Case No: 2302852/2016

EMPLOYMENT TRIBUNALS

Claimant: Mrs. L. Rose

Respondent: Nightingale Hammerson Trustee Company Ltd

Heard at: **London South, Croydon**
On: 1-4 August 2017 and in chambers on the 24 November 2017.

Before: Employment Judge Sage
Members: Ms. S. Campbell
Ms. N. O'Hare
Representation:

Claimant: Ms. E. Godwins Legal Consultant

Respondent: Ms. B. Huggins Counsel

RESERVED JUDGMENT

1. The Claimant's claim for disability discrimination is dismissed on withdrawal
2. The Claimant's claim for unfair dismissal is not well founded and is dismissed.
3. The Claimant's claim for age discrimination is not well founded and is dismissed.
4. The Claimant's claim for wrongful dismissal is not well founded and is dismissed.

REASONS

1. By a claim form dated 15 December 2016 the Claimant claimed unfair dismissal, age discrimination, associative discrimination. The Claimant complained that dismissal was an unfair sanction and the termination of her contract was unfair, wrongful and a detriment. The claims for a redundancy payment and holiday pay were dismissed on withdrawal prior to the hearing.

2. The Respondent denied all claims against them claiming that the dismissal was for misconduct and stated summary dismiss and was fair

and within the band of reasonable responses. They also denied all claims of discrimination.

The Issues

3. The issues were set down by EJ Elliott at a hearing dated the 9 February 2017 seen at pages 41-42 of the bundle. In outline, they were as follows:
   a. **Unfair dismissal** – What was the reason for dismissal? The Respondent asserts that it was for a reason related to conduct following a complaint from a resident in her care, which is a potentially fair reason for dismissal. It must prove that it had a genuine belief in the misconduct and that this was the reason for dismissal. The Claimant's case is that she was dismissed because she was 60.
   b. Did the Respondent hold that belief in the Claimants conduct on reasonable grounds?
   c. Was the decision to dismiss a fair sanction, that is, was it within the band of reasonable responses for a reasonable employer?
   d. If the dismissal was unfair, did the Claimant contribute to the dismissal by culpable conduct? This requires the Respondent to prove on the balance of probabilities that the Claimant actually committed the misconduct alleged.
   e. Does the Respondent prove that if it had adopted a fair procedure the Claimant would have been dismissed fairly in any event? And/or to what extent and when?
   f. In respect of the Claimant's claim for **age discrimination**, did the Respondent dismiss the Claimant because of her age?
   g. Has the Respondent treated the Claimant as alleged less favourably than it treated or would have treated the comparators? The Claimant relied on a hypothetical comparator being a care worker under 45 however it was clarified by the Claimant (page 47 of the bundle) on the 15 February 2017 that they relied on a named comparator of Gertrude. The Claimant withdrew her claim for disability discrimination by association at the commencement of the hearing.
   h. For the purposes of Wrongful Dismissal – does the Respondent prove that it was entitled to dismiss the Claimant without notice because the Claimant had committed an act of gross misconduct relied upon.
   i. The Claimant states that she is entitled to 12 weeks' notice.

Witnesses

The witnesses before the Tribunal were as follows:
The Claimant and for the Respondent we heard from
Mr Leigh Director of Operations
Ms. Chibanda Head of Care
Ms. Simmons Chief Executive

Findings of Fact

4. They are agreed or on the balance of probabilities are found to be as follows:

5. The Claimant was employed by the Respondent as a Health Care Assistant "HCA" from the 14 April 2003 until her summary dismissal on the

4 July 2016. The Respondent is a charitable organization operating two nursing homes for people of the Jewish faith.

6. The Tribunal were taken to a number of the Respondent's policies in the bundle, the Moving and Handling Policy at pages 51-52 which confirmed that "*a team approach should be adopted when using mechanical aids – single handling in such instances is not recommended"***.** The Tribunal were taken to the Respondent's values and mission statement at page 54 of the bundle where it stated that all residents are to be treated with "*respect and dignity*". The values included "*putting residents at the heart of all we do*" and "*acting in a polite and courteous manner*" and "*supporting residents to live their lives and fulfil their wishes and needs*". The Safeguarding Adults at Risk Policy was at pages 73-90 of the bundle; the Tribunal were taken to paragraph 4.4 at page 76 which stated that psychological abuse included the following types of treatment "humiliating" and "ignoring and depriving an individual of the right to choose". The Tribunal were also taken to paragraph 9.1 of the Safeguarding Policy on page 80 which stated *"The individual should be reassured that they will be involved in decisions about what will happen. If they have specific communication needs, provide support and information in a way that is most appropriate to them".* It was clear from these policies that the Respondent placed great emphasis on the importance of the person centred care approach where the individual would actively participate in and have responsibility for their own care. The active involvement of the resident was therefore essential to ensure that this was achieved.

7. The Tribunal were taken to the disciplinary policy which was at pages 91-7 of the bundle. It stated at paragraph 13.1 that acts of gross misconduct *"will normally lead to dismissal without notice or pay in lieu of notice (summary dismissal)".* Gross misconduct was defined in paragraph 13.6 as *"Non-compliance with a safety code so as to endanger life or risk of causing serious injury".* Under paragraph 13.8 it was stated to be gross misconduct to *"disregard [the Respondent's] procedures and rules so as to put [the Respondent] at risk".* It was also stated to be an act of gross misconduct to commit a *"serious or repeated breach of health and safety rules"* (paragraph 13.13) and *"serious neglect of duties or a serious or deliberate breach of contract or operating procedures"* (paragraph 13.15).

8. The disciplinary procedure was at pages 106-114 of the bundle where it stated that minor conduct issues can often be resolved informally and the discussions should be held in private whenever there is a cause for concern. It stated that "*where appropriate, a note of any such informal discussions may be placed on your personnel file but will be ignored for the purposes of any future disciplinary hearings*" (page 106).

9. At the time of her dismissal the Claimant had one first formal warning on her file dated the 26 May 2016 (see pages 159A-C), she did not appeal this warning and made no complaint about the procedure followed. The Tribunal noted that the Claimant alleged that the Respondent unfairly and without cause escalated the informal warning to a formal one. There was no evidence before the Tribunal that this was the case and it was not something raised by the Claimant at the time as she did not appeal the

warning nor did she raise this concern in the subsequent disciplinary hearing that led to dismissal. The Tribunal find as a fact that the decision to give a formal warning was reasonable taking into account the facts before the Respondent.

10. The incident that led to dismissal occurred on the 29 and the 31 March 2016 and the complaint was seen in the bundle at pages 124-7 of the bundle. The complaint was made by a gentleman known as AC, who stated that on the 29 March 2016 that the Claimant was "**sloppy and not willing to help him at all. She declined to shave him and she wasn't very pleasant. She asked him to get up from bed to wash him but he answered that he cannot sit up properly and she called him a "liar". Finally, he didn't like the whole attitude".** The complaint on the 31 March 2015 was that the Claimant said to AC "**do not tell me my job"** when he asked her to put some wrappers from a cake he was eating in the bin. He also stated that she started to give him a bed wash and started washing his face, but this was something he normally did for himself. He also found it unacceptable that she wiped his face with a dry wipe and when he asked her for a towel, she brought it but "not kindly". He complained that she asked him to sit up, which he was not able to do and she gave him a 'superficial wash and didn't dry him properly'. He felt she was in a rush. He described her as being "nasty and mean" and "shouting all the time" and told him that "carers do not want to work with him". The complaint also went on to state that AC said he was going to make a complaint and she said "do so".

11. The Tribunal saw AC's care plan on pages 121 to 123 of the bundle, it stated that two people were required to use the standing hoist and he was to be attended by two staff on washing, dressing and all transfers to "promote comfort". There was no reference to a daily shave in his care plan but it was not disputed that AC had capacity and was able to express his wishes and preferences in relation to his personal care.

12. The Respondent set up two investigation panels to investigate AC's complaint, the first was on the 5 April led by Mr Pedzisi which was a safeguarding investigation, the notes were at pages 128 to 141. At page 130 of the notes, it reflected that the allegations were put to the Claimant; she was asked whether it was appropriate to tell AC he was being difficult, she replied "*he's the one being difficult*". She was later recorded to have said that perhaps she should not have said this and accepted that she had told him he was being difficult (page 135 and 139). On page 131 of the minutes the Claimant was shown to have accepted that she had not read his care plan and had not asked AC what he was capable of doing. The Claimant also stated that she was unaware that AC wished to have a daily shave; she conceded that she should have asked AC if he wished to have a shave (page 133-4). The Claimant confirmed that she had attended training on Person Centred Care "PCC" and under that policy she was required to ask the resident for their preferences (see above at paragraph 6).

13. The Claimant denied calling AC a liar but accepted that she queried whether he could sit up unaided as she had seen him sitting in a wheelchair. The Tribunal therefore find as a fact that although she may have not used the word 'liar' she was questioning the truthfulness of what

AC had told her. The Claimant conceded in the safeguarding meeting that she had said to AC "don't tell me my job" and accepted that it was not the right thing to say (page 137). The Claimant also accepted that she had prepared the water and had the flannel in her hand to wash AC and she informed him she was going to wash him. Her evidence to the investigation was "*because I told him I'm going to do it and he was like flat on the bed and he didn't respond with say a no or yes*" (page 138) this did not appear to be consistent with the values principles of PCC (see paragraph 6) to involve the resident in decisions about their care. The Claimant confirmed that she alone operated the standing hoist which appeared to be contrary to the instructions set out in the care plan (page 121) which stated "on standing hoist for all transfers with two staff".

14. In the safeguarding hearing, the Claimant was reminded that this was a potentially a safeguarding issue and she was asked whether she had spoken to anyone about it; after changing her evidence a number of times she accepted that she had not. The Claimant also conceded that when AC said he was going to complain, she did not escalate this to anyone and her reply to this statement was "*OK, I will say I can also say what your behaviour was*". The Claimant told the Tribunal in answers to its questions that she had asked him nicely why he would lodge a complaint against her, however this was not consistent with the contemporaneous evidence before the Respondent, which was not a pleasant or polite response to AC. The Tribunal find as a fact that the initial interview with Mr Pedzisi dealing with safeguarding issues highlighted a number of areas of concern where the Claimant's conduct did not appear to be consistent with the policies or ethos of the Respondent in relation to PCC. There was sufficient evidence to justify referring the matter for an investigation under the disciplinary process.

15. Ms Chibanda only joined the Respondent on the 4 April 2016 and was given the responsibility of investigating the matter under the disciplinary process. When Ms Chibanda was assigned the role of investigations manager she was handed the investigation carried out by Mr Pedzisi which was described as an interview "from a safeguarding point of view" (paragraph 10 of Ms Chibanda's statement). The letter calling the Claimant to a disciplinary interview was dated the 5 April 2016 at page 141A of the bundle, it was confirmed that the purpose of the interview was to establish the facts. The Claimant accepted in cross examination that she understood the allegations referred to in the letter. The interview took place on the 14 April 2016 (see pages 148-151). Ms Chibanda confirmed that she identified the six charges and confirmed that it was only the care of AC that was being investigated. The Claimant had not been suspended and worked throughout the investigatory and disciplinary process.

16. In the disciplinary investigation interview, the Claimant accepted that she had not read AC's care plan and the minutes reflected that her evidence was that she had "*gotten to know them and their needs by asking them. She stated that she should've read the care plan*". She stated that she had been unwell on the day in question which may have resulted in AC confusing her not feeling well to being rude. She accepted that she did not tell anyone she was unwell but started to feel sick when she was at work.

17. The Claimant was asked in the meeting if putting AC on the edge of the bed was an appropriate way of handling him and she was asked if this could be done in another way; the Claimant confirmed that she "*would get two people to assist, but there wasn't enough staff to do so*" (page 149). She was then asked about the operation of the hoist, she stated that one person can use the hoist, but confirmed that she had not been told that the standing hoist could be used by one person, she had seen her colleagues operate it with one person although the Claimant was unable to provide any evidence of others using the hoist with only one person present. The Claimant confirmed that she had recently been trained and had been informed that two people were required to operate the standing hoist (see page 150 of the bundle). The notes also reflected that Ms Chibanda questioned what the Claimant did when observing bad practices and she confirmed that she did not question her colleagues nor did she report bad practice when she saw it.

18. In the interview, the Claimant at first stated that she could not recall being asked to throw away wrappers or saying to AC "*don't tell me how to do my job*" but she was taken to her comments made in the meeting to Mr Pedzisi and she was then able to recall the incident, stating that the reason she said this was because AC kept repeating himself "over and over". The Claimant was taken to page 150 of the bundle in cross examination in relation to the comment "*don't tell me how to do my job*", she accepted that she said this but stated it was nothing to do with putting rubbish in the bin; she stated that when she was asked this by Mr Pedzisi she couldn't remember the resident asking her to put anything in the bin (pages 125 and 135). The Tribunal noted that the Claimant's evidence on this point appeared confused but she conceded that this was said.

19. The Claimant was asked about the comment she made to AC, that as he had shaved the previous morning, "*he didn't need a shave*", the Claimant was recorded to have said that she should not have said this and should not have done what she did but she "*did not do it deliberately*" (page 151). When this was put to the Claimant in cross examination, she stated that she said to him "*as you had one yesterday I suppose you do not need one*" and when he replied "OK" she took this to mean that he was "*OK and didn't want one*". It was noted that her response in cross examination was different to her evidence given to the investigation; the Claimant did not state that the minutes taken were incorrect. The Tribunal find as a fact that she had decided for AC that he did not need a shave and this appeared to be contrary to the Respondent's policy on PCC and appeared to be contrary to the safeguarding policy as it deprived the right of AC to choose (see above at paragraph 6). The Claimant accepted in the hearing that she should have written an incident report when AC told her he was going to report her but did not do so.

20. The Claimant was asked in cross examination about the conversation about washing AC's face; the Claimant stated that she "*asked AC's permission and he said yes*", she stated that she "*didn't force myself*". It was put to the Claimant in cross examination that she did not ask AC and she had made a presumption of what he could do, which she denied. She was asked if she hadn't asked the resident how would she know his capabilities and she replied, "*by looking at the care plan*". It was put to the Claimant in cross examination that she hadn't read the care plans and her

response was as follows: *"I didn't do all of it before the morning I did mention that, whether they put it in the notes or not*". The Claimant was then taken to her responses in the safeguarding meeting at pages 131 when she stated that she didn't know if she had read the care plans and then admitted that she hadn't been through them. The Claimant clarified this in cross examination by saying that she "*didn't go through the complete care plan*" and that she "*generally didn't go through all the care plan*". In the investigatory meeting the Claimant told Ms Chibanda that she had not looked at AC's care plan (page 148). The Tribunal noted that the Claimant's evidence given in cross examination did not seem to be consistent with the notes taken at the time. As the Claimant made no complaint that the notes taken were inaccurate and this was not put to the Respondent's witnesses, the Tribunal find as a fact that she had not read any care plans after the safeguarding meeting. The Claimant's evidence to the Tribunal that she may have read part of the care plans was inconsistent with the evidence before the Respondent during their investigations and was found by the Tribunal to be unreliable.

21. The report produced by Ms Chibanda (see pages 143 to 147 of the bundle) concluded that the Claimant did not provide the resident with a professionally acceptable service on the day because she failed to read the care plan before attending to him. It was noted that the care plan was crucial to the provision of PCC as well as manual handling and hygiene. She concluded that the case should be referred to a disciplinary hearing due to the serious concerns about the Claimant's conduct. She felt that the Claimant had failed to treat AC as an individual by failing to take into account his "unique qualities, abilities, interests, preferences and needs" (paragraph 25). Ms Chibanda also concluded that the Claimant failed to care for AC in a Person Centred way and in accordance with his care plan as he was capable of washing his own face. She concluded that the Claimant made AC sit up in bed when he was not capable and by doing so abused her authority (paragraph 27). It was also concluded that the manner in which the Claimant moved AC put her own and AC's health and safety at risk. It was also concluded that operating the hoist with one person again put both her and AC's health and safety at risk. Finally, it was concluded that telling AC he was "being difficult" was likely to affect his emotional health which she concluded was "tantamount to abuse" (paragraph 31).

22. In cross examination Ms Chibanda conceded that she did not record in her report that the Claimant had apologized or that the daily shave was not recorded in AC's care plan. She denied that the report she produced was biased but conceded that it reflected a one sided view, she stated that the apology was not recorded because the report was looking at the factual allegations. Ms. Chibanda accepted that the care plan did not specifically state that AC wished to wash his own face but she stated that as he had capacity he was able to make his preferences known. Although the Tribunal noted that Ms. Chibanda had accepted the report may be one sided, the minutes recorded the Claimant's apology and she was able to repeat the apology in the disciplinary hearing. The Tribunal conclude that the omission of the apology did not undermine the accuracy of evidence that had been gathered in the course of the investigation that was reflected in the report.

23. The Claimant was called to a disciplinary hearing by a letter dated the 1 June 2016 (see pages 160-1 of the bundle), there were six allegations which were as follows:

    a. That on the 29 March 2016 the Claimant declined to provide care to a resident;
    b. On the 29 and 31 March 2016, the Claimant failed to provide Person Centred Care to residents;
    c. On the 31 March 2016, the Claimant did not behave politely with a resident;
    d. On the 31 March, the Claimant abused her authority in relation to a resident;
    e. The Claimant did not follow the resident care plan in regard to hygiene and
    f. The Claimant did not follow the resident care plan in regard to safely moving and handling of a resident.

    The letter advised the Claimant of the right to be accompanied and warned her of the range of likely outcomes (which included dismissal).

24. The disciplinary hearing took place on the 22 June 2016 (see pages 162-180 of the bundle) and was conducted by Mr Leigh Director of Operations, Ms Chibanda attended to present the management case. The Claimant attended without a representative and confirmed to Mr Leigh that she was happy to continue unrepresented.

25. In relation to allegation 1, Ms Chibanda provided the evidence that she had found in relation to this allegation and the Claimant was given an opportunity to respond (see pages 163-4). The minutes reflected that the Claimant was somewhat confused as to which factual scenario they were talking about, she confused this allegation with the request for her to throw away wrappers. Her responses appeared to be contradictory as on page 165 of the minutes she stated that she did not recall being asked to throw paper in the bin but then she stated that "*I told him that when he asked me to throw the tissue in the bin, I told him that he was not to tell me to do my job. I did not say anything to him at that stage, about anything*".

26. The Claimant accepted in the hearing that she did not give AC a shave "*because he had a shave the day before*" (page 165) and she accepted that she had not checked his care plan and one of the reasons she gave for not checking it was because she had moved to the ward on the 20 July the previous year (which was 8 months before the incident); she conceded that she still had not read his care plan at the date of the hearing. The Claimant stated that HCA's only go through the daily notes (not the whole care plan).

27. The Claimant told the hearing that she had vomited at work and had not disclosed this to the nursing staff; however she accepted that she knew that if she had these symptoms, she should not attend work, however despite knowing this stayed on shift, failed to report this to anyone and returned to work the next day.

28. On the charge of not behaving politely in respect of her asking AC "why are you being difficult"; she again stated that this was something she should not have said (page 167 of the bundle). She denied shouting at

AC, which the Tribunal find as a fact was the case but it was not the tone or volume of what was said it was the nature of the comment that was considered to be inappropriate.

29. The hearing then turned to allegation four which was abuse of authority and Mr Leigh tied this allegation in with safe handling of a resident and failing to follow the care plan (page 169). The Claimant told the hearing that she carried out the manouvre on the 31 March because she saw other staff do it and she thought she could do it on her own. The Claimant confirmed that she had read the Manual Handling documents and confirmed that she knew "*we are not allowed to do hoisting on our own. I know that*" (page 170). The Claimant confirmed that she had attended the Manual Handling Course the previous year (October/November) and that the right way to use the hoist was for it to be operated by two people. The Claimant confirmed that she knew that the "right way is for two of us to operate it" (page 172). The Claimant stated that she carried out the handling alone because although there were three others on night duty they were busy. She confirmed that she did not ask her partner on duty to help because she was busy with another resident.

30. The hearing then discussed the Claimant using pillows to prop up AC in bed against the bed's wall while dressing him; she conceded that during this time she was not supporting him. The Claimant also confirmed that since 31 March she still had not read the care plan (page 177 and 178) and had not gone through any of them (page 179). It was her evidence that "*you just know*" which residents cannot do their personal care. The evidence before the Respondent was therefore consistent that the Claimant had not read the care plans of any of the residents by the date of the disciplinary hearing on the 1 June despite this being discussed with the Claimant in the safeguarding meeting on the 5 April (where the Claimant accepted that she should have checked the care plans – page 133) and in the disciplinary investigation (page 148).

31. The outcome was that the Claimant should be dismissed by a letter dated the 4 July 2016 (see pages 181-3) it found all six allegations against the Claimant proven. The Claimant was summarily dismissed, the Respondent concluding that the conduct amounted to gross misconduct.

32. Mr Leigh was taken in cross examination to the outcome letter under allegation 1 which found that the Claimant had declined AC care by telling him 'don't tell me what my job was' (in response to the request to throw paper in the bin). Mr Leigh told the Tribunal that for him the Claimant declined to do something that was reasonable. The Tribunal noted however that the letter calling the Claimant to the disciplinary hearing referred to the incident on the 29 March where the Claimant asked AC to sit up and declined to shave him and called him a liar (see above at paragraph 10). The incident referred to by Mr Leigh took place on the 31 March and Tribunal noted that there was some confusion in the dismissal manager's mind as to which facts were being considered under allegation one. However even though Mr Leigh had conflated the factual scenarios in allegations one and two, the hearing minutes confirmed that they were discussed together and the Claimant was able to give her evidence in response to each allegation (see page 163 of the minutes).

33. The second allegation was failing to provide PCC and the dismissal letter referred to AC's preference for a daily shave and to the Claimant's failure to read the care plan. It was put to Mr Leigh in cross examination that the care plan made no mention of a daily shave and he replied that "*AC made it clear he has a daily shave, it is a prompt*" and as he had the capacity to state a preference it was "*our expectation is that you will ask somebody*". This evidence appeared to be entirely consistent with the ethos and values of the Respondent as well as the expectations discussed in the safeguarding meeting (see page 133). The Claimant accepted that should have asked AC for his preference on that day and the Tribunal conclude that the Claimant had decided that AC did not need a shave which was contrary to the PCC.

34. Mr Leigh was taken in cross examination to his conclusion in relation to allegation 3 (page 182 of the bundle) where he concluded that the Claimant saying to AC "*why are you being difficult*" was considered to be unacceptable. It was put to Mr Leigh in cross examination that his conclusion that this *"could have affected someone's emotional health which is tantamount to abuse*", was inaccurate because it only "could" have affected AC's emotional health, it could not be abuse. Mr Leigh accepted that his conclusion could have been worded differently however it was still his view that this was unacceptable behaviour. The Tribunal conclude that Mr Leigh's evidence was clear and consistent that the Claimant's conduct could have had a detrimental effect on AC's emotional health, this was accepted by the Claimant who conceded that her behaviour was inappropriate both in the safeguarding meeting and in the disciplinary hearing where she accepted that she should not have said this to AC (page 167 of the bundle and paragraph 12 above).

35. Mr Leigh's conclusion on allegation 4 (page 182 of the bundle) was that the Claimant was unfamiliar with AC's abilities to sit upright and making him sit propped up was an abuse of authority. It was put to Mr Leigh in cross examination that AC did not complain about being assisted to sit up (page 125 and page 169) however the Tribunal noted that Ms Chibanda put to the Claimant in the disciplinary hearing (page 169) that she "abused her authority" by applying unsafe manoevres when handling a resident and this was a concern that had come to light after conducting the investigation; this was a concern that they felt needed to be addressed. Mr Leigh's conclusion was that it was clear from the complaint made by AC that he could not sit up on his own and the Claimant *"made him do something he may not want to do but he acquiesced*" and this was concluded to be an abuse of authority.

36. Mr Leigh was asked in cross examination about his conclusion reached about allegation 5 (washing and shaving described in the letter as 'personal hygiene' at page 141A and identified as allegation 6); he replied that AC had the right to say what he wanted done and what he could do for himself. His concern was the Claimant didn't ask AC if he would like to do this for himself. Mr Leigh was taken in cross examination to his decision at page 182 on allegation 5 and it was put to him that he didn't record the Claimant's evidence given in the hearing that Ms. Chibanda had accepted that the Claimant asked permission and he in fact relied upon what the Claimant had told Mr Pedzisi, which he accepted. He was then taken to page 137 of the notes in the safeguarding interview where

the Claimant confirmed that she told AC she was going to wash his face and it was put to him that the allegation should not be upheld; he replied that if AC was happy he would not have complained. Mr Leigh told the Tribunal that he was content that his conclusion reached was correct on the facts that the Claimant did not speak with AC to find out the support that he needed.

37. Mr Leigh was then asked in cross examination about his conclusions in respect of Allegation 6 (which was referred to in the letter as allegation 5) that the Claimant used bad practice when manually handling the resident which was a potential danger to herself and others (page 182). He was taken to page 170 of the disciplinary hearing notes where the Claimant confirmed that she knew she was not allowed to do hoisting on her own but had seen others do it, Mr Leigh told the Tribunal that he knew what her evidence was but he came to the conclusion that there had been a clear instruction for this to be done by two members of staff and the Claimant confirmed that she had done this alone. Mr Leigh concluded from the facts that the Claimant had not followed the care plan about safely moving a resident and his role was to "judge her behaviour and conduct". The Tribunal find as a fact that the evidence before him was entirely consistent with his conclusion reached in the dismissal letter. The Claimant had admitted she had recently received training in Manual Handling and was aware that two people were required to work the standing hoist yet despite this she had used the hoist alone, against training and contrary to what was set out in the care plan. There was also no evidence before the Tribunal that this advice had been regularly been departed from and the Claimant had provided no names of those who had acted contrary to the training given.

38. Mr Leigh in deciding the appropriate outcome took into account the recent warning for breach of health and safety rules. He concluded that although the incidents occurred prior to the events that led to dismissal, he concluded that the Claimant should have reflected on the matter but she had "continued to endanger another resident" (paragraph 17 of his statement). He concluded that her conduct fell "*a long way short of what is expected*" and that the Claimant "*had not treated the resident as an individual (PCC), had abused her authority (abuse), endangered herself and the resident (health and safety) and had been rude*". He was asked about this in cross examination and he confirmed that he had sight of was the outcome letter at pages 159A-B and the report from Ms Chibanda. He accepted that the written warning was referred to in Ms Chibanda's report at page 143 and a cause for concern on the 3 May had been escalated to a formal warning on the 26 May 2016.

39. He also took into account that the Claimant admitted that she had not read the care plan during the investigation process during April and May (and had still not when she attended the hearing in June see paragraph 18 of his statement). Although it was put to Mr Leigh in cross examination that the job description did not include a reference to reading the care plan he told the Tribunal that the job description had been written a long time ago and since then they had put in place training. He confirmed that "*if you have not read the care plan you are putting yourself and the other person at risk; it is not a suggestion. Falls in older people are a huge issue"*. He

concluded that the conduct was so serious that dismissal was the only option.

40. It was put to Mr Leigh in cross examination that none of the single allegations amounted to gross misconduct and he disagreed saying that there was a serious breach of health and safety rules. However, he candidly accepted that he should have been more explicit in the dismissal letter as to which of the allegations amounted to gross misconduct. Mr Leigh was asked what part of the Claimant's conduct amounted to gross misconduct and he stated that he felt her behaviour was not acceptable and had gone against written procedures and had not complied with values which would be life enhancing for the residents. He went on to state that the "*conversation with Simon, him trying to get the Claimant to read the care plans but she still wasn't doing it, despite her saying she had learned a lesson. The warning letter on file to attested to the fact that what she had done was dangerous and now we have something else*". It was put to Mr Leigh in cross examination that the Claimant should have been dismissed with notice but he disagreed saying "*her shouting don't tell me what my job is, I accept that she was not raising her voice but I considered there were a number of different issues that were not up to standard. We would expect that could cause physical and emotional harm*". It was put to Mr Leigh by the Tribunal that the Claimant was a long serving employee and he was asked what he took into account when deciding to dismiss and he replied *"If I thought at the time we are on the edge of a final warning and dismissal, I would have [given her a warning] but I was firm in my view that we had gone past that. My primary duty was to the residents, one has to make decisions where the rights and duties clash".*

41. Mr Leigh confirmed that the Claimant made no mention in the disciplinary hearing that she felt that age was a factor in the dismissal and he had no idea of the Claimant's age when he heard the disciplinary. It was put to him in cross examination that he would not have dismissed Gertrude and he replied that he did not know who she was and the first time he heard the name was when the ET arrived. It was also put to him that he relied on the issue of the standing hoist because of the Claimant's age (which is why he concluded that she was not safe); he denied this saying a person of any age doing this would be unsafe.

42. The Claimant appealed the decision to dismiss by a letter dated the 11 August 2016 (see pages 185-6 of the bundle). The appeal hearing was convened on the 27 September 2016 (page 187-8) and was heard by Ms. Simmons the Chief Executive, who had joined the Respondent on the 11 November 2013. The Claimant presented a written submission to the appeal panel (see pages 188B-C); in this document the Claimant made no reference to her claim that the dismissal was discrimination because of age. The Claimant did not state that she believed that she had been treated less favourably because of age or that stereotypical assumptions had been made about her skills or physical abilities. The appeal statement accepted that some sanction appropriate such as a "written warning or redeployment" or providing support and supervision. This appeared to be an admission that her conduct had fallen below the required standard and a lesser disciplinary award was appropriate. She again apologized for her behaviour.

43. The notes of appeal were on pages 189-210. Ms Simmons confirmed to the Tribunal that she was considering Mr Leigh's decision, not just the care plans and risk assessments. Ms Simmons felt that it was worrying that at the appeal the Claimant still hadn't appeared to read the care plans. Ms Simmons concluded that the "*penny had not dropped; it was to read the care plans, follow the training, report bad practice and to chat to patients where possible. This is what we need to decide whether the sanction was the right one. This was not reassuring and showed that [Mr. Leigh] assessed this correctly – it was a breach of the Health and safety code*".

44. It was put to Ms Simmons in cross examination that it was not fair as the claimant had been employed for 13 years and the Claimant had reassured her that she would not do it again; Ms Simmons response was "*I have chaired a few appeals and I ensure we take everything into account, are they new to the unit, she had been there for eight months, have we trained, were they using equipment that they had never used before? Is this the first incident? This is what I looked at. None of those things applied. This was not one incident, there was another one, there were two manual handling incidents. Actually, also having gone through the paper, she threw up on the unit, she should have reported this, so there was a pattern. The penny wasn't dropping. The evidence didn't support me taking a second chance; the Claimant said she took a chance. If you continually take chances one day there will be an incident. We are regulated by the CQC and have to have care staff understand risk and go through care plans."* She stated that this was one of the easiest decisions she had taken. No questions were put to this witness in cross examination about age discrimination. It was not put to Ms Simmons that the appeal process was unfair or that it failed to deal with all the points raised by the Claimant.

45. The outcome was dated the 7 October 2016 (pages 202-204); her appeal was unsuccessful.

46. Closing Submissions of the Claimant

47. These were in writing and they were as follows:

48. The C has brought 3 complaints to the Tribunal
Unfair Dismissal
Breach of contract – wrongful dismissal
Direct discrimination because of age

Submissions on unfair dismissal

49. The R is not the final arbiter of its own conduct in dismissing an employee I respectfully remind that the Tribunal that is why we are here and the test is whether the dismissal was within the range of ***reasonable*** options open to a ***reasonable*** employer. The Tribunal are allowed to make an objective finding on what a reasonable employer would do

50. The R's would want the Tribunal to believe that they acted reasonably in upholding all 6 of the allegations put to the C in the disciplinary process. We would submit that it is the Tribunal's role to make an objective finding

about whether the R's did in fact act reasonably in upholding those allegations in light of what a reasonable employer would do

51. It is the C's case that the R did not and for at least 3 of the allegations the R did not have reasonable grounds to hold the belief in the C's misconduct

52. **Allegation 1 –** was specific and it was clear – the C was accused that on the 29 March 2016 she declined to provide care to a resident – and this we know was related to the resident's complaint about her declining to shave him – set out clearly on page 125
    - this was what was investigated by Ms Chibanda and in cross examination what Ms Chibanda told the Tribunal was the allegation

    but by the time we arrive at the disciplinary meeting – what we have is a new allegation that Mr Leigh is being asked to consider. He has the resident's complaint, he has the investigation report – he should know what the allegation is. Page 182 – allegation 1 is still set out in exactly the same way it had been from the invitation to the disciplinary meeting and the way it is set out in the investigation report.

53. In fact the investigation report where Ms Chibanda sets out her findings and recommendations - it doesn't even say the c declined to provide care by refusing to throw rubbish in the bin at the request of the claimant. Mr Leigh sets out the reason why he wants us to believe he decided to uphold allegation1- these we can quite clearly see are on facts that were not related to allegation 1 and was not the resident's complaint of what happened that day

54. *On page 163 of the transcript* – Mr Leigh asks Ms Chibanda to provide information on how ***'we'*** came to the conclusion in allegation 1- he didn't say you, he said we – bearing in mind this is a recorded transcript – the meaning of what he says is clear – it was not an error. He had already made up his mind to accept whatever he was told by Ms Chibanda so far as it would lead to upholding all of the allegations – and that is why he didn't correct the error about what that allegation related to and make an independent finding on the facts and come to an independent conclusion about that allegation

55. The C is accused of a specific allegation – if the finding that he sets out in upholding it - is wrong in fact, then it was not within the reasonable range of responses for him to have upheld it. If the Tribunal find that this allegation was upheld on the reasons set out in the dismissal letter that that is procedurally unfair – it was not the original charge

    Allegation 4 – On 31 March 2016 you abused your authority in relation to a resident

56. Ms Chibanda based this particular allegation on what she misunderstood the resident was actually complaining about – Ms Chibanda erroneously believed that the resident could not sit up and the C made him sit up when it was something he could not do – that was not the resident's complaint and indeed the resident could sit up, he just needed support in doing so.

57. Page 125 - it's quite clear on a reading of this document that what the resident is complaining about is that he was asked to do things he could

not do independently – he was asked to sit up, she asked him to push himself to the end of the bed and he is complaining that cannot sit properly by himself – his complaining that ***he*** managed i.e. he managed himself to sit up. We know he is capable of sitting on the bed – because his care plan on page 122 says he can – this specifies that the resident requires one carer to wash and dress him – 1 carer that helps him to sit on the bed while dressing him. Ms Chibanda – misunderstood the resident's complaint – she did not ask him any further questions to seek clarity about it.

58. In cross examination she referred to the incident on the 29th March – when the C in response to Simon about calling the resident a liar said I didn't call him a liar I told the resident you can sit in the wheelchair, but as we can see on page 125, his complaint about that incident is similar – she asked him to do something – he told her I cant. The C's account of what happened that she did help the resident to sit up, he didn't do it alone, she used pillows to support his back, so he could sit up – was not disputed by her managers in the disciplinary process

59. Turning to Mr Leigh - in cross examination – on asking him to confirm that the actual complaint the resident was making was that he could not sit by himself, Mr Leigh accepted it – but then and we would submit unconvincingly sought to maintain his unreasonable grounds for upholding that allegation – 'the c acquiesced, he sat up with help but it was something he didn't want to do…. '. The R did not have reasonable grounds for upholding the belief that the C abused her authority – they misunderstood the resident's complaint once they accepted the c's account that she helped him to sit up – there was no longer any reasonable grounds for sustaining that belief – it was not within the reasonable range of responses for him to have upheld it

60. The issue of propping the resident up with pillows I address later in my submissions on allegation 6

Allegation 5 – C did not ***follow*** the care plan in regard to hygiene, once again this was a specific allegation. It was not the resident's actual complaint but it arose from his complaint that the C washed his face without warning and this is something that he usually does himself and so because of what the C told Simon in the initial investigation interview that she did not know what his care plan said about washing his face because she had not read it – this allegation resulted.

61. Now it is important for me to say this before I continue on my submissions about allegation 5

– in relation overall to the R's approach to misconduct where it relates to the care plan –

62. The two allegations of misconduct related to care plans – allegations 5 and 6 are specific the C is accused of not ***following*** – the care plans – it was never an accusation as far as misconduct is concerned that she did not **read** the care plan. Now that is a really important distinction and the reason why is because the R's on their own evidence have said the care plan is a file that comprises assessments, it comprises specific support needs and it comprises daily care notes – in addition a resident's

preferences about the care they want to receive can override what is ***specified*** in the care plan – the daily notes may provide an update to what is specified in a document like the ones we have on pages 121-123.

63. In addition – the care plan may not be clear – there may be contrary information in the care plan – it may contain errors. Ms Chibanda in her investigation report made recommendations on clarifying aspects of the care plan because clarity was indeed needed – so it cannot be the case as the R's have attempted to present in these proceedings – that it was an essential fundamental requirement for the C to read all of the care plan.

64. The misconduct issue has never been and was never about the C failing to **read** the care plan – if it was that charge would have been put, it was not the charge – the charge was ***she did not follow*** the care plan.

65. Returning to my submissions on allegation 5 – that the C did not follow the care plan in regards to hygiene, the only documents that were produced in support of this allegation were the extracts in the bundle at pages 121-123 – we know that because it is set out in the transcript on page 163 at the disciplinary. The residents care plan on hygiene is on page 122 – it specifies that the resident needs full support with washing and dressing from 1 staff – that implies that it is the carer who is to wash the residents face. Ms Chibanda as part of her investigation into this allegation considered an additional document that was never produced and has not been produced in this hearing and that is that the resident has capacity to make decisions and that he can make his preferences known. That was the document she relied on, in saying the allegation should go to disciplinary, but she still never produced it. The daily notes about the residents care – that are also part of the care plan, have also not been included - which could have provided an insight into what the daily care practices were of the other carers in relation to this resident

66. On the document Ms Chibanda relied on that is not included – if that was the document that she was relying on as part of her investigation then in acting fairly that is the document she should have produced So there is a question of procedural fairness here – in that the evidence used against the c was never shown to her. In any event the c had already accepted she never went through his care plan.

67. We understand that because of that document - the accusation essentially was that the C did not get ***permission*** from the resident to wash his face because the resident has capacity to make decisions and make his preferences known and he has complained that she washed his face without warning. In the disciplinary meeting before Mr Leigh – page 166, it is quite clear that Mr Leigh on hearing the C's account accepts that she asked his permission and then on page 167, Ms Chibanda also accepts that the C obtained the resident's permission before she washed his face. That was the evidence Mr Leigh had and his conclusion if he had truly been acting like a reasonable employer would have been is that the care plan was followed

   – because she did obtain the resident's permission before she begun to wash his face

68. Unsurprisingly, however, what we have on page 182 which outlines his findings on that allegation is a complete departure from the evidence he heard and accepted at the time in the disciplinary meeting and is an unreasonable and deliberate attempt by the Respondent to change the substance of the allegation and what the C was actually accused of.
    He goes back to the C's original interview to find evidence against her
    - in para 16 of his witness statement he sets out the excerpt he was relying on which is on page 131 – and solely about the issue of washing the residents face.

    However in that same document the C gives the same account to Simon – on page 137, as she gave to Ms Chibanda in the investigation meeting and that she gave in the disciplinary meeting and was accepted as the C asking the resident for permission to wash his face. We must bear in mind that the C was not accused of failing to read the care plan – she was accused of failing to follow the care plan – that's the charge.

69. Mr Leigh only considered the issue of washing the face and that's the issue we submit that the Tribunal have to decide on whether there was a reasonable ground for sustaining the belief in misconduct for that allegation and we submit, it's quite clear that it was not in the range of reasonable responses for the R to sustain the belief they had in the C's misconduct where it relates to this – once they accepted she asked permission a reasonable employer would conclude that she did follow the care plan and the allegation could not be upheld

70. Of the remaining 3 allegations and of the R's belief about the C's misconduct overall - it is the C's case that the decision to dismiss was not a fair sanction and it was not a reasonable response for a reasonable employer

    Allegation 2 – was that the C on the 29th and 31st March failed to provide person centred care to a resident

71. Mr Leigh's decision on this allegation on page 181 – now he only makes a decision about the shaving incident which happened on the 29th March 2016, so that is quite clearly the only misconduct issue as far as this allegation is concerned before the Tribunal that the dismissing manager upheld. He refers to the fact that because she had not read his care plan, she was unaware of his preference for a daily shave. Taking into consideration all of the circumstances – His care plan does not actually specify his preference – this was something that the resident would have had to make known to the carer himself. Additionally, Ms Chibanda learned from the resident that he did not always have his daily shave immediately and he did give allowance when carers were busy

72. Now from the offset, during the disciplinary process the C accepted that she did not shave the resident, she should have asked and allowed him to have his preference, she fell short on that day. Her account was that it was not an outright refusal, she made a decision for him she would not be repeating it. The c gave her account to Mr Leigh – it is set out on page 176 – and told Mr Leigh she would live and learn, she should have done his preference and shaved him, she apologised – that would have been the finding that a reasonable employer would have come to in considering the sanction – it was a one of incident, it was one resident, in 13 years, 1st time a resident has complained.

73. **Allegation 3** – was that the C on 31 March 2016 did not behave politely with a resident – this was related to the resident's complaint about C saying he was difficult. Now once again we would say – this was a specific allegation. The C before and at the investigation meeting was not accused of being emotionally abusive to the resident. That was never the charge. However unfairly in Ms Chibanda's investigation report she includes an excerpt from the safeguarding policy about psychological abuse. She then makes a finding that she has not established, that what the C says may have caused some emotional abuse. She doesn't however – change the charge against the C, she doesn't convert it to on the 31 March 2016 you were psychologically or emotionally abusive to the resident. The charge remains the same throughout the disciplinary process up until the time of the disciplinary outcome and the C's account on this does not change - she asked the resident 'why are you being difficult', she explained the context of her saying this – set out on page 168, she explained that she was feeling unwell, she was not shouting, her tone of voice was soft, page 180 Ms Chibanda tells Mr Leigh – I do understand she did it in a quiet way, she did not shout'. Mr Leigh sets out his findings to this allegation on page 182 – and states it was tantamount to abuse. He, like Ms Chibanda – like the R overall - were deliberately and unreasonably attempting to overstretch and convert the charge to psychological abuse – yet this had not been established.

74. On page 76 – we have the safeguarding policy on what psychological abuse is – now Mr Leigh was fully aware of what this says – at paragraph 4.4 – it states psychological abuse can be defined as behaviour that *has* a harmful effect and the examples are set out clearly and it is quite clear – that the c's question to the resident why are you being difficult, her not being polite – is not psychological abuse. It was a general conduct issue – and that's how the charge was put in accordance with the R's code of conduct on page 98 she accepted, she apologised and most importantly she did not do it again. That would have been the finding a reasonable employer taking into account the circumstances would have come to – they would not have concluded that it was psychological abuse

75. **Allegation 6** – a specific allegation that the C did not follow the resident care plan in regards to safely moving and handling a resident – this was the only allegation that had no relation to the resident's complaint on page 125, he didn't complain that she was the only one caring for me and she used the standing hoist on me alone. This allegation came because in the C's initial safeguarding interview with Simon she told him she used the standing hoist on the C to move him to the wheelchair. She is then questioned about her doing that. Once again – the issue was about her not ***following*** – it was not about her not ***reading*** the care plan. Mr Leigh's finding on this set out on page 182

76. In regards to the C's handling of the resident alone, by using pillows and the bedrail to support him to sit up so she could bathe and dress him and then transfer him to the standing hoist – my submissions are as far as the care plan is concerned – to establish whether or not the C did in fact ***follow*** the care plan, we would have to look at what it says and it is plainly on this point not clear. Page 122 states one carer to be involved with

washing and dressing – so that is one carer to be involved with sitting the resident on the bed, one carer to be involved with standing hoist when dressing the resident and then we have on page 123 – to be attended by two staff on washing, dressing and all transfers to promote comfort. Ms Chibanda said it was that part that needed clarity – and that was she made her recommendation. So this is an important question the Tribunal have to answer – is it reasonable for an employer to find an employee guilty of misconduct by relying on a care plan that is not clear. I would respectfully submit it's not reasonable – a reasonable employer would have taken that into consideration when deciding on the sanction. The C accepted in the disciplinary meeting that she should have got help rather than propping him up with the pillows, she accepted that in general it was not part of the moving and handling guideline but as far as following the care plan is concerned – it's quite clear, the mistake the C made was not a failure to follow the care plan – the care plan is not clear, that can't be held against her – her mistake was not identifying that actually for this particular resident, it was unsafe to prop him up with pillows.

77. Since that incident, she had not done that again, she recognised what she did, she had indeed changed. A reasonable employer would have taken that into consideration when making it's finding on this allegation. In regards to the C operating the resident alone into the standing hoist and transferring him to the wheelchair, the care plan sets out in page 121 dated 31 December 2015 that two members of staff are to operate the standing hoist. The C's account is that this was her first time doing nights and she was told by her colleague Gertrude – that the resident requires a single carer, you go to him and I will go to Ms Wise. In addition her account was that the practice with this resident was that only one carer operated the standing hoist with him. He was the only resident that had a standing hoist. The R's haven't produced the resident's daily notes which form part of his care plan, so it may well be the case that at the time – other carers had indeed been operating the standing hoist with the resident alone. Also – it is relevant that it is not the resident who complained that she moved me to the standing hoist alone – so on a balance of probabilities it is likely that there was a practice of him being transferred by carers with the standing hoist alone. It is page 121, that the R's relied on in upholding this allegation and also the c's admission that in her training hoists in general are to operated by two people.

78. In the disciplinary meeting the C accepted it was bad practice, she accepted there was a safety element to this and since that time as far as it pertained to this resident's care, she had implemented safe practice. From page 176 – when she is asked by Mr Leigh had she had reason to use the standing hoist – her response was directly related to this question – (a response that Ms Simmons unreasonably and unfairly distorted in the Tribunal proceedings in order to use it against her – which the C explained when she was giving her evidence).The C's response set out on page 176 in regards to using the standing hoist with this resident is that she does not go to him alone, she gets a colleague to help him on to the toilet, page 177 she is caring for him around the unit, this is why she has not read through all of his care plan - she has even told colleagues that they're not supposed to operate standing hoist with him alone– most importantly - she it's quite she does not repeat the mistake in relation to his safety that she had done before

79. The C did raise the issue, that some carers were still operating the standing hoist alone with that resident, she had asked for the resident nurse in charge to corroborate this and what actually was required for this resident – so it was quite clear there was still a question about it in the disciplinary meeting. On this allegation – a reasonable employer would have come to the conclusion that the C did not follow the care plan on page 121, however, a reasonable employer would have taken into consideration the circumstances about what happened at the time, the fact that there does seem to be practice of operating the standing hoist alone by other employees, and they would have taken into consideration how the employee had behaved after that incident in considering sanction.

80. The general guidance on moving and handling, page 52 sets out that a team approach should be adopted when using mechanical aids, single handling is not recommended – it does not say single handling is forbidden – it's not recommended, that means employees in some circumstances may operate a mechanical aid by themselves. There definitely does seem to be a suggestion on the R's own document, page 122 of the care plan that a standing hoist can be operated alone by a carer. A reasonable employer in upholding this allegation would have taken these factors into consideration

81. Looking overall at the R's belief about the c's misconduct re: The C's admission that she had not read through all of the care plan - a reasonable employer would not have held it against her in the way that the R's have about her not reading ALL of the care plan – I've made earlier submissions on this point in relation to that that apply– the c was not guilty of misconduct because she did not read through all of the care plan, it was not a contractual requirement, the resident could have preferences that override what is specified within the care plan.

82. Re: the C not throwing papers away that the resident asked her to, it's the C's case that she never admitted to this, in any event – it was not a neglect of care as far the R's policies are concerned. Person centred care is not a policy, it's not in the disciplinary rules that person centred care must be provided. Where it relates to care – and the neglect of care or withholding of care – that can be found in the safe guarding policy – page 77 – paragraph 4.6, it's about ignoring the medical or physical care needs of residents – withholding the necessities of life. So, even if a reasonable employer had found that the c had declined care in this way – it was not a serious neglect of care

Re: the formal warning

83. Whilst the C acknowledges she did not complain about the formal warning at the time – it is disturbing that an incident that took place on 21st February 2016, was identified as cause for concern – set out in page 143 of Ms Chibanda's investigation report, something she was told by HR and the Tribunal has seen such cause for concerns not allowed to form part of the disciplinary process– which we know in the R's procedure on page 106, paragraph 3.2 – this cause for concern between the time of the investigation report – and the disciplinary meeting which was just under 2 months was now a formal warning – so on the advice of HR, Mr Leigh could now take it into account.

84. The formal warning – it was for an incident on 21 February 2016, the C attended a disciplinary about this several months later and it was issued on 26 May 2016, the outcome of that letter was that the C should receive monthly supervision and she would be re-trained in personal centred care training. Mr Leigh took it into consideration in finding that the C had breached the R's health and safety procedures in regards to care of resident in close proximity to the incident that took place on 29th and 31 March 2016. He, we would say did not act as a reasonable employer would have – he disregarded the fact that since the two incidents – the C had indeed changed. Both incidents had occurred several months prior to the disciplinary meeting where he was to make his decision – since those two incidents – the C had in fact changed. The C had worked for 13 years for her employer, she loved her job, a reasonable employer in the circumstances would not have dismissed.

85. As far as the appeal is concerned – the C had asked for reinstatement because the sanction was too harsh. Once again, the R, disregarded the circumstances about whether or not the C had changed, she had, the penny had dropped – they just chose to act unreasonably and not see it – they refused to see it, even though the evidence was staring at them right in the face – they had already made up their minds – there was nothing the c could say that would make them change it. The C was right, she was reading the essential documents related to the residents care – assessments and daily notes and she was alert to what she was told in the nurses handover meeting – but to hold the c to a standard that is unreasonable that she should read all of the care file – a care file – that has errors, may not be updated in some places, is unreasonable and unfair – the R's knew what they were doing.

86. The C did acknowledge the safe handling of the standing hoist as far as that resident was concerned, she set that out in her appeal letter, it may or may not have been recorded incorrectly in the appeal meeting minutes initially - if Ms Simmon's heard her saying that what she did was correct, that was subsequently corrected later in the meeting, where she again accepted it, like she had in her letter, like she had demonstrated before she was dismissed

    – the R's had no intention of dismissing her – that's why what was a cause for concern – was now converted to a formal warning – so that Mr Leigh and Ms Simmons could take it into account – we accept they may not have been involved in the decision to add it – however, they certainly based on their unreasonable findings - had no intention from departing away from the allegations that Ms Chibanda had set out and this was why at the start of the disciplinary meeting Mr Leigh said 'how have ***we*** come to our conclusions'

87. This was a job she was passionate about – in the appeal meeting she said she spends more time caring for residents than she does for her whole family – it's a job she cares about and loves – she has an elderly mother, she has a disabled daughter, she knows what it means to care for people who are frail. She had made mistakes, a reasonable employer would not

have dismissed such an employee in those circumstances – so a finding a unfair dismissal should be awarded

88. In regards to contributory fault, we would say that the C did not contribute to her dismissal, because there was a pre-determined decision to dismiss her, however, if the Tribunal find that she did – then any contribution is so minimal – it should not affect her compensation

Gross Misconduct

89. It is the C's case that none of the allegations that the R found against her amounted to gross misconduct and she should not have been summarily dismissed. The allegations were set out in the investigation letter dated 5 April 2016 – page 141A-141B in the bundle.

90. There is nothing there that says that these allegations are deemed to be gross misconduct in accordance with the disciplinary procedure – indeed even the way that they are described do not suggest that they are gross misconduct allegations.

91. In the letter on page 160-161, the invite to disciplinary - the same allegations, not identified as gross misconduct, the options at the conclusion of the hearing – do not specify summary dismissal – now the letter does say that the disciplinary action against you in accordance with Nightingale's disciplinary procedure will be considered with regards to the allegations.

92. So that would mean looking at the allegations in relation to the disciplinary rules on misconduct:

93. **Allegation 1** – declining to provide care on 29 March – if the gross misconduct that Mr Leigh found was a serious neglect of duties and care in that she did not throw away paper as the resident had asked her to – then that is not gross misconduct. We see set out on page 77 what a serious neglect of care is – paragraph 4.6 and declining to throw away paper is not amongst them, neither is declining to shave a resident defined as a serious neglect of care.

94. **Allegation 2** – on 29th and 31st March 2016, failed to provide person centred care to a resident in that she did not shave the resident in accordance with his preferences. Person centred care is not a policy, it is not a contractual requirement, it forms part of the R's values, but it is not identified as an operating procedure. The duty of care means promoting wellbeing and making sure that people are kept safe from harm, abuse and injury. Declining to shave the resident is not gross misconduct.

95. **Allegation 3** – The C did not behave politely with the resident because she asked the resident why are you being difficult, she was not found to have shouted at the resident, she was not found to have used an aggressive tone – the charge did not change from not behaving politely to emotional and psychological abuse – it was never established in fact that the C did actually emotionally harm the resident, it was that it could have happened – so she was not guilty of gross misconduct on page 76 para 4.4 – it specifies what psychological abuse is – the C was not guilty of that.

96. **Allegation 4** – the C abused her authority – did the C in actual fact abuse her authority? She did assist the resident to sit up, she helped him, she supported him with this. Even if the Tribunal find that she did abuse her authority – the submission is that this was not gross misconduct, she did not do it deliberately, it was not a serious neglect of her duties. The health and safety rules on page 120 4.13.8, states that employees must understand that wantonly, knowingly or deliberately not complying with health and safety rules and procedures can result in disciplinary action. That was not the case here. It was not a deliberate action on the part of the C, she thought at the time she had to care for the resident alone. The risk to the resident by propping him up on either side with pillows, while she was in front of him, was minimal, it was unlikely in fact to cause to serious injury or death. It was not a serious breach of health and safety rules because it was not deliberate. It was not in fact gross misconduct.

97. **Allegation 5** – failing to follow care plan regarding personal hygiene. The C, washed the resident's face, rather than allowing him to wash his face initially himself – this was not gross misconduct. His care plan, did not specify his preference. If it is found she did not in actual fact obtain permission, then in any event, it is still not gross misconduct. The C did not do so deliberately, neither was it a fundamental breach of her employment contract.

98. **Allegation 6** – failing to follow care regarding safely moving and handling the resident, the care plan states that the resident should be transferred with the standing hoist by two people. This practice we say on a balance of probabilities was not being carried out by the other carers and the c assumed wrongly that that was the practice because she had not read his care plan. She did not deliberately set out to breach the rules.

99. Outside of the care plan, there was no fundamental requirement to operate manual aids with two people, it was recommended, but it was not a fundamental requirement. The C says that when she went for training on manual handling it did not include the use of a standing hoist. She however, accepted his care plan required this. As to standing hoists only ever being allowed to be operated by two people because there was a serious risk of injury and death – we would say that is wrong. The Tribunal have an independent document on page 212g – that shows standing hoists can be operated with one carer – as you can see from the picture example – there is one carer there. Was there a risk of serious injury and death by the C using the standing hoist alone with the resident. We would say no, a risk of injury maybe, but not serious injury or death – the standing hoist is a secure mechanical aid. On this allegation alone the C had not committed gross misconduct

100. Based on the formal warning – breach of health and safety code and taking into consideration the breach of the care plan for safely moving and handling the resident – taking the two together did that amount to gross misconduct? In that it was a serious and repeated breach of the health codes? – once again we would say no, taking into consideration none of the acts were deliberate and both incidents had occurred several months before and the c had changed. They were not wilful breaches, neither were they fundamental in the way the R has attempted to describe.

Age Discrimination

101. There is no other reason that the R as a whole acted the way that they did – Mr Leigh did not act independently in his decision – his mind was already made up, the R acted outside the range of reasonable responses, they did not conduct any disciplinary action against younger carers who continued to use the standing hoist alone with the resident. The C was the only one who was dismissed and the C's case is that that was on the basis of age.

102. **The Respondent's submissions** were in writing and were as follows:

103. The Respondent referred to their skeleton argument which the Tribunal had before them, and the Respondents accepted that they had the burden to establish that they had a fair reason to dismiss the claimant under section 98(2), which confirmed that conduct can be a potentially fair reason to dismiss. The Tribunal were reminded that they were not to judge the Respondent by their own views or standards, but by that of a reasonable employer. The question for the Tribunal is whether a reasonable employer in the same circumstances could have reached a similar conclusion and whether such a conclusion is within the range of reasonable responses. The Tribunal will be aware of the background to the dismissal, the Respondent is a charity who is entrusted with the provision of providing care to some of the most vulnerable adults with in our society. Residents on the unit are made up of those who may be without capacity.

104. The Respondent received a complaint which was seen at pages 124 to 127 bundle from a resident who will be called AC who has capacity the complaint was in relation to the provision of care provided by the claimant, on two separate occasions. It was reasonable for the Respondent to investigate the entirety of the care provided. It would have been remiss of the Respondent to have only focused purely on the aspects of the complaint. Any reasonable employer would have considered all of the claimant's actions in relation to AC.

105. The claimant's contract of employment incorporates the disciplinary rules which was seen at page 63. At clause 5.1.2. These are policies and procedures that the claimant confirmed she was familiar with. The rules at pages 92 to 97, to which the Tribunal should pay particular notice are contained in pages 93 to 96. Point 7 headed health and safety at paragraph 7.1 states "employee must meet the obligations laid down for them in the Nightingale Hammerson health and safety policy". Point 7 .5 states "employees must not engage in dangerous or reckless behaviour" and paragraph 7.6 states "employees must take care in respect of the health and safety of colleagues and third parties" (for the avoidance of doubt Respondent's counsel emphasised the word must in the above paragraphs). At paragraph 8.1. It states "acts of violence, threatening behaviour, or verbal abuse will not be tolerated. Such behaviour is considered gross misconduct". The rules proceeded to detail gross misconduct under point 13, stating that it would normally lead to summary dismissal without notice or pay in lieu of notice. It also states that the list is not exhaustive before giving examples.

106. Those examples include important matters for the Tribunal to take into consideration (see page 95), paragraph 13.3 maltreatment of residents; paragraph 13.6 non-compliance with the safety code so as to endanger life or risk causing serious injury; paragraph 13.8 (see page 96), disregard of Nightingale Hammerson procedures and rules so as to put Nightingale Hammerson at risk; paragraph 13.3 serious or repeated breaches of health and safety rules; paragraph 13.5 serious neglect of duties or a serious or deliberate breach of contract operating procedures; and 13.18 use of inappropriate language.

107. The Respondent had in place a number of policies which the claimant acknowledged under cross examination she was familiar with and understood. These are detailed at page 2, paragraph 12 of my skeleton argument dated 31 July 2017.

108. The submissions on unfair dismissal were set out and counsel referred to the test in Burchell which is again referred back to the skeleton argument at page 1, paragraph 5. The Respondent must hold the belief that the claimant was guilty of the misconduct which must be reasonably held. The Respondent had a complaint from AC. There was no reason to question that it was malicious in nature. The Respondent undertook an investigation firstly in relation to safeguarding as required as part of the Pan London and Wandsworth Safeguarding Protocols and Procedures, and secondly under the Respondent's disciplinary policy, into the concerns raised and the provision of care as a whole provided by the claimant to AC on the dates in question.

109. The claimant at all times understood the nature of the complaint and the allegations against her. The claimant confirmed this during cross examination. The claimant did not say at any time, even during her appeal what she understood to be allegation one is not what the Respondent found at the disciplinary. The reason for this, in my submission, is because the claimant was clear on all allegations in relation to her conduct; there was no doubt for her. There was overlap between the broad headings of the allegations and the nature of the complaint by AC.

110. Allegations one and two at the disciplinary hearing allegation one (failure to provide care) and allegation two (failure to provide person centred care) were taken together because they were interlinked (see page 165 the bundle). The claimant knew and understood that.

111. When you consider the dismissal letter, dates are not given under the conclusions reached by Mr Leigh, he simply records the broad headings. Of note, he finds correctly that the claimant was asked by AC to put some rubbish in the bin, which she declined to do. AC could not do it for himself. It was care he required. Care which the claimant refused to give. This is evidenced in the bundle at pages 135, 145 and 165, where the claimant confirmed a request had been made of her and she refused.

112. At first, the claimant could not recall the incident, however, that she stated at the disciplinary. "I told him that when he asked me to throw tissue in the bin, I told him that he was not to tell me to do my job.". It is clear from the minutes of the investigation meeting at pages 148 to 151 of the

bundle that the allegations were not discussed in any specific order. The claimant was asked to speak about what happened and discussions flowed from the claimant's version of events.

113. The claimant accepted under cross examination that such a refusal would be a decision to decline care. Her view was she carried out his basic needs and that was enough. Despite their being contemporaneous notes of the interviews with the claimant, she denied under cross examination, making such a comment. The claimant accepted at the disciplinary that she did not pick up the papers (see page 164).

114. Person centred care is at the heart of the Respondent's ethos. The claimant's role is to support residents to live their lives and fulfil their wishes and needs (see page 54 of the bundle). It was the claimant's duty to respect and protect AC's rights, including his right to live as independently as possible, and to make their (sic) his choices (see page 57 of the bundle).

115. The claimant confirmed at no time did she read the care plan the extracts of which are in the bundle nor did she ask AC what he could or could not do. The claimant made it clear throughout the investigations and the disciplinary (see page 131 of bundle) that she was not aware that AC could do stuff himself. She did not know his preferences. Even when he expressed the preference for a shave (see page 165), the claimant made a decision for AC by stating as he had one the previous day, one was not required. The claimant made a decision which took away AC's independence (see pages 132 to 133 and page 145). This behaviour fundamentally undermines person centred care, which is at the heart of the Respondent's ethos.

116. The claimant accepted that she did not provide person centred care. Whilst the claimant may have apologised and said she would live and learn, this was not a one-off incident; this had to be taken in the light of the other matters of complaint. There is no evidence before the Tribunal that this was the claimant's only complaint. The Respondent's witnesses stated that they did not examine the entirety of the claimant's personnel file, however, noted there was to other causes of concern and a written formal warning from the file.

117. The claimant did not give any evidence about whether or not other complaints had been raised during her service. The claimant did not raise concerns with the Respondent that reference is made the disciplinary or appeal that other causes concern on file.

118. The dismissal letter at page 181 of the bundle is clear under this heading, the Respondent was considering more than just the shaving instants that encompass the entire ethos of the care, falling below the standard expected of a reasonably competent employee. The letter set out more than just the non-shaving incident. It was the fact is, the claimant had not respected AC's needs and wishes.

119. Turning to allegation three, the disciplinary rules are clear, which was seen at page 96 of the bundle at paragraph 13.18, the use of inappropriate language is gross misconduct. The Respondent safeguarding policy at

page 74 of the bundle states that abuse is not tolerated. Rule 3.2 at page 75 of the bundle states that a lack of respect may be an abuse of power and can include a single or repeated incidents.

120. The policy confirms at paragraph 4.48, page 76 of the bundle that psychological behaviour has a harmful effect on a residents emotional health. The dismissal letter at page 182, the bundle is clear the comment "why are you being difficult?" could have affected someone's emotional health, which is tantamount to abuse. The important words are "could have". The allegation did not need to be changed, the effect of the wording could have affected AC , such effects are deemed to be tantamount to abuse.

121. The claimant was fully aware and appraised of the Respondent's policy in particular safeguarding and the disciplinary rules and in my submission knew her words could amount to abuse.

122. This is against a background of the claimant not only stating to AC he was difficult, but also stating to him that she had heard staff say he was difficult (see page 139 bundle). The claimant denied in cross examination, she had said to him that other staff said he was difficult, however; this is in contradiction to the contemporaneous evidence of the safeguarding interview. The claimant at no time stated that the interview notes were incorrect or inaccurate, at times, the claimant signed the notes (at pages 151 and 159 of the bundle). The claimant was given an opportunity to comment and amend the notes (see pages 193 and 204, the bundle).

123. There was no overstretching of the allegation. The claimant's evidence has not been consistent and to say otherwise is misleading. Her evidence was contradictory under cross examination. The Respondent's disciplinary rules are clear. The use of inappropriate language under paragraph 13.8 is gross misconduct. The allegation was made out the comments were not respectful or person centred. Whilst the claimant offered to apologise, this was only at the appeal stage.

124. Turning to allegation 4 that the claimant acted in a dangerous and reckless manner by being unfamiliar with AC's abilities. Had she read the care file/plan she would have known that AC was unable to sit up. However, in a dereliction of care, the claimant instead implied that AC was misleading her. AC felt she had called him a liar. It was a reasonable perception for AC to have. Her response "but he sits in a wheelchair" (see page 134 to 135 the bundle) see admitted to the use of words. AC's response was, he could not sit up. No misconception in the understanding of the complaint. The claimant was fully aware of the complaint. Nowhere in the claimant's case does she state he is capable of sitting on the bed and suggest otherwise is ludicrous. Further, AC stated he could not sit up, this would have been clear to the claimant had she read the entirety of the care plan and on taking into consideration what AC actually told her.

125. The claimant knew the practice of propping AC up on pillows was not acceptable practice. Whilst AC acquiesced, this was not acceptance of an unsafe practice (see page 149 of the bundle). The claimant knew AC could not sit up yet. She asked him to come closer to the edge of the bed (see page 138) and she failed to recognise the risk.

126. The Respondent had reasonable grounds for upholding the complaint, AC could not sit up. He stated this to the claimant and she disagreed with him and continued to ask him to do these things. He was incapable of doing. She put him at serious risk of injury or harm by her actions. This is not what the Respondent would expect from a competent employee. The claimant ignored all training adjudging herself capable. The Claimant abused her authority arguing with AC and asking him to perform tasks he could not.

127. How can the Respondent trust the claimant in future to provide safe care to its residents?

128. Turning to allegation number 5, the claimant admitted this allegation. She had not read the care plan at all, prior to providing care to AC. The plan is not to be considered in isolation, it is part of a larger file. The important aspect is ‘moving about’ (see page 121 of the bundle). There is no doubt about how AC should be moved. It is two staff; this is repeated in the additional care section (see page 123 of the bundle). There would be no confusion for an experienced health care assistants such as the claimant. However, the claimant put herself and AC at risk of serious injury and harm.

129. If the claimant was in doubt she ought to have sought clarification, from the nurse in charge or ought to have fallen back on her training. The claimant had completed practical moving and handling training on 3 March 2016 (see page 212D the bundle) . The claimant confirmed on several occasions (see pages 140, 150, 170, 172) that the training provided stated that two staff are required.

130. Whilst under cross examination, the claimant attempted to deny the standing hoist was referred to in the training. However, at the investigation (see page 150 of the bundle) with Ms Chibanda, the claimant was asked when she was trained was she informed that one person could use the standing hoist, the claimant replied no that it was supposed to be done with two people.

131. The claimant has attempted to rely on page 212 G of the bundle . However this is not a document relied upon or produced by the Respondent. It does not state how to operate the standing hoist. Nor is this is a similar model to that used by AC. It was not put any of the Respondent’s witnesses that the document indicated that one person could use the standing hoist. Regardless the Respondent’s policy was that two people were required, the health and safety policy at page 52 of the bundle states ‘a team approach should be adopted when using mechanical aids-single handling in such instances is not recommended’.

132. The Tribunal is to consider the claimant’s conduct only and those of whom she now seeks to rely on as comparators. The claimant did not give any names of other employees who had adopted same practice as she did. Claimant was repeatedly asked for names which she could not recall (see pages 140, 150 and page 170). The claimant did not mention her colleague Gertrude until February 2017. The claimant failed to recognise repeatedly that she put AC at risk, one such example is at the appeal

hearing where she stated 'I did not think there was much of a risk' (see page 193 of the bundle. Allegation 5 is not related to the face washing incident.

133. Allegation 6 of not following the care plan implies to follow it the Claimant would have to read it. It is ridiculous to suggest there was no requirement to read it. Not only did the Claimant fail to read the care plan she also failed to ask AC of his capabilities or preferences. She made assumptions based on what she heard others say. The Claimant failed in her duty. She knew he had capacity and therefore ought to have asked him. She failed as per AC's care plan to request his cooperation. The Claimant did not obtain permission from AC. The Claimant told AC what she was going to do. The conduct was admitted by the Claimant and therefore the allegation was made out. The dismissal letter encompassed the lack of knowledge of any of Ac's needs not just face washing. It was the whole hygiene related care which the Respondent was referring to, with one particular incident being highlighted.

134. Reasonable investigation – the allegations were made out and admitted by the Claimant, therefore a belief in the guilt was reasonably held. The Claimant was given three separate opportunities to put her version of events. The investigation was clear and transparent. Ms Godwin has attempted to make an issue out of the 'we' comment during the disciplinary hearing. Mr Leigh was clear in his evidence that he had not been involved in the matter before his appointment by HR. His words were 'if you are implying that I had a conversation with Ms Chibanda that I had reached a conclusion, I was not a party at all, no part in the process. It was a familiar 'we' not a party and not formed a view". The Respondent had undertaken a detailed and robust investigation and disciplinary process. They had a reasonable belief in the Claimant's guilt; she was entrusted with the care of vulnerable adults. Some of the residents have capacity whilst others do not. The Respondent has policies and procedures to protect these individuals and to ensure that they receive a high standard of care. The Claimant's conduct fell below a reasonable standard on more than one occasion.

135. The Claimant put AC and herself at risk during manual handling on two or more occasions. There was no recognition of the risk during the process (pages 172 and 193) or even on the issuing of her ET1 (page 16). The Claimant did not provide person centred care, she declined to shave AC, and she took away his independence by ignoring his request and by washing his face when he is capable of doing that himself.

136. The Claimant declined to believe AC when he said he was unable to sit up, retorting she had seen him sit in a wheelchair. The Claimant told AC not to tell her to do her job and called him a difficult man stating that no other carers liked working with him. The Claimant failed to read AC's care plan at all, yet Ms Godwin seeks to criticize the Respondent about it's contents. The Claimant did not even have the courtesy to ask AC what assistance he required or what he was capable of.

137. The Claimant is a person who takes chances (page 172) with adults 'at risk' who ignores her training and decides to judge herself capable. The Respondent was left in a position of how could they trust an employee

who even at the appeal hearing, did not accept she had put herself and AC at risk (page 193). How could the Respondent have continued the employment relationship with the Claimant when they could not have the utmost trust and confidence in the Claimant to undertake her duties and not put their residents at risk of harm or serious injury?

138. Mr Leigh was clear he did not believe that the Claimant could provide such care, even at the appeal stage the Claimant did not recognize the risk. Mr Leigh at the appeal hearing (page 198) was clear he felt the sanction went to the heart of the employment contract, he felt it was a number of issues were (sic) the Claimant fell short. The Claimant exposed herself and the resident to situations of serious risk. The provision of care is more than just fulfilling basic needs its about enhancing the experience, hence the reason for person centred care. Mr Leigh felt that consistently AC had not been given the benefit of such care, despite training. It was a fundamental breach of contract that went beyond the final written warning. There was a recent disciplinary hearing for unauthorised use of a mobile phone. It was a breach of the health and safety policy and the code of conduct. A formal written warning was given to the Claimant (page 159A-B), after two causes of concern had been recorded. There was no change in the Claimant's approach. It showed a pattern of bahaviour where the Claimant either could not or would not change. Mr Leigh felt it was beyond a final written warning, because some acts are so serious in nature they destroy the employment relationship.

139. At the appeal the Claimant was still stating 'I did not put him at risk because I handled him safely' (page 200) and 'no harm came to him or myself'. This was further demonstrated in the ET1 (page 15-16) where the Claimant stated "it is unfair for the Respondent to expect me, to go look for someone to assist me in the discharge of my duty. I knew there were no floating staffs and even if there was I did not need one because I know I have the skills and ability to manage the maneuvering on my own safely and I did". It is clear that the penny had not dropped with the Claimant even now, she is adamant that she put no one at risk. The Claimant could not or would not change in her approach. For Ms Godwin to suggest now for the first time that the Respondent held back in dealing with the mobile phone incident, has never been pleaded by the Claimant. It was raised for the first time at the Tribunal. The Tribunal ought to disregard Ms Godwins submissions in this respect. Further it is clear the timeline for both matters from incident to disciplinary are the same, I would ask the Tribunal to find as fact there was no delay by the Respondent in this regard. This allegation by the Claimant is unfounded and misconceived. The Respondent has a paramount duty to protect its residents from harm. Their ethos is to put the resident at the centre of all they do. They are the most vulnerable adults in our society. It's all their employees' duty to keep the residents' safe from abuse, harm or serious injury. It is clear the Claimant cannot change. This is demonstrated by her repeated breaches of health and safety.

140. The Respondent does not have to prove each allegation was gross misconduct to have a fair dismissal under section 98(2)(b). Even a single allegation being made out is sufficient. Mr Leigh was clear it was the cumulative effect of the incidents, coupled with the earlier breaches of health and safety code which confirmed to him, gross misconduct was

made out and dismissal warranted. It would appear from Ms Godwins submissions that the Claimant accepts three allegations of gross misconduct were made out. The Claimant's claim for unfair dismissal ought to be dismissed as unfounded and misconceived.

141. Age discrimination – the legal test is set down in the skeleton argument (and will not be replicated in this decision). A mere assertion of a difference in treatment or status is not enough. The Claimant has been unable to shift the burden to the Respondent. There is no foundation to her claim. There is nothing from which the Tribunal could conclude. There is no evidence that Gertrude, who was first mentioned in February 2017 is even an appropriate comparator. There is a lack of evidence there is no material difference in circumstances. No evidence that Gertrude had two causes of concern or written warning on her file for health and safety breaches or complaints from residents. The Claimant did not raise any matter of age at the appeal hearing. Her oral evidence confirmed Mr Leigh could have no knowledge of her age, he was not involved in rota allocation and at no time did they discuss age. Mr Leigh had no knowledge of the Claimant's age nor could he know Gertrude's age as he did not even know who she was. This claim is misconceived and ought to be dismissed.

142. Wrongful dismissal – it is submitted the test for gross misconduct is made out and therefore it was reasonable for the Claimant to be dismissed without notice.

143. Contributory fault/ Polkey – the legal position is set out in the skeleton argument (which will not be replicated in this decision). It is submitted that the Claimant contributed to her dismissal by her own actions, in filing to recognize risk. If there was any procedural defect, which is denied, it is submitted that the Claimant failed to raise these at any time including failing to plead as part of her ET1. The Claimant was given every opportunity to state he case and had the full opportunity to state her case and had the opportunity of a full appeal. All claims ought to be dismissed as unfounded and misconceived.

144. The Claimant's response was received in writing on the 1 September 2017 and was considered by the Tribunal but will not be replicated in this decision.

Cases Referred to by the Respondent in their skeleton argument

BHS v Burchell [1978] IRLR 379
Sainsbury's Supermarket v Hitt [2003] IRLR 23
ILEA v Gravett [1988] IRLR 487
A v B [2003] IRLR 405
Salford Royal NHS Trust v Roldan [2010] IRLR 721
Iceland Frozen Foods v Jones [1982] IRLR 439
Shamoon v Chief Constable of the RUC [2003] UKHL 11
Igen v Wong [2005] IRLR 258
Hewage v Grampian Health Board [2012] IRLR 870
Madrassy v Nomura International PLC [2007] 246CA
Nelson v BBC (no 2) [1980] ICR 110
Polkey v A E Dayton Services Limited [1987] IRLR 503 HL
Software 2000 Ltd v Andrews and others [2007] ICR 825

King v Eaton No 2 [1988] IRLR 686
Gover and others v Propertycare Limited [2006] EWCA Civ 286
O'Donoghue v Recar and Cleveland Borough Council [2001] IRLR 615 CA

The Law
Section 98 Employment Rights Act 1996

(1) In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair, it is for the employer to show--

(a) the reason (or, if more than one, the principal reason) for the dismissal, and
(b) 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.

(2) A reason falls within this subsection if it--

(a) relates to the capability or qualifications of the employee for performing work of the kind which he was employed by the employer to do,
(b) relates to the conduct of the employee,
(c) is that the employee was redundant, or
(d) is that the employee could not continue to work in the position which he held without contravention (either on his part or on that of his employer) of a duty or restriction imposed by or under an enactment.

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

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

Section 13 Equality Act 2010 Direct discrimination

(1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.

(2) If the protected characteristic is age, A does not discriminate against B if A can show A's treatment of B to be a proportionate means of achieving a legitimate aim.

The Decision

The Unanimous decision of the Tribunal is as follows:

145. Turning first to the Claimant's first claim of direct age discrimination, the Tribunal conclude that there are no facts from which we can conclude that the Claimant has been treated less favourably because of age. The Tribunal had before it mere assertions of a difference in age and a difference in treatment, this is not sufficient of itself to move the burden of proof. There was no evidence to suggest that the Claimant had been treated less favourably because of age. There was also no evidence to suggest that the comparator Gertrude was "the same or not materially different" in order to be an appropriate comparator. To be comparable Gertrude would have to have been in possession of a warning, contrary to the Respondent's policies and procedure and have faced similar allegations to those made against the Claimant and not dismissed as a result. There was no such evidence before us.

146. The Tribunal also considered the evidence that the Claimant made no mention to the dismissal or the appeals manager that she felt that she had been treated less favourably than her comparator Gertrude because of age. There was no evidence to suggest that Mr. Leigh was aware of the Claimant's age or that he treated the Claimant less favourably because of age. There being no credible evidence to support this claim we conclude that it is not well founded and is dismissed.

147. Having dismissed the Claimant's claim for age discrimination, we find as a fact and on the balance of probabilities that the Claimant was dismissed for misconduct (and not because she was aged 60). The Tribunal conclude that there was consistent and credible evidence to show that the reason for dismissal was misconduct and this was the genuine reason for dismissal.

148. The next issue before the Tribunal is whether the Respondent held a belief on reasonable grounds that the Claimant had committed an act of gross misconduct. We conclude, taking into account our above findings of fact that the Respondent held a belief on reasonable grounds after carrying out a reasonable investigation. The complaint by AC raised serious issues of health and safety, safeguarding matters, care issues and breaches of the Respondent's ethos and values. These individual acts taken together were serious matters that required investigation. It was noted by the Tribunal that AC was a vulnerable adult and the complaints raised were potentially serious in nature. The investigation carried out by the Respondent was fair and thorough and even though the Claimant has suggested that the report produced by Ms. Chibanda was not fair or balanced because it failed to record the Claimant's apology, the Tribunal conclude that it fairly represented the facts of the case that needed to be considered at a subsequent disciplinary hearing. The notes were attached to the report where the apology was recorded and the Claimant had an opportunity at the disciplinary hearing to repeat the apology as part of her defence and plea in mitigation.

149. The Respondent followed a fair investigatory process and disciplinary hearing, allowing the Claimant to respond to the allegations and to put forward evidence in her defence. The Claimant did not suggest that any further investigation was required, she accepted that she was aware of the

allegations and she was able to respond to them. The Respondent gave the Claimant an opportunity to be accompanied and set out in the letter calling her to a disciplinary hearing the types of sanction that were available to the Respondent, which included dismissal. Even if there had been an element of procedural unfairness arising out of Mr Leigh's confusion over the facts that applied to each numbered allegation (and none were apparent to the Tribunal), any confusion or unfairness caused as a result of that confusion was corrected at the appeal stage. The Tribunal noted that that very few questions were put to Ms Simmons in cross examination about the appeal process and it has not been put to us that the appeal process was unfair or failed to deal with all the points put forward by the Claimant on appeal.

150. The Claimant's evidence to the disciplinary hearing about whether she had read the care plans was confused. Although the closing submissions made on behalf of the Claimant placed a great deal of emphasis on the distinction between failing to follow the care plans (which was the allegation) and the conclusion reached that the Claimant had failed to read them (which was not the precise allegation). This distinction appeared to be highly artificial. It was obvious to the Tribunal that to be sufficiently informed about a person's needs, the carer had to have read the care plan (or have been informed about the contents of the care plan by others). The Respondent was entitled to assume that if the Claimant had not read the care plan it was highly likely that she would be unaware of its contents and would, as a consequence, not be aware of what the resident could or could not do or what type of care was required. This was a reasonable conclusion to reach on the facts before them and the Claimant had provided no evidence to suggest that she had acquainted herself with the details of the residents' care plans. It was also noted that the Respondent was concerned that the Claimant had still not read the resident's care plan by the time the disciplinary hearing took place. The Tribunal has found as a fact that the Claimant had accepted in the safeguarding meeting that she should have read the care plans of those she attended but admitted in the disciplinary hearing that she still had not read them. This showed a lack of insight entitling the Respondent to conclude that the Claimant was either incapable or unwilling to change her practice. The two allegations of failing to follow the care plans in relation to hygiene and safe moving and handling were found to be proven on their facts and due to the Claimant's admissions that the document had not been read (see above at paragraphs 26, 30 and 37 of the findings of fact).

151. The Claimant accepted in the disciplinary hearing that she was aware that the standing hoist had to be operated by two people and also accepted that she had received recent training in the operation of the hoist; despite her evidence, she operated the hoist alone. This was an admission that she failed to comply with safe practices and in doing so put herself and the resident at risk. Although it has been put to the Tribunal in closing submissions that it was "common practice" that this had been regularly deviated from by staff, the Claimant produced no evidence of this to the disciplinary hearing and none to the Tribunal. It was reasonable for the Respondent to conclude that the Claimant had failed to act in accordance with her training and had placed herself and others at risk and that this was an act of gross misconduct as there was consistent evidence

before the Respondent for them to conclude that the Claimant had committed a serious breach of the health and safety rules and a serious breach of operating procedures (breach of paragraphs 13.13 and 15 see above at paragraph 6 of the findings of fact)

152. The Tribunal took into account the vulnerabilities of the residents at the Respondent care home and the high standards set by the Respondent to provide PCC. Although it was submitted on behalf of the Claimant that the expectation of PCC was not a term of the contract, it was a standard required of all those providing care to ensure that all residents received compassionate and dignified support. To require all those who provide intimate care to the residents to act in accordance with this ethos was a fair and reasonable expectation. The disciplinary policy stated that it was an act of gross misconduct to "disregard" the Respondents procedures and rules. The Tribunal noted that the Claimant had accepted in the safeguarding meeting (page 133) that she had received training in PCC and had completed a workbook on the subject (page 133-4), therefore she had been provided with training and guidance on the importance of this procedure. The Respondent's policy emphasized the importance of the carer talking to the residents to empower them to take responsibility (as far as was reasonably practicable) for their own care and to express their preferences (see above at paragraph 6). Despite providing this training, the Claimant failed to act in a manner that was consistent with the care standards and in doing so fell below the standards required of an HCA..

153. The Claimant was found to have acted contrary to the principles of PCC by not asking AC if he wanted a shave or asking him if he wished to wash himself (instead of telling him he was going to be washed) and to that extent allegation 2 was found to be proven. She accepted that she made assumptions about AC's needs and failed to put his wishes at the centre of the delivery of care and therefore breached the standards expected of her. The Claimant accepted in the safeguarding hearing and in the disciplinary hearing that she should have asked AC about his preferences. The Claimant also accepted that she refused to throw away a tissue when asked to do so by the resident, therefore allegation 1 was found to be proven on the facts. Although the allegation of failing to throw away a tissue was less serious than some of the other allegations, it was evidence that was sufficient for the Respondent to conclude that the Claimant had refused to carry out the resident's reasonable requests.

154. The Claimant was also found to have behaved impolitely to a resident when she asked him why he was being difficult (allegation 3). The Claimant conceded in the disciplinary hearing that this was not something that she should have said (page 167). The Claimant admitted behaving impolitely and apologized for her actions. The Respondent was entitled on the evidence to conclude that this charge was proven. Although the submissions made on behalf of the Claimant claim that the Respondent had never established that AC was caused emotional harm by the Claimant's conduct, the Tribunal note that this was not the charge, it was not behaving politely which was admitted by the Claimant. The dismissal letter made reference to Ms. Chilbanda's opinion that this "**could** have affected someone's emotional health", the dismissal letter did not state that the conduct had adversely affected AC's emotional health, it was considered to have the propensity to cause such harm. This opinion

explained why the Respondent felt that this allegation was serious and could amount to an act of gross misconduct, the Respondent was entitled to reach this conclusion on the evidence before them and in the light of the vulnerabilities of those residing in the care home.

155. Allegation 4 was found to be proven as the Claimant was found to have propped AC up using pillows and made an assumption that he could sit up because she had seen him sit in a wheelchair. She accepted that she had not read his care plan and had adopted a dangerous practice by propping him up and disputed what AC had told her (by questioning whether he could sit up). Although the Claimant in closing submissions stated that this was not a serious neglect of duties, the Tribunal conclude that it was another example of the consequences of not reading the care plans. The Claimant had adopted an unsafe practice placing herself and the resident at an avoidable risk of harm and this conduct could amount to an act of gross misconduct (see paragraphs 13.13 and 13.15 of the disciplinary policy at paragraph 6 of the above findings).

156. The Tribunal accept the submissions of the Respondent that they were entitled on all the evidence before them to conclude that the Claimant's conduct was so serious so as to amount to an offence of gross misconduct entitling them to summarily dismiss. The Respondent was entitled on the evidence before them to conclude that the six allegations were found to be proven and those allegations together amounted to an act of gross misconduct. The Tribunal also conclude that the decision to dismiss was within the band of reasonable responses.

157. The evidence of Mr Leigh was felt to be balanced, consistent and fair; although it was noted that he became somewhat confused with which facts applied to which numbered allegation (especially in relation to allegation 1 and 2, see above the Claimant's written submissions and our conclusions above at paragraph 149), the Claimant accepted in answers given in cross examination that she knew the allegations against her and was able to respond to those allegations. The Tribunal also conclude that even though the categorization of the allegations became confused in the outcome letter, this did not adversely impact upon the fairness or thoroughness of the process followed and upon the decision reached on each factual allegation. There was also no injustice caused to the Claimant arising out of the manner in which Mr Leigh recorded his conclusions on each allegation and no complaint was made by the Claimant at the appeal stage that she had suffered any prejudice. We conclude that Mr Leigh's handling of the disciplinary process was fair and balanced and the conclusions reached were within the band of reasonable responses open to a reasonable employer.

158. It is alleged in the Claimant's closing submissions that there was evidence of predetermination (see above at paragraph 54), however the Tribunal were satisfied that Mr Leigh played no part in the investigation or in the formulation of the charges. The Tribunal noted that the investigations manager had only just joined the Respondent's organization the day before she was assigned the role to investigate the matter and there was nothing to suggest that she had discussed the investigation or the findings in her report with Mr Leigh. There was no evidence to suggest

that the outcome was predetermined and the Tribunal were satisfied that the decision was reached by Mr Leigh alone after considering all the facts.

159. It is not for the Tribunal to substitute it's view for that of the employer or to rehear the evidence. The Tribunal accept that the policies and procedures adopted by the Respondent were necessary and proportionate for the care sector, which is strictly regulated. The Claimant had been found to have breached many of the standards expected of an HCA. The Respondent was entitled to conclude after considering all the evidence (including the live warning on file) that the Claimant's conduct when taken as a whole, was so serious so as to amount to gross misconduct. This conclusion was one that was well within the band of reasonable responses open to an employer and is a decision which is fair.

160. The Tribunal also conclude that the Respondent has proved that the Claimant's conduct was sufficiently serious to amount to gross misconduct, entitling them to summarily dismiss. The Tribunal conclude therefore that the Claimant's claim for wrongful dismissal is not well founded and is dismissed.

Employment Judge **Sage**

Date: 12 December 2017