EMPLOYMENT TRIBUNALS

BETWEEN

CLAIMANT		**RESPONDENT**
MR P PRITCHARD	**V**	**CARDIFF AND VALE UNIVERSITY HEALTH BOARD**

HELD AT: **CARDIFF** **ON:** 2, 3, 4, 5, 9, 10, 11 & 12 MAY 2017

BEFORE: **EMPLOYMENT JUDGE** **N W BEARD**
MEMBERS **MR BRADNEY**
MRS BISHOP

JUDGMENT

1. The claimant's claim of unfair dismissal pursuant to section 98 of the Employment Rights Act 1996 is not well founded and is dismissed.
2. The claimant's claim of unfair dismissal pursuant to section 103A of the Employment Rights Act 1996 is not well founded and is dismissed.
3. The claimant's claim to have suffered detriment pursuant to section 47B of the Employment Rights Act 1996 is not well founded and is dismissed.

REASONS

Preliminaries

1. The claimant was represented by Mr Harris of Counsel; the respondent by Mr Graham also of counsel.

2. The claimant claims to have been dismissed and suffered detriments because he had made public interest disclosures. In the alternative he argued that he was, in any event, unfairly dismissed. The claimant prepared a list of issues, after some discussion and alteration these were agreed by the respondent. The issues are as follows:
   2.1. Did either of the following amount to an effective dismissal of the claimant by the respondent:
      2.1.1. Demotion from qualified perfusionist to trainee perfusionist on 19 May 2016?

2.1.2. Demotion from trainee perfusionist to an administrative role at the Wales Heart Research Institute on 2 August 2016?

2.2. Do the following amount to disclosures qualifying for protection for the purposes of section 43B(1) of the employment rights act 1996?

2.2.1. The claimant's email to Noel Kelleher and others dated 19th of June 2015?

2.2.2. The meeting on 7 August 2015 between the claimant, Mr Coslett and Miss Deglurkar?

2.3. If so, did the investigations, disciplinary proceedings and (if they do not amount to dismissals) the above demotions amount to detriments that the claimant was subjected to on the ground that he made a protected disclosure (section 47B)?

2.4. Was the claimant subjected to the following detriments as a result of making disclosures.

2.4.1. The investigation (from 13 August, 2015 to 16 March, 2016) that recommended on 16 March, 2016 that disciplinary action should be taken against him.

2.4.2. Being taken through disciplinary proceedings, despite this being inappropriate and unfair, from 5 May to 19 May, 2016.

2.4.3. Being demoted on 19 May, 2016.

2.4.4. Being subjected to the disciplinary appeal process between 19 May 2016 and 16 September, 2016.

2.4.5. Being subjected to disciplinary proceedings in respect of his registration status. Despite this being inappropriate and unfair, from 13 July 2016 to 16 March, 2017.

2.4.6. Being demoted on 2 August, 2016.

2.5. If the claimant was effectively dismissed by the respondent on 19 May 2016 was the reason for his dismissal:

2.5.1. the fact that he had made one or more protected disclosures pursuant to section 43B ERA 1996?

2.5.2. His alleged conduct?

2.5.3. Some other substantive reason in law, namely gross negligence and/or failure to meet the required professional standards?

2.5.4. A different reason falling outside the potentially fair reason for dismissal contained in section 96 ERA 1996?

2.6. If the claimant was dismissed for a potentially fair reason being his alleged conduct or for some other reason in law, namely gross negligence and/or failure to meet the required professional standards, then taking into account all of the circumstances, including the size and administrative resources of the respondent's undertaking, did the respondent acted reasonably or unreasonably in treating that reason as a sufficient reason for dismissing the claimant?

2.7. If the claimant was effectively dismissed by the respondent on 2 August, 2016, was the reason for his dismissal:

2.7.1. The fact that he had made one or more protected disclosures pursuant to section 40 3B ERA 1996?

2.7.2. Some other substantive reason in law, namely a breakdown of relationships within the perfusion team and the potential impact on patient safety?

2.7.3. A different reason falling outside the potentially fair reason is the dismissal contained in section 96 ERA 1996?

2.8. If the claimant was dismissed or some other substantive reason in law, namely a breakdown in relationships within the perfusion team and the potential impact on patient safety, then taking into account all the circumstances including the size and administrative resources of the respondent's undertaking, the respondent

acted reasonably or unreasonably in treating that reason as a sufficient reason for dismissing the claimant?

The Facts

3. The claimant began his employment with the respondent in the summer of 2011 but had worked in the NHS for a total of 26 years by 2016. The claimant was employed as a Senior Perfusionist; this is a highly specialised role involved in surgical procedures where a heart bypass is required. Perfusionists control the heart and lung machines which are used in such procedures. This is a role which requires significant training and is overseen by the Royal College of Perfusionists. The claimant was employed in the respondent's grade structure at Band 8a. The respondent is a Health Board within the Welsh NHS structure, which amongst other things provides cardiopulmonary surgery to its patients. The claimant's contract is set out in an offer letter, a contract document and a supplemental statement of terms and conditions. The supplementary statement of main terms and particulars of employment indicates it is applicable to all staff working for the respondent and supplements the One Wales contract of employment and job description to form the claimant's contract of employment. In section 1.1 The following is set out *"your employment with the UL HP is subject to the personnel and employment policies, rules and procedures formally adopted by the UL HP notified to you from time to time."* The contract of employment in clause 6 sets out the claimant's normal place of work as being in the University Hospital of Wales. However, it then sets out "*there may be occasions when you will be requested to work at other locations within Cardiff and Vale University local health board. The organisation reserves the right to reasonably transfer you, following consultation, to any of its locations, in accordance with the needs of the service".*

4. The tribunal should point out at the outset some general observations of the claimant's place of work and relationships with colleagues as a form of scene setting. Additionally, we will set out some observations of our view of the witnesses called by the respondent. Having seen Mr Rodd, Mr Kelleher and Mr Jones, the tribunal take the view that personal relationships between those individuals and the claimant were extremely dysfunctional. It is clear to us that Mr Rodd and Mr Jones in particular, did not like the claimant. There was disputed evidence as to whether Mr Kelleher, on more than one occasion, had told the claimant that nobody in the perfusion team liked the claimant. In the circumstances, we see no need to resolve that dispute, because it was clear to us from the evidence heard and from the report that we read prepared by Ms Blackwell, that the claimant was an outsider in the Department. The tribunal is not in a position on the basis of the evidence that we heard to come to a conclusion as to the reasons for this poor relationship, but we are convinced of its existence.

5. The tribunal draws a distinction between those three witnesses and the others called by the respondent. In our judgement, the other witnesses were professional and detached in their approach to dealing with the claimant. We would go further and indicate that they were approaching all matters in the most even-handed way.

6. In September 2014, the claimant made an error. The claimant was the lead perfusionist in a surgical procedure. He had set up the heart lung machine and completed a checklist, however he had not correctly replaced the cap on the reservoir containing a substance called isoflurane. This problem was not identified

prior to surgery commencing and had to be corrected, in the course of the surgery, once a second perfusionist had identified the problem. Whilst no harm was caused to the patient, a break in the bypass occurred which meant that the patient was without oxygen for a short time. As a result of this, following a learning lessons investigation, the claimant was supervised for five surgical procedures. As no intervention was required during those five procedures, no further intervention was undertaken.

7. As part of the lessons learned from this process the respondent instituted a procedure where a second perfusionist would carry out a second check following a duplicate checklist. This process was to be mandatory, however it is again clear from the evidence that the tribunal heard that the second check was not always carried out. The tribunal are again clear that, although wrongly, Mr Jones understood the second check to be voluntary not mandatory. The claimant indicated that by researching previous records he had made a list of those occasions when the second check was not carried out by various perfusionists; he had compiled a document showing this. In cross examination, the claimant was pressed on the accuracy of this document. He was asked as to how one perfusionist was shown as not having carried out the second check process on his compiled document, but in a letter from the claimant was shown to have carried out a second check on the same date. The claimant said that there must have been another procedure on that date. Pressed further on this the claimant accepted that there were no documents demonstrating any more than one procedure was undertaken by that perfusionist on that date. The tribunal considered that the claimant's compiled document was not a reliable means of discovering when individuals had complied or not complied with the second check process.

8. On 19 June, 2015, following an incident where Mr Jones refused to engage in the second check process, the claimant sent an email to the respondent. The email asked for clarification as to how the second check should be performed, indicating his view that two perfusionists should take part, and stating that he was openly coming into conflict with individuals who refused to take part. He set out that he believed it to be a safety issue. Mr Jones was clearly aware of this document as he writes an email on 22 June, 2015, setting out his views on the second check Mr Jones felt that the second checklist was impractical; this view seems to have generally been accepted because at a meeting in July 2015 to sort out the appropriate approach to a second checklist all perfusionists, including the claimant, agreed that the second checklist should be limited to 5 items. This limited the second check to those items that it was possible for the second perfusionist to properly review. This was introduced as a system on 1 August, 2015, whereby there would be a primary check by the lead perfusionist with some twenty one items, followed by a secondary check limited to the five items.

9. On 4 August, 2015 Mr Jones criticised the claimant's practice, citing three incidents, the first of which had occurred on 23 July 2015. Mr Jones had taken photographs of all three incidents, in evidence he could not explain why he had waited a number of days gathering this information before reporting it. The tribunal took the view that Mr Jones had not liked the claimant raising his failure to complete the second checklist and was because of that, looking for mistakes by the claimant. Mr Kelleher was on annual leave and so Mr Coslett had to deal with the complaints. Mr Coslett worked in the directorate which covered the perfusion department, but was not part of the Department itself. Mr Coslett was Mr Kelleher's line manager for business matters, he had no clinical control, having no medical expertise. Mr Jones' information was

provided to Mr Coslett. He told Mr Jones to enter it onto the Datix system. Mr Coslett approached the clinical board for advice, because Mr Kelleher, the senior expert in the perfusion department, was not available to advise on technical matters. The instruction provided by the clinical board was to approach the Royal College of Perfusionists for advice. The eventual advice they provided was that because machinery had been moved, it was not possible to prove that the first incident was the responsibility of the claimant, and that in respect of the other two incidents, while the claimant's approach was not orthodox it was something that the Department should develop a standard operating procedure in order to deal with the matter.

10. The instruction from the board was not to suspend the claimant following the complaint, but he was not to carry out clinical work. This decision was not properly communicated to staff, and led to further problems on 5 August, 2015 between the claimant, Mr Jones and one other perfusionist. The claimant raised a concern about these problems on 6 August, 2015. (The claimant contends that these two perfusionists should have been disciplined on that occasion, however, the tribunal's conclusion is that the respondent having communicated poorly could not properly pursue disciplinary matters.) As a result of raising this complaint the claimant met with Mr Coslett and the lead cardiothoracic surgeon on 7 August, 2015 to discuss it. In his witness statement the claimant states "I expressed serious concerns about the management of the perfusion department and the treatment of the dual checklist as voluntary". The claimant gave no further detail as to what he said in the course of the hearing, and there is no document which sets out the words used by the claimant at that meeting about dual checklists. Mr Coslett attempted to convince the claimant that mediation was an appropriate way of dealing with the matter. However, on 10 August, 2015 the claimant indicated that he wanted to raise the complaints in a formal grievance.

11. The claimant had returned to ordinary working, and was assisting in a procedure on 13 August, 2015 as lead perfusionist. Mr Jones was to carry out the second check; he discovered that the claimant had made a mistake in the setup of the heart-lung machine. Two items of tubing were transposed in set up, all of the evidence points to this being a fundamental error. The claimant had dealt with the primary checklist. The primary checklist consists of the claimant entering onto a computer screen attached to the machine that he has checked the items set out. The claimant in his evidence first indicated that he used the checklist as a to-do list, however, when questioned further changed his approach. Given matters which we will describe later, the tribunal are of the view that the claimant did treat the checklist as a to-do list and not as a means of checking out work already undertaken by him. Therefore, in the circumstances, the claimant had made two errors: the first was the assembly of the machine in the wrong way; the second was indicating on the checklist that it was correctly assembled. To this must be added the conclusion of Mr Morgan, with which the tribunal agreed, that the claimant had, in fact, also failed to carry out the checks required by the checklist.

12. Mr Jones reported this error to Mr Coslett, the tribunal are of the view that Mr Jones was in part motivated to make this report by the matters which were raised in the 19 June, 2015 email. However, we are also of the view that he would have been under a professional duty to make this report in any event. Mr Coslett once again, because of the absence of Mr Kelleher, reported the matter to the clinical board. On this occasion the clinical board advised a "learning lessons" investigation should be undertaken. Mr Coslett was questioned about this difference in approach to the

matters raised on 4 August, 2015. He told us, and we accept, that the matters reported to him on 4 August were technical matters about the build of the heart-lung machine. He contrasted this to the matter on 13 August, which not only clearly involved a failure to build a machine correctly but also a failure to complete the checklist. In those circumstances, there was no technical matter upon which he needed specific advice, and the clinical board was clearly of the view that this was an error, hence its instruction for an investigation to be carried out. Because of the seriousness of the mistake alleged the clinical board decided that the claimant should not carry out clinical work whilst the investigation was ongoing.

13. Mr Coslett carried out a "learning lessons" investigation into this error. He had not undergone training in respect of "learning lessons" investigations, and he carried out the investigation alone. Two clinicians had earlier refused to carry out the investigation because they did not have training. The "learning lessons" process is in the form of an all Wales guidance document. The document indicates that the purpose of learning lessons is to put things right. The guidance indicates that the investigation to be carried out by more than one person unless it is reasonable to do otherwise. As a process "learning lessons" is meant to discover what happened, how it happened, why it happened, and look for a solution or a means of preventing an incident happening again. The process is not directly linked to disciplinary matters, although of course if disciplinary issues are discovered, they may be dealt with under other policies.

14. In the "learning lessons" process the claimant admitted that he had transposed the two tubes. The claimant further admitted that he had not corrected this error when dealing with the checklist. The claimant had initially told Mr Coslett that he had not completed the primary checklist at the time when Mr Jones attended to carry out the second check. It was demonstrated to him by the computer timings on the primary checklist that this explanation was incorrect; the claimant then accepted that he had checked off the checklist prior to Mr Jones attendance. Mr Coslett concluded that, by indicating that the checklist was completed, the claimant demonstrated that he had either failed to carry out a check on the tubing or falsified the entry. Mr Coslett concluded that there was nothing to demonstrate that the claimant did not have the skills to carry out the build of the machine properly. In evidence before us it was clear that the claimant had the relevant knowledge, experience and the skill to assemble the machine correctly. The claimant had explained to Mr Coslett that the patient had an unusual condition and because the claimant carried out research into that condition on that morning, that he was under time pressure.

15. Given his conclusions in the "learning lessons" report Mr Coslett decided that the disciplinary policy ought to be followed in respect of the claimant's error. The basis for his conclusions were that the claimant did not lack the necessary skills or ability to carry out the work correctly, that pressure of time should not amount to an appropriate excuse and that there was nothing else to indicate a capability issue. He concluded that the claimant did not set up the machine incorrectly intentionally but did not consider that this took it outside of the disciplinary policy. Mr Coslett was appointed to carry out the disciplinary investigation.

16. In the circumstances, it was agreed that the claimant should undertake office-based work in the perfusion department whilst the disciplinary investigation was ongoing. There was a meeting on 21 September, 2015 at which there was a verbal altercation between the claimant and Mr Kelleher observed by Mr Coslett. The claimant raised a

grievance about this which Mr Coslett investigated, and of course to which he was a witness. Mr Coslett upheld the claimant's grievance, he was Mr Kelleher's line manager and he met with Mr Kelleher to feedback the grievance result, and further set out future expectations of behaviour. This matter remained on Mr Kelleher's personnel file for one year.

17. Mr Coslett was asked to conduct the disciplinary investigation into the following allegation *"on 13 August, 2015, Mr Prichard failed to properly set up the heart-lung machine and to complete the checklist to confirm this which put the patient in his care at risk. This was not the first incident and Mr Pritchard had been involved in where the bypass machine had not been set up correctly."* Mr Coslett interviewed several people, including Mr Jones, Mr Kelleher, Mr Rodd and the claimant, producing a written report with his conclusions. The report sets out a balanced description of the evidence provided by each of the witnesses and the mitigation put forward by the claimant. The mitigation included in the report covered the clinical condition of the patient, working relationship issues (including a hostile working environment) non-compliance by others with the dual checklist process and that the heart-lung machine was relatively new in the department. In respect of this last matter Mr Coslett ascertained that the equipment had been used for 12 months by the time of the incident.

18. The claimant suggested in cross examination of Mr Coslett that he was aware of the claimant's communications with the respondent on 19 June, 2015 and 7 August, 2015, Mr Coslett accepted this. The claimant further suggested that Mr Coslett approached the investigation in an unfair way because of these communications. Mr Coslett told us, and we accept, that he was pleased that the claimant had raised the issues on 19 June 2015, as it ensured the implementation of the policy which Mr Coslett had initially introduced. Mr Coslett also told us that he had arranged for an audit to take place as to the use of the second checklist which examined the practice as from 1 August, 2015 (discovering that there was 100% use of the second checklist at that stage). The claimant criticised Mr Coslett for not setting up an audit which dealt with behaviour before 1 August, 2015. Mr Coslett told us that he was concerned with the situation post the agreement for the new second checklist. Mr Coslett was concerned with the situation going forward rather than what had happened in the past. The tribunal accepted that evidence and reject the claimant's contention that, in essence, Mr Coslett was confining the scope of evidence in order to avoid criticism of other staff who had failed to engage in use of the second checklist. We should also make clear that in respect of Mr Coslett we reject the allegation that he was working in conjunction with all the managerial and HR staff involved in the investigation and disciplinary process to "punish" the claimant for raising the matters that he had.

19. The decision as to whether to proceed to a disciplinary hearing was that of Mr Temby. He decided that the claimant should face a disciplinary hearing. Criticism was levied at Mr Temby for not providing a rationale for this decision, he explained that that was not the general approach and that he did not consider doing so. The claimant also raised the issue that in the document used by Mr Temby to approve moving forward to a disciplinary hearing, there was no indication that no case to answer was an option (other options were set out). Mr Temby told us that the choice offered of moving the matter to the capability process would effectively mean that there was no disciplinary case to answer, therefore, the absence of the no case

option was not important. He was fully aware of the available choices and he considered the disciplinary action was appropriate.

20. We were taken to both the capability and disciplinary policies of the respondent. Section 2.3 of the capability procedure reads as follows: *"this policy and the procedures detailed below are designed to deal with those cases where the employee is lacking in some area of knowledge, skill or ability, resulting in a failure to be able to carry out the required duties to an acceptable standard"* section 2.4 sets out *"this policy is to be used where genuine capability issues exist, rather than a deliberate failure on the part of the employee to perform to the standards of which they are capable. In the event of a deliberate failure by the employee, reference will be made to the organisation's disciplinary policy."* In the disciplinary policy section 10.5 the policy provides *"the investigating officer should normally be appointed from a different department to that in which the employee works. Investigating officer should have the specialist skills and/or knowledge relevant to the case being investigated. This may be an individual from another health board"* section 15.3.2 provides *"an appropriate member of the workforce and OD (HR) department, (with no previous involvement in the case), who advises the hearing on procedure and employment issues, and can assist the disciplinary officer establishing the facts of the case."* In section 17, a table is set out showing potential sanctions, dealing with other formal action short of dismissal there is an indication that an alternative sanction to dismissal may be offered where dismissal is appropriate, and which may be offered to the employee instead of dismissal, the following words are used *"the employee would have the opportunity to consider this option and respond in writing within seven calendar days accepting this variation in their terms and conditions as an alternative to dismissal."* In dealing with types of conduct under the heading serious misconduct the claimant asked the respondent's witnesses about the appropriateness of a "*failure to comply with conditions of service or working procedures"* as representing the claimant's level of culpability. The respondent referred to the gross misconduct descriptions and in particular gross negligence which read "*any action or failure to act which could result in serious damage to property or equipment, or endanger the health and safety of others. Failure to give appropriate care and protection to patient within the "UHB's" care".*

21. Mr Temby considered that the claimant's admitted conduct clearly fell within the disciplinary definitions. The claimant had admitted failing to correctly assemble machinery, and of failing to identify that incorrect assembly by means of the use of the checklist. The claimant's contention was that the existence of the dual checklist meant that there were no dangers to the patient, because the second check was meant to and did identify the failing. Mr Temby disagreed, his view was that the primary checklist covered a far greater scope than the second checklist, and in any event, the failure was one which if not detected, could have led to harm to the patient. The evidence before Mr Temby permitted this conclusion. However, in his evidence to us, what seemed of significant importance to Mr Temby was the claimant's lack of insight. The claimant's response to the question, how would he assure that a similar failing did not happen in the future are said that he could not because he was human. Mr Temby was expecting a response, where the claimant indicated that he would take steps to be more alert or generally review his practice in order to avoid such mistakes. He considered this to be a significant problem in terms of trusting the claimant's care for patients in the future. The tribunal consider that Mr Temby had sufficient evidence to draw these conclusions, based both on the report and the evidence given at the disciplinary hearing. Mr Temby decided that the

claimant could have been dismissed, but he was prepared to offer him the alternative employment of a trainee perfusionist. Although this would result in a drop in salary and status for the claimant, Mr Temby thought it an appropriate sanction in order to ensure that the claimant would be supervised for a considerable period. The letter sent to the claimant set out that this was an offer of employment as the alternative to dismissal, that letter was sent on the 23 May 2016. The claimant was given seven days to respond.

22. The claimant contended that Mr Kelleher should not have given evidence at this hearing. The disciplinary hearing took the form of an adversarial process, the claimant was entitled to question witnesses and to challenge their evidence. The claimant had raised issues about his working environment and there were technical issues related to the use of the machinery, Mr Kelleher was well placed to give evidence in this regard.

23. Mr Jonathan Pritchard was the HR adviser to Mr Temby. Mr Pritchard had been approached by Mr Coslett after the disciplinary investigation had concluded in March 2016. Mr Pritchard told us that he probably met with Mr Coslett to discuss the matters raised by him. Those matters related to Mr Coslett's concerns about relationships in the perfusion department if the claimant was to return to work after the disciplinary hearing. Mr Coslett was seeking advice as to steps he might take to improve relationships and prepare for the claimant's return.

24. The respondent requires that the clinical perfusionists that it employs are registered with the Royal College of Perfusionists. It has a policy which sets out that a failure to register or a lapse in registration would result in a disciplinary investigation being undertaken. The policy indicates that it is the responsibility of the employee to be aware when registration is due for renewal, and failure to obtain or maintain registrations lead to disciplinary action, including dismissal. The investigation requirement is set out in mandatory terms, indicating that if, within given timescales, registration was not renewed. "*This will be investigated under the UHD disciplinary policy and could lead to disciplinary action."* In order to renew registration the college required the claimant to have carried out a certain number of procedures. The claimant was one and a half procedures short of the requirement. His position before us was that he expected to be able to return to work prior to registration to complete the limited number of procedures required. The tribunal accept that this may been the claimant's state of mind. The respondent, however, was made aware of the claimant's failure to register. Mr Jonathan Pritchard wrote to the claimant asking for clarification as to why the registration had lapsed. The claimant responded to this, explaining that he had sought an extension of time from the Royal College but his request had been denied. It was also then set out that the claimant had informed the Royal College of the disciplinary process outcome and that the college had made a decision that is registration would be suspended until a college council meeting which was due to pay place on 23 June, 2016. It is clear that at this point in time there was a great deal of confusion as to the responsibilities of the college and of the employer in relation to the claimant's change in status from qualified perfusionist to trainee. Mr Jonathan Pritchard told us, and we accept, that he commenced the investigation process because it was mandatory to do so. The decision made at the end of that investigation was that there was no case to answer.

25. The claimant returned to work as a trainee perfusionist, having written to the respondent indicating that he was not accepting the decision, and was returning

under duress until his appeal. This letter was dated 3 June, 2016. The claimant returned to work took place on 25 July, 2016.

26. On 27 July, 2016 the claimant had been told to observe a procedure. He chose a procedure where Mr Jones was the lead perfusionist. Mr Jones was significantly disturbed when entering the operating theatre to find the claimant present. He left the operating theatre to speak to Mr Kelleher. Mr Kelleher, because Mr Jones was obviously distressed, contacted Leanne Morse. Mrs Morse was HR officer with no previous dealings with the claimant or Mr Kelleher. She spoke to Mr Jones and then with Mr Kelleher to the claimant. In the meeting with the claimant, he insisted that if Mr Kelleher was present, then the door should remain open. From what she had been told and observed Mrs Morse concluded that the groundwork had not been properly prepared for the claimant's return to work. As a result, she made the decision to send the claimant home and make arrangements for ACAS mediation to be undertaken. Thus, the claimant was sent to work in an administrative role at the Wales Heart Research Institute on 2 August 2016. However, the arrangements for his educational training as a trainee perfusionist were maintained. It is clear that Leanne Morse had no connection with or significant knowledge of the perfusion department before this. What is also clear is that Mrs Morse had no awareness of any of the claimed disclosures made by the claimant.

27. Mr Morgan conducted an appeal hearing. He developed a different understanding of the claimant's evidence. His understanding was that the claimant had not conducted the checks required for the checklist. He used the phrase that the claimant had not completed the checklist and had admitted as much. This was on the basis that although the claimant had told him that he had entered the ticks into the checklist showing he had conducted the checks, he had not actually done so. Given our understanding of the claimant's evidence before us, we accept that this was a legitimate conclusion for Mr Morgan to draw from the claimant's evidence. However, this was bolstered by Mr Morgan's examination of the equipment used by the claimant which demonstrated that he had entered the ticks in the space of a few minutes, whereas Mr Morgan's researches showed that others took much longer to do so. When questioned about the seriousness of the claimant's conduct Mr Morgan was passionate in his response. He said that the claimant was working in the "kill zone" and that the mistakes that the claimant had made could, in the appropriate circumstances, have caused serious harm to a patient. He too was concerned about the apparent lack of insight on the part of the claimant as to the seriousness of his conduct. Again, in our judgement Mr Morgan had sufficient evidence to draw these conclusions.

28. Mr Morgan, Mr Pritchard and Mr Temby were included in the claimant's list of individuals who were acting to the claimant's detriment on the basis that the claimant had made disclosures, and their decisions are made on that basis. These were bald assertions by the claimant with no basis in evidence other than the general relationships that exist between high-ranking individuals in an organisation. The tribunal rejected that view entirely, in our judgement, each of those individuals were acting appropriately and, in some cases, it may be said leniently, in dealing with the claimant.

The Law

29. The Employment Rights Act (ERA)1996 provides:

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

29.2. In section 43B: *(1)In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following—*

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

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(d)that the health or safety of any individual has been, is being or is likely to be endangered,

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29.3. In section 43C*:*

(1)A qualifying disclosure is made in accordance with this section if the worker makes the disclosure in good faith—

to his employer, or

(2)A worker who, in accordance with a procedure whose use by him is authorised by his employer, makes a qualifying disclosure to a person other than his employer, is to be treated for the purposes of this Part as making the qualifying disclosure to his employer.

30. In ***Bolton School v Evans [2007] ICR 641*** it is made clear that it is the disclosure of information that gives rise to the protection. In ***Fecitt & Ors v NHS Manchester EWCA Civ 1190*** Elias LJ held that liability arises if the protected disclosure is a material (more than trivial) factor in the employer's decision to subject the claimant to a detrimental act. Dealing with an argument related to the applicability of interpretation of discrimination law this area he considered that the reasoning in EU analysis is that unlawful discriminatory considerations should not have any influence on an employer's decisions and that the same principle is applicable where the objective is to protect whistleblowers. This creates an anomaly with the situation in unfair dismissal where the protected disclosure must be the sole or principal reason before the dismissal is deemed to be automatically unfair.

31. The PID provisions also raise issues on the burden of proof. In respect of detriment there is a reversal of the burden of proof once a claimant has proved that they have made a protected disclosure and suffered a subsequent detriment, section 48(2) Employment Rights Act (ERA) 1996 places the burden of proof on the respondent to prove, on the balance of probabilities, that the treatment was "*in no sense whatsoever*" on the ground of the protected disclosure. The tribunal must answer these questions when considering the burden of proof in a PID dismissal case. Has the claimant shown that there is a real issue that the reason advanced by the respondent is not the real reason for dismissal? If so, has the respondent proved his reason for dismissal? If not, has the employer disproved the section 103A reason advanced by the claimant? If not the dismissal is for the section 103A reason. This is set out in ***Kuzel v Roche [2008] IRLR 530*** on that approach it is possible to find that an employer has disproved the section 103A reason without establishing its own reason (i.e. both reasons advanced are not the real reason for dismissal).

32. In our judgment, following the above, the tribunal will have to consider whether the alleged detriment was in no way whatsoever because the claimant had made a

disclosure. In the case of unfair dismissal we will have to consider whether the disclosure of information was the sole or principle reason for dismissal. In both case we will have to ask whether the conduct relied upon by the respondent is properly separable from the provision of information. We must be careful that the sheer number of incidents of disclosure does not cloud our judgment as to that essential question.

33. Detriment is to be considered in the same manner as it would for discrimination cases i.e. that a reasonable worker would or might take the view that he had been disadvantaged in the circumstances in which he thereafter had to work ***Shamoon v Chief Constable of the Royal Ulster Constabulary [2003] IRLR 285.*** There is support for this approach to be found in ***Pinnington v The City & County of Swansea and Anr. UKEAT/0561/03*** where HHJ McMullen refers to ***Shamoon*** in dealing with the issue of detriment (paragraph 81) albeit obiter and also in **Dr I M Korashi V Abertawe Bro Morgannwg University Local Health Board *UKEAT/0424/09***

34. There must be a link between the detrimental treatment or dismissal and the disclosure. Also this must be "deliberate" in the sense of a conscious or unconscious motivation on the part of the respondent because of the disclosure and not for some other reason ***London Borough of Harrow v Knight [2003] IRLR 140.***

35. With regard to unfair dismissal, the relevant legislation begins with section 98 of the Employment Rights Act 1996, which provides:

> *(1) in determining for the purposes of this part, whether the dismissal of an employee is fair or unfair, it is for the employer to show the reason (or, if more than one, the principal reason for the dismissal, and that is either a reason falling within subsection 2 or some other substantial reason of a kind such as to justify the dismissal of any employee holding the position which the employee held.*
>
> *(2) a reason falls within this subsection if it ---*
>
> *relates to the conduct of the employee. -----*
>
> *(4) in any other case where the employer has fulfilled the requirements of subsection 1, the determination of the question of whether the dismissal is fair or unfair (having regard to the reason shown by the employer)*
>
> *(a) depends on whether in the circumstances (including the size and administrative resources of the employers undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee, and*
>
> *(b) shall be determined in accordance with equity and the substantial merits of the case.*

36. The respondent is required under Section 98 of the Employment Rights Act 1996 to prove the reason for dismissal. Thereafter, the burden of proof is equal between the respondent and the claimant in respect of the fairness of dismissal.

37. The respondent relies on conduct as the reason for dismissal and therefore, the tribunal will have cognisance of the decision in ***British Home Stores v***

Burchell but take account of the change in the burden of proof in respect of the fairness of the dismissal.

37.1. ***British Home Stores v Burchell*** requires the tribunal to ask itself a series of questions. The first of these questions is whether, there is a genuine belief on the part of the respondent that the claimant is guilty of the misconduct upon which they made the decision to dismiss?

37.2. The next question (if there is a genuine belief in guilt) is whether that is a sustainable belief on the evidence available. In other words, is it a logical conclusion that the respondent could draw on the evidence that it has gathered. The

37.3. The third question is, whether the evidence that has been gathered is sufficient in all the circumstances of the case; in terms we are asked to consider whether the respondent has carried out an investigation that is within the type of reasonable investigation a respondent could carry out in the circumstances.

37.4. Thereafter, we have to ask ourselves, the substantive question, did the punishment fit the crime.

37.5. We remind ourselves of the guidance of the Appeal Courts in these latter two matters that the tribunal should not to substitute our decision for that of the employer. Therefore, we have to ask ourselves the question, did the decision to dismiss, fall within the band of reasonable responses to the circumstances found to exist by the employer?

Analysis

38. Did either of the following amount to an effective dismissal of the claimant by the respondent (a) demotion from qualified perfusionist to trainee perfusionist on 19 May 2016? (b) demotion from training perfusionist to an administrative role at the Wales Heart Research Institute on 2 August 2016?

38.1. In our judgment, the claimant was dismissed on the respondent's receipt of the 3 June 2016 letter.

38.1.1. The respondent had offered the claimant alternative employment as an alternative to dismissal, it was clearly entitled to do so under the disciplinary policy.

38.1.2. The disciplinary policy was contractual. It is clear from the wording of the supplementary contract documentation of the policies were incorporated into the claimant's contract. These were not policies that were incapable of incorporation for being for instance, too vague.

38.1.3. The policy entitled the respondent to offer an alternative to dismissal if which accepted by the claimant would be a variation of the existing contract.

38.1.4. The claimant did not accept those terms, given the contents of the outcome letter that dismissal was the alternative, it is clear from that point the claimant was dismissed from his contract.

38.2. However, the claimant had accepted to work for the respondent on the new terms, albeit under duress. He was paid statutory sick pay in this period, the respondent did not indicate to the claimant that it would not accept his work, and the respondent was conducting investigations into the claimant's registration before the claimant returned to work on 25 July, 2016. In our judgement, this

means that the claimant and the respondent by implied agreement had entered into a new contract of employment engaging the claimant to carry out the work of a trainee perfusionist.

38.3. There was no interruption of the claimant's relationship with the respondent, given that as one contract ended the other implied agreement started. In those circumstances, whether it is called an agreement or an arrangement the claimant's employment continued within the meaning of section 212 of the Employment Rights Act 1996.

38.4. There was no dismissal on 2 August, 2016. The claimant's terms of agreement, other than his status as trainee perfusionist, remained as they were prior to dismissal.

38.5. Those terms included a term which allowed the respondent to move the claimant in line with the needs of the service. There was, albeit brief, consultation with the claimant about the move. It was intended as temporary, and it met the needs of the service in that moving the claimant was less likely to disrupt patient care and any other alteration to the perfusionist service, because of his trainee status.

39. Do the following amount to disclosures qualifying for protection for the purposes of section 43B one of the employment rights act 1996? (a) the claimant's email to Noel Kelleher and others dated 19th of June 2015? (b) The meeting on 7 August 2015 between the claimant, Mr Coslett than Miss Deglurkar? In our judgement, and as was correctly conceded by counsel for the respondent the 19 June e-mail is qualifying disclosure. It contains information about a situation and relates to the safety issues that the situation might affect and it is directed to the claimant's employer. The second claimed disclosure is not proved to be qualifying. We have no evidence as to what was said, in those circumstances we are not able to say information was provided to the respondent nor that the information related to one of the specific categories which qualifies for protection.

40. If so, did the investigations, disciplinary proceedings and (if they do not amount to dismissals) the above demotions amount to detriments that the claimant was subjected to on the ground that he made a protected disclosure (section 47B)? We are required to consider the conscious or unconscious motivations of the respondent.

40.1. It is clear, on the evidence that we have found that Mr Jones was likely to be motivated by the claimant's disclosure, albeit in a minor way considering his already considerable dislike of the claimant.

40.2. However, the decisions once he had made his report were not motivated by the disclosures at all. All the decision makers, the clinical board, Mr Coslett, Mr Temby and Mr Morgan were motivated by the conduct of the claimant in making their decisions.

40.3. We did not consider that the investigation (from 13 August, 2015 to 16 March, 2016) that recommended on 16 March, 2016 that disciplinary action should be taken against him was in any way motivated by the disclosure on 19 June, 2015. Mr Coslett was making his decisions because the claimant had failed to follow a primary checklist and made a serious build error. The disciplinary proceedings that followed were neither inappropriate nor unfair.

40.4. The sanction imposed on the claimant on 19 May, 2016 was entirely within the band of reasonable responses for the claimant's conduct, given the respondents policies. Indeed, some employers would have dismissed summarily.

40.5. Similarly, the disciplinary appeal process between 19 May 2016 and 16 September, 2016 had no connection with the claimant's disclosure.

40.6. The disciplinary proceedings in respect of his registration status were automatic, given the mandatory nature of the respondent's policy. They were not motivated by the claimant's disclosure on 19 June, 2016.

40.7. The tribunal do not consider that the claimant was demoted on 2 August, 2016, he was relocated for the needs of the service. In any event this was not because of the claimant making the disclosure but because of the state of relationships between the claimant and his colleagues as observed by Mrs Morse. She was not even aware of the disclosure in June 2015.

41. The claimant was, effectively, dismissed by the respondent on 3 June 2016 and the reason for his dismissal was his conduct.

41.1. The claimant had admitted the errors of which he was accused, he provided no explanation which would account for those errors, the finding of gross negligence was a reasonable one in all the circumstances.

41.2. The claimant's interpretation of the capability procedure would not permit the respondent to discipline those who are careless. That cannot be the basis of the disciplinary policy, particularly in environments where carelessness can lead to serious harm.

41.3. The procedure adopted by the respondent did not follow its policy to the letter. But was nonetheless reasonable in all the circumstances. The requirements for investigation are far less onerous where an admission is made.

41.4. This was a case about explanations for the claimant's conduct and not the conduct itself. Such explanations can only realistically come from the claimant where there is no indication of any other external reason for the conduct.

41.5. The decision made by the respondent was based on a genuine belief in the misconduct, the evidence was sufficient to support that belief, and sufficient investigation had been undertaken.

41.6. In our judgement, the decision to offer the claimant new employment as an alternative to dismissal was within the band of reasonable responses that could be made to conduct of this nature. The claimant's refusal to accept that new employment means that the dismissal, resulting from that refusal was reasonable. Dismissal was the primary option, the claimant refused the alternative, it was reasonable for the respondent to return to the primary option.

42. Given our findings the claimant's claims of unfair dismissal, both on the grounds of having made a protected disclosure, and so-called ordinary unfair dismissal are not well founded and are dismissed.

43. The claimant's claim of having suffered detriment on the grounds of having made a protected disclosure are not well founded and are dismissed. The. Recipes the as you just come this is a

Sent to the parties
On 7 June 2017

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EMPLOYMENT JUDGE W BEARD

for Secretary of the Tribunals

Dated: 5 June 2017