EMPLOYMENT TRIBUNALS

Claimants: (1) Mrs J Clark
(2) Mrs C Ingham

Respondent: Liverpool & Broadgreen University Hospitals NHS Trust

Heard at: Liverpool **On:** 9, 10 and 11 December 2019 and 17 January 2020 (in chambers)

Before: Employment Judge Benson

REPRESENTATION:

Claimant: Mr M Mensah, Counsel
Respondent: Ms J Ferrario, Counsel

JUDGMENT

The judgment of the Tribunal is that:

1. The claimant Mrs Ingham was unfairly dismissed.

2. The respondent breached the contracts of employment of both claimants by dismissing them without notice.

REASONS

Claims and Issues

1. The claims brought by Mrs Ingham are of unfair dismissal and breach of contract in respect of her notice period. Mrs Clark's claim is one of breach of contract only. The issues were identified and agreed with the parties' representatives at the outset of the hearing.

Evidence and Submissions

2. The Tribunal heard evidence from the claimants, Mrs Ingham and Mrs Clark. The respondent called Ms M Dewhurst, the Chair of the Disciplinary Panel, Mrs J Stamper, the Chair of the Appeal Panel and Ms M Brown, acting Matron. I was referred to an agreed bundle of documents and both Mr Mensah and Mrs Ferrario, provided written and oral submissions.

3. I have made my findings of fact based upon the evidence I have heard and the documents to which I have been referred. I have not explained my reasoning where the facts are not in dispute or where there has been no credible challenge.

Findings of Fact

4. Mrs Ingham and Mrs Clark were employees of the Royal Liverpool and Broadgreen University Hospitals NHS Trust until they were dismissed without notice by reason of misconduct on 7 August 2018. The allegations found proved against them were wilful neglect of patients and causing injury through serious negligence. Mrs Ingham commenced employment on 1 June 2005. Mrs Clark was employed by the respondent for some 15 years and then decided to take her pension and return. As such her employment commenced on 1 December 2015 for the purposes of this Tribunal.

5. Both claimants worked as Healthcare Assistants ('HCAs') on Ward 5X at the Royal Liverpool Hospital. They had worked regularly on that ward for a number of years and were experienced HCAs. The ward was normally staffed by two Registered Nurses and two HCAs. One of the Registered Nurses was the nurse in charge.

6. The respondent had a number of policies which were contained on their intranet. One of those policies related to close supervision of patients known as the Close Observation Policy.

7. There was no formal policy written or otherwise in relation to the taking of breaks at the date of the incident which led to the claimants' dismissals. A new policy was introduced shortly afterwards. No minutes of any staff meeting in which staff where told to notify the nurse in charge if they were to leave the ward were produced to the Tribunal.

8. Mrs Clark and Mrs Ingham normally worked on the night shift, being 7.30pm to 8.00am.

9. On 2 March 2018, a patient fell out of his bed. On that night there were four HCAs on duty and two nurses.

10. On 3 March 2018, both claimants attended for work. Although Mrs Clark attended the handover session at the start of the shift, Mrs Ingham was not present. At that handover session, the nurse in charge advised those present that on that evening there were six HCAs and two nurses as there were a number of the patients on the ward who required close observation. Close observation required that a staff member had the patient in sight should any issues arise. The patients that required close supervision comprised three patients in Bay 8, one patient in Bay 9 and one

patient in Bay 7. Mrs Ingham volunteered to look after the three patients in Bay 8 and Jill Caulfield, an HCA who was a regular bank employee on the ward, was asked to supervise the patient in Bay 9. Maria Thomas was not responsible for any close observation patients but had patients in Bay 6 who were confused and so allocated herself to that bay, once she had carried out other duties.

11. A patient in Bay 8 who was under close observation fell out of his bed. At the time of the fall Mrs Ingham and her colleague Mrs Clark were not present on the ward as they had left the ward to go on a cigarette break. They had not advised the nurse in charge that they had left the ward. They returned to find the patient had fallen. They cleaned him and assisted in putting him back into bed. A nurse practitioner was called. That nurse then attended the ward and assessed the patient. Following that initial assessment, a doctor was called. When the doctor attended the ward, the patient was assessed and an x ray was booked. The patient was then taken for an x ray which confirmed that he had broken the neck of his femur. When he returned to the Ward, he was settled back into bed.

12. The claimants continued working the remainder of their shift that night and worked their normal shifts (subject to holidays) thereafter.

13. On 12 March both claimants were suspended. They provided a brief summary of the events of 3 March to Maria Brown, the Ward Manager. No statement of these conversations has been provided. The letters sent to them confirming their suspension stated that allegations which were being investigated were that they had left the ward on an unallocated break without informing the nurse in charge. In doing this they had left a Bay unattended which contained a number of patients who required close supervision at all times.

14. The claimants remained suspended for almost five months until their dismissals on 7 August 2018.

15. Some staff, but not all who were on duty that evening provided statements relating to the internal (as opposed to the disciplinary) investigation into the fall.

Investigation

16. On 3 May the claimants each received a letter from a Ms Murphy confirming that she had been appointed to investigate the incident on 3 March 2018, specifically that:

a. they may have failed to follow Trust policy in relation to ill treatment or wilful neglect of patients;

b. they may have committed actions which were in breach of contractual terms of employment therefore causing loss, damage or injury through serious negligence.

17. As part of her investigation Ms Murphy spoke to other staff who were on duty that night on the dates indicated in brackets. These were Maria Thomas an HCA (10 April); Elizabeth Ofori-Kumah the nurse in charge (10 April); Sean Kenny, a staff nurse (25 May); Jill Caulfield, a bank HCA (2 May); Maria Brown, the Ward Manager

(16 May) and Elizabeth Wall, a bank HCA (16 May). On 14 May Ms Murphy met with the claimants who provided their version of the events.

Authorisation of Breaks generally

18. Ms Ofori-Kumah, the Nurse in charge advised that she had previously told the claimants not to go on breaks together but that they still did this. She had raised this with Maria Brown. She also said that Mrs Ingham and Mrs Clark did not tell her when they were going on a break. She said that she would ask staff if they had sorted out their breaks and that they didn't always get a break and sometimes they had multiple breaks.

19. Maria Brown was asked about the arrangements for taking breaks. Mrs Brown confirmed that night shifts worked differently from day shifts. She had never spoken to the claimants about going out for unofficial breaks. The nurse in charge had approached her about the claimants going for breaks without telling her and although she had raised this with staff in the safety huddle which took place at the beginning of the night, that might not have reached the claimants because at the time it was held they were never present. She felt that the structure of breaks needed sorting out.

20. Maria Thomas confirmed that she didn't take her hour break all at once but would go out three times during the shift for a smoke. When she took a break, she would always inform the nurse in charge if she was leaving the ward. She said that the claimants sometimes didn't take a break.

21. Mr Kenny explained that the HCAs usually discussed breaks between themselves and agreed when to go. Although this was an informal arrangement, they usually asked the nurse in charge if they took informal breaks.

22. Ms Caulfield confirmed that if the nurses are busy the HCAs would sort out their own breaks and that smoking breaks were not common. When asked about breaks, Elizabeth Wall confirmed that they would normally start at 1am and that sometimes the nurses allocated breaks.

What was agreed about breaks that night?

23. Ms Ofori-Kumah had along with other staff, provided a statement a week or so after the patient's fall. In her statement she stated that the claimants had gone off the ward leaving the Bay unattended without informing any trained staff and had asked the Bay 9 HCA to watch Bay 8. Neither Sean Kenny nor Ms Ofori-Kumah had been advised by the claimants that they were leaving the ward for a break. Ms Caulfield stated that the HCAs had discussed breaks but agreed that it would be impossible to take breaks as the ward wasn't sufficiently staffed and instead they would have a quick bite to eat outside the bays. In her interview with Ms Murphy on 2 May 2018 she said that no-one had a break and they had no-one to cover. Ms Wall said she didn't know that the two claimants had left the ward that evening. Maria Thomas wasn't asked.

What time did the claimants go on their break?

24. Ms Caulfield wasn't sure on the timings of that night. Ms Wall was of the view that on 3 March the claimants may have been off the ward for 5-10 minutes.

What time did the fall occur?

25. In answer to questions raised by Ms Murphy, Maria Thomas confirmed that the patient had fallen at approximately midnight. Ms Ofori-Kumah said that the incident occurred just before midnight. Sean Kenny also said that the incident had happened at midnight. Ms Caulfield recalled that the incident had happened later in the night though she was unclear when. According to Ms Murphy, she later said 1.30am. Ms Wall confirmed that she put the time of the fall at around 11pm but that it could have been later.

Who was responsible for the patient when he fell?

26. Ms Caulfield had provided an earlier statement which described the incident. In that statement she gave her version of the events of that night. She was carrying out close supervision of Bay 9 when Mrs Ingham had asked if she could watch Bay 8 while she went for a quick 5 minutes for a cigarette. She agreed to this as her patient was asleep in Bay 9 and all of Bay 8 were asleep. Ms Caulfield assumed Mrs Clark was going to cover her bay. While she was hovering between the two rooms the buzzer in room 9 went off. As no one else was available, she went to answer it. Shortly after that she heard a bang and she and others ran to Bay 8 and found the patient had fallen. She accepted blame for the incident as she considered she should not have left the room.

Remorse

27. Mrs Brown confirmed during her interview that she had met with the claimants and that they were remorseful.

<u>Claimants' investigatory meetings</u>

28. The claimants attended meetings with Ms Murphy on 14 May at which they gave their version of the events of 3 March. This was the first time the claimants' version of events was recorded. At this stage they had not seen the statements of the other staff.

29. Mrs Ingham confirmed that on that evening, after she had finished with a patient at about 10am, she had handed over her close observation patients to another HCA who was covering room 9, and she and Mrs Clark had gone for a smoke break. In answer to Ms Murphy's questions she confirmed that she rarely took her one-hour break in one go and instead would take 3-4 short breaks during the night. The nurse in charge would tell the HCAs to sort out their breaks themselves and that with the number of staff on the ward that night she wouldn't ask the nurse in charge whether she could go. She considered it was safe to leave the patients. She confirmed that had never been spoken to about unofficial breaks and had never read the minutes from the ward meetings (which she didn't attend).

30. During Mrs Clark's meeting with Ms Murphy, she confirmed that she was not allocated any patients for close observation that evening and after the handover, carried out the ward round, dealing with any changes and serving teas and coffees.

There were four HCAs who smoked and at around 10.30 to 10.45 she and Mrs Ingham went out and the other two HCAs went next. When she came back the patient had fallen. He was put back into bed and the doctor came to see him. In answer as to questions by Ms Murphy, she confirmed that there was another HCA outside room 8 but that she didn't think she was looking after anyone in that bay, though there was a patient who would come to sit outside who may have been with the HCA.

31. She said that she and Mrs Ingham hadn't been off the ward prior to the smoke break and the five HCAs had discussed their breaks and the other HCAs knew where they had gone. She was asked about telling the nurse in charge if they went on a break. She explained that if it was busy they would inform the other HCAs and that nurses and HCAs are very separate. If it was quiet sometimes they would speak to the nurses. She had not been spoken to before about leaving the ward for cigarette breaks and that when they went for their break, in her view the ward was left safe. Mrs Clark later added some points of clarification that the nurse in charge would tell staff to sort out breaks amongst themselves and that the HCAs would judge whether it was OK to go on a break depending on how many staff there were to cover and that they would never leave patients unsupervised.

32. Mrs Ingham received the notes of her meeting on 23 June. She wrote to Ms Murphy with a statement of what she says happened. In it she referred to not being sure of the time the patient fell, but that after they had got the patient settled, the other staff went for their cigarette break and then after that she and Mrs Clark went out to get a pizza for them and the staff.

Investigatory Report

33. Ms Murphy produced an investigatory report which found there was a case to answer.

34. On 16 July 2018, the claimants were notified that the investigation had found that they had allegedly breached Trust Policy rules in that they:

a. may have failed to follow Trust policy in relation to ill treatment or wilful neglect of patients;

b. may have committed actions which are in breach of contractual terms of employment therefore causing loss, damage or injury through serious negligence.

35. On 27 July 2018 they were invited to disciplinary hearings to take place on 7 August 2018 and provided with a copy of the investigatory report and appendices. They were warned that their employment could be terminated. Within that report, the claimants saw what their colleagues said about the incident and the time which they said the patient had fallen. Further that Ms Murphy's view was that the patient had fallen at approximately midnight.

36. In that report Ms Murphy highlighted that there were inconsistencies between the witnesses concerning the time at which the incident had occurred. Ms Murphy stated that the patient had fallen at midnight and that this was supported by PENS

entries and the ICE x-ray referrals. These were internal Trust documents. They were not enclosed with the investigation report. Other witnesses, specifically the claimants and Ms Caulfield disagreed on these timings.

37. The report further highlighted that as the claimants had said they had their breaks for about 10 mins between 10.30 and 11.00pm, but they had returned after the break to find the patient had fallen (which Ms Murphy said was at midnight), it was unclear how long they had been away from the ward. She referred to the claimants going out to get Pizza for everyone, and that Mrs Clark became confused as to where they were when the patient fell.

38. Ms Murphy concluded with Mitigating and Aggravating factors as set out in her report. These included as mitigation:

a. That neither of the claimants had been spoken to directly before about informing the nurse in charge when leaving the ward.

b. That there was no structure to breaks on the ward on night duty.

c. That both claimants had advised a bank HCA that they were going on a break, but the HCA said this was at 1.30am.

d. That Mrs Ingham never normally informed the nurse in charge when going for a break.

39. And as aggravating factors:

a. Ward minutes are available for all staff to read including information about breaks.

b. That Mrs Ingham didn't attend the morning 'safety huddles' because she leaves her shift early.

c. That the claimants left the ward at between 10.30 and 11pm and the patient fell at approximately midnight.

d. That the nurses and other HCAs, other than Ms Caulfield did not know that they had left the ward.

e. That Ms Clark was the only person who said they had got together to organise breaks.

f. That only the claimants mention that they went off the ward to get Pizza for everyone and that everyone else said no-one had been off the ward before the claimants left for their break.

g. That Mrs Ingham changed her statement part way through, in relation to which of the HCAs she had asked to cover the room.

h. That the claimants had at least 3 unofficial breaks during the night shift.

40. She concluded with her findings that the claimants did not inform the nurse in charge that they were leaving the ward. That Mrs Ingham did ask a Bank HCA to cover Bay 8, however this was not reasonable as she was already covering Bay 9 and this was also not following the ward process which was to ask the nurse in charge. She stated that there was conflicting evidence which was due to there being multiple breaks and staff members being unsure during which break the patient actually fell and fractured his hip. There was however no doubt that the claimants had left the ward without authorisation. Further that there was no structure to breaks on the ward during night shifts.

41. The issue as she saw it was that the claimants did not inform or seek permission from the nurse in charge when leaving the ward for breaks (either official or unofficial). As a result, a patient fell while left unattended and broke his hip which could have been avoided if they had asked permission and appropriate cover had been provided.

42. Both investigatory reports made more general recommendations going forward, including:

a. Breaks to be structured on the Ward i.e. allocated by the nurse in charge

b. Break allowance to be explained to all staff

c. All staff to report to the nurse in charge when leaving and returning to the ward

d. All staff to have a full handover before commencing their shift.

Disciplinary Hearing - Mrs Ingham

43. A disciplinary hearing took place on 7 August with Mrs Ingham. The panel was chaired by Marie Dewhurst.

44. Mrs Ingham was very upset as she considered that what had been said by her colleagues was not true. She told the panel that all the HCAs had discussed breaks outside Room 8 before she and Mrs Clark went on their break at 10.30pm to 10.45pm and that the other two smokers had then gone on theirs. She accepted that she should not have left her colleague to observe two rooms. She confirmed that she hadn't seen the minutes of the ward meetings in which staff had been reminded about telling the nurse in charge if they left the ward.

45. Mrs Ingham's representative questioned the time of the fall and asked Ms Murphy what she had looked at on the PENs system to check the time. Ms Murphy confirmed that she had looked at the timelines to cross check. She said that PENS confirmed that they were bleeped at midnight and they attended straight after they were bleeped. Mrs Ingham stressed that she was not lying as her break was from 10.30 to 10.45. She confirmed that she knew her break was at that time as when they had gone out again, this time for Pizzas, that was later in the evening. She knew this as the Pizza shop closed at midnight and they were there as it was about to close. Ms Murphy confirmed that she had difficulties with the timelines and that the PENs and the X-ray were the only things to go by. She said the PENS showed the referral was made at 12.15am and the x ray completed at 1.30am.

46. Mrs Ingham told the panel that both nurses knew that they were going out to get a pizza and they had no objection. Further that the doctor and one of the staff nurses had some of it to eat. She confirmed that the nurse in charge had not spoken to her about not going out for a break without informing her. Mrs Ingham reiterated that her time line was correct and that the other staff were trying to cover themselves.

47. After an adjournment of 15 minutes the claimant was dismissed for ill treatment or wilful neglect of a patient and causing loss damage or injury through serious negligence. Ms Dewhurst found the allegations proved and further considered that the claimant had shown no insight or remorse.

Disciplinary Hearing - Mrs Clark

48. Mrs Clark's disciplinary hearing took place immediately after Mrs Ingham's before the same panel. Her investigatory report was a template of Mrs Ingham's including irrelevant references to Mrs Ingham's case.

49. In Mrs Clark's disciplinary hearing, Mrs Clark's representative again asked whether the PENS entries correlated with the fall. Ms Murphy confirmed that she had looked back at the record and it confirmed the fall at approximately 12.00am followed by 12.15 referral for x-ray and that it was all documented around midnight. Mrs Clark was adamant that she had not told any lies and that she had not just walked off the ward as the 5 HCAs had stood together and agreed when they would all take their breaks. Four of them were smokers and they were all aware that Mrs Clark and Mrs Ingham had gone to take their break. She confirmed that she, Mrs Ingham, Maria Thomas had all discussed with Ms Caulfield who would watch Room 9. Mrs Ingham and Mrs Clark were to go for a smoke first, followed by Ms Caulfield and Maria Thomas.

50. Mrs Clark said that when she left, she had no concerns about the safety of the patients or the ward. She had been on duty on previous nights and knew the patients. The patient in Bay 9 was in his room and she had understood from the handover, that the reason for his observation was that he might walk off the ward, but the end of the ward was blocked off so she knew that couldn't happen. She was adamant that the time they went on their break was between 10.30pm and 11.00pm for approximately 15 minutes. She said that everyone knew that they had gone to collect a Pizza later in the evening. She said that the nurse practitioners and the doctor had also come to the ward but she wasn't sure what time.

51. Mrs Clark said that she deeply regretted what had happened to the patient, and could not work out why the statements said different times. She accepted that she had not asked the nurse in charge if she could go for her break on that occasion, but that the nurse would know that they were going if they referred to going out for 'fresh air'. She said that 9 times out of 10 she would tell the nurse in charge. When she was asked if the nurse in charge had ever told her not to leave, she said that in the past, she had been told 'not to go yet'. She denied that she had been told that two staff could not go on a break together. On 3 March she considered that, with the number of HCAs on duty, she did not leave the ward unsafe.

52. After a short adjournment of 10 minutes or so, Mrs Clark was also dismissed without notice on the grounds of wilful neglect.

53. Letters confirming the claimants' dismissals were sent dated 17 August 2018. They summarised the findings of the investigation being that:

a. They left the ward without authorisation from the nurse in charge. This subsequently left patients who were receiving close observations unattended and resulted in a patient falling and causing injury to themselves.

b. There was evidence to suggest that there were several unofficial cigarette breaks taken on the night in question without the nurse being notified and without regard to the safety of the patients.

c. The incident could have been avoided as there was adequate staffing on the ward in the night in question.

d. In relation to Mrs Ingham only, she had asked a bank HCA who was providing close observations in a neighbouring bay to look after the bay of patients that Mrs Ingham was observing whilst she left the ward on an unauthorised break.

54. Mrs Dewhurst noted that Mrs Ingham acknowledged she should not have left the bank HCA observing two bays and that there was a dispute in that the other HCA said she did not know that Mrs Ingham and Mrs Clark had left for a break.

55. Mrs Dewhurst felt that neither Mrs Ingham nor Mrs Clark had any insight into the seriousness of their actions and further that in Mrs Inghams' case there was no evidence of remorse or acceptance that her actions resulted in patient harm. She considered that it was no defence that breaks had been taken in that way on the ward for a number of years and that could not excuse their actions, and finally that the incident could have been avoided as there was sufficient staffing on shift to ensure close observations be accommodated without risk to patients.

56. She considered that their actions amounted to gross misconduct under the Trust's disciplinary rules being: ill-treatment or wilful neglect of patients; and causing loss, damage or injury through serious negligence.

Grounds of appeal

57. Mrs Ingham and Mrs Clark appealed against this decision by letters of 23rd August. Their letters were similar and the grounds of appeal included that: the investigation was flawed and did not follow the trust policies; there was no leadership structure and as such ad hoc processes had been employed by support staff due to the lack of direction from senior members of the ward team; and they did not fail to follow lawful instructions as they were never given any. Finally, both drew the appeal officer's attention to their exemplary disciplinary records which they said had not been considered.

58. Mrs Ingham and Mrs Clark also set out further grounds of appeal in correspondence of 4 September 2018. They drew the panel's attention to; minimal

training; the acknowledgement that witness statements were conflicting in and around the question of breaks, including that Mr Kenny highlighted the informal approach taken on the ward in relation to this and his reporting about the degree of uncertainty. Further, that the investigating officer was suggesting that breaks were taken in a fraudulent manner and there was no evidence of this; that there was nothing which related the patient's fall to the wilful neglect by the claimants, and had that been the case they would have expected a report to the police; that they had never maliciously or knowingly neglected the service user; that the nursing observation policy was not contained within the investigator's report, which suggested a lack of transparency; that the minutes of ward meetings were not emailed to the claimants and that they were not advised of changes in ward procedures; that the investigating officer failed to ask about the location of each member of staff and that the investigation on the face of it related to different times and opinions in relation to the incident with no clarity. Further that Mrs Ingham was very remorseful.

Appeal Hearings

59. Meetings took place on 29 October 2018 before a panel chaired by Mrs Stamper, the Deputy Director of Nursing and Assistant Chief Nurse for Scheduled Care.

60. A management statement of case was produced and presented by Marie Dewhurst. It gave the management's view upon the grounds of appeal. It included the following points:

a. that the claimants' exemplary employment records were irrelevant and not pertinent to the details of the case and that the panel's duty was to review the findings of the investigation and not to judge character:

b. that the claimants were experienced HCAs and aware of their responsibilities.

c. it was accepted that there was some informality on the night shift, but there was still an expectation that the nurse in charge would be notified when an HCA was leaving the ward.

d. it was also accepted that on 3 March there appeared to have been a group decision amongst the HCAs about breaks. Mrs Dewhurst however referred to Ms Caulfield's statement that it would be impossible to take breaks that evening and keep the ward sufficiently staffed.

e. that the minutes of the meetings which Mrs Ingham and Mrs Clark did not attend, should have been read by them and criticises them for not attending the safety huddles.

f. that key to the decision to dismiss was the decision on how and when the breaks were taken.

g. that it was not within the remit of the panel to relate the patient's fall to wilful neglect as a reason for their dismissal;

h. that she considered that there was no recognition by the claimants that leaving the Ward 3 or 4 times a night for a cigarette break was wrong;

i. that the panel felt that if the claimants were to return to duty this was a behaviour which would be repeated.

j. Further the report noted that Mrs Ingham's version in her statement indicated that her break was at 10.30, however as the patient fell at 12 midnight and was on the floor when they returned, this amounted to an inconsistency. It also questioned how long she was actually away from the ward and said that the panel considered that she was off the ward for longer than 10 minutes.

k. It also noted that Ms Ingham insisted that the patient must have fallen between 10.30 and 10.45 when they returned from their unofficial cigarette break but that she had left to get the pizza at 11.30.

61. The report then summarised the Disciplinary Panel's points in their decision to dismiss:

a. the story presented by Mrs Ingham and Ms Clark was inconsistent with regard to timelines and details to those provided by the rest of the staff.

b. Mrs Ingham had admitted that she left the Ward 3 or four times per night for a cigarette break. The panel felt that there was a significant lack of insight into how this might impact on patient care. It suggests leaving the ward was a frequent occurrence which gave cause for concern.

c. going out for a pizza was potentially an attempt to cover up how long the claimants had been absent from the ward.

d. While the organising of breaks on the ward was flagged as a potential cause for concern, the panel did not feel that this was significant.

e. Staff frequently sorted out their own breaks; however, they would always do this by keeping the safety of the patients in mind. By leaving the bay unattended the claimants' in their view would have been fully aware of the potential consequences.

f. that Mrs Ingham had changed her statement part way through the interview. She initially said she asked someone working the floor to cover her roommate, then when questioned during the same interview about this she changed this to asking the person looking after Bay 9.

62. This report was provided to the claimants and the appeal panel. Mrs Ingham made further comments in a letter dated 24 October. She accepted that she should have told the nurse in charge but that they didn't that night because the nurse knew how they took their breaks. She said that not everyone told the nurses in charge because they tell the HCAs to sort it out amongst themselves. She denied taking any unofficial breaks. She pointed out that there were other documents which would assist the panel such as the patient's notes and questioned whether the other staff's statements were properly looked into.

63. During the hearing Mrs Ingham suggested that the other staff were covering their backs because they were not telling the truth about the breaks and the time of the patient's fall. She said that she was sorry that she hadn't told the nurse in charge and felt that because there were 6 HCAs on duty that night, that did make a difference. It also meant that it was permissible for two to go out at once.

64. She said that the patient in Room 9 often sat with her, and did not really need to be under close supervision as he would normally sit with the HCA. She raised the fact that others went for as many breaks and she accepted that she had made a mistake. She also raised that she had been sent out to buy Pizza by colleagues after the incident. When Mrs Stamper asked why this was relevant, she said her colleagues had said the fall had happened at that time, the nurse in charge and others knew where she was. She did however reaffirm that the fall had happened between 10.30 and 10.45. Mrs Stamper asked whether she had arranged a handover meeting and the claimant said she didn't but provided the explanation that he was a 'special' i.e. under close supervision.

65. The decision to dismiss Mrs Ingham was upheld. The Appeal Panel's reasoning was not detailed in Mrs Stamper's outcome letter but it is set out in her witness statement and in her evidence to the Tribunal.

66. She states that Mrs Ingham's position on the time when the incident took place is unclear and refers to the confusion regarding the relevance of the Pizza purchase, saying that the Mrs Ingham had tried to 'backtrack'. She considered that claimant's evidence did not correlate with the evidence gathered in the investigation, in that the medical records provided that the fall was around midnight because the patient was referred at 12.15am and was taken for an x ray at 1.30.

67. In cross examination, it was put to Mrs Stamper that the evidence about the time of the fall, which had now been provided to the Tribunal by Maria Brown, was accurate.

68. During her cross examination, Mrs Brown, having worked through the timings, considered that it was approximately an hour to an hour and a half after the fall before the x ray request (which from the records was at 00.27) would have been made. Mrs Brown had explained that the PENS times were the entries from the medical staff not the time that the patient fell. Mrs Stamper agreed with Mrs Brown's view on the time of the fall and said that she thought that Mrs Ingham and Mrs Clark were correct in their timings. Although Mrs Stamper says that this was her position at the time she made the decision to uphold the appeal, I find that unlikely based upon the outcome letter and appeal notes and indeed what she says in her witness statement. She did not seek to clarify the timing issues by way of further investigations as part of the appeal.

69. Mrs Stamper was of the view that the staff would tell the person in charge before taking a break, even a toilet break. She found Mrs Ingham's evidence on this contradictory and noted that Mrs Ingham had apologised.

70. She was concerned by Mrs Ingham's suggestion that the person in the adjoining Bay 9 didn't really need close supervision. She considered that this was

not Mrs Ingham's decision to make. She had asked Ms Caulfield to look after both Bays without the necessary supervision.

71. Taking these points into account, the panel concluded that on 3 March Mrs Ingham had left the ward without authority, which had resulted in patients being left without adequate supervision. As a result, a patient had fallen which wouldn't have happened had she had authority to take her break. They considered her actions to amount to gross misconduct and upheld the decision to dismiss without notice.

72. Mrs Clark's appeal took place immediately thereafter.

73. Mrs Stamper felt that Mrs Clark's evidence was also contradictory in relation to the timings. Again, Mrs Stamper at the appeal hearing worked on the basis that the incident had occurred around midnight and did not seek any further evidence to clarify this.

74. She considered that the issue around timing was a side issue and that Mrs Clark had been dismissed because it was found that she had taken a break without authority which had left a patient unsupervised. Although Mrs Clark did not have direct responsibility for the patient who fell, as a 'floating HCA' she could have covered Mrs Ingham when she had gone on her break such that the ward would have been properly staffed.

75. The decision to dismiss Mrs Clark on the grounds for gross misconduct was upheld.

76. In her witness statement Mrs Stamper suggests that Mrs Clark appeared to give conflicting evidence which focussed on deflecting the situation from the consequences of their decision to which break was taken when.

77. In cross examination Mrs Stamper agreed that it was the severity of the injury to the patient which resulted in the sanction of dismissal. She accepted that without the severity the outcome could have changed. No other staff were disciplined in respect of this incident.

78. Mrs Stamper had little regard to the service or disciplinary records of the claimants. She considered that there was a lack of insight and no remorse shown by the claimants.

79. At the time of their dismissal and appeal hearings the claimants did not have sight of the PEN records.

Wrongful Dismissal

80. For the purposes of the wrongful dismissal claims of Mrs Ingham and Mrs Clark, the Tribunal has considered its own view and finds the following.

81. On 3 March 2019, once the patients on Ward 5X were settled down for the night, Mrs Ingham, Mrs Clark and the other HCAs, gathered together to decide who was taking breaks when. It was the practice of some of the HCAs to take their hour break to which they were entitled for the night, in smaller breaks of 15 minutes or so in order that they could have cigarette breaks. Mrs Ingham and Mrs Clark, at

approximately 10.30pm that evening, decided to take their first 15 minute break at that time. It was agreed that other two HCAs would take their breaks when the claimants returned.

82. It was a general practice for staff to let the nurse in charge know when they were going on a break, but it was not practical or workable for this to happen all of the time. Sometimes the nurse in charge would have to leave the ward to go to another ward, or might be with other patients or dealing with relatives. As Mrs Clark said 'nine times out of ten', she would let the nurse in charge know, but there was a level of discretion and sometimes staff would let other colleagues know instead when they were going on a break. The key issue for the Respondent and all staff working on the ward was to ensure that there were sufficient staff on the ward to ensure that the safety and care of the patients was maintained. At times this meant that they had no breaks.

83. The nurse in charge that evening told the HCAs to sort out their breaks between themselves. By this she anticipated that the staff would sort out both the times that they took their breaks, and the sequence in which they took their breaks without reference to her. She expected however to be notified when staff went on breaks and was unhappy that his didn't always happen. She knew that the claimants went out for breaks without telling her. The claimants had not been spoken to about this.

84. The claimants would however normally tell the nurse in charge if they were leaving the ward.

85. On this occasion Mrs Ingham and Mrs Clark made their own assessment as to whether it was safe for them to leave the ward together. They considered that it was, having regard to the number of HCAs on duty, and their own experience of the patients they understood were under close supervision, and that Ms Caulfield was watching Bay 8. During the Tribunal hearing, it became clear that there was confusion as to which was the patient under close supervision in Bay 9. From the evidence I heard, there was confusion as to the identify of this patient. He was described by the claimants as a gentleman who did not sleep and spent much of the night sitting with the HCA who was carrying out close supervision. The claimants understood that he was under close supervision as earlier in his stay he had tried to wander off the ward, but this no longer appeared to be a problem. The patient in Bay 9 whom the respondent considered was under close supervision was a gentleman who had respiratory problems and was confined to bed. It was this patient who needed Ms Caulfield's attention when she was looking after the two Bays.

86. Ms Caulfield was an experienced HCA and was carrying out the same role as Mrs Ingham and Mrs Clark. If she did not feel it was safe to watch the two Bays she would have said so.

87. Mrs Ingham, in asking Ms Caulfield to carry out that role, considered that she could do so safely.

88. Although the Close Supervision Policy made it clear that patients should always be closely supervised, meaning that they should be watched, for various

reasons HCAs would have to "take their eyes off" the patients who were under close supervision if there were more pressing demands.

89. Mrs Ingham and Mrs Clark left the ward for approximately 15 minutes for a smoke break. This was part of the hour break to which they were entitled.

90. Normally that hour would be taken between midnight and 2.00am, but again it was clear that sometimes the staff did not get breaks, and there was little structure as to how and when breaks were taken.

91. While they were away from the ward, a patient in Bay 8 got out of bed, and slipped. At that time, Ms Caulfield had left her position outside Bay 8 to answer a buzzer in Bay 9. Mrs Ingham and Mrs Clark returned to the ward to find the fallen patient who they assisted back into bed and the nurse practitioner and doctors came to see him. The time of the fall was between 10.30 and 10.45pm.

92. They then went back to work. At approximately 11.45, the staff decided that they would like to have a pizza, and Mrs Ingham and Mrs Clark left the ward with the knowledge of both the Registered Nurse and the nurse in charge to collect a pizza for themselves and some of the other staff. There was no issue with them leaving the ward for this purpose or concern raised by the nurse in charge.

The Law

Unfair Dismissal

93. Section 98 Employment Rights Act 1996 reads as follows:

> **"(1) In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair, it is for the employer to show –**
>
> **(a) the reason (or, if more than one, the principal reason) for the dismissal and**
>
> **(b) that it is either a reason falling within sub-section (2) or some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held.**
>
> **(2) A reason falls within this sub-section if it … relates to the conduct of the employee …**
>
> **(3) …**
>
> **(4) Where the employer has fulfilled the requirements of sub-section (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".**

94. Conduct dismissals can be analysed using the test which originated in **British Home Stores v Burchell [1980] ICR 303**, a decision of the Employment Appeal Tribunal which was subsequently approved in a number of decisions of the Court of Appeal.

95. The "**Burchell** test" involves a consideration of three aspects of the employer's conduct. Firstly, did the employer carry out an investigation into the matter that was reasonable in the circumstances of the case? Secondly, did the employer believe that the employee was guilty of the misconduct complained of? Thirdly, did the employer have reasonable grounds for that belief?

96. Since **Burchell** was decided the burden on the employer to show fairness has been removed by legislation. There is now no burden on either party to prove fairness or unfairness respectively.

97. The circumstances relevant to assessing whether an employer acted reasonably in its investigations include the gravity of the allegations, and the potential effect on the employee: **A v B [2003] IRLR 405**.

98. A fair investigation requires the employer to follow a reasonably fair procedure. Tribunals must take into account any relevant parts of the ACAS Code of Practice on Disciplinary and Grievance Procedures 2015.

99. The appeal is to be treated as part and parcel of the dismissal process: **Taylor v OCS Group Ltd [2006] IRLR 613.**

100. If the three parts of the **Burchell** test are met, the Employment Tribunal must then go on to decide whether the decision to dismiss the employee was within the band of reasonable responses, or whether that band fell short of encompassing termination of employment.

101. It is important that in carrying out this exercise the Tribunal must not substitute its own decision for that of the employer. The band of reasonable responses test applies to all aspects of the dismissal process including the procedure adopted and whether the investigation was fair and appropriate: **Sainsburys Supermarkets Ltd v Hitt [2003] IRLR 23.** The focus must be on the fairness of the investigation, dismissal and appeal, and not on whether the employee has suffered an injustice. The Tribunal must not substitute its own decision for that of the employer but instead ask whether the employer's actions and decisions fell within that band.

102. In a case where an employer purports to dismiss for a first offence because it is gross misconduct, the Tribunal must decide whether the employer had reasonable grounds for characterising the misconduct as gross misconduct. The position was explained by HHJ Eady in paragraphs 29 and 30 of **Burdett v Aviva Employment Services Ltd [UKEAT/0439/13].** Generally gross misconduct will require either deliberate wrongdoing or gross negligence. Even then the Tribunal must consider whether the employer acted reasonably in going on to decide that dismissal was the appropriate punishment. An assumption that gross misconduct must always mean dismissal is not appropriate as there may be mitigating factors: **Britobabapulle v Ealing Hospital NHS Trust [2013] IRLR 854** (paragraph 38).

Unfair Dismissal Remedy

103. There were three remedy issues which could be determined in this hearing if they arose.

Polkey

The first arises out of the nature of a compensatory award for unfair dismissal under section 123(1) of the Employment Rights Act 1996:

> **"(1) Subject to the provisions of this section and sections 124 and 126, the amount of the compensatory award shall be such amount as the tribunal considers just and equitable in all the circumstances having regard to the loss sustained by the complainant in consequence of the dismissal in so far as that loss is attributable to action taken by the employer."**

104. It has been established since **Polkey v A E Dayton Services Limited [1988] ICR 142** that in considering whether an employee would still have been dismissed even if a fair procedure had been followed, there is no need for an all or nothing decision. If the Tribunal thinks there is doubt whether or not the employee would have been dismissed, this element can be reflected by reducing the normal amount of compensation by a percentage representing the chance that the employee would still have lost his employment. Although this inherently involves a degree of speculation, Tribunals should not shy away from that exercise. A similar exercise was also required by what was then section 98A(2) (part of the now repealed statutory dispute resolution procedures), and the guidance given by the Employment Appeal Tribunal in paragraph 54 of **Software 2000 Limited v Andrews [2007] IRLR 568** remains of assistance, although the burden expressly placed on the employer by section 98A(2) is not to be found in section 123(1).

Contributory Fault

105. The second is a reduction by way of contributory fault. It can apply both to the basic award and to the compensatory award by virtue of differently worded provisions in sections 122 and 123 of the Employment Rights Act 1996 respectively:

> **"Section 122 (2): Where the tribunal considers that any conduct of the complainant before the dismissal (or, where the dismissal was with notice, before the notice was given) was such that it would be just and equitable to reduce or further reduce the amount of the basic award to any extent, the tribunal shall reduce or further reduce that amount accordingly….**
>
> **Section 123 (6): Where the tribunal finds that the dismissal was to any extent caused or contributed to by any action of the complainant, it shall reduce the amount of the compensatory award by such proportion as it considers just and equitable having regard to that finding."**

106. As to what conduct may fall within these provisions, assistance may be derived from the decision of the Court of Appeal in **Nelson v BBC (No 2) [1980] ICR 110** to the effect that the statutory wording means that some reduction is only just and equitable if the conduct of the claimant was culpable or blameworthy. The Court went on to say (*per* Brandon LJ at page 121F):

> **"It is necessary, however, to consider what is included in the concept of culpability or blameworthiness in this connection. The concept does not, in my view, necessarily**

> **involve any conduct of the complainant amounting to a breach of contract or a tort. It includes, no doubt, conduct of that kind. But it also includes conduct which, while not amounting to a breach of contract or a tort, is nevertheless perverse or foolish, or, if I may use the colloquialism, bloody minded. It may also include action which, though not meriting any of those more pejorative terms, is nevertheless unreasonable in all the circumstances. I should not, however, go as far as to say that all unreasonable conduct is necessarily culpable or blameworthy; it must depend on the degree of unreasonableness involved."**

ACAS Code

107. The third remedy issue related to the ACAS Code of Practice on Disciplinary and Grievance Procedures 2015. An unreasonable failure to follow the Code by an employer can result in an increase of up to 25% in the compensatory award: section 207A Trade Union and Labour Relations (Consolidation) Act 1992. An unreasonable failure by a claimant can result in a reduction in compensation also limited to 25%

Breach of Contract – Notice Pay

108. Subject to certain conditions and exceptions not relevant here, the Tribunal has jurisdiction over a claim for damages or some other sum in respect of a breach of contract which arises or is outstanding on termination of employment if presented within three months of the effective date of termination (allowing for early conciliation): see Articles 3 and 7 of the Employment Tribunals (England and Wales) Extension of Jurisdiction Order 1994.

109. An employee is entitled to notice of termination in accordance with the contract (or the statutory minimum notice period under section 86 Employment Rights Act 1996 if that is longer) unless the employer establishes that the employee was guilty of gross misconduct. The measure of damages for a failure to give notice of termination is the net value of pay and other benefits during the notice period, giving credit for other sums earned in mitigation.

Decision of the Tribunal

Unfair Dismissal – Mrs Ingham

The reason for the dismissal

110. The respondent contends that the reason for dismissal was misconduct, being its belief that Mrs Ingham had been guilty of ill-treatment or wilful neglect of the patient in Bay 8 on 3 March 2018.; and/or caused injury to him through serious negligence.

111. I therefore go on to consider the three stage test set out in BHS v Burchell.

Did the Respondent genuinely believe that Mrs Ingham was guilty of that misconduct?

112. It is for the respondent to show that it had a genuine belief in the guilt of Mrs Ingham.

113. I find that both Mrs Dewhurst and Mrs Stamper both believed that the claimant had committed the misconduct. Mr Mensah submits that the test of ill treatment/wilful neglect and/or causing injury through serious negligence is a high hurdle. That may be the case, but having heard the evidence of both witnesses, at the time they made their decisions I am satisfied that both had a clear belief based upon the facts as they were presented with that the actions of Mrs Ingham that night met that test.

114. Their belief however was not based upon reasonable grounds nor had a reasonable investigation been undertaken for the reasons set out below

115. Section 98(4) requires a Tribunal to consider whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating Mrs Ingham's conduct as a sufficient reason for dismissing her. I must consider this in accordance with equity and the substantial merits of the case. I must not substitute my own view and must consider whether the decision which the respondent made falls with a band of reasonable responses which a reasonable employer could have come to.

Was there a reasonable investigation?

116. The investigation of this incident was undertaken by Ms Murphy. There were flaws in that investigation which I find took the investigation outside the band of reasonableness.

The time of the fall

117. The first flaw was the failure by Ms Murphy to accurately ascertain the time at which the patient fell. This resulted in the whereabouts of the claimants, and the whole sequence of events of that evening becoming confused and imprecise. It was clear from the early stages of the investigation that there was disagreement about this. Mrs Ingham and Mrs Clark were clear that they took their break somewhere between 10.30pm and 10.45pm for ten or fifteen minutes, and found the patient had fallen when they returned. Ms Murphy had statements from other staff saying that the patient had fallen around midnight and Ms Caulfield saying later that night. This was an anomaly which Ms Murphy failed to look into further.

118. She had the information to hand in the PEN and ICE reports which would have enabled her to work this out with reasonable accuracy. Instead, she took the word of the other staff and disbelieved the claimants without further enquiry. Indeed, when Mrs Ingham's representative asked Ms Murphy what she had looked at on the PENs system to check the time, she confirmed that she had looked at the timelines to cross check. This cannot have been accurate. Mr Mensah at the Tribunal hearing took Mrs Brown, an experienced senior nurse, through the timeline and demonstrated within a few minutes that the patient could not have fallen at midnight and must have fallen around the time which the claimants had said. Mrs Brown accepted this, as did Mrs Stamper in her evidence. This exercise could have been carried out by Ms Murphy or indeed Mrs Dewhurst or Mrs Stamper at any time during this process, particularly as the claimants were adamant about the timings and their movements throughout their disciplinary meetings. They did not do so. Neither did Mrs Stamper or Mrs Dewhurst ask to see copies of any documents which assisted

with the time of the fall. In coming to their conclusions, they relied solely on what the investigating officer had reported.

119. The consequences of this failure were that the questions which were asked of the claimants and other staff about the events of that evening were on the basis that the incident happened at midnight. This influenced the manner in which Mrs Ingham and Mrs Clark responded to questions in the disciplinary and appeal meetings. Both focussed on timings and that their colleagues were telling lies**.** Indeed, Mrs Stamper confirmed that there was confusion. It further caused confusion as to which breaks were being referred to, how long the claimants had been absent from the ward and whether they were dishonest in this respect. Mrs Dewhurst was of the view that there was a possibility that the claimants were off the ward for an hour and a half and not the 10 minutes or so they claimed.

120. The claimants' honesty was something which formed part of Mrs Dewhurst's and Mrs Stamper's considerations when coming to their findings. In her report to the appeal panel, Mrs Dewhurst concluded that the accident had happened at midnight, and she suspected that the claimants' mention of pizza and having permission to leave the ward to collect the pizza was a fabrication. Further that the story presented by Mrs Ingham and Ms Clark was inconsistent with regard to timelines and details to those provided by the rest of the staff. Mrs Stamper concurred. She stated that Mrs Ingham's position on the time when the incident took place was unclear and referred to the confusion regarding the relevance of the Pizza purchase, saying that the Mrs Ingham had tried to 'backtrack'.

121. These are in my mind all issues which flowed from the failure to carry out a reasonable investigation into the time of the patient's fall.

Failure to make further enquires

122. Both Mrs Dewhurst and Mrs Stamper relied upon the findings of the investigating officer and made no further enquiries themselves even though there were clear inconsistencies within the statements. This was in regard not only to the time of the fall. For instance, in relation to the pizza, although the claimants referred to this and its relevance to the timing of the fall, and that other staff members including the nurse in charge and the staff nurse knew that they were leaving the ward, no one was asked about this. Further no one asked exactly what instructions Ms Ofori-Kumah had given to the claimants and other staff about taking a break that night. Mrs Ingham suggested during the appeal hearing that the other staff were covering their backs because they were not telling the truth about the breaks and the time of the patient's fall. She pointed out that there were other documents which would assist the panel such as the patient's notes and questioned whether the other staff's statements were properly looked into. Mrs Dewhurst and Mrs Stamper did not follow this up. They relied upon the evidence with which they were presented, inconsistent as it was. Mrs Dewhurst in her evidence advised the Tribunal that she didn't feel it was necessary to undertake any further investigation. With so many inconsistencies on so many points, a reasonable investigation would have involved seeking to clarify these issues with the other witnesses and asking further questions of them.

Delays within the investigation

123. There was a delay in the claimants and other witnesses being spoken to formally about the events of 3 March. Although the nurses were spoken to shortly afterwards as part of the internal investigation into the incident, others including the claimants were not. Mrs Brown spoke to the claimants briefly a week or so after the incident to suspend them but no notes were taken of that discussion. It was then not until some two months later that they and other staff provided their version of the events of that evening to Ms Murphy during the formal investigation. Mrs Ingham was asked in cross examination whether she had made some notes herself soon after the event and she confirmed that she had. Mrs Ingham's version was however reasonably consistent throughout the process, but it was the other staff whose evidence may have been impacted by the delay. A reasonable investigation would have been undertaken without delay. No real explanation was provided for that delay and the inconsistencies in the witnesses' statements support the impact that it had upon their recollections.

Was Mrs Dewhurst's and Mrs Stamper's belief based upon reasonable grounds?

124. Both the disciplinary panel and the appeal panel concluded that Mrs Ingham was guilty of serious negligence or wilful neglect in that on 3 March she had taken a break without authority and had left a patient whom she should have been watching under the close supervision policy without adequate supervision and whilst she had done so, the patient had fallen causing serious injury.

125. During the hearing before me, both Mrs Dewhurst and Mrs Stamper have sought to focus on the essence of the allegation ie that the claimants left the ward without authorisation and put a patient at risk thereby causing him harm. Their decision however was influenced by other factors which I have identified above and which were not properly investigated and/or which were inaccurate.

126. Mrs Dewhurst's report which she produced to the appeal panel expanded upon the disciplinary panel's reasons. She said to the appeal panel that the key to the decision to dismiss was how and when the breaks were taken. There has been a great deal of focus in this case as to what were the rules about breaks. The Trust had no written policy at the time about the taking of breaks. It was accepted that Mrs Ingham didn't attend the ward meetings and so wouldn't have heard Mrs Brown provide any guidance on taking breaks. The minutes of those meetings were not provided to the Tribunal and the respondent was unable to confirm that Mrs Ingham (or Mrs Clark) had seen them.

127. The original position of the respondent in the disciplinary process was that the nurse in charge would allocate breaks to be taken by the HCAs and they would take their hour break sometime between 12am and 2pm. It became apparent in the investigation however that on the night shifts that was not the position. The nurse in charge on Ward 5X would normally tell the HCAs to sort out their breaks between themselves. She expected however to be notified when a member of staff left the ward to go on a break and was unhappy that this didn't always happen. She knew that the claimants went on breaks without telling her. She had raised with Mrs Brown in the past that the claimants went on breaks together, but Mrs Brown had not raised this with the claimants.

128. There was confusion in the minds of respondent as to the difference between official and unofficial breaks. The claimants and some others on the night shift took 3 or 4 short breaks of 10-15 minutes, rather than taking a full hour at one time. This allowed them to go out to have cigarettes during their shifts. Mrs Dewhurst and Ms Murphy had in their mind that the smoking breaks which the claimants took, including the one during which the patient fell, were therefore 'unofficial' breaks as opposed to part of their official hour break. This influenced both when coming to their conclusions and demonstrated their failure to understand how breaks on the nightshift worked.

129. It was accepted by the Investigating Officer as part of her report that there needed to be some formal guidance about breaks as the arrangements for the taking of breaks on night shifts was unsatisfactory. In fact, a new policy on breaks was issued by the Trust only days after the patient's fall in March 2018.

130. Having considered the evidence with which they were presented, Mrs Dewhurst's and Mrs Stamper's conclusion when they came to their decision was that there was an expectation that the nurse in charge would be informed if a staff member was leaving the ward and that claimants had left the ward without telling the nurse in charge, when they should have done so.

131. This was a reasonable view to come to and seemed to generally be the practice of the staff on the ward including the claimants, though as confirmed by the nurse in charge and the claimants, it did not happen all of the time. Mrs Ingham accepted in her appeal hearing that she should have told the nurse in charge and that she was sorry that she hadn't. On that evening, she said she didn't do so because generally the nurses told the HCAs to sort out their own breaks between themselves and they knew how they took their breaks. She also felt that it made a difference that there were 6 HCAs on duty that night. This also meant that it was permissible for two HCAs to go out at once. She had therefore left the ward on that evening without telling the nurse in charge whereas she would generally do so.

132. Mrs Ingham did not believe however that when she left the ward, she had left the patients without adequate supervision or that she was risking her patients' safety. Her evidence was that she and the other HCAs had spoken together and agreed to take their breaks two at a time. There were once again discrepancies between what the other staff said about this, possibly because of the confusion about the time of the fall and which breaks were being referred to, but it was accepted by the respondent that Mrs Ingham did tell Ms Caulfield that she was going on a break and asked Ms Caulfield to keep an eye on the patients in her Bay. Ms Caulfield was a Bank HCA as such Mrs Dewhurst considered that she would not have been able to say no to Mrs Ingham when asked to cover. There was no evidence that Ms Caulfield felt pressured in that way and this view was not based upon reasonable grounds. She was an experience HCA whom Mrs Ingham knew and who had worked on the ward for some two years. Indeed, she felt responsible for the fall as she had moved away to look after another patient. Just because she was a bank HCA her level of responsibility or her position in the hierarchy within the ward was no different than that of Mrs Clark or Mrs Ingham. There are a number of different reasons why staff may work on a bank basis, and it does not necessarily mean that they are any less experienced, or less competent at their role. It was not therefore a reasonable

basis for Mrs Dewhurst to come to her view that by leaving Ms Caulfield watching her patient, that was leaving the patient without proper supervision.

133. The issue however in the respondent's view was that under the Close Supervision Policy the patients in Bay 8 should not have been left to be supervised by Ms Caulfield as she was already supervising another patient in Bay 9. Mrs Ingham's and Mrs Clark's explanations that the patient in Bay 9 didn't really need close supervision was in Mrs Stamper's view not their decision to make. Her focus was that when taking breaks, the staff would always do this by keeping the safety of the patients in mind and she considered that by leaving Ms Caulfield looking after two Bays, Mrs Ingham and Mrs Clark would have been aware that they were risking patients' safety.

134. She considered that had Mrs Ingham told the nurse in charge that they were having a short break, that nurse would have made the decision whether to ask someone other than Ms Caulfield to cover Bay 8 or whether she was happy that she could cover both in view of the type of close observation the patient in Bay 9 needed and that other patients were asleep. In Mrs Ingham not telling the nurse, Mrs Stamper considered that she did not give the nurse in charge the chance to make that decision. But does that amount to ill treatment/wilful neglect or serious negligence?

135. Mrs Ingham had left the patient for a short period in the care of another competent and experienced HCA and believed that patient would be safe. That HCA had agreed to do it and took on that responsibility. There were 6 HCAs which was an unusually high number, and in her view, having spent time with the patient in Bay 9, she felt that he didn't need close supervision. Mrs Ingham knew that under the Close Observation Policy, it was her responsibility to look after the patients in Bay 8, but there were additional staff on that night and she made a judgment call in asking Ms Caulfield to cover, albeit that it was not her call to make. She accepted that she made a mistake and that she shouldn't have left Ms Caulfield to look after two bays.

136. What appears to have made the respondent conclude this was serious negligence/wilful neglect was the injury which was caused to the patient. Although Mrs Dewhurst in her report to the Appeal panel says it was not within the remit of the panel to relate the patient's fall to wilful neglect as a reason for their dismissal, Mrs Dewhurst's evidence was that the key thing for her was the seriousness of the incident and the outcome for the patient. Mrs Stamper accepted that without the severity of the injury to the patient, the outcome could have changed. The focus of the respondent appears to have been the seriousness of the outcome as opposed to the seriousness of the claimant's conduct.

137. Wilful neglect and serious negligence are high hurdles as Mr Mensah has said. For the reasons above - and against a background of unclear arrangements about breaks, managers not understanding how breaks are arranged and taken, and where the nurse in charge knew that Mrs Ingham would leave the ward without telling her and no-one had raised this with Mrs Ingham - there were no grounds upon which it was reasonable for the respondent to conclude that Mrs Ingham deliberately ill-treated or neglected her patient, or that her conduct was something which would amount to serious negligence.

Was the decision to dismiss within a band of reasonable responses open to a reasonable employer?

138. For the reasons above, I find that the investigation in this matter was not within a band of reasonableness and that the respondent's belief that Mrs Ingham was guilty of wilful neglect or serious negligence resulting in injury to a patient was not based upon reasonable grounds. As such the decision to dismiss cannot be said to be within a band of reasonable responses.

139. In coming to this conclusion, I also note that the respondent did not - and felt that it should not - consider Mrs Ingham's previous long service and exemplary disciplinary record. Further, although Mrs Dewhurst considered there was a lack of remorse on the part of Mrs Ingham, this is not borne out by Mrs Brown who confirmed that Mrs Ingham was indeed remorseful. These are factors which any reasonable employer should consider when coming to a decision to dismiss an employee.

140. I find therefore that Mrs Ingham was unfairly dismissed and her claim of unfair dismissal succeeds.

ACAS Code

141. In coming to my decision, I have had regard to the ACAS Code on Disciplinary and Grievance Procedures. Although the respondent has sought to follow the Code and its own disciplinary procedures, my conclusions concerning delay and the flaws in its investigations are areas where the Code has not been followed. The respondent failed to establish the facts upon which they then relied in dismissing Mrs Ingham. I award an increase of 20%.

Contributory fault

142. Although I have found that there were no reasonable grounds for concluding that Mrs Ingham's conduct amounted to wilful neglect or serious negligence, I find that leaving her patients In Bay 8 when she was required to closely supervise them, even though she considered that they were safe, was in breach of her responsibilities under the Close Observation Policy. Mrs Ingham had in the past had to leave patients she was watching under close supervision if there were more pressing needs. Going on a break, particularly two HCAs together was not a pressing need and Mrs Ingham should not have taken this step without notifying the nurse in charge that she was doing so. Although she may have felt confident in making that decision, that was not her decision to make, it was that of the nurse in charge. This was culpable and blameworthy conduct and I find that this contributed to her dismissal. Further under the respondent's disciplinary policy, examples of misconduct which would warrant disciplinary action include 'unauthorised absence from duty' and 'failure to adhere to agreed Trust Policies and Procedures, including own department protocols'. Mrs Ingham was in breach of her responsibilities to the patient under the Close Observation Policy and assessing the facts as a whole I find that her and her employer were equally to blame for her dismissal. I consider that it is just and equitable to reduce Mrs Igham's awards under sections 122(2) and 123(6) Employment Rights Act 1996 by 50%

Polkey

143. A fair procedure was not undertaken by the respondent. Had a fair procedure been followed, I do not consider that there was any real chance that Mrs Ingham would have been dismissed. The investigation was flawed in a number of respects and as a result, the decision to dismiss Mrs Ingham was influenced by suggestions that she had been dishonest as to how long she had been absent from the ward and in respect of her version of events. Her actions were more properly categorised as misconduct with the Trust's procedures. Mrs Ingham had a clean disciplinary record and had been a Trust employee for a number of years. As such I consider that she would have received a warning and that she would not have been dismissed.

Breach of Contract – Mrs Ingham and Mrs Clark

144. For the reasons stated above, I do not consider that there were grounds upon which Mrs Ingham's actions could be categorised as wilful neglect or serious negligence amounting to gross misconduct. I am also of the same view in relation to Mrs Clark.

145. The manner in which staffing on this ward and the allocation of breaks was run was flexible and without any real structure. HCAs were allowed to decide things for themselves such as when they took breaks and in what order. They would generally tell the nurse in charge that they were going but sometimes that was not practical to do and instead they arranged it around themselves. I consider that both claimants satisfied themselves that the patients in Bays 8 and 9 could be watched by Ms Caulfield sitting outside both bays. It was unusual to have the number of staff on duty as there were that evening and they made a judgment call having regard to the patients that were in the bays. There was confusion in the Tribunal hearing about who was the patient that was supposed to be under close supervision in Bay 9 that evening. This may have been because of the delay in obtaining statements in these proceedings and memories becoming hazy. Different views were put forward by the claimants and by the respondents. It is difficult to understand how there could be that confusion, however I am satisfied that both claimants believed that in leaving the ward they were of the view that the patients were and would be safe. It cannot therefore be said that they were guilty of wilful neglect or serious negligence. As I have found, it seems that it was the injury to the patient which caused the respondent to dismiss rather than the claimant's conduct.

146. I consider therefore that the claimants' conduct did not amount to gross misconduct under the Trust's policies and rather would be categorised as misconduct. As such the respondent has breached their contracts by not providing them with notice of their dismissals.

147. Both claims of breach of contract therefore succeed.

Remedy

148. This matter will now listed for a remedy hearing with a time estimate of one day.

Employment Judge Benson

Date: 9 March 2020

JUDGMENT AND REASONS SENT TO THE PARTIES ON

10 March 2020

FOR THE TRIBUNAL OFFICE