New Zealand Employment Relations Authority Decisions

Lewers v Northland District Health Board (Auckland) [2011] NZERA 461; [2011] NZERA Auckland 303 (12 July 2011)

Last Updated: 5 August 2011

Note: An order prohibiting the publication of certain information is found at para [108] of this determination

IN THE EMPLOYMENT RELATIONS AUTHORITY AUCKLAND

[2011] NZERA Auckland 303 5318515

BETWEEN

NATALIE LEWERS Applicant

AND

NORTHLAND DISTRICT
HEALTH BOARD
Respondent

Member of Authority: Representatives:

Investigation meeting:

Additional information provided:

R A Monaghan

A Schirnak, counsel for applicant

5. Dench, counsel for respondent

24 and 25 March 2011 at Whangarei

6. April 2011

Determination:

12 July 2011

DETERMINATION OF THE AUTHORITY

Employment relationship problem

[1] Natalie Lewers says her former employer, Northland District Health Board (NDHB), first suspended then dismissed her unjustifiably following a breach of policy on her part. She seeks reinstatement and other remedies.

[2] The NDHB says both the suspension and the dismissal were justified.

Background

[3] The NDHB employed Ms Lewers as a public health nurse. Ms Lewers worked in a public health team whose responsibilities included carrying out immunisation programmes for students at schools in the Whangarei and Kaipara area.

She is a highly qualified and experienced nurse, having completed certain nursing qualifications to 'expert' level as well as several post graduate papers, and being about to complete a master's degree in nursing.

1. The 24 August incident

[4] Ms Lewers' dismissal followed an incident at a Whangarei secondary school on 24 August 2010. A team comprising Ms Lewers, three other public health nurses (PHNs) and two students attended the school that morning in order to administer the HPV vaccination.

[5] The necessary equipment was packed into a van which Ms Lewers and one of the three PHNs drove to the school. Ms Lewers was the site co-ordinator. That role included the assignment of duties for the day to the rest of the team. She said she asked the team to unpack the van while she attended to calling the students who were to be vaccinated. Meanwhile team members set up vaccination stands and the recovery and Adverse Events Following Immunisation (AEFI) stations in the main hall of the auditorium. I do not detail those events any further because they may be relevant to other personal grievances awaiting investigation, but they are not relevant to Ms Lewers' dismissal.

[6] Twelve students were to be vaccinated. They arrived at the auditorium and preparations for their vaccination continued.

[7] The nurse assigned to the AEFI station and who was responsible for setting it up, Sophie Adamson, could not find the required 'crash' kit. The kit should have been packed in the van for transport to the school, but was not there. It contained emergency equipment and should have been in a large plastic box marked for use in the AEFI area. The emergency equipment was necessary for the response to any anaphylactic reaction to the vaccination. Anaphylactic reactions are treated by the immediate administering of adrenaline, with oxygen also being administered to assist with breathing if there are respiratory problems. Accordingly the crash kit included adrenaline, syringes, needles, tools for keeping airways open, and the ambu-bags used to move air into the lungs when assisted breathing was necessary. The kit also included a regulator for the oxygen cylinder which was part of the emergency equipment.

[8] Ms Adamson left to obtain a crash kit, and advised Ms Lewers she was doing so. Ms Lewers decided that vaccinating should commence without the crash kit. The reasons she gave in evidence were:

. about an hour remained before the school needed the auditorium to be

vacated, and scheduling constraints meant that morning was the only time

available for the administration of those particular vaccinations;

. the vaccinations were the third in the series of vaccinations, and none of the

students to be vaccinated had experienced an adverse effect during the earlier

vaccinations;

. in the unlikely event that a student experienced an adverse effect this time,

three EPI pens containing adrenaline were available in the adjacent student

health centre for the treatment of any student who needed adrenaline;

. a medical centre was located less than 1 km away;

. Ms Adamson was likely to return in no more than 10 minutes; and

. overall, staff could be deployed and adrenaline could be obtained and

administered quickly if necessary.

[9] Ms Lewers also said in evidence that, as an expert nurse - with her vast knowledge, experience and skill - she was able to assess the level of risk to the students and determine an appropriate course of action. At the time she assessed the risk to be very very low. Vaccinating began.

[10] Within a few minutes Michelle Thomson, a senior PHN who was present at the school but not as a member of the vaccinating team, entered the auditorium. Ms Lewers informed Ms Thomson that vaccinations had started without a crash kit.

[11] It was common ground that the conversation included: Ms Thomson's comment to the effect that vaccination would not have been done that way where Ms Thomson had worked before; and her comments on the availability of an ambulance service and the medical centre down the road. Ms Lewers and Ms Thomson disagreed about whether for her part Ms Lewers commented on her experience that vaccinating went ahead without resuscitation equipment when she worked in Saudi

Arabia, and expressed the view that there was an over-reaction in New Zealand. They also disagreed over the extent to which, if at all, Ms Thomson went further than commenting on alternative sources of emergency support and indicated that the arrangement was satisfactory.

[12] Whichever account is more accurate, commencing vaccinations without a crash kit was acknowledged to be a very serious matter and not in accordance with fundamental and very well-known requirements I detail later in this determination. Ms Lewers was seeking to suggest Ms Thomson either condoned or at least did not object to the decision to commence, and said she felt reassured by Ms Thomson's reaction. However not only was Ms Lewers the site co-ordinator but she had taken pains to emphasise the extent of her knowledge, experience and expertise. In the light of that her statement that: 'I *thought to myself that if there had been any real risk, Michelle would have intervened and told me to stop'* was unconvincing.

[13] Another aspect of the exchange concerned Ms Lewers' acknowledged request of Ms Thomson not to say anything about the incident to Meryll Frear, the clinical nurse manager and Ms Lewers' immediate manager. Ms Lewers explained the request in her evidence by saying she - as well as two colleagues who were doing the vaccinating - felt intimidated by Ms Frear, and she was wary of how Ms Frear would react. She put the point more colloquially in her oral evidence, saying her concern was that if Ms Frear found out 'we *are done'*. I also found that explanation unconvincing. Later in this determination I discuss the allegations of bullying by Ms Frear which led Ms Lewers to take such a view of the repercussions if Ms Fear was made aware of the incident. For present purposes I observe that Ms Lewers' actions were so plainly in breach of procedure, and she knew it, that she should have expected any manager at least to be seriously concerned about them if they became known. Saying she felt reassured in that respect by Ms Thomson's response was again unconvincing from someone of her seniority and experience.

[14] Ms Thomson's explanation of her acknowledged failure to attempt to stop the vaccinating was: *'Natalie comes with quite a reputation and I did not feel like disagreeing with her or creating a scene.'* That was a reference to a view held by several of the NDHB's witnesses to the effect that Ms Lewers herself could be forceful and even intimidating. Further to her own role in the incident, Ms Thomson also said during the subsequent disciplinary investigation and to the Authority that she knew what had happened was unacceptable and she regretted not standing up to Ms Lewers. However, she reported the incident to Ms Frear on the afternoon of 24 August, and prepared a written incident report.

[15] Up to 5 or 6 students had been vaccinated by the time Ms Adamson returned with the crash kit. None of those students experienced an adverse reaction.

[16] Ms Adamson said in evidence it had never occurred to her that Ms Lewers would go ahead without the crash kit. However since there were students present she did not wish to make a scene, and proceeded to the AEFI area to set up the equipment. She said that Ms Lewers followed her over, and asked whether anyone at the office had seen her or whether she had told anyone there was no crash kit at the school. Ms Adamson replied that she had been seen and she did advise of the lack of a crash kit. She also said that Ms Lewers commented there was no point in setting up the equipment, and referred to her extensive experience in vaccinating without there being an anaphylactic reaction.

[17] Ms Lewers denied making those comments to Ms Adamson. However her acknowledged request of Ms Thomson not to report the matter leads me to consider it likely she sought to test with Ms Adamson the possibility that the absence of the crash kit would become known, so I accept Ms Adamson's account. In addition the evidence Ms Lewers gave in the Authority regarding the significance of her qualifications and experience is similar in kind to the comment she was said to have made to Ms Adamson. On balance I accept Ms Adamson's account of that matter also.

[18] Ms Adamson spoke to Ms Frear about the incident later on 24 August. She said she delayed completing a formal incident report until the next morning because she feared Ms Lewers would hold a grudge and that it would be difficult to work with her.

[19] The respective incident reports assessed the incident as extreme risk and high risk. Ms Frear alerted her own manager Kathryn (Kath) Bowmar, the service manager, to the matter.

2. The suspension

[20] Ms Bowmar conducted the disciplinary procedure in her capacity as acting general manager during an absence of the general manager.

[21] At about midday on 25 August Ms Bowmar and Ms Freer met with Ms Lewers and the two nurses said to have commenced vaccinating without a crash kit being available. Ms Bowmar raised the possibility of suspension, but Ms Lewers denied there was also an offer of union representation which she declined. It was common ground that Ms Lewers stated almost immediately that she took full responsibility for the incident and apologised. Ms Bowmar responded that there was a process to go through and she would seek advice from human resources.

[22] There a further meeting at 2 pm, after Ms Bowmar had obtained advice. Ms Lewers and her colleagues were formally

advised of their suspensions on pay pending an investigation. The investigation procedure was outlined. All three nurses were concerned about whether they would lose their jobs, and Ms Bowmar repeated that there was a process to be followed.

[23] Ms Bowmar concluded suspension was appropriate because a serious breach of safety had been admitted, and she was concerned about the possibility of further breaches of safety if the nurses were distracted by the pending investigation. She was also concerned because she had received information that Ms Lewers had been trying to find out who reported the incident, and in her view Ms Lewers could be intimidating.

[24] The reference to Ms Lewers' efforts to find out who had reported the incident was based on information from Ms Frear to the effect that Ms Lewers had attempted to contact Ms Adamson. Ms Frear had warned Ms Adamson that Ms Lewers would be upset and angry and would try to contact her. Ms Lewers did try to contact Ms Adamson on 25 August. On Ms Frear's advice Ms Adamson did not answer the calls, and Ms Lewers simply left messages asking her to contact her. Ms Lewers also contacted other nurses to enquire about Ms Adamson's whereabouts. Ms Adamson said in evidence she felt hounded. She sent Ms Frear a text message confirming she had been contacted and ending with the word 'Scary'.

[25] Ms Lewers explained in evidence that she made the calls because Ms Adamson was part of the vaccinating team and she was concerned that Ms Adamson was also in trouble. She did not have an opportunity to provide this explanation at the time.

[26] Ms Lewers also telephoned Ms Thomson on the morning of 25 August. She asked Ms Thomson whether she had informed Ms Frear of the incident. When told that was the case, Ms Lewers reacted by asking whether Ms Thomson realised how much trouble Ms Thomson had got her into, said she thought they were *'a team'* and hung up. Ms Lewers explained in evidence she was hurt that Ms Thomson had not spoken to her before reporting the incident. Ms Thomson described this exchange in an interview after the suspension had been imposed, so it was not taken into account when the decision was made. It is, however, relevant to the extent to which Ms Lewers was concerned about the implications if the incident were reported.

[27] A letter dated 25 August 2010 confirmed the suspension and advised that the matter was considered serious and warranted further investigation. It also said:

Our next meeting is scheduled for Wednesday 1st September 2010 9 am.

3. The investigation

[28] Later on 25 August both Ms Adamson and Ms Thomson spoke to Ms Bowmar, and provided their accounts of the incident.

[29] On the morning of 26 August Ms Bowmar interviewed two student nurses who were observing the vaccinations on 24 August for training purposes. That afternoon Ms Bowmar spoke separately to Ms Lewers and the two nurses who had carried out the vaccinations.

[30] Ms Lewers gave Ms Bowmar an account of the chain of events on 24 August, which included an account of her conversation with Ms Thomson and the comment that Ms Thomson had not sought to stop her. She acknowledged she was wrong and explained that she was very busy. She made particular reference to being late because she had unexpectedly been obliged to provide transport for a student that morning, and said she had rushed. She did not mention that she had carried out a risk assessment, let alone provide the details subsequently provided to the Authority.

[31] Ms Bowmar sought advice from the NDHB's human resources advisor, Michael Gould, and the two agreed the matter should proceed to a disciplinary process.

[32] By letter dated 27 August 2010 Ms Lewers was asked to attend a meeting on 1 September 'to discuss the matter further'. The letter identified the areas of concern as being: the vaccination of 12[1] students at the high school knowing there was no emergency equipment available, and the request that Ms Thomson not inform the clinical nurse manager this had been done. The letter also offered the opportunity to bring a support person and said Ms Lewers would be given an opportunity to explain. It advised that:

... if the allegation of misconduct is established disciplinary action up to and including dismissal may be taken as a result of the outcome of this meeting.

[33] Ms Lewers did not advise that she had instructed a representative, but for her part on 30 August Ms Bowmar notified the New Zealand Nurses Organisation (NZNO or the union) of the date of the meeting. She also forwarded to the union copies of the incident reports and the statements taken during the investigation.

4. The disciplinary meeting

[34] A disciplinary meeting went ahead on 1 September 2010. Mr Gould and Ms Frear attended although Ms Bowmar ran the meeting. Ms Lewers attended with another nursing colleague Ruth Jarman, and a representative of the NZNO.

[35] Ms Bowmar opened by referring to the two incident report forms, naming the people to whom she had spoken during

her investigation, and noting that Ms Lewers had taken responsibility for continuing with the vaccinations in the knowledge that Ms Adamson had left to get the missing emergency equipment. She went on to discuss the protocols for school vaccination programmes, before referring to Ms Thomson's account of Ms Lewers' comments about her experience in Saudi Arabia and the request that Ms Frear not be informed of the incident. She also referred to Ms Adamson's account of the exchange with Ms Lewers regarding the need for the emergency equipment, and the query about whether Ms Adamson had been seen collecting the crash kit.

[36] Ms Lewers denied Ms Thomson's account of her remarks about Saudi Arabia and about New Zealanders overreacting, and denied telling Ms Adamson she had been carrying out vaccinations without safety equipment for a long time and there had been no anaphylactic reactions. She also denied asking Ms Adamson about whether anyone at the office saw her collecting the crash kit. There were further exchanges about whether her two colleagues were aware of Ms Adamson's departure, but that matter is relevant to their personal grievances so I take it no further here.

[37] Ms Bowmar went on to address the vaccination procedures and Ms Lewers' explanation that she was busy, before inviting Ms Lewers to speak.

[38] Ms Lewers responded that she agreed with the concerns, and acknowledged going ahead without the crash kit and that she was wrong. She said she was sorry and would follow protocol in the future. She also commented on the general lack of preparedness when she arrived at the school (having been delayed herself) and that *'it all just started rolling'.* Finally she made further reference to Ms Thomson's apparent condoning of her actions.

[39] Her union representative added that emergency facilities - referring to the local medical centre - were available a few minutes away. He also said that Ms Lewers had ' *some home things'* going on. Ms Jarman emphasised Ms Lewers' openness and honesty about the incident, her acknowledgement that the matter was serious, and that this was the first time Ms Lewers had faced disciplinary action.

[40] Ms Lewers had prepared letters of apology for the student nurses and for the DHB, which she gave to Ms Bowmar. The letters are full, open and frank acknowledgements of wrongdoing. Ms Lewers also spoke of her willingness to undergo supervision and retraining, and drew attention to the positive aspects of her employment history.

[41] Ms Lewers said in evidence that Ms Bowmar, Ms Frear and Mr Gould seemed unmoved by what she had to say. They were unwilling to enter into further discussion and it quickly became apparent to her that the purpose of the meeting was to advise the outcome of the investigation rather than to further it.

[42] The meeting was adjourned to allow a consideration of the response.

5. The decision to dismiss

[43] Ms Bowmar was the decision-maker. She believed that Ms Lewers had not provided any new information during the meeting, and noted Ms Lewers had admitted what she did was wrong and was remorseful. Ms Bowmar believed there was a question about whether Ms Lewers could be trusted again.

[44] In addressing that question she weighed up a number of matters. She assessed the possibility of training and supervision but concluded Ms Lewers' background and experience meant the problem was not one of a lack of training or a need for supervision. She said in evidence that she admired Ms Lewers for apologising, and part of her wanted to give Ms Lewers another chance. On the other hand Ms Lewers' action was very serious, it was deliberate, and Ms Lewers had attempted to cover it up by asking Ms Thomson not to report it. Ms Bowmar did not accept that any action or inaction of Ms Thomson's excused Ms Lewers.

[45] Accordingly Ms Bowmar formed the preliminary view that summary dismissal would be appropriate.

[46] When the meeting resumed Ms Bowmar advised of her preliminary view, and offered the opportunity to make further comment before the final decision was made. She also offered Ms Lewers an opportunity to think about the matter overnight, but

Ms Lewers declined. She replied that she had nothing to add, other than to repeat that she would not act that way again.

[47] Ms Lewers said in evidence she was told the mitigating factors she had raised - namely the time pressure she was under and her length of service without disciplinary action - would not be taken into account. Mr Gould and Ms Bowmar denied saying that, rather they indicated that the mitigating factors did not outweigh the seriousness of her conduct. I am unable to make a finding about the precise words used, but on the evidence I find the approach was to consider the mitigating factors and to conclude those factors did not excuse the conduct.

[48] There was another break during which it was suggested on behalf of Ms Lewers that her resignation be offered. Mr Gould had concerns about the lateness of the suggestion, and the possibility of a constructive dismissal being raised if it was accepted. Ms Bowmar also believed matters had gone too far to consider a resignation. Because there was serious misconduct

her decision was to proceed with a summary dismissal.

[49] This decision was confirmed in a letter also dated 1 September 2010, and prepared after the meeting had ended. The serious misconduct comprised the vaccination of the students knowing there was no emergency equipment available, and the request that Ms Thomson not advise Ms Frear of the incident.

The NDHB Code of Conduct and disciplinary procedures

1. The code of conduct

[50] The NDHB Code of Conduct applies to all employees. It opens by saying its purpose is to inform employees, and records that it set out agreed expectations as well as providing employees with a guide to the standards of behaviour required of them.

[51] The standards of behaviour include requirements that the employer's policies and procedures be complied with, and that duties be performed properly and safely.

[52] The code of conduct also states that, in distinguishing between misconduct and serious misconduct, regard should be given to the consequences or risks to which the conduct could expose the organisation, including to patients, clients or staff. Examples of the distinction between serious misconduct and misconduct are set out in appendix one of the NDHB's disciplinary policy. The provisions relied on here read in part:

1. Expected behaviour: compliance with the organisation's policies and standard procedures, including by laws and delegations

(a) Minor misconduct

(b) Serious misconduct

. Deliberate breaches of organisation policies and/or standard procedures and/or by-laws

7. Expected Behaviour: Perform duties properly and safely (a) Minor misconduct

(b) Serious misconduct

. Negligence, carelessness, indolence, inefficiency or incompetence in discharge of

his/her work which seriously affects quality of work or the efficiency of a service. . Sleeping ...

. Behaviour affecting or likely to affect the safety and/or cause injury to other

persons . Improper conduct ...

. Failure to observe posted or recognised safety procedures, working in an unsafe manner or failing to make proper use of safety equipment where such equipment is installed or provided.

2. Disciplinary procedure - Suspension

[53] The suspension provisions are found in part 6 of the disciplinary procedure. Relevant provisions include:

6.1 Definition

. Suspension is not, of itself, a disciplinary action, it is a step which may be taken in order to investigate whether or not disciplinary action is needed. Nevertheless the employee must be afforded all the procedural rights associated with a disciplinary interview before a decision to suspend is taken.

6.2 Use of suspension

Suspension is to be used only in serious cases where i[t] would be inappropriate in the circumstances for the employee to remain on duty.

Such circumstances shall be:

. the presence of the employee would be detrimental to the investigation

. the presence of the employee in the workplace is considered a risk to

themselves or the health and/or safety of others and there are no suitable

alternative duties available.

[54] Suspension is also referred to in part 4, which sets out the procedure for investigating incidents and occurrences. The relevant paragraph reads:

In some circumstances an employee may be suspended from duty on pay or transferred to other work while an investigation of misconduct is being investigated. Only a General Manager may suspend an employee and then only after a formal documented meeting has been held with the employee to consider whether suspension is warranted.

3. Disciplinary procedure - Dismissal

[55] Of the remainder of part 4, key provisions include:

The investigation should normally include:

. interviewing the employee and giving him/her a chance to explain

. interviewing other people, if appropriate. If there are witnesses to an alleged

breach they must be interviewed promptly before memories fade
. Checking records, or verifying facts by other means

When an employee whose conduct is in question is being interviewed he/she is to be:

. given prior written warning of the nature and subject of the

allegations being investigated;
. given the opportunity (during the interview) to explain the incident or

deny the occurrence

. at the end of the interview (or soon thereafter) given clear advice as to the

result of the interview, and of any conclusions reached. There must be an adjournment prior to this advice being given to enable the head of department/manager to consider the employee's explanation before making a decision

. given the opportunity to be accompanied at the interview by a representative [56] Part 7 is headed 'Dismissal'. Many of the provisions address the procedure to be followed once the decision to dismiss has been made. Otherwise relevant provisions include:

Dismissal of an employee is a serious matter and should occur only when the organisation is satisfied there is no other appropriate means of resolving the situation.

7.1 Methods: giving notice/summary dismissal

... a full investigation must be made and there must be sound reasons for the actions taken, in particular in accordance with the principles of fairness the employee must be allowed to state his/her reasons for the breach. .

7.4 Authority to dismiss

Only General Managers have the authority to dismiss an employee. No dismissal shall be effected without:

(a) ...

(b) Consultation with the Director of Nursing and Midwifery and/or ... where appropriate

[57] Part 2 sets out the general principles to be applied in the disciplinary process. They include requirements of impartiality, consistency and fairness which Ms Lewers says were breached.

Immunisation policies and procedures

1. The New Zealand Immunisation Handbook

[58] Nurses carrying out vaccinations must comply with the Ministry of Health's New Zealand Immunisation Handbook. Appendix 3 sets out immunisation standards.

[59] The standards refer to Chapter 2 of the handbook. The chapter defines anaphylaxis as:

. a very rare, unexpected and occasionally fatal allergic reaction. Anaphylaxis develops over several minutes and usually involves multiple body systems. .

In general the more severe the reaction the more rapid the onset. .

[60] Without rapid treatment anaphylaxis can progress to respiratory failure and death, although with rapid and appropriate treatment it is managed effectively.

Anaphylaxis on the delivery of a vaccine is rare, but it is well recognised. Further, it is a severe but eminently treatable condition, so despite its rarity it is vital to be prepared to manage it. This includes having the required emergency equipment available. The importance of proper management extends beyond the undoubtedly extreme implications for an individual of any failure to do so, to the public interest in that an outcome involving severe injury or death would seriously damage public and provider confidence in vaccination.

[61] A table sets out the initial response to or management of anaphylaxis, including the administration of adrenaline, together with oxygen in the case of breathing difficulties. The handbook also says about management:

There is no place for conservative management of anaphylaxis. Early administration of adrenaline is essential.

Remember: events happen without warning. Appropriate emergency equipment must be immediately at hand whenever immunisations are given, and all vaccinators must be familiar with the practical steps necessary to save life following an anaphylactic reaction.

[62] Regarding adrenaline, the handbook says:

Intramuscular injection of 1:1000 adrenaline is the preferred treatment of anaphylaxis and should be universally available when vaccinating.

[63] Expert evidence was given by Dr Nikki Turner, a qualified medical practitioner who holds a number of post graduate diplomas and a master's degree in public health, as well as a Fellowship of the Royal College of General Practitioners. She is also the Director of the Immunisation Advisory Centre (IMAC) at the University of Auckland, a senior lecturer at the university and a general practitioner in Wellington, and one of the authors of the handbook.

[64] Dr Turner had been provided with a copy of Ms Lewers' statement of evidence. She was careful not to comment on Ms Lewers' conduct other than to say that a risk assessment had been done when the standard regarding the availability of emergency equipment was set. I understood her to mean that considerations of the kind Ms Lewers referred to were taken into account when the standard was set, so that there was to be no scope for any further risk assessment such as the one Ms Lewers said she carried out.

2. Vaccination procedures

[65] Nurses who administer vaccines must hold a current Non-Medical Vaccinator Authorisation. Ms Lewers held such authorisation, dated 10 May 2010. To obtain the authorisation she had completed a training and audit process. A record of the assessment dated 20 April 2010 referred expressly to anaphylactic reactions, in particular to knowledge of the existence of a written protocol and of the need for suitable equipment for resuscitation.

[66] Several other NDHB documents re-stated relevant contents of the handbook. These included the 'Management of Anaphylaxis in Community Settings' which opened with the statement:

Every registered comprehensive (RCN) ... administering medications or vaccinations within a community setting must have emergency equipment at hand

[67] The 'Procedure for Year 7 Immunisation Programme' included:

8. Vaccination team to carry emergency drugs kit at all times [68] The 'Vaccination Day Guidelines' provided:

6. Ensure anaphylaxis equipment is set up

[69] From this and other related documentation it was clear that immunisation procedures were heavily emphasised and reinforced.

The justification for the suspension

[70] The test of justification for the suspension is whether suspension was the action a fair and reasonable employer would have taken in the circumstances at the time.

[71] The suspension provisions in the NDHB disciplinary procedures are relevant here. Two issues arose in respect of the way they were applied to Ms Lewers, namely whether:

(i) the procedure was in accordance with clause 6.1; and
(ii) suspension was warranted under clause 6.2.

1. The procedure under cl 6.1

[72] Clause 6.1 refers to the obligation to afford all of the procedural rights associated with a disciplinary interview before making a decision. That appears to be a reference to obligations located elsewhere in the procedure to: advise the employee of the allegation to be answered; offer an opportunity for representation; provide an opportunity to be heard on the matter - or here to be heard on whether a suspension should be imposed in the meantime; and consider the responses with an open mind. The reference would appear to include the *'formal documented meeting'* specified in part 4 of the procedure.

[73] There was a meeting, but its scope was limited and alternatives to suspension were not canvassed.

2. Circumstances warranting suspension under cl 6.2

[74] Clause 6.2 identifies two circumstances in which suspension may be used, in terms which can arguably be interpreted to mean suspension is limited to those two circumstances. The circumstances are that:

. the presence of the employee would be detrimental to the investigation; and . the employee's presence in the workplace is a risk to themselves and/or the health and safety of others, and there are no suitable alternative duties available.

[75] Regarding the first of these, since the incident had already been reported and Ms Lewers had not denied it I do not accept that Ms Lewers' continued presence in the workplace would be detrimental to the investigation.

[76] There are three limbs to the second of the circumstances where suspension may be warranted, and all three must be met. With reference to them, firstly I do not accept on the evidence that Ms Lewers' upset feelings were sufficient to amount to a risk to herself if she stayed in the workplace. Secondly, I do not accept that Ms Lewers' continued presence created a risk to the health and safety of others. To the extent that there were concerns about possible intimidation of colleagues, these had not been adequately enquired into. Thirdly, only very limited enquiry into the possibility of alternative duties was carried out. Ms Lewers had already been required to cease carrying out vaccinations and bicillins, and I am not persuaded that there were no other suitable alternative duties available.

3. Conclusion on the justification for the suspension

[77] Although breach of a disciplinary procedure may not necessarily lead to a conclusion that the associated disciplinary action was unjustified, I find that the breaches here were sufficiently substantial to warrant a finding that Ms Lewers' suspension was unjustified.

4. Remedy

[78] Ms Lewers seeks compensation for the injury to her feelings resulting from the unjustified suspension.

[79] I accept that she was very distressed during the whole of the disciplinary process. However, she was also guilty of significant contributory conduct so that there is no scope for a substantial award of compensation for the injury associated with her suspension.

[80] For these reasons the NDHB is ordered to compensate Ms Lewers for injury to her feelings in the sum of $3,000.

The justification for the dismissal

[81] The test of justification for the dismissal is whether dismissal was the action a fair and reasonable employer would have taken in the circumstances at the time.

[82] The existence of the conduct at the centre of the decision to dismiss was not disputed. This personal grievance has focussed on whether summary dismissal was the sanction a fair and reasonable employer would have imposed in response. Ms Lewers said it was not, because:

(i) the mitigating factors she raised were not listened to;
(ii) the outcome was predetermined;

(iii) Ms Frear had bullied Ms Lewers and was adversely disposed towards her;

(iv) there was disparity of treatment; and

(v) there were several procedural flaws, including in particular several breaches of the NDHB's disciplinary procedures.

1. Mitigating factors

[83] Ms Lewers said the mitigating factors she raised were not listened to or considered. I have found that the factors she raised were listened to, but were found not to outweigh the seriousness of her conduct.

[84] Further to that, in reliance on *White v Auckland District Health Board*[2] it was submitted that an employer should not act as a sponge and, in effect, that the NDHB should have been more proactive in obtaining further details of Ms Lewers' explanation. I do not accept that submission. Ms Lewers told Ms Bowmar she was busy, and mentioned reasons why. There was nothing to suggest to Ms Bowmar that she should ask more questions about the extent of Ms Lewers' busyness. Moreover, on the additional information available to the Authority concerning the constraints on Ms Lewers' time on 24 August, I consider it unlikely that further enquiry would have made any difference.

[85] To the extent that the risk analysis might have amounted to a mitigating factor, it should have been raised either in the interview of 26 August or on 1 September. It was not, so cannot be used to impugn the employer's decision. There were, in any event, difficulties with it.

[86] Regarding the need to vacate the auditorium, there was a dispute in the evidence about the extent of the late running of the vaccinations if any. Ms Lewers suggested the vaccinations were running up to 20 minutes late, although the records indicate that was not quite the case. It is more likely the vaccinations were running some 10 minutes late. In any event the point is as Dr Turner put it - Ms Lewers had substituted an assessment based essentially on convenience for strict compliance with the immunisation standard.

[87] Dr Turner also referred to the significance of the absence of any adverse reactions during the earlier vaccinations in the sequence. She said anaphylaxis was likely to be more common after repeat doses and it was important to stay prepared regardless of whether the dose was the first, second or third. Ms Lewers offered a different view, which she said was imparted to her by a tutor.

[88] Further to the availability of EPI pens, EPI pens are auto-injectors pre-filled with adrenaline for the emergency treatment of anaphylaxis. Three EPI pens were kept in a locked cupboard in the school's first aid room. They were purchased by the parents of three students who needed them and prescribed for the use of those students, although they could of course have been used on 24 August if necessary. Ms Lewers had seen them some 2 - 3 weeks before the 24 August incident and must have been relying on an assumption that they were still there. Fortunately, they were.

[89] The NDHB submitted that Ms Lewers' risk assessment was constructed after the event. Questioning of her regarding the thought she gave at the time to the availability of EPI pens in particular suggests in the alternative that she knew the explanation would be unacceptable, as she said she knew that offering the information would go against her. The point, however, is that Ms Lewers allowed vaccination to go ahead because she felt under pressure and subsequently sought to cover up her decision. The explanation she gave at the time was unacceptable, and the NDHB was entitled to form that conclusion.

2. Predetermination

[90] In addition to her view that the disciplinary meeting had been called to announce the outcome of the employer's investigation rather than to listen to her explanations, Ms Lewers pointed to the changing of the security access code for the office where she was based.

[91] I do not accept that the disciplinary meeting was called to announce the outcome of the disciplinary explanation.

[92] As for the second concern, the NDHB explained that the codes for the relevant group of offices were scheduled to be changed because of a burglary. The code for one office had been changed already, while the planned change for the office where Ms Lewers was based was brought forward and actioned on the day of her dismissal. I understood Ms Frear to have been the instigator and to accept that there was a link. While this is unfortunate I do not consider it evidence of predetermination sufficient to call into question the fairness of Ms Bowmar's decision on the dismissal.

3. Ms Frear's role

[93] Ms Lewers argued strongly that the dismissal was unjustified because of Ms Frear's involvement in the disciplinary procedure, and that Ms Frear was adversely disposed towards her and had bullied her.

[94] Ms Frear was neither the investigator nor the decision-maker. She was present during the disciplinary meeting, but in her capacity as Ms Lewers' immediate manager only. Although she gave Ms Bowmar her opinion of the seriousness of Ms Lewers' conduct, I do not accept that she exerted any improper influence over or had any improper input into the decision to dismiss. Ms Bowmar made her decision based on her own view of the seriousness of the conduct and of the explanation she was given.

[95] As for the matters Ms Lewers raised in support of her view that Ms Frear bullied or was adversely disposed towards her, some incidents were trivial or petty. Of those with potentially more substance, one concerned Ms Frear's actions in respect of Ms Lewers' continuing work on night shifts at a residential care unit in addition to her full time position at the NDHB. A second concerned the management of conflict arising in the public nursing team in 2009, after the end of a personal relationship between two of its members. Ms Lewers was not a party to the relationship. A third concerned Ms Frear's

handling of a concern expressed about Ms Lewers' allegedly grumpy behaviour during a visit to another school in or about May 2010.

[96] In July 2010 Ms Lewers and a colleague approached Margareth Broodkoorn, the Director of Nursing, to express a concern about what they said was Ms Frear's bullying. Their concern related to Ms Frear's questioning of them regarding the secondary employment both were undertaking at the residential care unit. They believed Ms Frear was being unfair and unreasonable, that their secondary employment was carried out in their own time, and that it was not impacting on their work for the DHB. Ms Broodkoorn believed the questioning could not be classed as bullying and that Ms Frear was following up on an issue that needed to be addressed. No separate personal grievance has been raised in respect of those bullying allegations.

[97] I do not accept that any of the above actions amount to other than genuine attempts by Ms Frear to address matters she was entitled or even obliged to address in her role as manager. To embark on an assessment of the merits of the associated disputes is beyond the scope of this investigation. I do not accept their mere existence means Ms Frear was adversely disposed to Ms Lewers, or that anything in the limited extent to which Ms Frear was involved in the circumstances of Ms Lewers' dismissal renders the dismissal unfair or unjustified.

[98] For similar reasons, I do not accept that anything in Ms Frear's actions can reasonably support such a fear of Ms Frear that Ms Lewers asked Ms Thomson not to report the 24 August incident. Ms Lewers was correct in recognising the likelihood that Ms Frear would be concerned about the incident, but not correct in attributing the concern to an adverse personal view of Ms Lewers herself rather than of her conduct.

4. Disparity of treatment

[99] Ms Lewers also argued strongly that her dismissal was unjustified because of a disparity in the disciplinary sanction imposed on her, and the NDHB's response to certain other incidents. She believes the disparity is indicative of the bias against her.

[100] The applicable legal test is set out in *Chief Executive Officer Department of Inland Revenue v Buchanan (No 2)3.* It poses three questions, namely, -

. is there disparity of treatment?

. if so, is there an adequate explanation?

. if not, is the dismissal justified notwithstanding the disparity?

[101] Further to the third question, even without an explanation the mere existence of disparity does not necessarily render a dismissal unjustified. All of the circumstances must be taken into account.[3]

[102] In *Sutherland v Air New Zealand Limited*[4] the Employment Court said of what is meant by 'disparity of treatment':

I do not think it is desirable for this Court to exhaustively define disparity. There must, I accept, be a sufficient degree of similarity and materiality for comparison to be made. But I think it is preferable for the Court or [Authority] to assess whether the proven facts of any case amount to such. Factors such as the identity of the employer, position held by the employees, the general nature of the conduct, and the like are all relevant and will assist in the assessment of whether a valid comparison can be made.[5]

[103] Turning to Ms Lewers' allegations, none concerned proceeding without a crash kit in the way Ms Lewers herself had but some concerned the incident of 24 August.

[104] In particular Ms Lewers complained that Ms Adamson was not disciplined for leaving the school without advising either of the nurses carrying out the vaccinations of the lack of a crash kit. That matter may be relevant to and raised in the personal grievances being brought by those two nurses as a result of their dismissals, and which are yet to be heard. I address it here by saying only that, if the allegation about Ms Adamson's conduct is true, I do not consider the conduct to be comparable with that of Ms Lewers. There is no disparity as far as Ms Lewers is concerned. I make a similar finding about the complaint of failure to discipline Ms Thomson for not attempting to stop the vaccinations.

[105] As to the additional allegations of disparity of treatment, the first two concerned breaches of other standards in the immunisation handbook. In that respect they might meet the comparable conduct test.

[106] One of the alleged breaches was reported. It was found to amount to an error in the calculation of a timeframe for a vaccination schedule, and did not lead to any disciplinary action. However, there was a significant difference in the levels of risk associated with that incident and the one involving Ms Lewers. There was also a significant difference in the nature of the conduct in that Ms Lewers deliberately substituted her own judgment for that enshrined in the relevant standard, as distinct from making a mistake while attempting to follow the standard. Thirdly, Ms Lewers went ahead knowing of her

breach, while in the second incident vaccination stopped when the breach was identified. The nature of the conduct overall was not sufficiently similar to warrant a finding of disparity.

[107] The second of the alleged breaches of an immunisation standard concerned a potentially serious incident which was not reported, and the existence of which could not be verified after a further check of the NDHB's records following the Authority's investigation meeting. In these circumstances I am not satisfied there was any disparity.

[108] I confirm the oral order made during the investigation meeting prohibiting the publication of the name or any details identifying the student whose circumstances were the subject of the allegation.

[109] Of the remaining allegations, Ms Lewers also referred to a further potentially serious incident albeit not one raised as a breach of an immunisation standard. Ms Lewers said she observed it herself, although she acknowledged that she did not report it. She said she believed it had been brought to the attention of the management, but did not provide any other details. Again, the existence of the incident could not be verified and no report could be located following a further check of the NDHB's records after the Authority's investigation meeting. Again, in those circumstances I am not satisfied there was any disparity.

[110] Another allegation of disparity concerned Ms Frear's failure to commence a disciplinary investigation following receipt of an allegation of bullying made against another PHN. The circumstances were sufficiently different from Ms Lewers' not to amount to disparity of treatment in the event the associated allegations were true. Moreover the background to the complaint concerned the conflict in the workplace to which I have already referred, and which Ms Frear was attempting to manage.

[111] Finally, there was an allegation concerning the unauthorised taking home of a vehicle overnight which did not attract disciplinary action, and of requirements regarding Ms Lewers' studies which she said were not applied to other people in similar circumstances. Even if the allegations are true the associated incidents were not sufficiently similar in nature or quality to justify a finding of disparity of treatment.

[112] Overall none of the allegations of disparity of treatment met the threshold indicated by the first two questions in *Buchanan.* There was no disparity sufficient to vitiate the justification for Ms Lewers' dismissal.

5. Procedural flaws and breaches of disciplinary procedure

[113] There were numerous criticisms of the conduct of the disciplinary process.

[114] Of those which may have substance, the first concerned Ms Lewers' evidence that she was uncertain of the purpose of the 1 September meeting. On the information in the letter of suspension alone she would have good reason for that uncertainty, as well as to be uncertain of the purpose of the 26 August interview with Ms Bowmar. However following the letter of 27 August she should at least have understood what she would be asked to address at the meeting, and that dismissal was a possible outcome. Although she sought to indicate that she did not receive the letter, it was Ms Jarman's evidence that she retrieved it for Ms Lewers.

[115] If Ms Lewers went into the meeting not expecting the possibility of dismissal, that is not because of any failure to bring the possibility to her attention. Moreover, she was given the opportunity to take more time to address Ms Bowmar's preliminary view, but chose not to do so.

[116] A concern was expressed about the fact that Ms Lewers was not advised Ms Bowmar had spoken to the communicable diseases training advisor. I do not accept there is anything of substance in the concern, particularly as the person was spoken to for the purpose of obtaining training records and copies of relevant protocols.

[117] With reference to part 7.4 of the disciplinary procedure much was made of the failure to consult with Ms Broodkoorn before effecting the dismissal, and Ms Broodkoorn's subsequent comment to the union representative that dismissal seemed harsh.

[118] The reason given for not consulting Ms Broodkoorn was that there was a national guideline which had been breached. Accordingly there was no need to consult Ms Broodkoorn on clinical practice.

[119] For her part Ms Broodkoorn gave evidence that she made the comment attributed to her without being in possession of all of the facts, in particular regarding the extent of Ms Lewers' departure from practice.

[120] In hindsight consultation with Ms Broodkoorn would have been desirable -not because of a need to further assess the clinical practice in question but because of the wider issues concerning Ms Lewers. These include not only the issues Ms Frear was attempting to manage and Ms Lewers' reaction to Ms Frear's attempts, but the appropriate view to be taken of all of those matters in the light of Ms Lewers' lengthy period of service.

6. Conclusion on the justification for the dismissal

[121] Overall I do not believe this is simply a matter of a senior and experienced person making a poor decision in the face of pressure she was experiencing on a particular day. This is a matter of a senior and experienced person who considered herself an expert substituting her own judgment for that contained in a well-known clinical standard. Her conduct was not adolescent personal behaviour of the kind in *White,* rather it was a significant decision made in a clinical matter. Even if Ms Lewers had panicked when she realised the implications of her action for her ongoing employment, her conduct in particular in asking Ms Thomson not to report the matter is an aggravating feature. Actions of that kind contributed to the loss of trust her employer expressed at the time in reaching its decision to dismiss.

[122] There were flaws in the disciplinary procedure. However because of my overall view, as well as the more specific findings detailed in this determination, I find dismissal was the action a fair and reasonable employer would take in the circumstances. Accordingly the dismissal was justified.

Summary of orders

[123] The NDHB is ordered to pay to Ms Lewers the sum of $3,000 as compensation for the injury to her feelings caused by her unjustified suspension.

Costs

[124] Costs are reserved.

[125] The parties are invited to reach agreement on the matter. If they are unable to do so any party seeking costs shall have 28 days from the date of this determination in which to file and serve memoranda on the matter. The other party shall have a further 14 days in which to file and serve a reply.

R A Monaghan

Member of the Employment Relations Authority

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[1] This was the number of students to be vaccinated, but nothing here turns on the number of students actually vaccinated before Ms Adamson returned.
[2] [2007] ERNZ 66
[3] [2005] NZCA 428; [2005] ERNZ 767 (CA); leave to appeal declined in [2006] NZSC 37; [2006] ERNZ 512
4 *Samu v Air New Zealand Limited* [1995] NZCA 504; [1995] ERNZ 636
[4] [1993] NZEmpC 106; [1993] 2 ERNZ 386
[5] at p 397
