EMPLOYMENT TRIBUNALS

Claimant: Mrs J Nwofor

Respondent: HCS Domiciliary Care Ltd

Heard at: Watford **On:** 12 & 13 January 2023

Before: Employment Judge Maxwell

Appearances
For the claimant: Mr Nwofor, Claimant's Husband
For the respondent: Mr McCrossan, Counsel

REASONS

1. These written reasons are provided further to the Respondent's request of 23 January 2023.

2. By a claim form presented on 29 December 2021, the Claimant complained of unfair dismissal. The Respondent denied the claim.

Evidence and Procedure

3. I received witness statements and heard evidence from:

   3.1 the Claimant;

   3.2 Mr Ravin Bheekha, Service Manager;

   3.3 Ms Fiona George, QA & Training Manager;

   3.4 Ms Linda Checksfield, Operational Director.

4. I was provided with a bundle of documents running to 193 pages.

5. As beginning of the hearing I spent some time with parties clarifying the written material which I had received. It transpired, the Claimant had additional documents she wished to rely upon. Examining these, one was in effect a supplemental witness statement and the other an email passing between the Respondent and the local authority about the incident for which it says she was

dismissed. These additional documents were admitted into evidence with the consent of both parties.

6. I explained the process that would be followed over the course of this two-day hearing, namely: my pre-reading; hearing witness evidence; the parties making their closing submissions; my deliberations; giving judgement and reasons; and then dealing with remedy if the Claimant succeeded. I invited time estimates for cross examination (having explained what this involved). Mr McCrossan indicated he would need 90 minutes with the Claimant. Mr Nwofor said he would need 20 to 30 minutes per witness. In the event, Mr Nwofor's cross examination of all three witnesses overran: Ms George was one hour and 10 minutes; Mr Bheeka 50 minutes; and Ms Checksfield 55 minutes. I was satisfied this extension was appropriate to allow, given the Claimant was not legally represented and Mr Nwofor was doing his best on her behalf in an unfamiliar environment. One consequence of this was that in the event the Claimant succeeded, then it would be necessary to deal with the question of remedy or another occasion. 1 hour 30 minutes was allowed to Mr McCrossan in cross-examination (I indicated that I would require strict adherence to the timetable by a professional representative).

7. Both parties made oral closing submissions and kept to the time-limit I had set of 30 minutes.

Facts

Witness Evidence

8. Although I was satisfied that all witnesses were doing their best to give honest and accurate evidence, where necessary to resolve a dispute of fact I preferred the evidence of the Respondent's witnesses, each of whom gave clear and direct answers to the questions put, which were consistent with the documentary evidence before the Tribunal. The Claimant's evidence was in some respects less satisfactory. When I referred her to a copy of her witness statement and asked if she had read this before, the Claimant said no. After reading through it, the Claimant said the statement was true. Given this apparent uncertainty, I asked how the statement was prepared. The Claimant told me her husband had drafted it, she had read it before but did not immediately recognise it. There were some notable differences between what the Claimant was recorded as saying to her employer in contemporaneous documents and the contents of her statement for the Tribunal now. One of the Claimant's arguments, pursued with some vigour at the hearing before me, was to the effect that the colleague she was working with on 2 October 2021, Bernadette Farrell, was Shift Leader and, therefore, her senior. On this basis it was argued Ms Farrell rather than the Claimant was the responsible person (or more so) when the incident for which she was dismissed occurred. Despite having been interviewed at length, actively participated in the disciplinary hearing and appeal, making both oral and written representations, the suggestion that she was junior on the night in question emerged for the first time in her witness statement for the Tribunal. I preferred the evidence of the Respondent's witnesses to the effect that the Claimant and Ms Farrell were both support workers of equal status and there was no shift leader. Their evidence in this regard was clear and consistent with the

documents I was shown. There were also other discrepancies in the Claimant's evidence to which I refer below.

Background

9. The Respondent is a domiciliary care agency, providing supported living accommodation and support to clients with learning difficulties.

10. The Claimant commenced her employment 10 May 2004 as a Support Worker. She was based at the Respondent's Pathway House premises. Her role was to support tenants with their day-to-day living needs.

11. In her claim form, the Claimant stated that she had not received any prior warning during her 17 year employment. This is not correct. She had received both informal advice and formal warnings about her performance or behaviour. The last such occasion prior to dismissal was on 14 August 2020, when Ms Checksfield found her asleep at work, which was dealt with informally. Whilst any formal warnings may have expired, this did not entitle the Claimant to make a positive assertion that none had ever been issued to her.

12. The Respondent, operates in a heavily regulated environment. It has various policies and procedures, with which staff are required to be familiar. The Claimant and her colleagues underwent training at regular intervals, covering various subjects relevant to the work they did. In her evidence the Claimant accepted she had received training in the Respondent's policies.

13. The Event Recording procedure included:

> **An event is unplanned or unexpected, it is usually preventable and may or may not result in injury or illness. It may result in damage to equipment or property. We separate events into the following categories:**
>
> **• Near Miss**
>
> **• Accident**
>
> **• Incident**
>
> **[…]**
>
> **Accident**
>
> **An HSE defines an accident as: "An event that results in injury or ill health." All accidents must be recorded on the 'Accident or Incident Record'. Where there is an injury or a potential injury, a member of staff with a current E.F.A.W. certificate will assess the person and take the appropriate action. Examples of an accident are:**
>
> **• Fall**
>
> **• Burn or scald**
>
> **Incident**

> **An incident may or may not result in an injury but could cause emotional upset. There may be intent to cause harm. All incidents must be recorded on the 'Accident or Incident Record'. Where there is an injury or a potential injury, a member of staff with a current E.F.A.W. certificate will assess the person and take the appropriate action. […]**
>
> **Recording**
>
> **All events must be recorded, this is a legal requirement. The event must be recorded in a timely manner. The member of staff dealing with the event must complete the 'Event Record' as soon as possible after the event has been dealt with. The record must be completed before the member of staff ends their shift.**
>
> **There are two records to record events. There is a 'Near Miss' record and an Accident or Incident' record. Staff must use the correct record for the event.**
>
> **Once the manager has been alerted to the event, they complete a follow up record. This records the actions that the manager has taken to deal with the event and to prevent a reoccurrence of the event. All event records must be complete, accurate and legible.**
>
> **When an event is related to a tenant, the event is always recorded on their daily log. As the detail is recorded on the event record, the log entry can be brief and refer the reader to the record. For example, the record entry could be "AB had an accident, she is okay, please see the accident record." Other records may need to be completed, such as a behavioural chart.**

14. As can be seen, the Respondent's policy not only requires the recording of accidents but also near misses. It is not the case that employees may choose not to record an event such as a fall because they are of view the client suffered no injury. Furthermore, the duty to make a record applies to members of staff "dealing" with an event. The obligation Is not one that only arises where an employee witnessed an event. An employee who arrives at the scene shortly after an event and then deals with it is obliged to make a record. The Claimant was aware that all events had to be recorded and had received training in how to do this.

15. Separately from creation of an event record, it was also necessary under this policy to make an entry in the daily log for the client and an example is given in the policy of what this might say where there has been a fall without injury.

16. The importance of recording events is underlined by the information set out in the policy about the relevant statutory framework, the need to make external reports and the explanation that such records may be examined in legal proceedings:

> **Depending on the event or the person involved, record might be sent to ILDT.**
>
> **We are required to send records of events to CQC where they are notifiable. In some cases, events are required to be reported to HSE (the Health and Safety Executive). Such events come under RIDDOR**

> **(Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Please read the RIDDOR guide from HSE.**

17. There is also an obligation to report such an event to the on-call manager:

> **A manager is on-call at all times. Staff must ensure that they are aware of the person allocated as 'on-call' during their shift. They are available for advice and support when an event occurs. The member of staff dealing with the event must make the decision as to when they contact a manager to report the event. In some cases, where the event is minor, this can be left until the manager of the service is next in the service. In more serious cases the on-call manger must be contacted immediately. In an event where any of the emergency service come to the service the on-call manager must be contacted immediately.**

18. The Respondent's first aid policy reiterates the need to record events:

> **Recording & Reporting**
>
> **It is a requirement that all accidents, incidents and near misses are recorded. The record must be completed as soon as possible after the event. The correct format must be used. Other records must be completed as required. All records are kept according to data protection guidelines. Recording is important because:**
>
> **• it is a requirement**
>
> **• it means that information is not forgotten**
>
> **• it clarifies further action such as; changes to prevent the accident reoccurring**

19. The Respondent's disciplinary policy emphasises the importance of employees complying with the Respondent's policies and procedures:

> **HCS Domiciliary Care Limited's vision is to provide a high-quality supported living service to our tenants. All staff are expected to work towards our vision and values. Staff are expected to be a role model for the organisation, to conduct themselves in a positive and professional manner, to adhere to our policies and procedures and work to their job description. Where the conduct or performance of an employee falls short of this, disciplinary action will be considered. No disciplinary action will be taken against an employee until the case has been fully investigated. The procedure may be implemented at any stage if the employee's alleged misconduct warrants this.**

20. The meaning of gross misconduct and examples are provided in the disciplinary policy:

> **Gross Misconduct**
>
> **Gross misconduct is when the actions by an employee are very serious or have very serious effects. Examples of gross misconduct are:**
>
> **• theft or fraud**

> **[…]**
>
> **• gross negligence (serious lack of care to their duties or other people causing loss, damage or injury through serious negligence)**
>
> **[…]**
>
> **• bringing the organisation into serious disrepute**
>
> **[…]**
>
> **• a serious breach of health and safety rules**
>
> **• a serious breach of confidence.**

The Incident

21. On 2 October 2021, two of the Respondent's clients (referred to as "T1" and "T2") were sitting in the lounge. T1 was highly vulnerable. The following information from a subsequent DBS referral was agreed as being accurate:

> **[T1] was on end-of-life support and passed away on 24/12/2021. [T1] had a learning disability. In addition, she had dementia, dysphagia, epilepsy and Down's Syndrome. She communicated non-verbally, this includes being unable to tell anyone if she was in pain. She was frail, not able to weight bear, with low mobility. She took blood thinning medication. She was incontinent. [T1] needed full support with mobility, personal care and eating and drinking.**

22. When in the lounge area T1 sat in a special chair, which included a lap belt so as to stop her from falling. The care provided to T1 was subject to a specific risk assessment and this included provisions with respect to the risk of falls:

> **• I use a hoist for transfers. If I am not supported correctly then I and those supporting me could be harmed.**
>
> **• If I am not seated correctly in my armchair, wheelchair, or commode/shower chair, I am at risk of discomfort, postural issues, pressure areas and falls.**
>
> **• I sometimes lean to the side when seated. If I were to sit in a chair / equipment without arms then I could fall. I could fall to the side if in sitting position on my bed**
>
> **• My upper body sometimes falls forwards when I am sitting, particularly if I fall asleep. If lap- belts on chairs and equipment are not fastened, then I could fall.**
>
> **[…]**
>
> **I have a tilting armchair, with head and torso support and a lap belt. The lap belt must be fastened.**
>
> **[…]**
>
> **A member of staff should always be in the lounge with me.**

23. Support workers who were tasked with providing care to specific clients, were obliged to read the risk assessments for them.

24. The Claimant and another colleague, Bernadette Farrell, were on duty during the day shift on 2 October 2021. They were both support workers, neither was senior to the other. Specifically, I do not accept the Claimant's evidence that Ms Farrell was Team Leader or Shift Leader. This assertion of a hierarchy in which the Claimant was junior, is a new matter, appearing for the first time in the her witness statement and is notably absent from her representations (oral or written) during the Respondent's internal proceedings.

25. The Claimant was allocated to provide care to T1 on this day. She had extended her hours by agreement with a colleague to provide cover for him.

26. Unfortunately, T1 fell from her chair onto the floor. Neither the Claimant nor Ms Farrell summoned medical assistance, contacted the on-call manager, made an entry into the log about this fall or recorded the incident in any other way and nor were the staff on handover told what had happened. The Claimant and Ms Farrell put T1 back into her chair.

27. There is uncertainty and disagreement between the parties as to precisely what happened immediately before and after T1's fall. For the purposes of determining whether the Claimant was unfairly dismissed, it is unnecessary for me to make specific findings in this regard (beyond that which is agreed) and I do not do so. My task is to review the fairness of the Claimant's dismissal based upon the information the Respondent had at the time.

28. The Respondent's management only learned of the fall on 14 October 2021 (12 days after the event) when a report was made by one of the Claimant's colleagues, Hopal Clayton.

Investigation

29. On 14 October 2021, the Claimant was suspended from work pending an investigation. This was confirmed in a letter of the same date, which included an allegation in the following terms:

> **gross negligence (serious lack of care to your duties or other people causing loss, damage or injury through serious negligence).**

30. The investigation was carried out by Ravin Bheekha. He conducted 13 interviews and obtained relevant documents, including the daily log completed by the Claimant without mention of this incident.

31. I am satisfied the notes of each interview (signed as agreed by the interviewee) are an accurate reflection of what was said (they are not put forward as being verbatim). The notes of the interview with T2 included :

> **he saw [T1] fell on the floor and called "Bernie" for help. […] Bernadette was in the same room writing her book. […] Josephine came as well to get [T1] up.**
>
> **[…] said that Bernadette told him not to say anything.**

32. The notes of the Claimant's interview included:

> **Josephine Nwofor supported [T1] on the 2nd October 2021. Josephine was meant to finish her shift at 20:00 but instead finished at 22:00 as she swapped with Pius Nkaru. I asked her if she had informed the house manager, she replied no but would inform the manager later.**
>
> **Josephine said Bernadette administered [T1] her medications. Josephine went in the kitchen to have her tea. Josephine said that Bernadette called her and when she came in the communal lounge, she found [T1] sitting on the floor while Bernadette was supporting her to sit upright.**
>
> **Josephine said [T1] was hoisted back to her wheelchair. Josephine carried a visual check with Bernadette who is a certified first aider.**
>
> **I asked Josephine what the right procedure is if someone had an accident such as a fall like [T1]. She said to call an ambulance.**
>
> **I explained that she should have called an ambulance for potential injury or call 111 for medical advice, call manager on call and house manager as well if the matter is of a serious nature and then filled an accident/incident report and finally wrote it in the log sheet.**
>
> **I asked Josephine, "How she thought [T1] end up on the floor that night". Josephine replied, "I don't know".**
>
> **I asked Josephine, "Can you remember if you put her lapbelt on". Josephine replied, "I can't remember"**
>
> **Josephine said it was her colleague who gave [T1] her medication and I asked who administered the medication, do you have to undo the lapbelt? She replied, "no"**
>
> **I asked her after [T1] had been hoisted on to her chair, "Did you had a discussion with your colleague if one of you should call an ambulance, call 111, fill an accident/incident report or call the manager". Josephine replied, "I did not mention it to her nor Bernadette mentioning it to me".**
>
> **Both have not observed HCS Domiciliary Care Ltd policy and procedure of Event recording, emergency first aid at work, safeguarding and health and safety.**
>
> **I asked Josephine," Did you tell [T2] to keep quiet". Josephine replied "No"**
>
> **I asked Josephine," who assisted her when assisting [T1] with personal care?"**
>
> **Josephine replied, " Josephine Namutebi"**

33. Amongst other things, during this interview the Claimant was asked whether she had any discussion with Ms Farrell about seeking medical assistance for T1 or event recording. As above, the Claimant said this was not discussed.

34. Josephine Namutebi was also interviewed. She denied assisting the Claimant with T1's personal care (which may have necessitated undoing the lapbelt) on the day in question.

35. The notes of the interview with, Hopal Clayton, included:

> **Hopal was on duty on the 5 th October 2021 and noticed the bruise on [T1] chin and had a good look at it.**
>
> **On Thursday 14th October 2021 Hopal was on duty. Hopal overheard Josephine Nwofor on her mobile phone in the laundry room. Hopal overheard the word '[T2]' and 'fall'**
>
> **Hopal said that [T2] and fall does not go well in the same sentence. Hopal said that she has a good rapport with [T2]. Hopal went into [T2]'s room and had a chat with him. Hopal asked [T2], "Did you fall?" [T2] replied to Hopal, "[T1] fell" she said [T2] put his finger to his lip and said that he had been told that he must not say it to anyone.**
>
> **Hopal asked Jospehine "Did [T1] fall?" Josephine said "No."**
>
> **Hopal told Josephine that she must inform the manager about it otherwise Hopal would report it." At that moment the argument became heated.**
>
> **Hopal went to her manager Sarah Ager-Fitzgerald about Josephine Nwofor that Josephine is not a team player and wish not to be working with her.**
>
> **Sarah A F, the manager informed Hopal, "Josephine made a complaint against you that you shouted at her."**
>
> **Hopal informed the manager, "Did she tell you why I shouted at her."**
>
> **Hopal gave a detail account to the manager of what she heard and what [T2] told her.**

36. The notes of the interview with Ms Farrell included:

> **Bernadette explained after giving medications and writing her logbooks, she went in the laundry room with a basket when one of the tenants, [T2] called her name.**
>
> **When Bernadette came back in the communal lounge, she found [T1] on the floor. Bernadette said that [T1] was on her knees and face on the floor with the her palm of her hand on the floor as well. Bernadette sat [T1] up on the floor and called Josephine multiple times for help. Bernadette described Josephine reaction time when she entered the communal lounge from the kitchen was slow and lack of spontaneity upon seeing [T1] on floor. Bernadette asked Josephine, "Did you strap [T1]?" Josephine replied to Bernadette, "Yes, yes." Bernadette also observed that the lap belt was pushed at back of the chair and by observing where the lap belt was, Bernadette believed that [T1] was not strapped on her chair. Bernadette also mentioned that on several occasions when the lap belt is done, it is hidden under her jacket as it is not visible.**

Bernadette believed it was highly likely that when [T1] came back from her personal care after 19:00 that the seat belt was not done. Bernadette raised a question that it requires two staff to assist [T1] with personal care at least one of them should have ensured her seat belt was done.

Bernadette carried out a visual check to ensure she is not injured. Bernadette is a first aider with a valid qualification.

Bernadette told Josephine that when night staff come, she will report it to them and on that night the two members of staff were Blessing Kazanga and Irene Namukasa. Bernadette also wrote it in the shift planner that [T1] must be observed for movement.

Bernadette questioned why she must be the one writing the incident form and call for medical assistance when she was not the one supporting [T1].

Event recording policy clearly states the staff who come across the incident in the place is the one completing the incident report while other member of staff can call for medical assistance. As a first aider, Bernadette should have call for an ambulance for potential head injury or concussion or call 111 for further medical advice.

I asked Bernadette, "Did you tell [T2] to keep quiet about the incident?" Bernadette replied, "No I did not tell [T2] to keep quiet and why would I tell him that when he is the one who called me."

Bernadette also stated that she told blessing to observe […] and if anything, happen to call her the following morning.

The allocation sheet only stated "[T1]= relaxing in the lounge, please observe her for movement"

This is not specific to the fall.

Bernadette admitted it was not entered in-.the logbook or calling 111. She also said that Josephine should have written something as well. Bernadette feels that it always her who must do everything, and others would not.

[…]

Bernadette claimed that after medication, Josephine should have been in the lounge with the tenant to observe the effect of the medication rather sitting in the kitchen.

Bernadette repeated it again that she accepted that she could have written that report or called 111 but annoyed that if Josephine had done what she should have done in the first place, then she would be here talking to me.

37. Mr Bheekha recommended disciplinary action be taken against a number of employees arising from this incident, including the Claimant and Ms Farrell. In response to this, Ms Farrell resigned and did not, therefore, attend a disciplinary hearing.

Disciplinary Hearing

38. By a letter of 28 October 2021, the Claimant was required to attend a disciplinary hearing. The letter attached the notes of interviews for T2, Ms Farrell, Ms Clayton and the Claimant herself, along with various records, the risk assessment for T1 and policy documents. She was advised of her right to be accompanied and warned that the outcome may be dismissal. The allegations were set out follows:

> **1. That on 2nd October 2021, you swapped your shift finish time from 20:00 to 22:00. You did not contact the on-call manager to get agreement for this.**
>
> **2. That on 2nd October 2021, you failed to follow [T1]'s risk assessment. [T1] was left alone in the lounge.**
>
> **3. You failed to follow [T1]'s risk assessment. Her waist strap was not fastened and she fell from her chair.**
>
> **4. You failed to follow HCS Domiciliary Care Ltd's policies and procedures, specifically:**
>
> **• Event Recording Policy**
>
> **• First Aid Policy**
>
> **• Health & Safety Policy**
>
> **• Statement of Purpose**
>
> **5. You did not follow our open and transparent way of working and covered up the incident, including giving a false account by omitting to record the incident. Another tenant was asked to not report the incident.**

39. The Claimant attended her disciplinary hearing on 3 November 2021. The decision-maker was Fiona George. Sarah Ager-Fitzgerald attended as note-taker and I am satisfied these minutes accurately reflect what was discussed.

40. The allegations were recited and Ms George explained the first matter (shift swapping) was treated as misconduct, whereas the remaining allegations were considered as gross misconduct.

41. The Claimant said she was aware that the risk assessment for T1 required her to not be left alone but Ms Farrell was with her. The Claimant was in the kitchen having her dinner when Ms Farrell called for her.

42. The Claimant said she was not sure there was a risk assessment for T1's use of a lapbelt. She did, however, know the lapbelt should be fastened and did not know why it was not.

43. Ms George said it was the Claimant who had been allocated to work with T1 and it was her responsibility to check the lapbelt. The Claimant did not disagree with this. Asked whether she had checked this, the Claimant's response is recorded as follows:

Josephine said that after dinner she supported [T1] with personal care. She did not check or touch the lap belt after bringing her back to the lounge. Josephine said that she positioned [T1] in a reclined position in her chair in the lounge. She did not check the lap belt.

Fiona asked Josephine why she did not check [T1]'s belt and she said because it had not occurred to her that she had not fastened it.

44. The Claimant was then asked about when she learned of T1's fall and what was done, thereafter:

Fiona asked Josephine when she knew that [T1] had fallen, Josephine said it was when BF called her.

When she went to the lounge [T1] was sitting on the floor and BF was beside her. Fiona asked what happened next. Josephine said they checked her to see if there were any obvious injuries.

Fiona asked in what capacity Josephine checked, she answered that she checked her body and face for any injuries.

Fiona reminded Josephine that her first aid training was out of date because she had been on leave during the last set of training. Fiona asked whether BF had assessed [T1] and whether they had a conversation about who the first aider was. Josephine said no. Fiona asked whether BF had assessed [T1] before Josephine came in and Josephine said she did not know.

Josephine stated that they could not see any obvious injuries. They then hoisted [T1] back into her armchair.

Fiona asked if they did anything else after this. Josephine said no because her colleague had told her not to worry, Josephine was not working the next day but BF was and BF said she would complete the accident form the next day.

Fiona asked Josephine what the company's policy said about recording events. Josephine said to record the incident or accident. Fiona asked when it needed to be written by.

Josephine said it should be written after reporting . Fiona clarified what the policy says: 'as soon as possible, and before the member of staff has left their shift.' Fiona asked why Josephine accepted BF saying she would write it the next day when this was not the policy.

Josephine said she thought BF would do what she had said. Fiona reiterated that what BF had said she would do was not the correct procedure. The correct procedure was to record it before the shift ends. Fiona asked why Josephine did not ask BF to do it before they left the shift. Josephine does not know why she did not say anything. Fiona clarified that Josephine left the shift knowing it was not completed.

Fiona asked Josephine whether she took part in the handover to night staff. Josephine said that BF had shown her what she had written on the handover form to look after[T1].

> **Fiona asked whether Josephine had told the night staff that [T1] had a fall. Josephine answered no. Fiona asked why she had not told them, and Josephine said that she did not know the reason why.**

45. Whereas at interview the Claimant had denied any conversation with Ms Farrell about event recording, at the disciplinary she explained not making a record herself because Ms Farrell had said she would do it. The Claimant was pressed further in connection with record keeping and not telling others what had happened:

> **The handover form only stated that [T1] should be monitored, it did not explain why or mention that she had a fall. Fiona confirmed that this was correct and night staff had not been informed of the fall and Josephine said yes.**
>
> **Josephine wrote the daily log for [T1] on 02/10/2021. It does not mention that she had a fall. Fiona asked why. Josephine answered that she had written it before the fall. The fall happened between 20:30 and 20:45 and she had written the log before this.**
>
> **Fiona asked why the record had not been completed between 20:45 and 22:00 when Josephine's shift finished. Josephine said she did not know.**
>
> **Fiona asked whether Josephine thought it was important for others to know that [T1] had a fall. Josephine said it is.**
>
> **Fiona asked Josephine whether she had a discussion with her colleague about calling NHS 111 or an ambulance. Josephine said no.**
>
> **Fiona asked whether Josephine thought she should have called the on-call manager or whether she had a discussion about calling with BF. She said they did not discuss it.**
>
> **Fiona stated that [T1] is frail and had fallen and hit her face. Fiona asked why Josephine had not felt it important enough to record and report. Josephine said that it was because she was not there when the fall happened, so she did not know how it happened. When she came in [T1] was on the floor.**
>
> **Fiona reminded Josephine that she had fallen, regardless of how it happened. Josephine had a responsibility for her safety. Fiona asked whether she thought her falling was important and Josephine said yes. Fiona asked her why she had not reported it if she thought it was important. Josephine could not say why.**

46. In her evidence at the Tribunal, the Claimant said she had not completed the daily log because she forgot. At the disciplinary hearing she told employer she did not know why she failed to do this. The Claimant also denied any conversation with Ms Farrell about seeking medical assistance or contacting the on-call manager.

47. The Claimant denied having told T2 not tell anyone else about this incident. Asked whether there was anything she wished to add to be taken into account when a decision was made, the Claimant's representations included that she did

care about T1. She was then asked, again, about the lack of medical attention being sought and record-keeping:

> **Fiona asked again why she did not get medical help for [T1], why she falsified documents and did not report if she cared. Josephine said she had not lied in the log, she just hadn't written it. Fiona clarified that not recording accurately is falsifying a document.**
>
> **Fiona said that she is not clear why medical help was not sought for [T1] and Josephine was unable to give an answer.**
>
> **Ravin asked Josephine whether she had completed an accident/incident form before and Josephine said yes. He reminded Josephine that there is a section on there that asks whether it has been recorded in the daily log.**
>
> **Josephine said that she had not recalled that at the time. It had not occurred to her to put it in the log because she had finished writing it.**

48. Following an adjournment to consider the position, Ms George informed the Claimant she had decided to dismiss and this was explained in the following terms:

> **• Josephine swapped her finish times and did not discuss it with a manager. Josephine's explanation was that she did not know but the policies are clear. This was a failure to follow policies and procedures.**
>
> **• [T1] was left on her own in the lounge and her lap belt was not fastened. It was Josephine's responsibility to ensure that she was not on her own and her responsibility to fasten and check the lap belt. Josephine's omission caused the fall.**
>
> **• Failure to follow policies and procedure - events, first aid, risk assessment, health and safety, statement of purpose. Josephine failed to follow these and was not clear on them. Staff are asked to read them and they are discussed in team meetings and covered in training.**
>
> **• Josephine did not work in an open and transparent way and because of this and the failure to follow the other policies and procedures [T1] did not get any medical intervention until almost two weeks later.**
>
> **The first point is misconduct but the rest are gross misconduct. Fiona summed up that from what Josephine has said it is clear that she did not follow the policies and procedures. Josephine also came across as not particularly caring about the policies and procedures. Josephine did not show caring and compassion to [T1] and because of these reasons Fiona stated that she is upholding all of the allegations which is gross misconduct.**
>
> **Fiona explained that gross misconduct means dismissal with immediate effect. A referral will also be done to DBS for barring. Fiona told Josephine that she will get everything explained in writing.**
>
> **Fiona asked whether Josephine had any questions. She said she realises she made a mistake but did not purposely treat [T1] badly. She does not understand how everything happened. She asked why she had not got a**

> **written warning first and Fiona explained that it was because it is gross misconduct.**
>
> **Misconduct can be inadvertent or deliberate. The seat belt not being fastened appeared to be inadvertent, however not recording or reporting appears deliberate. It is a breach of trust between Josephine as the employee and the organisation.**

49. On 4 November 2021, the Claimant's husband wrote on her behalf in the following terms:

> **On my return from an oversea trip last night, I met my wife Josephine in a terrible state, crying and sobbing. On inquiry, she told me what happened at her work place and her failure to document and report the incidence to the management, which was a great omission and violation of company policy.**
>
> **As much as possible, I saw her predicaments and regrets over her failure and tried to comfort and support her with little or no effect because of her thought of the possible outcome of her omission.**
>
> **Consequently, my wife and I sincerely apologize for her misconduct and plead greatly for Leniency for the management to spare her job.**
>
> **If that fails. Kindly consider retiring her next month when she will be 70 years old which seem to be the current Government retiring age. In order for her to maintain a fair record of service after 17 years of dedicated service in your organisation.**
>
> **Or advise her to submit an application for her retirement, which ever that fits in with the management policy.**
>
> **With respect and sincere regards, we appeal to the management to temper Justice with Mercy, the incidence was a great regret. Your kind consideration is greatly appreciated.**

Notably, at this stage, Mr Nwofor's husband understood the Claimant to be admitting that she had failed to document or report T1's fall and recognised this was a serious omission and breach of the Respondent's policy, for which misconduct she wished to apologise.

50. The decision to dismiss was confirmed in a letter of 9 November 2021:

> **A full investigation of the facts surrounding the complaint against you was made by Ravin Bheekha. At the disciplinary hearing you were afforded the opportunity to respond to the allegations arising from that investigation. Having carefully considered the representations that you made at the hearing, I have found that your explanations are insufficient and you have been unable to provide any reasons which might mitigate the circumstances presented.**
>
> **We have also carefully considered your employment as a whole and any mitigating factors, including your previous disciplinary conduct, employment position, length of service, experience and your individual circumstances, in order to consider whether a lesser sanction in place of dismissal may be appropriate, such as redeployment or a final written**

warning. Unfortunately, we have not been able to identify any mitigating circumstances or appropriate alternatives to dismissal. For this reason, I find that the appropriate course of action to take in response to your conduct, is to terminate your employment on grounds of gross misconduct and because I believe that going forward no further trust and confidence can be placed in you.

I would refer you to the following aspects of your conduct which are, in my view, wholly unacceptable and which have led to your summary dismissal:

• That on 2nd October 202 1, you swapped your shift finish time from 20:00 to 22:00. You did not contact the on-call manager to get agreement for this.

• That on 2nd October 2021, you failed to follow [T1] risk assessment. [T1] was left alone in the lounge.

• You failed to follow [T1]'s risk assessment. Her waist strap was not fastened and she fell from her chair.

• You failed to follow HCS Domiciliary Care Ltd's policies and procedures

• You did not follow our open and transparent way of working and covered up the incident, including giving a false account by omitting to record the incident. Another tenant was asked to not report the incident.

• Failing to uphold duty of care and to keep our tenants safe

• Failing to follow an open and transparent way of working by seeking to cover up the incident

Whilst the outcome letter refers to T2 having been asked not to report the incident, this was not in fact a finding Ms George made against the Claimant and did not contribute to the decision to dismiss. Its inclusion in this letter was an error, having been incorrectly transposed into the outcome letter from the original allegations.

51. The Claimant appealed against her dismissal. She provided detailed grounds in writing, running to 7 pages. She developed 4 points, which she summarised as:

1) The hearing was greatly biased.

2) The Hearing failed to consider the key facts of the issues surrounding each case.

3) Unjustified referral of internal omission to DBS with a view to tarnish my employment record.

4) The unfair termination of my employment to be reasonably reviewed.

52. The Claimant attended her appeal on 1 December 2021. The decision-maker was Linda Checksfield. There was a very extensive discussion of the Claimant's appeal grounds.

53. The Claimant's appeal was not upheld and the decision is this regard was communicated by way of a letter dated 7 December 2021. This included:

> **Having read the investigation report, the notes of the disciplinary hearing and having listened to the recording of the disciplinary hearing I find that the hearing followed the ACAS Code of Practice and HCS Domiciliary Care Limited's Disciplinary Procedures.**
>
> **The hearing chair took time to ensure that you were comfortable and clear of the hearing remit. You were treated respectfully throughout the hearing by the chair, notetaker and investigating officer. You were given ample opportunity to respond to the allegations. You were given ample opportunity to state any mitigating factors. You were given ample opportunity state your case and make additional points. The hearing clearly addressed the facts. You admitted that the allegations of gross misconduct were true.**
>
> **I have considered the document you brought to your appeal:**
>
> **You appear to suggest that [T1] herself, or a faulty belt could be the cause of it coming undone. I have considered whether [T1] could undo the waistbelt herself and found that she is not able to undo the waistbelt herself. I have considered whether the waist belt was faulty and found that this was not the case.**
>
> **On the contrary, shortly before the incident you provided personal care to [T1] alone and were therefore responsible**
>
> **You provided personal care to [T1] and were responsible for ensuring that the waistbelt was fastened and it is reasonable to conclude that it is highly likely you did not fasten the waistbelt following the personal care.**
>
> **In any event, it was your responsibility to ensure that the waistbelt was fastened at all times.**
>
> **Whilst I note that you were assisting your colleague by agreeing to cover the remainder of his shift, changes to a rota must be cleared with a manager. This is set out in our policies and procedures**
>
> **You said that you asked your colleague to support [T1], whist you took a break and that she agreed. Having reviewed the evidence I find it reasonable to conclude that this was not the case.**
>
> **Whilst I appreciate that you have apologised for failing to record the incident, I consider this to be a very serious omission. Your failure to record the incident and to handover to colleagues that [T1] had had a fall, meant that she was not observed as she should have been. In addition, I consider your failure to deal with the incident in accordance with our procedures by not getting [T1] any medical attention a very serious breach.**
>
> **I find that by not recording the incident, not informing your colleagues or the manager of the incident a very serious breach and a failure to follow our open and transparent way of working by seeking to cover up the incident. I accept that you did not ask [T2] not to tell anyone. I understand from speaking to Fiona that this allegation was dropped during the**

> **disciplinary hearing. Whilst the dismissal letter does refer to this in general terms, I apologise if this was not made clear.**
>
> **I have considered your previous service record and your length of service.**
>
> **Unfortunately, my findings are that the breaches are serious and justify the allegation of gross misconduct being upheld.**

Law

54. Pursuant to section 98(1)(a) of the **Employment Rights Act 1996** ("ERA"), it is for the respondent to show that the reason for the claimant's dismissal was potentially fair and fell within section 98(1)(b).

55. If the reason for dismissal falls within section 98(1)(b), neither party has the burden of proving fairness or unfairness within section 98(4) of ERA, which provides:

> **In any case where the employer has fulfilled the requirements of subsection (1) the determination of the question whether the dismissal is fair or unfair having regard to the reason shown by the employer -**
>
> > **(a) depends on whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as sufficient reason for dismissing the employee, and**
> >
> > **(b) shall be determined in accordance with equity and the substantial merits of the case.**

56. Where the reason for dismissal is conduct the employment tribunal will take into account the guidance of the EAT in **BHS v Burchell [1978] IRLR 379**. The employment tribunal must be satisfied:

    56.1 that the respondent had a genuine belief that the claimant was guilty of the misconduct;

    56.2 that such belief was based on reasonable grounds;

    56.3 that such belief was reached after a reasonable investigation.

57. The employment tribunal must also be satisfied that the misconduct was sufficient to justify dismissing the claimant.

58. The function of the employment tribunal is to review the reasonableness of the employer's decision and not to substitute its own view. The question for the employment tribunal is whether the decision to dismiss fell within the band of reasonable responses, which is to say that a reasonable employer may have considered it sufficient to justify dismissal; see **Iceland Frozen Foods v Jones [1983] IRLR 439 EAT**.

59. The band of reasonable responses test applies as much to the **Burchell** criteria as it does to whether the misconduct was sufficiently serious to justify dismissal; see **Sainsbury's Supermarkets v Hitt [2003] IRLR 23 CA**.

60. Where an appeal hearing is conducted then the **Burchell** criteria must also be applied at that stage, in accordance with the decision of the House of Lords in **West Midlands Co-operative Society v Tipton [1986] IRLR 112** and the speech of Lord Bridge:

> **"A dismissal is unfair if the employer unreasonably treats his real reason as a sufficient reason to dismiss the employee, either when he makes his original decision to dismiss or when he maintains that decision at the conclusion of an internal appeal."**

61. After an appeal, the question is whether the process as a whole was fair ; see **Taylor v OCS Group Limited [2006] IRLR 613 CA**, per Smith LJ:

> **46. […] In our view, it would be quite inappropriate for an ET to attempt such categorisation. What matters is not whether the internal appeal was technically a rehearing or a review but whether the disciplinary process as a whole was fair.**
>
> **47. […] The use of the words 'rehearing' and 'review', albeit only intended by way of illustration, does create a risk that ETs will fall into the trap of deciding whether the dismissal procedure was fair or unfair by reference to their view of whether an appeal hearing was a rehearing or a mere review. This error is avoided if ETs realise that their task is to apply the statutory test. In doing that, they should consider the fairness of the whole of the disciplinary process. If they find that an early stage of the process was defective and unfair in some way, they will want to examine any subsequent proceeding with particular care. But their purpose in so doing will not be to determine whether it amounted to a rehearing or a review but to determine whether, due to the fairness or unfairness of the procedures adopted, the thoroughness or lack of it of the process and the open-mindedness (or not) of the decision-maker, the overall process was fair, notwithstanding any deficiencies at the early stage.**

Conclusion

Reason

62. The reason for dismissal was that the Respondent, in the person of Ms George at the disciplinary hearing, had a genuine belief Claimant was guilty of the misconduct alleged (save for the element which concerned T2 being told not to tell anyone else about the incident).

63. No, or no credible alternative reason for dismissal has been advanced. Mr Nowfor did in closing submissions suggest Ms Farrell and Ms Clayton conspired to secure the dismissal of the Claimant because she agreed to do too much overtime. I did not understand him to say that Ms George made her decision for this reason but in any event I accepted the evidence she gave me as to the reasons for her decision, and this is reflected in what she is recorded as saying to the Claimant at the end of the disciplinary hearing and in the dismissal letter.

Grounds

64. There were reasonable grounds to support a conclusion that the Claimant had swapped shifts without the permission of her manager. The Claimant admitted doing this, albeit she sought to justify the position by saying that her colleague had begged her to. This was in any event not treated as gross misconduct.

65. There were reasonable grounds to support a conclusion the Claimant had not followed the risk assessment for T1 in that she was left alone. The Claimant gave evidence at the Tribunal, she was only away for 5 minutes to have a cup of tea and had arranged with Ms Farrell to provide cover. This is not, however, what she told her employer at the time, which was that she was away for 10 or 15 minutes having her dinner because it would have been too late for this by the time she got home.

66. There were reasonable grounds to support a conclusion the Claimant had not followed the risk assessment with respect to the lapbelt. The Claimant admitted to having provided personal care (i.e. with cleaning and toileting) to T1, which would have necessitated the lapbelt being undone. On returning T1 to her chair in the lounge, it would be necessary for the lapbelt to be fastened. The Claimant was responsible for T1 that evening. It fell to the Claimant to ensure the lapbelt was done up. Evidently, the lapbelt was not done up, as T1 fell. The Respondent could, reasonably, reject as unlikely the suggestion advanced at the appeal that T1 undid her own belt. The Claimant admitted she did not check the lapbelt after bringing T1 back into the lounge. She said she did not check it because it had not occurred to her that she had not fastened it. The simplest explanation for what happened based upon the evidence the Respondent had received, was that the Claimant forgot to fasten or check the lapbelt after personal care had been provided to T1 and this is why she fell.

67. The Respondent had reasonable grounds to support a conclusion that the Claimant had not followed its policies and procedures. The event recording policy applied to the Claimant. She had neither made a record of the incident nor referred to the fall in T1's daily log. This omission was a clear breach of her duty under the policy. Whilst Ms Farrell was also under a duty to create an event record, this does not mean the Claimant was relieved of it, rather it applied to them both. The explanation that Ms Farrell assured the Claimant she would make a record the following day was not mentioned at interview and when advanced at the disciplinary, it was pointed out this would not comply with the policy as employees were required to make a record before the end of their shift. Separately from the event record, T1's daily log was created by the Claimant and the omission of any reference to the fall is glaring. Whilst the Claimant said she had completed the log before the fall, it would have been a simple matter to add to this. Furthermore, given a very frail and highly vulnerable client, who could not communicate verbally (i.e. explain if she was in pain) had fallen, the decision not to seek immediate medical attention is astonishing. The same could be said of the failure to contact the on-call manager. All of these matters would appear to be in breach of the Respondent's policies.

68. These many omissions are so very striking, there is an obvious inference to draw that they were not inadvertent but rather were deliberate, intended to avoid the Claimant or Ms Farrell being punished for T1's fall. Whilst I do not myself

draw that inference, as it is unnecessary for me to make findings of fact about precisely what occurred, I am satisfied it was open to the Respondent to do so. Accordingly, therefore, it had reasonable grounds for its conclusion as to a lack of transparency and cover-up.

Investigation

69. Mr Bheeka's investigation was extremely thorough. He interviewed a large number of employees and one client. He explored relevant factual matters with them. In some cases, including the Claimant and Ms Farrell, these were lengthy discussions. Mr Bheeka obtained relevant documents. No appropriate lines of enquiry have been identified which he failed to pursue.

70. Whilst in his closing submissions, Mr Nwofor suggested the Respondent ought to have investigated the conspiracy he alleged, this was not the way the Claimant defended herself time.

Procedure

71. the Respondent carried out a full and fair disciplinary and appeal process. The allegations and the material to be relied upon by management was provided to her in advance. She was advised of her right to be accompanied. She was warned that (save for the shift swapping) these matters were considered as amounting to gross misconduct and she was at risk of dismissal. The allegations and evidence were discussed fully. The Claimant took the opportunity to engage with these matters and explain her position. She was not prevented from advancing her defence. Both the decisions to dismiss and reject her appeal involved a careful consideration and analysis, as is reflected in the detailed rationales provided in writing at the time.

Sanction

72. The misconduct found against the Claimant, plainly, fell within the examples of gross misconduct in the handbook including gross negligence, serious breach of health and safety rules and serious breach of confidence (unsurprisingly, the Respondent's trust in the Claimant was undermined by these events). Furthermore, whilst in the course of the Tribunal hearing I expressed some doubt about whether the Claimant's failure to include the fall in T1's daily log could amount to fraud (because it was not being done to obtain a pecuniary advantage) I was persuaded by Mr McCrossan that falsifying documents to retain employment might amount to fraud. Given the Respondent found a cover-up, therefore, these omissions could be said to have been fraudulent, as the obvious reason for the same would be to avoid dismissal.

73. Separately from an analysis of whether not the misconduct found fell within the examples given in the Respondent's disciplinary policy, these matters on their own facts clearly amount to gross misconduct. An extremely frail and vulnerable client fell because the lapbelt intended to prevent this obvious risk from materialising had not been done up. It was the Claimant's duty to fasten this belt and check that had been done. When T1 fell, care for her was not summoned, required reports were not made, the on-call manager was not contacted and staff on handover were not told what happened. Instead, on the findings made

by the Respondent, the Claimant and Ms Farrell sought to cover their tracks. The matter only came to light because a diligent employee discovered what had happened and brought this to her employer's attention. The concealment of neglect and wrongdoing in care homes is a matter of real public concern. The conduct found would plainly tend to destroy trust and confidence.

Conspiracy

74. Mr Nwofor's closing submissions advanced (at some length) a conspiracy by Ms Farrell and Ms Hopal who were said to comprise or be part of a "gang" or "syndicate" which concocted a plan to dismiss the Claimant because she was always willing to carry out overtime. The events of 2 October 2021 were said to be the implementation of this plan. This scenario was not supported by the Claimant's witness statement or any other evidence before the Tribunal, had not been put in cross-examination and emerged for the first time in Mr Nwofor's submissions. The Respondent's management were said to have used the product of this conspiracy as a "weapon" against the "innocent Claimant". I make no such finding.

Unfair Dismissal

75. In all circumstances, the Claimant's dismissal was not unfair.

Employment Judge Maxwell

Date: 13 March 2023

Sent to the parties on:

14 March 2023

For the Tribunal Office: