that the claimant is required to update the system if her arrival or departure time changes for any reason.

(s) On 22 May the claimant activated her Communicare system at 6.44am even though her shift did not finish until 7.00am and even on the evidence of the claimant, which was accepted by the Tribunal, she actually left the home of JB somewhere between 6.55am and 7.00am. In the opinion of the Tribunal this was entirely inconsistent with the written instructions which appeared at page 865 which, in plain English, required the claimant to log in "when you leave a patient's home". There is no suggestion that it should be activated some 16 minutes before that occurs.

(t) The claimant told the Tribunal that she did this regularly and there was evidence within the bundle that that was indeed the case. The respondent accepted that they did not regularly check or monitor the log in and log out times of their employees unless they failed to log out. In that case there was a system of alarms which would be activated by the system at five minute intervals, and if the claimant had failed to log out then the first of those alarms would have been activated at 7.05am, some five minutes after her shift. The claimant gave no evidence at all as to why she would not have been able to log out once she had left JB's home apart from suggesting that firstly she had been told that she could log in or log out early, and secondly that she logged out because there were problems due to volumes of electronic traffic in actually logging out at the beginning or end of a shift. However, the claimant produced no evidence to the Tribunal at all other than her own words to substantiate those two serious allegations. Furthermore, the suggestion that the claimant had been instructed that she could log in or log out early or late was something which was vehemently denied by the respondent. In the absence of any evidence and in view of the vehement denial of the respondent, the Tribunal finds that there was no evidence at all to substantiate these two serious allegations made by the claimant. The Tribunal finds that the claimant logged out at 6.44am for her own personal convenience in order to avoid having to do so when she had left her shift, which should have been at 7.00am. The Tribunal is unable to find any evidence to suggest that any other conclusion for that timing is justified.

(u) Having logged out of Communicare at 6.44am the Tribunal then finds that the claimant did not (as previously found above) have any conversation with JB. The Tribunal finds that as the claimant says she did at paragraph 15 of her witness statement she then took his urine bottle from his bedside table and told him that she was going upstairs to empty it. She then spent time away from JB, emptying and rinsing the bottle, using the toilet herself and then came downstairs with the bottle. The Tribunal is aware that telephone calls then took place between 6.46am and 6.52am, six minutes, with JB who was in obvious

medical distress. Transcripts and timings of those telephone calls were presented to the Tribunal at pages 1081-1101. It was agreed that the first telephone alert (as opposed to a telephone call) was raised by JB as a result of his state of medical distress at 6.46am on 22 May. That alerted Careline, the provider of the pendant around the neck of the claimant which enabled him to alert Careline to his medical distress. In turn Careline called NHS Direct on 111 one minute later at 6.47am. JB was then engaged in telephone calls. He said that he was being sick and that he could not get his breath. The NHS Direct operator then had a telephone call with JB timed at 6.50am. The transcript of that telephone call appeared at page 1093. JB confirmed that "I can't do owt" and "I can't do anything". JB was asked to stay on the line. However he did not do that. There was no contact with him from 6.52am. At page 1095 the operator confirms that his understanding of JB was that "he was struggling". Not surprisingly NHS Direct continued to make attempts to contact JB again by ringing him back. However, JB did not pick up the phone.

(v) The claimant has suggested at page 1019 in her statement that JB was sufficiently lucid at that stage to be concerned about the claimant coming back downstairs from emptying his urine bottle and finding that he was on the phone that he put the phone down. No evidence whatsoever was presented to the Tribunal to substantiate that suggestion. Furthermore, no evidence was put to the disciplinary or appeal hearings to substantiate that either. The only sensible conclusion is that if the claimant had indeed come back whilst JB was on the telephone that he would have been obviously relieved and would have asked the claimant to take over the telephone conversations in order to get him the care and attention which he so obviously needed. The claimant in making that suggestion about JB putting the telephone down the claimant was coming back into the room is, in the opinion of the Tribunal, entirely and completely unreasonable and without any evidence whatsoever. It is completely contrary to the tone and content of the telephone logs which clearly show that JB was in significant medical distress. The only logical and reasonable conclusion is that if the claimant had come back into the room that JB would have been extremely relieved that she was then able to provide him with care herself and to take over the telephone calls.

(w) The Tribunal had considerable difficulty in making findings of fact about the timings of when the claimant came back into the room having been upstairs and when she took her bags out to the car. The Tribunal accepts that the claimant took her bags out to the car after she had been upstairs to deal with the patient's urine bottle and to use the toilet. The Tribunal finds as a fact than when the claimant came back down to the room the patient cannot have been using the telephone as obviously the claimant would have noticed that. In her statement at page 1019, previously referred to, the claimant says that the conversation that she had with the patient to ask him if there was anything that he needed and the patient replying that there was not must have been "6:52". This was exactly the time that the telephone

conversation between the patient and NHS Direct ended. The Tribunal ultimately concluded that the telephone calls must indeed have ended by the time that the claimant came back downstairs but, importantly, before the claimant went out to her car with her bags. The Tribunal finds that when the claimant came back downstairs the telephone calls had ended. Without having any conversation with JB, despite what she has suggested to the contrary, the claimant then went out to her car for approximately two minutes. The Tribunal finds that this must have been after 6.52am. Instead of caring for the patient in the last eight minutes of her shift the claimant took one of her two bags out to her car leaving the claimant unattended. There was no need for the claimant to go to her car. She accepted that. It was simply a timesaving exercise for the claimant because she had two bags and if she had provided care to JB until the end of her shift then she would have had to have taken two trips to her car. However, each trip would only take two minutes and so this decision making on the part of the claimant was, in the opinion of the Tribunal, completely flawed. Not only did the claimant leave the patient unattended for a period of approximately two minutes, but she left his external door to his house on the latch and unsecured. She assured the Tribunal that the door was closed but it was not locked and the patient was therefore left vulnerable during that period of time when the claimant was going to and from her car as clearly her primary thoughts were not on the patient but were on making her arrangements to get her bag to the car so that she did not have to make that trip effectively in her own time after the shift had finished at 7.00am.

(x) The claimant gave evidence to say that when she returned from putting her bag in her car that she does not wear a watch but that she saw the time on her phone as being 6.55am. The Tribunal accepts that as being accurate. If, as the claimant alleged, the journey to and from her car took approximately two minutes, then that journey was in the opinion of the Tribunal undertaken between 6.53am and 6.55am.

(y) After coming back into the home of the patient at 6.55am the Tribunal finds that the claimant did not provide any care to JB after that. The claimant put the notes which she had compiled at page 299 into the kitchen and then told JB that she was leaving. The only acknowledgement which she received from the patient was that he raised one hand for the wrist in acknowledgement. The claimant alleged, as the Tribunal has just stated, that the patient raised his hand in acknowledgement. However, that was an assumption on the part of the claimant. The claimant did not make any final checks on the condition of the patient before she left despite having effectively left him on his own for at least ten minutes between 6.45am and 6.55am when she came back from putting her bag in her car. The Tribunal finds that the mind of the claimant at that stage was on finishing her shift and leaving to go home. The claimant acknowledged that she left the patient's home at somewhere between 6.55am and 7.00am. There was, therefore, no evidence that the claimant actually finished her shift. The claimant was paid until 7.00am. However, much more importantly the claimant was expected to provide the highest levels of care and attention to the patient until the end of her shift at 7.00am. The Tribunal

finds that the claimant did not do that. She certainly did not do that during the five minute period between 6.55am and the end of her shift at 7.00am. The claimant did not do that between 6.52am and 6.55am when she was away from the hour putting her bag in her car and returning. The claimant did not make any final checks or obtain any reassurances about the condition, health and welfare of JB between the time that she went upstairs to empty his urine bottle at about 6.45am until the time that she left his home.

(z) The movements of the claimant between 6.43am and 7.00am were not included in the claimant's notes at all other than her recording that “I will lock up and put key in safe on my leaving at 7.00am”. It was put to the Tribunal that those words were capable of different interpretations. It is not clear whether there is or is not a full stop after the word “safe”. However, the following line begins with the words “on” without using a capital letter, but the comment “All appears fine” does use a capital “A”. The Tribunal finds that the words “I will lock up and put key in key safe on my leaving at 7.00am” are words which are to be read as one sentence and not two sentences. This is therefore a note written by the claimant which is in advance of her leaving the home of the patient. The Tribunal finds that the comment “All appears fine” is not a note which was made by the claimant at the time that she left. The claimant herself acknowledged that she did not leave at 7.00am but that she left somewhere between 6.55am and 7.00am. The Tribunal finds, therefore, that the comment “All appears fine” was written at the same time as the preceding sentence and was not therefore a contemporaneous record or indeed accurate record indicating the health and wellbeing of the patient at the time that the claimant actually left. It was instead a comment which the claimant entered into the notes at the time that she wrote that she would lock up and put the key in the key safe at 7.00am. It is even possible, looking at page 229, that that note was written as early as 5.45am which is the timing of the only other entry in those notes. The claimant was unable to give any satisfactory evidence about the timing of those entries. Contrary to the instructions given to the claimant the notes are clearly not contemporaneous and neither are they an accurate or proper record of what had happened. There is no comment whatsoever in any of the written notes maintained by the claimant of any of the events between 6.43am and 7.00am, because the Tribunal finds that the note written about what the claimant is going to do when she leaves is not a note which was written contemporaneously and was certainly not written between 6.43am and 7.00am in the opinion of the Tribunal. This is, in the opinion of the Tribunal, consistent with the mood of the claimant which was that her priority was to make arrangements for the shift to end and for her to be able to leave promptly or indeed slightly early as the claimant acknowledged that she did. The notes maintained by the claimant at page 229 are wholly inadequate and inaccurate. They are not in any way records which meet the standards required by the staff handbook at page 871. They are not effective. They are not factual or consistent or accurate. They are not written as soon as possible after an event has occurred. Indeed important events between 6.43am and 7.00am are omitted completely. They do not provide “current

information" on the care and condition of the client. They are not accurately dated or timed. They are not chronological and neither do they provide "clear evidence" of the care which was given to the patient during the course of the shift, and in particular omit entirely any notes relating to the period between 6.43am and 7.00am.

(aa) It is known that following the medical alert which the patient himself raised at 6.45am that medical staff did attend. They arrived at 7.03am. The patient was not breathing and had no palpable pulse. Basic life support was started and an ambulance back up was requested. This is all recorded in the statement of Darran Bailey at page 1071. Medical treatment continued to be supplied to the patient but it was stopped at 8.34am. This information, in the opinion of the Tribunal, is relevant because the claimant has suggested that at or around 6.55am when she returned from putting her bag in the car that there was nothing at all wrong with the claimant as far as she could see. However, when the patient was then first observed by medical staff at 7.03am he was unconscious and never recovered. That is a gap of only eight minutes. The Tribunal believes that if the claimant had taken proper care to examine and consider the health and welfare of the patient before the end of her shift that it would have been obvious that the patient was in significant distress and was relying on the expertise of the claimant due to that level of medical distress. The Tribunal finds that the only evidence that the claimant had of the state of JB prior to leaving was him raising his wrist on her departure. That would suggest that JB was unable to raise anything more than his wrist. The Tribunal believes that on the balance of probabilities the medical condition of the claimant at that stage was that he was extremely weak. He had been recorded as being breathless by the claimant and his breathlessness had got to a stage where he had reported to NHS Direct that he "could not do anything". That was the extent of the medical distress and condition of the patient between 6.46am and 6.52am. He was unconscious and had no pulse by 7.03am. The Tribunal does not consider that it is at all reasonable to conclude that shortly prior to the departure of the claimant that the patient was indeed able to engage in a conversation with her where he was able to reassure her that he did not need any care or attention or indeed need anything before she went home. Such a conclusion would be to fly in the face of the events from 6.46am onwards until the patient was found unconscious at 7.03am.

(bb) The record and detail of the disciplinary investigation which was subsequently carried out by Mrs Finney was described in her witness statement and was accepted by the Tribunal and indeed by the claimant as being an accurate record of the process which led to the claimant being suspended. There was, however, an investigation meeting between Mrs Finney and the claimant on 24 June 2016 and notes of that investigation interview appeared in the bundle at pages 122-128. Mrs Finney goes on to accurately summarise in paragraph 16 onwards of her witness statement the content of that investigation interview. At paragraph 19 the claimant alleges that when she came down from rinsing out the patient's urine bottle and having used the toilet herself that despite what is now known about the medical distress

of the patient and the telephone calls which had taken place between 6.46am and 6.52am that when she came back to put his urine bottle in a particular place in the cupboard by his bed that the patient was sufficiently lucid to raise an objection to where the urine bottle was going to be placed by the claimant. The claimant alleges that in that statement that she was told by the patient, "don't put it there, put it there".

(cc) The Tribunal finds that this discussion did not take place. It is alleged to have taken place almost immediately after the ending of the telephone calls with NHS Direct and at a time when the patient had been unable/unwilling to answer return telephone calls which were being made to him by NHS Direct. To suggest that the patient was unwilling to participate in such telephone calls is in the opinion of the Tribunal entirely fanciful. It was the patient who had himself requested medical assistance at 6.46am. The only logical conclusion in the opinion of the Tribunal is that the patient was actually unable to participate and answer the return telephone calls. However, the claimant asks the Tribunal to accept that at that time the patient was able to argue and dispute with the claimant about the location of the urine bottle. The Tribunal finds that that would be an entirely unreasonable conclusion to come to. All the evidence points in a very different direction. It points in a direction of the patient being in significant medical distress and even unable to answer telephone calls which were being made to him once the telephone call had ended abruptly at 6.52am. This description by the claimant of the alleged condition of the patient is not true. The Tribunal finds that it was part of a pattern presented by the claimant to seek to persuade her employers that when she came back into the room having been upstairs and that when she came back from putting her bag in her car that there was nothing about the condition of the patient that should have alerted her to anything, and that if anything happened to the patient that it must have happened after she finished her shift. The Tribunal finds, however, that that was an artificial and untrue attempt by the claimant to persuade her employers that lucid conversations had taken place between her and the patient at the relevant times. The Tribunal finds as a fact that those conversations did not take place, lucid or otherwise.

(dd) As a result of the disciplinary investigations of Mrs Finney the claimant was suspended and she was then required to attend a disciplinary hearing to answer three allegations. Mrs Whincup was then appointed to conduct the disciplinary hearing. Her history of employment and qualifications was set out in paragraphs 2 and 3 of her witness statement. The full details and records of the investigation which had been carried out by Mrs Finney were sent to Mrs Whincup. In a letter dated 17 November 2016 the claimant was sent a letter by Mrs Whincup asking her to attend a disciplinary hearing and that letter set out three specific individual allegations of misconduct, and they were as set out in paragraph 18 of her witness statement. They allege that the claimant had left her shift prior to 7.00am, that she had failed to make an accurate record in the patient's notes and that she had failed in her duty of care and had been negligent in her role as a healthcare

assistant. The balance of the statement of Mrs Whincup goes on to describe in detail the disciplinary process, including the disciplinary hearing. That detailed and lengthy explanation was accepted by the Tribunal as an accurate record.

(ee) At pages 923 onwards Mrs Whincup prepared a series of handwritten notes as preparation for the disciplinary hearing. It was argued on behalf of the claimant that those notes clearly demonstrated that Mrs Whincup had made up her mind about the outcome of the disciplinary hearing prior to it taking place. It was argued on behalf of the claimant that Mrs Whincup had a closed mind and that in effect the decisions about termination of the employment of the claimant had already been made at the time that these notes were made by Mrs Whincup. The Tribunal was referred to a number of specific comments in those pages, and they included:

- On page 923 Mrs Whincup records that something that the claimant was saying about timings was not true. She writes: "This could not have been the case". That is an obvious statement of fact as opposed to making a note of a question which needs to be put to the claimant in order to enable Mrs Whincup at the conclusion of the disciplinary process and before she reaches any decision to consider.

- Again on page 923 Mrs Whincup alleges that another timing "cannot be correct". Again that is not a note of a question to be asked but appears to suggest a conclusion on the part of Mrs Whincup.

- On page 925 there appears to be a list of conclusions which Mrs Whincup has made. She makes comments that the claimant has not been professional, indicating a conclusion and not a question.

- At page 930 Mrs Whincup's notes say: "Contradiction all the way through". This again suggests much more of a conclusion than preparation for questioning at a disciplinary hearing.

- Returning to page 924, Mrs Whincup writes: "Fraud!" if the claimant was leaving her shift early. It was suggested that this was an extreme reaction to the claimant admitting during the course of the disciplinary investigation that she had left early but only left early by leaving some time between 6.55am and 7.00am. The claimant, despite having her phone, had never made an accurate note of the time that she had left. On her own evidence she could have left at 6.55am.

(ff) The Tribunal carefully considered as part of its judgment process and reasoning process the full copy of the notes of preparation which were made by Mrs Whincup. The Tribunal accepts that there are certain parts of the notes which could and should have been phrased differently but overall the very clear impression gained by the Tribunal

was that they were a genuine set of notes prepared by Mrs Whincup to enable her to carry out the disciplinary hearing. The notes are littered with question mark after question mark indicating that Mrs Whincup is aware of the need to ask questions. The Tribunal is not persuaded that Mrs Whincup prepared these notes with a closed mind or that she had in any way pre-judged the outcome of the disciplinary hearing, either at the time that she was preparing those handwritten notes or at any other time.

(gg) The witness statement of Mrs Whincup then goes on to describe the disciplinary hearing and to confirm that ultimately she decided (paragraph 70 of her statement) that each allegation was a gross misconduct offence. She says she reached that conclusion "after careful deliberation". The claimant was told verbally there and then at the conclusion of the disciplinary hearing that she was going to be dismissed summarily, and the conclusions were then set out for the claimant in a letter dated 7 December which was included in the bundle at pages 175-181. Mrs Whincup noted the apparent lack of appreciation for the seriousness of the situation, and that the claimant throughout the process did not express any remorse or indicate how she might significantly have changed her working practices in the future. The Tribunal accepts that as part of her decision making process Mrs Whincup took into account the length of service of the claimant. However, the Tribunal recognises that length of service has two different sides to it. It is obviously something which needs to be seriously considered by an employer, but at the same time the claimant had been employed to do the job of work that she was employed to do for some 20 years. She was extremely experienced. She was aware of the policies and procedures of the respondent company and must have been well aware of the overwhelming responsibilities to provide the highest levels of care to the patients that she was entrusted with on every shift. Mrs Whincup concluded that those standards of care fell well below the standards which were expected not only by the employer but also, perhaps more importantly, by the patients and by their families.

(hh) A number of character witnesses were also submitted for the claimant. They appeared in the bundle. The Tribunal finds as a fact that Mrs Whincup took those into account. However it was acknowledged on behalf of the claimant that those witnesses had never actually worked on any shift with the claimant because the nature of the work meant that the claimant worked alone. Furthermore, the Tribunal accepts the evidence of Mrs Whincup that she did not have a closed mind to the relevant disciplinary sanction. She considered alternatives but rejected these in view of the seriousness of the conduct of the claimant and the fact that the claimant had not indicated that there was in her opinion anything that she could or should have done differently during the time that she was caring for the patient.

(ii) The claimant appealed her dismissal. Mrs Thorley was appointed to hold that appeal. Her background and expertise are set out in her witness statement and this was accepted by the Tribunal. The

claimant's letter of appeal was dated 14 November 2016 and appeared in the bundle at page 183. The letter of dismissal prepared and sent by Mrs Whincup had found (page 177) that the claimant was away from the patient's home entirely between 6.44am and the end of her shift at 7.00am. The conclusion of Mrs Whincup was not that the claimant had been engaged with washing out the patient's urine bottle or using the toilet herself or going out to her car or coming back before she then left. The conclusion of Mrs Whincup was that the claimant left the home of the patient at 6.44am and never returned. In her letter of appeal the claimant makes it clear that she did not leave until after 6.55am. The claimant blames the standard of her note keeping on the fact that the usual paperwork which would have been available to her was not available to her to enable her to make proper notes. Finally she denied that she had fallen the duty of care which she was required to provide to the patient.

(jj) The claimant was notified of the date of the appeal in a letter dated 21 December, the appeal to be heard on 24 January 2017. The claimant then sent a supplementary statement to add to her letter of appeal and that appears in the bundle at pages 187-189. The third point made in that letter somewhat surprisingly suggested that the employer had instead failed in its duty of care to the claimant by putting her with this patient who was known to be challenging, indicating that in the opinion of the claimant that that was neglecting her wellbeing and had left her open and vulnerably exposed. The letter of appeal went on to say that the claimant was appalled and distressed and that she had been caused injury, harm and loss. She said at the bottom of page 87 that she had been treated with "utter contempt". She said on page 188 that she did not leave her shift early, but during the course of the hearing it was openly recognised for and on behalf of the claimant that she left her shift somewhere between 6.55am and 7.00am and the claimant was singularly unable to provide any evidence of the exact time that she left. She alleged in her statement at page 188 that it was 7.00am when she actually left but that was not consistent with the evidence which she gave to the Tribunal on oath. She claimed that she always made good notes on every occasion, despite the complete absence of any notes having been made to cover the period from 6.43am to 7.00am. The claimant indicated at page 188 that she had attempted to provide care for the patient when checking for pressure damage but that the patient had refused to allow her to do that. None of that is recorded by the claimant in her medical record notes at page 229. The appeal letter concluded on page 189 that the claimant believed "wholeheartedly that she had done nothing wrong", and that her actions were appropriate and at no time had she neglected the patient.

(kk) The statement of Mrs Thorley goes on then to describe the appeal process and to confirm that an appeal hearing was heard and that ultimately the decision made by Mrs Thorley was to uphold the decision to dismiss the claimant. She wrote to the claimant to confirm that in a letter dated 31 January 2017 which appeared at pages 215-219. Mrs Thorley found that each of the three allegations was upheld, which meant that she also concluded that the claimant had not been in the

home of the patient between 6.45am and the end of her shift at 7.00am. Her reasoning for her conclusions was set out in her letter and was set out in paragraph 26 of her witness statement. The Tribunal accepted this as the reasoning of Mrs Thorley.

The Law

7. The law relating to unfair dismissal on the grounds of misconduct is very well recognised and very well established. This was accepted and recognised by both legal representatives for the respondent and the claimant. The issues had been discussed and set out in a note from the Preliminary Hearing. The law and the principles to be applied by the Tribunal had been discussed and agreed with the parties at the outset as has been already recorded in this Judgment.

Discussion and Conclusions

8. The Tribunal therefore went on to consider each of the three allegations of gross misconduct which had led to the dismissal of the claimant. The appeal had taken place by way of review and not re-hearing and that was agreed between the parties. Both Mrs Whincup and Mrs Thorley had concluded, therefore, that the claimant had been guilty of three individual allegations of gross misconduct and that on the basis of those conclusions the claimant should be summarily dismissed.

9. The Tribunal therefore went on to consider each of the three allegations and the reasoning for the conclusions which had been reached by Mrs Thorley and Mrs Whincup in respect of each of those three allegations.

10. The first such conclusion was that the claimant was not in the home of the patient between 6.44am and 7.00am. The conclusion of the Tribunal is that that conclusion was unreasonable and that it was a conclusion which was not reached on reasonable grounds. Whilst there were undoubtedly important and significant inconsistencies in the evidence of the claimant about her alleged conversations and discussions with the patient between 6.44am, and 7.00am, there was no evidence to contradict what the claimant said consistently throughout which was that between 6.44am and probably 6.52am that the claimant was out of the room upstairs washing out the urine bottle of the patient and using the toilet herself, generally to prepare herself for the end of her shift. The respondent did not put forward any cogent reasoning as to why this evidence should be rejected by the Tribunal. The claimant had been consistent about that throughout. In the opinion of the Tribunal it was not reasonable for the respondent to reject that evidence of the claimant. At paragraph 33 of the witness statement of Mrs Whincup she describes how she questioned the claimant about the urine bottle. However, questioning is not on the basis that what the claimant is saying is wrong but her questioning is on the basis of the timing of when that operation should have taken place.

11. It was being suggested by Mrs Whincup to the claimant that emptying the bottle should have taken place perhaps some ten minutes later towards the end of the shift, but in the opinion of the Tribunal those ten minutes are inconsequential. It seems entirely reasonable to the Tribunal that the claimant should attend to the urine bottle at approximately 6.45am instead of doing so approximately ten minutes later at 6.55am. There is no question on the part of the respondent that it was something which the claimant had to attend to and that she should do it either at or towards the end of her shift. The Tribunal found as a fact that the claimant actually did attend to

the urine bottle and use the toilet herself and that she was away from the room in which the patient was located from between certainly 6.46am when the Careline alert was lodged by the patient and 6.52am when the telephone calls to him ended, and probably even 6.53am as after 6.52am attempts were made by NHS Direct to re-contact the patient by telephone. None of this was heard by the claimant. The claimant indicated that the door was closed and that she was away upstairs.

12. On the balance of probabilities the Tribunal was prepared to accept that evidence from the claimant. For those reasons the Tribunal concludes that the decision made by both Mrs Whincup and by Mrs Thorley that the claimant was not in the patient's home at all between 6.44am and 7.00am is not the reasonable conclusion of a reasonable employer as it was not based on reasonable grounds. On that basis the first ground for the dismissal of the claimant cannot be properly or reasonably established by the respondent company.

13. The Tribunal noted that the actual wording of the disciplinary allegation was that the claimant had left her shift prior to the finish time of 7.00am. However, the crucial finding by the respondent was that the claimant left at 6.44am and it is that finding which the Tribunal cannot accept was a reasonable conclusion based on reasonable grounds. It is clear from what Mrs Whincup says in her dismissal letter at the bottom of page 176 that the respondent is not accepting what the claimant is saying about being upstairs and going to her car. This is clear because Mrs Whincup says, "Even if I were to accept that you were upstairs for a short period of time and also that you took some items to your car". What is clear from her conclusions on page 177 is that she did not accept that evidence and that she concluded that the claimant was absent from 6.44am. It is that conclusion which the Tribunal does not find reasonable and does not believe was based on reasonable grounds.

14. The second allegation was that the claimant failed to make accurate and/or timely records in patient JB's nursing notes. From the findings of fact made by the Tribunal it is very clear that the Tribunal agrees with the conclusions of the respondent witnesses. The notes made by the claimant were not in any way adequate. They did not comply with the requirements for note taking which had been clearly set out by the respondent in its policies and procedures and to which the Tribunal has already referred much earlier in this Judgment. The claimant had 20 years' experience. The claimant is entrusted with vulnerable patients on behalf of the employer. Furthermore, there is a reasonable and proper expectation on behalf of the families of those patients that not only will care be provided but that there will be a reliable and comprehensive and contemporaneous record of the care which is taken.

15. The claimant has made reference during the course of the disciplinary investigation, the disciplinary hearings and the appeal process to various discussions which she says that she had with the patient. Not one of those is properly or reasonably documented. In the view of the Tribunal the second allegation was found proven and found proven overwhelmingly on very reasonable grounds. The Tribunal will turn shortly to whether or not that was a stand alone allegation of gross misconduct which would justify the summary dismissal of the claimant.

16. The third allegation found proven against the claimant was that she had failed in her duty of care to JB and his family and that she had been negligent as a Marie Curie assistant. No evidence was presented to the Tribunal that the standard of care

provided by the claimant had in any way been inadequate or negligent prior to 6.44am, some 16 minutes prior to the end of her shift. There was no evidence at all from any source that the standard of care offered by the claimant up until 6.44am had not met the standards expected by the respondent, expected by the patient and expected by his family. The allegation against the claimant of a failure to provide an acceptable standard of care centred on the time period between 6.44am and 7.00am. However, both Mrs Whincup and Mrs Thorley concluded that between that time the claimant was not at the home of the patient at all. If that was the case then this allegation would have been found proven overwhelmingly. However, the Tribunal has already found that the claimant was in the patient's home, albeit away for a period of approximately two minutes when she took her bag to her car between probably 6.53am and 6.55am. It is true that during those two minutes the patient was left unattended and that the door was left unlocked. The Tribunal has already made a finding that the conversations which the claimant allegedly had with the patient about his wellbeing and attempts to provide reassurance did not take place.

17. The Tribunal has found as a fact that the claimant was focussed on the end of her shift and taking steps to prepare for the end of that shift from 6.44am onwards as opposed to having as a priority the care of the patient. There is no doubt that the patient was challenging. That is recognised by the respondent. However, the claimant had 20 years' experience of looking after terminally ill patients in this way, and if the patient is challenging or even grumpy then that is something which the claimant had the experience and expertise to deal with. It did not provide her with an excuse to withdraw care from the patient even if that was only between 6.44am and the time that the claimant left the home of the patient. The Tribunal accepts, however that it was perfectly proper for the claimant to have been away for a few minutes emptying and washing the urine bottle and using the toilet herself. It is easy to see how that process could/would have taken 6/7/8 minutes as the claimant has described. During that period the Tribunal does not believe that it was reasonable for the respondent to have criticised the care which was given to the patient.

18. On a proper examination, therefore, there was a short period of time during which the claimant failed to provide an acceptable standard of care to the patient. She certainly did not do that during the time that she was away putting her bag in the car. In the opinion of the Tribunal it must have been obvious to the claimant if she had taken proper care and attention of the patient when she came back from dealing with the urine bottle and then came back from putting her bag in the car that there was something about the patient which was deserving of her immediate attention. She has sought to persuade her employer and the Tribunal that the patient was lucid and capable of reasonable conversation, and making his point and even raising objections. The Tribunal has rejected that evidence as being untrue. The conclusion of the Tribunal is that there were periods between 6.44am and when the claimant left to go home when the standard of care offered to the patient was not at the standard which the patient, her employer and the patient's family were entitled to expect.

19. The Tribunal therefore having made its findings in respect of allegations 2 and 3 then considered whether or not they amounted to gross misconduct in the reasonable opinion of a reasonable employer. Did those decisions fall within the band/range of a reasonable employer faced with the information which the employer had? The conclusion of the Tribunal is that the note taking of the claimant was so inadequate that it was the reasonable conclusion of a reasonable employer that that amounted to serious misconduct. Insofar as the standard of care offered to the

patient is concerned, the conclusion of the Tribunal is that that equally amounted to serious misconduct and that the claimant has made deliberate attempts to cover up what, in the opinion of the Tribunal, she must have recognised was an inadequate standard of care by alleging that she had various conversations with the patient which, in the opinion of the Tribunal, simply did not take place. Of course they should have taken place. They should have been included in the notes. The claimant was well aware that when she left at 7.00am that the patient would then be on his own. He would therefore be particularly vulnerable. It was incumbent upon the claimant to make every proper effort to ensure that the needs of the patient were being met and could be met in the immediate period after she left at the end of her shift. The conclusion of the Tribunal is that the claimant made no such attempts and no such efforts. She was dealing with someone who was grumpy and uncooperative. He may well have been challenging and may well have indicated that he did not want the type of care which the claimant was used to providing. However, all that is irrelevant. The claimant is an experienced nursing professional and irrespective of the personalities and conduct of the patient she was obliged, under the terms of her contract of employment and the policies and procedures of the respondent, to provide the highest levels of care, service and attention to the patient until the end of her shift at 7.00am. The conclusion of the Tribunal is that she did not do that.

20. The Tribunal therefore went on to consider whether on the basis of the findings under allegations 2 and 3 that the decision to dismiss the claimant was the reasonable decision of a reasonable employer. The respondent had made it clear that it had made individual findings in respect of each of the three allegations, and that it had decided that each of those three allegations amounted to gross misconduct and that each of those individual allegations justified dismissal on its own. There was no indication on the part of the respondent that there had been any amalgamation of the behaviour of the claimant between 6.44am and the end of her shift which examined, as a whole, had then been considered to be gross misconduct. Instead the respondent had divided up the conduct into three separate allegations, had considered them separately, had made separate conclusions about them and had concluded that each of them justified summary dismissal.

21. The Tribunal has already set out its reasons as to why the conclusions of Mrs Whincup and Mrs Thorley were not the reasonable conclusions of a reasonable employer in respect of the alleged absence of the claimant from 6.44am onwards. The claimant had, however, acknowledged that she had left her shift somewhere between 6.55am and 7.00am and her note keeping was completely absent about that point for reasons which the Tribunal has already concluded.

22. The conclusion of the Tribunal is that individually, set on their own, neither allegation number 2 nor allegation number 3 justified a conclusion that there was conduct on the part of the claimant which was sufficiently serious to warrant summary dismissal. It is to be emphasised that the respondent made it very clear that their witnesses, Mrs Whincup and Mrs Thorley, had considered each individual allegation separately and that there had been no amalgamation or accumulation of the conduct of the claimant between 6.44am and the end of her shift.

23. The conclusion of the Tribunal, therefore, is that the dismissal of the claimant was unfair and that it was outside the range of reasonable responses available to a reasonable employer on the basis that the respondent had approached the conduct of the claimant by considering three separate individual allegations and deciding

them quite separately and independently without any overarching view of the conduct of the claimant between 6.44am and the end of her shift. Taken separately, they did not individually amount to gross misconduct.

24. It was discussed and agreed with the representatives of both the claimant and the respondent that if a decision was made by the Tribunal that the decision of the employer was outside the band/range of reasonable responses that the Tribunal would then have to go on to consider two separate legal principles, namely:

(1) What is known as and what was recognised by both legal representatives for the claimant and the respondent as a "**Polkey**" argument. In other words, if the respondent had approached the conduct of the claimant between 6.44am and the end of her shift in its entirety and looked at each aspect and then thought about the overall conduct of the claimant during that period what, on a percentage basis, is the likelihood that the claimant would have been dismissed in any event?

(2) Having found that the claimant had been unfairly dismissed it would be the obligation of the Tribunal to consider contributory conduct both in respect of a potential basic award and a potential compensatory award.

25. The Tribunal therefore went on to consider what the approach of the respondent would have been if a fair and reasonable decision making process had been followed, and what the decision of a reasonable employer would have been. In the opinion of the Tribunal a reasonable employer would have separately looked at each individual aspect of the conduct of the claimant, concentrating particularly on incidents between 6.44am and the end of her shift. However, insofar as the note taking is concerned, there were legitimate and serious concerns about the note taking of the claimant throughout her shift. The claimant had indicated that that was because she did not have the official note paper from the respondent but the Tribunal found that to be an utterly fanciful allegation bearing in mind that the claimant had paper and pen available and had been able to make notes at page 229.

26. In the opinion of the Tribunal, a reasonable employer would have concluded that the overall conduct of the claimant, without separating it into separate individual allegations, would have been so serious that it amounted to gross misconduct which would have justified the summary dismissal of the claimant. The reasons why a reasonable employer would have concluded that would have been:

(a) The claimant did not complete her shift until 7.00am and openly admitted that she left somewhere between 6.55am and 7.00am.

(b) The recordkeeping of the claimant was grossly inadequate and failed to meet any of the reasonable standards and policies and procedures of the respondent company.

(c) The claimant was more interested in making sure that she took one of her two bags to her car prior to the end of her shift than she was on providing proper care and attention to the patient who was, on any interpretation, in significant distress at the very time that the claimant was away from the home between what was probably 6.53am and 6.55am. That was the very time at which the patient was relying on the

claimant for the highest levels of care and attention, particularly due to the fact that the claimant was shortly to end her shift and that after that the patient would be on his own, which the claimant was well aware about.

(d) A reasonable employer would have concluded that the conversations which the claimant says that she had with the patient simply did not take place and had been invented by the claimant in order to cover up what were obvious and serious inadequacies in the care that she provided to the patient. An alternative was that the claimant did not actually invent them but that she was reporting conversations which she perhaps might usually have with this particular patient. None of those conversations were, of course, recorded in her notes at page 229.

(e) A reasonable employer would have concluded that from 6.44am onwards the claimant was much more interested in doing what was a bare minimum to complete her shift and then to get away. This even involved her taking one of her two bags to the car when what she should have done, on any reasonable interpretation, is to have taken the bags at the end of her shift. She could not be providing the proper level of care and attention to a terminally ill patient during the two minutes that she was taking her bag out to the car. That would have been obvious to the claimant.

(f) In the opinion of the Tribunal the evidence available of the medical distress of the patient was such that it would have been clear to the claimant if she had paid proper attention to the welfare of the patient between 6.44am and the end of her shift that he was in significant distress. It is clear that he was because at 6.46am he was in such distress that he operated his Careline alert and he was then able to describe his levels of distress to the people he spoke to by telephone. The claimant, however, would seek to persuade the respondent and the Tribunal that in fact all was well when she came back from her car at 6.55am, and that indeed all was well when she came downstairs back into the room before going out to her car. That evidence cannot be reliable. The only reasonable conclusion of a reasonable employer would have been that the claimant did not pay sufficient care and attention to the needs of the patient, either when she came back into the room having been upstairs or when she came back from her car, and the reasons for that were because she was more concentrated on her finishing her shift and getting away from a patient who was grumpy and uncooperative and with whom clearly she did not have any professional bond or relationship.

27. In the opinion of the Tribunal, therefore, the claimant was guilty, on an overall picture, of gross misconduct. The claimant's representative accepted that if the Tribunal came to that conclusion that the appropriate **Polkey** reduction would be 100% and that was a proper and professional acceptance for her to make. If the respondent had not artificially divided the conduct of the claimant in the three ways that it did but had instead examined the overall conduct of the claimant on 21/22 May, then in the opinion of the Tribunal it is inevitable that the claimant would have

been found to be guilty of gross misconduct and the decision to dismiss her summarily would have been the decision of a reasonable employer and would have been within the band/range of reasonable responses of a reasonable employer.

28. For identical reasons the Tribunal would conclude that contributory conduct, both in respect of a basic and compensatory award, should be at the level of 100%. The conduct of the claimant was serious and significant. She very badly let down her employer and she equally badly let down the patient and her family who were not surprisingly extremely distressed to find what had happened. In those circumstances the claimant had caused/contributed to her dismissal to an extent of 100% and that would have justified the Tribunal in making a 100% deduction for contributory conduct both in respect of a basic and compensatory award.

29. Finally, it is proper for the Tribunal to comment on the representations which were made on behalf of the claimant by her legal representative in her closing comments:

(a) The Tribunal has rejected the suggestion that Mrs Whincup pre-judged her decision to dismiss the claimant.

(b) It was suggested that in order for there to be a reasonable investigation of a reasonable employer that the employer would have had to look at the medical notes maintained by the claimant at page 229 and compare them with the medical notes which were maintained by others. The Tribunal does not find that to be a necessary step in order for the investigation to be the reasonable investigation of a reasonable employer. If the notes of others had been found to be similarly inadequate then there is no evidence at all to suggest that the respondent would not have taken equally serious disciplinary action against those other employees. If the notes of the claimant were similarly inadequate then that would have simply added to the seriousness of the conduct of the claimant. The Tribunal does not accept that this step was necessary in order for there to have been the reasonable investigation of a reasonable employer.

(c) It was put on behalf of the claimant that far too much emphasis had been put on the Communicare log out time of 6.44am. The Tribunal has accepted that that was the case because in the opinion of the Tribunal Mrs Whincup and Mrs Thorley placed far too much emphasis on that in order to conclude, unfairly and unreasonably, that the claimant was not at the patient's home from 6,44am onwards. It was suggested that the other log out details of the claimant should have been examined. However, the significance of the timing at 6.44am in the opinion of the Tribunal was that that was simply the start of the period following which the claimant failed to provide an adequate or reasonable level of car and attention to the patient, and equally completely ignored her requirement to keep and maintain comprehensive and contemporaneous records. In the opinion of the Tribunal that was the relevance of the log out time of 6.44am. It was an indication of the start of the thought process of the claimant as to what her approach was going to be between 6.44am and the end of her shift. That process was centred on her own needs and what she

wanted to do prior to the end of her shift, as opposed to being centred entirely on the continuing need to provide the highest levels of care and attention for her patient.

(d) It was suggested that because the claimant had not been found guilty of gross misconduct in 2013 when there was another time when her medical notes and records were criticised, that the standard of the notes which she maintained on 21 and 22 May could not and should not amount to gross misconduct. The Tribunal has already dealt with this and rejected it as being a reasonable suggestion. The note keeping of the claimant as demonstrated at page 229 properly fell into the category of serious misconduct in the opinion of the Tribunal for the reasons which it has already expressed.

30. Finally, the Tribunal was urged by both the legal representatives of the claimant and the respondent that the claimant was more credible than the respondent's witnesses and vice versa. The Tribunal did not find that to be an issue that it needed to deal with. The Tribunal has set out in this Judgment its reasoning for rejecting important and essential elements of the evidence of the claimant, but that is not to reject the evidence which she gave at the Tribunal but to reject the evidence which she gave about the events of 22 May from the first time that she was alerted to it. The Tribunal accepted without any hesitation that the claimant found giving evidence upsetting and difficult. The Tribunal allowed the claimant a number of breaks in order to regain her composure which was obviously fair and appropriate. This was not a case which was decided one way or the other because one set of witnesses or one witness was more credible than the other. The case was decided by the Tribunal on the basis of the reasoning of the respondent and the evidence which was put forward by the claimant, which was confusing and unreliable insofar as the timings of contact with the patient were concerned, particularly from 6.44am onwards on 22 May. Credibility or lack of credibility of witnesses was not therefore an issue which influenced the judgment of the Tribunal.

Employment Judge Whittaker

Date 28th November 2017

JUDGMENT AND REASONS SENT TO THE PARTIES ON

14 December 2017

FOR THE TRIBUNAL OFFICE