Case Number: 3333823/2018

EMPLOYMENT TRIBUNALS

Claimant		**Respondent**
Mrs G Duku	**v**	**Healthcare Homes Group Ltd**

Heard at: Watford **On**: 3 & 10 June 2019

Before: Employment Judge Smail

Appearances

For the Claimant: Mr M Sprack, Counsel
For the Respondent: Ms A Rokad, Counsel

RESERVED JUDGMENT

1. The Claimant was unfairly dismissed by not being afforded an appeal.

2. There will be a 60% Polkey reduction of the compensatory award.

3. There is no additional reduction for contributory fault.

4. There is no reduction to the basic award.

5. The Claimant was wrongfully dismissed without notice and so is entitled to a notice payment.

6. The Claimant did agree to revert to bank hours after returning from extended leave. There was no guaranteed minimum work and so the Claimant is not entitled to be paid between returning from extended leave and the date of dismissal.

7. The Claimant is entitled to holiday pay for the appropriate part of the extended leave. She was contractually entitled to holiday pay for that period and that is a contractual debt outstanding on the date of termination.

8. Calculation of compensation will be undertaken, if necessary, at the remedy hearing.

REASONS

INTRODUCTION

1. By a claim form presented on 3 October 2018 the Claimant claims unfair dismissal, wrongful dismissal (that is to say dismissal without notice), unlawful deduction of wages, and holiday pay. She was summarily dismissed for misconduct on 29 June 2018. The dismissal related to the care of a 92 year old woman who died in the Respondent's care on 24 December 2017. The Claimant was employed as a nurse. The dismissal claims relate to the summary dismissal.

2. The unauthorised deductions from earnings and holiday pay claims relate to the status of the Claimant between her return from extended leave (between 12 January 2018 and 31 March 2018) and her dismissal on 29 June 2018. The Claimant says she was suspended on her previous contract. The Respondent says as a condition to being given permission for extended leave, she agreed to revert to a bank hours contract which had no guaranteed minimum.

THE ISSUES AND LAW

Unfair dismissal

3. The tribunal has had regard to section 98 of the Employment Rights Act 1996. By section 98(1) it is for the employer to 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(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.

   This has been interpreted by the seminal case of British Home Stores 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 a fair investigation and procedure?
   (d) Was dismissal a reasonable sanction open to a reasonable employer?

4. I have reminded myself of the guidance in Sainsbury's Supermarkets v Hitt [2003] IRLR 23 (CA) 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 there may be a band of reasonable 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 s. 98(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. In judging the reasonableness of the employer's 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 employee's conduct within which one employer might reasonably take one view, whilst another quite reasonably take another. The function of the employment tribunal, as an industrial jury, 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

5. 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 prove this.

Unlawful Deduction from Wages

6. The deceased died on 24 December 2017. The Claimant was suspended, she says, in January 2018. The Claimant did not receive any pay during what she says was a suspension. The Claimant claims salary between the date of her suspension and the date of her dismissal on 29 June 2018. The period concerned is 12 January 2018 to 29 June 2018. The Claimant accepts she asked for six weeks' unpaid leave during that period. The Respondent disputes that it has to pay salary during the period of suspension. It says that the Claimant's engagement had been varied to a zero hours contract and as such no pay is due.

Holiday Pay

7. If the Claimant did revert to bank hours, then there is outstanding an amount of contractual holiday pay, subject to the Claimant being lawfully dismissed summarily.

FINDINGS OF FACT

8. The Claimant began working for the Respondent as a nurse at The Chase Care Centre on 8 July 2013. The Chase Care Centre is a 110 bedded care home and has six units over three floors. The Claimant worked mainly on night duties where she oversaw two units.

<u>The Claimant's contractual status between returning from extended leave and dismissal</u>

9. The Claimant's initial statement of terms and conditions of employment, when first employed, described her hours as being bank hours to be worked Monday to Sunday on a rota basis. She was expected to work overtime up to an average of 48 hours per week over the last 16 week period unless opting out which required reasonable notice. That was with effect from 8 July 2013. On 20 March 2015 her contracted hours were changed to 42 hours a week instead of bank hours.

10. On 16 July 2017 the Claimant requested annual leave from 12 January 2018 to 21 February 2018 and five weeks' leave without pay from 21 February 2018 to 28 March 2018 with a view to resuming back to work on 31 March 2018. The reason for the request was to enable her to care for her husband who was having a prostate operation in the second week of February 2018, in Ghana.

11. The Claimant had a supervision with Joanna Mosses, the then Home Manager for the Respondent, on 19 September 2017. The request for annual leave and extended unpaid leave was discussed. It was mentioned that in normal circumstances no more than two weeks' holiday can be taken at any one time unless exceptional circumstances apply. Ms Mosses advised that if the Claimant wished to take the extended period of annual leave she would have to liaise with the Regional Director as he would have to authorise it. However, she was not able to authorise the further five weeks unpaid leave as requested unless the Claimant was able to provide evidence that her husband needed one-to-one care and support post-surgery.

12. Ms Mosses tells me that no further evidence was received and therefore the leave was not authorised. Ms Mosses continued to attend work whilst undergoing treatment for cancer until 21 January 2018 when she commenced sick leave. She remained on sick leave until her resignation and last working day on 31 March 2018. She maintains that it was mutually agreed and accepted by the Claimant that her existing employment contract with the Respondent would terminate with effect from 12 January 2018 so that she could go to Africa to look after her husband and that in its place she commenced an engagement as a bank/casual worker on a zero hours basis with immediate effect from 13 January 2018, that is to say without a break in continuity. So Ms Mosses suggests that there was a deal that in return for

being allowed to go to Africa for that extended period the contract changed to a bank/casual worker on a zero hours basis contract.

13. Mr Knowles, the operations manager, tells me that he was told by the care service manager (Agampodi Gayathilake) that the Claimant had transferred to a bank contract with effect from 13 January 2018 and that she was currently overseas. He recalled that upon her return the Claimant did contact the Respondent to enquire about available shifts. She was informed that there were no available shifts, however she could attend training. To the best of his knowledge, the Claimant did not raise any query in regard to owed wages whilst staying at the home. Such a change in contract is not confirmed in writing.

14. The Claimant alleges that her line manager, Ms Mosses, agreed to the holiday request and advised her to remind her a month before the due date. The Claimant says she reminded her in December 2018 and the line manager said she could leave from 15 January 2018. The Claimant says that when she returned from holidays she was suspended by the Respondent and that she has not received any salary since suspension. Joanna Mosses denies that the Claimant was suspended.

15. There is a record of supervision, handwritten, for the 19 September 2017. There is an entry for annual leave which says that the author had informed the Claimant as per company policy employers are allowed a maximum holiday, by which 2 weeks was apparently meant, and that she had explained to the Claimant that she was free to liaise with the Director regarding having one month off to be with her husband in Africa who was having prostate surgery. The author advised that they cannot grant five weeks' leave even unpaid.

16. Under cross-examination in evidence Ms Mosses confirmed her position that the Claimant did agree to go on a bank contract. The Claimant's options were to resign the job or go on the bank. The fact that Ms Mosses was undergoing treatment for cancer contributed to the fact that there was no written record of this agreement, she says, but Ms Mosses was clear that the matter was agreed.

17. There is no correspondence from the Claimant during the relevant period claiming payment.

<u>Mr Knowles' decision to dismiss</u>

18. The Claimant was dismissed summarily by letter dated 29 June 2018. The letter was written by Charles Knowles, the operations manager. The dismissal arose out of the Claimant's actions and omissions surrounding the death of the resident, CM. There were three headlined concerns about those matters. First, a failure to inform the next of kin in a timely manner that the resident's condition had deteriorated and was dying; secondly, a failure to follow advice/instructions from a GP; and thirdly, failure to keep

adequate records and follow procedures. Mr Knowles decided to dismiss the Claimant summarily. He deemed the Claimant's explanations to be unsatisfactory. He listed the following considerations in that regard.

19. First, the Claimant stated she called the deceased's daughter only once. She had time to wash, dress and lay out the deceased before the daughter's arrival to the home and decided against calling her to inform of her death. Secondly, there was no evidence that the deceased was on a palliative list at the time of her passing (that is to say no end of life drugs) and she did not call the GP at the time of the deceased's deterioration. She did not refer to other nurses in the home for any other clinical opinions. Thirdly, the Claimant did not dispute that the on-call GP left instructions to contact them for any deterioration. She did not follow standard procedures regarding verification of death; there was no evidence of the Claimant checking for vital signs in the deceased records and when asked about checking for signs of life she referred to the deceased taking her medication. Mr Knowles concluded that the allegations made against the Claimant amounted to a serious failure to abide by her code of conduct relevant to her employment with the company amounting to acts of gross negligence, serious incompetence or dereliction of duties, which allegations he upheld.

20. It is not relevant to Mr Knowles' decision in this matter, but is a comfort to the Claimant, that subsequently on 14 September 2018 the Nursing and Midwifery Council did not withdraw the Claimant's registration. The NMC concluded that it had not been unreasonable for the Claimant to wait for the arrival of a family member to inform them of the death given that she knew someone was on the way. Secondly, the Claimant had contacted the GP to certify death and thirdly the record keeping errors, whilst representing poor practice, were not serious enough to amount to serious professional misconduct and therefore could not result in a finding of current impairment to practice.

21. Mr Knowles took the decision to dismiss and I have recorded the essence of his dismissal letter above. In his witness statement he tells me he deemed the Claimant's responses to the matters aired in the investigation report to be unsatisfactory. He says she should have been fully aware of the correct process to have followed in terms of verifying the death of the resident and how to show sympathy to the deceased's daughter when informing her of her mother's death. Actions and conduct on the day fell significantly below the expected standards. It was also clear to him that she had not kept clear and accurate records relating to the deceased's care leading up to her death.

22. He criticised the fact that no attempt was made to call the daughter again after the deceased had in fact died. The deceased was not on palliative care at the time of her passing, therefore the deceased's death may have been deemed as unexpected and therefore subject to police and/or coroner investigation. He was unaware why the coroner was not informed at the time of the death. The Claimant, he stated, had not sought any advice from the GP at the point the resident was reported to be gasping despite the GP

notes instructing this. Instead she had made the decision to contact the next of kin first before seeking any medical advice as instructed. He felt she should have called an ambulance or the out of hours GP who could have made an attempt to revive the deceased with end of life medication that would have relieved her gasping and provided her with further treatment. It was also of concern that she had not sought any advice he says, from any other professional nurses who were working at The Chase.

23. In the case of an unexpected death and as an exercise of clinical judgment even for an expected death the verification of death involves checking up to two minutes respiration (stethoscope); heart sounds (stethoscope); palpable pulse; unresponsive pupils (torch); muscle tone/pain stimuli; and checking evidence of hypostasis/rigor mortis.

24. The Claimant maintains she did verify death by checking pulse, checking response to stimuli and checking breathing. She did not check using a stethoscope, that is for a doctor. The verification policy that I have cited from was only sent to her, she says, in the course of the investigation

Complaint from the Deceased's daughter

25. This represented the origin of the matter. The deceased's daughter came to visit Ms Mosses on 27 December 2017. She was upset. She did not inform Ms Mosses that she wished to make a formal complaint only to ensure that others were not treated in the same way her mother had been. In the event, on 30 January 2018 the daughter, LM, wrote a letter. She decided to delay sending the letter until after the funeral, which took place on 23 January 2018.

26. The daughter had been with her mother for approximately four hours on 23 December. She had raised concerns regarding a chesty cough. At approximately 8pm, having left The Chase, the daughter received a call from Tojo to say that she had been correct and that a call was placed with the GP. She was asked for her position on hospital referral and she gave that as unless it was something that the home could not deal with then hospital admission was not desired.

27. At midnight on 23 December she received a call, from the Claimant, to say that the GP had been called and had prescribed antibiotics. A dose had been administered but her mother was gasping. The GP was going to be called again but it was not known if they would visit again. The daughter asked whether she was being told to come to the home, the daughter relates that she was told no, but her mother was gasping. She decided to go anyway and arrived at the home at approximately 12.45. She went up to the relevant wing. The nurse (the Claimant) approached her and the daughter introduced herself. She walked up to the end of the corridor to her mother's room in silence, the nurse pushed the door open and she could see from the doorway the corpse of her mother. The daughter observed "she's dead", the nurse replied: "I told you she was gasping", the daughter

said: “why didn’t you tell me”, the nurse said again “I told you she was gasping”.

28. The daughter regarded the conversation as ridiculous, she was deeply shocked and further shocked by the behaviour of the staff. The nurse in question was the Claimant. She was told that someone had been with her when she died. The deceased had been washed, was laying straight and was in a nightgown, her mouth was open. The room had been tidied and the bed raised. Not one word of sympathy was expressed by the nurse, claimed the daughter, as she was let out of the section of the building. She says she was not offered sympathy, a chair or a drink or any concern for her welfare.

29. The daughter recommended that all staff should know promptly and clearly to communicate with relatives, she should not have had to spell it out but if she had known she would have wanted to be with her mother when she passed away. Relatives needed to be sensitively and clearly informed when someone had died and be offered at the very least a word of sympathy and possibly even a glass of water. The relatives need to be asked whether they wished to view the dead body. The daughter’s position was the issue was not about resources, funding or even training but common human decency.

30. Ms Mosses had informed her on 27 December that she would conduct an internal investigation and would get back to her within two weeks. It was requested that no night staff should attend the funeral, day staff did. The daughter had heard nothing officially from the Respondent as at 30 January 2018 and suggested that it felt that her mother’s life was not important; her death was unimportant; and relatives were at best an inconvenience and their feelings irrelevant. The matter had had an effect on the daughter’s mental health and she wished to prevent anyone else being damaged in the same way. The daughter was informed that the Claimant was on three months’ leave from The Chase, a written version of events was being sought.

Maria Jansen’s investigation

31. Maria Jansen, regional clinical support, invited the Claimant to an investigation meeting on 2 May 2018. The same three concerns as were contained in the dismissal letter were headlined in the invitation letter.

32. Maria Jansen compiled an investigation report. This was before Mr Knowles and relied upon by him in his decision set out above. The report took 2 days to complete including interviewing the Claimant. The investigation was in light of the daughter’s complaint. All the care notes were looked at, in particular for 23 and 24 December 2017. A meeting was held with the Claimant who was asked for a statement but one was not submitted at the meeting, the Claimant informed the meeting that she had given a copy of her statement to the Regional Director; the Regional Director denied receipt of any statement.

33. Maria Jansen analysed the timeline. At 19:50 on 23 December the Deceased’s chestiness had increased and the decision was made to call the out of hours doctor. The doctor came at 21:00 and prescribed Amoxicillin

three times a day for chest infection. The doctor had written "treatment by antibiotics and fluids review if worsen". At 23:30 the carers were assisting when the Claimant nurse was called to check the patient as she was gasping for breath. The Claimant put her into recovery position and went downstairs to telephone the daughter about her condition. The nurse says she informed the daughter that the patient was gasping for breath when she was coming downstairs to inform her and that she did not know if she would be alive by the time she reached upstairs. The daughter did not mention those words in her complaint, of course. The daughter was telephoned between 23:30 and midnight. The carers informed the Claimant that the deceased died at 12:05am. The daughter came at 12:30am and left at 12:40am. The out of hours doctor was informed at 12:45am, death was confirmed by the out of hours doctor at 09:55 on 24 December 2017, time of death being five minutes past midnight. At 13:30 it was arranged by the family that the Co-operative Funeral were coming to collect the body, the family also collected the deceased's ring. The Claimant, Josephine and Rebecca were on duty the night of 23 December 2017; Tojo was on duty during the day of 23 December but not 24 December. It was noted that the Claimant said that she'd helped the carer to provide last offices which took about 30 minutes on her return from phoning the daughter. The Claimant claims to have been writing notes when the daughter arrived at about 12:30. The Claimant claimed that she met the daughter near the office and told her "Oh Connie is dead" and walked with her to the room. The Claimant provided a chair and told the daughter that she was still waiting for the doctor to confirm death.

34. According to Maria Jansen the following matters were of concern as a result of her investigation.

    34.1 The GP was not called when the resident deteriorated, the death was not expected and the GP's instructions were not followed in that there was no evidence that fluids were given as the fluid charts were not completed, the out of hours GP was only requested to certify death at 12:45am.

    34.2 The Amoxicillin 500mg capsule was given with thickened orange juice – the resident was on a pureed diet and she had swallowing difficulties. Taking the capsule may have been very difficult seeing as the resident was poorly already.

    34.3 Events from the night were already recorded at 23:30 and the resident died at 12:05.

    34.4 The carer informed the nurse that the resident died at 12:05am but there was no mention at all that the nurse verified the death.

    34.5 Last offices were immediately carried out but it was an unexpected death – policies and procedures not followed.

    34.6 The daughter was not informed of the outcome of the GP visit earlier, she did not get clear information when she was called around

midnight to inform her that her mother was "gasping" and no sympathy was expressed/shown when she visited the home.

34.7 The Claimant was adamant that she handed all the information over in the morning to Tojo but records suggested he was not on duty on the morning of 24 December.

34.8 No basic support was given to the resident when she was gasping – only put in recovery position as the Claimant thought there was a risk of aspiration – but emergency services not called, out of hours GP not contacted or suction used (as there was a risk of aspiration).

34.9 Records were not completed after 18:00, fluid change, repositioning, safety observations, continence management and daily notes made by the Claimant were not very comprehensive as it was not clear from the notes why the deceased was put in the recovery position, what her condition was, why the nurse thought there was a risk of aspiration, etc. There was no verification of the death by the nurse.

35. The recommendation was that the matter go to a disciplinary hearing.

36. In interview with Ms Jansen the Claimant was asked if the doctor said to contact him if the condition worsened then why was not the doctor informed when the deceased began gasping. The Claimant replied it was a short space of time and she got off the phone to the daughter and by that time she was upstairs the deceased had died. The Claimant was asked whether at any point she took her vital signs from when she took over at 11pm. The answer was "no". The Claimant was asked about the wisdom of trying to swallow a large capsule given that the deceased was on a pureed diet, the nurse insisted it wasn't a large capsule and the deceased swallowed it okay.

37. In evidence before me Ms Jansen confirmed that her particular concerns were the failure to consult with the GP when the deceased's health deteriorated; the decision to dispense the medication with thickened orange juice when the resident was on a pureed diet owing to swallowing difficulties, particularly when the resident was unwell; incomplete and insufficient records completed by the Claimant; and there were no records to confirm that the Claimant verified the death of the resident. This was an unexpected death. In the case of an unexpected death the emergency ambulance should have been called, either the police or the coroner should have been called. She also concluded that the communication the Claimant had with the deceased's daughter fell below the standards expected of a professional nurse and lacked sympathy given that her mother had just died. All of this was before Mr Knowles.

<u>The care notes</u>

38. The Claimant entered the following note in the care record. The first was for 20.00.

> CM was restless and chesty. When I took over from the day nurse he told me he has informed her daughter and had called the out of hours doctor who will come later to see her, but the daughter did not want hospital admission. The doctor came at 2100 and prescribed caps amoxicillin 500mg, three times a day for chest infection, which started with thickener fluid.

39. The second set of notes are clearly back timed to 23.30. The Claimant wrote-

> The carers were assisting her when they called me to check her as she was gasping for breathing. I helped them to put her into recovery position and I went downstairs to inform her daughter about her condition and said in addition that she was gasping for breath when I was coming downstairs to inform her but I don't know if she will be alive by the time I will reach upstairs. It was around 1200 midnight but the carers said she passed on at 12:05 AM. The daughter came around 12:30 AM and left at 12:40 AM and she asked me to call the funeral directors when the doctor certify the death and that they will come in the morning. The out of hours doctor informed at 12:45 AM. Not yet in. I phoned at 6 AM and the receiver said her name is on the list, but the doctors are very busy, but he will come. RIP 24/12/17 at 12.05AM…

No appeal allowed

40. Mr Knowles' decision conferred the right of appeal against it. If the Claimant wished to appeal she was informed in the letter dated 29 June 2018 that she should state her grounds for appeal in writing to the Operations Regional Director within five working days giving the full reasons as to why she believed the disciplinary action taken against her was either inappropriate or too severe.

41. On 6 July 2018 the Claimant's solicitors wrote to the Respondent stating that the Claimant would be appealing against the decision of summary dismissal and the claim forms would be reaching them soon. That letter was acknowledged on 12 July 2018 by the Respondent. The Respondent's letter stated that it was not their policy to accept instruction from or respond directly to third parties in regard to employment matters. It was noted that the Claimant was intending to lodge her appeal against the decision in writing. The solicitors were informed that all appeals had to be received within five working days from the date of the outcome letter, therefore any appeal received from the Claimant outside of that period would not be valid nor considered owing to being out of time.

42. On 9 July 2018, purportedly received on 12 July 2018, the Claimant confirmed she wished to appeal. The grounds would be in response to each of the three bullet points or reasons on which they based the decision which were all denied. The Claimant stated: (1) she did not fail to inform the next of kin at a timely manner as alleged; (2) she followed the advice/instruction of the GP; (3) she did keep accurate records and followed standard procedures; insufficient consideration was given to her explanation and her dismissal was unfair.

43. By further letter dated 12 July 2018 the Respondent wrote to the Claimant that appeals were required to be lodged within five working days from the date of the letter, therefore they deemed her appeal to be lodged out of time

and therefore would not be in a position to respond to it. Accordingly, the Claimant did not have an appeal against her dismissal.

44. In respect of appeals, the disciplinary procedure provides that if the employee is not satisfied with a disciplinary decision they may appeal in writing, within five working days. It goes on later in the document to say all appeals must set out the grounds on which they are making the appeal.

CONCLUSIONS

Unfair dismissal

45. The decision not to permit the Claimant an appeal was a decision which no reasonable employer would have made and was outside the range of reasonable responses. As the ACAS guide to Discipline and Grievances at work states, the opportunity to appeal is essential to natural justice. The policy provides for 5 working days. The Claimant by her solicitors lodged notice of intention to appeal, in the form of a holding letter, by letter dated 6 July 2018. The dismissal letter was sent on Friday 29 June 2018. Let us assume it was received on Monday 2 July 2018. I agree with Mr Sprack's submission that the first working day must be Tuesday 3 July. Monday would not be a whole day. So the Solicitors sent their letter on Friday 6 July which was the fourth working day. The Claimant sent her letter on Monday 9 July which was the 5th working day, and so sent in time in any event.

46. The solicitor's letter on 6 July was in any event enough. This is a difficult case. Mr Knowles' letter was sent 9 days after the disciplinary hearing. The disciplinary hearing was 6 weeks after the investigation report was concluded. I do not read the disciplinary procedure as requiring that the final grounds of appeal have to be in the letter notifying the appeal. The appeal grounds can be refined at a later date. The holding letter was enough to notify the Respondent there was going to be an appeal. The Respondent's position to refuse to acknowledge a solicitor's letter was unreasonable. An employee can act by a solicitor. The ACAS guide states that the period for lodging an appeal should be specified. It states that 5 working days is commonly felt appropriate although this may be extended in particular circumstances.

47. In this case the Respondent's refusal to acknowledge the solicitors' letter and its interpretation of 5 working days represented an opportunistic attempt to frustrate an appeal. In a case of this complexity, that position was so unreasonable that no reasonable employer would have adopted it. An appeal was lodged in time, as were grounds. If I am wrong about the grounds, then the only fair position was to acknowledge the appeal was lodged in time and expect grounds within a reasonable period of time. Receipt of the grounds on 12 July having been sent on 9 July was well within such a reasonable period.

48. Accordingly, the Claimant lost the chance of reinstatement on appeal. This was not a negligible chance. We know, for example, that the NMC viewed the matter differently from Mr Knowles.

49. Some of Mr Knowles reasoning was unreasonable. It was outside the band of reasonable response to criticise the Claimant for waiting to tell the daughter her mother had died until she arrived at the home. The Claimant's position that she did not want to call the daughter again when she was driving was perfectly fair.

50. It was outside the band of reasonable responses to criticise the Claimant for failing to verify death by use of a stethoscope when the practice at the home was not for nurses to use a stethoscope.

51. There were fair criticisms made of the Claimant that her notes were well short of best practice. She did not record verifying death, although she was adamant she did by using methods other than the stethoscope. The entry in the notes were back-timed (although obviously so and not concealed).

52. When the deceased deteriorated the Claimant did not telephone the out of hours doctor as that doctor had asked. In her witness statement to the Tribunal she says she tried to call the out of hours doctor before ringing the daughter, but that was not recorded in the notes and was not argued in the internal hearings. She did not do it and there were reasonable grounds for thinking she did not do it.

53. However, that failure cannot be said to be causative of death. That has never been contended by the Respondent. The carers informed the Claimant that the deceased was deteriorating. The Claimant decided to call the daughter. She had to go downstairs to do so because there was no working telephone on the floor of the deceased's room. When she came back upstairs the deceased had died. Telephoning 999 would have made no difference, although the principal challenge has been that she failed to call the out of hours doctor. That doctor would not have attended instantly. It is important not to lose sight of the fact that the deceased was a frail 92 year old.

54. There is also fair criticism that the Claimant did not communicate and deal sensitively with her mother's death to the daughter. Otherwise why would the daughter send in such a detailed complaint.

55. There is no doubt that a belief in misconduct was the reason for the dismissal. There were reasonable grounds for believing in misconduct: poor note-taking; communication failure with the daughter upon her arrival and there is a debate to be had about whether the out of hours doctor should have been called before the daughter, not that it would have made any difference to the deceased.

56. The debate to be had in the appeal, had it been provided, was what was the extent of the misconduct and whether dismissal was a fair sanction.

57. Doing the best I can, in my opinion the Claimant had a 40% chance of not being dismissed on appeal. Put another way, there was a 60% chance that she would have been fairly dismissed. Whilst the Claimant did not have live

warnings, she had been challenged previously about note-taking. So there is a Polkey reduction of 60%.

58. There is no further reduction for contributory fault. The Claimant's culpability is adequately covered in the 60% Polkey reduction.

59. I do not criticise the Respondent for failing to interview the carers present at the time, or the nurse handing over. The facts and issues were reasonably clear from Ms Jansen's investigation report and the investigatory and disciplinary interview with the Claimant.

60. The approach to the compensatory award will be on the basis that there was an expectation of a reasonable amount of work being given to the Claimant on a bank basis. That will include analysis of her pattern of work when on bank hours at the beginning of her employment.

61. There will be no reduction to the basic award. I wish to mark my disappointment at the fact no appeal was afforded.

Wrongful dismissal

62. Whilst the Respondent had cause to discipline and consider dismissal, I do not find that the Respondent proves the Claimant made repudiatory breaches of contract viewed objectively. I do not find that she committed a serious failure to abide by the professional code of conduct relevant to her employment with the company or gross negligence, serious incompetence or dereliction of duties. It was established that there was poor note-taking and poor communication with the daughter and for those reasons, given previous concerns about note taking, dismissal was an option. However, in my judgment dismissal needed to be with notice. I do not find on the balance of probability that she committed repudiatory or gross misconduct. She was guilty of poor conduct as stated but that is different. In my judgment she is entitled to a notice payment.

The contractual basis during suspension

63. Plainly the Claimant was suspended in that she was given no work on return from leave. This was so whether she was on bank hours or fixed hours. If she was on bank hours there would have been an expectation of a reasonable amount of work.

64. On the balance of probability I find that it was agreed that she would revert to bank hours as a condition of being given permission for extended leave, much of which was unpaid. I accept the evidence of Ms Mosses on this. I have struggled with this because the Respondent did not record this in writing. The position, however, makes sense to me. There was no written claim to payment made by the Claimant during the period between returning from leave and the date of dismissal. There would have been if she thought she was owed it. The supervision note corroborates the Respondent's position. Further, the Claimant had been on bank hours before so this was not new. I

accept no minimum amount of bank hours had been agreed. Accordingly, the Claimant was not entitled to be paid during the period of suspension.

Holiday Pay

61. The Claimant is entitled to holiday pay for the period of leave taken in January/February 2018. She was not lawfully summarily dismissed. She did, however, revert to a bank contract upon return. The appropriate calculation can be undertaken at the remedy hearing, as appropriate.

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Employment Judge Smail

Date: ……03.10.19……..

Sent to the parties on: ..04.10.19..

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For the Tribunal Office