EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: 4102334/2022

5

Held in Glasgow on 16-20 and 23 January 2023

Employment Judge B Campbell

Members Ms J Anderson and Mr D Frew

10 **Ms A Henderson**	**Claimant** **Represented by:** **Mr M Lappin -** **Lay Representative**
15 **GCRM Limited**	**First Respondent** **Represented by:** **Mr K Forrest -** **Counsel**
20 **Mr Mark Tomnay**	**Second Respondent** **Represented by:** **Mr K Forrest -** **Counsel**
25 **Ms Ella Tracey**	**Third Respondent** **Represented by:** **Mr K Forrest -** **Counsel**

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JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The unanimous Judgment of the Employment Tribunal is that:

1. the claimant made protected disclosures to her employer compliant with section 43A and 43B of the Employment Rights Act 1996;

35 2. the claimant was not automatically unfairly dismissed under section 99 of the Employment Rights Act 1996 by reason of making protected disclosures, and that claim is dismissed;

3. the claimant was subjected to a detriment by the first respondent under section 47B of the Employment Rights Act 1996 by reason of making protected disclosures;

4. the claimant was not subjected to an unlawful detriment by the second or third respondent under section 47B of the Employment Rights Act 1996, and her claims against those parties are dismissed;

5. the claimant was unfairly dismissed contrary to section 94 of the Employment Rights Act 1996; and

6. Remedy in respect of the successful claims will be determined at a further hearing.

REASONS

General

1. This claim arises out of the claimant's employment by the first respondent which ended on 3 February 2022 with her dismissal. The claimant asserts that she was automatically unfairly dismissed by reason of having made a series of protected disclosures to her employer, and that the respondents separately subjected her to a detriment for the same reason, with the alleged detriment being the act of dismissal itself. She claims that her dismissal was unfair even if it was not by way of her making protected disclosures. The first respondent contends that it dismissed her fairly for reasons unconnected with the making of protected disclosures.

2. The parties had helpfully prepared an indexed and paginated joint bundle of documents. Numbers in square brackets below are references to the page numbers of the bundle.

3. The parties had agreed a list of issues and also a chronology of agreed facts. It had been agreed that evidence in chief would be taken from witnesses by way of written statements, with the exception of two witnesses who attended at the claimant's request but subject to witness orders issued by the tribunal.

4. Evidence was heard from firstly the claimant and from three further witnesses called by her, namely Dr Marco Gaudoin (Medical Director of the first respondent), Ms Tracey Hamilton (former Nursing Manager of the first respondent) and Mr Brett Buchanan (not employed by the first respondent, but who works alongside and supervises the claimant in a separate counselling role she undertakes). For the respondents, evidence was heard from Mr Mark Tomnay, the first respondent (UK Commercial Director of TFP Fertility Group Limited) ('TFP'), Ms Ella Tracey, the second respondent (Managing Director of TFP), Professor Tim Child (Group Medical Director of TFP) and Ms Lyndsey Zujovic, Group Director for Embryology with TFP. TFP is a group company of the first respondent.

5. All of the witnesses were found generally to be credible and reliable. Observations on the witnesses' evidence are given in the tribunal's findings below where relevant. There were conflicts in some areas of the witnesses' evidence and those are also dealt with below.

6. At the conclusion of the evidence the parties' representatives provided submissions orally and supplemented by written notes, which were considered by the tribunal and where appropriate are referred to below.

Legal issues

7. The parties had agreed a list of issues as reproduced below with minor amendments made by the tribunal. The legal questions before the tribunal were therefore as follows.

Automatically unfair dismissal under s103A ERA / detriment as a result of making a protected disclosure under s47B ERA

1. Did the claimant make one or more protected disclosure within the meaning of sections 43A-C of the Employment Rights Act 1996 (**"ERA"**)? In particular did the claimant make disclosures of information within the meaning of section 43B(1) ERA? Specifically, those alleged disclosures as set out at paragraphs 6 – 20 of her ET1.

2. For each of the alleged disclosures, did the claimant reasonably believe that the information she disclosed tended to show one of the failures set out in s43B ERA and if so, which was it?

3. For each of the alleged disclosures, did the claimant reasonably believe that the disclosure(s) of information was in the public interest within the meaning of section 43B(1) ERA?

4. If the claimant has been deemed to make any qualifying disclosures, was the reason, or if more than one, the principal reason, for the claimant's dismissal that she had made one or more of those protected disclosures such that she was automatically unfairly dismissed contrary to section 103A ERA?

5. Was the claimant subjected to a detriment on the ground that she had made protected disclosures contrary to s47B ERA? The detriment alleged is dismissal.

Unfair Dismissal under s103A ERA

6. What was the reason for the claimant's dismissal? Was it one of the potentially fair reasons for dismissal set out in s98 ERA? The respondents allege conduct or 'some other substantive reason'.

7. Did the first respondent reasonably believe that the claimant was guilty of gross misconduct?

8. Did the first respondent have reasonable grounds on which to base that belief?

9. Did they carry out as much investigation as was reasonable in the circumstances?

10. Did the decision fall within the band of reasonable responses?

11. If not, could the first respondent have fairly dismissed the claimant on notice for some other substantive reason.

12. If the decision to dismiss was procedurally unfair, would the outcome still have been the same if the respondent had followed a fair process.

13. If the tribunal determines that there has been an unfair dismissal, what percentage reduction should be applied for contributory fault on the part of the claimant.

Applicable law

5 8. By virtue of Part X of ERA, an employee is entitled not to be unfairly dismissed from their employment. The right is subject to certain qualifications based on matters such as length of continuous service and the reason alleged for the dismissal. Unless the reason is one which will render termination automatically unfair, the employer has an onus to show that it fell within at 10 least one permitted category contained in section 98(1) and (2) ERA. Should it be able to do so, a tribunal must consider whether the employer acted reasonably in relying on that reason to dismiss the individual. That must be judged by the requirements set out in section 98(4), taking in the particular circumstances which existed, such as the employer's size and administrative 15 resources, as well as equity and the substantial merits of the case. The onus of proof is neutral in that exercise.

9. Conduct is a potentially fair reason for dismissal of an employee. Where the reason for dismissal is the employee's conduct, principles established by case law have a bearing on how an employment tribunal should assess the 20 employer's approach. Relevant authorities are considered below under the heading 'Discussion and Conclusions'.

10. An employee may alternatively be fairly dismissed for *'some other substantive reason of a kind such as to justify the dismissal of an employee holding the position which the employee held'* under section 98(1)(b) ERA. As such the 25 law recognises that there are circumstances where it may be appropriate to terminate an employee's service but which do not neatly fall into one of the designated categories of capability, conduct, redundancy or illegality in the contract. An employee dismissed for some other substantial reason must still be treated reasonably in the process, bearing in mind the specific reason for 30 dismissal and the employer's size and administrative resources, as well as general fairness.

11. If an employee is dismissed because the only or principal reason is that they made one or more protected disclosures, their dismissal will be automatically unfair under section 103A ERA. Protected disclosures are defined in part IVA of ERA. A disclosure must first be a 'qualifying disclosure' according the terms of section 43B ERA. This means that it is a disclosure of information which in the employee's reasonable belief is being made in the public interest. The employee must reasonably believe that the disclosure tends to show at least one of the following:

'(a) that a criminal offence has been committed, is being committed or is likely to be committed,

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

(c) that a miscarriage of justice has occurred, is occurring or is likely to occur,

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

(e) that the environment has been, is being or is likely to be damaged, or

(f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

12. A qualifying disclosure will only be protected if communicated to an appropriate party as provided for in sections 43C to 43H. A qualifying disclosure to an employee's employer will be a protected disclosure.

13. Section 47B ERA provides that an employee who has made one or more protected disclosures should not be subjected to a detriment on that ground, whether by their employer's action or failure to act. This extends to acts or omissions by the employer's other workers in the course of their employment or agents who are operating with the employer's authority – section 47B(1A).

Such acts or omissions are deemed also to be the responsibility of the employer.

Findings of fact

The following findings of fact were made as they are relevant to the issues in the claim.

Background

14. The claimant was an employee of the respondent with a continuous period of employment for statutory purposes beginning on 15 March 2003 and ending on 3 February 2022. On the former date she began a period of employment with a company within the Nuffield Health group and her contract transferred to the first respondent in October 2018 by the operation of the Transfer of Undertakings (Protection of Employment) Regulations 2006. As such her period of service with Nuffield counted towards her overall period of continuous service with the first respondent.

15. The respondent is a clinic providing fertility services and care, primarily in relation to IVF. It was established around 2006 and is based in Glasgow. It is now part of a group of companies operating similar clinics throughout the UK and in Europe operating under the name 'The Fertility Partnership' or 'TFP'.

16. The claimant is an embryologist. She qualified as such in 1995 and worked in various roles around the world before taking up the role of Laboratory Manager at the fertility clinic within the Nuffield Hospital in Glasgow in March 2003.

17. Fertility clinics including the first respondent are regulated in the UK by the Human Fertilisation and Embryology Authority (**'HFEA'**) which is a statutory body. They must be licenced to practice by the HFEA and in doing so they must comply with its standards and directions. Each clinic must nominate a 'Person Responsible' (**'PR'**) for ensuring that the licence conditions are met and that any additional guidance issued by the HFEA is followed. The PR will also be expected to report certain events to the HFEA which might amount to

a breach of licence conditions or be otherwise serious. These are referred to as 'reportable incidents'.

18. The claimant was the PR for the fertility clinic at the Nuffield Hospital from 2015 until October 2019, a year after her transfer to the first respondent. The role continued to the latter date as she had certain tasks to perform in order to wind down the operation at the Nuffield and ensure that patient records and material were properly disposed of or allocated elsewhere.

19. The claimant was the most senior embryologist at the Glasgow Nuffield clinic. Between 200 and 250 cycles of fertility treatment were undertaken there per year.

20. On joining the TFP group the first respondent became subject to additional direction and management oversight by the group board. There was an initiative to standardise a number of practices and processes across clinics in the group. This began in 2020 and was referred to as the 'unification project'. It was run by the Group Director of Embryology, Lyndsey Zujovic. She like the claimant is a qualified embryologist. She is an employee of TFP.

HFEA and the regulatory regime

21. The HFEA is required by the Human Fertilisation and Embryology Act 1990 to maintain a statement of general principles which it considers should be followed by clinics carrying out licenced activities under that Act. The way the HFEA meets this requirement is by issuing a Code of Practice (the '**Code**') which contains both regulatory principles and guidance notes.

22. The Code contains 33 guidance notes, each made up of mandatory requirements, interpretation of those mandatory requirements, guidance and references to other legislation, professional guidelines and further information.

23. The Code also contains 13 regulatory principles which the HFEA expects each licenced centre to comply with. The claimant made specific reference to principles 5, 7, 8 and 9 in her claim and those are as follows:

"We expect the person responsible to ensure that their licensed centre demonstrates adherence to the following principles when carrying out activities licensed under the Human Fertilisation and Embryology Act 1990.

Licenced centres must:

5 *…*

5. give prospective and current patients and donors sufficient, accessible and up-to-date information to enable them to make informed decisions

…

10 *7. Conduct all licensed activities with skill and care and in an appropriate environment, in line with good clinical practice, to ensure optimum outcomes and minimum risk for patients, donors and offspring*

8. Ensure that all premises, equipment, processes and procedures used in the conduct of licensed activities are safe, secure and suitable for
15 *the purpose*

9. Ensure that all staff engaged in licensed activity are competent and recruited in sufficient numbers to guarantee safe clinical and laboratory practice."

24. The claimant also referred to standard licence condition T72 which reads as
20 follows:

'T72 The critical processing procedures must be validated and must not render the gametes or embryos clinically ineffective or harmful to the recipient. This validation may be based on studies performed by the establishment itself, or on data from published studies or from well-
25 *established processing procedures, by retrospective evaluation of the clinical results of tissues provided by the establishment.'*

25. The following are also standard licensing conditions:

> *"T2 Suitable practices must be used in the course of activities authorised by this licence and in other activities carried out in the course of providing treatment services that do not require a licence.*
>
> *…*
>
> *T12 Personnel in the centre must be available in sufficient number and be qualified and competent for the tasks they perform. The competency of personnel must be evaluated at appropriate intervals.*
>
> *…*
>
> *T17 A centre must have suitable facilities to carry out licensed activities, or other activities carried out for the purposes of providing treatment services that do not require a licence."*

Transfer from Nuffield Glasgow clinic to the first respondent

26. In September 2018 the claimant and her colleagues in the Nuffield fertility clinic were made aware that the first respondent was to purchase their operation. The purchase was completed in the following month and the claimant together with seven colleagues became employees of the first respondent. The first respondent already operated a clinic in another part of Glasgow and that is where the practice, and its employees, transferred.

27. The first respondent was already a larger clinic than the Nuffield and before the transfer was undertaking around 600 cycles of fertility treatment per year.

28. The claimant's direct line manager post-transfer was Mark Tomnay, who at the time was the General Manager of the Clinic, and an employee of the first respondent. He later took on the responsibility of being Regional Manager for three other clinics in the TFP group. By the time of the tribunal hearing his employment had transferred to TFP Fertility Group Limited and he had taken on the role of UK Commercial Director. He was based at the first respondent's Glasgow Clinic throughout. His deputy manager was a Ms Maggie Morrison. Neither of them are medically qualified or experienced specifically in the field of embryology. Their role was to manage the overall running of the clinic.

29. The claimant became the Laboratory Manager on transferring to the first respondent. The previous Laboratory Manager had left around a week before and the claimant did not get the opportunity to discuss any details of the role with that person. Her Deputy Laboratory Manager was a Ms Nicole Gibson, who is also an embryologist. The claimant was given a set of induction documents which set out the procedures to be followed in the lab. There were no documents relating to the role of Laboratory Manager specifically and the claimant was not given any training. Another embryologist in the claimant's team named Clare Noble was the HFEA Person Responsible for the first respondent.

30. As the claimant remained the Person Responsible for the Nuffield clinic she had to spend time closing down the operation over a number of months following the transfer of her employment to the first respondent. Much of the work could only be done from the Nuffield hospital and so the claimant had to travel there either during her working time with the respondent or in her own time. This could amount to as much as one day per week when the work was at its peak during the three months immediately following the transfer.

31. The claimant considered that the first respondent's laboratory was under-staffed and found it challenging to undertake her residual duties as Person Responsible for the Nuffield clinic at the same time as acting as Laboratory Manager. She sensed that Mr Tomnay was reluctant to release her to deal with the former. When she discussed with him the challenges she was experiencing, he told her not to go to the Nuffield. She believed that was not an option and went there outside of her working time so as not to cause further issues with him.

32. The claimant and Mr Tomnay did not have a particularly positive working relationship for the first year following the transfer. They were professional in carrying out their respective roles individually, but did not work harmoniously or with much respect for each other. The claimant raised this with Mr Tomnay in a meeting in September 2019 and he agreed it was the case. They both resolved to behave more courteously and supportively towards each other. However, although there was less friction between them from that point, the

claimant's experience was that Mr Tomnay did not become any more supportive of her.

33. The claimant believed that the first respondent's laboratory was not working optimally. The lab space was not effectively used. Some procedures were not as efficient as they could have been and some of the equipment was older than its equivalent in the Nuffield clinic. It took up time to maintain and check, and at times would not function properly. The claimant asked Mr Tomnay for new equipment but tended to be told that there was no budget allocation for it in the current year and that it may be reviewed in the future. She changed the configuration of the lab to make better use of the limited space and brought over some equipment from the Nuffield, both of which helped.

IVF procedures at the first respondent's clinic

34. The first respondent offers in-vitro fertilisation (**IVF**) services to the public. It is a private clinic and clients pay for the service. The most common process undertaken is for patients to donate eggs which are then frozen and later thawed for fertilisation. Fertilised eggs which become embryos will be implanted in the patient around four days later. Additional embryos produced may also be frozen at that stage for future implanting. A small proportion of eggs used (around 10%) come from third-party donors rather than the patients who are receiving the treatment. The freezing and thawing process is however the same.

35. An alternative method to the above is to inseminate eggs freshly removed from the patient or a donor, usually within a space of four hours. No freezing or subsequent thawing of the eggs is therefore necessary. Again, additional viable embryos produced may be frozen. There is less risk attached to freezing, storing and thawing embryos than there is in relation to performing the same process on eggs.

36. There are advantages and disadvantages with each method of fertilisation. Freezing and thawing eggs allows more flexibility around the time of insemination and there is no need to have the donor of the sperm present at the time of egg collection. It is more likely that with using frozen eggs that it

will be known there are enough of them to undergo the fertilisation process and ideally successfully produce a healthy embryo. The ideal number of eggs to use was generally thought to be six. The downside with this process is that the freezing and thawing processes both carry risk of egg loss or degradation, and they must be done carefully and under particular conditions.

37. By contrast, using fresh eggs will avoid any risk associated with freezing, storing and thawing the eggs, but logistically can be more challenging as the male donor must be present at the time the eggs are extracted from their patient or the patient's egg donor. It is possible that at that time not enough eggs can be extracted and so the insemination process either cannot proceed, or it has a reduced chance of success. On average, only 60 to 70% of eggs will be fertilised and so starting with a smaller number can result in a negative outcome.

38. The Nuffield Glasgow clinic used the fresh egg method of IVF. They considered egg freezing at one point but a decision was taken against it, based on medical literature available at the time which suggested the fertilisation success rate was lower. The first respondent uses the egg freezing method. It offers patients the option to purchase batches of frozen donor eggs, starting with a minimum of six per batch. It too could point to literature, and practice elsewhere throughout the world, suggesting that the process when done correctly offered satisfactory results.

39. The first respondent aimed to have at least 80% of frozen eggs purchased survive the thawing process and therefore be viable for insemination. If the proportion fell below 50% they offered the patient the option to proceed or to start the process again. Although there may be little or no financial disadvantage, this could be emotionally difficult for the patient and others close to them. It often fell to the claimant or another embryologist to explain the position to the patient and offer them the choice.

'Qpulse' system and incident reporting

40. The first respondent operated a software-based system for recording incidents within the lab which required any kind of response or follow up. This

included incidents which would be reportable to HFEA and also matters less serious, but which by their nature suggested there should be a review of, or change in, practice at the lab. The system went by the name of Qpulse.

41. Any member of staff could report a matter within the Qpulse system, and the Person Responsible had additional responsibility for dealing with reportable matters. A degree of judgment would be required as to whether some more minor matters should be logged. In the Glasgow clinic staff tended to err on the side of reporting as compared with clinics elsewhere in the group. This tended to be reflected in a higher number of logged matters for Glasgow, without necessarily showing that there were more issues there.

The claimant's concerns about (i) IVF procedures and (ii) staffing and operation of the lab

42. Despite making changes in the lab upon her arrival in the last quarter of 2018, the claimant continued to be concerned at success rates for fertilisation being below those at the Nuffield. She estimated that the survival rate of eggs after thawing fell below 50% in around a quarter of cases. She discussed this with Ms Noble and Ms Gibson, her fellow embryologists in the lab.

43. She first raised a concern with management at a weekly management meeting on or around 20 March 2019. Those meetings were regular, and attended by Mr Tomnay, his deputy Ms Morrison, senior medical staff such as Dr Gaudoin the Medical Director, whoever was the Quality Manager at the time (a number of people held the role during the relevant period), the nurse manager Tracey Hamilton, the donor co-ordinator Ms Pat Ambrose, the claimant as Lab Manager and Ms Noble as the Person Responsible.

44. The claimant mentioned that egg survival rates after thawing appeared to be low in some cases. She conveyed that it was becoming particularly difficult and stressful for her lab team as poor outcomes were becoming more common. She pointed out that patients' prospects of successful fertilisation were being impacted. She believed the respondent should switch to using fresh eggs as she was used to doing at the Nuffield.

45. Dr Gaudoin was sympathetic to the claimant's concerns and agreed that if the data showed particularly poor success rates, moving to working with fresh eggs and freezing embryos shortly after fertilisation may be a better alternative. The claimant remembered his response particularly clearly as he had challenged her views on medical issues a number of times previously. She made a note in the meeting that he '*likes*' her suggestion [712].

46. As well as concerns over fertilisation success rates and the impact on patients and staff, the claimant believed that the lab was not appropriately staffed. She believed that the issue was a combination of too few staff overall, and a lack of fully competent or adequately experienced individuals in certain roles. A particular issue was that some individuals were newly qualified and had not built up their skills and experience, a process which can take up to two years. As a result they needed more supervision and worked more slowly. More experienced staff had to take time to train them. She considered the effect of these factors was that the lab staff were working under excessive pressure and that the level of patient care was at risk of being detrimentally affected. She believed that errors and reportable incidents were more likely as a result.

47. The claimant first voiced her concern about staffing with Mr Tomnay at a meeting between the two on 30 August 2019. She had prepared a list of points to go through with him in advance, and made brief notes in the meeting itself [713, 719]. She mentioned that there was a lack of suitably trained staff in the lab, that this created risk of incidents such as loss of patient material, and that staff were struggling with the demands placed on them. She raised that the amount of non-embryology duties asked of embryologists was unusually high in her experience and had the effect of making the embryology tasks more difficult to complete. At times, procedures were being completed at higher speed than normal and without breaks. She mentioned that there would be bottlenecks in the process caused by large quantities of patient material requiring to be processed around the same time for medical reasons, and this meant that some days were especially demanding. She asked Mr Tomnay if he could review the process of scheduling patients for treatment which was in operation in order to even out demands on the lab better. She believed that

this would improve outcomes from IVF processes and raise standards of care. She suggested the types of staff in terms of experience and skills which she believed needed to be recruited.

48. Mr Tomnay did not make changes suggested by the claimant. He believed that she could manage the lab more efficiently with the staff and equipment which were there.

49. The claimant had a further meeting with Mr Tomnay on 13 September 2019. This is the meeting referred to above, at which they identified their method of working together needed to improve. Again she took brief notes [714, 720]. She raised a concern over what she saw as poor success rates from the egg freezing and thawing process. She considered that the situation had not improved since she raised it in the management meeting that March. She believed that patients were not being offered the best service possible and were effectively being misled about their prospects when the results were considered. She again advocated a change in practice to the use of fresh donor eggs. The claimant had spoken to the egg donation co-ordinator, Ms Ambrose, who believed that it would not be possible to change the process under the existing set up as it would overload the nursing team who liaised with the patients.

50. Mr Tomnay was sympathetic to the claimant to a degree and said that he heard what she was saying. However, the need to provide more capacity within the nursing team if the change was to be made appeared to be an obstacle. The first respondent continued to operate using the freezing and thawing method.

51. The claimant attended a management team meeting on 24 September 2019. Mr Tomnay and other senior employees were present. The Nurse Manager, Tracey Hamilton, raised that the nurses were working a larger proportion of their weekends in order to cover their duties, and that this was having an impact on their work on weekdays also. The amount of time required to cover processes undertaken on Sundays in particular had increased. The claimant added that her own team were being similarly stretched. Embryologists would

generally have to spend more time on the premises on a Sunday than the nurses if procedures were taking place. In some cases, staff in the lab were working for as many as twelve days without a day off. She said that there was a significant risk of fatigue impacting on the quality of work being undertaken and an increase in the possibility of incidents. Dr Gaudoin said that people were '*whingeing'* about working 12 days in a row. His view was not supported by others in the meeting. The claimant made notes during the meeting [715, 721]. There was no perceptible change to working demands following the meeting. Both the nurse team and the lab staff were expected to reconfigure rotas to deal with any demand.

52. The claimant had had a meeting on 8 January 2020 with the Quality Manager in Glasgow at that time, who was named Laura. The claimant was then asked to attend a meeting on 13 January 2020 with Mr Geoff Trew, Group Clinical Director and Ms Jude Fleming, Executive Vice-President for Northern Europe and Chief Operating Officer of the TFP group. She was not given advance notice of the subject of the meeting.

53. At the start of the meeting the claimant was given a document in table form which appeared to show all incidents reported for Glasgow on Qpulse between two dates. There were 14 live matters. The claimant was asked about the incidents. She was asked about one in particular, a reportable incident and therefore the ultimate responsibility of Ms Noble as the PR. Out of date vitrification (freezing) media had been used to freeze embryos. The claimant was asked how many patients were potentially affected. She was unable to tell from the report, and undertook to check. She emailed the details the next day to them [133].

54. When emailing Mr Trew and Ms Fleming on 14 January 2020 the claimant began by making the point that she would appreciate better notice of any further meetings they intended to hold, and advance sight of any documents they wished to discuss. By this time she was aware that both individuals had met with Ms Noble and gained a better understanding of the situation from that. The claimant confirmed that she herself had been on holiday when the

incident occurred, and that Ms Noble had led the investigation and prepared a report which listed the patients affected.

55. The claimant accepted that she had some responsibility for being aware of which matters were outstanding on Qpulse at any given time, and for resolving them. It was not her responsibility alone and in particular the PR was the main owner of any reportable incidents. The claimant's knowledge of the system, and what would be recorded on it, was picked up on the job. She did not receive training. Shortly after she joined the first respondent the incumbent Quality Manager left and their replacement likewise had to become familiar with the system by their own efforts. At that time the role of Quality Manager also included responsibility for reviewing and progressing the resolution of any live matters, although a subsequent Quality Manager passed responsibility back to those working in the lab by the end of 2019.

56. The claimant said in her email that she had raised issues with Qpulse to previous Quality Managers, and had requested training. She acknowledged that she had not fully kept on top of the outstanding issues, but referred to the other responsibilities she had at the time. She believed that her meeting with the Quality Manager Laura the week before had resolved some of the outstanding issues.

57. The claimant had a telephone call with Ms Zujovic on 6 July 2020. The purpose was to follow up on the discussions Mr Trew and Ms Fleming had held with the claimant in the January of that year. They discussed that the number of outstanding issues on Qpulse had been reduced to one. Ms Zujovic stressed the importance of good practices to ensure that incidents were properly handled in the future.

58. The matters covered in the call were referred to in a letter of 9 July 2020 from Ms Zujovic to her [149-150]. Ms Zujovic raised the volume of incidents previously logged. She agreed that reporting any incident should happen, and pointed out that a large number could suggest one or more type of issue in the lab, such as a lack of training, a need to review processes or equipment issues. She noted that a number of issues had been with audits which had

either not taken place as intended, or which had been failed. She suggested the claimant delegate some of these to other lab colleagues, but to retain overall scrutiny and responsibility if so. She also stressed ownership – that the claimant accept she was ultimately responsible for the operation of the lab as its manager. The claimant accepted that she now had this responsibility (even if she did not solely carry it until early 2020). It was noted however that Ms Noble would retain prime responsibility for HFEA reportable incidents, and the claimant would focus more on internal matters. Ms Zujovic also said that some of the Qpulse entries suggested a lack of clarity in relation to who had primary and secondary responsibility for certain tasks. Finally, she recommended reinstatement of fortnightly meetings with the Quality Manager to review and take action on any open incidents, as this had been effective since its implementation but had been interrupted due to the Covid-19 pandemic. She signed off by saying that Mr Tomnay would continue to monitor her performance in this area and feed back to her and Mr Trew if he felt that was necessary.

59. There appeared to be no further matters that required to be addressed with the claimant by Ms Zujovic in the immediately following months.

60. On 26 October 2020 Ms Gibson emailed the claimant about an HFEA reportable incident which had occurred the previous week [163]. A dish of patient material had been wrongly disposed of. Ms Gibson took responsibility and suggested some changes in procedure. She asked whether she should continue to hold responsibility for cryostorage as well as Health and Safety and her normal embryology duties. The claimant sent the email on to Mr Tomnay with comments of her own [162]. She believed that the incident highlighted the need to remove Health and Safety responsibility from Ms Gibson. She was mindful that in her time as an employee of the first respondent, this was the third reportable incident caused by Ms Gibson. The claimant believed that Health and Safety responsibility should sit with the Quality Manager. At the time the first respondent was recruiting to replace one who had left. She went on to say:

"The incident in general is a reminder of how stretched we are in the lab. New staff will stretch us more as we go through an induction and training period. I'm asking you to please bear in mind that I do not wish to lose a lab staff member to another role – or if we do – it is vital that a period of notice is served bearing in mind the forecast activity and the number of new starts we will be coping with."

61. Mr Tomnay replied to say that he viewed the incident as human error. He left it to the claimant to decide how the various responsibilities would be covered but said that a new Quality Manager had not been identified yet and Health and Safety responsibility could not be moved. In a further email to Mr Tomnay the claimant expressed the view that the HFEA didn't believe in human error, and effectively expected every incident to be traceable to a process which could be improved, or an issue capable of being addressed. She repeated her view that Health and Safety sitting within the lab was ironically adding to the stress on her team, and again asked if it could be incorporated in the Quality Manager role.

62. In a follow up email Mr Tomnay agreed that human error needed to be explained, which was why he wanted a full investigation of the incident. The claimant replied to say that she was investigating the matter alongside all of the other tasks she was covering [160]. She was undertaking this task in place of Ms Noble, the PR, who was unavailable at the time. The claimant said in her email:

"Nicole took it on over lockdown as it was a mess and things had fallen behind (the 2 people previously allocated to do it had not had time to keep on top of it). Nicole does not have time to keep on top of it now – but neither does anyone else – we are short staffed (being resolved and hopefully this will fill the cryo gap) and currently working beyond our capacity and vulnerable to equipment failure and incubator space issues (and now Covid absence). And yes, there was a significant equipment failure being dealt with on that day. It is no secret that the lab is short-staffed and we are busier than ever – cryo, H&S and other non-urgent tasks will be on the back burner (and are part of the reason why Nicole lost focus – that's not an assumption, that's a fact).

You have been great at recruiting new staff but they aren't in the door – and when they arrive it will take 3 to 6 months for them to be truly useful. And God help us if we lose Karis.

To 'fix' things in the short term I'd suggest we look at working with more manageable patient numbers to take the pressure off – but I know that is a lead balloon and you have your deadlines to get patients through. (Not to mention the patients' expectations themselves)."

63. The claimant's investigation report was submitted to the group Regional Quality Lead, Becky Munford, on 4 November 2020. Ms Munford replied with some comments and revisals to the report before it was due to be submitted to the HFEA [164-165]. She added a recommendation to update one of the standard operating procedures around witnessing a check of dish numbers used, and also suggested a review of lab workload planning. She said:

"It concerns me that there were so many factors that caused lack of focus on the work, sufficient that a highly experienced embryologist could make this mistake. I know the clinic is set to be very busy for months, if workload and staffing is an ongoing issue we risk more incidents, hence the suggestion for a review now."

64. There was no discernible change to patient numbers or scheduling following the incident or the recommendations made in response to it.

65. The claimant emailed the senior management team of the respondent on 30 October 2020 [158]. She was flagging up that she had added the subject of egg freezing to the agenda for the meeting later that day. She was trying at this stage to get an understanding of what the other clinics in the group were doing, in terms of the process they were using and their success rates. She mentioned that the Oxford-based TFP clinic had briefly tried egg freezing before reverting to using fresh eggs. At group level a decision had been taken to use egg banking, i.e. a higher capacity for storage of frozen eggs. This approach had been used in other countries and offered a partial solution to the issue of eggs becoming non-viable at the point of thawing, or before. By having additional eggs banked they could be used as a back-up option. The

claimant understood that each clinic still had the choice not to bank frozen eggs and to use mainly fresh ones, and wanted this to be discussed among the team. Mr Tomnay replied to explain his understanding, which was that the policy would be adopted uniformly across the group and this was in the process of being set up, having seen some early publicity material. He felt that it should continue to be dealt with at group level rather than have individual clinics decide whether they would use one process or other, or both.

66. On 13 January 2021 the claimant emailed a number of senior individuals and/or managers at the clinic, namely Dr Gaudoin, Mr Tomnay, Ms Noble, Ms Morrison, Clinical Consultant Dr Mariano Mascarenhas, Ms Ambrose the Donor Co-ordinator and Ms Hamilton, the Nurse Manager [206]. She attached to the email some egg thaw data she and a technician colleague in the lab, Nathali, had been working on. The attachment was not produced to the tribunal. The email said that the data showed what the claimant expected, which was that (in essence) under a previously used system of freezing and thawing ('**Kitizato**'), there was a low proportion of egg survival, but embryo development from the point of fertilisation of a viable egg was good. This was contrasted with the system which replaced Kitizato, '**Vitrolife**', which yielded results showing better egg survival rates following thawing, but more issues with fertilisation of the eggs and their subsequent development as embryos. She ended the email by saying that she hoped the data could be discussed at the next meeting, and that it suggested to her that the preferred practice would be to freeze embryos after fertilisation of fresh eggs, rather than freeze the eggs themselves.

67. On 3 June 2021 the claimant added to an email chain also involving Dr Gaudoin and Mr Tomnay. The subject was a process of insemination abbreviated to **'ICSI'.** This involves insemination of an egg by a single sperm via injection. The main alternative is in-vitro fertilisation, where a number of sperm are placed with the egg and insemination is left to occur naturally. The discussion was about the fact that the first respondent carried out a lower proportion of inseminations using ICSI compared to other clinics in the group, namely 35% as opposed to 60%. The claimant felt that the first respondent

might be viewed at group level, and by Mr Tomnay, as not confirming to its standards or practices, whereas she felt that there was no need for the proportion of ICSI inseminations to be greater than it was. The process is more time-consuming in the lab and involved an additional cost to the patient. There is some evidence of a greater likelihood of abnormalities at later stages of development. Dr Gaudoin agreed with the claimant in what she was saying.

68. On 16 June 2021 the claimant sent an email to the senior management team, copied to the Deputy Lab Manager and Deputy Nurse Manager, revisiting her previous concerns about staffing and workload issues and following discussion with other managers [283-284]. The email read:

“Hi

Can I please put this 'out there' for discussion/consideration as we can never find time in the working day or in an evening to meet.

I am speaking mostly from the lab point of view but believe the other teams have the same issues –

We have workloads/patient numbers that are very difficult to keep on top of with our current staffing levels and skills mix. In the lab we ensure the clinical workload is met (with all trained team members working extra hours) – but we are far behind dealing with orders, enquiries and all of the commitments the lab team are required to carry out. We have now added inducting and training 3 new staff members (not to mention implementing biopsy and applying for the HFEA licence.)

I am asking that we considering lowering the clinical workload to gain some space to catch up and implement changes and training (sorry Mark!). or at least look at things we can 'pause' for now. Examples from the lab could be any imports into the lab (continue with donor sperm), external AMH samples and any type of sperm analysis or retrieval which is not for couples actively seeking treatment at GCRM (so no storage and shipping elsewhere, for example) – and, dare I say it – pause the implementation of biopsy/PGT (sorry again Mark).

I know this is a controversial request. I don't believe in grinding on 'as usual' is beneficial at the moment. Not for morale and staff retention. Not to mention the risks of errors with so many partly trained staff.

5 *As I say – I'm putting this 'out there' – it'd be good to hear the other team's thoughts and suggestions.*

Thanks

Ann"

69. The only response the claimant received was from Mr Tomnay, later that day [282]. He emphasised that the first respondent had recently spent over 10 £300,000 on new equipment and upgrades, as well as recruiting new staff. He said they were spacing out patient treatments as much as possible, but were working with a backlog of 6 months. He acknowledged there was a training deficit, and said that was where a need to plan came in. Looking further ahead, the figures for new patients showed a reducing number. He 15 suggested that the claimant should be *'looking at training plans for all your staff … so we can understand the gaps better.'* He said he needed more from the claimant and could not simply be repeatedly asked for the answers and have to come up with them. He said he was not against pausing some processes where external obligations allowed.

20 70. The claimant felt she had already suggested the things Mr Tomnay was asking her for. She said that other recipients of the email thanked her verbally for sending it. Ms Hamilton told her that Mr Tomnay didn't like to be sent emails like that. In her evidence she described the email as '*ballsy*' and expanded that she had done likewise at an earlier point and received an 25 adverse reaction from him. She had learned to raise things more carefully, on a one-to-one basis and verbally with him.

71. On 22 July 2021 the claimant sent an email to Lorna Young, the first respondent's group Senior HR Business Partner [243]. This was in response to an email from Ms Young to her on 28 May 2021, discussing the outcome 30 of a grievance the claimant had raised about Dr Gaudoin, and its

consequences. Ms Young had told the claimant that there was recognition of a concern she had raised about the way Dr Gaudoin addressed her, which was being dealt with. This was to include an apology from him. She had sent the claimant the final version of the grievance outcome, as previously the claimant had been sent only a draft. Ms Young offered the claimant a further meeting if she thought it would be beneficial.

72. The claimant in her email apologised for taking time to respond to Ms Young. She explained that she had finally had the chance to give proper thought to the process and wanted to arrange a meeting with Ms Young. She said she was struggling in her role, mainly due to high workload and staffing issues, and needed to *'air some concerns.'* She also stated that she did not have a personality clash with Dr Gaudoin, but believed he had been unwelcoming to her from the point of her arrival. She believed that any apology he made should be public rather than addressed only to herself.

73. On account largely of the claimant's annual leave, Ms Young emailed the claimant back on 12 August 2021 to explore a date for her to visit the Glasgow clinic for a meeting. The claimant replied with details of her availability and based on that Ms Young confirmed she would visit on Thursday 26 and Friday 27 August 2021.

74. The claimant replied to an email chain regarding patient starter lists on 13 and 17 August 2021 [296-301]. The chain began with an email from Mr Tomnay on 4 August 2021 in which he was asking various members of the senior management team to look at increasing the speed of certain processes. He asked if those concerned could look at bringing the weekly patient starter list up to 25. The claimant was on annual leave at the time but Dr Mascarenhas replied to say he would pick up with her and Ms Hamilton on her return regarding starter lists. On 13 August 2021 following her return the claimant confirmed she was happy to meet and discuss the matter. She said:

"Just to put my thoughts down re 25 starters per week. By 17th September we will be down by 2 full time experienced embryologists. (And only 'up' by one trainee Daniel plus a vacancy to be filled for which we have no UK based

candidates). We have struggled with the lab workload at the current starter list level with these 2 embryologists in place.

…

"The initial solution is suitable recruitment and the replacement of some of the lab equipment – in particular the other incubators which should give us more, reliable capacity. In the meantime the current capacity can be a struggle (particularly on the busier weeks)."

75. Mr Tomnay replied to the chain within an hour of the claimant's email to give his thoughts on how the lab may be able to cope with the increase in weekly patient numbers. He mentioned that a member of staff had returned for three days which would help, and that other departments may be able to share the workload the lab would otherwise have. He anticipated that even by raising patient starter levels to 25, there would only be between 17 and 21 cycles run per week, which he believed was manageable.

76. Dr Mascarenhas also replied that day, partially to agree with Mr Tomnay but also to ask whether some changes to lab procedures being implemented at group level (as part of the unification project) could be postponed, as he expected implementation of the changes and retraining would take up some of the available time of the lab staff.

77. The claimant was next to respond, the following day. She wished to point out that Mr Tomnay's basis for estimating the level of work which would be involved was in her view inaccurate. She said that the processes for new patients were more time-consuming. She went on:

"I can't see how the lab can increase numbers and work safely until we sort out staffing, equipment and hours. TFP alignment is causing changes which take up more staff time and incubator space (both a current limiting factor). I'm trying to address these issues and working with Linzi [Zujovic] to do this."

78. On 20 August 2021 the claimant replied to an email from Lyndsey Zujovic, the Group Director of Embryology earlier in the day [310-311]. Ms Zujovic had asked the claimant how she was getting on with 'the unification tasks' and

wished to check whether she was able to get two days out of the lab each week to attend to them.

79. The claimant's response stated that they were 'chipping away' at the tasks but that she was not manging to secure two or even one day away from the lab to devote to the project. She said this was partly to do with people being on annual leave and partly related to the number of new or returning staff members who had to go through an induction or training.

80. She went on to say:

"We are stretched extremely thin (more bodies but not yet 'there' with skills).

Mark [Tomnay] is also pushing to increase the number of fresh cycles through the clinic. This doesn't feel safe (and I have passed this on) but I know he is working to a different agenda."

81. The email also said that the claimant recognised a number of actions emphasised by Ms Zujovic had not been implemented, but mentioned that two full time embryologists plus another member of lab staff had been off work for a period, causing a delay in the steps being taken. She acknowledged that her response sounded like a list of excuses but said:

"…we are genuinely stretched here (and about to have a full time embryologist return to Aberdeen for personal reasons without being able [to] recruit a suitable replacement)."

82. She signed off to acknowledge that her response would not be what Ms Zujovic was hoping for, but that her team were aware of the need to co-operate in the unification process and were making as much progress as they could.

Discussion around termination of employment, suspension and disciplinary investigation

83. As a result of the emails exchanged between the claimant and Ms Young, the Senior HR Business Partner, in July and August 2021 Ms Young visited the Glasgow clinic on 26 and 27 August 2021. Mr Tomnay came to ask the

claimant if she was ready to meet with Ms Young. He said that Ms Young would see her now, and she followed him to a meeting room where Ms Young was already present. The claimant understood the meeting was happening as she had requested and would be between Ms Young and herself alone, but Mr Tomnay remained and it became clear that he would be participating in the meeting. The claimant had intended to speak confidentially about Mr Tomnay and therefore no longer had the opportunity to do so.

84. What followed was a protected conversation or, put another way, 'pre-termination negotiations' within the meaning of that term in section 111A of ERA. As such, the details of the conversation are only admissible as evidence in the claimant's case, and can only be considered by the tribunal, in relation to the claims relating to protected disclosures – i.e. her detriment claim under section 47B and her automatic unfair dismissal claim under section 103A ERA. They cannot be considered as part of an 'ordinary' claim of unfair dismissal – i.e. one under section 98 ERA. The tribunal treated the facts of this meeting accordingly in deciding the claimant's complaints below.

85. There was not however any discussion of the issues the claimant had asked to speak to Ms Young about.

86. At the end of the meeting the claimant was asked to leave the premises and remain at home for the time being. She received an email from Ms Young that evening going over what had been discussed.

87. Agreement could not be reached between the parties in relation to termination of the claimant's employment with the first respondent.

88. Mr Tomnay sent the claimant a letter on 6 October 2021 [409]. It stated that a number of allegations had been raised regarding her conduct and itemised two, namely:

    88.1 A recent HFEA reportable incidents in line with the HFEA Code, section 27; and

    88.2 A failure to follow reasonable management requests.

89. The letter said that if these concerns were well founded they could amount to "*serious negligence/gross misconduct and/or lead to a loss of trust and confidence in your ability to perform your role.*"

90. Mr Tomnay confirmed that the claimant was now formally suspended from her duties pending completion of the investigation. She remained on full pay.

91. Ms Young carried out a disciplinary investigation as authorised by Mr Tomnay. The outcome of the process was a report [394-397] which indicated that the investigation commenced in August 2021 but did not contain a completion date. Initially there were two issues to be investigated, which were:

    91.1 A lapse in the process of checking the levels of liquid nitrogen in tanks within the lab; and

    91.2 The use of the wrong type of media for handling patient eggs.

92. Both incidents had been reported on Qpulse. The second was an incident reportable to the HFEA.

93. Ms Young interviewed Mr Tomnay and Ms Zujovic as part of the investigation. She said in her report that they spoke from a technical point of view as Ms Young did not have full technical knowledge of the issues.

94. The **first incident** was summarised as being where an untrained lab technician named Keerthi Gnanaprabha was left to check the nitrogen levels within a set of tanks (also referred to as 'dewars'). The tanks contained liquid nitrogen for the storage of patient material in frozen form. The tanks had to be topped up weekly from a larger tank of liquid nitrogen to compensate for the slow leakage over time. The technician had omitted to top up the tanks one week and this was noticed the following week by another embryologist who reported it to the Deputy Lab Manager, Ms Gibson. The claimant was on leave at the time. The tank was refilled at the point the low level of nitrogen was noticed. When questioned Ms Gnanaprabha said she was too busy to check the levels and had not mentioned this to management at the time. There was said to be no back up or checking system, or training records. There was however a failsafe mechanism involving an alarm sounding and text

messages being sent to named contacts if the temperature of the tanks rose to a particular level, as it would do after a certain amount of nitrogen leakage. The temperature did not increase to the point where the alarm was triggered. Ms Gnanaprabha was the wife of Dr Mascarenhas, one of the consultants at the Glasgow clinic.

95. The **second incident** was described as the use of wrong fertilisation medium. The medium was in the form of a liquid product supplied in a bottle which had a brand label. It is added to the culture dishes used for handling eggs and embryos. The normal medium which the first respondent used was a product named 'GIVF+'. The plus symbol indicates that the medium is supplemented with a handling agent, to make the eggs easier to manipulate. By error the unsupplemented version of the same product 'GIVF' had been ordered and was being used for some patient fertilisation processes. Products were ordered by lab technicians through an online ordering system and signed off by the claimant. The claimant often had a number of orders made up of multiple products to approve at a single time, and did not scrupulously check each item on each order to ensure the product referred to was the correct one. She focussed more on the quantities being ordered. Until shortly before the incident it was not possible for staff at the first respondent to order the unsupplemented version of the product. This had been added as an ordering option as part of the group lab unification programme as it was used in other clinics within the group. The claimant checked the order but did not spot the error. Products should also be checked by a member of lab staff when an order is delivered. Whenever the product is used in a procedure on a given day it should also be checked when taken from the store, to ensure it is the correct product and has not passed its 'use by' date. The report stated that *'no checks were undertaken when the Lab Manager put the media into stock which caused the wrong product to be used from the 09/08/2021 and was continued to be used until 18/09/2021…'.* This was inaccurate in that it tended to be other members of staff who received and checked orders once delivered, and who put the media into the culture dishes each day, not the claimant. However, it was correctly noted that the claimant later observed the

eggs to be more sticky than normal when in dishes and intended to check the medium, but did not.

96. Both incidents were considered to be serious and in breach of the first respondent's group standards. They were considered to be potential examples of gross incompetence.

97. Various documents were consulted and collated as part of the investigation. Those included the Qpulse reports for the two incidents [398-404] and various emails.

The claimant's grievance

98. The claimant submitted a written grievance to Ms Young and Ms Zujovic on 8 September 2021 [316]. She began by referring the meeting called by Ms Young and Mr Tomnay on 26 August 2021. She did not accept that the criticisms made of her performance were fair. She said that the non-conformities raised were within a normal tolerance for the type of lab the first respondent operated. She concluded that she was being *'singled out and unfairly treated'*.

99. The claimant went on to say that she had raised a number of issues at various levels and itemised those over 12 bullet points. Those were, in brief:

99.1 A shortage of staff in the laboratory, the time required to train new staff, the impact on other laboratory tasks and increased risk of incidents;

99.2 A member of staff leaving was allowed to shorten her notice period against the claimant's wishes, as the claimant believed her skills were needed;

99.3 She had asked that certain patient-focussed processes be paused or restricted in number, with reference to fatigue and pressure on her team, potentially leading to mistakes. She understood the nursing team were similarly affected to the laboratory staff in this respect;

99.4 She had had difficult conversations with disappointed patients about delays in their treatment, which she had reported to Mr Tomnay;

99.5 There were plans to increase the number of treatments within the clinic, which she believed would add to the problems she was reporting;

99.6 Lab space was limited and the entire building was not fit for purpose, and there would be health and safety issues and increased risk of incidents if that were not addressed before any increase in activity levels was introduced;

99.7 The continued use of egg freezing, and the plan to establish an egg bank, were not in the patients' best interests;

99.8 She had questioned the proposal to increase the number of ICSI fertilisation processes, which she saw as not being justified clinically, potentially detrimental to embryo health, and which would increase the cost to patients;

99.9 The way consent forms were drafted and the fact that they were not always completed to record patient consent to certain procedures;

99.10 She referred to a *'huge amount of duties and responsibilities'* that the lab staff had outside of lab-based work itself, which led to risk of errors and incidents;

99.11 She had challenged some standard operating procedures which had been introduced from other clinics in the group as part of the unification programme, as she believed some of them would not work well and were being introduced too quickly;

99.12 She had also criticised the way those new procedures were to be introduced, which she believed would not be accompanied by adequate training or support.

100. The grievance letter made a number of other points, including:

100.1 That she had felt unwelcome as an employee of the first respondent *'from the beginning'*, and believed the desire of the first respondent at

the time was to take the Nuffield patient caseload but not its employees;

100.2 She had no handover when she joined as the previous Lab Manager had already left, and she believed that individual had also taken issue with management;

100.3 She had been given no Qpulse training, and the meeting which Mr Trew and Ms Fleming held with her to discuss the Qpulse list of live issues was unfairly carried out;

100.4 She believed that a previous grievance raised against Dr Gaudoin had *'marked [her] card'*, and that it was not dealt with promptly or fairly;

100.5 A *'bigger picture'* was being pieced together to remove her from the employment of the first respondent. She said she had:

"asked too many questions, tried to take care when implementing changes, raised numerous items of concern, tried to prevent further risky stretching of the system and tried to ensure the lab team work as safely as possible. I believe it is no coincidence that after I sent emails to both the Director of Embryology and the UK HR Lead expressing the wish to speak about safety and other concerns I find myself in the position I am in."

101. On 6 October 2021, the same day as Mr Tomnay's letter confirming there would be a disciplinary investigation and that she would be suspended from work, Ms Young sent the claimant a letter inviting her to take part in a virtual grievance hearing to be chaired by Ms Zujovic [421-423].

102. A grievance meeting was held on 26 October 2021. It was attended by the claimant and the Quality Manager at the time, Tracey Motley. Ms Zujovic chaired the meeting and was assisted by a Ms Elaine Barclay from HR. Notes were taken and a summary typed up after the meeting [440-464]. The notes are expressly stated not to be verbatim. They are accepted as a sufficiently accurate summary of the discussion.

103. Ms Zujovic had a discussion with Ms Gibson, the Deputy Lab Manager on 3 November 2021. A summary was made of the points covered [468]. Ms Gibson was asked about the layout of the lab and the way some processes were carried out within it. She stated it was too small and confined a space. There was a risk of staff bumping into each other. An upturned bin was being used in place of a trolley as there was not space for two trolleys at once. She had raised her concerns with the claimant about the lab set up, workloads and staffing levels, cycle ratios and the amount of non-lab administrative work that had to be done. She understood that the claimant had then escalated those concerns to the management team.

104. Ms Zujovic issued a grievance outcome letter on 13 December 2021 [544-552]. It stated that statements had been taken from Ms Noble, Dr Mascarenhas, Mr Tomnay, Ms Morrison and Ms Hamilton as well as Ms Gibson, although notes of any such discussions were not provided to the tribunal as part of the hearing bundle.

105. The majority of the claimant's complaints were not upheld. Her concerns over staffing and workloads were partially upheld as Ms Zujovic accepted that the there were challenges in the lab caused by resignations, sickness, maternity leave and the need to train new and less experienced staff. She calculated that the lab was short by 0.8 of a full-time embryologist. However, she went on to list other types of staff and support available to the embryologists which she believed compensated for effectively being an embryologist short. Ms Zujovic placed responsibility for having the correct number and mix of staff with the claimant as lab manager and said that by the claimant's own admission that had not happened. She stated that the issue had now been addressed by recruiting new staff, using embryologists from other group clinics or locums, and training new staff at other group clinics.

106. Ms Zujovic took the view that a number of the complaints raised were about matters the claimant herself should have prevented or resolved.

Grievance appeal

107. The claimant sent a grievance appeal document to the first respondent on 20 December 2021 [559-565]. She raised a number of issues over six pages, not all of which are relevant to the claims before the tribunal.

108. The claimant took issue with Ms Zujovic being the person responding to her grievance. She felt this led to an outcome which was simply to repeat and justify the first respondent's and the group's practices and policies. She was effectively saying that Ms Zujovic was too close to the issues she was complaining about, and could not be fully impartial.

109. The claimant referred back to the issues around staffing, workload and embryology practices that she said she had raised repeatedly with others before. She responded in more detail to Ms Zujovic's findings in relation to each of her original grievance points.

110. It appears from the material provided to the tribunal that the appeal was never heard. The focus at this point switched to the disciplinary process.

Disciplinary hearing and dismissal

111. The disciplinary process had been paused to allow the claimant's grievance to be heard. On 16 December 2021 Mr Tomnay wrote to the claimant to say that he had investigated a number of allegations against the claimant following his letter of 6 October, and that he wished to arrange a disciplinary hearing for 20 December 2021 at 9.00 am via Teams. The letter was therefore sent on a Thursday, albeit by email, seeking to convene the hearing for the following Monday morning.

112. The letter outlined that issues had been raised with the claimant previously, specifically in February and July 2020, but that this did not appear to have resulted in a reduction in serious errors occurring in the lab. She was reminded that she should remain away from the workplace on suspension. Mr Tomnay said that the first respondent had also to consider whether the matter related to the claimant's performance or conduct, saying that the claimant was an experienced lab manager and fully aware of what was required of her. It

was therefore *'not a capability or training issue, but issues of potential negligence.'*

113. Mr Tomnay proposed to chair the hearing himself with support from an HR Business Partner. The claimant was reminded of her right to be accompanied by a work colleague or trade union official.

114. The disciplinary allegations were set out as follows:

1 Recent HFEA reportable incidents, namely:

a. The use of unsupported media in handling embryos which was reported on 18 August 2021. It had been ordered and received in error and only detected after embryos were placed in the media, in some cases for a number of days. The claimant was deemed responsible for all incoming orders of supplies and for ensuring there were checks in place to ensure the correct products were delivered and used (the wrong media incident).

b. A failure to keep the Nitrogen tanks topped up to correct levels as reported on 1 July 2021. Again the claimant was held responsible for ensuring that the tanks were kept topped up and that there was a system in place to ensure it was done and records were kept. She should also have organised training for any staff involved (the nitrogen tanks incident); and

c. She had failed to respond to feedback provided by a Vitrolife representative who had visited the Glasgow clinic. That individual was employed by the company which provided some of the products and equipment used by the first respondent and other clinics in the group. His name was Bert Stewart and he had visited the lab on two occasions to check on operations and provide suggestions for improvement. The allegation against the claimant was that some surfaces used for thawing eggs ('**stages**') were set at too high a temperature. She was said to have refused to allow him to adjust any heat settings on the first occasion, and then on his second visit some

time later the stages were still too hot, and he again recommended that they be adjusted, which they then were (the **Vitrolife expert issue**).

d. Failure to follow reasonable management requests in relation to the unification programme being led by Lyndsey Zujovic and supported by Mr Tomnay himself.

115. As such, the original two allegations which had prompted the disciplinary investigation in August 2021 were supplemented by two further complaints.

116. The letter ended by saying that the allegations *'may constitute serious negligence/gross misconduct and/or lead to disciplinary action which could range from a written warning to dismissal without notice.'*

117. The claimant received the letter by email on 17 December 2021 and emailed back to Mr Tomnay to say that she had not been given enough notice of the hearing to prepare. She asked him for a number of documents to allow her to respond to the allegations, and said there was further information she needed. She had not prepared a list of those, but planned to do so early the following week. Being excluded from her workplace since late August 2021 she was unable to gather any documents herself. She asked that the hearing be postponed until that be dealt with.

118. Mr Tomnay replied later that day to say that the claimant had been given four days' notice of the hearing and that it related to *'matters you are very familiar'.* As transpired, in relation to at least the two new allegations this was not the case. Nevertheless Mr Tomnay agreed to postpone the hearing and, given that the Christmas period was approaching, he suggested the alternative dates of 4 to 6 January 2022. He indicated that his availability in that month would be restricted and another person might chair the disciplinary hearing instead.

119. The claimant emailed back on 20 December 2021 to disagree with the assertion that she was familiar with the allegations. She said she had been isolated from work for almost four months by that point without access to any

documents other than her emails. She attached a document outlining the further items she wished to see [558]. This was the date that she also submitted her grievance appeal, as discussed above.

120. The disciplinary hearing was rescheduled to 28 January 2022 and the claimant was sent a further letter to confirm the change. The letter was substantially the same as that sent by Mr Tomnay on 17 December 2021. However, the hearing was now to be chaired by Ms Ella Tracey, the Managing Director – UK for the group. It was also now to be in person, taking place in the first respondent's boardroom.

121. Ms Tracey had joined the first respondent's group on 4 January 2022 – i.e. less than three weeks before the claimant's disciplinary hearing. She took over responsibility for managing all of the clinics within the UK, including the first respondent. She was at the time therefore at a level senior to Mr Tomnay.

122. The hearing was attended by the claimant, Ms Tracey and a note taker. The claimant's preferred colleague representative was no longer available and so she was unaccompanied. A note of the hearing was later typed up [569-578]. It shows that the hearing began at 10.30am and ended at 2.21pm.

123. Ms Tracey summarised the allegations. In relation to the nitrogen tanks, she said that there was no record of anyone being trained in filling them, no back up checks to ensure the error identified would not happen again, no fail-safes involving a second person double checking that the process had been properly undertaken, and no reporting. The incident was not reportable to the HFEA but considered severe. It was noted that there was an alarm system designed to notify designated individuals in the event of levels dropping below a set level, and that the alarm was not triggered.

124. In relation to the use of unsupplemented media Ms Tracey said that the correct process for ordering supplies involved the lab manager checking and authorising each order. She referred to the order which had erroneously been placed and noted that the claimant appeared to have signed it off. The error was in that the product GIVF was ordered instead of the supplemented version which was named GIVF+. There was no check when the media was

delivered and no further checks during ten days of using the media in the lab. This incident was noted to be reportable to the HFEA.

125. There was discussion about these first two allegations before moving on to the others. The claimant mentioned that she had responded to both matters in her grievance and Ms Tracey confirmed she had seen the grievance documents, including meeting notes. Those could be considered part of the material in the disciplinary process if the claimant wished.

126. The claimant accepted that the nitrogen tanks were not topped up on the date in question, but disputed any assertion that the member of staff entrusted with the task was untrained. She said that anyone who was asked to top up the tanks had been trained. She had personally observed the member of staff, Ms Gnanaprabha, topping up the tanks on two occasions to ensure she was able to do it, and she had received separate training in relation to the health and safety aspects of handling liquid nitrogen. She had told Ms Gnanaprabha that the tanks needed to be topped up weekly. It was unrealistic to expect the Lab Manager to personally monitor the tanks on behalf of those whose task it was. High workloads and pressure on the time of the embryologists was the reason why the check was not made. The lab was a member of staff short at the time. There had never been documenting of the training which people received for working with nitrogen. A checklist had later been introduced to record when the topping up was done. There was now a daily rota showing each person's tasks, and this would be revised if a person did not come in. The claimant wanted to know if Ms Gnanaprabha herself had been disciplined for her part in the incident, and said that she felt the first respondent was trying to dismiss her because of the issues she raised in her grievance. Ms Tracey assured the claimant she did not think there was an attempt to dismiss her and matters were still being investigated.

127. The claimant read out her statement of response to the allegation of using the wrong media in embryo dishes. A member of lab staff had ordered 'GIVF' instead of 'GIVF+' by mistake and the claimant had not noticed that when signing off the order. She said ordering is done at speed. The 'plus' part of the product name, or its absence, was easy to overlook. If the product delivered

matched what was ordered, as it would in this case, a person would not necessarily recognise that an error had been made at that time. It is standard procedure to check the media when put into a dish, but this appeared not to have been done by others in the lab, including other embryologists. It should have been possible to spot the difference in product by its label at that point. The claimant was on leave for the initial days when the wrong media was used. When she suspected that something was wrong she asked other embryologists whether the media was supplemented and they told her it was. She assumed the bottle had already been checked. She began to suspect other items used in the process may have accounted for the difference in embryo handling, especially as the embryos were developing well. Others continued to use the media and it was not a mistake confined to the claimant. There was no damage to the embryos in the end and they developed at least as well as normal. On identification of the cause of the issue, the unsupplemented version of the media had been removed from the first respondent's order list so that it could not again be ordered in error.

128. Ms Tracey asked the claimant how she could be sure the same thing would not happen again. Aside from it no longer being possible to order the media which caused the issue, the claimant said that people were encouraged to use one product at a time and check its use by date, although this could depend on how busy staff were.

129. Ms Tracey adjourned the hearing for half an hour to go and check whether Ms Gnanaprabha had been trained to top up the nitrogen tanks, and if so whether that was documented. Evidence of her completing online Health and Safety training was found but whether any other training had been given was not documented and would need to be vouched another way. She noted that when the claimant had earlier been asked who was trained to top up the tanks, Ms Gnanaprabha had not been mentioned. The claimant said she must have forgotten to mention her along with the others she named. Ms Tracey also said she had checked with Mr Tomnay who had told her that Ms Gnanaprabha had not been trained. The claimant said he would not necessarily know, and that Ms Tracey should ask Ms Gibson or Ms Gnanaprabha herself.

130. The discussion moved on to the claimant's co-operation with the clinic unification programme. This was allegation number '2' in the list provided in the disciplinary hearing invitation letter. The essence of the complaint was that the claimant has not actively carried out steps towards unification of procedures across clinics in the group.

131. As Ms Tracey found that the allegation was substantiated, but that was reversed on appeal, it does not ultimately form part of the respondent's justification for dismissing the claimant. It is referred to below in relation to the claimant's appeal against her dismissal.

132. Ms Tracey proposed to adjourn the disciplinary hearing as she felt that it would not be possible to discuss all of the allegations in sufficient depth, carry out any necessary further enquiries, and make a decision in the same day. One allegation, namely failure to follow advice of the Vitrolife expert, had not been covered at all. Ms Tracey read out the allegation and asked the claimant if she had *'any concerns'*. The claimant said she had asked for more information as she didn't clearly understand what the issue was. She explained how the heated pads were operated in the lab. Ms Tracey undertook to clarify what the issue was more closely. The hearing was adjourned over the weekend until the morning of Monday 31 January 2022.

133. The disciplinary hearing was reconvened on 31 January 2022, but only briefly. Ms Tracey told the claimant that she had reflected on everything said in the original hearing, and wished some more time to explore some of the points the claimant had raised. The meeting would be further convened at an early convenient date to be agreed.

134. Ms Tracey emailed Ms Zujovic later on 31 January 2022, asking if the two could speak for 20 to 30 minutes in relation to some aspects of the unification project, and compliance by the Glasgow lab. After the conversation Ms Zujovic emailed Ms Tracey to say that in all but one of the clinics in the group she could find no electronic record of training documents relating to the handling of liquid nitrogen, although that did not rule out that they were kept.

She accepted the point, made by the claimant, that Glasgow was not an outlier in that sense.

135. As part of Ms Tracey's investigation of the claimant's defence, a statement was taken from Mr Tomnay by Ms Young on 2 February 2022 [582-585]. He was asked what he knew in relation to whether Ms Gnanaprabha had been trained to top up the nitrogen tanks. He said that he was told at the time of the incident that she should not have been asked to refill the nitrogen tanks, that she had not been trained by the incumbent Quality Manager, Frances Roebuck as the claimant had said, and that Ms Gibson had been *'really worried'* about the omission. He said he asked the claimant shortly after that time what had happened, and she had replied that Ms Roebuck was supposed to have trained Ms Gnanaprabha but had not done so. Ms Young explained to Mr Tomnay that the claimant was now saying something different, and that she had left Ms Gnanaprabha's initials off a list she had given of people she knew to be trained only by accident. Ms Young then said, according to her note, that *'The Company needed to prove that Keerthi wasn't trained.'* Ms Young asked him if there had been a sheet on the wall on which people would sign off having completed topping up since before the incident. He believed so. Ms Young then summarised the incident by saying that on the balance of probability Ms Gnanaprabha had not been trained to top up the tanks. She asked why then would Ms Gnanaprabha be asked to do it. Mr Tomnay said it was not part of her duties, although she would have been asked to do it.

136. Ms Young also raised the ordering of supplies with Mr Tomnay. He had nothing of substance to add by way of clarification of the process. The discussion was brought to an end, although Mr Tomnay contacted Ms Young shortly after to confirm that Ms Gibson had conveyed her concern about the nitrogen tank incident to Ms Morrison, his Deputy. Ms Young therefore telephoned Ms Morrison. She remembered asking the claimant to put in place a daily checklist on the wall of the lab containing the task, to ensure it was not overlooked again. She said *'it was the stupidest, craziest time at work ever.'*

She had been to the lab around three weeks later and didn't see the checklist on the wall.

137. Ms Young had planned to speak to Ms Gnanaprabha but she was on annual leave at the time, and so no conversation took place. She spoke to the embryologists Ms Gibson, the Deputy Lab Manager and Ms Noble, the PR on 3 February 2022 and made a note referring to the conversation [586]. Ms Gibson said she knew of no evidence either way to support or contradict whether Ms Gnanaprabha had been trained to top up the nitrogen tanks. Ms Noble said that Ms Gnanaprabha had stated she had not been properly trained by the outgoing Quality Manager, and she should have been supervised the first one or two times she did it. Ms Noble had put in place a training document to record that this training had been given. When asked by Ms Young whose responsibility she believed that was, she said it was her own and the Lab Manager's.

138. Ms Tracey reconvened the disciplinary hearing on 3 February 2022. The claimant again attended alone. A note was again taken by a member of Human Resources who prepared a typed version afterwards. Ms Tracey said that she had now reviewed all of the evidence in the investigation, what had been discussed in the initial disciplinary meeting and the points the claimant had raised. She said she had gone away to confirm certain details and recognised that the claimant had raised some matters in her grievance.

139. Ms Tracey discussed the nitrogen tanks issue. She said that she had investigated further whether Ms Gnanaprabha had been trained to top them up. She said after speaking to Mr Tomnay, Ms Morrison and Ms Gibson she could find no further evidence of her being trained by Ms Roebuck before her departure, or another remember of the team. She added that there were no systems in place to track or audit the filling of the tanks, even after the incident. The claimant should have seen to that. Instead her Deputy did. The claimant had not reported the incident, suggesting that her leadership was lacking.

140. Ms Tracey next raised the incident involving use of unsupplemented media in the lab. She said that the claimant had not checked the order containing the

error and nor had she escalated the matter once it had been discovered. She had not checked the relevant bottle despite suspecting that something was different and there was nothing in place to double check for errors in orders.

141. She mentioned the laboratory unification project. She said the claimant had been *'dismissive and unsupportive of the Company strategy'* and thought the changes were unnecessary.

142. Ms Tracey said that all of these issues fell within the claimant's responsibility and that there was a consequent lack of leadership and a breakdown in the trust and confidence the first respondent had in her. This led Ms Tracey to decide to dismiss the claimant for *'the numerous and collective examples of poor performance and leadership in fulfilling the duties of [her] role.'* Ms Tracey clarified that the claimant was not however being found guilty of gross misconduct.

143. The HR note-taker confirmed that the claimant would be paid in lieu of notice and accrued holidays. Her service with the first respondent was therefore to end with immediate effect. It was confirmed that the claimant had the right of appeal against her dismissal. A note of the meeting and a formal dismissal letter would follow. The meeting was brought to a close.

144. Ms Tracey prepared a letter confirming her rationale for dismissing the claimant which was sent on 11 February 2022 [644-647]. As well as covering the three allegations she had referred to in the meeting of 3 February 2022, she set out her findings in relation to the remaining complaint, namely failure to respond to guidance of the Vitrolife expert in relation to the set-up of equipment in the lab. In relation to that matter, Ms Tracey said that the heated stages were too hot after a second visit by the individual, and that this had been fed back to the claimant after the previous visit, but she had not changed anything or allowed the Vitrolife expert to adjust them. She said she had a reasonable belief to that effect and that she did not accept the claimant's statement, which was that the temperature of the cabinet in question as opposed to the stage housed within it was at the correct level, and that the

cabinet was only used for warming dishes in any event, and so its precise temperature was not critical.

145. In terms of how Ms Tracey categorised her findings, she said that they could have amounted to gross misconduct through cumulative negligence in the performance of the claimant's role, and in relation to her failure to follow reasonable management instructions (this in relation to the unification process). However, when taking into account all of the circumstances, the mitigation the claimant put forward, her length of service and previously clean disciplinary record, it had been decided to terminate her employment on notice.

146. As such, it was not completely clear from reading the letter whether the claimant was being found guilty of gross misconduct, but with a slightly less severe sanction of dismissal with notice on account of mitigatory factors, or whether she was being dismissed with notice for some reason other than gross misconduct. In her evidence, including her witness statement, Ms Tracey used essentially the same words to describe the decision she had reached. She said in paragraph 29 of her witness statement that she concluded that the claimant was guilty of gross misconduct, that she was also grossly negligent and that she had caused a significant breakdown in trust and confidence. The last sentence of that paragraph reads:

"Despite having a reasonable belief that the Claimant was guilty of gross misconduct, I took into account the Claimant's length of service and previous record and terminated her employment on notice."

Dismissal appeal

147. The claimant appealed against her dismissal by a letter dated 21 February 2022 [648-654].

148. At or around the time of submitting her appeal the claimant returned the note of her disciplinary hearing on 28 January 2022, with amendment she had made [655-665]. Those included the addition of text to say:

148.1 That staff normally had to *'go through hoops'* to be able to order a new product from the standard list of items available – thus making it less likely that any given order would contain a product not used in the lab, as had happened with the unsupported media;

5 148.2 Another embryologist also noticed a difference in the handling of embryos placed in the unsupported media (the implication being that she did not follow this up further and did not have action taken against her);

148.3 She had not been provided with any documentation relating to the
10 receipt of the order despite asking, and so could not comment on what had happened when the order arrived;

148.4 That there was a change in Mr Tomnay's account of whether Ms Gnanaprabha was trained in topping up the nitrogen tanks – he had first said she was not trained, and then said she was not properly
15 trained;

148.5 She deleted an entry stating that she had asked for an outcome to the process that day, rather than any adjournment and further investigation. She said she simply wanted the meeting to end for that day at the point it was raised, i.e. at 12.55 pm; and

20 148.6 She disagreed with an entry which had her agreeing she had enough staff, saying that she only agreed there had been an increase.

149. Also around his time the claimant also annotated a copy of the note made of Ms Holden's discussion with Mr Tomnay on 2 February 2022 [666-670]. Extensive comments and questions were added. The claimant took issue with
25 a number of things he had said and raised questions where she believed there was a lack of clear or complete information.

150. An appeal hearer was appointed, namely Professor Tim Child, Group Medical Director of TFP. He was based at another clinic in the first respondent's group. He was given access to all of the material available to Ms Tracey, together
30 with the claimant's appeal grounds, but not at that time the annotated notes

she had returned around the same time. He therefore also had access to the documents related to her grievance.

151. A virtual hearing was arranged for 21 March 2022. In attendance were Professor Child, Ms Barclay from Human Resources, a further note-taker, the claimant and a colleague or companion. Notes were taken and later converted into typed format [673-686].

152. After introductions, Professor Child began by summarising what he understood to be the reasons for the claimant's dismissal. Those were the four reasons which had been upheld by Ms Tracey based on the original allegations.

153. Professor Child then asked to hear from the claimant. She raised that she had not seen the statement given by Mr Tomnay until after she had been dismissed, and took issue with a number of aspects of it. It was agreed that the claimant would provide the version of the discussion with her annotations.

154. The general format of the remainder of the meeting involved the claimant making reference to sections of her detailed appeal letter and commenting on those, where requested providing clarification.

155. The claimant said that the level of reported incidents in Glasgow was not atypical compared to other clinics in the group, and that she felt singled out. Nor were training documents or records used customarily in other clinics. She said that Mr Tomnay and Ms Zujovic should have given her more support and had escaped criticism. She emphasised how busy the clinic was at the time the two incidents in the lab occurred. She discussed the level of staffing and the makeup of skills and experience within her team.

156. There was discussion about whether Ms Gnanaprabha had been trained on topping up nitrogen tanks. The clamant reiterated that she believed Ms Roebuck had trained her and should have recorded that as part of her duties as Quality Manager. It was recorded that Ms Gnanaprabha had received training on the health and safety and handling aspects of nitrogen, and the claimant herself had observed her going through the process to ensure she

did it properly, which she did. She said that no detailed statements had been taken and the decision was taken based on hearsay, largely from Mr Tomnay. She said it was *'nonsense'*. She said later in the meeting that there had never been a standard operating procedure in the lab around topping up the nitrogen tanks. Initially a technician named Paul had carried it out, and then Ms Roebuck took the task over when he left, before giving it to Ms Gnanaprabha after she joined. The claimant was just continuing with the approach which already existed. There was no lapse or omission in relation to Ms Gnanaprabha which did not equally apply to those who had undertaken the task before her. She mentioned that both Ms Roebuck and another technician left the first respondent's service shortly before the incident. The claimant herself had been on leave when the incident occurred.

157. The subject of the discussion moved to the ordering and use of the wrong type of media. The claimant said she was still waiting to see documentation showing the order as it was placed and as it was later delivered. Later in the meeting she said it was understood in the lab that it was not an option to order versions of products which were not used by them. She said the issue had been properly escalated when it came to light.

158. The claimant also stated that she had received no documents in relation to the allegation of failing to implement advice of the Vitrolife expert. She was lacking some of the details and said she had never been made aware that there was an issue at the time.

159. There was also discussion about the claimant's alleged failure to co-operate in implementing the unification programme.

160. The claimant said again that she did not agree with aspects of the statements given by Mr Tomnay and Ms Morrison after the initial hearing on 28 January 2022, but had not been given the chance to comment on them before Ms Tracey took her decision.

161. After the claimant had been given the opportunity to explain her appeal grounds the meeting was brought to an end. It was agreed that Professor Child would benefit from reading the grievance documents as well as those

prepared as part of the disciplinary process, and that the evidence of Ms Gnanaprabha should be clearly noted.

162. Ms Gnanaprabha was interviewed by Ms Barclay on 9 May 2022 via Teams. A note of the discussion was made [688-689]. Ms Gnanaprabha said she understood the responsibility was initially that of the technician named Paul, but she was shown how to do it after he left. She wasn't given any paperwork to confirm her responsibilities or the importance of the task. She was asked to confirm that she received one day of training but no documentation. She said that was correct, and that Ms Roebuck had shown her how to perform the task. She was asked what her responsibilities were after that point, and said that she needed to top the tanks up once per week. When asked if there was anything to document having done so, she said there was an Excel spreadsheet to be filled in afterwards and a weekly checklist of duties. People had to initial the tasks they had completed. She had a copy of the Excel spreadsheet but felt uncomfortable about providing a copy to Ms Barclay. Ms Barclay is noted to have said at the time that she would obtain a copy from Ms Gnanaprabha's supervisor, but there was no record of that having happened and the spreadsheet was not made available to Professor Child or the claimant at the time, or to the tribunal subsequently. When asked if she had anything to add, Ms Gnanaprabha said the training was insufficient when she first started (although did not specifically refer to the tank replenishing process) but had got better, and that she had subsequently been given something to document that she had received training on topping up the tanks.

163. Professor Child was on leave when Ms Gnanaprabha was interviewed but by 8 June 2022 he had returned and reached a decision in relation to the claimant's appeal. His decision was conveyed in a letter dated 8 June 2022 [690-693]. He dealt with each of the claimant's appeal points in turn.

164. In relation to the wrong media incident, he accepted that no harm was done to embryos but considered equally that damage could have occurred. He also accepted that the claimant was not the only responsible person in the ordering chain, but that final responsibility did lie with her as the lab manager. He noted

that she was unaware that the unsupplemented version of the product could be ordered on the first respondent's system, but felt that as significant sums were spent on supplies there was a duty to check orders carefully. He was not persuaded that the incident was reported promptly enough as nine days had elapsed since the media was initially used, despite the claimant initially being on leave and then good embryo development causing the claimant to believe that there was no serious issue. He said there ought to have been a standard operating procedure involving incoming stock being checked as it was put into storage or being used for the first time.

165. Regarding the nitrogen tank incident, Professor Child said he expected there would have been standard operating procedures covering the process and records of those who had been trained. He acknowledged that from day to day that fell within the remit of the Deputy Lab Manager, Ms Gibson, but again saw that ultimate responsibility fell with the claimant. He noted that the claimant had said she had omitted Ms Gnanaprabha's initials from a list of people who were trained in the task, but said that in fact she had not been trained until more recently. This was an error and did not reflect what Ms Gnanaprabha herself had said to Ms Barclay. Professor Child noted the claimant's point that Ms Gnanaprabha had not been interviewed before the decision to dismiss her was taken by Ms Tracey, but confirmed that this had now been rectified and Ms Gnanaprabha confirmed what he was now saying. He said:

“Keerthi's statement supports the above [i.e. that she had only been trained more recently] and the records which indicated that she had not been trained.'

He then went on to say 'She didn't receive a SOP document or any other relevant documentation to accompany the ad hoc training that she had received.”

This contradicts the statement made immediately before – that she had initially not received any training at all.

166. He found that the claimant should have ensured that an SOP – standard operating procedure - was in place, whether drawn up by her or her deputy.

Ms Gnanaprabha had stated to Ms Barclay that there was an Excel spreadsheet that she had to complete as a record of when she performed the task, and that the process also featured in a separate more general list of weekly lab tasks to be completed and signed off. This is not referred to. He said there was no process or system in place to track or audit the completion of the task. Those documents covered the former although not necessarily the latter – i.e. there was a process in place whereby the completion of the task was to be recorded (in two places) but there was no additional system for checking back after the fact to ensure it had been done.

167. In relation to the Vitrolife expert matter, Professor Child said he had now read an email exchange between the claimant, the expert Mr Stewart and Ms Zujovic on 24 May 2021, and that Mr Stewart had said that during his previous visit the claimant had prevented him from changing the temperatures of various workstations within the lab. He had also said that the settings were still too high at the time of the latter visit, and the claimant had allowed him to change them at that time. He noted the claimant's account of the matter but said he could find no evidence to support what she had said.

168. As discussed above, Professor Child's enquiry into the claimant's compliance with the unification scheme led him to conclude that the claimant had substantially co-operated, and that delays were due generally to external factors and not the claimant's own inaction or resistance. Rather than minimal compliance (the claimant was initially believed to have completed around 10% of her tasks) it was accepted that her compliance level was closer to 80%. He therefore upheld her appeal on this point and accepted there was no disciplinary finding to make against her.

169. In summing up, Professor Child said that he was mindful of how stretched the claimant had said she and her team were, but being busy did not excuse the two Qpulse incidents which occurred. He concluded that on the basis that three of the original four allegations remained upheld, the decision to dismiss the claimant was a reasonable response. Each could amount to gross negligence in itself and cumulatively the outcome was even more justifiable. He closed by saying that even if that were not the case, the claimant's failings

were significant enough to cause a breakdown in the trust and confidence her employer had in her ability to perform her role, and her employment would still have been terminated for some other substantial reason as Ms Tracey had outlined in her dismissal letter.

170. The claimant's appeal was therefore ultimately unsuccessful. This represented the last stage in the first respondent's internal disciplinary procedure.

171. With his letter the claimant was sent the emails he had viewed and relied on in order to uphold Ms Tracey's finding that the claimant had failed to follow the Vitrolife expert's guidance. This was the first time she was aware of that material being relied upon, or had seen any documentation at all relating to the issue. She was unable to provide a detailed response by that point as the appeal process had concluded.

Claimant's interactions with Mr Stewart of Vitrolife

172. Mr Stewart was an employee of Vitrolife, a supplier of equipment and products to the first respondent. As such he visited the lab from time to time and offered guidance and assistance in relation to the setup used there. At times he would carry out temperature mapping of the areas where the processes were undertaken. This involved the use of a temperature probe to take measurements in different places. Outside of these visits the first respondent would carry out its own temperature checks. The claimant and others had done so at various times. If there was a nonconformity in temperature that would be noted and possibly reported, then rectified. There was no record of this ever happening.

173. On one of his visits to Glasgow Mr Stewart offered to adjust the temperature of one of the heat stages to match a new type of dish being used. The thickness of the base of the dish which would be placed on the heat stage was the main factor in determining which setting had to be chosen in order to achieve the correct temperature (namely at or as close as possible to 37 degrees Celsius). Mr Stewart offered to change the heat settings for a number of stages to suit the new style of dish. The claimant asked him not to change

all of them immediately as they were still using other types of dish with a different thickness of base. She asked him to give her a note of the setting for each stage which would match the new dish, which she planned to adjust herself as more of the new dishes were brought in to replace the older ones. In this way she maintained that she did not refuse his advice. As the older dishes were replaced, the temperature settings of the stages were adjusted.

174. Documents provided to the tribunal, but not given to the claimant during the disciplinary process, showed that the temperatures of a number of the heat stages had varied between Mr Stewart's initial visit in May 2020 and his subsequent return a year later. So, for example, on 12 May 2020 the heated stage within hood 1 was at 36.6 degrees, for hood 2 it was 36.8 degrees and for hood 3 it was 37.4 degrees, whereas on 26 May 2021 the corresponding temperatures had been 37.4 degrees, 37.5 degrees and 37.0 degrees [250-265].

175. Professor Child accepted in his evidence that it would have been reasonable for the claimant to have these records during the disciplinary process in order to explain her position properly.

Discussion and conclusions

Did the claimant make protected disclosures?

176. The first question to be determined by the tribunal was whether the claimant made one or more protected disclosures as the term is defined in section 43A to 43C of ERA.

177. The claimant's case broadly was that she made protected disclosures of two types, in each case on a variety of dates, to a number of people and in different ways. Those two types of disclosure were:

176.1 firstly, that the respondent was carrying out procedures which were not worthy of clinical validation because of their poor success rates and, related to that, that patients were not being given full and accurate information on which to make decisions (referred to below as **'embryology disclosures'**); and

176.2 secondly that due to a combination of shortages in staff and/or skills, high workloads and challenges around the physical operation and configuration of the lab itself, there was an unacceptably high level of risk of errors and incidents, some of which could impact on patient outcomes, and this was supported by the fact that some incidents (such as the wrong media and nitrogen tanks issues) had already occurred (referred to below as **'staffing disclosures'**).

178. Both types of disclosure were said to qualify for protection under section 43B ERA by tending to show the past, present or likely future breach of a legal obligation incumbent on the first respondent, thus falling within limb (b) of that section. The legal obligation in question was one or more conditions of the first respondent's licence to operate a fertility clinic as granted by the HFEA.

179. The tribunal accepted that the mandatory requirements of the HFEA Code, as well as certain provision of the Human Fertilisation and Embryology Act 1990, imposed a legal obligation upon the first respondent in operating as a licenced fertility clinic. If it failed to meet those requirements the first respondent would be in breach of the conditions of its licence and technically no longer authorised to perform the functions and provide the services for which it was established, or at least it would be at risk of the licence being restricted. The HFEA would be entitled to take such action under its Compliance and Enforcement Policy.

180. In relation to the **embryology disclosures** the claimant relied on Regulatory principles 5 and 7, as well as Standard Licence Condition T72 which are detailed above.

181. In relation to the **staffing disclosures**, the claimant relied on Regulatory Principles 7, 8 and 9. She did not specifically refer to any of the standard licensing conditions, although the tribunal noted that the way in which she articulated her case made it clear that she had in mind circumstances which would be an actual or potential breach of one or more of Standard Licence Conditions T2, T12 and T17, also quoted above.

The embryology disclosures

182. Dealing with the embryology disclosures first, those were said to consist of:

181.1 Her raising concerns verbally, and with written background material, about the success rates of using frozen and thawed eggs to the Senior Management Team of the first respondent at a weekly management meeting on 20 March 2019;

181.2 Further comments made to Mr Tomnay in a meeting between the two on 13 September 2019. This was the meeting designed to clear the air between them and re-introduce a level of mutual respect and co-operation. The claimant said that she continued to be concerned about low survival rates of eggs undergoing freezing and thawing, and that she felt staff were being dishonest with patients about their true probability of conception;

181.3 The contents of an email from the claimant to the Senior Management Team on 30 October 2020 in which the claimant again advocated for a move to using fresh eggs for fertilisation. She used as examples that other clinics in the group did not use frozen eggs, or only did so in a very small number of cases (the Nurture clinic), or had briefly tried the option before reverting back to using fresh eggs (the Oxford clinic);

181.4 The claimant's email of 13 January 2021 to a number of senior staff within the first respondent including Mr Tomnay, Dr Gaudoin, Dr Mascarenhas and Ms Morrison. With that email she provided more detailed information about egg survival rates after freezing, comparing data under two methods which had been used at the Glasgow clinic, Kitizato and then Vitrolife. She gave the view that neither was effective enough to be satisfactory. She said she was awaiting further information; and

181.5 The email from the claimant dated 3 June 2021 in which the claimant added to a chain of emails started by Mr Tomnay and also including Dr Gaudoin. In that, she (and Dr Gaudoin) expressed the view that there was no obvious clinical need for Glasgow to increase the proportion of fertilisation cases undertaken by the ICSI method, as had

been encouraged at group level and practised at other clinics. The claimant believed that the method was not preferable to normal in-vitro fertilisation, could lead to complications in a small number of cases, and would be more expensive for patients.

5 183. The tribunal accepted that those disclosures took place and involved the claimant conveying 'information' to a sufficient degree of detail that the recipients could appreciate not just that she had a sense of grievance, but the specifics of her concern. She was referring to a process or a particular situation and not merely expressing that she was unhappy in some way. Each 10 disclosure was made to her employer, in the sense that it was communicated to one or more people more senior to her, or individuals with a specific and material degree of responsibility for a function with importance in terms of the first respondent's authority to practice under its licence.

184. The tribunal also considered that the claimant was genuine in her belief – i.e. 15 that the procedures involved in collecting, freezing, storing and thawing of eggs for fertilisation did not yield adequately successful results on a consistent enough basis, and that patients were not being fully informed about the prospects of their treatment being successful. She genuinely believed that Regulatory Principles 5 and 7, and Licence Condition T72 were being 20 breached as a result, and thus by extension that the first respondent had breached a legal obligation, or was in the process of breaching a legal obligation, or would be likely to do so in the future.

185. Further, the claimant had a reasonable belief that her disclosures were made in the public interest. The persons affected in her mind were existing and 25 potential future patients of the first respondent. The Court of Appeal confirmed in ***Chesterton Global Limited v Nurmohamed, [2017] EWCA Civ 979*** that the tribunal should consider whether a claimant subjectively believed that the disclosure was in the public interest, and then judge whether that belief was objectively reasonable. There is no absolute test of what is 'public' and what 30 is not, but the claimant subjectively believed that her concerns affected a wide enough group of people, current and future, to pass the 'public interest' threshold.

186. However, by contrast the tribunal was not satisfied that the claimant's belief in there being a past, current or future breach of a legal obligation was a reasonable one. This point also requires to be tested objectively. The tribunal considered there were two challenges with the claimant's case on this point.

5 187. Firstly, there was a lack of sufficient evidence to support her view. So, for example, the claimant referred in her statement to noticing there were 'less successful outcomes' using the freezing/thawing method at GCRM compared to using fresh eggs as she had done at the Nuffield clinic. The expected survival rate was 80%. She said she noticed the survival rate was less than 10 50% 'in perhaps one quarter of cases'. She did not say how many cycles this translated to, when or for how long the situation was observed to continue.

188. Secondly, there was a large body of evidence from various sources which ran contrary to her view. Egg freezing is a process commonly used in fertility clinics worldwide and so could not realistically be challenged in itself. It was 15 generally accepted to be a difficult process to conduct and consistent results were not easy to achieve. It was approved and implemented by a number of qualified medical practitioners both within the first respondent and its wider group. That included Dr Gaudoin, Dr Mascarenhas and Professor Child, who had an additional authority member role in connection with the HFEA itself. 20 There was no evidence that the first respondent's own conduct of the process was so deficient that it ceased to be fit for purpose. Dr Gaudoin stated more than once in the documents provided to the tribunal that had there been a sufficiently clear and consistent pattern of significantly poorer survival rates, her would have supported a change to the use of fresh eggs. This was 25 accepted by the tribunal to be his genuine position. However it was not established on the evidence that this stage was reached. The first respondent's procedures met the validation requirement of Licence Condition T72.

189. Additionally, if the survival rate fell below 50% there was a provision in place 30 which allowed the patient to obtain a refund, to re-start the process, or proceed with the number of eggs obtained if they preferred. This was in recognition of the unpredictable nature of IVF treatment, and also illustrated

that patients were being adequately informed about the uncertainty of the process. The literature they received gave a statistical comparison between success rates of fresh versus frozen egg fertilisation and provided further information about the process in sufficient detail [740-749]. It was made clear that the process could result in no viable embryos at all being produced. The information given to patients was not misleading, certainly not to the extent that the first respondent was in breach of its licence conditions.

190. Therefore, whilst the claimant was entitled to hold her view that a breach had occurred, was occurring or would occur, and did so genuinely, when considering the lack of evidence to support that view and the body of evidence and opinion on the subject generally, the tribunal found that it was not objectively reasonable to hold that belief at the time she did.

The staffing disclosures

191. The staffing disclosures were said by the claimant to consist of the following:

190.1 The claimant's concerns, raised verbally, to Mr Tomnay at the meeting between the two on 30 August 2019. In that discussion the claimant said there were insufficient properly trained staff in the lab and that this raised the risk of incidents which could have consequences for the service or care provided to patients. She also said the embryologists including herself were stretched by the workload level and the number of non-embryology tasks they had to carry out;

190.2 Comments the claimant made to the Senior Management Team at a management meeting on 24 September 2019. Ms Hamilton had raised concerns on behalf of her nursing team about working long hours, including at weekends and being more stretched in the process. The claimant added that her own team of lab technicians and embryologists were similarly challenged and in some cases had had to work 12 days continuously, increasing the risk of fatigue and loss of focus and therefore errors and incidents;

190.3 The claimant's email to Mr Tomnay dated 28 October 2020 and similar verbal comments following Ms Gibson accidentally disposing of some patient material, a reportable incident and her third of the year. The claimant forwarded an email to Mr Tomnay that Ms Gibson had sent her about the incident. The claimant added her own views which included that the occurrence of the incident emphasised that Ms Gibson's role contained too many non-embryology elements and that it was a reminder of how stretched staff in the lab were at that time. She added that the addition of new staff would further stretch those working there already, who would need to take time to induct and train them. She said the lab were short-staffed and working beyond capacity, as well as being vulnerable to equipment failure and space shortage issues;

190.4 The email from the claimant dated 16 June 2021 to the Senior Management Team, in which she repeated her concerns about workloads in the lab, a shortage of skills and the amount of administrative and ancillary tasks which had to be managed alongside clinical work. She again raised that with the recruitment of three new staff, in the shorter term her existing team would have the additional pressure of inducting and training those individuals. She asked for the number of new patients to be temporarily reduced until matters were realigned, failing which whether Mr Tomnay would pause lower priority tasks for a time. She specifically mentioned the risk of errors occurring if matters continued the way they were;

190.5 The claimant's email to Ms Young from HR on 22 July 2021 as part of a conversation dating back to May of that year, in which she had sought a meeting because she was struggling with her role primarily due to the *'high workload and staffing issues',* as well as wishing to *'air some concerns'*;

190.6 The claimant's emails of 13 and 17 August 2021 as part of an ongoing discussion about increasing the size of patient starter lists. The latter was sent nine days before she was asked to remain away from work

whilst negotiations over her proposed departure, and then the disciplinary process, were carried out. In the earlier email she said the lab team had struggled with workloads as they were, and with the introduction of a biopsy service would cause more difficulty. In the later email she said, against the background of two embryologists leaving, that she could not see the lab increasing patient numbers and working safely until staffing, equipment and hours were addressed; and

190.7 The email which the claimant sent to Ms Zujovic on 20 August 2021 as part of a conversation between the two. The claimant again repeated her concerns over too few skilled staff, the proposed increase in patient numbers, and her feeling that operating under those conditions did not feel safe.

192. In addition, the tribunal considered that the claimant made further disclosure of the same matters, or referred to earlier disclosures, as follows:

191.1 Provision of her email of 20 August 2021 along with her grievance submitted on 8 September 2021 – as such she was re-stating the information in that email at that date;

191.2 Her grievance itself, dated 8 September 2021. In that document she summarised in some detail the staffing concerns she had raised, namely staff shortages, skills deficiencies, members being able to leave earlier than their notice period would require, time taken to train new staff, previous incidents (some of which were reportable to the HFEA), additional hours being worked, the volume of non-clinical administrative tasks, the effect on her health, her previous request to pause less critical processes or limit certain treatments, staff fatigue levels, problems with equipment and the lab space itself, challenges experienced by the nursing team, and the overall effect this had in terms of increased risk of incidents and errors. She also restated her view on what would be likely to happen if patient numbers increased and new processed were carried out in the lab, as was planned; and

191.3 Her submissions at her grievance hearing on 26 October 2021 as minuted by the first respondent, in which she explained the matters she had raised in her grievance statement.

193. All of these disclosures contained enough detail (or referred to a sufficiently detailed previous disclosure) to be 'information'.

194. Again, the tribunal reached the view that the claimant was genuine in her belief in the veracity of what she was saying, namely that she believed that the combination of factors she was raising was real and created a material risk of incidents. She was credible before the tribunal in that respect and the respondent did not challenge her in relation to it.

195. The claimant's belief that she was making her disclosures in the public interest was also genuine and objectively reasonable. What caused her concern was the actual and potential detrimental effect of the matters she was reporting on herself, her colleagues and the current and future patients of the clinic. The substance and impact of those matters which she was experiencing directly were sufficient for it to be reasonable for her to believe that a wide enough group of people were being or could realistically be impacted.

196. It was also objectively reasonable for her to believe that her disclosures tended to show that a breach or breaches of a legal obligation had been taking place, were taking place at the time of the disclosure, and were likely to take place in the future. She was reporting on real matters and issues, such as staff shortages and people including herself working longer hours. She had identified aspects of the lab setup which were inefficient or which increased the risk of errors or accidents. She saw that some of the equipment was becoming less reliable or obsolete. Some of the incidents recorded on Qpulse, including the use of unsupplemented media and omission of refilling nitrogen tanks were reasonably believed by her to be real life examples of the wider problem she was trying to raise. Some of her colleagues agreed with her at various times, including Ms Hamilton, Ms Munford and Dr Mascarenhas. Objectively, she was entitled to believe that Regulatory Principles 7, 8 and 9 were being infringed, and would be further infringed – whether or not it could

be authoritatively determined that they were. Although she may not necessarily have had them in mind at the time of making her disclosures, the nature of her concerns as raised equated to breach of Standard Licence Conditions T2, T12 and T17.

5 197. The tribunal therefore found that the staffing disclosures (including those made as part of the grievance process) were protected disclosures.

Was the claimant subjected to a detriment by reason of making protected disclosures?

198. The claimant alleged that she suffered the detriment of dismissal by reason
10 of making her protected disclosures. Under section 47B ERA, a detriment is generally considered to be something which an employee would consider to be unfavourable to them. In some cases that can be a finely balanced question, but in this case the claimant believed that the detriment she suffered was her dismissal. It is clear that to be dismissed from one's employment
15 would amount to a detriment.

199. An employer must not subject an employee to a detriment 'on the ground' that they made a protected disclosure. Subsequent case law has established that when assessing whether there is a connection between the making of protected disclosures and a detriment, they need not be the sole or even the
20 main causal factor, but they must have a material (i.e. more than trivial) influence – ***NHS Manchester v Fecitt and others [2012] IRLR 64.***

200. If the employee proves that they made protected disclosures and that they suffered a detriment, it is for the employer to show that the reason for the latter was not the former – section 48(2) ERA. If the employer cannot do that, the
25 tribunal may draw an inference that the cause of the detriment was the making of the disclosures, although it is not bound to do so.

201. Consideration must be given in this case to who dismissed the claimant. She was dismissed by Ms Tracey who was an employee of a different company in the first respondent's group, albeit that she had management oversight of the
30 first respondent and authority to take decisions on its behalf in the disciplinary

process. She was therefore acting as the first respondent's worker and/or its agent and with its authority under section 47(1A) ERA. She had only joined the group a matter of weeks before taking on the task of hearing the claimant's disciplinary case. The claimant's protected disclosures were not originally made to her.

202. However, it was clear to the tribunal that Ms Tracey was extensively informed and guided in the process by Ms Young from HR and Mr Tomnay as the claimant's manager in particular. They had involvement with the claimant going back months if not years in relation to the subject matter of her protected disclosures. It was Mr Tomnay who decided to commence a disciplinary process after the claimant declined to leave under a negotiated settlement, and Ms Young who carried out the investigation on his instructions and into issues that he identified. Mr Tomnay initially planned to hold the disciplinary hearing, only handing the matter over to Ms Tracey when its postponement meant that he would no longer be available. By her own admission Ms Tracey had little or no knowledge of the disciplinary allegations brought against the claimant (decided upon by Mr Tomnay with assistance by Ms Young) in terms of why they were deemed serious examples of potential misconduct, the details of what happened or even the context around them. She had never been to the Glasgow lab and nor did she speak to anyone in Glasgow other than Mr Tomnay. She relied on both individuals for information and guidance, both in terms of the way they shaped the investigation process and the more direct information they gave her when she requested it. She spoke to Mr Tomnay during an adjournment of the claimant's disciplinary hearing.

203. As established in ***Royal Mail v Jhuti [2019] UKSC 55,*** an individual manager making a decision such as whether to dismiss a colleague can be imputed with the knowledge of those who influence and guide them. Given the heavy reliance Ms Tracey placed on the materials prepared by Ms Young and Mr Tomnay, the various decisions they took earlier in the process, and the further guidance they both provided, it is open to the tribunal to find that the motivations of Mr Tomnay and Ms Young had a material influence ultimately on Ms Tracey's decision. The tribunal does not go so far as to share the

claimant's view that Mr Tomnay ordered Ms Tracey to dismiss the claimant, as he would have had no authority to do so and the tribunal accepted that Ms Tracey would have wished to make what she saw as her own decision. The tribunal did however conclude that those two individuals influenced the otherwise unaware Ms Tracey to a significant degree. As they were so heavily motivated towards disciplinary action by the claimant's protected disclosures themselves, that filtered through into the decision Ms Tracey took.

204. It is a requirement of the above finding that Ms Young and Mr Tomnay were themselves motivated to initiate and then to conduct a disciplinary investigation against the claimant, and to interact with Ms Tracey in a way which were driven by the claimant making protected disclosures. This is the tribunal's conclusion on the evidence. The claimant had repeatedly raised her concerns, in detail, and had met with resistance from management. A number of her staffing disclosures were made to Mr Tomnay individually, or as part of a group, and he was the person the claimant was clearly expecting to make the changes she was asking for. She would not allow matters to drop and as time went on was seeking to escalate them. She was also citing them as part of the reason for reported incidents on the Qpulse system which were being framed as lapses in her leadership of the lab. To address them would involve time and money. It would impact negatively on patient numbers and therefore income of the clinic. The first respondent and particularly Mr Tomnay did not want to do that and reached the view that it would be better to have the claimant leave her role. When she would not agree to do so by negotiation they took the formal route.

205. The tribunal therefore concluded that the making of the claimant's protected disclosures had a material influence on her dismissal. Her claim under section 47B ERA is therefore upheld.

The detriment claims against the second and third respondent

206. The tribunal considered whether either Mr Tomnay or Ms Tracey had subjected the claimant to a detriment for making protected disclosures as

individuals distinct from their actions in the capacity of agent of the first respondent.

207. The conclusion of the tribunal was that both acted within the scope of their roles as either a worker of the first respondent (as Mr Tomnay was at the time) or a representative or agent of it acting within the authority they had been given (as both he and Ms Tracey were). Mr Tomnay did not subject the claimant to the detriment of dismissal at all, and only had a less direct influence over it. The decision was Ms Tracey's, but she acted principally on behalf of the first respondent and only secondly as an individual.

208. As a result, and because the claimant cannot be compensated twice for the acts of Ms Tracey as an individual and as a worker or agent of the first respondent, the tribunal's view therefore is that the first respondent is the appropriate and only party to be held liable for the detriment caused to the claimant.

209. The complaints against the second and third respondents should therefore be dismissed.

Was the reason, or the principal reason, for the claimant's dismissal that she had made protected disclosures – automatic unfair dismissal under section 103A ERA?

210. Although the tribunal found, as above, that the claimant making her protected disclosures had a material influence on her dismissal, it did not find that they were the sole or principal reason for the dismissal, as they would have had to be in order to result in an automatically unfair dismissal under section 103A. They contributed to a lesser degree than that. The tribunal's findings as to the reason or reasons for the claimant's dismissal are below.

211. It follows that she was not automatically unfairly dismissed within the terms of section 103A ERA.

Was the claimant unfairly dismissed contrary to section 94 ERA?

What was the reason for dismissal – section 98(1) and (2) of ERA?

212. The onus falls on an employer dismissing an employee to establish that the reason for dismissal was one which was potentially fair, and therefore being at least one of the reasons mentioned in section 98(1) and 98(2) of ERA.

213. Ms Tracey found that all four allegations against the claimant were well established and decided to dismiss the claimant as a result. By virtue of the partially successful appeal process, the dismissal was ultimately upheld on three of those findings, namely the claimant's part in each of the wrong media incident, the nitrogen tanks incident and the Vitrolife expert issue. The claimant's alleged resistance to the unification project ceased to be part of the reason for her dismissal.

214. The language used by Ms Tracey in both her letter of dismissal and her evidence to the tribunal was not completely clear, as discussed above in the tribunal's findings of fact. The tribunal concluded on the basis of all of the evidence before it that the claimant was dismissed by reason of her conduct, which is a potentially fair reason within section 98(2)(b) ERA. The tribunal took into account that it was a disciplinary process which was followed, which is the normal mechanism for dealing with issues of conduct in the workplace. Although the following of such a process does not always result in a finding of misconduct, the tribunal took from Ms Tracey's evidence that she concluded that the claimant wilfully acted in a way contrary to its policies, standards or instructions, or was so negligent in performing her role that it became an issue of her conduct rather than a capability matter where she lacked competence or skills, or required support. Ms Tracey's comments about the availability of summary dismissal as an option are consistent with that – the sanction is normally only open to an employer in the most serious of conduct breaches and it was only through choice and when considering mitigatory factors that she took the decision to dismiss with notice instead.

215. The tribunal was therefore persuaded that in being dismissed for the three allegations which survived the appeal process, the claimant was dismissed by reason of her conduct. The making of her protected disclosures (and indeed disclosures which were not protected under section 43B) was part of

the overall picture but they were not the sole or principal reason for the claimant's dismissal.

General reasonableness of the respondent's process – section 98(4) of ERA

5 216. The tribunal next had to consider whether all of the requirements of section 98(4) of ERA had been satisfied. Neither party has an onus to prove their case over the other under these provisions.

217. In assessing the overall reasonableness of an employer's actions in cases of dismissal for conduct, the principles in ***British Home Stores Ltd v Burchell***
10 ***[1978] IRLR 379*** will be relevant. According to that authority three things must be established for a conduct related dismissal to be fair. First, the employer must genuinely believe the employee is guilty of misconduct. Secondly, there must be reasonable grounds for holding that belief. Third, the employer must have carried out as much investigation as was reasonable in the
15 circumstances before reaching that belief. Each of those is considered below.

Burchell part 1

218. Ms Tracey maintained that she genuinely believed the claimant was guilty of some form of misconduct, whether labelled as such or as gross negligence. The claimant disputed that this was her genuine belief. She thought that Ms
20 Tracey had effectively been set up by Mr Tomnay to dismiss her after he had planned to do so himself. If so, she was following his direction and not forming her own conclusions.

219. The tribunal concluded on the evidence that Ms Tracey was genuine in her belief about the claimant. How well informed she was about the matters which
25 were the subject of the allegations is a different question, and dealt with in relation to the detriment claim above, and further below. She was guided and influenced by others in reaching her decision and the principle established in ***Royal Mail Ltd v Jhuti*** referenced above applies to this question as well as that of whether the making of the claimant's disclosures contributed to a
30 detriment. That said, the tribunal accepted that she genuinely believed she

was dismissing the claimant for the reasons she gave in her dismissal letter. Further, the tribunal considered that the key influence upon her, Mr Tomnay, also held the view that the claimant's part in the dismissal matters involved misconduct on her part, although at the same time he also considered her to be a problematic colleague in repeatedly raising complaints and requests, some which were protected disclosures, and which were inconsistent with his own views, priorities and constraints.

Burchell part 2

220. The respondent argued that it had reasonable grounds on which to form its belief in the claimant's misconduct. The claimant contested this position. She disputed that she was guilty of any form of misconduct or negligence, other than the most minor type which could be explained in the context of her demanding working conditions.

221. The claimant was ultimately dismissed for a combination of three reasons and the tribunal reviewed each in turn.

Nitrogen tanks incident

222. There were essentially three aspects to the allegation against the claimant. She was held responsible by Ms Tracey for a technician being untrained in the task and who performed it unsupervised. She was also found to have failed to implement a system for checking and auditing that the topping up process was being carried out weekly as was required. It was also held that she did not report the incident when it came to her attention.

223. Based on the facts as found by the tribunal, the technician had been trained to top up the tanks. She had gone through a prepared online training module focussing on the safety aspects of handling liquid nitrogen and she had been shown how to top up the tanks by the Quality Manager Ms Roebuck before she left the first respondent's service. The claimant had observed the technician perform the process twice and was satisfied that she knew how to do it. What should not be lost was that that the issue was in the technician forgetting to top up the tanks and not with her lacking the competence to do

so. She confirmed when questioned both that she knew how to top up the tanks and that she knew they had to be topped up regularly. There was no deficiency in her training, and if there had been it would not have been reasonable to expect the claimant to know or be responsible for it.

5 224. The fact that there were no written records showing that the technician had been trained was held against the claimant. However, there were no records of any member of staff being trained in the process, going back to before the time the claimant joined the first respondent. Nor was there a consistent practice of keeping training records in the other clinics within the group.
10 Further, maintaining any training documents was primarily the responsibility of the Deputy Lab Manager, not the claimant.

225. In relation to the checking and auditing deficiency, there was a system for checking that the tanks had been replenished. A sheet was put on the wall adjacent to the tanks which was to be filled in by each person when they
15 performed the task, to include name, date and time. The technician kept her own spreadsheet of when she carried out the task, although her reluctance to produce it during the dismissal appeal process was accepted without question. Thirdly, the lab had a daily rota of tasks to be performed, one of which was the topping up. This served as a reminder if nothing else. There
20 were accordingly as many as three ways that performance of the task was being prompted or recorded. However, by her own admission the claimant did not have anything in place for auditing the task in the sense of conducting a review to ensure it was being performed at the right times and documented accordingly. It would have been (and in the event was) more by chance that
25 a second pair of eyes noted an omission by the person due to carry out the process, and this is how the oversight was detected. Neither the claimant nor anyone else had a standing action to double check compliance with the requirement.

226. As regards reporting the incident, the claimant raised it via Qpulse on 19 May
30 2021, the day it was discovered. She made this point in her appeal against dismissal. At the same time the tanks were topped up and therefore the

immediate situation was rectified. The failsafe alarm was not triggered and there was no damage to patient material within any of the tanks.

227. Accordingly, the mistake made was in the technician forgetting to carry out a relatively simple task which she confirmed she had been trained to do. She was experienced and indeed well-remunerated enough to be trusted with the task. The incident was a one-off, it was reported promptly and no harm was caused. There was an automatic back-up system which was not triggered. The claimant had not put in place a practice of checking that the tanks were being topped up and recorded as such. This was her only omission. There were not reasonable grounds to conclude that she was guilty of misconduct or gross negligence.

Wrong media incident

228. Very little was said in the dismissal letter about Ms Tracey's conclusions in relation to this allegation. She simply said that the claimant confirmed *'that the wrong media had been used and not properly checked despite your own misgivings…'.*

229. Going by the original allegation, it again involved a number of separate aspects. It was put to the claimant that she had not checked the order which contained the erroneous product specification thoroughly enough when signing it off, and so had not spotted the mistake. It was said that there was no system in place for checking delivered products against the order placed. Nobody subsequently checked the media when it was stored in a fridge within its bottle. The media was used for nine days before the bottle was checked.

230. The claimant admitted that she had authorised the placing of the order which contained the error. That error was to order the standard version of a product rather than the 'plus' or supplemented variant. The claimant said she had missed the error as she had so many orders to check, each one containing lists of products, and she was pressed for time. The media is itself the same in appearance, composition and function, and the only difference between the two is the addition of a handling agent. Up until a short time before it had not been an option for the Glasgow lab to order the unsupplemented version of

the product, but that had been changed as part of the unification product as it was used by other clinics in the group. In the nine-day period when the media was used, she and other embryologists had noticed that fertilised eggs within the media were sticking to the dish which contained them more than usual, but could still be manipulated. The growth of the embryos was as positive if not more so than normal and therefore the media itself was not thought to be the cause and other factors were considered, such as the dishes or handling implements. The claimant asked either a technician or another embryologist whether it was the correct media being used, and was told that it was. She was on leave at the beginning of the nine-day period and only returned at some point after the wrong media had been introduced.

231. Based on the evidence the tribunal reached the view that Ms Tracey did not have reasonable grounds on which to find that the claimant was guilty of misconduct over this incident. There was a combination of errors on the part of various individuals which contributed to the wrong product being ordered and not detected as such sooner than it was. The claimant may have discovered the error earlier than she did in different circumstances but she was not guilty of misconduct or serious negligence.

Vitrolife expert issue

232. Ms Tracey concluded that it was clear that the claimant had not followed the express recommendations of the Vitrolife expert. She considered it was reasonable to believe that the claimant would not allow him to make required temperature adjustments on the earlier of his two visits, and that he therefore found the settings too high a year later and had to change them then. Ms Tracey could find no evidence to back up the claimant's explanation, which was that the temperature of the surface as tested would be higher than the temperature of any dishes placed upon it, and that the cabinet was only being used to warm dishes rather than heat them for a prolonged period. There was no documentation to cover any steps the claimant took to protect the business.

233. As became apparent at and indeed after the claimant's appeal against her dismissal, there was a lack of clarity in the allegation. The claimant was unsure exactly what she was being accused of. During her appeal further documentation was recovered to assist Professor Child in understanding the allegation, but it was not passed to the claimant and so she was not able to comment on it. Professor Child accepted in hindsight that it would have been reasonable to provide it to her. By the time of the tribunal hearing the claimant had been able to review the documents and could point out that the temperatures taken at different points within each of the cabinets had changed between Mr Stewart's visits and were within an acceptable tolerance, undermining the assertion that they had not been changed in the interim and were still too hot. The claimant was able to explain to the tribunal why she had asked Mr Stewart not to change any settings on his first visit. It was also clear to the tribunal once the additional reports were examined that the temperature of the heat stages were within an acceptable tolerance given their recorded values and the scope for instrument calibration error.

234. Mr Stewart was not contacted to clarify any aspect of his two visits to the Glasgow lab or his interactions with the claimant. In preparation for the hearing of her claim the claimant sought a statement from him and one was produced, extending to four pages and 28 paragraphs, albeit that it was unsigned. Mr Stewart did not attend the tribunal and was not cross-examined. The contents of the statement were therefore treated with caution by the tribunal. Nevertheless, in it he accepted that he was incorrect to say in an email dated 21 May 2021 to Ms Zujovic that the set point temperatures were no different than from the previous year (as borne out in the reports obtained by Professor Child at the appeal stage). He accepted they had been changed. He also said that on his first visit his recommendation was not to change the temperatures at the set points, but rather at offsets, which were points a short distance away from the set points themselves. This recommendation was made in order to seek a more uniform temperature throughout a given cabinet.

235. What was clear to the tribunal in considering this allegation was that firstly it was not put to the clamant in a clear way with enough detail that she could

properly answer it. It followed from this that her attempted response did not persuade Ms Tracey that she had done nothing wrong. An attempt to rectify this was made at the appeal stage, but this only effectively clarified the issue for Professor Child and not the claimant herself. Yet more evidence was gathered after the appeal was concluded to clarify the position further. The evidence could have been gathered earlier. Each time further information was obtained, it became clearer that there was no substance in an allegation of misconduct. The claimant had not ignored or refused a request made by Mr Stewart. Nor could any of the respondent's witnesses explain why this was a potential example of misconduct.

236. Therefore the tribunal concluded that it was not reasonable to conclude that the claimant had committed an act of misconduct by failing to follow the advice of the Vitrolife representative.

237. The culmination of the above considerations was that the tribunal was not satisfied that the first respondent had reasonable grounds on which to conclude that the claimant was guilty of either misconduct serious enough to justify dismissal, or gross negligence.

Burchell *part 3*

238. The third limb of ***Burchell*** requires consideration of whether the employer carried out as much investigation as was reasonable in the circumstances in order to reach its genuine belief in the employee's misconduct. That does not require an employer to uncover every stone, but no obviously relevant line of enquiry should be omitted.

239. The legal test, as emphasised in ***Sainsbury's Supermarkets Ltd v Hitt [2003] IRLR 23*** is whether the investigation fell within a band of reasonable approaches, regardless of whether or not the tribunal might have approached any particular aspect differently.

240. The respondent submitted that a sufficiently adequate investigation had been undertaken. On this issue the claimant disagreed.

241. The tribunal found that there were a number of issues with the investigation, summarised as follows:

238.1 The investigation took an excessive amount of time to complete. It commenced some time in August 2021. It was concluded on or shortly before 16 December 2021, which was the date when Mr Tomnay wrote to the claimant requesting her attendance at a disciplinary hearing. Considering the number and nature of the matters which were investigated, and the volume of documentation which was reviewed, the tribunal considered that the investigation ought to have been concluded sooner. Throughout that time the claimant was isolated from her workplace, and so any delay was particularly prejudicial;

238.2 No final investigation report was prepared. The copy produced to the tribunal was incomplete and in particular only dealt with the original two allegations – wrong media and nitrogen tanks – and did not cover the two additional issues – Vitrolife expert and unification process – which were later incorporated into the process;

238.3 The investigator Ms Young interviewed only Mr Tomnay and Ms Zujovic, and relied only on evidence provided by them. As a result the scope of the investigation was too narrow. Key evidence was not gathered, some as referred to above; and

238.4 The claimant herself was not interviewed as part of the investigation, and although that could not be said to be an absolute requirement of a reasonable investigation, it contributed to a lack of clarity in relation to the allegations (particularly in relation to the Vitrolife expert) and missed opportunities to review other relevant documents and speak to witnesses who would have provided helpful clarification. For example, Ms Gnanaprabha the technician, Mr Stewart the Vitrolife expert and Ms Roebuck, the former Quality Manager were not approached. This resulted in the claimant only being given the opportunity to respond to some the allegations for the first time in her disciplinary hearing, and Ms Tracey being forced to undertake further investigation within a

compressed timescale, the result of which was that there was still relevant material and witness evidence that she did not or could not obtain before taking the decision to dismiss the claimant.

242. The tribunal was mindful that the standard an employer requires to meet is that of a reasonable investigation and not a perfect or unlimited one. The process must fall into the middle ground of what a reasonable employer would do.

243. It cannot be said that the omission of one individual document or witness from the investigation would itself render the process unreasonable. However, the tribunal reached the view that the cumulative effect of the various shortcomings in the investigation in this case took it outside of the band of reasonable processes which an employer was entitled to follow.

244. Therefore it is found that the second and third requirements of Burchell were not fulfilled. The respondent did not have reasonable grounds on which to conclude that the claimant was guilty of misconduct or gross negligence, and related to that it did not undertake a reasonable investigation into the claimant's conduct.

245. As a result the claimant's dismissal was unfair according to the test to be applied under section 98(4) ERA.

The band of reasonable responses

246. In addition, and despite already reaching the conclusion that the claimant's dismissal was unfair, the tribunal considered the additional requirements of a fair dismissal on grounds of conduct.

247. In addition to the Burchell test, a tribunal must be satisfied that dismissal fell within the band of reasonable responses to the conduct in question which is open to an employer in that situation. The concept has been developed through a line of authorities including ***British Leyland UK Ltd v Swift [1981] IRLR 91*** and ***Iceland Frozen Foods Ltd v Jones [1982] IRLR 439.***

248. The principle recognises that in a given disciplinary scenario there may not be a single fair approach, and that provided the employer chooses one of a potentially larger number of fair outcomes that will be lawful even if another employer in similar circumstances would have chosen another fair option which may have had different consequences for the employee. In some cases, a reasonable employer could decide to dismiss while another equally reasonably employer would only issue a final warning, or vice versa.

249. It is also important that it is the assessment of the employer which must be evaluated. Whether an employment tribunal would have decided on a different outcome is irrelevant to the question of fairness if the employer's own decision falls within the reasonableness range and the requirements of section 98(4) ERA generally. A tribunal must not substitute its own view for the employer's, but rather judge the employer against the above standard.

250. The tribunal found that dismissal as a sanction fell outside the band of reasonable responses to the claimant's conduct in this claim. Its reasons were:

247.1 With reference to the discussion of the second part of the Burchell test above, there were insufficient grounds for finding that the claimant was guilty of gross misconduct or gross negligence. To a lesser degree she carried some responsibility, for example by not putting in place a practice of double checking the weekly topping up of nitrogen tanks. These were matters more suited to performance management or informal action than a disciplinary process. They did not, individually or cumulatively, justify dismissal;

247.2 The deficiencies in the respondent's investigation of the issues as referred to above under the third part of the Burchell test;

247.3 The fact that Ms Young as investigator and Ms Tracey as the dismissing manager had insufficient knowledge of the subject matter of the allegations which ultimately led to the claimant's dismissal;

247.4 The claimant not being provided with the relevant documents before her disciplinary hearing, and even at the appeal stage not being given new documents relied upon by Professor Child;

247.5 The claimant being held entirely culpable for the matters which were the basis of the disciplinary allegations, despite responsibility for them being shared if not owned by others, and no other employee apparently being considered responsible to any degree;

247.6 The historic nature of some of the allegations; and

247.7 The fact that the issues, to the extent that they involved a failure or breach at all, had been promptly rectified some months before the date of dismissal.

251. Therefore, mindful of the above approach which a tribunal must take in dealing with the question of reasonableness, it is found that dismissal of the claimant was not within the band of reasonable responses open to the respondent in these circumstances.

***Polkey* consideration**

252. Although not raised in the respondents' closing submissions, the tribunal considered whether, to the extent that there was any procedural unfairness in the respondent's process, the claimant would have been fairly dismissed had a fair procedure been followed. In doing so it referred to the well-known decision of the House of Lords in ***Polkey v A E Dayton Services Limited [1987] ICR 142***. The court confirmed in that decision that a tribunal may reduce compensation to reflect the likelihood that the respondent's procedural errors made no difference to the outcome. It was part of the respondents' overall case that there was a weight of evidence of culpable conduct on the part of the claimant which was at least partly accepted by her.

253. The ***Polkey*** principle requires the tribunal to consider what would have happened had this particular employer followed a procedure that met the test of fairness. That outcome may be something which is certain, although such

cases are rare. The tribunal must therefore assess the percentage probability of a fair dismissal if it can.

254. The tribunal considered that the first respondent's shortcomings – outlined above in relation to parts two and three of the ***Burchell*** test and also in relation to the band of reasonable responses – were so numerous and material that it could not be said with sufficient certainty that the claimant could and would have been dismissed fairly had those shortcomings not been present. Those errors and matters are not all procedural. Some are substantive, such as whether adequate evidence to establish gross misconduct or gross negligence existed, had a more thorough investigation taken place. The tribunal found that the respondent could not or would not have dismissed the claimant fairly on grounds of her conduct. It is not possible or appropriate to make a ***Polkey*** deduction in relation to the claimant's dismissal on grounds of conduct.

255. The separate question of whether a ***Polkey*** deduction could be made to reflect the possibility of a fair dismissal for another reason is dealt with below.

Contributory conduct

256. It is necessary next to consider whether any award of compensation should be reduced to reflect the degree to which the claimant's own conduct contributed to her dismissal. This duty falls on a tribunal whenever findings are made suggestive of contributory conduct, and in any event the issue was raised by the respondents in in their submissions. Mr Forrest on their behalf argued for a high reduction on the basis that the claimant was 'equally responsible' for her own dismissal. The factors said to be relevant to that were, in summary:

253.1 She was experienced enough to know what her role entailed and what the first respondent required of her, but appeared to be unwilling to adapt the greater demands placed on her after the transfer from Nuffield;

253.2 She had a negative attitude and did not plan for the lab adequately, causing or contributing to the problems she reported;

253.3 She spent too much time trying to influence colleagues in relation to things she was dissatisfied with and as a result had less time to devote to her responsibilities; and

253.4 She could not manage her colleagues in the lab properly or interact with other senior managers.

257. Not all of the above matters relate to conduct. Some are restatement of a lack of skills.

258. A tribunal may reduce both a basic and compensatory award to reflect contributory conduct. There are slightly different considerations for each, but the broad approach is the same, namely what is a just and equitable approach to take. According to the Court of Appeal in ***Nelson v BBC (No.2) [1979] IRLR 346*** in order for a reduction to the compensatory award to be appropriate, the conduct in question must be culpable or blameworthy, it must have caused or contributed to the dismissal and the reduction must be just and equitable.

259. That approach is effectively distilled into four separate questions (as per ***Steen v ASP Packaging Ltd UKEAT/23/11***) which are dealt with as follows:

256.1 **What is the conduct said to give rise to contributory fault?** In this case, it is said to be the claimant's unwillingness to fulfil the requirements of her role. The tribunal however did not find that the claimant was unwilling to carry out her responsibilities. It found, in summary, that she performed her duties as well as she could, given the competing demands on her time and the various challenges she faced, and reported;

256.2 **Was that conduct blameworthy?** The tribunal was not satisfied that any aspect of the claimant's conduct was blameworthy. As found above, there was no fair basis to dismiss for misconduct (or gross

negligence). Any issues with her conduct were significantly more minor and explicable by the conditions she was working under;

256.3 **Did the blameworthy conduct cause or contribute to the dismissal?** As there was no blameworthy conduct, this question does not apply;

256.4 **If so, to what extent should the award be reduced, consistent with what is just and equitable?** This question also does not apply.

260. Although the same detailed analysis is not required in relation to a basic award of compensation, and a broader approach can be taken, it is generally unusual for a different reduction to be applied. There is no reason in this case to view the relevant background differently and accordingly any basic award should not be reduced.

Possibility of alternative reason for dismissal – some other substantial reason

261. The respondents argued that if the claimant had not been dismissed by reason of her conduct, she had been dismissed for 'some other substantial reason' under section 98(1)(b) ERA.

262. As above, the tribunal found that the claimant had been dismissed for the sole or principal reason of her conduct, albeit unfairly in terms of the requirements of section 98(4). An employee cannot be dismissed for more than one sole or principal reason.

263. However, it agreed that it was relevant to consider whether the claimant could have been fairly dismissed for an alternative substantial reason. The answer to that question could have a bearing on any compensatory award granted, again on the basis of the principles set out in the ***Polkey*** decision.

264. The tribunal noted that dismissal under this statutory provision can only be fair if the reason is 'substantial', and not trivial or insignificant. The reason must justify dismissal as opposed to a lesser sanction. The test is applied to the individual and the role that they carry out specifically.

265. The tribunal found that although the dismissal letter of Ms Tracey concluded that there was *'a breakdown in trust and confidence in your ability to run and manage the Lab at GCRM'*, she reached that conclusion on the basis of the same flawed process which led to her conclusion that there had been gross misconduct or gross negligence, when there had not. In particular she had no direct knowledge of the claimant's relationship with the first respondent having just joined the group, and she relied on the partial and inaccurate advice and material of her colleagues. Further, the decision to dismiss was based on Ms Tracey's conclusions as regards the claimant's participation in the unification process, which were overturned on appeal.

266. Additionally, and referring back to its conclusions in relation to conduct being the reason for dismissal, the tribunal considered that when all of the evidence was considered, any of the claimant's failings were a more minor part of a larger overall picture involving demanding workloads, staffing challenges and the implementation of new practices as required by the first respondent's group.

267. As such, the tribunal could not be satisfied that the first respondent would have been able to discharge the burden of proof upon it to show that there was a fundamental breakdown in the trust and confidence it had in the claimant, to the extent that dismissing her was a fair option open to it. The parties may have reached that stage at a future point, but to enquire further along that line would be speculative.

268. Accordingly the tribunal does not consider it appropriate to make a ***Polkey*** deduction to reflect any prospect that the claimant could have been fairly dismissed for some other substantial reason were she not dismissed on grounds of conduct.

Conclusion

269. On the basis of the above, the claimant has succeeded in some but not all of her claims. As originally (albeit provisionally) ordered:

266.1 a one-day remedy hearing in person will be listed by separate correspondence;

266.2 Within 28 days of the date of this judgment, the claimant will provide to the respondent and copy to the tribunal an updated schedule of loss dealing with the remedy she now seeks based on the complaints which have been upheld, together with any additional relevant documents related to that matter;

266.3 Not later than 14 days after the claimant's deadline above, the respondent will provide to the claimant and copy to the tribunal an updated counter-schedule of loss together with any additional documents related to that matter on which it wishes to rely;

266.4 The parties are encouraged to agree as many aspects of loss as is reasonable, given the overriding objective of the employment tribunal contained in rule 2, and in particular the parties' obligation to assist the tribunal;

266.5 Not later than 7 days before the remedy hearing the parties will submit to the tribunal electronically a joint remedy bundle containing any relevant documents as referred to above, and the necessary number of hard copies will be provided for the remedy hearing;

266.6 Should either party wish to vary any of the above orders they must do so, copying the other party, within 14 days of the issuing of this judgment and proposing their alternative.

Employment Judge: B Campbell
Date of Judgment: 21 April 2023
Entered in register: 24 April 2023
and copied to parties