EMPLOYMENT TRIBUNALS

Claimant		**Respondent**
Ms P Lewin	**v**	**Leonard Cheshire Disability**

Heard at: Watford **On**: 31January & 1 February 2019

Before: Employment Judge Smail

Appearances

For the Claimant: In person.
For the Respondent: Mr T Wood, Counsel

REASONS

1. By a claim form presented on 15 August 2018, the claimant claims unfair dismissal and breach of contract in the form of failure to pay notice pay.

2. The respondent says it fairly dismissed for misconduct, said to be gross and accepted the claimants alleged repudiatory breach of contract justifying it in dismissing without notice.

The Law and the Issues

3. Unfair Dismissal

3.1 The Tribunal has had regard to Section 98 of the Employment Rights Act 1996. By Section 98, subsection 1 it is for the employer to the show the reason, or if more than one, the principal reason for the dismissal. A reason relating to the conduct of an employee is a potentially fair reason. By Section 98, subsection 4, where the employment 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 the administrative resources of the employers undertaken 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.

3.2 This has been interpreted by the seminal case of BHS -v- Burchell 1978 IRLR 379 EAT as involving the following questions:

a) was there a genuine belief in misconduct?

b) were there reasonable grounds for that belief?

c) was there fair investigation and procedure?

d) was dismissal a reasonable sanction open to a reasonable employer.

3.3 I have reminded myself of the guidance of Sainsbury's Supermarkets -v- Hitt 2003 IRLR 23 Court of Appeal that at all stages of the enquiry, the Tribunal is not to substitute its own view for what should have happened but judge the employer as against the standards of a reasonable employer bearing in mind that there may be a band of responses. This develops the guidance given in Iceland Frozen Foods -v- Jones 1982 IRLR 439 EAT to the effect that the starting point should always be the words of section 98, subsection 4 themselves that in applying this section an employment tribunal must consider the reasonableness of the employer's conduct, not simply whether they, the employment tribunal consider the dismissal to be fair.

3.4 In judging the reasonableness of the employers conduct an employment tribunal must not substitute its decision as to what was the right course for that of the employer. In many, though not all cases, there is a band of reasonable responses to the employees conduct within which one employer might reasonably take one view, whilst another quite reasonably take another.

3.5 The function of the Employment Tribunal is to determine whether in the particular circumstances of each case, the decision to dismiss the employee fell within the band of reasonable responses, which a reasonable employer might have adopted. If the dismissal falls within the band, the dismissal is fair, if the dismissal is outside the band it is unfair wrongful dismissal which is in breach of contract.

4. Notice Pay

4.1 An employee is entitled to notice of dismissal and compensation in lieu, unless as a matter of fact as determined objectively by the Tribunal on the balance of probability, the employee committed a repudiatory breach of contract entitling the employee to dismiss without notice by way of acceptance of the breach. The burden is on the employer to improve this.

Findings

5. The claimant was employed by the respondent as Service Manager of the respondents Arnold House Residential Care Home in Enfield. This was a care home for physically disabled adults between the age of 18 and 65. Some of them may also have had learning disabilities. Many residents require being given medication.

6. The claimant was dismissed in respect of two charges of misconduct. First, failing to safeguard service users owing to failure to provide safe systems for medication management, this includes omission of medication due to insufficient stock control. Secondly, potential organisational reputational damage with regard to the medication omitted for 19 days during November and December 2017 for a service user. It is understood that the second charge is also an example of the first charge and the reputational damage that is alluded to is a difficulty with the Care Quality Commission (CQC), and as we shall see that body had an involvement in this case.

7. These charges that were upheld were said to justify dismissal for gross misconduct under Part 2.4 of respondent's disciplinary policy. One entry in particular has been referred to by the dismissing officers, that is "abuse or neglect of people who use our services including where an employee fails to draw to the respondent's attention abuse or neglect of service users by others". There might also have been reference to serious negligence, for example in not following the requirements of a risk assessment.

8. In terms of explaining the reference to abuse, under the Safeguarding Adults Policy for England observed by the respondent under its obligations under the Care Act 2014, a type of abuse is listed as neglect and relevant acts or omissions include ignoring medical, emotional or physical care needs; failure to provide access to health care or support, withholding of the necessities of life, such as medication, nutrition, eating or clothing, for example, giving too much or too little medication, and failure to intervene in situations that are perceived as dangerous.

9. The respondent accepted that the emphasis is more on neglect in this case than intentional abuse.

10. The role also had key responsibilities. This job description in the bundle is more recent than the job description which would have applied at the time but there is no reason to think that the substantive obligations are in any significant way different.

11. Key responsibilities of this role include:

    11.1 "No. 2: providing leadership management and clear direction in the delivery of all services within your defined areas of responsibility."

    11.2 "No.11: liaise with all regulatory bodies to ensure their requirements are implemented, monitored and maintained."

11.3 "No 15: [perhaps most centrally in this case]: to ensure that people using the service receive support in line with agreed plans and expectations."

11.4 "There would also, of course, in a contract of employment be the implied term that employee would well and faithfully perform their role."

12. The claimant was employed between 16 October 1998 and 17 April 2018. She started as a support worker. she became a care supervisor in February 2006 and Deputy Manager from 1 April 2017. She told me that that was a name change rather than a substantive change; the Deputy Manager role was really the same as Care Supervisor, she tells me, she did that role from February 2006. On 1 August 2017 she was promoted to Service Manager and that meant she was the Registered Manager for this unit for the purposes of the Care Quality Commission.

13. The respondent is of course the well-known charity that provides care homes and I was told that there is a number of units in excess of something like 140.

14 The claimant was dismissed by Ms Jacky Hall, a Regional Manager by letter dated 20 April 2018 confirming what was said at a disciplinary hearing on 17 April 2018. She relied on the investigation report compiled by Mrs Susan O'Brien, the respondent's Head of Clinical Excellence, and other evidence that was put before the hearing. She listened to the claimants' representations in the disciplinary hearing and had before her, the list compiled by the complaint of points of mitigation.

15 The investigation report dated 18th March had been prepared by Mrs O'Brien – the head of Clinical Excellence. Most uncommonly, there had been a whistleblowing complaint by the Deputy Manager at Arnold House that medication was being mismanaged. The whistleblowing complaint was received on 20 February 2018. Mrs O'Brien was immediately appointed by the respondent on 21 February 2018.

16 Further the Deputy Manager had also informed Enfield Safeguarding on 8 February 2018. That resulted in an on the spot inspection by a Pharmacist Specialist for the Care Quality Commission on 22 February 2018.

17 This was not the first time that concerns about the management of medication had been raised at Arnold House. Internal audits by Liz Turton on 31 November 2017 and 1 December 2017 had made the service aware of concerns about unsafe and non-compliant medication management.

18 The internal audit tells us that Arnold house is registered with the CQC to provide personal care accommodation for 23 customers with complex physical disabilities. There are 21 people that live in the main service and 2 that live in a supported bungalow on site. This is in an old building over 2 floors and set in its grounds on the outskirts of Enfield.

19 The current manager, the claimant, had been in post for 2 months but was well established with the respondent as she had worked there as the Deputy Manager for many years.

20 The new manager had recently had her interview with CQC and been approved as the Registered Manager of the service.

21 One of the questions for the internal audit was "is the service safe?" and the audit looks at these questions:

21.2 Is the service safe?

21.3 Is the service effective?

21.4 Is the service caring?

21.5 Is the service responsive?

21.6 Is the service well lead?

22 The overall rating for the service was 'inadequate'; safety was 'inadequate'; effectiveness was 'requires improvement'; caring was 'good'; responsive was 'required improvement'; and well lead was 'inadequate'. Most directly for this case we are looking at the findings on safety and Liz Turton wrote as follows:

22.2 "Medication storage and administration within the service was observed not to be safe. Keys were left in medicine cupboards that were not attended to. Medication signatures were missing from Medication Administration Records (MAR) charts and there was no system in place for checking medicine signatures at the handover of shifts. Where medicines were handwritten onto charts they had not been signed by two staff members. Where variable dose medicines were prescribed, staff did not record the dosage given, therefore it was difficult to count medicine stocks. Medicine orders did not take place weekly and the monthly audits had not taken place since July 2017. The medicines signatory list was not up to date or complete. PRN medicine protocols were not in place and there were no pain charts recording pain levels for customers when they had received PRN pain relief in medicines. Customer photographs were not on the front cover of all medicine charts when checked. Room and fridge temperatures were not recorded and the medicine fridge needed to be defrosted. There were large amounts of stock medicines and this was stored in the cupboard that did not lock. The cupboard door where stock medicines were stored needed to be changed to a keypad system. Topical medicines recordings were not always completed. Controlled drugs were recorded correctly, however there were old medicines still in the controlled drug cupboard dated from 2014 that had been discontinued. The controlled drug cupboard also needed to be cleared as it contained other items that should not be stored there. Some creams and liquids have date openings identified upon them but not all".

22.3 This was discussed with the manager who was going to ensure that this would be completed in the future. The team leaders on duty were aware of the medicines policy so the matter of medication of

management had been clearly flagged up by Liz Turton. She also observed that most of the team leaders were out of date with the medicine competency checks and no one had completed the Boots Advanced Medicines Training.

22.4 The manager said that this would be completed by the end of December 2017 and Liz Turton concluded that the above issues outlined around medication could be deemed a potential breach of Regulation 12 around Safe Management Medication so the matter was flagged up as possible breach of Health & Safety and Legal Requirements.

23 Hannah Abilgaard was appointed a Regional Manager from 1 November 2017 and became the claimants line manager. She put an action plan in place designed, amongst other things, to address these concerns.

24 The claimant unusually for someone who had established length of service, was under a probationary period under her contract in respect of this promotion and her probation was extended.

25 Rosemary Lawrence, the Nursing Health & Professional Trainer also found similar concerns around medication management on her visit on 14 November 2017.

26 The issues were clearly flagged up in November and December 2017. Because of the whistle-blowers contact with Enfield Safeguarding, Enfield Safeguarding arranged for a Pharmacist Specialist for the CQC to attend on 22 February 2018.

27 The Pharmacist Specialist for the London Region was called Celia Asuagwu, she sent in a detailed email report on 23 February 2018 following her visit the previous day. She wrote a summary of the medicine issues so that the respondent had the information they needed to safeguard people in the home. Her use of words there is significant. She copied in the CQC's Lead Inspector for Arnold House. The matter was flagged up at regulatory level. She made general findings and particular findings. I am going to focus on this in detail because as ever the devil is in the detail and this was the detail that was before Miss Hall and the investigator Mrs O'Brien and Mr Club. The general findings were:

27.1 Poor communication between GP surgery, pharmacy and care home.

27.2 Only current fridge temperature readings being taken, not minimum, maximum and current – that was highlighted in the previous audit conducted by Boots in July 2017. It was also highlighted by Liz Turton.

27.3 Missed doses due to poor stock management.

27.4 MAR charts did not always have up-to-date allergen information.

27.5 The lack of clarity for topical medicines and discrepancies noted between the MAR charts and the topical administration records.

27.6 MAR sheets not an accurate reflection of the medicines that should be given.

27.7 MAR sheets have duplicate entrants for the same medicine staff were still signing both entries for the same time period.

27.8 Expired medicines were not removed from general medicine supplies.

27.9 Co-codamol and paracetamol prescribed together for PRN use for a number of people. Whilst this can be done safely under certain circumstances, given the number of medicines, the related concerns found, this is risky practice.

28. The detailed findings related to 13 residents. I will do my best to summarise as it is important.

28.1 RS: the MAR chart was not signed from 13 January 2018 – 15 February 2018 for mirtazapine, one tablet at night. This is an antidepressant. The MAR chart was not signed from 30 January 2018 – 16 February 2018 for atorvastatin, that is a tablet for lower cholesterol. The MAR chart was not signed between 30 January and 15 February 2018 for Senna tablets, 1-2 tablets at night, a tablet for constipation. The MAR chart was not signed on the 1, 8, 15 or 22 February 2018 for colecalciferol tablets, one tablet each week, this is a vitamin d supplement.

28.2 DF: there was an INR blood test due on 3 January 2018, it is not clear if this was done and no evidence of current prescription and dose of warfarin from the INR clinic. However, staff were administering warfarin doses as per the last instruction from the INR clinic dated 22 December 2017. Attempts had been made to get a blood test done that week but were unsuccessful. No medicines care plan or risk assessment was in place for this high-risk medicine. Mrs O'Brien in evidence explained to me the significance of this, warfarin being a blood thinning drug – there had to be regular blood tests taken by District Nurses, so as to make clear what the level of warfarin administration needed to be. This was said to be an important record omission, or an important omission in her clinical supervision.

28.3 TH: there was a dispensing label for an appointment which was to be applied twice a week for 7 days, then once a week for 7 days, then on the weekend only for 2 weeks, then to be stopped. The tube was dispensed on 5 February 2018 and had been signed daily since 12 February 2018. Whilst the start date was not clear, staff said that this was the third tube that the resident had had. Looking at the dosage instructions, this item should have been stopped by now or at least reviewed by a doctor if it was supposed to be continued.

28.4 MF: Diclofenac GL was listed on the MAR chart but doses had not been signed and there was no supply in stock. Senna was not listed on the MAR sheet, was in stock and was dispensed on 14 December 2017.

28.5 VH: ketoconazole shampoo with a dose to be applied twice weekly was listed on the MAR chart but not signed. Staff said that they do not administer this. Naproxen tablets were not listed on the MAR chart but supply was stored with the rest of the regular medicines for this resident. Was this medicine required?

28.6 GU: Movicol liquid was prescribed as “give 25mls twice a day, can be increased to 3-4 times a day according to patient need”. It was signed only once a day and no records made to explain why. Forceval capsules were not signed between 12 February – 21 February 2018 and the inhaler was no listed on the MAR sheet but was in stock and had been dispensed on 1 February 2018. Paracetamol tablets were dispensed on 18 June 2017 from the Royal Free Hospital, not clear whether this was a current medicine and was not listed on the MAR chart.

28.7 PY: Cerazette tablets were not given between 27 November and 15 December and that was confirmed by looking at the stock count record for that time period.

28.8 AM: the MAR sheet was not signed for amitriptyline tablets at night on 14 February 2018. MAR not signed for simvastatin 40mg tablets at night on 14 February 2018.

28.9 AW: carbamazepine liquid was listed on the MAR sheet twice and signed twice.

28.10 PP: the MAR chart was handwritten and when the pharmacy printed MAR chart, staff signed all the doses again, however signatures and entries did not match. The MAR chart said that codeine phosphate should be taken one tablet a day, reduced to one a day as per the neurologist, try stopping on 15 February 2017. Has that medicine been reviewed? Does the resident still need it?

28.11 JD: the PRN protocol said when taking paracetamol, do not give ibuprofen, however staff still offered paracetamol. Whilst it was

refused by the resident, if the resident accepted it this would not have been in line with PRN protocols. Do the staff read and following the PRN protocols.

28.12 JS: Vensir XL modified release 75mg capsules, morning dose was not signed on 21 February 2018. Sitagliptin 100mg morning dose not signed on 21 February 2018, was prescribed both paracetamol 500mg caplets, 2 caplets four times a day, and co-codamol tablets 15-500mg, two – four times a day. Co-codamol was an emergency supply sent on 31 December 2016. Was it still required? Risk that it could have been given with paracetamol in error.

28.13 AH: two entries on the MAR charts for the same period for paracetamol both signed. Paracetamol on the MAR chart were soluble tablets but yet both normal and soluble tablets in stock. Topical MAR chart for 6 November 2017 for Betamethasone valerate with fusidic acid cream was only signed once a day but should have been applied twice day. Eumovate ointment not listed on a topical MAR chart.

29. I have gone into the detail because that was the detail before the investigating officer, the dismissing officer and the appeal officer. It records what the respondent says to be systemic failures to comply with Medicine Record Management and insofar as there was a failure to administer that which was prescribed, the respondent makes the really centrally important point that this needed to be reported electronically to the monitoring unit as a failure upon discovery.

30. Sue O'Brien, the Head of Excellence, attended on 23 February 2018. She attended the day after Celia Azeagru attended. Mrs O'Brien had the information from Celia Azeagru.

31. Sue O'Brien was able to confirm the CQC findings. Sue O'Brien recognised that there were residents who had not had all of their medication available as prescribed for that day. She brought in, as a matter of emergency, the Boots Regional Business Manager to assist. In her own review of the records, Mrs O'Brien also made reference to failures that had been discovered earlier. She noted that in November concerns had been raised with the claimant and the claimant's line manager that in respect of one resident a carrier bag contained medication – there was an open carrier bag in the claimant's office contained medication for a diabetic resident who had not received Metformin prescribed for diabetes for the previous three days. She observes in her report, that diabetes is a serious condition whereby missed medication could cause serious harm to the individual at best and may lead to the person requiring hospitalisation or at worse death.

32. There was also reference to a case which formed the subject matter of the second charge, that there had been a resident who had not received her contraceptive medication for 19 days. The medication was an oral contraceptive that the line manager had informed Mrs O'Brien had been

prescribed for heavy periods. The claimant did communicate her misunderstanding that the medication was prescribed for facial skin condition and that the resident had also been prescribed some cream. The claimant added that the doctor had switched the service user to liquid form and had been trying differing forms for the condition the medication was taken for.

33. Mrs O'Brien observed that the medication was not for a skin condition but was an oral contraceptive used for heavy periods. The claimant said she was unaware of that. The claimant also said in interview that she was aware that the medication had been missed but she was unaware the service user had missed the medication for 19 days until it had been brought to her attention.

34. The claimant also stated that she conducted weekly audits and monthly audits of medication. The claimant said she looked at her weekly audits but was unable to give any reason as to why the missed medication was not on them.

35. As part of her investigation, Mrs O'Brien interviewed the whistle-blower who was Catalin Filipoiu, who was the Deputy Manager. He was interviewed first on 23 February 2018 and then by rearrangement on 26 February 2018 by telephone. I infer that it was that which was the fuller interview. She interviewed the Regional Manager, Hannah Abdulgaard, by telephone on 5 March 2018 and on 7 March 2018 she interviewed the claimant at a local hotel for the purposes of confidentiality.

36. On 14 March 2018, Sue O'Brien in essence highlighted four serious concerns in her report. First, the missing of the day's diabetic medication; secondly, the missing of the 19 days oral contraceptive; thirdly, the inappropriate approach to warfarin and failure to monitor blood tests and dosages; fourthly and perhaps and most fundamentally, the fact that the reporting rules were simply not being followed at Arnold House. Wherever there is a single medication omission or error, the rules are that this has to be emailed into the respondent's monitoring unit and that had not happened during the claimants' period of being the Service Manager.

37. This was the central criticism perhaps from the respondent that there was simply no monitoring and reporting as there needed to be under the policy relating to the management of medication.

38. The disciplinary hearing took place on 17 April 2018. Ms Hall relied principally on the report compiled by Mrs O'Brien which, in turn, exhibited all the other matters I have made reference to, including the "on the spot" record from the CQC Pharmacy Specialist. I should have said earlier, the significance of that report was an "on the spot" unannounced investigation as to what was happening as could be observed on the day of attendance.

39. Ms Hall upheld the allegations and she also prepared a short note of her detailed reasoning which was read out to the claimant when she was told

that she was going to be dismissed and attached to the dismissal letter. Ms Hall said as follows,

> "I have again considered the allegations very carefully, listened to and considered the information from both sides and find that there were systemic and multiple failures in medication management at Arnold House. The errors that were identified by CQC and our internal audit through our own internal processes have been identified by Pauline and action should have been put in place to address these. The amount of time that these issues covered was sufficient to give ample opportunity to address the areas specific to the allegations. Pauline was responsible for and carried out the weekly and monthly medication audits but the issues we have heard about today were still not addressed in a timely manner or reported appropriately to any internal or external processes although she said she was familiar with these. The errors included medication not being given as they were not in stock, including diabetic medication which could have had serious or even fatal consequences; a service user not receiving their medication for 19 days without any explanation or record of why this had happened; and no warfarin care plan for a service user on this medication, despite policy and audit forms clearly stating that this was required. In addition, she failed to report these omissions through the appropriate channels. When making my decision under the disciplinary process, I considered her time in the role of Service Manager and length of service with Leonard Cheshire. Whilst she was new to the post, she had covered the role previously and therefore knew the service and staff team well. I acknowledge that she found the staff team challenging and they were trying to move the service forward, but ultimately, as the Registered Manager she is responsible for ensuring the safe systems of medication management. I found her performance in this respect was sufficiently poor so as to constitute gross misconduct. Therefore, I consider that would be an inappropriate sanction, due to the serious nature and potential fatal consequences of her action. I concluded in this case that summary dismissal was a fair and measured sanction."

40. I pushed Ms Hall in evidence on this conclusion and explored with her whether or not a final written warning, coupled with re-training or a demotion would not have been more appropriate. She told me and I accepted that she did consider these matters but she rejected them given the length of time of the problem, which minimally is from November 2017 until the end of February 2018; and the extent of the claimant's experience in the role. And it is right, of course, that whilst the claimant had been Service Manager from 1 August 2017, she had in fact been working at a senior level in Arnold House for a great many years.

41. The argument seems to be if she could not get it right with all that experience, then the trust and confidence in her was lacking to the extent that a dismissal was the appropriate sanction. That was Ms Hall's argument; indeed, Mr Clubb on appeal said much the same.

42. His conclusion at the appeal hearing is set out on page 218 of the bundle and he concluded:

> "Having carefully considered everything presented to me in relation to the investigation, original disciplinary hearing and at the appeal hearing, I find that the sanction of dismissal was appropriate for the following reasons:
>
> 42.1 Medication errors were unreported and went on for a significant period of time.

42.2 One service user did not receive prescribed medication for 19 days – this was not reported as a medication error and the claimant admitted her failure to report this as a safeguarding alert.

42.3 One service user who was diabetic did not receive prescribed medication for three days, this was not reported as a medication error and the claimant admitted her failure to report this as a safeguarding alert.

42.4 The claimant failed to ensure that the team leaders followed clear policy and instruction of the safe management, control and administration of medicines. The credibility of the detail found this in the medication audits carried out by the claimant were called into question given her failure to act on the areas identified.

42.5 Had daily stock controls been implemented as the claimant had suggested during the hearing there was an expectation and risk of running out of prescribed medication would have been minimised and most certainly would not have happened to the extent highlighted in the investigation report."

43. He believed on the balance of probability that gross misconduct had occurred and therefore upheld the decision to dismiss. When he was pressed on this - I put to him the issues and possibilities of demotion and final written warnings - his position was that even though there had been significant length of service with unblemished disciplinary record, that was outweighed, in his judgment, by the lack of trust and destruction of trust in confidence represented by the seriousness of the situation and the haphazard way in which medication was administered. The failure to notify the appropriate channels, and he makes the point in his written conclusions, which was also made by Mrs O'Brien, that there is a notification obligation, not just internally, but also externally to Enfield Safeguarding where there has been a serious failure to administer medication. There was poor stock control and the two specific examples of one resident not getting medication for 19 days, the other for three days, made in his judgment the position serious to the extent that dismissal was required and again he emphasised that the failures to notify internally the safeguarding team.

44. The claimant did not take her opportunity in this case to cross-examine any of the witnesses in detail. That might be by reason of lack of research into Tribunal proceedings, or lack of preparation. I have no doubt that the claimant was under significant stress throughout this matter, but it also was not professional that she did not put her case to the witnesses. I was not assisted by her failure to put her case in detail to the witnesses, giving them the opportunity to meet her criticisms. That said, I tested the witnesses on points that seemed to me important.

45. I do of course have the claimant's witness statement in which she makes certain points. So, I will turn to some of those points.

46. One of her points is that it could be inferred that the whistle-blower had a malicious intent and that the respondent should have taken that on board. The difficulty with that criticism is that what he told the respondent was

borne out by the "on the spot" CQC inspection and in fact it was that "on the spot" CQC inspection which was in many ways the most telling evidence. Matters of concern had been flagged up in November but the "on the spot" inspection by the CQC demonstrated that the claimant had not managed to turn around the administration and management of medication. That point seems to me to deal with her malicious intent argument.

47. It also deals with many of her other complaints. She alleges that she was not given access to information that would have assisted her. She makes an important point about asking for her note books. The respondent claimed it intended to allow her access to her note books. I do not see a record from, for example her representative - and she was represented throughout the internal process - that there had been a material failure to allow the claimant access to any information which could in anyway have mitigated that which was found by the CQC or Mrs O'Brien. I note that it was intended that the relevant notebooks would be sent to her by the time of the disciplinary hearing on 10 April 2018. Juliette Harman emailed her to say that I have received an email saying that Hannah, [line manager] is sending you the notebook from your office, let me know if it arrives so I can let Maggie know.

48. Further, for this Employment Tribunal the claimant has not pointed to any evidence she has obtained through disclosure which in any way counter-indicates that which the respondent found through Mrs O'Brien's inspection, including relying upon the CQC Report. The evidence found by the CQC, as analysed by Mrs O'Brien in her investigation report, together with matters that were flagged up in November 2017 - none of the detail of that has, in any sense, been contradicted by any evidence that the claimant did or might have obtained through disclosure.

49. So, when she says there was a failure to provide all relevant documents; that she was unable to respond to issues which occurred after suspension; that the Respondent failed to provide access to her personal records; all of those points are not made out in any materially relevant way from evidence before the Tribunal. She does not point to any evidence which in any way contradicts the findings of the respondent which she might otherwise have had access to. On the contrary, it seems to be me that the respondent sought to ensure that she had access to whatever she need to have access to. The problem with the Claimant's position is that the CQC's inspection was an "on the spot" inspection, it simply described how it was on the 22 February 2018.

50. It is right that statements were not obtained from team leaders, although there was an interview of the whistle-blower, but the respondent's point being that even as they did accept that there were management challenges in managing the team leaders, the responsibility for medication management rested with the Service Manager. This I think points to an important aspect to this case, that essentially, it is a results-based assessment. The respondent arrived at the views that they did based upon the description of what was happening at Arnold House, based upon

what was observed by the various people who observed the management of medication. There was plenty of evidence that the management was not effective.

Conclusions

51. In conclusion on the questions I have to find:

51.1 Was there belief in misconduct? Yes - the reason for dismissal was misconduct.

51.2 Were there reasonable grounds for that belief? Yes - perhaps the most key job responsibility was to ensure that people using the service received support in line with agreed plans and expectations. Plainly the administration of medication in a place such as Arnold House, is of fundamental importance. There was substantial evidence that this fundamental aspect was simply not being managed appropriately. I take on board the fact that the management witnesses that I have heard from have experience across the respondent's service. They will know how residential care homes such as this, housing people with significant disabilities, should be run and that the management of medication needs to be accurate and reliable. They found that this simply was not being delivered.

51.3 Was there a reasonable investigation? Yes – there was. The primary evidence was from audit inspections undertaken by people who know what they are doing. The claimant was given opportunity to state her case in the investigation with Mrs O'Brien. She was given her opportunity to state her case in the disciplinary hearing and on appeal and nothing she could say could contradict the findings open to the respondent to make.

51.4 There was a fair procedure, I have dealt with the claimants' criticisms she raised in her written statement.

51.5 Was dismissal a fair sanction? This is something I focused on in my own questioning of the witnesses. I pushed them to address whether alternative sanctions might be appropriate. Their conclusion that the length of time of the problem, the extent of the failure to deliver the care in the material way and the failure to report medication failures as required combined to justify the dismissal. This position was, in my judgment, a reasonable one. They did not demote. They might have done but they decided to dismiss and that was reasonable because they had reasonably lost confidence in the claimant.

52. In terms of unfair dismissal, it is my conclusion that this dismissal was not unfair and that the claim fails.

53. I also have to determine the claimant's breach of contract claim. She says she should have been paid notice for this dismissal. The respondent says she was in repudiatory breach of contract. Again, I refer back to the key

responsibility that it was her job to manage the team, her job to ensure that service users were supported safely. I myself, baulked a little bit at the use of the word “abuse” but there certainly was serious neglect and it gives me no pleasure in this making this conclusion.

54. I have heard the claimant and I have watched her. She is no sense a malicious person. She did not deliberately hurt anyone. One does have the impression that this job was perhaps too much for her. Whether that is true or not, whether she had been over-promoted or not, she sadly did fail to deliver in this role and there was a repudiatory breach. The respondent was entitled to withhold notice. In some ways I am sad about that, they might have paid a notice payment, but they were entitled not to because the claimant was in repudiatory breach of her contract. She was in repudiatory breach of the key responsibilities identified in paragraph 11 above.

55. In all the circumstances, I find that these claims are unsuccessful.

_____
Employment Judge Smail

Date: …30 April 2019……..

Sent to the parties on: .....

.....
For the Tribunal Office