EMPLOYMENT TRIBUNALS

Claimant: **Mrs M Emery**

Respondent: **Barchester Healthcare Ltd**

REASONS

Background

1 The Claimant was employed by the Respondent in the position of part-time Night Senior Carer at Denmead Grange Care Home from 20 January 2020 until 15 September 2022 when she was summarily dismissed for gross misconduct following an incident that occurred on 12 May 2022. The Claimant pursues claims of unfair and wrongful dismissal. The Claimant submits that the allegations made against her following this incident were incorrect, malicious and defamatory and damaged her disciplinary record and professional reputation.

2 The Respondent is a care provider which operates care homes throughout the United Kingdom providing a range of services from assisted living to residents suffering from dementia. It employs approximately 17,000 staff. The Respondent submits that it carried out a reasonable investigation into the incident and that following a disciplinary hearing the manager conducting the hearing held a reasonable belief that the Claimant had committed gross misconduct by failing to follow procedures which were in place for the safety of its residents and to avoid potential legal liabilities, and that her dismissal was within a range of reasonable responses available to the Respondent.

3 The Tribunal was provided with an Agreed Bundle of Documents comprising 273 pages: **Exhibit R1**. The Tribunal received evidence on behalf of the Respondent from Ms Abbie Johnston, General Manager, Denmead Grange Care Home; Mrs Sarah Hayman, Senior General Manager (South Region) and Mr Martin Corrigan, Regional Operations Manager (South) who gave their evidence in chief by written statements: **Exhibits R2, R3 and R4**. The Claimant gave evidence in chief by written statement: **Exhibit C1**. The Tribunal made the following findings of fact after considering all the oral and documentary evidence put before it during the hearing following due consideration of the submissions it received from the Claimant and Mrs Laxton on behalf of the Respondent.

Findings of Fact

4 The Claimant is a qualified Nurse who has worked in health and social care for over 40 years and who had worked in a position of full time Matron and Manager of a nursing home before joining the Respondent. She did not renew her Nurse PIN registration after she joined the Respondent because of the nature of her work as a Night Senior Carer. Denmead Grange is a 60 bed Care Home. It has two floors; the ground floor provides residential care. The first floor provides care for residents suffering from dementia.

5 The Claimant was on night duty on 12 August 2022 when she responded to an emergency bell set off by her colleague Mrs Trigg, who was then working on the first floor. She had found an unresponsive resident ("R") lying across the threshold of the door to his room, half in and out of the room and partially in the corridor outside his room.

6 The Claimant immediately attended on Mrs Trigg at the scene and took charge of the incident. After examination she concluded R was dead. She instructed Mrs Trigg to fetch a hoist. They used the hoist to move R into his room and to lay him on his bed. This was because the Claimant and Mrs Trigg could not close the door, wanted to remove him from obstructing the hallway, which was a thoroughfare for other Residents, and to preserve R's dignity and privacy. They noted that while he was being moved there were possibly two exhalations of breath.

7 The Claimant went to phone 999 after they had lifted R on to his bed. Another colleague (Yvonne) had arrived on the scene by this time. When the Claimant left them Mrs Trigg and Yvonne were changing R's pyjamas because he had urinated at the time of his fall. Subsequently, Mrs Trigg contacted R's next of kin. She informed them that he had been found dead on his bed. The police attended the scene following the Claimant's 999 call. They interviewed the Claimant and Mrs Trigg.

8 Mrs Trigg completed the required documentation to record the incident which included the Progress and Evaluation Records, the Healthcare Professional Record and the Wellbeing Observation Record for R. She wrote that R had been found dead on his bed at approximately 8.20 pm on 12 August 2022. However, at the handover meeting which the Claimant and Mrs Trigg held with those taking over from them on the morning shift it was stated that R had been found in the doorway of his room and had been hoisted on to his bed.

9 There was an obvious contradiction between what had been recorded by Mrs Trigg and the information provided to the morning shift about the circumstances of R's death. It was clear that it had been unexpected and unwitnessed but unclear as to whether he had been found after a fall in his doorway or on his bed. This was reported

to Ms Johnston who concluded that she should attend on the Claimant and Mrs Trigg to ascertain what had occurred. She met with each of them separately on 16 August.

10 Ms Johnston asked the Claimant to describe what had happened after she responded to the emergency bell. The Claimant said that she had called 999 while Mrs Trigg went to fetch the hoist. The police were called to the scene. The Respondent was on his bed and in his new pyjamas when they arrived. They interviewed the Claimant and then interviewed Mrs Trigg. The Claimant sent a note to Ms Johnston on the day after her interview to clarify what she had said to her during the interview. This stated as follows:

> *"I have thought about it overnight and I think I said it wrong yesterday.*
>
> *I rang 999 after we had put him in the bed and I went to get his green folder from the Office.*
>
> *Also, they said not to move him but we had already put him on the bed. They said don't let anybody else touch him but when I went back they had already changed his pyjamas"*

11 During her interview Mrs Trigg informed Ms Johnson that the Claimant had said they should report that R had been found dead on his bed which is what Mrs Trigg had documented in the records she had completed in respect of the incident. However, when she had confirmed this to the police during their interview with her they had told her that this contradicted what the Claimant had said to them which was that R had been found dead and then lifted on to his bed. Mrs Trigg apologised to the police interviewer for becoming confused and agreed that the Claimant had correctly described what had happened.

12 Ms Johnston was concerned that R had died unexpectedly and that the Claimant and Mrs Trigg, who could not verify R's death had moved his body before the required verification of his death had been completed. She suspended them on 17 August pending her further enquiries. Their suspensions were confirmed to them in separate letters sent to each of them on 17 August. These letters confirmed that she was investigating allegations that they had not followed appropriate checks when finding R on the floor and had not sought appropriate advice before moving him. The letters attached a Q+A to explain the suspensions. They also gave details of the Employee Assistance Helpline that was available to them.

13 On 19 August the Claimant wrote to Ms Johnston in respect of the matters which the suspension letter sent to her had explained were now under investigation. In this letter she described her observations of R after she had been called to the scene by Mrs Trigg. She wrote that she was unaware that either of them had been trained to deal with such a situation. She explained that her intention had been to ensure the

deceased's privacy and dignity and to avoid other patients having to walk over, or round him which could have created a hazard in the corridor outside his room.

14 Ms Johnston conducted a further brief interview with the Claimant on 25 August to clarify the position in respect of what had been documented and initially reported to the police by Mrs Trigg. The Claimant explained to Ms Johnston that Mrs Trigg had not been able to cope with the situation after she round R dead. She had taken over and after checking R's pulse and chest had decided to move him off the floor. She denied that she had told Mrs Trigg that they should report that R had been found dead on his bed.

15 When she had concluded her investigation into the incident Ms Johnston prepared two Investigation Reports dealing with the Claimant's and Mrs Trigg's involvement. Her Report included notes of her meetings with the Claimant and Mrs Trigg and other members of staff that she had interviewed and the Claimant's training record. The conclusion of her Investigation Report states as follows:

> *"I feel that this incident requires formal action to be taken. The correct policy and procedures were not followed when this individual was found on the floor. Also the documentation does not show that any of the appropriate actions or checks were carried out before moving the individual"*

Ms Johnston's recommendation was that the matter should progress to a disciplinary hearing. Ms Johnston made the same recommendation for Mrs Trigg who attended a separate disciplinary hearing at the end of which she was dismissed.

16 Ms Johnston sent a letter to the Claimant on 2 September inviting her to a disciplinary hearing on 8 September. This letter informed the Claimant that the hearing would be conducted by Mrs Hayman, a Senior General Manager, who would be accompanied by a minute taker. The allegations to be considered at the disciplinary hearing were stated to be as follows:

- *You did not follow appropriate checks when a resident was found on the floor.*
- *You did not seek appropriate advice before moving a resident found on the floor.*

It was explained to the Claimant that if the allegations were proved it would be considered Gross Misconduct and her employment might be terminated. She was also informed that she could be accompanied at the hearing by either a work colleague or an accredited Trade Union official.

17 Ms Johnston was not involved with the disciplinary proceedings apart from answering questions which Mr Corrigan raised with her following the appeal hearing. There were two other matters which were connected to R's death which Ms Johnston had to deal with. Ms Johnston attended on the deceased's family to inform them that R had died after collapsing in the doorway of his room and had not been found dead on his bed as they had been informed shortly after his death. Ms Johnston was also required to

complete a report in the format submitted to the Respondent by the CQC, the relevant Regulatory Body, in respect of R's unexpected and unwitnessed death.

18 Mrs Hayman read all relevant papers in advance of the disciplinary hearing. These included the Claimant's letter of 19 August with her response to those matters that were under investigation during the suspension. The hearing proceeded on 8 September. The Claimant chose to attend the hearing by herself. The notes taken at the hearing were agreed as a true record by the parties and were signed by the Claimant.

19 There was no dispute as to the relevant facts. She confirmed that she had taken over from a distressed Mrs Trigg on arrival at the scene. She referred to the checks she had carried out on R. These could not be verified because neither the Claimant nor Mrs Trigg had recorded that any checks had been carried out by the Claimant as they should have been. The Claimant was satisfied R was dead. She accepted that in her position of carer, she could not verify R's death and that verification was required by a suitably qualified medical professional or the police in these circumstances.

20 Mrs Hayman sought the Claimant's explanation of why she had not immediately telephoned 999 to take advice as to the situation which she was facing and had moved R's body before making that call and before his death had been properly, and formally, verified by a qualified medical professional or the police. The Claimant told Mrs Hayman that she had left people on the floor in the past and dialled 999 but on this occasion she and Mrs Trigg wanted to put R on his bed to make him more private and dignified and were not able to close the door to his room if they did not do so. They were also aware that R's wife was resident at Denmead Grange and they did not want her to see him on the floor.

21 When Mrs Hayman explained the Respondent's policies and procedures directed that R should not have been moved the Claimant informed her that she had done so many times in similar situations. The minutes record that she then said to Mrs Hayman: "I'm sorry but I would always move them". She also informed Mrs Hayman that during moving and handling training carers had been told that residents could be moved in an emergency.

22 Mrs Hayman reserved her decision. She set out her decision in writing to the Claimant in a letter she sent to her on 15 September 2022. She was satisfied that the Claimant was aware of the procedures to which she had referred her during the disciplinary hearing. She could not verify the checks which the Claimant may have made on R. This was because these had not been recorded. Therefore, she could not be satisfied that the appropriate checks had been made. Furthermore, The Claimant had not sought appropriate advice (by calling 999) before moving R who should not have been moved before there had been a formal verification of his death.

23 Mrs Hayman considered that the Claimant had been responsible for serious and substantial failings and was concerned that Claimant did not accept that she had done anything wrong and that these failings could not be mitigated by her length of service

and excellent disciplinary record, and recent personal difficulties which the Claimant had submitted to her. Her letter informed the Claimant that she had decided to summarily dismiss her with immediate effect from 15 September 2022. Her letter informed the Claimant that she was entitled to appeal against her decision. She enclosed the Respondent's Notification of Appeal Form to assist the Claimant in pursuing an appeal if she decided to do so.

24 After receiving Mrs Hayman's letter of dismissal on 20 September the Claimant submitted an appeal on 24 September in which she enclosed extensive written representations together with a copy of the First Aid Handbook from which she referred to the Doctor ABCD and DRABCD flowcharts at pages 12 and 13 of the Handbook. The Claimant set out the outcome she sought from the appeal in the following terms: "*I would like a letter of apology and my dismissal to be overturned although I have no intention of being reinstated. I would like a reference to be provided to a future employer and payment for my notice period*".

25 Mr Corrigan, a Regional Operations Manager (South), was assigned to hear the Claimant's appeal. He had no previous involvement with the disciplinary proceedings. The appeal was held on Zoom on 18 October in the presence of a notetaker. The Claimant had been advised of her right to be accompanied to the hearing but chose to attend by herself. Mr Corrigan had read all relevant documents in respect of the investigation, the disciplinary hearing and the Claimant's representations in respect of her appeal in advance of the hearing. The parties are agreed that the notes of the hearing are an accurate record of the discussions between Mr Corrigan and the Claimant during that hearing.

26 During the appeal hearing the Claimant maintained, as she still maintains, that the Respondent's Falls Policy was not relevant to the incident she was dealing with. This is because she had substantial nursing experience and was satisfied that the Respondent was dead. The key representation which she submitted to Mr Corrigan was that the procedures referred to in the flowcharts in the Respondent's First Aid Handbook gave her a discretion to move R's body before seeking advice by telephoning 999 and without waiting for formal verification of his death. She did not accept that she had contradicted express directions in Appendix 3 of the Respondent's Fall Policy or the Respondent's Unexpected Death procedure for that reason.

27 Mr Corrigan reserved his decision at the end of the hearing. This was to give himself time to consider the submissions that had been made to him by the Claimant and what he had discussed with her during the appeal hearing. He sought clarification from Ms Johnston on three matters. Firstly, whether the Claimant had undertaken valid verification training, which she had not. Secondly, whether the CQC, the Regulatory Body who had to be informed of the circumstances of R's death had been informed that it had been unexpected; which it had. Thirdly, whether R had been attended by a GP prior to the incident; which he had not.

28 Mr Corrigan found the Claimant's position inexplicable and unsustainable. He considered that the Respondent's procedure for Unexpected Death made it clear that for all unexpected deaths the deceased should not be moved, the relevant authorities should be contacted (by a 999 call) and the deceased and his / her environment should be unchanged before the arrival of the police at what potentially could be a scene of crime if investigation disclosed potentially suspicious circumstances as to what had occurred and caused the Resident's death.

29 Mr Corrigan was frustrated that the Claimant did not understand why her actions had been investigated and continued to maintain that the Respondent had acted incorrectly in pursuing the investigation and the disciplinary procedures in respect of her actions. He was also concerned that the Claimant continued to insist that she had done nothing wrong and would follow the same course of action if similar circumstances arose in the future. He explained to the Tribunal that what he considered to be the Claimant's intransigence did not provide him with any grounds for mitigating the sanction of summary dismissal imposed by Mrs Hayman at the disciplinary hearing.

30 Mr Corrigan sent his outcome letter to the Claimant on 21 October 2022. He had concluded by this time that the matter had been dealt with properly and thoroughly at the disciplinary hearing. He was also satisfied that the correct decision had been made at that hearing. He set out in his letter the reasons he believed that the Claimant's dismissal was the correct decision. These were as follows:

- *You failed to follow our falls policy to not move a resident who had fallen on the floor. I do not accept that you could not divert other residents away from R, whilst he lay on the floor.*
- *You failed to call 999, whilst he was on the floor. I do not accept that you did not have a working mobile handset with you as a valid reason why you did not call 999, whilst he was on the floor.*
- *You do not have a valid Nurse PIN and therefore you were not in a position to declare the gentleman as dead.*
- *You agree that this was an unexpected death and should have been treated as a "scene of crime" until the Police arrived. Instead you hoisted this man into his bed and his pyjamas were changed prior to the Police arriving".*

The Law

31 In determining whether a dismissal is fair or unfair it is for the employer to show the reason for dismissal, or if there is more than one, the principal reason. This must be one of the potentially admissible reasons set out in the Employment Rights Act which in this case the Respondent submits is the Claimant's conduct on 12 August

2021.Once the employer has shown the reason for dismissal it is then for the Tribunal to be satisfied that the employer acted fairly in dismissing for that reason.

32 The case of **British Home Stores v Burchell 1980 ICR 303** established a three-fold test (the Burchell Test) in cases involving allegations of misconduct. The employer must show that it held a genuine belief that the employee was guilty of the misconduct alleged against him/her and that it had in mind reasonable grounds upon which to sustain that belief, and at the stage on which this belief was formed on those grounds it had carried out as much investigation into the matter as was reasonable in all the circumstances.

33 This means that the employer need not have conclusive proof of the employee's misconduct – only a genuine, and reasonable belief, reasonably tested. The function of an Employment Tribunal, is not to determine an employee's guilt, or innocence, but to consider the behaviour of an employer in terms, and in the context, of a statutory test of fairness.

34 The Burchell Test applies equally to the question of whether it was reasonable for the employer to treat that reason as a sufficient reason to dismiss the Claimant. This shall be determined in accordance with the equity and substantial merits of the case. This involves the Tribunal asking itself whether what occurred fell within a range of reasonable responses of a reasonable employer to these circumstances. This test also applies in a conduct case not only to the decision to dismiss but to the procedure by which the decision was reached by the employer.

35 In assessing the reasonableness of the employer's conduct, the Tribunal must not substitute its view of the right course of action for that of the employer. In many (although not all) cases there is a band of reasonable responses to the employee's conduct within which one employer might reasonably take one view, another employer quite reasonably another view.

36 It can be difficult to define what type of behaviour amounts to gross misconduct. This is conduct which an employer considers serious enough to justify summary dismissal. An employer’s disciplinary policy should give examples of what the employer regards as gross misconduct. Each case has to be considered on its own facts.

37 Gross misconduct must comprise an act which fundamentally undermines the employment contract the employee has with the employer. The Respondent’s disciplinary policy provides a list (which is illustrative and not exhaustive), of what it considers to be gross misconduct. The Respondent's policy provides such a list which includes a breach of health and safety requirements and gross negligence. Both the employer and the employee owe to each other a duty of trust and confidence which

is an implied term that applies to the employer and the employee in every contract of employment.

Conclusions

38 The Tribunal is acutely aware that the Respondent's business operates in a demanding regulatory environment. Its published procedures which are circulated to employees throughout its business provide support and care to its residents and its staff when meeting the challenging and distressing situations that can, and will, arise and to ensure compliance with relevant regulatory requirements. The Tribunal is satisfied that the Respondent dismissed the Claimant by reason of her conduct which is a potentially fair reason for dismissal.

39 It was the contradiction between what was documented in respect of R's death and described to the morning shift which resulted in Ms Johnston's investigation of, firstly, where R had died and, secondly, how the Claimant and Mrs Trigg had dealt with his unwitnessed and unexpected death. Ms Johnston established that the Respondent had been found in his doorway by Mrs Trigg after an unwitnessed fall. She conducted a thorough and well-documented investigation and her findings of how this situation was then dealt with by the Claimant and Mrs Trigg are not disputed. The only area of dispute was between the Claimant and Mrs Trigg as to whether they had initially agreed that they should say that the Respondent was found dead in his bed as Mrs Trigg subsequently recorded in the Respondent's written records which required completion.

40 Ms Johnston reasonably concluded that there had been apparent failures by the Claimant and Mrs Trigg to follow established procedures in dealing with the situation they confronted in the early evening of 12 August 2022. It was also reasonable for her to conclude that these matters should be referred to separate disciplinary hearings. She gave the Claimant due notice of the disciplinary hearing, the allegations that were to be considered and relevant documents which enabled her to prepare for the disciplinary hearing. The Claimant's written representations and the representations she made to Mrs Hayman at the disciplinary hearing established that she was aware of the allegations under consideration and was able to set out her position in respect of those matters in her discussion with Mrs Hayman at the disciplinary hearing.

41 It is agreed between the parties that it was essential to verify R's death and that neither the Claimant nor Mrs Trigg could do so. The Claimant decided to move R's body before telephoning 999. When she did so she was told by the call handler not to move R's body or to let anyone else touch him which were the required steps set out in the Respondent's Falls Policy for Major Injury at Appendix 3 and Unexpected Death procedure. Mrs Hayman decided to summarily dismiss the Claimant by reason of these undisputed facts.

42 The Respondent's Falls Policy must have been potentially relevant because R had suffered a fall. The flowchart at Appendix 3 of the Falls Policy deals with three separate scenarios: no injury, minor injury and major injury. The Respondent's

position was that R fell within the major injury category because he was unresponsive on the floor and his death could not be verified by the Claimant and Mrs Trigg. The flowchart for a major injury makes clear that a resident should not be moved and a 999 call should be made.

43 There can be no doubt that the Unexpected Death procedure applied to R. If the Tribunal had had any doubts about that then those were resolved by the fact that when the Claimant rang 999, as she herself explained to Ms Johnson and Mrs Hayman, she had been asked a number of questions and was directed by the call handler not to move R's body and to ensure that no-one else touched him, which will have involved sealing off the relevant area until the police arrived. This is in accordance with the direction given in the Respondent's Unexpected Death procedure. On the evidence available to it the Tribunal has found that it was reasonable for Mrs Hayman and Mr Corrigan to conclude that with three members of staff attending the scene the Claimant would have been able to take steps to seal off the immediate area around R to avoid any difficulties with other residents until the arrival of the Police.

44 The Tribunal is satisfied that within the regulatory environment in which the Respondent operates an unexpected death requires a carer to make an immediate call to 999 to take advice and that a body should not be moved or touched by anyone until verification of the death has been completed. It is clear that any departure from this procedure could result in serious difficulties and have potential legal implications for reasons that Mr Corrigan explained to the Claimant at the Appeal Hearing. Such steps as had been carried out by the Claimant to check on the Respondent had not been recorded by either her or Mrs Trigg. Furthermore, however it arose the circumstances in which R had been found had also been wrongly recorded and the family had been given incorrect information about the circumstances of his death although the Respondent did not pursue these matters in the Claimant's disciplinary proceedings.

45 The Claimant does not accept that she acted incorrectly or in contravention of the Respondent's procedures. She continues to maintain that the Respondent's findings are wrong and that they should not have subjected her to an investigation or disciplinary proceedings. Her position is that although she had followed the Unexpected Death procedure in the past she had no obligation to do so when dealing with R and made it clear that she would take the same action again if she was faced with a similar set of circumstances in the future.

46 An unexpected and unwitnessed death presents a number of potential serious issues and difficulties for all concerned of which the Claimant would, or should, have been aware from her extensive experience in nursing. She had failed to follow the relevant procedure but was not prepared to make any admission of error and showed no appreciation of the Respondent's position or apparent understanding of the reasons it was so concerned about what she had done. She remained steadfast in refusing to

accept that she had done anything wrong and made it clear that if similar circumstances arose in the future she would do the same again.

47 The Tribunal has concluded that following a thorough investigation and fair disciplinary hearing Mrs Hayman held a genuine belief on reasonable grounds following a reasonable investigation that the Claimant had not followed appropriate checks and had not sought advice before moving R as a result of which she had not followed the Respondent's required policies and procedures for dealing with R's unexpected and unwitnessed death.

48 The Tribunal then had to consider whether the Claimant's dismissal fell within a range of reasonable responses of a reasonable employer to these circumstances. The context for this consideration has already been referred to. The Respondent operates and its employees work in a highly regulated environment in which the Respondent sets out procedures which need to be followed by many thousands of staff to ensure its obligations towards the needs of all parties involved are met. The Claimant's actions and explanations for them and her refusal during the course of the disciplinary proceedings to accept any fault for them substantially undermined the Respondent's trust in her. Mr Corrigan conducted a comprehensive appeal in which he fully engaged the Claimant, tested the findings made by Mrs Hayman and gave careful consideration as to whether the particular circumstances which the Claimant had faced could be dealt with by a lesser sanction than dismissal but reasonably concluded that the Claimant's actions and her representations had made her continuing employment untenable. After consideration of all the evidence placed before it the Tribunal has found that the Claimant's dismissal did fall within a range of reasonable options for a reasonable employer in these circumstances. It has also found that her conduct amounted to a fundamental breach of her contract of employment with the Respondent which entitled the Respondent to summarily dismiss her without notice.

49 The Claimant's claims of unfair dismissal and wrongful dismissal are dismissed for these reasons.

Employment Judge Craft
Dated 13 February 2024

Sent to the Parties on 20 February 2024

For the Tribunal Office: