EMPLOYMENT TRIBUNALS

Claimant: Mr A Hussein

Respondent: Maria Mallaband 16 Limited

Heard at: Manchester **On:** 26 July 2019
16 October 2019
28 October 2019
(in Chambers)

Before: Employment Judge Feeney

REPRESENTATION:

Claimant: Ms J Wilson-Theaker, Counsel
Respondent: Ms F Mewies, Solicitor

JUDGMENT

The judgment of the Tribunal is that the claimant was unfairly dismissed.

REASONS

Introduction

1. The claimant brings a claim of unfair dismissal following his dismissal by the respondent on 27 December 2018 for gross misconduct. The claimant withdrew his unlawful deduction of wages claims.

Claimant's Submissions

2. The claimant states that the respondent dismissed him on unreliable evidence and did not have reasonable grounds for concluding he was guilty of the misconduct alleged. The respondent's argument that he would have been dismissed anyway for falsifying records was not credible neither did the claimant contribute to his dismissal.

Respondent's Submission

3. The respondent submits that their investigation was adequate and the evidence gathered was sufficient to establish the claimant was responsible for the gross misconduct alleged. They could also have dismissed him for falsifying records, and that the claimant contributed in any event 75% to his dismissal.

The Issues

4. The issues for the Tribunal to decide are:

(1) Was the claimant unfairly dismissed in that the respondent did not meet the **BHS v Burchell** test, namely that:

(a) The investigation into the misconduct was inadequate; and

(b) The respondent did not have reasonable grounds for considering that the claimant was guilty of the misconduct alleged?

(2) Could the respondent have dismissed the claimant in any event for falsifying records under the **Polkey** principle?

(3) Did the claimant contribute to his dismissal, and if so to what extent?

Witnesses and Evidence

5. For the claimant the Tribunal heard from the claimant himself and for the respondent the Tribunal heard from Linda North, HR Manager, and Jenny Delic, HR Director.

6. There was an agreed bundle.

Credibility

7. As far as credibility was relevant to the issues, the respondent's witnesses lacked credibility. They were evasive, would not make concessions, stated they were not clinicians when asked to consider medical matters but did give a clinical opinion when it suited them. They could not explain their findings simply saying they had a reasonable belief or 'something happened'. Mr Hussein was a credible witness he admitted his faults and had plausibility.

Findings of Fact

The Tribunal's findings of fact are as follows:

8. The claimant was employed by the respondent as a bank Registered General Nurse and he had an agreed shift pattern. There was a dispute as to when the claimant started. The claimant stated he started on 10 October 2012, the respondent stated that he began working for their predecessor on 20 September 2014. There was a TUPE transfer to the respondent in May 2015. The claimant relied on the list of staff provided to the respondent when they took over the

business, this stated he was employed from 10 October 2012 The respondent argued that prior to the 2014 date he was employed as a bank worker and did not have employee status(relevant if for example a basic award was made).The respondent pointed to his contract of 17 October 2014 which said his employment started on 20 September 2014 and no previous service counted which stated no previous service counted, they believed that was the point he was taken on as an employee and that the information the claimant relied on included his time as a worker. The claimant produced bank statements but they did not show regular payments from the respondent until July 2014. I find that the claimant's employment started in September 2014 as per the contract of employment and that this was introduced to 'capture' his regular attendance after several years of his attending irregularly as a worker.

9. The claimant worked at a care home run by the respondent for elderly residents, many with dementia. Obviously, the respondent took all safeguarding concerns very seriously and required extremely high standards to provide the highest level of care to residents. Any type of neglect, abuse or ill treatment of residents was likely to be regarded as gross misconduct and be a dismissible offence. Of course, in relation to a nurse such allegations can form part of an action in relation to their Regulatory Body and they could end up struck off and unable to practice entirely as a result of such allegations.

10. The claimant believed that Louise Douglas, Care Manager at the Home the claimant worked at, had a small grudge against him as a result of him wanting to swap shifts in November 2018. He had also been reprimanded about a medicines error he was involved in and the fact that when he attended training consequent on that he left early because he had been working all night. He was advised he needed to complete the training by Ms Douglas and undertake medicine competency with one of their clinical leads.

11. Ms Douglas stated that the claimant had a permanent contract with the respondent for 24 hours a week which was performed over two shifts and he was not a bank member of staff. Notes from a meeting on 8 November 2018 show that Ms Douglas and the claimant did have quite an argument about whether he could have 11 November off.

12. What was not mentioned at this meeting was that the previous day Ms Douglas had met with a patient. CH, regarding a complaint. CH had advised her daughters that she had been roughly handled by a male member of staff the night before and that she had been "thrown around the bed", Ms Douglas' notes state that CH described it as "abuse". This appeared, however, to be the information via the daughters. Ms Douglas then met with CH on 7 November, who said:

> "It was a tall black man. He was rough with her while attending to her and he threw her around the bed. She described it in her own words as 'abuse' In addition she also said that when he came into her room at night he also completed intimate personal care, changing her pad. She said he does not always wash her. In addition she said that he sometimes did not talk to her."

13. Ms Douglas' note continued as follows:

> "I met with CH again approximately an hour later and she told me the same again. She said when he comes in it's usually on his own but he has sometimes been with a big black lady too but not always with somebody else. She was fully orientated and appeared quite lucid. She remembered I had spoken to her earlier and accurately informed me of significant events that were happening in Manchester that night. She told me she felt reassured that the man would not be seeing to her again.
>
> I met with CH the following day with her care coordinator, TK, and her daughters, and she gain repeated the same version of events as she had done the previous night and said she felt frightened but reassured that he would not be attending to her again."

14. Ms Douglas sent an email to HR (Mr Daniel Younghusband) and asked him to advise. She noted she had sent a safeguarding referral and was sending a CQC referral the next day.

15. Mr Younghusband advised CH to document her conversation with the daughters and with the resident and to have a minuted investigation meeting with the resident asking the usual who, what, where, when type questions.

16. The CQC referral form was not referred to by Linda North when making the disciplinary, and the claimant alleges the failure to consider this was a failure in the investigation and the disciplinary hearing. This was the most contemporaneous document recording CH's allegations.

17. This identified that two people were involved, a male and a female, black or black British or African. The relevant information was:

> "Resident RAH380 reported to her daughters when they visited that a male nurse who was on last night (SMAH029), who was a tall black man, was rough with her whilst attending to her. She said he undressed her and attended to her personal hygiene when alone and threw her around the bed. She described it in her own words as 'abuse'. The resident repeated this to me when I met with her and again a little later and she reiterated the same information that the black male nurse who was on duty the previous night was rough with her. She said he attends to her alone and changes her pad. Sometimes he does not speak to her. In addition she said that sometimes there was a female member of staff present and sometimes not. She also said that there was a big black woman carer who was also rough with her (SMAHO27). An investigation has commenced. The staff members involved are not on duty and will be suspended without prejudice to allow an investigation to take place, therefore there will be no further contact with the resident."

18. Louise Douglas undertook an investigatory meeting with the claimant on 9 November 2018. It is relevant to note that no investigation was made in respect of the alleged other abuser, the "big black female carer". Ms Delic advised in evidence that there was no such person employed by the respondent.

19. Ms Douglas advised the claimant that she had received a complaint from a resident in regards to, “the way you have attended to her and her needs at night. She has specifically named you so I want to discuss this with you”. Of course this was not true as she had not named him. We did not hear from Ms Douglas so there was no opportunity to ask her why she said this. The claimant argues it shows she was prejudiced against him from the start.

20. Mr Hussein stated that he was not prepared to go ahead with the meeting, he wanted to get a lawyer and he wanted the meeting recorded. However there was some dialogue.

21. Ms Douglas went on to describe the allegation as:

> “One of the residents has made an allegation that when you have attended to her you have done it alone and that in her words you have been rough and that she has felt it was abuse.”

22. Mr Hussein denied it.

23. Ms Douglas went on:

> “Her words are you have attended to her and you have been rough. Her words are it felt like abuse and that sometimes you’ve gone in and not spoken to her and you have attended to her female intimate hygiene, so you’ve changed her pad and you’ve done it alone and not always had a female member of staff present.”

24. Mr Hussein replied:

> “I do not do any personal care for any residents.”

25. Mr Hussein stated that he did not want to go ahead without a representative.

26. Mr Hussein was advised that he was being suspended from duty whilst the matter was investigated. He received a letter dated 9 November confirming his suspension and saying that the allegation was:

> “That when attending to a vulnerable resident in your care you have acted in a manner that is inappropriate:
>
> - Specifically it is alleged you have acted roughly and without proper care and attention.
>
> - In addition it is alleged you have failed to ensure the dignity of the said resident.”

27. In that letter the claimant was invited to a further investigatory meeting on 13 November. Unfortunately, due to a mix up he failed to attend that as he thought arrangements were being made to ensure his union representative could be present and as he heard nothing he presumed it was not going ahead while that was

arranged. However, the respondent took the view that he had failed to attend and sent him a further letter on 16 November stating that as he had refused to discuss the allegations and failed to attend the re-arranged investigatory meeting they were moving to a disciplinary hearing. They said:

> "Taking into account your refusal to discuss the allegations at your first investigatory meeting, your failure to attend the second arrange investigatory meeting, I hold that the company has taken all reasonable steps to investigate this issue thoroughly with you and can advise that the case is being progressed to a disciplinary."

The letter went on to say:

> "The reason for the hearing is to discuss the following allegations of gross misconduct:
>
> (1) An acute breach of the company's disciplinary policy:
>
> - Specifically it is alleged that through your actions you have committed an act of gross negligence, acting roughly and without proper care and attention to a vulnerable person in your care;
> - In addition it is alleged that you have failed to ensure the dignity of the said resident.
>
> (2) Loss of trust and confidence in you by the company."

28. A meeting was arranged for 22 November 2018. The respondent sent the claimant the notes of the investigatory meeting, confirmation of suspension, resident CH's care plan entries, resident CH's notes, Louise Douglas' witness statement and the company policy on safeguarding adults, disciplinary policy and dignity and privacy policy.

29. It was noted on CH's file that amongst other physical matters she had frontotemporal dementia (cognitive impairments) and severe anxiety and depression.

30. The claimant had made entries on CH's notes for that evening, as had the other people on duty. On 7 November 2018 at 5:15 he had entered as follows in respect of CH:

> "Settled and slept for long periods. Repositioned in bed to relieve pressure. Diet and fluids tolerated. Night medication administered. Check routinely for safety."

31. The claimant had written on 4 November that CH was also repositioned in bed, as he had done on a number of occasions during October.

32. There was also a note from 8 November from a mental health nurse ("TK") which stated that:

> "Family concerned about increasing anxiety – safeguarding investigation. Discuss with manager, family and C. Notes review. C recalls a particular male who she alleges was rough with her and completed intimate personal care on his own. Male allegedly did not communicate what he was doing. C felt frightened. No evidence of injury. C accepted reassurance that this male would not do her care again and that her care would be completed by a female. Family and C are satisfied with this. Male to be interviewed on his return by manager, not working for the next few days."

33. Louise Douglas' note on CH's file stated:

> "CH told her daughters that at night she has been handled roughly by staff members and it felt like abuse."

34. It was recorded that no injury was found.

35. On the same night other notes were entered by JP, PZ, SR, ES, IS and TC. Later on on that day MH and Jose N also put in observations. Rachel L and Jose N appeared to be the staff on duty overnight with the claimant. Most of the observations were in relation to the fluid intake chart and observations that the claimant appeared to be sleeping.

36. The claimant's disciplinary hearing finally took place on 6 December as this was when his RCN representative was available.

37. Rachel B attended the hearing as a witness for the claimant. She was asked to confirm she was working on 6 November over to 7 November with Jose and the claimant. She said she started at 8pm. She was giving supper to residents, Jose had gone around the rooms putting in pads for residents and that then they both went around the rooms putting in pads, towels and wet wipes in the bedroom. She finished supper about 8.45 and started putting residents to bed. The night nurse (i.e. the claimant) gave the medications. She put the residents to bed with Jose and then in the morning they got the residents up, apart from one or two which she got up herself. She was asked whether she was aware whether Jose went to provide personal care in a resident's room. She said she went into one. Again she was asked whether Jose had gone in by himself. She said "yes, in the morning" and he also went to check in the early hours whether people were asleep. She was not aware of Jose carrying out personal care during the night. She confirmed that she put her own notes into the system and she was asked to confirm that Jose had put in an entry which she did. She was asked whether Jose was non white and she agreed that he was. He was Filipino. She confirmed she wrote her own notes on the residents; she did not write notes for anybody else.

38. The claimant's RCN representative Mr Hopton raised the possibility of racial bias in that the resident may not have been accurate in describing the alleged perpetrator as a tall black male, and that if there was some accuracy in it Jose N should have been suspended too. He also raised the possibility of whether the resident with dementia could distinguish between different "black ethnicities". Ms North said that someone Filipino would not necessarily be described as a "black

man". Mr Hopton thought this was an automatic assumption by Louise Douglas that the "black man" referred to was the claimant.

39. The claimant had advised that the note he had filled in on CH's notes, i.e. the repositioning and other matters, was not referring to matters he had definitely done himself but what he assumed had been done by the assistants. He had assumed that the assistants had changed the resident's position, but it turned out the resident did not need repositioned according to her care plan. Mrs North then said, "was the claimant saying his notes were falsified and not a true account?" The claimant advised it was very busy and they were short-staffed that night. He denied that he had actually had contact with the resident despite what he had put in the resident's notes. As explained earlier, he said he put that in because he had assumed the other assistants had done that and that he had spent most of the evening booking medications in that had just recently been received. He said he had written the notes on an assumption of what people had told him and after doing the notes he had compiled a list of missing medication which after he had finished he started early morning medication, around 6.15am to 8.00am.

40. The claimant said he did not think he had gone into the resident's room at all that night because he was giving meds. He was asked again and he said no he did not. He went into her bedroom to give her her medication and that is the only time. Ms North asked him why would the resident make up this allegation and the claimant replied: she has got dementia, they were short-staffed, there was no time to work on the floor; Rachel went up, and he does not give personal care to any female alone. He had prevented the previous week two male members of staff showering a resident who was female and he asked Rachel to help but she was not qualified. The claimant argued this showed he was acutely sensitive to the privacy of female residents.

41. Louise Douglas was sent to interview Rachel B after this meeting on 13 December. Rachel Brennan confirmed that she put her notes in herself and would only really go and discuss with the Registered Nurse anything unusual which happened. She confirmed she had never seen the claimant giving personal care to any of the residents. She confirmed the showering incident. She was asked whether Jose could be mistaken for a "big black man" and she thought not.

42. Jose was also interviewed. He agreed he had given personal care and could not remember whether Rachel was present or not. He would report unusual matters to the nurse. He confirmed he had not seen the claimant doing personal care, he only does medication, which was about 7.00am. He was asked whether he thought he could be mistaken for the claimant and he said "no". He confirmed his ethnic origin was Filipino.

43. CCC was also interviewed and she was asked whether she had booked medication in which AH. She said she did, at about 4.00am. She was asked whether RB had come from the ground floor to cover for her and she said that she had.

44. Louise Douglas also met with the resident again on 17 December and asked her what had happened again regarding her complaint where she felt like she was thrown around the bed. She was asked if it had happened since and she said "no".

She was asked if she had seen the member of staff since and she said "no". She showed her pictures of two different men who were not staff members but one who was black Caribbean/African descent and one that was Filipino, and the resident had pointed to the Caribbean/African descent individual (who was Idris Elba) as similar to the person who had treated her roughly.

45. The claimant was invited back on 21 December with his union representative to advise on the further investigations. Louise Douglas confirmed that they had looked into whether the resident could have got mixed up between the claimant and Jose; she explained how this was determined and that the resident had confirmed that the Idris Elba picture resembled the man she was making the allegation against: the picture of a Filipino man was not. It was pointed out that was on 17 December, sometime after the first allegation. The claimant suggested that they should take into account the fact that the resident had dementia and if she had prejudice in mind against a coloured person that she would still repeat that. He pointed out that it was said by CH that he often changed the pad and washed her regularly, but now it was said to be only once. Ms North set aside the intimate personal care matter and confirmed that they had eliminated that it was not Jose. Also, the individual said they had not seen the perpetrator since 7 November, for which period the claimant had been suspended whereas Jose N had not been. Mrs North also pointed out that he had said he had repositioned the lady and the claimant repeated that this is what he normally wrote.

46. The claimant said that if Jose and Rachel had changed the pad it is possible that that is when the rough handling took. Ms North stated that if he was still maintaining that he had put assumed information into the claimant's file he was falsifying documents. The claimant said it was a common practice to write in what was standard to do on a night shift.

47. Ms North emphasised that the lady was very consistent. The claimant repeated that both RB and Jose had never seen him change a resident and he never did personal care with a female. Ms North said she was not discussing that. She also pointed out that he was considerably taller than Jose and more likely to fir the description of tall black man. He finally said that it was not him that was changing the pads and repositioning residents, it was the team. He had booked medications in, had written "slept well, repositioning pressure relief, diet and fluid tolerated," but he did not actually do these things. He stated that maybe it was a cultural difference and it was a way that things were written from his country and that English was not his primary language.

48. The claimant was again asked why the resident would make the allegation and he said, "because she was confused". Ms North persisted and said, "Well, she said that whoever it was had done it she had not seen since that date". The union representative said that everything had been said. The union representative stated it could be malice, it could be hallucinations, they were dealing with a potentially unreliable witness. There were three possibilities:

- That the claimant did it;

- Somebody else did it; or
- It did not happen.

49. The union representative submitted the most likely situation is that it did not happen, particularly as the claimant says he never did personal care and in fact JM and RB had changed CH's pad. This was a large element of CH's complaint and yet everybody agrees that the claimant would not have done this. The claimant was incredibly busy that day with the medication coming in and therefore it seemed extraordinary to imagine he would change the lady's pad and give her a roughing up whilst he did it when he was so busy. It was a major inconsistency that there was no record of the claimant changing the pad. There was corroboration that he never did personal care.

50. The RCN representative's notes stated that LN had been quite aggressive and hostile to the claimant and had retorted that he was falsifying documents if he was making entries for others. He noted that they made the following points:

(1) The witness is unreliable – no corroborative evidence;

(2) Three possible explanations – the most likely is that it did not happen;

(3) All witnesses say that AH does not do personal care;

(4) No reason to think AH would take into his head to go into the lady's room, change her pad and rough her up;

(5) Very busy night with new meds and nobody says they asked AH to help with personal care;

(6) Allegation includes change of pad but no mention of this in the record;

(7) AH often writes notes for the work of others;

(8) Management failed to ask witnesses whether they gave the information to AH to make the entry. General question only hence management evidence is flawed;

(9) Management failed to ask JM whether it was him;

(10) AH plainly honest and consistent in denial;

(11) Not in AH's nature to do such a thing;

(12) Allegation is that AH did not speak to resident – inconceivable would keep quiet for one minute.

51. On 27 December 2018 the respondent wrote to the claimant advising him that he was being dismissed, however it was not clear exactly what he was being dismissed for. The letter went through the events and the evidence gathering. The main paragraph relating to the dismissal was:

"As a company we place the utmost trust and confidence in the people that we employ and it is important that this trust is reciprocated by not only ourselves as a management team but also the company's regulators and internal stakeholders such as the Local Authority, the CQC and the resident relatives. You told me that your records were based on assumptions, that they were not factually accurate. If there is doubt in the honesty of your recordkeeping then this cast doubts on your actions of that evening and your honesty and credibility, and thus I believe you have severely breached the mutual trust and confidence between the company and yourself."

It is not clear how this falls within the allegation of gross negligence for the purposes of establishing a fair dismissal for misconduct.

52. The claimant's RCN representative appealed this on the grounds of:

(1) The sanction of dismissal was too harsh; and

(2) The allegation is based on a single allegation made by a resident with dementia. No corroborative evidence such as witnesses or injury identified to the resident.

53. The appeal was arranged for 30 January 2019 and the claimant's representative drew up a statement of case.

54. The relevant points made were that:

- there was no corroboration of the resident's account;
- there were no injuries;
- no consideration of the previous good character of AH, his unblemished record;
- no other resident has ever complained about AH;
- that the care staff on the shift on the night in question were not asked about the care they provided to the resident or how she appeared on their shift or the actual allegations;
- undue emphasis was placed on the claimant making a note that CH was repositioned in bed even though he explained why he had done this;
- the fact that the other carer said that AH never did personal care only medication was not taken into account;
- further, that there was bias during the investigation as Louise Douglas initially told the claimant he himself had been personally identified as the perpetrator when this was not true, which suggests that LD had jumped to conclusions that it was the claimant from the description;

- the fact that it could have been mistaken identity was not considered;
- JN and RB were not questioned carefully enough.
- It was identified that JN had provided care to the resident that night and personal care but that was not looked into in any detail. It was irrelevant to ask RB and JN whether they thought the claimant could be mistaken as JN, as JN would obviously say "no" as anyone would do, but that was used to bolster the case against the claimant;
- The respondent relied too heavily on CH repeating her allegations when this may simply be a symptom of her own, in effect, bias.

55. In this the claimant confirmed that he had only been in the room to give medication; he was too busy to do personal care and he "does not do it anyway with female residents". The claimant's union representative suggested that the resident could have been confused due to dementia and suggested that as the claimant was the last person she had seen that day before making the complaint when he had given her her medication she could have got confused. Why had the resident waited until 6 o/clock the next day when the carers who had looked after her during the day had not been interviewed? Neither had the two members of staff been questioned about the specific allegations. The claimant thought LD was biased against him. Again he stated that he had written up what he thought he had happened from the information he had got that evening rather than things he had done himself. He was asked about the fact that that only nurses can write up the care they personally provided or general observations, but carers put in their specific entries and a nurse cannot say something has happened unless they witness it. The claimant agreed with this. He also said that she was not the only one that he would put "repositioned" in for. His union representative said that it is likely Jose had changed the pad and he had never been asked about that. Jenny Delic said that the claimant did not witness matters in the notes as if he had done it self.

56. The claimant also raised that he thought LD was annoyed with him for trying to swap shifts. The claimant stated that he thought after six years' service with no phoning in sick that the respondent would have considered more what he had to say, and the RCN representative also pointed out that when CH was asked whether she had seen the perpetrator again she had said "no", but Jose had actually been moved upstairs so she would not have seen Jose either.

57. Ms Delic interviewed RB again. RB was asked what she remembered about the evening of 6 December but she said it was a long time ago. She said it was a busy night and she was working with JN. They were together. She thought that Jose had asked her to go to CH but she was not sure, it was such a long time ago. She was asked whether she would have made a note on the care plan if she had, and she said yes, she would. She stated that the male nurse when it was quiet kept coming in and out of the lounge and speaking to her and Jose about different things. Jose went for a break and then it was only RB and the nurse. She could not remember anything else. She said she was moved to a different floor and had not

worked with Jose since. RB said that she was aware that CH did not need to be repositioned.

58. I note that in her witness statement Ms Delic says that RB confirmed that CH had said a male had thrown her around the bed, however this was something RB had heard but not necessarily directly from CH at all. In addition to the tribunal Ms Delic said she had interviewed LD but there were no notes of that.

59. Ms Delic agreed that the claimant's dismissal should stand. She stated the reason for this was the reasonable belief that CH's allegations were on the balance of probabilities true and not fabricated. This was on the basis that:

(1) CH's evidence was clear and consistent.

(2) That the claimant had written CH was repositioned in bed. Ms Delic did not accept that the claimant had written this on an assumption that somebody else had done this, rather she was satisfied that the claimant did reposition CH.

(3) She was satisfied there was no racial bias or discrimination in the process. The perpetrator was described as a black male on a number of occasions and she was satisfied with the way in which he was distinguished from JN.

(4) There was a lot of corroboration between the different accounts given by CH to form a reasonable belief that CH's account was credible.

(5) It was reasonable to conclude CH was not describing JN when making the allegation, even though JN did provide personal care.

(6) The disagreement with LD had not been raised before and there was nothing to suggest LD had acted improperly. She was satisfied there was no ill feeling on LD's part and it had no bearing on the decision to dismiss Mr Hussein.

60. Ms Delic stated she did not believe the decision to dismiss was too harsh because of the importance of caring for residents properly even in the light of the claimant's clean record, length of service, etc. She felt he could not be trusted to return to a position of care within the Home. She wrote to the claimant on 6 February setting out in full her reasons for upholding the decision to dismiss.

Respondent's Policies

61. In respect of recordkeeping the policy said:

"In line with best practice the daily report should reflect the care given in relation to areas that have been identified as requiring support and also reflect on the person themselves, how they have spent their day, what they have been occupied in, how they may be feeling or behaving, what health changes they are experiencing and what social interaction they have made. Any

general comments should be documented on the report accordingly and may include GP visits, contact with relatives and any change in a service user's health. Staff must always remember that all documentation must be detailed and appropriate as this evidence could be relied upon in a court of law.

The general rule for staff to remember is that if care has been delivered it must be documented accordingly otherwise it is impossible to prove therefore 'if it has not been written down, it has not happened'. It is equally important to document refusal of an individual to comply with care delivery."

62. The disciplinary policy included as gross misconduct fraud, attempted fraud or deliberate falsification of any document or company record.

63. Gross negligence included significant damage to the company or custom and property through negligence, and "gross negligence in carrying out your duties".

<u>LN's Cross Examination</u>

64. LN was asked whether CH's anxiety and depression could result in her being confused. She said it did not always result in this. She was therefore proffering an opinion based on clinical knowledge, but later on she would say that she was not in a position to make clinical judgment about such matters. She agreed that she had not had the CQC report when she made her decision. This had been filled in by LD and suggested multiple people involved. She said she thought this was just an error. She also said she did not think it was unusual for somebody to be roughly handled and not bruise.

65. LN accepted that the accounts varied that CH gave. She was asked whether if she had seen that report she would have sought out the other person referred to, the female, and stated she may have done. She agreed it was an error to say that the claimant had been named by CH when he had not: he had said from the start, and it was corroborated, that he did not provide personal care to residents. She agreed that she did not ask RB if she had ever seen the claimant provide personal care or whether the claimant had repositioned CH. Neither had the respondent explained that only the rough handling was to be pursued. She agreed that the respondent had not added any allegations regarding the claimant stating he had made notes of things he had not witnessed himself. She said she did not believe that he put a note in but had not done any repositioning himself.

66. LN was asked whether the inconsistencies meant that she should believe that it was less likely the claimant had done what he was accused of and replied, "but you can't rule it out". She was asked if that meant the claimant had to prove his innocence beyond reasonable doubt. She was asked whether she considered that the fact that CH was completely wrong about the personal care situation and the second person suggested that her evidence was unreliable. The respondent would again point to the fact that the claimant had pout "repositioning" in the note.

67. LN also made clear that she relied also on the fact that CH had made no other allegations against any other members of staff.

<u>JD's Cross Examination</u>

68. JD agreed she had not seen the reference to the CQC. It was pointed out this was the most contemporaneous document as it had to be put in within 24 hours and suggested that two people were involved. JD thought that it was not something that needed to be taken into account as it was to be separately addressed by the CQC. She said if she had seen it she would have said there was no-one of that description i.e. a large black lady working for them, and it was suggested that if that was correct then did it not undermine CH's narrative? JD also revealed that she had actually tried to see if there was a member of staff that met that identity but she did not mention this in her witness statement. No-one else was suspended in any event. JD said it was still the fact that she had described the claimant.

69. It was put to JD also that they had heavily relied on CH having made no previous allegations against members of staff, however the CQC form showed that she had made an allegation against another member of staff, and about which the respondent said that person did not exist. JD said she relied on the fact that CH was settled, lucid, not difficult or challenging normally. She said that the CQC referral made no difference to her, and she was asked did it not cast doubt on the claimant's allegations that she might have made up the allegations as here was an allegation against a second person and the respondent was saying that person did not exist. She said she did not have the full information.

70. It was put to her that the CPN's note just said "male" not "tall black male" Her response was LD had done specific interviews in order to establish more detail. JD said the main evidence was the entry on the system regarding the repositioning and the fact that the claimant was the only tall black man on duty that day.

71. In relation to the issue regarding failure to question Jose***,*** JD said she did not speak to him again although she had spoken to RB, because she could not get hold of him.

72. JD when questioned about the fact that the claimant did not perform personal care said, "we don't positively know that he didn't".

73. In respect of mitigation, JD said they had a zero tolerance policy towards any sort of abuse, however it was pointed out the claimant was not dismissed for abuse. She said nevertheless the respondent could not take the risk of it happening again.

74. JD agreed that she did not look into any medical evidence about what drugs CH was taking so as to assess whether or not it was possible that she could hallucinate as a side effect of her medication irrespective of the effects of dementia.

75. JD confirmed that she did not think the inconsistencies in CH's account, for example the second person that did not exist, undermined the credibility of the rest of her account.

76. It was also put to JD that other members of staff had put a similar entry to the entries the claimant had put in. JD said, "well WR wasn't accused of anything". It was pointed out the claimant had made a number of similar entries with other

patients. JD said if she believed that he had done that she would have dismissed him for falsifying documents. It was pointed out that WR and SA also appeared to have made similar entries (case summaries), so would they be dismissed too? She said yes. In respect of why she had upheld the dismissal JD said something had happened that night and CH was scared.

77. In relation to the claimant being dismissed for falsification of records, his representative pointed out that the definition in the respondent's policy was deliberate falsification of records.

The Law

Unfair Dismissal

78. Section 98 of the Employment Rights Act 1996 sets out the relevant law on unfair dismissal. It is for the employer to show the reason for dismissal, or the principal reason, and that the reason was a potentially fair reason falling within section 98(2). Conduct is a potentially fair reason for dismissal. In **Abernethy v Mott, Hay & Anderson [1974]** it was said that:

> "A reason for the dismissal of an employee is a set of facts known to the employer or it may be of beliefs held by him which caused him to dismiss the employee."

79. Once the employer has shown a potentially fair reason for dismissal a Tribunal must decide whether the employer acted reasonably or unreasonably in dismissing the claimant for that reason. Section 98(4) states that:

> "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 sufficient reason for dismissing the employee; and
>
> (b) shall be determined in accordance with equity and the substantial merits of the case."

80. In relation to a conduct dismissal **British Home Stores Limited v Burchell [1980] EAT** sets out the test to be applied where the reason relied on is conduct. This is:

(1) did the employer Did the employer genuinely believe the employee was guilty of the alleged misconduct?

(2) were there reasonable grounds on which to base that belief?

(3) was a reasonable investigation carried out?

81. In relation to a professional job subject to a regulatory body where a finding may effect the individual's ability to continue in their chosen career the employer must be particularly careful in its investigation and in reaching its conclusions **A vs B EAT (2003**) and **Salford Royal NHS Foundation Trust v Roldan CA (2010)**

82. In respect of deciding whether it was reasonable to dismiss **Iceland Frozen Foods Limited v Jones [1982] EAT** states that the function of the 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."

83. The Tribunal must not substitute its own view for the range of reasonable responses test.

84. In respect of procedure, the procedure must also be fair and the ACAS Code of Practice in relation to dismissals is the starting point as well as the respondent's own procedure. In **Sainsbury's PLC v Hitt [2003]** the court established that:

"The band of reasonable responses test also applies equally to whether the employer's standard of investigation into the suspected misconduct was reasonable."

85. In addition, the decision as to whether the dismissal was fair or unfair must include the appeal (**Taylor v OCS Group Limited [2006]** Court of Appeal). Either the appeal can remedy earlier defects or conversely a poor appeal can render an otherwise fair dismissal unfair.

<u>Polkey</u>

86. The House of Lords in a decision of **Polkey v A E Dayton Services Limited [1988]** decided that where a case is procedurally unfair a decision would still be of unfair dismissal even if there was a strong argument the procedural irregularity made no difference to the outcome unless the procedural irregularity would have been utterly useless of futile. Rather the question of the irregularity making no difference would be addressed in terms of remedy. This principle has also been extended to cases where dismissal is substantively unfair, although it is most likely to apply to procedural irregularity cases. The outcome can be that it would have made no difference and the claimant, although unfair dismissed, would be entitled to no compensation or the rectification of the problem would have resulted in a delay in the claimant being dismissed and therefore the claimant receives compensation for that delayed period.

<u>Contributory conduct</u>

87. The Tribunal must always consider whether it would be just and equitable to reduce the amount of the compensatory award pursuant to section 123(6) of the Employment Rights Act 1996, where an employee by blameworthy or culpable actions, caused or contributed to his dismissal. If the claimant did so do the Tribunal will have to assess by what proportion it would be just and equitable to reduce any

compensatory award, usually expressed in percentage terms. The three principles are:

(1) That the relevant action must be culpable or blameworthy;

(2) It must have actually caused or contributed to the dismissal; and

(3) It must be just and equitable to reduce the award by the proportionate specified.

88. These principles were set out in **Nelson v BBC No. 2 [1980]** Court of Appeal.

Submissions

<u>Claimant's Submission</u>

89. The claimant submitted that the respondent's witnesses were evasive, would not make concessions, constantly said they had enough evidence rather than looking at the totality of the evidence, concluded that something happened. The evidence was improperly weighed as no account was taken of the fact that CH was demonstrably wrong on some matters. JD had accepted that JN provided personal care to CH which made it less likely that the claimant had gone to CH's room, but she said, "we can't know he didn't do it", which is completely the wrong test.

90. The claimant was much more credible. He was prepared to make concessions and he was honest about his deficiencies regarding note taking from the start.

91. Regarding when he started employment, the list of employees when the respondent took over stated that he had begun work on 10 October 2012.

92. The respondent had on many occasions said that they could not have trust and confidence in the claimant, that is why he was dismissed. However, they had not advanced an SOSR case only a misconduct case.

93. Re reasonable belief and the deficiency of the investigation, the claimant identified as follows:

(1) The failure to assess the credibility of CH in the light of additional material;

(2) The failure to interview Jose properly and/or interview him again at the appeal stage;

(3) The failure to take into account how busy the claimant was with his medication;

(4) There was not a clear picture of exactly what CH said on each occasion;

(5) The respondent's position regarding the claimant's notes was inconsistent. In order to bolster their case in relation to CH they did not

accept that he had written in them matters that he assumed had taken place, but on the other hand said that this showed that he was not a credible witness;

(6) That the evidence showed that other nurses had made entries which were summaries of other summaries;

(7) They had failed to consider that CH had no evidence of any physical injuries. JD did not accept that this had any probative value whatsoever;

(8) Although it was said on a number of occasions that they were not clinicians, they were making clinical judgments, for example by deciding that the absence of injury was not unusual;

(9) The very salient fact that a second person had been identified by CH who had never been investigated or identified and now the respondent said did not exist had not been taken into account at all in assessing CH's credibility;

(10) Neither of the carers were asked whether they saw the claimant enter CH's room, nor were they asked whether they had been in CH's room directly or provided personal care directly. The fact that they both said that the claimant never provided personal care was not taken sufficiently into account;

(11) Further, mitigation was not considered at all.

(12) Regarding **Polkey** or contributory conduct, that the claimant could have been dismissed for incorrect notetaking. This would be outside the band of reasonable responses when clearly other employees at the claimant's level had done the same thing. It was clearly a matter for retraining and possibly a warning and would not be a matter for dismissal: it would be outside the range of reasonable responses.

Procedural issue:

(13) The claimant was told that he had been personally identified;

(14) The respondent had not undertaken an investigation;

(15) The witnesses were not asked salient questions.

Respondent's Submission

94. The respondent submitted that:

(1) The investigation and disciplinary process fell within the band of reasonable responses. CH had told her daughters and she had identified the person as a tall black man and she had repeated this on a number of occasions. The claimant was the only person on shift that night that met that description. The claimant understood what the allegation was.

(2) It was reasonable not to complete the investigation because of the claimant's failure to attend the meeting and the investigation had in fact been completed to a requisite standard by the time of the disciplinary hearing and/or the appeal/

(3) There was no reason why CH would make the allegation up and no evidence that she had a tendency to make up allegations or suffer from hallucinations.

(4) The entry in the record saying she had been repositioned was clearly corroborative evidence that the claimant had been in her room.

(5) CH had also said that she had not seen the perpetrator since the incident, which again was corroboration it was the claimant, who had been suspended.

(6) Whilst there was evidence Jose had given personal care that evening to CH, there was no evidence he had been rough with CH.

(7) The claimant could have been dismissed for his recordkeeping.

(8) It was clear that gross negligence is gross misconduct according to the respondent's policy.

(9) If proven the allegations clearly warrant dismissal given the vulnerability of the residents of the Home.

(10) The claimant's employment date was 20 September 2014. The claimant has not provided any bank statements prior to then to establish that he was continuously employed throughout that period. He was a bank worker employer sporadically until he entered into a regular contract on 20 September 2014. No continuous employment established.

95. The respondent submitted that any award should be reduced by 75% for contributory conduct in respect of his false entry in the note-keeping and secondly because he did not attend the investigatory meetings.

Claimant's Reply

96. The claimant replied as follows:

(1) CH had a condition of anxiety and depression so being frightened would arise from her condition.

(2) There was no evidence from the letter of dismissal that any mitigation such as length of service had been considered at the time.

(3) Obviously the claimant and other person working there had the opportunity to carry out rough handling of CH, but there was no intent or motive suggested in this case.

Conclusions

<u>BHS v Burchell</u>

97. I find the respondent does not meet the BHS v Burchell test on the following grounds:

(1) Investigation (leaving aside that the respondent did not complete an investigation stage) – the investigation was inadequate taking into account the investigations that were undertaken at the disciplinary hearing and appeal stage for the following reasons:

(a) No account was taken of the inconsistencies in CH's account, particularly as matters developed. Examples are that a second person was initially stated to be involved, again described as a black person. Also, that the perpetrator was someone who had undertaken personal care of the claimant, which all the evidence pointed to the claimant not doing; Further TK's record of what CH said had not referred to the alleged perpetrator being black.

(b) There were closed minds and bias, for example the respondent saying that the fact that RB and JN stated repeatedly that the claimant did not do personal care rather than being seen as corroborative of the claimant's position was stated as showing nothing of the sort as "it didn't mean he didn't do personal care", (Ms Delic) Further, both witnesses repeatedly said they did not make clinical judgments yet proceeded to when it suited them, for example that rough handling would not necessarily result in bruising.

(c) A failure to look into CH's medical history and medication to see whether hallucinations or imagining could be a side-effect of her medication or her condition, and the failure to consider whether the fact that she was frightened was due to her condition of anxiety.

(d) JN and RB was never asked direct questions about what they did on that night or what they might have observed the claimant doing that night, and therefore the investigation was inadequate on these grounds. JN was never asked if he had roughly handled CH or whether he had changed her pad that evening.

(e) LD also knew that another person had been identified by CH as being a perpetrator of bad treatment as she had filled in the CQC form yet she never mentioned this issue at any point. When she contacted HR for initial guidance she just referred to the matters which might have identified the claimant. She also said that CH had named the claimant when this was not true, in the absence of any evidence from her the only reason for doing this was either entrapment or bias.

(f) The fact CH said she had not seen the nurse since and that the claimant was suspended was unduly relied on as the respondent assumed and did not check whether Jose had still been working on the ward.

(2) Reasonable grounds –the respondent did not have reasonable grounds to believe the claimant was guilty of the misconduct that he was charged with for the following reasons

(a) Whilst I appreciate that it is facile and patronising to dismiss an account presented by someone with dementia, and that it is also of the utmost importance in a Care Home to protect vulnerable residents from abuse and exploitation, there were very many reasons why the evidence of CH was not credible – they are set out above but to reiterate the reference to changing her pads when all the evidence pointed to the claimant not doing this, the reference to a woman in her own statements and in more detail in the CQC form yet no woman was identified. The fact that there was some consistency in CH's account did not override the inconsistencies. The fact that CH had not made an allegation before is not determinative either. It was equally true that no allegation had been made against the claimant before.

(b) The main evidence against the claimant, in addition to CH's account, was the note he made which suggested he was in her room repositioning her. The respondent took a very inconsistent position on this. They accepted that CH did not need repositioning from her care plan but drew no conclusions from this. Were they to assume from this that the claimant deliberately entered the resident's room in order to cause her harm, in which case obviously he should not have been charged with gross negligence.

(c) Further, they did not accept the claimant's explanation that he was summarising the position on the basis of what he believed had been undertaken that evening yet wanted to have this both ways as they said it showed that the claimant was not credible as was prepared to put his name to an inaccurate record – yet relied on it as accurate to decide CH's allegations were accurate and he was the perpetrator.

(d) Neither did the respondent take into account that the claimant had a number of times put this type of summary on patient records, as had other nurses. They did not consider that the claimant was possibly guilty of complacency or that he was so busy he would cut and paste a summary to ensure that something had been recorded, which in his view was likely to be accurate even though he had not personally witnessed the events.

(3) Procedure – the respondent's procedure is deficient in that they did not hold an investigation stage. They made no enquiry as to why the claimant had not attended the second meeting before deciding to proceed to a disciplinary hearing. They made assumptions themselves on the basis that the claimant had been somewhat difficult about the first investigatory meeting, wanting to have his representative, and instead of making enquiries just assumed the claimant was continuing to be difficult.

(4) The reason for the claimant's dismissal was not clear at the dismissal stage.

(5) Other matters regarding the process are identified above which could also be seen as procedural deficiencies in the procedure.

<u>Polkey</u>

98. The respondent cannot rely on **Polkey** in respect of the inadequacies in their investigation as it is not the case that those inadequacies made no difference to the outcome: they made all the difference to the outcome.

99. Regarding whether the claimant would have been fairly dismissed for his failure to properly record keep, they knew about this before the claimant was dismissed and of course could have pursued it then but it would have been inconsistent as they relied on the records being accurate to substantiate their finding on the original charge.

100. Considering as a **Polkey** issue I do not make a reduction on this basis of the following considerations.

101. JD's assertion in cross examination that she would have dismissed the claimant for this and any other nurse found to be doing the same thing, as it was evidenced other nurses were doing the same thing, I find unacceptable. It is highly unlikely that if she had discovered that several nurses were doing this that she would have dismissed all of them, not just because the respondent was in need of nurses but because it is a tenet of employment law that where several employees are making the same mistake the likely explanation is that the respondent has not made clear what is the correct way of behaving, and accordingly it is far more likely that they would have received at most a warning and retraining rather than dismissal because it was not something that could be regarded as gross misconduct as it was not deliberately falsifying records but taking a shortcut which appeared to be deemed acceptable.

<u>Contributory Conduct</u>

102. However, the claimant has contributed to his dismissal by the record he made that night regarding the repositioning and if he had made a more faithful record there would have been less evidence against him and therefore the chances of the respondent proceeding would have been proportionately less.

103. Accordingly, I find that any award should be reduced by 20% to reflect his contributory conduct.

Employment Judge Feeney

Date: 12 November 2019

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON

19 November 2019

FOR THE TRIBUNAL OFFICE

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