Note: An order prohibiting publication of some names and evidence applies to this determination

IN THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND

[2016] NZERA Auckland 322
5583207

	BETWEEN	LYNDA MARIE EMMERSON Applicant
	A N D	NORTHLAND DISTRICT HEALTH BOARD Respondent

Member of Authority:	T G Tetitaha
Representatives:	S Henderson , Counsel for Applicant S Hornsby-Geluk , Counsel for Respondent
Investigation Meeting:	25 to 28 January and 11 to 14 July 2016 at Whangarei
Submissions Received:	29 June 2016 from Applicant 8 and 14 July 2016 from Respondent
Date of Determination:	21 September 2016

DETERMINATION OF THE AUTHORITY

A. The application for leave and the application for personal grievances of unjustified disadvantages are dismissed.

B. There was sufficient evidence for the Northland District Health Board to conclude Dr Emmerson had committed serious misconduct.

C. The procedural defects were minor and did not cause unfairness.

D. The personal grievance of unjustified dismissal is dismissed. Costs are reserved.

Non publication order

[1] Pursuant to clause 10 of the Second Schedule of the Employment Relations Act 2000 (the Act), the Authority replaces the previous non publication order[1] with an order suppressing:

a) the publication of the names of persons referred to but who have not appeared before me in this proceeding including the identity of the two individuals (Drs A and B) who are currently the subject of defamation proceedings filed by Dr Emmerson in the High Court;

b) the names of the two nurses attending Dr Emmerson on 20 April 2015 (N1 and N2); and

c) the names and any evidence leading to the identification of any of Northland District Health Board's (NDHB) patients.

[2] A non-publication order regarding proceedings before another body has been raised. Despite a request for a copy of that order, none has been provided at the date of this determination. To avoid any prejudice to Dr Emmerson, the non publication order covers these proceedings as well.

Employment Relationship Problem

[3] Dr Emmerson claims the NDHB unjustifiably disadvantaged her during her employment and then unjustifiably dismissed her on 21 May 2015.

[4] NDHB denies disadvantaging Dr Emmerson. It submits the Authority does not have jurisdiction to investigate her disadvantage grievance because she failed to raise this grievance within 90 days; it does not consent to the grievance being raised late; and there are no grounds to grant leave to raise it out of time.

[5] NDHB submits it justifiably dismissed Dr Emmerson because her actions in prescribing controlled Class B drugs to her de facto partner BM was serious misconduct. It also says the dismissal of Dr Emmerson was procedurally and substantively justified because her actions destroyed any trust and confidence in her to act appropriately.

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1 *Emmerson v Northland District Health Board* [2016] NZERA Auckland 33.

Agreed Facts

[6] Dr Emmerson is a former lawyer. She graduated with Bachelors of Commerce and Law in 1996 and practised law in Whangarei for eight years. She then decided on a career change and enrolled at Otago University to study medicine.

[7] Dr Emmerson returned to Whangarei in 2011 to complete her medical studies. She interned then was employed by the NDHB in December 2012 as a house surgeon at the Whangarei Public Hospital.

[8] In March 2014 Dr Emmerson started working at the Tumanako Unit for mental health and addiction services. By 28 July 2014 she had been promoted to Psychiatric Registrar. Her job involved managing the physical and mental health of patients, including prescribing controlled drugs and psychotropic medications. Her supervisor was Dr B.

[9] In March 2014 Dr Emmerson separated from her de facto partner, BM. During the separation BM used methamphetamine to cope. They subsequently reconciled.

[10] Around this time Dr Emmerson began providing medical treatment to BM. Between 31 March 2014 until 1 March 2015 she prescribed BM the following medications:

- 90 x 40 mg tablets of pantoprazole. Pantoprazole tablets are gastro-resistant tablets for oral use[2];

- 240 x 50 mg capsules of tramadol-hydrochloride, 90 x 40 mg tablets of pantoprazole, 30 x 125 mg tablets of clavulanic acid and salbutamol. Tramadol-hydrochloride is used to treat moderate pain.[3] Clavulanic acid is used for short term treatment of common bacterial infections.[4] Salbutamol is administered through a Ventolin Inhaler for the treatment of asthma, bronchitis and emphysema[5];

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2 http://www.medsafe.govt.nz/profs/datasheet/p/Pantoprazoletab.pdf.
3 http://www.medsafe.govt.nz/profs/datasheet/a/arrowtramadolcap.pdf.
4 http://www.medsafe.govt.nz/profs/datasheet/c/Curamtabsusp.pdf.
5 http://www.medsafe.govt.nz/profs/datasheet/v/VentolinCFC-freeinh.pdf.

- 7 day treatment of clavulanic acid;

- 120 x 60mg dihydrocodeine tartrate tablets with two repeat prescriptions for the same amount. Dihydrocodeine is a semi-synthetic narcotic analgesic with potency between morphine and codeine. It is used for the treatment of chronic pain.[6]

- 30 x 5mg tablets of diazepam. Diazepam is used for treatment of anxiety.[7] It is a psychotropic medication.

- 90 x 40mg capsules of omeprazole and 30 x 5mg tablets of diazepam. Omeprazole is used to treat reflux oesophagitis or reflux disease, acid-related dyspepsia and peptic ulcers.[8]

[11] In October 2014 Dr Emmerson prescribed medication for her defacto partner's mother. This included 240 x 50 mg capsules of tramadol-hydrochloride and 10 x 100mg tablets of doxycycline. Doxycycline is a broad spectrum antibiotic.[9]

[12] All previous prescriptions had been written upon Dr Emmerson's own prescription pad. However in April 2015 this changed.

Controlled Drug Prescription

[13] On 20 April 2015 Dr Emmerson went to the controlled drugs room area in the Tumanako Unit. She spoke to N1, a Registered Nurse stationed nearby. N1 accompanied Dr Emmerson into the secure controlled drugs room. Dr Emmerson entered information into the controlled drugs register. N1 co-signed the register. Dr Emmerson left the room, returned and entered further information into the register. She then removed the controlled drugs script number 6683961. Dr Emmerson also spoke to N2, a Clinical Nurse Educator.

[14] The controlled drugs script was the property of the NDHB. The script was issued by the Ministry of Health and sequentially numbered. The use and information requirements for obtaining controlled drugs are set out in the Misuse of Drugs Act 1975 and its regulations.

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6 http://www.medsafe.govt.nz/profs/datasheet/d/DHCContinustab.pdf.
7 http://www.medsafe.govt.nz/profs/datasheet/a/ArrowDiazepamtab.pdf.
8 http://www.medsafe.govt.nz/consumers/cmi/l/losec.pdf.
9 http://www.medsafe.govt.nz/profs/datasheet/d/Doxytab.pdf.

[15] The same day Dr Emmerson used the controlled drugs script to prescribe her de facto partner BM 10 x 60mg tablets m-Eslon morphine SR and 20 x 20mg tablets of severodol. Both are class B controlled drugs[10] prescribed for the relief of both acute and chronic severe pain.[11]

Concerns raised

[16] Twelve allegations about Dr Emmerson came to the attention of the Clinical Director, Dr A. Dr A sent an email to John Wade, Group Manager Mental Health and carried out an investigation of the allegations. Dr A reported the findings to Mr Wade and Kim Tito, General Manager Maori Health Mental Health and Addiction Services.

[17] Mr Wade consulted Mark Stroud from the Human Resources Department. They determined Mr Wade would approach Dr Emmerson the following day about the allegations. The Residential Doctor's Union representative (RDU rep) was asked to be present.

[18] On 24 April 2015 Mr Wade went to the Tumanako Unit and asked Dr Emmerson to accompany him to a human resources meeting. The RDU rep and Mr Stroud were there. It was agreed Dr Emmerson would be placed upon paid leave while the matter was investigated. She collected her property and left the same day. A copy of the email setting out the concerns and later a copy of the minutes was given to Dr Emmerson.

[19] Later that afternoon Mr Wade received a call from the Nurses Union representative (NU rep). The NU rep advised that the nurse complainants in respect of 11 allegations were not prepared to support an investigation of those matters. A decision was made to only investigate the taking of the controlled drug script.

[20] On 29 April 2015 the Acting Clinical Nurse Specialist interviewed N1 and N2 regarding the events surrounding Dr Emmerson's removal of the controlled drugs script. Those interview notes were provided to Messrs Tito and Wade. They were not provided to Dr Emmerson.

[21] Mr Wade wrote to Dr Emmerson on 29 April 2015 advising the list of concerns had been revised. It was now alleged she had breached the NDHB

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10 Schedule 2 Misuse of Drugs Act 1975.

11 http://www.medsafe.govt.nz/profs/datasheet/s/Sevredoltab.pdf.

Disciplinary Policy and Code of Conduct by obtaining a controlled drug script, recorded "1 x 1 To sub acute" with illegible writing in the register then completed the script for controlled drugs for her de facto partner BM.

Investigation Meeting

[22] An investigation meeting was held on 6 May 2015. Dr Emmerson attended with her lawyer AJ. Messrs Wade and Stroud attended together with the NDHB solicitor, David Grindle. A copy of the Minutes was provided to AJ.

[23] On 12 May 2015 Mr Grindle wrote to AJ advising the NDHB believed her conduct constituted serious misconduct and wished to meet for the purposes of a disciplinary investigation.

Disciplinary Investigation

[24] On 14 May 2015 Dr Emmerson and AJ met with Messrs Grindle, Wade and Stroud. Kim Tito also attended for the first time. Mr Tito was the NDHB decision maker. Mr Stroud took minutes. No copy of the minutes was provided to Dr Emmerson until after dismissal.

[25] Mr Grindle wrote to AJ on 19 May 2015 advising a preliminary decision to dismiss Dr Emmerson. This was on the grounds she:

- failed to meet her professional responsibility to understand the guidance provided in Coles Medical Practice in New Zealand (Coles) and the Medical Council of New Zealand (MCNZ) standards;

- prescribed controlled drugs to her partner in breach of Coles and the MCNZ standards and had been doing this for over a year, which was an aggravating factor;

- breached NDHB Medication Prescribing Policy which references the 2010 MCNZ standards on Good Prescribing Practice;

- misappropriated hospital property, being script number 6683961 in circumstances when she knew or ought to know that the use of hospital scripts was not for administering drugs to non-patients who are relations; and

- breached the actual and implied terms of her employment which require her to conduct herself in the best interests of NDHB.

[26] The parties arranged to meet at Mr Grindle's offices on 20 May 2015 at 11 am. At 8am AJ emailed and later spoke to Mr Grindle seeking to change the date to 22 May. There was no agreement to the date change.

[27] Around 11am AJ telephoned Mr Grindle in Dr Emmerson's presence. Messrs Stroud and Tito were present with Mr Grindle during this telephone conversation. Mr Grindle took notes but no formal minutes were produced.

[28] Mr Grindle wrote to AJ on 21 May 2015 advising amongst other things the decision to dismiss would be confirmed and NDHB intended dismissing Dr Emmerson by close of business that day. AJ replied advising that the NDHB position was not accepted and noting Dr Emmerson was to be dismissed at close of business 21 May 2015. Mr Grindle wrote again that same day confirming her dismissal.

[29] On 25 May 2015 Dr Emmerson raised personal grievances including unjustified dismissal and disadvantages.

Issues

[30] The following issues are for hearing:[12]

(a) Were the unjustified disadvantages raised with the employer within 90 days?

(b) If not, should leave be granted to raise these personal grievances out of time?

(c) Was Dr Emmerson unjustifiably dismissed?

(d) If so, should she be reinstated to her former position?

Were the unjustified disadvantages raised with the employer within 90 days?

[31] Dr Emmerson alleges she was unjustifiably disadvantaged in her employment by a course of bullying by Drs A and B together. She was twice directed to file particulars about the disadvantages grievance including the dates and details of these

[12] Minute of the Authority dated 10 December 2015.

doctors' actions.[13] An amended statement of problem was filed on 1 July 2016. It alleged the last bullying incident occurred on an unspecified date in December 2015. This cannot be correct because she was dismissed by 21 May 2015 and the personal grievance of bullying by Dr B was raised on 25 May 2015. No grievance of bullying by both Drs A and B together has been formerly raised with the NDHB.

[32] A grievance is raised as soon as the employee has made, or has taken reasonable steps to make, the employer aware that the employee alleges a personal grievance that he or she wants the employer to address.[14] The onus is upon the employee to raise the grievance within 90 days. What is important is that the employer is made sufficiently aware of the grievance to be able to respond as the legislative scheme mandates.[15]

[33] Even if the intended date was in 2014 and the last bullying incident was taken as 31 December 2014, the 90 day time limitation expired on 31 March 2015.

[34] Bullying by Drs A and B was first raised in Dr Emmerson's evidence filed in the Authority on 20 November 2015. This was 234 days outside of the 90 day time limitation. Given there is no consent, leave to raise the grievance is required.

Should leave be granted to raise these personal grievances out of time?

[35] The Authority may grant leave if it is satisfied that the delay in raising the personal grievance was occasioned by exceptional circumstances and considers it just to do so.[16] Some exceptional circumstances are set out in s115 of the Act. Generally exceptional circumstances are "*out of the ordinary course, or unusual, or special, or uncommon*"[17].

[36] There was no evidence of any exceptional circumstance or that the interests of justice warrant the grant of leave. The application for leave and the application for personal grievances of unjustified disadvantages are dismissed.

Was Dr Emmerson unjustifiably dismissed?

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13 Minutes of the Authority dated 10 December 2015 and 8 March 2016.
14 Section 114(2) Employment Relations Act 2000 (Act).
15 *Creedy v. Commissioner of Police* [2006] ERNZ 517 (EmpC) at [36]
16 Section 114(4) of the Act.
17 *Creedy v Commissioner of Police* [2008] NZSC 31, [2008] 3 NZLR 7, [2008] ERNZ 109 at [31] to [32] Supreme Court applied the definition of "exceptional circumstances" per Lord Bingham of Cornhill in *R v Kelly* [2000] QB 198; [1999] 2 All ER 13

[37] It is accepted Dr Emmerson was dismissed. The onus falls upon her employer to prove whether its actions were what a fair and reasonable employer could have done in all the circumstances at the time.[18] Having regard to the resources available, the employer must prove it sufficiently investigated the allegations, raised the concerns with the employee, gave the employee a reasonable opportunity to respond and genuinely considered the employee's explanation prior to dismissal.

[38] A breach of the term of trust and confidence implied into every employment agreement by an act of serious misconduct may justify dismissal.[19] However there must not only be good cause to dismiss, but also the manner in which the dismissal is effected must be fair.[20]

[39] It is not necessary for an employer to be satisfied that an employee who breaches policy or a code of conduct has done so deliberately with *mens rea* or criminal intent. It is bound to investigate fully to establish why it occurred.[21]

[40] A dismissal is not unjustifiable if the procedural defects were minor and did not result in the employee being treated unfairly[22].

Serious misconduct

Could the employer have concluded Dr Emmerson knew or ought to have known her prescribing to BM was in breach of Coles and MCNZ standards?

[41] There is no doubt Dr Emmerson was more experienced than a junior doctor. She was a qualified lawyer with eight years' legal experience in criminal, family and employment law. She had been appointed to the position of Psychiatric Registrar for 1 year after 3½ years as a house surgeon. Her role required a high level of trust and confidence in her prescribing practices.

[42] Dr Emmerson admitted knowing the risks of prescribing to her de facto partner because of possible manipulation. She also knew prescribing controlled drugs was different from what she had done before.

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18 Section 103A(2) of the Act.

19 *Kereopa v Go Bus Transport Ltd* (2009) 7 NZELR 4 (EmpC) at [26].

20 *Hardie v Round* [2009] NZCA 421 at [22].

21 *Angel v Fonterra Co-operative Group* [2006] ERNZ 1080 (EmpC) at [81] citing *Wellington Road Transport IUOW v Fletcher Construction Co Ltd* [1983] ACJ 656 (*Hepi* case).

22 S103A(5) of the Act.

[43] Despite these concerns, she took no steps other than to read an outdated 2009 edition of Coles Medical Practice in New Zealand.[23] This did not sanction prescribing to her de facto partner. It stated "wherever possible, avoid providing medical care to anyone with whom you have a close personal relationship". It also referred to the MCNZ standard on *Providing care to yourself and those close to you* (MCNZ standard).[24] This MCNZ standard stated you "must not" prescribe to those close to you any drugs of dependence and psychotropic medication. She alleges she did not read this MCNZ standard due to naivety. I reject that submission especially given her legal experience. At best these failures were negligent.

[44] Dr Emmerson accepts she prescribed morphine and severodol to BM. These are drugs of dependence. She also accepted prescribing to BM diazepam - a psychotropic medication.

[45] Despite the above, Dr Emmerson alleged her prescribing still fell within the MCNZ standard. The MCNZ standard allowed treatment in "an urgent situation" until another doctor is available.[25] If urgent care is required, details of the consultation must be recorded. Dr Emmerson refused to produce BM's patient consultation notes due to an alleged breach of privacy. Consequently there was no evidence to support her belief she was able to prescribe BM drugs of dependence or psychotropic medications. It also gave the impression she had something to hide by this behaviour.

[46] The MCNZ standard also provides if urgent care is given, the care of the patient is to be monitored by another doctor. BM's admitted methamphetamine use should have signalled she take this precaution to avoid any possible manipulation. She never made a referral to another doctor or sought another doctor to monitor her treatment of BM. I reject the submission her prescribing fell within the MCNZ standard.

[47] Her prescribing to BM for 12 months and prescribing for her partner's mother indicated a propensity for her to prescribe without regard to policies and guidelines. It was open to her employer to reasonably conclude she knew or ought to have known prescribing to BM breached Coles and MCNZ standards.

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23 ABD at p148.

24 Respondent Bundle of Documents (RBD) MCNZ Statement on *Providing care to yourself and those close to you* 1 June 2013.

25 RBD MCNZ Statement *Providing care to yourself and those close to you* 1 June 2013.

Could the employer reasonably conclude she misappropriated the controlled drug script?

[48] Dr Emmerson admitted she did not seek authority to remove the controlled drug script and BM was not a patient at the hospital. There is no logical reason to remove the controlled drugs script in those circumstances.

[49] I have viewed the entry made by Dr Emmerson. Under "name of patient" the words "1 x subacute" have been crossed out and replaced with letters and numbers that appear to have been scribbled over. I understand this is BM's National Health Index (NHI) number. The controlled drugs register required that entries not be obliterated, cancelled, or altered consistent with the Misuse of Drugs Regulations 1977.[26]

[50] Dr Emmerson alleges she did not properly read the register. I do not accept this because of her conduct. She set about creating a false impression the controlled drugs script was for a patient in the hospital. She told N1 the script was for her partner and wrote "1 x subacute" in the register. This entry would have given N1 the false impression BM was a hospital patient. She then falsely told N1 that N2 had authorised the removal of the controlled drug script. This was instrumental in N1 agreeing to co-sign the register at all. She then returned and altered that entry after N1 had co-signed.

[51] There was no logical reason for entering BM's NHI number under "name of patient" as required by the register, other than concealment of his identity.

[52] N2 confirmed Dr Emmerson falsely told her the script was for a patient at the hospital. This was confirmed in the RDU rep notes from the 24 April 2015 meeting.[27] Dr Emmerson circled "4" on the controlled drugs script, meaning the script was for a hospital patient only.[28] BM was not a hospital patient. All of this was deliberate and misleading behaviour. It strongly suggests Dr Emmerson was attempting to conceal BM's identity because she knew she did not have the authority to take the controlled drugs script. There was sufficient evidence to conclude this was an act of misappropriation.

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26 Regulation 40 Misuse of Drugs Regulations 1977 requires all entries in the controlled drugs register to legibly and indelibly, include the particulars indicated in form 1 of Schedule 1.

27 ABD at p1 Union representatives notes of meeting 24 April 2015 confirm Dr Emmerson said "patient" to N2.

28 RBD at p 192 "Writing Controlled Drugs Prescriptions" Controlled Drugs Policy.

Could the employer reasonably conclude Dr Emmerson failed to meet her professional responsibility to understand the guidance provided in Coles and the MCNZ standards?

[53] I reject her submission NDHB failed to train her in its policies, Coles and the MCNZ standards. Her letter of appointment contained an expectation she adhere to (and therefore be aware of) the NDHB policies and procedures[29].

[54] I accept the Chief Medical Officer's, Dr Micheal Roberts, evidence every doctor has an individual responsibility to maintain their own knowledge of Coles and MCNZ standards to demonstrate they are competent and fit to practice medicine. The statutory mechanism for monitoring competency is the MCNZ.[30] It registers doctors and sets professional standards. Dr Emmerson was aware of this because she has previously stated it is the responsibility of competent doctors to be familiar with the MCNZ standards.[31]

[55] I also reject her submission that her failures were brought about by a lack of supervision. This was raised after dismissal and does not outweigh her professional responsibilities as stated above.

Was there evidence of any culture of self-prescribing and prescribing to colleagues and family within the hospital?

[56] There was no evidence to support this allegation. Every witness, including Dr Emmerson was well aware prescribing to those close to you was not condoned. All of the respondent witnesses, many of whom were experienced medical practitioners and nurses, denied any such culture within the hospital.

[57] Dr Emmerson gave three examples of this alleged culture. The first example was Dr B prescribing a single dose of diazepam to her father following his referral twice to the Whangarei Hospital Emergency Department. This was materially different to what Dr Emmerson did. Dr B reported the incident to the Unit Manager and Dr A. The prescribing was also reviewed by two other medical specialists.[32] Dr

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29 RBD at p345.

30 Health Practitioners Competence Assurance Act 2003.

31 Brief of evidence K Tito dated 18 December 2015 at para 13 sworn 14 July 2016; Applicants Bundle of documents (ABD) at p30.

32 Brief of evidence L Emmerson sworn 25 January 2016 at para 29; Brief of K Tito sworn 14 July 2016 at para 9-10.

Emmerson complained about Dr B to the MCNZ. The MCNZ was satisfied with Dr B's response and no further action was taken.[33]

[58] The second example alleged Dr X self-prescribed over the counter medications and antibiotics.[34] There was no evidence to support this allegation. Dr X denied any inappropriate prescribing. He also did not prescribe drugs of dependence in breach of the MCNZ standard.

[59] The third example was a general allegation of unnamed doctors self-prescribing and prescribing for work colleagues. There was no evidence other than submission to support this allegation. The NDHB was entitled to set the allegation aside.

[60] Even if there was any such culture, it did not remove her personal and professional responsibility to know and adhere to the guidelines and standards relevant to her prescribing to BM.

[61] There was sufficient evidence for the NDHB to conclude Dr Emmerson had committed serious misconduct.

Were the employer's actions leading to dismissal fair and reasonable in the circumstances?

Did the employer properly investigate the concerns?

[62] The investigation was carried out by a combination of Mr Wade and Dr A. Dr A reported to Messrs Wade and Tito. There has been no suggestion the NDHB failed to properly investigate the concerns before dismissal took place.

[63] There was an allegation Mr Wade behaved inappropriately in seeking Dr Emmerson out during a staff meeting on 24 April 2015. I reject that submission. There was no evidence he was acting in bad faith or intended to cause any unfairness to her by his actions on 24 April.

[64] I reject her submission the NDHB was required to obtain independent advice about her breaches of the MCNZ standards as part of the investigation process. Dr

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33 Third Brief K Tito sworn 14 July 2016 at [13].

34 Brief of evidence L Emmerson sworn 25 January 2016 at para 31; Brief of evidence K Tito sworn 14 July 2016 at para 18.

Michael Roberts, Chief Medical Officer provided this advice to Mr Tito which was replicated in the correspondence.

[65] Omitted from published version. Subject to non publication order.

[66] Omitted from published version. Subject to non publication order.

Were those concerns raised with Dr Emmerson?

[67] No issue has been taken with the raising of the concerns before dismissal.[35]

Was Dr Emmerson given an opportunity to be heard?

[68] Dr Emmerson met with the NDHB on 24 April, 6 and 14 May 2015. She witnessed a telephone call between Mr Grindle and her lawyer on 20 May 2015. She alleges Mr Grindle punitively cancelled the last face to face meeting because of her Facebook postings. She also alleged a lack of clarity about Mr Tito's decision making role and unfairness by his failure to ask her any questions.

Was the meeting on 20 May 2015 cancelled?

[69] I accept Mr Grindle's evidence supported by emails[36] that he was unaware of any Facebook posting until 2 June 2015 - well after the dismissal had occurred. Mr Grindle is an experienced employment lawyer. He understood the consequences for his client of him punitively cancelling a disciplinary meeting. There was no evidence he would be motivated to do so at all. Messrs Tito and Stroud had attended his offices for the purpose of attending a face to face meeting on 20 May 2015.

[70] Dr Emmerson alleged Mr Grindle cancelled the meeting based upon her one sided observation of her lawyer's telephone call to Mr Grindle. She did not summons her lawyer to appear nor produce her file or her lawyers filenotes to support this allegation.

[71] None of the parties' subsequent correspondence including the personal grievance letter[37] refers to any cancellation of a meeting by Mr Grindle. I accept Mr Grindle's evidence the telephone call on 20 May had taken place of any further

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35 Minute of the Authority dated 8 March 2016.
36 RBD at 335-338; Brief D Grindle sworn 12 July 2016 at para 45-46.
37 RBD at pp 310 -334.

meeting that had been proposed.[38] I reject the submission Mr Grindle punitively cancelled any meeting.

Was Mr Tito's role as decision maker unclear?

[72] I reject this submission. The correspondence makes it clear Mr Tito was the decision maker. There was no complaint until hearing that Dr Emmerson was unaware of this. The other attendees were clear Mr Tito's role was explained at the beginning of the disciplinary meetings.

Was Mr Tito's failure to ask questions unfair or unreasonable?

[73] I see nothing in Mr Tito's failure to ask questions on 14 and 20 May 2015 that created unfairness for Dr Emmerson. The opportunity to be heard does not have to be so formal that it is in the nature of a trial.[39] The opportunity to be heard means that the employee should have a chance to explain his or her actions, and this should be properly considered by the employer before any decision to dismiss is made.[40] Mr Tito is required to listen to and consider her responses. He is not necessarily required to do more. There was no suggestion he did not listen to or read what she provided.

Was there genuine consideration of Dr Emmerson's responses?

[74] Dr Emmerson submits there was prejudgment by Mr Tito because he took account of incorrect or unreliable matters such as the adverse performance review, misunderstood her anecdotal examples about Drs B and X and was prejudiced by viewing the original 12 allegations.

[75] Mr Tito is an experienced manager with 44 years in the health system. He admitted he was aware of her performance concerns. I accept his evidence he was able to put it aside.

[76] The evidence does not show Mr Tito misunderstood Dr Emmerson's concerns about Drs B and X. She simply disagreed with his conclusions.

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38 See above at para.32.

39 *Airline Stewards and Hostesses of New Zealand IUOW v Air New Zealand Ltd* [1982] ACJ 1.

40 *Cherrington v New Zealand Post Ltd* EmpC Auckland AC32/05, 28 June 2005 at [68].

[77] I accept Mr Tito was able to put aside his knowledge of the 11 allegations that were not being pursued. There was nothing to suggest Mr Tito was unable to do so other than speculation.

Breaches of Good Faith

[78] In addition to s.103A(3) of the Act, there are good faith obligations placed on an employer who is considering making a decision that may adversely impact on an employee's ongoing employment. Section 4(1A) of the Act requires an employer to provide the potentially affected employee with all relevant information and an opportunity to comment on it before the employee is dismissed.

[79] The failure to provide the relevant information from Dr A's investigations into the concerns about Drs B and X, the 14 May Minutes and the interviews with N1 and N2 before dismissal were breaches of good faith. As no penalty action is sought, no remedy for the proven breaches of good faith can be given.

[80] These breaches are also procedural defects. This does not mean there is a finding of unjustified dismissal. Section 103A(5) requires an examination of the circumstances to determine whether the procedural defects were minor and did not cause unfairness.

[81] Although I originally gave an oral indication these defects caused unfairness, I have had time to consider the submissions made to me following the oral indication and reflect further on the evidence below.

Does s.103A(5) of the Act apply?

[82] **Failure to provide information of Dr A's investigations into Drs B and X:** Given my above findings Dr B's and Dr X's allegations were materially dissimilar or lacked evidence, this defect could not cause any unfairness.

[83] **Failure to provide N1 and N2 interviews:** Dr Emmerson was present with N1 and N2 and able to give her account of events. The substance of the interviews with N1 and N2 was put to Dr Emmerson for comment in the correspondence and meetings. At hearing she did not greatly dispute what either nurse had to say. She simply disagreed that her actions were wrong. This defect did not cause unfairness to her.

[84] **Failure to provide 14 May 2015 minutes:** Dr Emmerson was present at the 14 May meeting. At hearing her submissions about inaccuracy did not take any issue with what was recorded. Rather she wished to produce more evidence about the matters set out therein in support of her case. The respondent's consideration of her responses from that meeting in the Minutes was conveyed to Dr Emmerson in its subsequent correspondence dated 19 and 21 May 2015. She was given opportunities to respond at the 20 May teleconference meeting and did so. This was not unfair to her.

[85] Given my finding of serious misconduct, the above procedural defects were minor. Therefore s103A(5) of the Act applies. The procedural defects were minor and did not cause unfairness. The application for a personal grievance of unjustified dismissal is dismissed.

[86] I am not required to consider reinstatement or any other remedies because the dismissal was justified.

[87] Costs are reserved. If either party seeks an order for costs a memorandum shall be filed and served within 14 days from the date of this determination. The other party shall have 14 days from receipt to file and serve a reply.

T G Tetitaha
Member of the Employment Relations Authority