EMPLOYMENT TRIBUNALS

Heard at: Exeter **On:** 16 to 19 January 2023

Claimant: Ms Karen Pracy

Respondent: Cornwall Partnership NHS Trust

Before: Employment Judge E Fowell

Ms E Smillie

Mr K Sleeth

Representation:

Claimant Datesh Patel of counsel, instructed by DLG Legal Services Ltd

Respondent Emily Skinner of counsel, instructed by Capsticks Solicitors LLP

JUDGMENT

1. The complaint of detriment at work for making a protected disclosure is upheld.

2. The claimant is awarded compensation in the sum of £20,713

REASONS

Introduction

1. These written reasons are provided at the request of the claimant following oral reasons given earlier today, and are limited to reasons on liability.

2. Ms Pracy worked for the Trust as a Health Care Assistant, specialising in mental health, until her dismissal on 10 September 2021. She was not in fact an employee, she worked as one of the bank staff or “Flexi Team Service” at the Trust’s hospital in Redruth, so the term used was that she was de-registered.

3. The hospital is exclusively for those with mental health problems and she worked there, on average, about two shifts each week. It was her only paid work. She also worked as a volunteer for an animal welfare charity. No criticism has been made of her performance, and it was clear to us that she cared for the patients. Her de-registration followed an incident in August 2021 when she went to a patient's home out of concern that the pets were not being fed, and then raised concerns with the RSPCA that they were being neglected. She says that this made her a whistleblower. The Trust took the view that going round to the patient's house was inappropriate, and that she overstepped her professional boundaries, and it was for that reason that she was de-registered.

4. The issues to be decided were set out in the Case Management Order on 27 September 2022 and so need not be repeated at the outset. We will return to them shortly.

5. When employees are dismissed for making a protected disclosure there are separate rules to consider in connection with the dismissal and with any earlier unfavourable treatment at work, referred to in the Employment Rights Act 1996 as detriments. The reason for the distinction is largely historic and need not concern us. Here, as Ms Pracy was not an employee, there is no difficulty in categorising her "de-registration" as a detriment, and that is the only detriment relied on.

Procedure and evidence

6. There was a bundle of 271 pages containing the documentary evidence. We also heard evidence from Ms Pracy, who was supported by two former colleagues, Ms Louise Nuzum and Ms Pauline Roberts. Ms Roberts attended to give evidence but there were no questions for her and so her evidence is unchallenged. Ms Nuzum did not attend but in her case too Ms Skinner indicated that her brief statement was not disputed. Another colleague, Mr Ross McLachlan, also provided a supporting statement which is in the bundle. For the Trust we heard from Ms Hayley Thompson (Workforce Staffing and Resources Lead), who took the decision to de-register the claimant; and Ms Leah Brewer (Head of Employment Relations) who considered a later complaint that she submitted. For convenience we will use the term dismissal rather than de-registration from now on.

7. Ms Thompson and Ms Brewer were not involved in the events that gave rise to the dismissal. They occupy much the same position as the decision maker and the appeal manager in a case of unfair dismissal. But in an unfair dismissal case, involving alleged misconduct, the task of the Tribunal is essentially to review the decision made and to decide whether it was a reasonable one in all the circumstances - whether there was a sufficient investigation and whether the offence was sufficiently serious to dismiss - not primarily to decide what actually happened. Here, we do have to make those findings, and it became clear to us

that there were many witnesses for the Trust who could have shed light on events but who have not given evidence. A number of senior staff, for example, were involved in discussions about Ms Pracy's actions and how to respond to them, but did not attend. There may be many reasons for this, and it is not for us to speculate about why it was left to Ms Thompson and Ms Brewer, but we have to decide the facts on the basis of the evidence available. It follows that the only witness we heard from on many of the events in question was Ms Pracy herself, and there was little challenge to her factual account. As may be expected, the main difference was over what role, if any, her various complaints about animal welfare played in the decision.

8. Having considered this evidence and the submissions on each side, we made the following findings of fact, which was limited to those necessary to reach our decision.

Findings of Fact

Background

9. Many of those admitted to the hospital are elderly and live alone. They often have pets for company, and when the owner is taken into hospital there is no one to look after them. It may be that a housing association or other agency is already involved with the patient, and they are aware of the difficulty, but from time to time the nursing staff will simply find out from the patient, whether on admission or later, that they have pets at home, and that no one is looking after them. For Ms Pracy, this was an issue close to her heart.

10. She had been an animal welfare volunteer for 18 years and so was more familiar with the legal position than most. She was aware of the existence of the Animal Welfare Act 2006, which essentially makes it an offence to allow an animal to suffer unnecessarily. She was also aware that there is an obligation on local authorities to look after the pets of those who are taken into hospital, if need be, and that the people tasked with this are the Approved Mental Health Professionals (AMPHs) at the local authority. Her understanding was that there was a multi-disciplinary approach, with the hospital working in close collaboration with the local authority or housing association to look after pets in need, and that the Trust had an obligation to act if these arrangements were falling down. It was put to her that she thought this was a moral obligation only, but it seems to us that she believed there was more to it than that, and that the hospital was bound to do something if an animal would otherwise be left to suffer.

The first incident - Moby

11. Ms Pracy began her work at the Trust in 2019, and the first such incident was late that year. Talking to a patient about his pet rat, Moby, she found that it had been

left alone in his flat. The patient had been admitted for two months so she was very concerned and spoke to the Ward Charge Nurse. The nurse promised that she would personally go and visit the flat the next day, but in the event she was unable to go, and Moby died.

12. Although Ms Pracy only worked for a couple of days a week she e-mailed the Ward Manager, Leanne Griffin, a number of times about this. Ms Griffin responded to her by e-mail on 23 December to say that having reviewed the notes she believed that the rat was alive when the patient was discharged and had been seen. However, she was aware that Ms Pracy was upset by the incident and commented that they should not relax their guard, that pets meant everything to some people and sometimes needed as much care and attention as the patients (page 59).

Second incident – abandoned cats

13. The next incident was over a year later. In January 2021 Ms Pracy heard that a patient had two cats at home. The patient's notes showed that there had been two visits to the property by AMHP staff, who noted that there were animal faeces and urine present, but no pets. The patient said she had two cats and a dog and Ms Pracy reported this to the Charge Nurse. Enquiries were made of those who had been out to visit but it was still not clear if there were animals at the house. So, at the end of her shift, Ms Pracy decided to go and see for herself. She drove to the address in her own time, a journey of about 25 miles, and looked through the letter box. There was a terrible smell and she could see a weak looking cat lying in the hallway. Then another cat appeared around a doorway. She went to a local garage and bought some cat biscuits, came back and posted them through the letter box. Then she went home and rang the RSPCA and the police. The next morning she told Leanne Griffin what she had done and also contacted the housing association. The upshot was that the cats survived and were taken away to a local cattery. The dog was found by a dog warden roaming the streets wearing a muzzle.

14. Ms Pracy was also in e-mail contact with Ms Griffin about this. The first alleged disclosure is said to be contained in two e-mails to her, dated 4 and 5 January 2021, at pages 61 and 62. In the first of these Ms Pracy stated that she was distressed to think that the animals had been without food and water for at least five days. In the second she thanked Ms Griffin for putting her mind at rest about the animals and said that this was not the first time that pets have been forgotten or missed with fatal outcomes, adding that she had no confidence in the process by which pets were cared for.

15. Ms Griffin was supportive, to a point. In her reply, on 5 January 2021, (page 62) she said:

> "I do appreciate you coming to me with your concern as you absolutely should but the ward's part is minimal in this particular incident and I believe we escalated appropriately when the issue was highlighted. I will however escalate further to the appropriate Manager/Lead for the AMHP service as it is their duty to ensure the safety of any animals when a patient has been detained to hospital.
>
> I believe I realise the distress these events have caused you and thank you for the care you provide not only to our patients but also their animals, we all know how much comfort our pets provide."

Complaint to the FTSU Guardian

16. The incident left her concerned that there was no effective coordination in these cases, and that even where AMPH staff were involved animals were being left to suffer. The Trust has a Freedom to Speak Up Policy (FTSU), which is at page 195. It begins:

> **Freedom to Speak Up (previously known as Whistleblowing) Policy**
>
> 1. Speak up – we will listen
>
> Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.
>
> You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

17. It goes on to explain the sort of concerns that might be raised and gives assurances that any concern would be kept confidential and that there would be no reprisals. It recommends that in the first instance a member of staff raises matters informally with their line manager, but if that is not appropriate they should contact the FTSU Guardian, in this case Ms Claire Watters. So, on 24 March 2021 Ms Pracy e-mailed Ms Watters, together with Ms Hannah Pile, the Clinical Matron (page 64). That is the second alleged protected disclosure.

18. It is a long and detailed e-mail. In it she recounted the events in January and the efforts she went to, to ensure that the animals were ultimately looked after. These were extensive and covered a period of weeks. She described the ineffective efforts by the police and others to locate the pets, and she ended by explaining:

> "I feel part of the problem here lies with the initial assessment of patients whether informal or formal, the wards admission form does not appear to have any questions regarding pets. If a patient indicated they may have a pet at home once on the ward,

there is no guarantee that this will be investigated further. These are just a few of my concerns. …

I would like to see procedures changed regarding pets when patients are admitted onto the wards."

19. Ms Pile replied on 31 March to say that she was forwarding the concerns to Dee Vujikov, the Manager of Carbis Ward, but nothing further was heard from her, or Ms Watters. So, on 23 April, Ms Pracy e-mailed her concerns to Ms Tamsyn Anderson, the Trust's Chief Operating Officer (page 70). This time she set out in an introductory paragraph that she was disappointed by the lack of response from the FTSU Guardian and repeated what she had previously sent.

20. Ms Anderson replied on 9 May, after a period of leave, and suggested a meeting. This was encouraging. Ms Anderson also passed on Ms Watters' apologies for the delay and said she thought she was simply being copied in, although that was not in fact the case.

21. In due course Ms Pracy and Ms Anderson did have a meeting to discuss the idea about changing the admission forms. Ms Anderson accepted that there was a loophole in the system and said she would discuss it further with Ms Watters in the next six to eight weeks. By the time Ms Pracy heard further from Ms Anderson however, there had been a further incident and much had changed.

The main incident involving seven cats

22. On Saturday, 7 August 2021, Ms Pracy was told by a colleague, Michelle, that a patient had seven cats at home. There was an arrangement in place for someone from the patient's housing association, Live West, to go in three times a week to feed them but that did not seem ideal. Ms Pracy told the Nurse in Charge, Mr Ross McLachlan. He agreed that it should be looked into and said to talk to the patient. The patient was distressed to hear that there was no one going in every day, so Mr McLachlan agreed (with the patient's consent) that Ms Pracy would go round in person at the end of her shift.

23. She got the keys from reception, bought some cat food out of her own pocket, and went to the property. When she got there, the house was in a mess. There were empty cat bowls all over the place and litter trays brimming over. There was faeces and cat sick on the carpet and up the stairs, with signs of blood. She found three cats there, one blind with three legs. She set about clearing it all up and putting down fresh food and water. She cleaned the carpet, then rang a friend to get some cat litter for her. Her friend also worked at the Trust, and also volunteered at the same animal charity. She agreed to help and came over with some cat litter, dropping it off outside by Ms Pracy's car. Ms Pracy then put the fresh litter down. Despite waiting a while, no other cats appeared, so she went home.

24. The situation had been much worse than she had expected. Her initial plan had been to return the key to reception straight away before going home but given that there were four cats missing she decided to go back in the morning before work and see if they had turned up. So, she went home and called the office to let them know. She spoke to a Dan Merritt, the bookings clerk in the Flexi Team, who agreed she should hang on to the keys.

25. When she got into work the next day she also told the Nurse in Charge, Louise Nuzum. She completed an incident report and made an entry on the relevant computer system for patient notes - RIO. Throughout the day she remained concerned about the missing cats and told Ms Nuzum that she wanted to ring the RSPCA but Ms Nuzum said that it would be better to discuss it with the Duty Manager first – Mr Charles Curtis – and so she telephoned him.

26. Mr Curtis was sympathetic. She offered to keep going round to look after the cats until there was a plan in place but he felt it was too far for her to be driving on her day off – all the way from St Ives to Redruth. It was above and beyond the call of duty. He said he would call an emergency meeting on the Monday morning. She asked to be included, although that was not a working day for her, and told him about the previous incidents as well. Again, he was sympathetic and appreciated her efforts.

27. That evening, a Sunday, Ms Pracy went back to check on the cats. She then e-mailed Mr Curtis to update him ahead of the Monday meeting. For some reason the e-mail (page 77) did not send until the next morning, but in it she explained that she had been round again, spent a couple of hours there giving the cats some company and replenishing all the bowls, and went into some detail about their neglected appearance. She also thanked him for his support, said she was distraught but glad to have been able to help, and repeated her offer to carry on looking after the cats if need be. We take it that she did all this, and kept Mr Curtis fully informed, because she felt that her concerns were being taken seriously and there was to be an emergency meeting the next day, so there was no objection to her continuing to help with the cats in the meantime.

28. However, when he received this, Mr Curtis did have concerns. He forwarded it that Monday morning to Jane Pearce, the Ward Manager (page 76). His e-mail explained that Ms Pracy had been considering phoning the RSPCA but he felt that the decision should wait for a weekday when a full multi-disciplinary team meeting could be held. He sympathised with her concerns and accepted that the cats could not be left in the state she found them but felt there had been no need to take further action on the Sunday. He was concerned that she had placed herself in a vulnerable position, attending by herself and perhaps taking the house key home. He said he had raised this with her but she was unconcerned and felt that the cats

were the priority. He asked that Ms Pracy be kept in the loop and for the "home visit/key situation" to be reviewed.

The RSPCA

29. In the meantime Ms Pracy had decided not to wait any longer and contacted the RSPCA herself. This telephone call to the RSPCA is the third alleged protected disclosure. She then rang to tell Mr Curtis what she had done. She described him as sounding taken aback. Shortly afterwards she had a call from the Ward Manager, Jane Pearce, asking for the keys back. She drove back into work and dropped the keys off, as requested.

30. There is another e-mail from Mr Curtis at 1308 that day (page 75) to Keri Sherriff, the Workforce Resourcing Officer – which we take to mean the person who arranges Ms Pracy's shifts - to let her know that Ms Pracy seemed stressed and he was worried about her. He said that:

> "Jane is following up concerns about her actions as she is placing herself in a vulnerable position visiting a patient homes out of hours. She has good intentions but I feel that her need to keep cats safe is blurring her professional boundaries and will need some supervision / support."

31. When Ms Pearce telephoned Ms Pracy that afternoon she warned her about this sort of intervention and said that she had taken the keys without permission. It is not clear how she formed that view, but the tone was no longer supportive.

32. The RSPCA took the matter seriously and acted promptly. Ms Pracy had a call back on Tuesday morning from an RSPCA Officer, who said that the animals should have been boarded when the patient was admitted to hospital and that a local officer would contact the ward to check on the cats as soon as possible. Ms Pracy told the officer about the previous breaches, and her response was that this was not acceptable, and a breach of the 2006 Animal Act: once any concern about a patient's pets come to the attention of the ward, they had a duty to act.

33. That afternoon the local officer rang her to say that he was unable to get through to the ward and was unable to access the property without keys. Ms Pracy then rang the ward to say that the officer needed the keys and was on his way. She also called the RSPCA the next day, Wednesday, to see what they had done. By then, the officer had been in and seen four of the cats. He said he would be returning shortly with a social worker to put down cages to catch the cats as they needed a health check and boarding.

The management response

34. All this appears to have set various wheels in motion. It was also on that day, Wednesday 11 August, that Ms Pracy received an e-mail from the FTSU Guardian, Claire Watters (page 84). It seems to have been copied to her in error, as it was addressed to Tamsyn Anderson. It is in fact an e-mail which forwards comments made by Hannah Pile, the Matron, and is worth quoting:

> "There [are] several issues in relation to this discussion that we have to look at: If a person is bought in under the mental health act then we would expect that the AMHP involved in the detention will ensure provisions are made, if we have concerns raised by a patient then we would contact the care [company] or duty worker at ICMHT to check the situation. If this is not possible I believe we can contact the RSPCA for advice or they will undertake a welfare check and make an assessment of the situation. I feel outside of my professional registration this would be the action I would personally take.

35. All this is an acknowledgement of the concerns raised by Ms Pracy, that the risk to abandoned pets should be addressed when the patient is admitted, as part of the professional duty of mental health professionals, and in case of doubt the RSPCA should be informed. The e-mail goes on however:

> It's important to raise that the most recent incident is a sensitive issue as we are having to link with HR in relation to a potential conduct issue. We should never access a patients house without permission and if that person is detained then we should be considering their capacity to make that decision before proceeding. In this instance I would suggest that contacting the RSPCA would be the most appropriate action if there is no clear plan that the safety of the animals is being addressed (having looked at the notes it does appear that there was a plan in place to address this). In doing this a member of staff is placing themselves in a vulnerable position for many reasons but I would highlight primarily risk of allegations and risk to self as we may know little about the patients property including who else is there or the temperament of any pets they may have.

36. This contains strong echoes of Mr Curtis' previous concerns, although the position appears to have hardened, so that it was not enough to have the patient's permission, it was first necessary to establish that the patient had mental capacity. There is in fact a bald statement here that Ms Pracy had accessed the patient's home without permission. It appears that there were now active discussions underway between the FTSU office, senior ward management and HR, all within two days of the report by Ms Pracy to the RSPCA.

37. Having seen this e-mail, Ms Pracy rang Ms Pile. Ms Pile stood by her view that Ms Pracy had taken the patient's keys without permission and without consent. Ms Pracy insisted that she had got consent from the patient, and also from the Nurse in Charge each time, and from Charles Curtis, at which point Ms Pile said that she

must have misunderstood. This discussion is evidenced by an e-mail from Ms Pile to Ms Pracy at 9.27 that evening (pages 89 to 91) when Ms Pile told her that she had not accused her of lying, but that there would be an investigation and review of the situation so that a thorough picture could be gained and lessons learned.

38. At 20.48 that evening Ms Pracy e-mailed back (page 86) to put on record that she was shocked by the contents of Ms Pile's e-mail, send via Claire Watters, and set out a further written account of the events of that weekend. She repeated that she had permission to go around to the property, both from the nurse in charge and from the patient, and that she kept everyone fully informed, raising an incident report and making an entry on the Rio system. Charles Curtis had commended her for what she had done and recognised that it was a matter of urgency. She added that it was only because she received no contact from anyone on Monday morning that she had decided to ring the RSPCA, who were now looking into the matter. This e-mail, which is essentially a repetition of the telephone conversation, is the fourth alleged protected disclosure.

The investigation

39. A week later, on 18 August, Ms Sherriff rang her and asked if she would like to talk to her about the patient's cats. They spoke on the phone, followed by a Teams call once she was next at work, going over the previous incidents as well. Ms Pracy was not aware that this was part of a disciplinary investigation (or fact find, as the Trust prefer to call it) or that Ms Sherriff was taking notes of what she said.

40. The record of that conversation appears in the fact find report at page 115. Once again, Ms Pracy explained that Ross McLaughlin had been supportive and said she could go and check on the cats. She added that she and her colleague Michelle had also spoken to the patient to see what she thought was happening; the patient explained that she has asked Live West to go in everyday and had given them her bank card to buy food. When she found out that they were only going in three days a week she put her fingers in her ears and became "really worried" – she told Ms Pracy to "do what you need to do" and Ms Pracy assured her that she would go in and check on them. Ms Pracy's recollection was that she was due to leave work at 4.30 pm but that Ross McLachlan said she could go at 4 pm, and she also asked another colleague, Liz, about getting cat food and whether she could claim the money back. She also mentioned the previous incident in January and her efforts to contact Tamsyn Anderson about this who had not go back to her. Finally, she said that she was unhappy with the e-mail from Claire Watters, and had phoned Hannah Pile to speak to her about this, and felt that Ms Piles' response was "very threatening and verging on bullying."

41. In fact, just as she had after her conversation with Hannah Pile, Ms Pracy then e-mailed Ms Sherriff to make sure that everything was on the record. Her e-mail of 19 August 2021, at page 101, is the fifth alleged protected disclosure.

42. In that written account she again confirmed that she had spoken to Mr Curtis on the Sunday about the situation and he had said that what she had done was commendable and above and beyond her role as a flexi HCA but was concerned that due to the distance for her to travel it was not sustainable for her to return everyday to feed the cats. He did appreciate however that it was a matter of urgency, he told her that he would call a team meeting on Monday morning to sort out a solution. However, he also told her, that if she felt that the RSPCA was the best option he would give her his full support. That e-mail to Mr Pile was in fact copied to Mr Curtis so that he had an opportunity to take issue with any point she made about his involvement.

43. There remained a lively degree of management interest in this incident, as shown by the e-mail at page 99. This is from Ms Underwood, the Employment Relations Manager, to Ms Carly Collins (Ms Thompson's manager) on 19 August, to pass on what she had heard from Ms Pile:

> "I wondered if you are aware of a situation regarding a Bank worker who worked at Longreach recently. Hannah Pile informed me that she interpreted consent from a patient to take her house keys and feed the cats. This became known following the Bank worker raising a FTSU concern about lack of care for patient's pets. I am told that not only did the Bank worker let herself in to feed the cats, she openly stated that she stayed in the house for about 2 hours. She took the keys home with her and only returned them when contacted by the ward."

Dismissal

44. Ms Pracy heard nothing further for several weeks. It is not clear why things took so long but it appears that Hannah Pile was on leave at the time which may have delayed things, a fact which also supports the view that she was involved in the decision.

45. On 10 September Ms Sherriff rang Ms Pracy at home, on her day off, asking her to come in for a meeting that day. She would not say what it was about. Ms Pracy was understandably reluctant and in the end Ms Sherriff passed the phone to her manager, Ms Thompson, the Workforce Staffing and Resourcing Lead, who told her that it was about the pets. She also told her that she could not have any more shifts until they had had a meeting, so Ms Pracy agreed to come in at short notice.

46. Ms Thompson explained that she ran the decision by her manager, Carly Collins, beforehand, who approved it. Ms Thompson also made no bones about the fact

that the decision had already been made, even before the fact find report was finalised. This was common knowledge, as shown by a text message at page 110, sent at 9.36 am on 10 September, by Ms Collins to Wendy Underwood, the Employment Relations Manager – presumably therefore the most senior HR person:

> "Hi Wendy, the worker will be de-registered with us, Keri is just finishing off the fact find document."

47. Ms Underwood was clearly personally involved in the case and replied to the effect that the "established facts" should be recorded and a meeting held with the individual.

48. That meeting was not therefore an opportunity for Ms Pracy to defend herself or explain things. There was a brief discussion about what happened. Ms Pracy agreed she had been to the property alone but said that she had permission and that there had been no requirement that she return the keys that day. However, Ms Thompson told her that she presented a risk to the reputation of the Trust and was taking away her registration. Ms Pracy left the room, understandably shocked.

49. The dismissal letter (page 130) followed on Monday, the next working day. It set out the four reasons for the decision:

- You asked a friend of yours, who does not work for Cornwall Foundation Trust, to attend the patient's property with cat litter, while you were at the property.
- You did not return the patients house keys to the ward following your initial visit to the property, as requested.
- You attended the property alone.
- You mentioned during the fact find, that you had previously attended a patient's property without permission and looked through the letterbox.

50. These conclusions were of course based on the fact find report carried out by Ms Sherriff, about which Ms Pracy knew nothing at the time. It is worth describing the contents. There was some confusion at this hearing about the appropriate policy in such cases, for members of the Flexi team like Ms Pracy. According to the Trust's Flexible Workers Policy, the normal disciplinary policy applied. According to the disciplinary policy (which is not in the bundle) it only applied to employees. However, the fact find report was prepared on a standard form, at page 111 onwards, which provides some guidance on a fair process. It states that it should be undertaken within 48 hours, that the key witnesses should be identified and spoken to, and it provided a template for the investigatory interviews.

51. The report listed those spoken to as Ms Pracy, Ross McLachlan and Louise Nuzum, but in fact only Ms Pracy was spoken to. The record of her telephone discussion and her follow up e-mail were set out in the report. Ross McLachlan simply had an e-mail from Ms Sherriff (page 106) about a month after the incident, asking if he remembered having a conversation with Ms Pracy about it. He replied, agreeing that Ms Pracy had wanted to pay a visit to the house to check on the cats, that he had let her when her shift ended, and he had said to bring the key back to reception. He was not asked specifically whether Ms Pracy had overstepped the mark by keeping the keys on the Saturday evening or asked to comment on her record of interview. There is also no record of any discussion with, or e-mail from, Louise Nuzum. Nor was there any follow up with Ms Pracy herself about the people who gave her permission to visit the house, and what was discussed over the rest of the weekend about the keys.

52. Charles Curtis was not interviewed either, although some of his e-mails were elicited and put in the report. (We note that the e-mail from Ms Pracy to Keri Sherriff setting out her account, and which was originally copied to Mr Curtis, was simply pasted into the report, so Ms Thompson would not have been aware that he had had the chance to comment on it.) The e-mails obtained from him included the initial short one set out above (para. 31), sent to Jane Pearce, explaining that he was concerned about Ms Pracy, and her reply, also on the Monday morning (page 122). Ms Pearce mentioned in her e-mail that she was aware of the situation which developed last Friday, that Live West had spent the whole time trying to get into the patient's house, that the keys didn't work, and when they got in they found there was no food left. She accepted that it definitely wasn't ideal and hoped that they would be able to make a proper plan that day to keep them safe. She added that they would definitely review Ms Pracy going on her own, that it was not safe to do so, but she would also keep her in the loop in regards to a plan. The tone is appreciative however and there is no criticism at that stage of Ms Pracy.

53. Regardless of the inadequacy of the report, it did contain a good deal of relevant information about the events in question and the history of similar incidents. Ms Thompson's evidence was that she was not aware of the first two protected disclosures - Ms Pracy's e-mail to Leanne Griffin on 5 January 2021 about the two neglected cats and dog, nor her e-mail to Hannah Pile and Claire Watters on 24 March 2021 about the same incident. We accept that. However, she would have been aware from the fact find report that there had been previous concerns raised about animal welfare, which had been raised with Claire Watters, the FTSU Guardian, and Tamsyn Anderson, the Chief Operating Officer.

54. She also told us that she was not aware of the e-mail sent to Hannah Pile on 11 August, the fourth alleged disclosure, but she was aware that they had spoken, and the e-mail sets out Ms Pracy's version of that conversation.

55. As is clear from the dismissal letter, one aspect which seems to have been seized on is the mention by Ms Pracy that she had invited a friend to help her at the house. Again, the circumstances of that visit were not explored. Ms Pracy's evidence at this hearing was that the friend also worked at the Trust and was an animal welfare volunteer. Further, she did not in fact tell her friend the address, simply asked her to drop the litter off at her car, round the corner from a local Co-op. On any view, the friend did not come into the house. Nor is there anything to suggest that she knew that the address was that of a patient at the Trust, let alone the name of the patient.

Appeal and Grievance

56. On 16 September 2021, Ms Pracy sent in a letter to appeal against this decision (page 137). She got no response. The view was taken that since she was not an employee she had no right of appeal. She then began early conciliation through ACAS and that did elicit a response, directing further correspondence to Leah Brewer, Head of Employee Relations.

57. So, on 25 October, she submitted a grievance instead (page 146). This led to a response from Ms Brewer to say that she could not raise a grievance but that she would treat it as a complaint (page 148). Ms Brewer then convened a meeting on 5 November 2021 to discuss it. Ms Pracy was not included. This was a purely internal meeting. Those present were Ms Thompson, as decision maker, Hannah Pile, Claire Watters and Sally Wilson, Associate Director of Workforce. It was therefore a collection of senior management, HR staff and the FTSU Guardian. Ms Brewer was clear that she did not undertake any review of the fact find as part of this process. She was however told of the reasons for the decision, presumably by Ms Thompson. According to her statement she was also made aware that Ms Pracy had raised concerns about patients' pets with Ms Watters but "on the facts presented to me" she was satisfied that the claimant had not been de-registered for raising her concerns. She also noted that another member of staff had raised concerns about animal welfare but their engagement had not been terminated. (This appears to have been a colleague called Kaley, who raised similar concerns internally, and there are e-mails from her at pages 82 and 83).

58. There are no minutes of that meeting, and it adds nothing to the fairness of the process to have an internal discussion of this sort. Nor does it shed much light on the reasons for the decision, although it is somewhat surprising that the FTSU Guardian was present. Ms Brewer did make some handwritten notes which are at page 150. The note states:

> KP - insistent that something should happen. Seems patient gave permission? "Approached Patient with student nurse." Patient told her "to do what she has to do" Male nurse in charge (Ross McLachlan) said "yes, here are the keys, you can go to the

> patients house, but can't do in work time. So she decided to go in own time. She didn't return the keys, nobody asked her to return the keys? And wasn't agreed at the time.

59. There is also a marginal note which states "got keys back on Monday". It went on:

> She went to another Patients home, not inside, but got the address from Rio. Never acknowledged that she'd done wrong. "She said she'd do it again" – concern. Her work with patients is wonderful but concerning that she checked addresses, visited the properties + said she would do it again.
>
> Over weekend visited again. Gave address to friends who brought back goods.

60. This seems to show that the facts were at least related to Ms Brewer, and although Ms Pracy would dispute much of the above it appears to show that it was accepted that she had permission to go, and there was at least some doubt about whether she was required to return the keys at the time.

61. Despite this information Ms Brewer rejected the complaint, and did so in even more emphatic terms than the dismissal letter (page 151). The reasons set out go beyond those of Ms Thompson in some respects. The relevant bullet points were as follows:

- You visited the patients' home on your own to feed the cat and did not return the keys until they were asked for
- You gave the address of the patients' home to a friend for them to deliver cat food to you
- You made further visits to the patients' home before returning the keys
- You accessed information from Rio about patient addresses when you had no right to access that information
- When questioned you said that you would do the same again.

62. She went on to say:

> The reasons for your de-registration on the bank are clearly identified and are about breaches to data protection, code of conduct and professional boundaries.

63. That is the first mention of this Code of Conduct, which appears in the bundle at page 204a. At para. 1.4 it states:

> When working with patients, colleagues and other agencies, all staff members are expected:
>
> - To make the care and safety of patients their first concern

- To offer consistent and appropriate services to patients, with due respect for boundaries.
- To respect patient confidentiality
- Not to borrow money from or lend money to patients
- To maintain professional relationships with patients, that does not abuse the power and responsibility of this relationship. This includes not entering into sexual or emotional relationships with patients.

64. Then at section 3.1 (page 204L), it states:

> **3 Code of Conduct when working with patients**
>
> 3.1 Boundaries between staff and patients can be difficult to define and maintain but are essential for the protection of staff and patients. The following points should assist staff in establishing professional relationships with their patients. However, any issues about boundaries should also be brought to the attention of the staff team and discussed openly so difficulties can be acknowledged, and solutions sought. Open discussion amongst staff and managers should include giving and receiving support and ensuring any boundary difficulties do not have to be tackled by an individual alone.

65. It may simplify things to state at this point that we can see no breach of this Code, given that on each occasion Ms Pracy had the consent of the patient. Going to the rescue of their neglected pets, at their request, and with permission of more senior staff, having been open about her intentions, is not in our view overstepping her professional boundaries to any extent. Nor is there any breach of confidentiality beyond the minimum necessary in an emergency situation. Some common sense has to be applied. In her evidence at his hearing, Ms Brewer said that she did not believe that the patient gave permission in August, although we are satisfied that she did.

66. Hence, the outcome of her complaint was that she was criticised for going to the patient's house in January and looking through the letterbox, on the basis that she had accessed information from the Rio system, even though she was commended by Tamsyn Anderson for this at the time and there was nothing to show that she had done anything without permission. The issue over the return of the keys was then varied to an accusation that she had not returned them until asked for. And a further allegation was added that she said she would do the same again, although that was never put to her.

67. Afterwards there continued to be exchanges between the various senior managers about the dismissal. Ms Anderson felt that they should continue to look at including the RSPCA within the Trust's policies, and it is clear that she had a

discussion with Claire Watters about the situation on 14 September. This was immediately after receiving an e-mail from Ms Pracy appealing the decision, in which they also discuss Hannah Pile's point of view (page 133).

68. As a footnote, others seemed to be as surprised as Ms Pracy by her dismissal. Mr McLachlan provided her with a statement of supports, at page 161, which states:

> "The decision to terminate Karen's contract left many of us on the ward baffled and frustrated. Everyone understands the role of policies and the utmost importance of patient confidentiality. We understand the nature of the contract that the Flexi Team has with its employees. But it seems utterly blinkered to lose someone so trustworthy, devoted and caring at a time when the service is facing an unbelievable level of pressure and an already sizable exodus of experienced staff due to the stresses and working conditions put upon them.

Applicable Law and Conclusions

Legal applications for animal welfare

69. To be clear, there are legal obligations for the welfare of animals. The Care Act 2014 does place a duty on local authorities, when a person is taken into hospital, to take any pets into their care where they cannot be cared for by family or relatives. They are given powers to gain access to premises and to obtain reimbursement from the pet owner. There is also a duty on them under the Animal Welfare Act 2006 to ensure that the welfare needs of animals are met while they are responsible for them, even if this is only on a temporary basis. It imposes a continuing duty on the owner to look after their pets, and it also contains wider provisions aimed at preventing unnecessary suffering. Section 4 provides that anyone commits an offence if by any act of theirs, or failure to act, causes a "protected animal" – i.e. a domestic pet, to suffer unnecessarily.

Was there a Public Interest Disclosure?

70. The parties were in agreement about the relevant legal framework and we were very much assisted by the expert submissions on each side. To begin with, section 43A Employment Rights Act 1996 provides that:

> In this Act a "protected disclosure" means a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H.

71. Then by section 43B:

> (1) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show [in this case] …

(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject.

72. In **Blackbay Ventures Limited (t/a Chemistree) v Gahir** 2014 IRLR 416 the Employment Appeal Tribunal gave the following guidance for Tribunals:

(1) Each disclosure should be identified by reference to date and content;

(2) The alleged failure or likely failure to comply with a legal obligation or matter giving rise to the health and safety of an individual having been or likely to be endangered or as the case may be should be identified;

(3) The basis upon which the disclosure is said to be protected and qualifying should be addressed;

(4) Each failure or likely failure should be separately identified;

(5) The source of the obligation should be identified and capable of verification by reference for example to statute or regulation;

(6) The employment tribunal should then determine whether or not the claimant has a reasonable belief referred to in section 43B(1) (above)

(7) The employment tribunal should determine whether the disclosure was made in the public interest.

73. We need to start therefore by examining each of the alleged protected disclosures and deciding whether they meet these requirements.

74. Firstly, each of them has been identified by reference to date and content.

75. The second requirement is to identify the alleged failure to comply with a legal obligation. It is not essential that the Trust have that legal obligation, as long as Ms Pracy had a reasonable belief that the information tended to show such a breach and that that belief was objectively reasonable (a point also made clear in the **Nurmohamed case** which we will turn to shortly).

76. We take the view that there was a legal obligation on the Trust, under section 4 of the Animal Welfare Act 2006, to ensure that unnecessary suffering was avoided, so that when it came to their attention that pets belonging to patients were not being cared for, were in fact starving or trapped in houses without food or water, they had a duty to act. Whether that action takes the form of calling the RSPCA, or alerting the local authority, or housing association or AMHP section, is a moot point. We cannot conclude that they were under any obligation to send a member of staff to check on the animals. As Mr Curtis observed, that was above and beyond the call of duty. But there was a duty to act. If we are wrong on that point,

it seems to us objectively reasonable for Ms Pracy to have taken that view. Hence, the second point is satisfied in each case. It also seems to us that in each case the disclosure in question was about the duty to prevent unnecessary suffering.

77. As to the third point, these were qualifying disclosure because they all provided information that tended to show that that duty had been breached. The mere making of an allegation is insufficient, unless some concrete factual information is also conveyed. It is well-established that saying: "you are not complying with health and safety requirements" discloses no information, but adding: "because the wards have not been cleaned for two weeks", does: **Cavendish Munro Professional Risk Management Limited v Geduld** [2010] IRLR 38. That is an indication of the level of detail required, which is modest.

78. More recently, in **Kilraine v London Borough of Wandsworth** [2018] ICR 846, the Court of Appeal stressed that 'information' and 'allegation' are not mutually exclusive and that Tribunals should consider instead whether the disclosure has "a sufficient factual content and specificity such as is capable of tending to show one of the six relevant failures". In each of these cases, Ms Pracy was making specific reports about specific animals, who were at risk and so we have no concern about this aspect.

79. The failure in each case is essentially the same, the prevention of unnecessary suffering, so there is no need to separate out different disclosures on that basis, as stated at point four.

80. The fifth point relates to the legal obligation in question, which we have just explained. There is no requirement that Ms Pracy spelt it out at the time.

81. As to point six, as already noted, we are satisfied that she had the required reasonable belief.

82. In relation to the RSPCA disclosure (the third disclosure) there are specific extra requirements, under section 43G1 of the Act, since the disclosure was to an outside agency, i.e.:

    (a) the worker must reasonably believe that the information disclosed and any allegation contained in it, is substantially true;

    (b) the worker must not have made the disclosure for personal gain;

    (c) one of the additional conditions in section 43G2 must have been met, (in this case that she had previously made a disclosure of substantially the same information to her employer); and

(d) in all the circumstances of the case it was reasonable to make the disclosure.

83. Once again, we can see no issue with any of these points. She had made previous complaints, the RSPCA was the obvious port of call in the circumstances, and Mr Curtis and Ms Pile had both approved this course of action in general.

84. The last hurdle for Ms Pracy is the public interest test. This has been considered in a number of cases, particularly in **Chesterton Global Ltd and Anor v Nurmohamed (Public Concern at Work intervening)** 2018 ICR 731, CA. That case concerned disclosures about accounting practices at the firm and the Court of Appeal identified a range of factors that would be relevant including:

(a) the numbers in the group whose interests the disclosure served;

(b) the nature of the interests affected and the extent to which they are affected by the wrongdoing disclosed;

(c) the nature of the wrongdoing disclosed; and

(d) the identity of the alleged wrongdoer.

85. The first point to make is that there was no selfish or personal interest involved whatsoever. In each case Ms Pracy was acting for the benefit of the patient. The concerns arose one at a time but it is a problem that might have applied to any patient. Her overriding concern was to make sure that it did not keep happening, hence her suggestion that the admission form include details about pet care, which is clearly of wider interest. Hence, the numbers affected were modest but over time could affect many patients. As already noted, her colleague Kaley had also raised the same or similar concerns.

86. The nature of the interests affected are also serious. It concerned the avoidance of unnecessary suffering, or even death, of the pets in question, which would be of acute interest to the patients concerned.

87. The nature of the wrongdoing meant that there was potential for a series of such failures, and any one of them would be a criminal offence.

88. Finally, the Trust is a public body, part of the NHS, of whom the public has high expectations, and many would be shocked to find that no effective action was being taken in such circumstances.

89. Overall, we are satisfied that the public interest test is clearly met in respect of each disclosure.

Causation

90. The final, and perhaps main consideration is whether Ms Pracy's dismissal was materially influenced by these disclosures, or any of them. The statutory test is whether it was "on the ground that" the worker made a protected disclosure but the Court of Appeal in **Fecitt v NHS Manchester** [2012] IRLR held that if the disclosure "material influences (in the sense of being more than a trivial influence)" the detriment, this test is met.

91. To begin with, it is clear that Ms Thompson, the decision maker, knew of at least two of the disclosures, the report to the RSPCA and the long e-mail statement that Ms Pracy gave as part of the fact find. We accept that she was not aware of the earlier two e-mails and the fourth disclosure, the e-mail confirming her report the RSPCA but she was aware of the subject matter in general terms, and that there had been complaints in the past about animal welfare to the FTSU Guardian. It is not necessary to attempt to attribute the cause of the detriment to an individual disclosure, even though each disclosure has to meet the legal tests set out above; it is sufficient that the detriment is materially influenced by a combination of disclosures. There is of course an extensive overlap between each of the last three, which all concerned the events in August, and it is significant that the last disclosure was part and parcel of the fact find exercise itself, but it is the third disclosure, the telephone call to the RSPCA, which seems to us the trigger for the events that followed. It was the only occasion on which an outside agency had been contacted about a failure of process by the Trust, and that alone distinguishes any complaints raised by Ms Pracy from those raised by her colleague Kaley.

92. Secondly there is the severity of the sanction. It appears to us to be out of all proportion to any perceived offence. We have already made our findings that Ms Pracy was not to any extent at fault in her actions, even when viewed against the Trust's Code of Practice. If there was a breach in respect of professional boundaries or patient confidentiality it was at the very lowest end of the scale, and those policies do not stipulate that any breach will result in dismissal. Nowhere is there any recognition in the dismissal letter or the outcome to the complaint that she was acting on an urgent basis to deal with animals at risk of unnecessary suffering. Those documents read as if Ms Pracy with carrying out such actions in normal circumstances and without permission. It is not simply a case of us substituting our view for the seriousness of the acts in question, it is quite clear from the supporting statement given by Mr McLachlan that it was also viewed in that light by her colleagues. The terms of his statement are striking but seem to us fully justified by the facts.

93. We are left to wonder why dismissal was in contemplation at all. Before he became aware of the report to the RSPCA, Mr Curtis did raise some concerns

about Ms Pracy placing herself in a vulnerable position, but there is no suggestion of any disciplinary action against her. His concern was to put in place some more durable arrangements and to provide some support to her during a stressful time. We fully accept that it could not be anything other than a short term intervention on her part, but that is all that it proved to be. It seems to us entirely sensible that she would retain the keys in the circumstances as she found them, pending some other arrangements being put in place, and if she had continued her actions unilaterally at that stage she could simply have been spoken to or warned about the need to observe professional boundaries.

94. The third main aspect is the lack of any real inquiry into her explanations. We are not so much concerned with the lack of fairness in the process, although that is marked, but with the fact that no one appears to have been listening to her. The key facts here are that she had permission from Mr McLachlan to go round to the house and to go alone, that she was allowed to take the keys for that purpose, at least no clarity about when she was obliged to return them. It seems to us that a measure of discretion would have been implied in the circumstances, so that when she found out how bad things were it would not have crossed her mind that she was doing anything wrong in making a return visit and bringing the keys back afterwards. That could have been explored by HR with Mr McLachlan, and the failure to do so is an obvious one. We had some difficulty in understanding the Trust's position that she was at fault in attending the house alone, since this was an urgent matter, and that is exactly what she had permission to do, both from her supervisor and the patient. The obvious point that she was taking this action voluntarily in her own time and at own expense. There was no question of anyone else being given time off to accompany her and so the implication of this criticism is that she should not have gone alone and should simply have left the animals to fend for themselves, despite the patient's concern.

95. Is not necessary to provide any detailed critique of the process followed, but we have already described a number of serious failures such as taking a statement from her without any indication that it might lead to her dismissal; failing to interview any other witnesses; inviting her to a meeting on her day off work at almost no notice; and the fact that a decision had already been made in any event. We have to assume that the Trust would ordinarily apply high standards of fairness to its staff and the contrast here calls out for some explanation.

96. The fourth aspect which troubles us is the sudden and sharp change in tone from those involved once Ms Pracy told Mr Curtis that she had contacted the RSPCA. Her evidence was that both his tone and that of Ms Pearce changed markedly. It led very quickly to the involvement of Ms Watters, who had clearly spoken to Ms Pile, and Ms Pile's comments were in turn forwarded to Ms Anderson. It also appears that Ms Pile reported this to Ms Underwood, who reported it in turn to Ms Collins, Ms Thompson's manager. Each successive e-mail appears to put a more

negative spin on the events in question. So, for example, the e-mail from Ms Underwood refers to Ms Pracy "interpreting consent from a patient" rather than having consent from a patient. Ms Pile appears to have decided from the outset that she did not have consent, and this view has persisted, even to the point where Ms Brewer gave evidence to us that she still did not believe that Ms Pracy had permission. At the risk of labouring the point, the only people who would know that, or about the keys, are Mr McLachlan, who was simply not asked and was in any event supportive, and Ms Pracy herself, whose account seems to have been ignored.

97. A particular feature worth mentioning is the contrast between the commendation which Ms Pracy received for her actions in January 2021 in going out to a patient's house and looking through the letterbox to find animals in a state of distress, and the fact that this was then raised as misconduct against her without any inquiry into the circumstances. The whole complaint about the friend bringing cat litter to the second property also appears to us to have a manufactured air.

98. This collective and negative view on the part of senior members of staff also seems to have been arrived at straightaway and is in sharp contrast to the months of delay which followed the initial concerns about animal welfare raised by Ms Pracy.

99. We have to focus on the decision made by Ms Thompson, and in those circumstances it would have been very difficult for Ms Thompson to hold out against this prevailing view, and it is understandable that she was swayed by it. In cases involving the dismissal of an *employee* it is sometimes suggested that the decision maker might be unaware of the disclosure in question, but the dismissal might still be automatically unfair if they were influenced by a third party, who did have the necessary motivation. Ms Skinner reminded us of the Employment Appeal Tribunal guidance in **Malik v Cenkos Securities plc** EAT 0100/17 that this is not permissible in detriment claims, because in such cases the employee can sue the third party directly. However, we do not see this as such a case. Ms Pracy could not know, when dismissed, that so many managers had taken this view, so as to sue them separately and individually. It may seem somewhat unfair that Ms Thompson is left to carry responsibility for this collective view. In reality she was simply part of the management group out of which the decision was made, but overall it is clear to us that the decision to dismiss was materially influenced by the disclosure to the RSPCA, and in those circumstances the Trust is liable. Accordingly, the claim is upheld.

Compensation

100. Written reasons for the decision on liability have not been requested, but losses have been assessed. The total was based exclusively on loss of earnings to date, with no future loss, on the basis that Ms Pracy is starting another job on Monday.

Employment Judge Fowell

Date 18 January 2023

Judgment & Reasons sent to the Parties: 31 January 2023

For the Tribunal Office