EMPLOYMENT TRIBUNALS

Claimant:	**Ms C Vickers**
Respondent:	**The Mid Yorkshire Hospitals NHS Trust**
Heard at:	**Leeds On: 3, 4, 5 and 6 December 2018**
Before:	**Employment Judge Davies**
Representation	
Claimant:	Ms Robinson (counsel)
Respondent:	Mr Budworth (counsel)

RESERVED JUDGMENT

1. The Claimant's claim of unfair dismissal is well-founded and succeeds.
2. The Claimant's claim of wrongful dismissal is well-founded and succeeds.
3. The Claimant contributed to her dismissal by culpable and blameworthy conduct and the basic and compensatory awards payable to her should be reduced by 25% as a result.
4. The chance that the Claimant would have been fairly dismissed in any event is nil.

REASONS

Introduction

1.1 These were claims of unfair and wrongful dismissal brought by Ms C Vickers against her former employer The Mid Yorkshire Hospitals NHS Trust. The Claimant was represented by Ms Robinson of counsel and the Respondent by Mr Budworth of counsel.

1.2 I was provided with two lengthy joint files of documents and I considered those to which the parties drew my attention. I heard evidence from the Claimant on her own behalf. For the Respondent I heard evidence from Mrs S Langworth (Assistant Director of Nursing Children and Radiology), Mr D Melia (Director of Nursing and Quality) and Mrs T Davies (Chief Operating Officer).

The issues

2.1 The issues to be determined were as follows:

2.1.1 What was the reason for the Claimant's dismissal? Did the Respondent have a genuine belief in misconduct on her part?

2.1.2 If the reason was misconduct, did the Respondent act reasonably in all the circumstances in treating that as a sufficient reason to dismiss the Claimant, having regard in particular to whether:
- 2.1.2.1 there were reasonable grounds for that belief;
- 2.1.2.2 at the time the belief was formed the Respondent had carried out a reasonable investigation in the circumstances;
- 2.1.2.3 the Respondent otherwise acted in a procedurally fair manner;
- 2.1.3.4 dismissal was within the range of reasonable responses?

2.1.3 If the Claimant's dismissal was unfair, what is the chance, if any, that she would have been fairly dismissed in any event?

2.1.4 If the Claimant was unfairly dismissed, did she cause or contribute to her dismissal by her own culpable and blameworthy conduct and should the compensatory and/or basic awards payable to her be reduced?

2.1.5 Did the Respondent act in breach of contract by dismissing the Claimant without notice or did she commit misconduct that entitled the Respondent to dismiss her without notice?

The Facts

3.1 The Respondent is an NHS Trust. The Claimant is a Registered Nurse. She started working for the Respondent in May 2006. At the time of the events with which I was concerned she was a Band 7 Team Leader responsible for the Children's Community Nursing ("CCN") and Jigsaw teams. The CCN team deals with children who are discharged from hospital with complex needs. The Jigsaw team cares for children and supports families in end of life or palliative circumstances. The Claimant managed 16-18 staff, with a total caseload of approximately 200 children.

3.2 Until these events, the Claimant had an unblemished disciplinary record. She had most recently received a very positive appraisal, scoring 3 or 4 on all criteria.

3.3 I set out below an outline chronology of the events leading to her dismissal. The documentation is extensive, including extensive records of investigation interviews, the disciplinary hearing and the appeal hearing. It is not possible to summarise that material, nor is it necessary to do so. Having outlined the chronology, I will deal in greater detail with a number of specific areas.

3.4 On 16 September 2017 a School Nurse ("SW") from one of the special schools attended by a number of the children within the caseload of the CCN team spoke to the Community Children's Matron ("CH") to raise a concern about the Claimant. That had been raised with SW by the foster carer of a child I will refer to as Child A. I refer to the foster carer as AF. CH spoke to AF, and concluded that this was more about a relationship breakdown between AF and the Claimant rather than concerns about clinical practice. CH passed this onto Mrs Langworth by email. On 21 September 2017 Mrs Langworth met SW and a second school nurse, LN. She spoke to AF by phone. AF, SW and LN subsequently put their concerns in writing. Some of the concerns were subsequently not upheld and I do not refer to them here. Among the other concerns raised by SW were concerns about the treatment of A, including continued treatment of constipation around 6-8 months previously using Movicol when A had a distended abdomen and was experiencing discomfort and concerns about the treatment of A's chest infection with IV antibiotics. SW raised a more general concern about the Claimant wanting to be in control. LN also referred to a range of concerns, including the continued use of Movicol for A's

constipation. AF raised that and other concerns, including about the Claimant seeking to control or influence the decision-making about A's care, in particular relating to the use of IV antibiotics, and about excluding AF and A's birth mother from involvement.

3.5 On 27 September 2016 Mrs Langworth met the Claimant to tell her that concerns had been raised. She outlined them. She told the Claimant that they were being informally investigated and might result in disciplinary action. They met again the next day. Mrs Langworth agreed to the Claimant's request that she carry out non-clinical work while the investigation was being carried out. The Claimant was also referred to Occupational Health.

3.6 On 29 September 2016 Mrs Langworth wrote to the Claimant to tell her that a formal investigation was to be carried out by GP, Head of Midwifery. She told her that the allegations being investigated were:

- "alleged controlling and scaring manner, and over focusing on end of life to foster carer;
- alleged controlling and inappropriate behaviours;
- alleged exclusion of other professionals from decisions regarding end-of-life care;
- alleged influence of other professionals to reach a decision regarding use of oral antibiotics instead of IV antibiotics for chest infection and cohesion [later corrected to coercion] of birth mother to agree to this against her wishes."

3.7 On 7 October 2016, Mrs Langworth met the Claimant to inform her that she was being suspended. The decision to suspend the Claimant was taken because the School Nurses had raised concerns about being emailed by the Claimant. Mrs Langworth had looked at the emails and confirmed that there was nothing untoward in them; they were just ordinary work emails. However, the School Nurses said that they thought the Claimant was making her presence felt and Mrs Langworth took the decision that she should be suspended. Mrs Langworth wrote to the Claimant to confirm her suspension. At the same time, she confirmed the date of an Occupational Health appointment and gave her a named contact at the Respondent. As outlined below, the Claimant's suspension proved to be lengthy. I record at this stage that there were failures to comply with the Respondent's policy of reviewing suspension fortnightly. Sometimes reviews were missed and sometimes they were late. Furthermore, there were difficulties with the named contact. The original person was absent for a period, and there was little communication with the replacement.

3.8 On 25 October 2016, Mrs Langworth, who was the Commissioning Manager for the investigation, wrote to the Claimant to tell her the terms of reference. They set out the allegations against the Claimant, which had been slightly varied.

3.9 In late October GP was replaced as lead investigator by CH. By early December a list of people to interview had been drawn up and a number of interviews took place between mid-December 2016 and January 2017. The Claimant was not interviewed at that stage. From the date when concerns were first raised, it took around three months for the first witnesses to be interviewed. I was not given any explanation of why that took so long. Terms of reference had been framed and a

list of potential witnesses drawn up, but there was no explanation why that could not have been done in a matter of days.

3.10 As a result of concerns raised during the initial investigation interviews, Mrs Langworth decided that a broader audit of children who had received end of life care over the past four years was required. That was undertaken by Dr B and CH. That led to concerns about two other patients. Mrs Langworth discussed those with senior managers and it was agreed that they should be referred to the police and the LADO. It is important to emphasise at once that the eventual outcome of the police investigation was that no action was taken against the Claimant. An independent expert reviewed the cases and concluded that there was no wrongdoing by the Claimant. The expert identified a small number of what were said to be shortcomings in clinical practice by the Claimant and another nurse. However, that took place much later. In January 2017, the position was that the police became involved and a number of joint meetings between the Respondent, the police and other agencies took place. A memorandum of understanding was signed. As a result, the Respondent was prevented from telling the Claimant that a police investigation was underway. The Respondent's own investigation had to be put on hold and parents of children under the care of her team were informed that the Claimant was not currently working for the Respondent. In addition, a referral was made to the Nursing and Midwifery Council ("NMC").

3.11 Inevitably, the involvement of the police led to a significant delay in the Respondent's disciplinary investigation and an enforced lack of candour on the Respondent's part with the Claimant about the reasons for that delay. In late February 2017 the Claimant submitted a grievance about the conduct of the investigation. That was never formally addressed or resolved. A number of senior managers at the Respondent were aware of the police investigation. Mr Melia had some involvement. He signed the memorandum of understanding, attended a couple of the early joint meetings and signed off the referral to the NMC. The Respondent's board were also informed, including Mrs Davies.

3.12 By early May 2017, the Respondent had been cleared to continue with its original investigation although the police investigation relating to 2 other children also continued at that time.

3.13 On 15 May 2017 Mr Melia wrote to the NMC. The terms of that letter on the face of it suggest pre-judgement and a predetermined course of action. Mr Melia expressed disappointment that there was delay in "the appropriate actions being taken against" the Claimant. He said that he had been able to get agreement from the police that the Trust could pursue its investigation into the initial concerns raised about the Claimant. He said that it was anticipated that a hearing would be established for June 2017 and said that he had asked that the hearing and any subsequent appeal be timed to coincide with the outcome of the police investigation. In his witness statement Mr Melia suggested that his wording had simply been unclear and that no decision had been taken for the matter to go to a disciplinary hearing. I was not persuaded of that. The content of the letter, taken with minutes of strategy meetings (in particular 3 March 2017) and the subsequent approach to the disciplinary investigation indicate that matters had been prejudged and that by this stage it was inevitable that a disciplinary hearing would take place.

3.14 On 11 May 2017 Mrs Langworth met the Claimant and provided her with updated terms of reference for the investigation. They were:

- "Controlling and inappropriate behaviours
  - The impact of behaviours on the wider team and team dynamics
- A complaint received regarding alleged controlling and scaring manner, and the over focusing on end of life towards a patient and their foster carer.
- Concerns have been raised from two nursing colleagues indicating the exclusion of other professionals from decisions regarding end of life [and a further allegation was not upheld]
- Influencing other professionals to reach decisions and the cohesion [coercion] of birth Mother to agree against her wishes for example the use of oral antibiotics instead of IV antibiotics and asking the foster carer not to call an ambulance if the child involved in the complaint became unwell when on an end of life care plan. (This is not in the plan unless joint MDT decision that end of life is imminent).
- Concerns in relation to behaviour towards second patients family members."

3.15 The Claimant was told that the last concern related to a complaint from a family member in a hospice who alleged that the Claimant was asked to leave approximately a year ago. No other details were given and the Claimant said that she had no recollection of any such incident.

3.16 By this stage, the Respondent had interviewed 23 people. The Claimant did not know who had been interviewed and was not provided with the transcripts of their interviews at this stage.

3.17 The Respondent suggested holding an investigation meeting with the Claimant on 25 May 2017. Because of the availability of the Claimant's trade union representative and others that investigation meeting could not take place until 4 July 2017. I saw a transcript of the meeting. It was conducted by CH with her two co-investigators and the Claimant was accompanied by her trade union representative, Ms Panther. The Claimant had not been given any detail in advance of her interview about the allegations made by any of those who had been interviewed. All she had in advance where the bullet point allegations in the terms of reference and the brief explanations Mrs Langworth had given her verbally. During a lengthy interview, wide-ranging allegations were put to her for the first time and she attempted to answer them. There is some reference in the transcript to the Claimant trying to look at clinical notes, but otherwise no documentation appears to have been provided to her in advance of or during the interview.

3.18 After her own interview the Claimant asked who had been interviewed by the Respondent. She was provided with a list of names but not with the interview transcripts. She requested that other people also be questioned. Apart from those who had left or were on sick absence, those people were eventually interviewed, although there was clearly an initial reluctance to do so.

3.19 The investigation report was completed by August 2017. On 1 August 2017 Mrs Langworth emailed the Claimant to say that she had received the statement of case from the investigating team and, having reviewed it, required the Claimant to attend a formal disciplinary hearing on 15 August 2017.

3.20 The Claimant was sent a formal invitation letter to the disciplinary hearing, together with the management statement of case and its lengthy appendices on 4 August 2017. The letter restated the bullet point allegations. The statement of case listed the 30 interviews that had now taken place. It set out selected extracts from the interviews in relation to each allegation. It included transcripts of all the investigation interviews; a chronology of the care relating to A, which had been compiled by CH from the SystemOne clinical notes; and some of the clinical records relating to A. It ran to more than 500 pages. This was the first time the Claimant had seen the allegations or underlying evidence in any detail. She asked for a number of witnesses to attend the disciplinary hearing as witnesses, because this was the first time she had the opportunity to challenge what they said. The Claimant prepared a statement of case, setting out in some detail her response to the management statement of case and attaching a number of supporting documents. Those included letters of support from parents and clinicians and copies of her most recent appraisal and 360° review.

3.21 Following a request by the Claimant, the disciplinary hearing was rescheduled to 21 and 22 August 2017. Mr Melia was the chair and there were two other panel members, at least one of whom was also aware that there was an ongoing police investigation at that time. Mrs Langworth presented the management case and the Claimant attended with Ms Panther. The intention was to record the hearing and produce a transcript. After the event, it transpired that there had been an issue on the first day and there was no recording. The only written evidence before me of the first day was in the form of notes produced by Mr Melia. They partly recorded questions he had written down before the hearing started and partly a very small number of comments or notes about the evidence. Mr Melia was not able to confirm precisely which was which. There was a transcript of the second day and I read it in full. Witnesses attended and were questioned by the Claimant on both days. On the second day Ms Panther took the panel through the Claimant's written statement of case and asked a number of questions of the Claimant. The panel asked her a small number of questions.

3.22 Mr Melia wrote to the Claimant on 8 September 2017 with the outcome of the hearing. After listing the evidence that had been before the panel, Mr Melia dealt with the allegations, so far as material, as follows:

"**Allegation one – Demonstrated controlling and inappropriate behaviours which had an impact on the wider team and team dynamics**
The management case gave evidence that these concerns manifest themselves through a range of issues including the following which were set out in their case;

- your handling of annual leave requests
- the manner in which you dealt with staff and the "Handprints" issue
- controlling funeral arrangements
- treating staff and families differently
- taking over end-of-life care for all children from other members of staff
- bullying
- your autocratic style and single-minded approach to decision-making
- your behaviour had an impact on the atmosphere and conduct in the office to the extent it caused a culture where staff couldn't freely speak and caused significant tension
- not inviting all professionals to a meeting at [named] school.

23 of the statements submitted to the panel stated that you have a controlling manner and style. Multiple witnesses evidenced that the office would go quiet when you arrived or were present and that you would occasionally shout at staff which resulted in an atmosphere containing tension. The atmosphere left staff feeling unable to speak freely and inhibited any discussions of clinical and professional issues as well as social interaction.
This culture allowed you to exercise your authority and control in a way which impacted on clinical decisions and patients. The panel heard;

- in taking control you took on care/nursing tasks other lower graded staff would have been appropriate to have carried out
- you kept the two teams separate (Jigsaw and Palliative Care) in order to maintain lines of control and authority
- you told staff not to contact other staff at [named hospice] about patients, unless through you. You attempted to make yourself the sole professional conduit in respect of your patients which allowed you to influence and control decisions that were being made.
- There was evidence that you also asked families to contact you in the event of clinical incident or need rather than emergency services or [named hospice]
- the panel heard from a number of witnesses that you would work and volunteer for most of the on-call shifts other than when you were on holiday

Witnesses testified that the atmosphere had changed considerably for the better since you have been on suspension from the team.
…
In particular the panel heard that you would undertake high levels of on-call and predominantly ensured you took Jigsaw on-call where there was end-of-life patients. Colleagues stated that this was further evidence of gaining control in order that families and other professional would predominantly use you as the conduit for decisions regarding patients.

During the presentation of your mitigation and defence, you asked all of your witnesses who worked as part of your team, whether they had control over their own diaries and working day. All witnesses responded that they did have this day-to-day control. You also asked the witnesses if you would intentionally upset people and all answered this direct question by saying no. You agreed that you would from time to time ask staff in the office to be quiet if you are trying to concentrate on a piece of work or were on a phone call. Some of the witnesses supported this evidence and agreed that you would occasionally request silence. You refuted the allegation that you would not let other staff contact [named hospice] directly.

Finding
The panel upheld this allegation on the following basis.

Whilst the evidence elicited from your questioning suggested that you didn't control work diaries for day-to-day activities of staff, the panel felt that this missed the point. The panel were satisfied that the control described in this allegation was exercised in a different way. The panel felt that there was some evidence to support some but not all of the transgressions listed above but the main concern was the impact and consequence of this behaviour as it affected clinical decision-making and patients.

There was significant evidence from the witnesses and in the statements saying that you did on occasions request silence to allow you to concentrate but that it was much more serious than this. Staff described how the room would go quiet when you entered or were present, accompanied by tension and they did not feel they could talk freely in front of you in case you overheard and intervened in their conversations about patients. Multiple

staff testified that you were difficult to approach and were fixed on your way of doing things with regard to patients and therefore you were not challenged sufficiently.

The impact of the tension and the quietness in the office was that it stifled personal and professional conversation which is not in the interests of transparency and patient care. Coupled with this, we also heard from witnesses how you were difficult to approach and could upset people as a result albeit not necessarily intentionally. This is contrary to the value and behaviours of the Trust and the culture in which we want our staff to work. Challenge and professional discussion is encouraged as it is essential in order to ensure the best decision-making for our patients.

The panel were concerned that this behaviour and approach was evidence of you excluding other professionals and dominating the decision-making regarding patients.

The panel also took into account the fact that the witnesses questioned had been a random sample and not chosen to support one particular line of enquiry for the management side. In fact, the majority of witnesses at the hearing were requested by you to support your case. Most witnesses provided evidence which in fact supported elements of the management case. You suggested that some of the witnesses were led to say you were controlling but the panel did not see evidence of this.

With regard to on-call – the panel felt that the levels of on-call were disproportionate and focused on those relating to end-of-life care. You felt you were the only member of the team who could provide this level of care and as such other professionals in particular CS who was a very experienced palliative care nurse, were excluded from doing this. The panel were satisfied that other staff could have shared this role.

The Panel appreciated that there was a lot of positive testimonial evidence regarding your character and skills. The panels view was that the majority of these were people external to the Trust who would not witness or possibly understand the other elements of your behaviour within the team. These were also people who did not work under your management line. On that basis the panel felt that the balance of the evidence was towards those who testified who were your direct colleagues and direct reports.

Allegation two – employed a controlling and scaring manner, and the over focusing on end-of-life was a patient and their foster carer

The management case set out evidence in relation to the following;

- Your decision-making in the treatment of Movicol to child a was detrimental and inappropriate
- Your handling of the concerns raised by child A's Foster mum about the Movicol treatment was not appropriate
- The incident concerning the administering of oxygen when child A was admitted to CAU was potentially detrimental to the child
  …
- The handling of the decision in relation to child A receiving IV antibiotics
- Exclusion of the foster carer in a meeting to discuss child A's care plan
  …

The panel heard from the foster carer who although not medically qualified, is a very experienced carer … and cared for child A everyday so understood her needs. The panel found that it was a matter of fact that the child had suffered from pain and abdominal distension as a result of receiving sustained and increasing doses of Movicol. Concerns were raised by the two school nurses and the foster carer about this. The child had also been prescribed picosulphate (an alternative treatment in the event that the Movicol failed to work) however you had told her not to use this. You had discussed the Movicol with Dr MH who had agreed with you regarding the increased dose. Dr B's professional

opinion was to reduce the morphine however after discussion with you his plan was not enacted.

Regarding the administering of oxygen in CAU, the panel heard that you had reduced the flow from 10 litres (as determined by the PAWS score) administered by HM to 5 litres. You stated in mitigation that you were not familiar with the PAWS score system and had you known, then you may have done this differently. You said in your bundle but you didn't recall reducing the oxygen however in the course of the hearing you were asked by a panel member to clarify your actions during this incident and you admitted that you had inappropriately reduced the oxygen flow. You also clarified in an additional written submission on Day 2 that you had got some details of this incident incorrect due to limited access to the notes and that you did not intend any harm to the child.

Issue of IV drugs – the panel heard from the foster carer that she had strong opinions about the need for administering antibiotics this way which she felt was in the best interests of child A. You stated that this decision had been made in conjunction with Dr D.

Finding
The panel upheld the allegation in relation to your decision-making regarding the Movicol, excluding (or not facilitating) the foster carer from the decision-making regarding the child and the appropriate administration of oxygen.

The panel felt that you had influenced Dr MH whereupon she had reflected on her own practice, she had made decisions acting upon advice and information from you alone. Dr MH had not seen the patient and relied upon your judgment. Your judgment in relation to the Movicol was flawed and the dosage was excessive and inappropriate and ignored the symptoms i.e. the bowel was rippling. The child was on an increasing dose of Movicol and you didn't take into account the childs pain, abdominal distension and increasing discomfort despite others reporting this. The panel found that you didn't challenge your own judgment despite the clinical presentation of the child which as a registrant, you should have been minded to do.

Once the results of the x-ray revealed that the problem was gas caused by the Movicol and the treatment stopped, the patient recovered quickly. The panel heard evidence that Dr B was also influenced regarding the use of morphine (which can cause constipation). It was also not appropriate for you to advise that child A's bowel was rested for 24 hours each week (by withdrawing nutrition) without there being specific guidance around this practice. The panel agreed that this was an appropriate treatment as a "one-off" to alleviate extreme symptoms but not appropriate as an ongoing intervention particularly for young child.

With regard to the oxygen, the panel was satisfied with the evidence from HM and JH that you reduced the oxygen. This intervention was detrimental to the child whose PAWS scores and saturation levels indicated that she needed a higher dosage than the one you gave. Despite admitting that you are not experienced in an acute setting nor familiar with the PAWS scores you decided to intervene in clinical practice outside of your professional scope of practice. You were not working in the CAU and nor did you have clinical expertise in this acute clinical presentation. The panel were particularly concerned about the manner in which you did this. You ignored the action of sister HM (who was clinically responsible patient in that setting) who had set the oxygen and you did not discuss your thinking or rationale with her when you changed the oxygen level. Your approach was to "march" across to the patient ignoring the other professionals in the room and carry out the change without discussion. The panel felt that this was evidence of your controlling behaviour.

…

The panel were concerned that you attempted to influence the relationship between the foster carer and the birth mother in order to exclude the foster carer from meetings. The panel saw evidence from the birth mother and maternal grandmother that they wanted the foster carer to be part of the decision-making process with regards to child A. The panel heard that you had had a good relationship with both and were not persuaded by your evidence to attempt to discredit their relationship.

Allegation three – concerns have been raised by two nursing colleagues indicating the exclusion of other professionals decisions regarding end-of-life and …

The management case presented witness evidence that you would take over all end-of-life care arrangements through reducing access to other professionals, stifling lines of communication and working most on-call shifts. Your behaviour therefore excluded others which prohibited learning and growth of other team members in acquiring these skills and also excluded professional challenge and enquiry.

Your explanation was that you were the senior nurse and therefore these tasks fell to you.

…

Finding

The panel uphold the allegation that you exclude other professionals from end-of-life care arrangements.

…

Conclusion

…

In considering the sanction in respect of these allegations, we have taken into account a range of factors including your length of service and prior disciplinary record as well as your mitigation. The panel concluded however that the allegation amounted to gross misconduct and that the only reasonable and appropriate sanction is that you are dismissed from your employment with immediate effect. In reaching this conclusion the panel considers that the allegation goes to the heart of the employment relationship and justifies the decision that you be summarily dismissed. …"

3.23 The Claimant appealed against her dismissal in a letter dated 13 September 2017. She provided detailed grounds of appeal in a statement of case stated 21 November 2017. They included that the decision to hold a disciplinary hearing was predetermined; a concern that the panel had missed evidence because of the volume of information; the lack of opportunity at the disciplinary hearing to point out evidence from the witnesses and cross-refer to the points made in their interviews; a misunderstanding of the discussions that took place; and the limited time in which to summarise the case. Further, the Claimant contended that the allegations did not amount to gross misconduct. The statement of case went on to deal in detail with the dismissal letter, cross-referring to evidence said to have been overlooked or misunderstood.

3.24 The appeal hearing took place on 28 November 2017. It was chaired by a Mr Jones and the other panel members were Mrs Davies and a Ms King. Mr Melia presented the case on behalf of the management, effectively seeking to have his own panel's decision upheld. The Claimant attended with Ms Panther. I saw and read in full a transcript of the appeal hearing.

3.25 The outcome was notified to the Claimant in a letter dated 12 December 2017. Her appeal was dismissed. The appeal panel found that there had been a failure to comply fully with certain aspects of the disciplinary policy but did not consider that the Claimant had suffered a material detriment as a result. The panel concluded that there had been sufficient time at the disciplinary hearing to allow both parties to present their cases and question accordingly. They said that they did not hear any evidence to suggest a significant undermining of the disciplinary panel's conclusions and were satisfied that the volume of evidence presented did not have any significant bearing upon the findings of the disciplinary panel. They concluded that the allegations against the Claimant amounted to gross misconduct. They dealt specifically with the incidents relating to Movicol and the administration of oxygen to child A. The appeal panel agreed with the findings of the disciplinary panel in these respects.

Legal principles

4.1 Unfair dismissal is dealt with by s 98 Employment Rights Act 1996. It is well-established that in a claim for unfair dismissal based on a dismissal for misconduct, the issues to be determined having regard to s 98 are: did the employer have a genuine belief in misconduct; was that belief based on reasonable grounds; and when the belief was formed had the employer carried out such investigation as was reasonable in all the circumstances: see *British Home Stores Ltd v Burchell* [1980] ICR 303. The burden of proof has of course changed since that decision: *Boys' and Girls' Welfare Society v McDonald* [1996] IRLR 129.

4.2 Furthermore, the question for the Tribunal is whether dismissal was within the range of reasonable responses open to the employer. The range of reasonable responses test applies to all aspects of the decision to dismiss including the procedure followed: see *Foley v Post Office; HSBC v Madden* [2000] ICR 1293 *Sainsbury's Supermarkets v Hitt* [2003] IRLR 23. I emphasise, therefore, that with respect to the unfair dismissal claim, it is not for the Tribunal to substitute its view for that of the Respondent. The Tribunal's role is not to decide whether the Claimant was guilty of the conduct alleged, but to consider whether the Respondent believed that she was, based on reasonable grounds and following a reasonable investigation.

4.3 The ACAS Code of Practice on Disciplinary and Grievance Procedures is relevant and I have had regard to it.

4.4 Pursuant to s 122(2) and s 123(6) Employment Rights Act 1996, the basic and compensatory awards may be reduced because of conduct by the employee. Under s 123(6) the relevant conduct must be culpable or blameworthy; it must actually have caused or contributed to the dismissal; and it must be just and equitable to reduce the award by the proportion specified: see *Nelson v BBC (No 2)* [1980] ICR 110 CA. By contrast, the basic award can be reduced where conduct of the Claimant before the dismissal makes that just and equitable. There is no requirement that the conduct should have caused or contributed to the dismissal. In *Hollier v Plysu* [1983] IRLR 260 the EAT suggested broad categories of reductions: 100% where the employee is wholly to blame; 75% where the employee is mainly to blame; 50% where the employee is equally to blame and 25% where the employee is slightly to blame.

4.5 Where the Tribunal considers that there is a chance that the employee would have been fairly dismissed in any event, then the compensation awarded may be reduced accordingly: *Polkey v A E Dayton Services Ltd* [1987] 3 All ER 974. Guidance on how to approach that issue is set out in the case of *Software 2000 Ltd v Andrews* [2007] IRLR 568.

4.6 As regards a claim for notice pay (wrongful dismissal), if an employer acts in breach of contract in dismissing an employee summarily, that is a wrongful dismissal and the employee will be able to recover damages in respect of the failure to give notice. However, a summary dismissal is not a wrongful dismissal where the employer can show that summary dismissal was justified because of the employee's breach of contract. Misconduct by an employee may amount to such a breach. This is so where the misconduct of the employee so undermines the trust and confidence inherent in the particular contract of employment that the employer should no longer be required to retain the employee: see e.g. *Briscoe v Lubrizol Ltd* [2002] IRLR 607 CA.

4.7 An employee's negligent failure to act can constitute gross misconduct justifying summary dismissal, even if not deliberate, dishonest or wilful, provided that it is sufficiently serious: see *Adesokan v Sainsbury's Supermarkets Ltd* [2017] ICR 590. Likewise, it is quite possible for a series of acts demonstrating a pattern of conduct to be of sufficient seriousness to undermine the relationship of trust and confidence between employer and employee, even where the employer is unable to point to a particular act that amounts to gross misconduct: see *Mbugaegbu v Homerton University Hospital NHS Foundation Trust* UKEAT/0218/17/JOJ.

Unfair dismissal

5.1 For ease of comprehension, rather than setting out detailed findings of fact about different aspects of the process above and then cross-referencing them below, what follows is a combination of further findings of fact together with an explanation of why, applying these legal principles, I have concluded that the Respondent did not act reasonably in all the circumstances in dismissing the Claimant as it did.

5.2 It was not disputed during the course of the hearing that Mr Melia (on behalf of the dismissing panel) genuinely believed that the Claimant was guilty of misconduct, and that that is why the panel decided she should be dismissed. I find that the reason for dismissal was a genuine belief in misconduct.

5.3 I therefore turn to the question whether the Respondent acted reasonably in all the circumstances in treating that as a sufficient reason to dismiss the Claimant. I have found that it did not. The reasonableness of the investigation, the grounds for belief, and the process followed overlap and I deal with them together below. I remind myself again that it is not for me to substitute my judgment or to determine at this stage whether the Claimant committed misconduct or not. The question is whether the process followed and the decision to dismiss the Claimant were within the range of what a reasonable employer might have done. I find that they were not. No reasonable employer would have dismissed the Claimant in the circumstances for the following reasons.

5.4 The investigation was lengthy. While the delay from January onwards was out of the Respondent's hands, there had already been a largely unexplained delay from mid-September to mid-December. The ACAS Code of Practice on Disciplinary and

Grievance Procedures emphasises the importance of investigating potential disciplinary matters without unreasonable delay and states that any period of suspension should be as brief as possible. The largely unexplained delay at the outset runs contrary to that. While this of itself would not render the dismissal unfair, it is one part of the picture that contributes to unreasonableness.

5.5 The Claimant was not interviewed until July 2017. That was almost a year after the allegations were first made, and the allegations themselves related in some cases to events that had taken place months or years before that. Again, the delay between January and May was unavoidable, and some part of the delay after that related to Ms Panther's availability. Nonetheless, it meant that by the time the Claimant was questioned, the events were no longer recent. This was compounded by the way the Claimant was interviewed. She was not provided with any detailed allegations or specific examples in advance of the interview. All she had were the bare bullet points in the terms of reference and what Mrs Langworth had outlined in their conversations. Nor was she provided with copies of the witness interview transcripts or the relevant documents. In her interview she was hearing the criticisms for the first time, and then trying to answer them with no proper detail and no underlying documentation (except access to some clinical notes).

5.6 The management statement of case was one-sided and reflected Mrs Langworth's adverse view, formed at a relatively early stage and when neither she (nor anybody else) had actually heard the Claimant's side of the story. For example, at one of the joint strategy meetings, on 3 March 2017, Mrs Langworth expressed the view that the Claimant could not work again in her role on the balance of probability. She said later in the meeting that in her opinion the risk was "way too high" to bring the Claimant back into her role, that there had been a breakdown of trust and that the Claimant could never work with the team or with Mrs Langworth again. She said that the Claimant could go for another job but the Respondent had to remember the risks about her working with children. In her witness statement Mrs Langworth said that this was based on her conversations with the two nurses and AF and on the evidence collated during the investigation from the Claimant's colleagues. She said that "nothing" had been said by the Claimant's colleagues that was supportive towards her. That was not a fair representation of the interviews. She said that this was just her opinion based on the evidence she had seen to date. It seemed to me that Mrs Langworth had formed a strong view adverse to the Claimant at this early stage and before the Claimant's version of events had been ascertained. On the evidence before me that view did not change. By the time the management statement of case was prepared, she wrote that it was "untenable" for the Claimant to return to her job or work for the Trust at all. In her oral evidence, Mrs Langworth explained that she thought it was her job to put the case against the Claimant. She said at one point, "I needed to support my case." That was her approach in assembling the management statement of case and in presenting the case to the disciplinary panel. That meant that the disciplinary panel was not presented with a balanced view by Mrs Langworth. It was therefore all the more important for them properly to understand the Claimant's case and scrutinise the evidence before reaching conclusions.

5.7 Mrs Langworth, Mr Melia and at least one other disciplinary panel member were aware at the time of the disciplinary hearing that the police were investigating other allegations concerning the Claimant. The Claimant was not. The Respondent was plainly in a difficult position in this respect – it wanted to progress its internal process,

it was not permitted to tell the Claimant about the police investigation, and it had limited alternatives available to it. However, if the context is that the disciplinary panel and the person presenting the management case are aware of a criminal investigation and the employee is not, again that points to the central importance of the panel properly scrutinising the evidence and guarding against preconception.

5.8 However, I find that the disciplinary panel did not properly understand the Claimant's case or scrutinise the evidence. There seemed to me to be a fundamental failure to grapple with the detail of her defence, bearing in mind that the first time she had been in a position to advance a detailed defence was at the disciplinary hearing. Plainly, there was material capable of supporting the allegations against the Claimant. But there was also material capable of undermining them, including the Claimant's own version of events. In many respects it was entirely unclear how, or even whether, the Claimant's side of the story had been considered. To a very significant extent the documents and the oral evidence at the Tribunal created the impression that the start and end of the enquiry was the fact that a large number of people had made negative comments about and criticisms of the Claimant. Mr Melia certainly seemed to have pre-judged matters before the hearing started. Many of the allegations and criticisms were at a very general level, without concrete examples and specifics. Where there were specifics, the panel simply does not appear to have grappled adequately with them. Examples of these fundamental shortcomings are set out below.

5.9 I start with the question of Movicol. This was one of the very small number of concrete examples (as opposed to generalised allegations), and one of only two specific examples the panel upheld in respect of allegation two. I have set out above the disciplinary panel's finding in relation to Movicol. In his witness statement Mr Melia explained the basis for the panel's finding. He referred to the evidence of the school nurses and AF. He also referred to Dr MH's evidence. He said that the Claimant had discussed the doses with Dr MH who had agreed with her regarding the increased dose, but that the panel felt that the Claimant had influenced Dr MH. Dr Melia did not refer to the Claimant's version of events, nor explain why that had been rejected.

5.10 When the Claimant had been asked about this on 4 July 2017 she said that obviously child A's constipation with Movicol had increased. The Movicol was increased in discussion with Dr MH at the hospice. They agreed the plan together. The Claimant subsequently got a call from SW questioning whether the Movicol was adding to it. She tried to contact Dr MH that day. She was unable to get hold of her but was on a study day with her the next morning and spoke to her. The Movicol was stopped the next day. The Claimant was asked about SW's account, that *she* had contacted the hospice. The Claimant said that Dr CH from the hospice had phoned her as she arrived at the study day and told her that SW had phoned her. The Claimant told Dr CH that she was going to see Dr MH and speak to her. That happened and then the Movicol was stopped. In response to SW's complaint that the Claimant had told her not to call the hospice Claimant said that she would never say that. Indeed, she pointed out that SW had contacted the hospice. The Claimant was then told that LN, SW and AF had all said that they had been expressing concerns about the Movicol for some time before it was actually stopped. The Claimant said that she had not had any conversations with them about their concern before that. Somebody had raised a concern to her and she had gone straight to Dr MH. One of the interviewers referred to the suggestion that the child had had an x-ray. The Claimant said that *she* sent

her for it in case she was missing something. A little later in the discussion the Claimant referred to the entries in clinical notes taken from SystemOne. The Claimant was asked about the suggestion that she was reluctant to deviate from the plan and she disputed that.

5.11 In her statement of case for the disciplinary hearing the Claimant gave an account that was consistent with this, referring again to the clinical notes. She also included a letter from Dr D. Dr D confirmed that the child had an x-ray on 3 March 2016 arranged by the Claimant because she was worried the child had abdominal distension. The Claimant phoned her to discuss the x-ray and after reviewing the images Dr D suggested to the Claimant that she rested the child's bowel for 24-hours with diaoralyte as the x-ray showed gassy distension which Dr D thought would settle if the bowels were rested. Dr D believed the Claimant put that plan in place.

5.12 The disciplinary panel therefore had before them differing versions of events. The school nurses and AF were suggesting that they had repeatedly raised concerns about abdominal distension and the use of Movicol with the Claimant but that she had insisted on continuing with the Movicol. The Claimant said that she referred the child for an x-ray when there was a concern about abdominal distension. Dr D advised a course of action as a result. As soon as SW suggested that the Movicol might be a problem the Claimant raised that with Dr MH and the Movicol was stopped. The Claimant did not dispute that SW had also raised her concern with Dr CH at the hospice.

5.13 The disciplinary panel preferred the account given by the school nurses and AF. A fair procedure would require any reasonable employer in reaching such a view properly to understand and consider the Claimant's account and any supporting evidence, and to have a rational basis for rejecting it. On the evidence before me there was no such rational basis. In particular:

5.13.1 Mr Melia's questions for the Claimant on this subject, written in advance of the disciplinary hearing, were: "Why did you question SW's actions in contacting Dr MH? AF says she raised concerns about distension, why didn't you act on that? Why would you persist with this treatment given the concerns of three people who saw child A regularly and your clinical observations? When Dr MH heard she said that treatment should stop – why haven't you brought this to her attention earlier?" All of these questions assumed that the account given by the school nurses and AF was correct. The Claimant was simply asked to explain *why* she had acted in the way they alleged, no consideration appears to have been given to *whether* she did so.

5.13.2 The disciplinary panel had before them the chronology prepared by CH as part of the management statement of case based on the entries in SystemOne. There were references to child A's constipation in the entries for late December 2015 and early January 2016. On 22 December 2015 the child's abdomen was soft and not distended and she was recorded as having no further problems with her bowels. On 7 January 2016 the Claimant had contact from AF telling her that the child's bowels had opened after increased Movicol but the result was liquid. The Claimant recorded that she gave advice about bowel management. There was no reference to pain or abdominal distension. The child was seen at the CAU for unrelated reasons in late January. The next reference to constipation was on 10

February 2016. The Claimant recorded that she had a telephone call from AF telling her that child A's bowels had not opened for five days. She was not distressed and there was no abdominal distension. The Claimant advised further increasing the dose of Movicol and *the Claimant* issued a prescription for alternative treatments including sodium picosulphate. The next entry is 18 February 2016. The Claimant recorded that she had discussed the child's bowel management with Dr MH and they had agreed a plan. Child A was to be given four sachets of Movicol daily as maintenance, five sachets if her bowels had not opened by day three and seven if her bowels had not opened by day five. The next entry was 2 March 2016. That was made by LN. She recorded that AF had contacted her to discuss concerns about bowel management and the large volumes of Movicol being administered. LN recorded at this stage that child A's abdomen was distended and causing her discomfort and distress. LN tried to contact the Claimant for advice but she was not at work so LN contacted the children's continence nurse to request advice. The advice is not recorded. There was an entry the following day, 3 March 2016, made by the Claimant. She recorded that she had had telephone contact with AF who told her that A's abdomen was very distended; she was distressed and had vomited the previous evening. The notes record that the Claimant discussed this with Dr D (consultant paediatrician) and requested a review on the CAU. The child had an x-ray and the notes record that the Claimant discussed this with Dr D. The x-ray did not show any evidence of obstruction or constipation and Dr D was to discuss child A's management with the hospice. The next day, 4 March 2016, CS, one of the Claimant's CCN nursing colleagues, made an entry in the notes. She had spoken to AF by telephone. AF told her that Dr D had advised diaoralyte feeds or admission to hospital for IV fluids. AF felt she could manage diaoralyte feeds at home. CS had advised to recommence feeds at half strength and then resume normal feeding regime. On 8 March 2016 the Claimant made an entry. She recorded a home visit to child A's foster home at which she was accompanied by Mrs Langworth. She recorded that A's abdomen was firm and distended and that she had been advised by AF that having a break from feed and diaoralyte had improved distension. The notes record the Claimant suggesting one day per week break from feed and diaoralyte to rest A's gut. The following day, 9 March 2016, SW made an entry. She referred to concerns about abdominal distension and the child being red in the face. She recorded that she had contacted the Claimant for advice who said she would ring the hospice and advise of the outcome. The Claimant made an entry on 10 March 2016 recording that she had discussed this with Dr CH at the hospice. The child's abdomen remained distended despite a large bowel movement the previous night and she had vomited. She recorded that Dr MH had advised diaoralyte only and was to arrange a test to exclude fructose intolerance as a cause of distension.

5.13.3 The chronology was consistent in a number of respects with the Claimant's version of events. It indicated that the first time concerns about abdominal distension were raised with the Claimant during this episode she spoke to Dr D and arranged an x-ray. That happened on 3 March 2016. It was Dr D who then gave advice for the child's care. That did not involve stopping Movicol. The Claimant's colleague, CS, advised on 4 March 2016. When the Claimant was involved again, on 8 March 2016, the distension had

improved. Further, Mrs Langworth was present on that occasion. When SW reported concerns to the Claimant the following day, she recorded the Claimant saying that she would ring the hospice for advice. There was no dispute that the Claimant spoke to Dr MH the next day at the study day and the Movicol was stopped.

5.13.4 Dr D's letter was also consistent with the Claimant's version of events.

5.13.5 In cross-examination, Mr Melia confirmed that AF had agreed at the disciplinary hearing that she did not raise any concerns about Movicol until the day it was stopped. He was asked about child A being x-rayed and he said that later in the events the child came into hospital and had an x-ray. Then the Movicol was stopped because the image showed the abdomen full of gas. That was consistent with the finding in the disciplinary letter but was not consistent with the Claimant's account, the clinical records or Dr D's version of events. They made clear that the x-ray took place earlier, at the Claimant's request, and that it was Dr D who then advised on the appropriate course of action. That was not to discontinue Movicol. No evidence was shown to me that could have sustained the finding the disciplinary panel made about the x-ray.

5.13.6 In cross-examination Mr Melia repeatedly asserted that the Claimant was responsible for monitoring the effect of the Movicol. He accepted that other nurses (members of the CCN team and school nurses) also had such responsibility. Mr Melia was asked whether the panel had considered the fact that AF had spoken to LN on 2 March 2016. He did not know. He was asked whether they had considered the fact that she spoke to another member of the CCN team on 4 March 2016. He said that the panel only considered the Claimant's actions. He said that the panel did not consider the fact that when Mrs Langworth was shadowing the Claimant on 8 March 2016 she did not identify any concern about the Movicol in view of the child's distended abdomen, although the Claimant's failure to do so was being characterised as gross misconduct.

5.13.7 Mr Melia was asked what the Claimant had done wrong in terms of monitoring. He said that the child was suffering pain and distress. The distension was increasing. The administration of Movicol was increased to 9 sachets per day. He was asked how this linked to the chronology as recorded in the care records and provided to the panel. He was not able to explain.

5.13.8 Mr Melia was asked how the panel had reached its conclusions, in view of the content of the chronology. He said that the school nurse and AF felt that they were being excluded from direct contact with the hospice and medical staff and frustrated in their attempts to manage it. It was put to him that the chronology suggested something different. He said that the evidence from the school nurses and AF was compelling. He was asked how the panel found it to be compelling, given the contradictory content of the chronology based on the contemporaneous records. He said that they gave compelling accounts of how they felt. He was asked whether those individuals were asked about the chronology. He said that they were asked about their actions.

5.13.9 Mr Melia's account seemed to me to be unclear. There was no clear or detailed understanding of what the Claimant was told, when she was told it and what, if any, action she took or failed to take. This was simply dealt with at the level of generality with which the school nurses and AF described it

in their initial accounts (months after the event). That was reflected in the findings in the outcome letter, for some of which there were simply no reasonable grounds. I find that Mr Melia approached this matter on the basis of the pre-determined view reflected in his questions written before the hearing and simply failed properly to grapple with the Claimant's account and the evidence capable of supporting it. No reasonable employer would do so.

5.14 I turn to the second specific example upheld by the panel in respect of allegation two: administration of oxygen to child A. The panel's finding is again set out in full above. The panel concluded that the Claimant had reduced the amount of oxygen administered to child A; that this was "detrimental" to her; and that this was outside the Claimant's professional scope of practice. Further, the panel was particularly concerned about the way the Claimant did this. It found that she ignored the action of HM (who was clinically responsible for the patient in that setting) and that she did not discuss her thinking or rationale with HM. Mr Melia reiterated those findings in his witness statement. He specifically confirmed that the panel was satisfied that the Claimant's actions were "detrimental" to child A, and that she did not discuss her thinking or rationale with HM. Mr Melia also indicated that the panel had taken into account that the Claimant only accepted on the second day of the disciplinary hearing that she had changed a therapeutic regime, for which she was not responsible, and without due regard for the clinical team or the clinical need of the child.

5.15 Again, it seems to me that there were not reasonable grounds upon which those findings could be based in the light of the evidence before the panel. In particular:

5.15.1 The panel's finding that the Claimant only accepted wrongdoing on the second day of the disciplinary hearing cannot be reconciled with the evidence before it. The Claimant had no advanced warning of this allegation when she was first asked about it on 4 July 2017. She was asked at that stage if she understood where a level of 5 litres had come from and she said that she had a conversation with Dr D and the nurse who was looking after child A about A's care plan and not escalating respiratory-wise. If they were doing oxygen at home or at the hospice they would be going to 5 litres. The Claimant was then told that a witness had said that a nurse had increased child A's oxygen in accordance with PAWS policy, the Claimant had reduced it back down to 5 litres immediately and the nurse had challenged her about it. At that stage the Claimant said that she remembered going in and child A's saturations were really good; she turned the oxygen back down to 5 litres and told them what she had done. This was after they had moved child A into another room and her saturations were fine. She said that she would not have put the oxygen down on a child whose saturations were low or who was struggling. It was also suggested to the Claimant that AF had said that the Claimant asked her to tell the nurses not to give child A more than 5 litres of oxygen. The Claimant denied that.

5.15.2 After that interview the Claimant was provided with the management statement of case, which included notes of an interview with HM. HM was the sister working on the CAU on 19 July 2016 when child A was admitted displaying signs of respiratory distress. HM said that she recorded A's observations, which included low oxygen saturation levels and a high PAWS score, so she immediately administered oxygen via a non-re-breathe mask

at 15 litres. Shortly afterwards the Claimant arrived. The Claimant asked HM how many litres of oxygen A was receiving and HM informed her she was receiving 15 because of her low saturations and current condition. HM recalled the Claimant saying that A should not receive more than either two or 5 litres of oxygen (HM could not remember which and did not have the patient's notes). She could not remember her exact response but she knew she would have explained to the Claimant that A's oxygen saturation levels were decreased and her PAWS score elevated and that she was giving her oxygen at a high level to increase her saturations. She could not remember if or at what point the oxygen was reduced but she discussed it with the medical staff who were treating A. She did not say that the Claimant had reduced the oxygen level or complain about her manner.

5.15.3 The management statement of case also included notes of an investigative interview with JH, a children's community nursery nurse. JH was not asked about this incident during her interview. However, after the interview CH emailed her to say that she believed she might have been present on the CAU on 19 July 2016. CH asked JH to provide any information she had about child A's condition, her observations and more specifically the amount of oxygen she was receiving. It is not clear what prompted this email. In any event, JH replied to say that she was present briefly that morning. Child A was admitted with breathing difficulties and the sister on the assessment unit came and put her on oxygen. She turned the oxygen up high. The Claimant then walked forward and without speaking to the nurse turned the oxygen down. The nurse very politely asked if there was a reason for this and the Claimant replied that she could not be managed at home on any more oxygen than 5 litres. Dr D then arrived and JH left the assessment unit.

5.15.4 Having seen this evidence, the Claimant addressed this issue in her statement of case prepared in advance of the disciplinary hearing. She pointed out that she had admitted in her interview reducing the oxygen but reiterated that this was when child A had moved rooms and her saturations were really good. She explained that the time she was talking about was around 5 pm before leaving for the day. She drew attention to the fact that at that time child A was on 7 litres with saturations in the high 90s. She went on to say that she had no recollection of reducing the oxygen in the morning but she drew attention to the fact that child A's saturations were slightly better on the second entry in the chart than the first, i.e. better on 5 litres than 10 litres. She suggested that the saturations must have been higher at some point between the first two entries. Plainly, she was acknowledging the possibility that she had reduced the oxygen in the morning as well. Further, she went on to explain that she did not work in a ward environment and therefore did not use PAWS but she "acknowledges[d] the concerns on reflection in terms of the PAWS and saturation level." However, she said that her oversight was not in any way detrimental to child A. The saturations did not drop lower and in fact after a few hours were much improved. The Claimant's position was therefore clear from her written statement of case. She accepted all along that she had reduced child A's oxygen in the afternoon. She did not recall doing so in the morning but she acknowledged the possibility that she had done so. She made clear that on reflection she could understand the concerns about this although she said that child A had suffered no detriment.

5.15.5 As set out above, there is no note of the first day of the disciplinary hearing. The notes of the second day record that the Claimant made a clarification at

the start of that day. It appears from the notes that she changed or corrected evidence she had given the previous day (I understand she had said on day one that something was not in the child's care notes, realised overnight that it was and corrected that). She then went on to remind the panel about what she said in her investigatory interview, accepting that she had had a conversation about not escalating the respiratory rate. She also reminded the panel that in her statement of case she had acknowledged the concerns on reflection in terms of the PAWS and saturation level.

5.15.6 In the light of the content of the Claimant's interview, her written statement of case and what she said at the start of day two, Dr Melia was asked when the panel found that the Claimant had changed child A's oxygen level. He said that it was early in her admission on the CAU. He said that the Claimant confirmed on day two that she had done this and should not have done. He accepted that on the first day she could not recall whether she had done so and said that she came back on day two and made a statement at the start of the hearing. He said that the panel had taken into account that there was "quite a long time in the preparation of the case for her to have done that reflection." He was asked what he meant by that and he said that there did not appear to have been any reflection before the hearing about whether the Claimant's actions were appropriate. Given the content of the Claimant's statement of case, produced promptly as soon as the extensive report and evidence were provided to her, there appears to have been no reasonable grounds for concluding either that the Claimant had had quite a long time to reflect or that she had not done so before day two.

5.15.7 Likewise, there appears to have been no reasonable grounds upon which the panel could have concluded that the Claimant ignored HM or that she did not discuss her thinking or rationale with her when she changed the oxygen level. Not only was the Claimant's own evidence, from the very outset, that she had discussed her rationale and the way child A's oxygen levels were managed at home with HM and Dr D, but that was also HM's written evidence. HM's recollection was that when the Claimant came into the room she asked how many litres of oxygen child a was receiving and then went on to explain her view that the child should not receive more than a particular level. HM therefore described a discussion with the Claimant about child A's oxygen levels as soon as the Claimant arrived. HM did not give evidence at the disciplinary hearing. JH was the only one making the allegation that the Claimant had changed the oxygen level when she arrived, but even she described a discussion between HM and the Claimant about it, and indicated that she had left the room when Dr D arrived. Mr Melia was asked about this in cross-examination. He said that child A's oxygen level was changed without any due consideration or discussion with the people that were looking after her. His attention was therefore drawn to what HM said about a discussion and he then said, "It didn't lead to a conclusion." He was asked whether the panel had taken into account the discussion as described by HM in reaching its decision and he said "there was discussion about PAWS. There was no discussion about the Claimant being part of the decision-making." That was not an answer to the question. Mr Melia confirmed that the panel's understanding was that the Claimant had changed the oxygen level after the discussion with HM. It was expressly put to Mr Melia that the Claimant had explained her thinking and rationale when changing the oxygen level. He said, "But she shouldn't have done it."

5.15.8 Mr Melia was also asked about the panel's conclusion that the Claimant's intervention was detrimental to child A. He was asked about the clinical notes and PAWS chart relating to the incident, which had been before the disciplinary panel. The clinical notes indicate that child A was seen by Dr D at 8:45 am and again at 12:20pm. The notes also confirm that child A was indeed transferred to a different room at 4pm and record that when she changed from her left side to her right side her saturations improved from 84% to 94%, both with 5 litres of oxygen. While difficult to read, the PAWS chart itself indicated that child A's initial oxygen level was 87% and she was on 10 litres of oxygen. At regular intervals throughout the day after that her saturation levels were recorded, as was the level of oxygen. She remained on 5 litres of oxygen for almost the entire time. Her saturation levels were 89% by 10am and improved through the day until they fell to 86 in the early afternoon before rising to 94 again by 4pm. The notes indicate that a variety of staff saw child A. For example, a Health Care Assistant recorded at 10am that she had informed the doctor about the child's respiratory rate and oxygen levels at that time. Given the panel's finding that the Claimant's conduct in reducing the oxygen level to 5 litres in the morning was detrimental to child A, Mr Melia was asked whether the panel had taken into account that the child had been seen by different members of the acute care team (including the consultant) throughout the day and seemed to have stayed on 5 litres. He said that the panel had considered that and concluded that child A was being cared for. He was asked the question again and he said that the child was being cared for appropriately by the acute clinical team who were responsible for her care. He was asked therefore if the panel's concern was about the level of oxygen or about the fact that the Claimant stepped outside her jurisdiction. Eventually he said that there was no detriment to child A, the issue was one of jurisdiction. He was therefore asked why in its outcome letter the panel said that the Claimant's actions were detrimental to the child. He said that child A did not come to clinical harm but it was outside the Claimant's jurisdiction. It was not possible to reconcile his answers with the content of the decision letter explicitly stating that the Claimant's intervention was detrimental to child A, as confirmed and indeed amplified in Mr Melia's witness statement.

5.15.9 At the end of this part of his evidence Mr Melia was asked whether, if the Claimant's intervention as regards the oxygen level had been the only matter, the panel would have characterised it as gross misconduct and summarily dismissed her. He said that it would not if this had been the only thing. It would not have been so formal. "People make mistakes…."

5.16 Accordingly, the disciplinary panel's approach to the two concrete examples was in my view one that no reasonable panel could have taken. This was not a case of reaching one of a number of possible views that were open to the panel on the evidence. Rather, it was a case of making findings that could not be supported by the evidence and that did not withstand scrutiny in cross-examination.

5.17 The remainder of the panel's findings were at a much more general level and I find that they too were made without any proper scrutiny or weighing of the evidence. To give some particular, further examples:

5.17.1 The first part of allegation three was that the Claimant excluded other professionals from decisions regarding end of life. The panel's decision is set

out above. They recorded the evidence presented by management as being to the effect that the Claimant would take over "all end-of-life care arrangements through reducing access to other professionals, stifling lines of communication and working most on call shifts" and the Claimant's explanation as being that she was the senior nurse and the tasks therefore fell to her. The outcome letter simply states that the panel upheld this allegation. In her written statement of case in advance of the disciplinary hearing the Claimant dealt with this in some detail. She acknowledged that she did a lot of on-call across both continuing care and palliative care. The Claimant described how the two nursing colleagues who had raised this complaint, CS and LG, both provided on-call for palliative care if they were not on leave. The Claimant said that in the past few years since they had been part of the team there had been five deaths. CS had been on leave for two of them and LG for one of them. The Claimant said that the team had all been developed in their end-of-life care skills. The evidence before the disciplinary panel included notes of the investigatory interview with CS. During that interview CS described her concerns about being excluded from palliative care for one particular patient. The circumstances were that she had known the child in a previous job and had been on her caseload in this team when the Claimant was on secondment. When the Claimant returned from secondment CS described being replaced by the Claimant in caring for the child. She said that she had raised this with the Claimant; they had had an argument and CS acknowledged that it had been a bit unprofessional on her part. CS did not say that the Claimant would take over all end-of-life care arrangements through reducing access to other professionals, stifling lines of communication or working most on-call shifts. For example, she said that the Claimant would do a lot of the on-calls but not that she took total control over it; she accepted that when she and LG were on-call it was up to them to sort things out; she accepted that when the Claimant was on holiday or on leave CS and LG managed situations. LG gave evidence at the disciplinary hearing. During the course of her evidence LG named five children for whom the team had provided end-of-life care at home. The Claimant asked her if there were any for whom she had not been involved in end-of-life care and LG said that there were none. LG acknowledged that she had been involved in the care of some of the children. She also agreed that she had been absent when one child died and CS had been absent on other occasions. In view of the evidence from the two nurses concerned, let alone the Claimant's account, there were no reasonable grounds to support the finding the disciplinary panel made on this part of allegation three.

5.17.2 As set out above, the management statement of case presented a one-sided view of the evidence. As regards allegation one, quotations from the investigative interviews were set out, sometimes out of context or partial quotations or inaccurate ones, so as to support the management statement of case. No balance was given. In the relatively short time available, the Claimant set out a number of criticisms and responses in her statement of case. In some respects she referred to evidence that contradicted particular points that had been made. In others, she highlighted where matters had been misquoted or quoted out of context. She drew attention to matters about which particular individuals could have been asked but were not. The Claimant also provided evidence from professionals and patients that was supportive of her. She asked for a number of the witnesses to attend the

disciplinary hearing so that she could question them about the evidence they had given. I have read all of that material in full. Undoubtedly, many of the witnesses were critical of the Claimant in a variety of respects. However, that was not the full picture. There were many positive comments and the criticisms were not all of the same nature. For example, while many witnesses used the word "control" or "controlling" it is a mischaracterisation to say that 23 people stated that the Claimant "had a controlling manner and style." For instance, some referred to specific situations only or to what might be regarded as appropriate managerial control. The panel simply does not appear to have grappled with the detail. Their approach, as reflected in the outcome letter, appears to have been to record (inaccurately) that 23 witnesses said that the Claimant had a controlling manner and style and to probe no further. There was no analysis of what each person said about control. There was no indication that they had considered those elements where the Claimant had produced evidence proving that what a witness said was incorrect, nor whether they had considered the implications of specific inaccuracies for the evidence of that person as a whole. I find that it was outside the range of what was reasonable in all these circumstances essentially to proceed on the basis that because large numbers of people said something it was likely to be right.

5.17.3 The panel's findings as set out in the decision letter went even further than the one-sided statement of case, and in a number of respects seem to have no basis in the evidence. For example, the panel suggested that the management statement of case and written statements showed that "multiple witnesses evidenced that … the Claimant would occasionally shout at staff …" when no witness said this. One referred to her being "quick to shout people down". The panel recorded that the Claimant would predominantly ensure that she took Jigsaw on-call where there were end of life patients and that colleagues stated that this was "further evidence of gaining control in order that families and other professionals would predominately use [her] as the conduit for decisions regarding patients." I was not shown any evidence before the disciplinary panel of any colleague making such statements.

5.18 Mr Budworth submitted that it would be unfair to give the Movicol and oxygen allegations a prominence that they did not have at the time of the disciplinary hearing. His submission was that the totality of the evidence before the disciplinary panel amply justified it in upholding the allegations and dismissing the Claimant as a result. I disagree. Firstly, it is clear that the Movicol and oxygen allegations did have prominence at the time. They featured prominently in the findings in relation to allegation two and were relied on as evidence of the Claimant's controlling behaviour, which underpinned allegation one. Secondly, as indicated by the examples above, when aspects of the findings in relation to the more general allegations were subjected to scrutiny by the Claimant concerns again quickly emerged: the disciplinary panel did not accurately record the evidence and the findings actually made by the disciplinary panel did not reflect the evidence.

5.19 Given the procedural concerns and fundamental shortcomings in the panel's findings, no reasonable employer would have dismissed the Claimant in those circumstances. It was allegations one and two that were regarded by the panel as the most serious: large parts of its findings on the two principal elements of allegation

two were not reasonably open to it on the evidence before it. Those findings affected the approach to allegation one, which in any event also was an unreasonable one.

5.20 I find that the shortcomings were not corrected at the appeal stage:

5.20.1 Ms Davies confirmed in her oral evidence that this was a review not a rehearing.

5.20.2 The appeal panel's approach seems largely to have been to ask Mr Melia during the appeal hearing the questions raised by the Claimant and to accept his reassurances. That was very much the impression given by the transcript of the appeal hearing and by Mrs Davies in her oral evidence.

5.20.3 The Claimant provided a detailed 35-page statement of case for her appeal. She went through in detail the disciplinary panel's findings as set out in the outcome letter, referring to and identifying evidence that contradicted or undermined those findings. By way of example, as regards the Movicol issue the grounds of appeal drew attention to the fact that both AF and the school nurse admitted at the disciplinary hearing that they had not raised concerns about Movicol until the day it was actioned; that it was the Claimant who prescribed picosulphate and this was not started only because a doctor suggested continuing Movicol; that there was evidence that the Claimant had discussed the Movicol with Dr MH and other doctors at the hospice on several occasions; that the Claimant had arranged for the child to be seen on CAU and have an x-ray because she was worried they were missing something; and that the child had been seen by Dr B and Dr D none of whom had stopped the Movicol. In relation to the oxygen issue the Claimant drew attention to HM's statement describing a discussion about the oxygen. She pointed out that HM's statement raised no concerns about the Claimant's manner that day. As regards allegation three, the Claimant's statement of case drew attention to the fact that LG had said in the hearing that she had been involved in every end-of-life care case that had occurred while she had been in post; another individual had given evidence that the Jigsaw on-call rota included CS, LG. the Claimant and GS and that it was CS who dealt with the end of life for a particular named child; that LG had given evidence that she had been on leave during one of the deaths that had taken place and CS had been on leave during two of them; and that two children's Macmillan nurses gave statements indicating that they all worked closely together and did joint visits.

5.20.4 In her cross-examination Mrs Davies was asked how the appeal panel had taken into account the Claimant's appeal and documentation. She said that the panel had predominantly relied on the questioning of Mr Melia and Ms Wilkinson (Deputy Director of Workforce) and questioning of the Claimant. She said that the panel had been through all the matters the Claimant raised when reading the material but not in questioning. She was asked what process the panel had gone through. She said that the panel did not consider the clinical decision-making but rather the Claimant's behaviours. That did not answer the question. In cross-examination Mrs Davies suggested that the panel checked "some of the evidence that cross-referenced" and also asked Mr Melia.

5.20.5 The appeal panel's outcome letter did not deal in any detail with the points advanced by the Claimant. The appeal panel acknowledged that with the volume of evidence presented there might have been differences of opinion or conflicting accounts but said that having heard the representations made

they did not hear any evidence to suggest a significant undermining of the disciplinary panel's conclusions. They did not deal with the specific points raised by the Claimant.

5.20.6 As regards the Movicol issue, the appeal panel's reasoning was:

> "The disciplinary panel found that you had ignored the symptoms despite others raising concern, i.e. the rippling of the bowel and abdominal distension and that your judgement was flawed despite the clinical presentation of the child. The appeal panel acknowledge that you did not prescribe or administer the Movicol but concur with management's view that you should have taken account of the child's presentation and acted upon this before others raised concern."

That simply did not address the specific points made in the Claimant's grounds of appeal.

5.20.7 As regards the administration of oxygen, the appeal panel recorded that this was viewed by the disciplinary panel as potentially the most serious matter. The panel noted that the Claimant admitted turning the oxygen down for a patient for whom she was not clinically responsible. The appeal panel recorded the Claimant's mitigation, that the child had not been desaturating at the time and that she had not considered the PAWS as this was not used in the community setting. The appeal panel recorded that the PAWS instructed for 10 to 15 L of oxygen to be given and that the Claimant's actions could have had a detrimental impact on the child. It recorded that management regarded the Claimant's actions as evidence of her controlling behaviour manifesting itself in a tangible way. The appeal panel said that after consideration of the evidence presented at the appeal they concurred with management's finding that she demonstrated controlling behaviours that had a direct impact upon patient care. Again, the panel did not address the points made in the Claimant's grounds of appeal.

5.20.8 Ms Davies indicated in oral evidence that she relied on the findings relating to Movicol and oxygen administration as evidence that the Claimant did have controlling behaviours that influenced care in determining whether what witnesses said in respect of allegation one was likely to be true.

5.20.9 Ms Davies indicated in her oral evidence that she did not consider whether the Claimant had made clinically appropriate decisions. She said that Mr Melia explained that the panel had reached its decision on the basis of the behaviours associated with the administration of Movicol, not with the appropriateness of her clinical decision. Her attention was drawn to the disciplinary outcome letter, where the panel said in terms that the Claimant's judgement in relation to the Movicol was flawed, that the dose was excessive and inappropriate and that the Claimant had failed to take into account the child's pain, abdominal distension and increasing discomfort. She confirmed that it was her understanding from Mr Melia that the panel's decision was about behaviours not clinical decision-making. She was asked whether it troubled her that the outcome letter said something different and she said that it did not. She was unable to explain why that was. She said that she did not get into the detail of Movicol being appropriate. She did not want to give the impression that she was trying to judge the clinical aspects. She was then asked about the administration of oxygen and it was put to her that there was nothing wrong in the Claimant's decision about oxygen. She said that there was. The child had a significant chest infection, the PAW score indicated that she required a high dose of oxygen. She had referred earlier in her evidence

to her belief that child A suffered a "prolonged period of respiratory distress" because she had her oxygen reduced at an inappropriate time. It was suggested to her that, contrary to her evidence, she was making clinical judgments. She said that the clinical judgments she made were, "Asking the expert Mr Melia if there had been an impact on patients and there was." She added that the evidence she "thought she saw" indicated that there was. The Claimant's detailed criticisms of the disciplinary panel's findings were drawn to Mrs Davies's attention. She was asked how the appeal panel could carry out its role of assessing whether the disciplinary panel had been correct having regard to those criticisms by asking Mr Melia. She said, "I asked him his rationale." All of this pointed to a failure properly to grapple with the detail of the appeal or to approach it independently and objectively.

5.21 For all of these reasons I find that the Respondent did not act reasonably in all the circumstances in dismissing the Claimant for misconduct. No reasonable employer would have dismissed her in those circumstances.

Wrongful Dismissal, Contributory Fault and *Polkey*

6.1 For the purposes of wrongful dismissal, contributory fault and *Polkey* (i.e. the question whether there is a chance that the Claimant would have been fairly dismissed in any event), it is necessary for me to make findings about whether the Claimant in fact committed misconduct as alleged. Mr Budworth submitted that I should find that the Claimant did commit the misconduct as set out in the management statement of case, based on the references within that statement of case to the underlying witness interviews. He invites me to take into account the requirements of the Claimant under her job description and the NMC Code of Conduct. He also referred to some references to what was said at the appeal hearing and to Mr Melia's handwritten notes of questions and/or answers. He submitted that the review of the evidence was enough and that there was "so much of it" that was enough. He did not call any witness to give evidence of the underlying criticisms of the Claimant. He submitted that that would have been disproportionate and unrealistic.

6.2 With the exception of her actions in reducing the flow of oxygen to child A (see below) I am not persuaded on the balance of probabilities that the Claimant committed any misconduct or was guilty of culpable and blameworthy conduct.

6.3 As regards allegation one, nobody has given direct evidence to me. It is not enough simply to say that a large number of witnesses have made criticisms. The witnesses said a range of different things, ranging from the minor to the more serious. In her witness statement for the Tribunal hearing the Claimant set out a detailed account giving her own version of events. She provided explanations and context. She included an appendix cross-referring what was said in the management statement of case with the underlying evidence, and drawing attention to mistakes, context and countervailing evidence. Some of the individuals gave evidence at the disciplinary hearing. The Claimant set out her recollection of evidence they gave that supported her version of events. There is no record of that evidence if it was given on day one. The Claimant identified lines of investigation in respect of some of the allegations that were not explored and witnesses who were not spoken to. I found the Claimant to be a straightforward and credible witness. She was measured and ready to make concessions as appropriate. In cross-examination, the allegations were repeatedly put to her in a generalised way and she insisted that it was necessary to consider

the detail. She referred to the appendix to her witness statement where she had done precisely that, addressing the assertion that 23 witnesses had accused her of having a controlling manner and style. When she *was* asked about specific examples, she gave clear answers. Sometimes she pointed to evidence to the contrary, sometimes she explained the context or gave a different perspective. She accepted that she was controlling to a degree, "But not of other people" - she said that she took her responsibilities seriously and wanted things to be done right. She accepted that she was upset to read how people had felt. In all of those circumstances, the untested accounts set out in the notes of the investigation meetings from 2017 together with the other documents to which Mr Budworth referred do not satisfy me on a balance of probabilities that the Claimant was guilty of demonstrating controlling and inappropriate behaviours as set out in allegation one.

6.4 Turning to allegation two, I have referred in detail above to the evidence that was before the disciplinary panel relating to Movicol, leading to my finding that the panel's decision was not reasonably open to it on the evidence. I have not heard from either School Nurse, AF or any other medical professional who was involved. The Claimant refers to evidence at the disciplinary hearing given by the School Nurse and AF, e.g. that they did not raise a concern about Movicol until the day it was actioned. The contemporaneous evidence in the chronology taken from SystemOne by CH is broadly consistent with the Claimant's account. The chronology shows the School Nurses contacting doctors and others for advice (e.g. the continence nurse). It shows that Child A was seen by a number of nurses during the time at issue, and was observed by Mrs Langworth herself who did not raise any concern about her distended abdomen nor suggest that there was anything controlling or untoward in the Claimant's manner. I am not persuaded on the basis of the evidence before me that the Claimant's approach to Child A's constipation and treatment with Movicol was inappropriate in any way, nor that it provides any evidence of controlling or inappropriate behaviours.

6.5 As regards the administration of oxygen, the Claimant accepts that she must have reduced child A's oxygen flow on 19 July 2016 shortly after her admission, although she does not recall doing so. The evidence indicates that this was done while HM was in the room and that there was discussion about the levels of oxygen administered to Child A in the home setting between the Claimant, HM and Dr D. It also shows that the oxygen remained at 5 litres for a number of hours, after Child A had been seen by Dr D and others. Her saturation levels gradually improved (only worsening temporarily when she was moved to a private room and put on her side). The Claimant has accepted ever since she prepared her own statement of case for the disciplinary hearing that reducing the oxygen flow without considering what was indicated by the PAWS was a cause for concern. She acknowledged in her witness statement and evidence to me that it was inappropriate. She said that it was not about control. She had been caring for the child at home for two hours and had come to hospital with her; she knew her well and was familiar with her care plan, which called for no more than 5 litres of oxygen. I find that it was culpable and blameworthy conduct to turn Child A's oxygen level down when she was in the CAU without considering the PAWS. However, it plainly was not gross misconduct. Mr Melia accepted that in his oral evidence. Nor do I find that it is evidence of controlling behaviour. As described by HM, the Claimant adjusted the oxygen while HM was

present and there was a professional discussion about the appropriate level of oxygen. A ward sister and paediatric consultant were involved in the child's care.

6.6 The only other specific aspect upheld by the disciplinary panel in respect of allegation two was not the subject of detailed evidence before me and the Claimant was not asked about it. I did not hear from any of the witnesses first hand. I am not satisfied that the Claimant was guilty of any misconduct in relation to exclusion of AF from a meeting to discuss Child A's care plan.

6.7 As regards allegation three, I have referred above to the evidence the Claimant identified as being inconsistent with the allegation that she excluded others from end-of-life care. She referred to what was said at the disciplinary hearing by LG and another witness, and to the evidence that showed that LG and CS were involved in end-of-life care for children during the relevant period. In her evidence to me she corrected incorrect information about the number of on-call shifts she had done (which Mrs Langworth had presented at the disciplinary hearing). Again, I am not satisfied on a balance of probabilities on the basis of the evidence before me that the Claimant committed any misconduct in this respect.

Wrongful Dismissal

6.8 Against those further findings of fact, I turn to the wrongful dismissal claim. The only culpable conduct I have found took place was turning Child A's oxygen level down. As set out above, that was not gross misconduct and Mr Melia accepted that it would not by itself have justified dismissal. The Respondent therefore acted in breach of contract by dismissing the Claimant without notice and her claim for notice pay succeeds.

Contributory Fault

6.9 The Claimant's culpable conduct in turning down the oxygen level did contribute to her dismissal. I find that it did so only to a limited extent: the Claimant was only partially to blame. It is important to remember that she did so with HM present; she did discuss her rationale with her; Dr D examined the child shortly afterwards; the child remained on 5 litres of oxygen thereafter; and her saturation levels improved. This is at the lower end of culpability and would, by itself, not have justified formal action. The Claimant's contribution was only slight and I consider that in those circumstances it is just and equitable to reduce the compensatory and basic awards payable to her by 25%.

Polkey

6.10 That brings me to the question of *Polkey*. Here, Mr Budworth submits that, if a fair procedure had been followed, the Claimant would, at the very least, have received a final written warning. He then draws attention to the suggested shortcomings in her practice that were identified in an expert report prepared during the police investigation. Mr Melia's witness evidence was that those matters alone would have led to a final written warning as a minimum. Mr Budworth submits that the cumulative effect of these two matters would inevitably have been the Claimant's dismissal.

6.11 However, I am not persuaded that there is any chance that the Claimant would have been fairly dismissed in any event. Starting with the matters for which she was dismissed, a fair procedure would have involved interviewing the Claimant promptly and after she had been provided with detail of the allegations and documentation. It

would have involved an investigation that looked for and presented exculpatory evidence, not one that was designed to support a particular case. It would have involved a disciplinary panel that did not pre-judge matters and that dealt with the detail of the underlying, contemporaneous evidence and properly weighed the evidence on both sides. Mr Melia said that if the only culpable behaviour had been adjusting the oxygen flow it would not have been dealt with so formally. That suggests that he did not consider that this element would have led to a disciplinary hearing and potentially a final written warning. As regards allegation one, while there were criticisms of the Claimant's manner and approach in the documentation, many of them related to matters that might be regarded as calling for training or a capability process, not a disciplinary one. There was also the theme of controlling behaviour that overlapped with the specific examples in allegation two. In all the circumstances I am not satisfied on the evidence before me that if the Respondent had followed a fair process the Claimant would have been subjected to any disciplinary sanction, still less that she would have been given a final written warning.

6.12 As regards the alleged shortcomings identified in the expert's report, the Claimant gave a detailed response to those matters in her witness statement. She explained that in a number of respects she had been following Trust practice, and gave other explanations for other concerns. She was not cross-examined about this. I was not shown any of the underlying documentation. On the basis of the evidence before me, the Respondent has not satisfied me that there is a chance that it would or could fairly have issued the Claimant with a final written warning in respect of these matters.

6.13 Accordingly, I find that there is no chance that the Claimant would have been fairly dismissed in any event.

Employment Judge Davies

Dated: 23 January 2019