NOTE: This determination contains an order at paragraph [9] prohibiting publication of certain information

IN THE EMPLOYMENT RELATIONS AUTHORITY
CHRISTCHURCH

I TE RATONGA AHUMANA TAIMAHI
ŌTAUTAHI ROHE

[2025] NZERA 11
3254259

	BETWEEN	GAY JOHNSTONE Applicant
	AND	ZXY Respondent

Member of Authority:	Lucia Vincent
Representatives:	Emily Griffin for the Applicant Tim McGinn, counsel for the Respondent
Investigation Meeting:	24 and 25 September 2024 in Christchurch
Submissions Received:	25 September and 10 October 2024 from the Applicant 25 September, 30 September and 15 October 2024 from the Respondent
Determination:	15 January 2025

DETERMINATION OF THE AUTHORITY

What is the Employment Relationship Problem?

[1] Ms Johnstone says ZXY unjustifiably dismissed her for failing to call an ambulance after an incident involving a resident she cared for (among other things). Ms Johnstone says she should have in hindsight called an ambulance, but that she did the best she could in the circumstances at the time and should not have been summarily dismissed for that. Ms Johnstone also says that ZXY unfairly treated her differently to a co-worker (Y) who received a final written warning for his involvement in the incident.

[2] ZXY says Ms Johnstone's conduct was a "gross dereliction of duty" and serious misconduct. Together with aggravating features like Ms Johnstone attempting to shift blame to her co-worker, the incident justified her summary dismissal, despite her otherwise unblemished 21 years' service with it.

[3] The parties were unable to resolve their employment relationship problem at mediation and have asked the Authority to resolve it for them.

How did the Authority investigate?

[4] Ms Johnstone lodged her statement of problem on 29 September 2023 and an amended statement of problem on 27 February 2024. ZXY lodged a statement in reply on 27 October 2023. Case management conferences occurred on 18 April 2024 and 6 September 2024.

[5] The Authority heard evidence and submissions at an investigation meeting in Christchurch on 24 and 25 September 2024. The Authority heard from Ms Johnstone and her union advocate, Samuel Hope. For the respondent, Cara Stewart and Rebecca Knowles gave evidence. Witnesses answered questions from representatives and the Member under oath or affirmation. Submissions were provided on the day and subsequently on the issue of non-publication.

[6] In accordance with s 174E of the Employment Relations Act 2000 (Act) this determination states relevant findings of fact and law, expresses conclusions on matters or issues requiring determination to dispose of the matter and specifies any orders made. It does not record all the evidence or submissions received, or process followed.

What are the issues?

[7] The Authority investigated the following issues:

(a) As a preliminary matter, should the Authority make a non-publication order?

(b) Did ZXY unjustifiably dismiss Ms Johnstone? In considering this issue the Authority must consider whether the decision to dismiss and how it was reached was what a fair and reasonable employer could have done in all the circumstances.

(c) If the Authority finds ZXY unjustifiably dismissed Ms Johnstone, what (if any) remedies should it award to Ms Johnstone and should any reduction for contribution be made?

Should the Authority make a non-publication order?

[8] ZXY asked for a non-publication order in relation to the organisation's name should it be successful in showing it justifiably dismissed Ms Johnstone. ZXY also sought an interim order pending any challenge should an order be refused.

[9] Given the findings of this determination, I have declined to make a permanent non-publication order. However, to preserve ZXY's position, I order that the interim non-publication order remain in place for ZXY's name pending any challenge. This order will last for 28 days after the date of this determination. It will then lapse unless ZXY notifies of a challenge, in which case it will continue until the outcome of that challenge is known, and any order by the Court made.

[10] Both parties agreed to anonymise the names of residents and staff mentioned who did not appear as witnesses. I have adopted an anonymised approach when referring to these people for fairness and privacy reasons. For consistency, where a name appears in correspondence, square brackets with the person's anonymised initial or surname have been used.

Who was involved in the incident?

[11] ZXY is an organisation that cares for individuals with intellectual disabilities. It contracts its residential care support services to the Ministry of Health and ACC. ZXY currently has six homes based in Ōtautahi / Christchurch. It takes its obligations to keep residents safe, seriously.

[12] ZXY employed Ms Johnstone as a Residential/Community Support Worker for three weeks short of 21 years. She worked almost all that time at the residence in which the incident for which she was dismissed took place. Ms Johnstone says she helped residents who required support to live independently, some of whom had complex needs and challenging behaviours. She enjoyed her work.

[13] It is common ground that prior to her dismissal, Ms Johnstone had no disciplinary record with ZXY. It appeared to be an amicable long-term working relationship prior to the incident.

[14] Ms Johnstone worked with a resident who I will call X since 2011. X has a known disability that gives him a strong driver to eat. He must be watched when eating as part of a choking risk management plan. Ms Johnstone says X can still sometimes require encouragement to finish his food.

The incident: what happened?

[15] The incident subject of the dismissal occurred on 27 April 2023.

[16] Ms Johnstone had performed a sleepover the night prior. Y arrived at work that morning for a couple of hours crossover. Ms Johnstone and he worked together to get residents ready for their days. X normally attends a marae during the day.

[17] Ms Johnstone was in the kitchen while Y watched X eating breakfast. Because of the layout of the house and the noise in doing the dishes, Ms Johnstone says the first thing that alerted her to an incident was when she saw Y moving quickly. When Ms Johnstone went to go see she observed Y helping X up on to his chair. She recalled Y telling her that X had lain sort of rigid on the floor. Ms Johnstone was unsure what had happened to cause what appeared to be a fall.

[18] After the incident, Ms Johnstone and Y both noticed X seemed alert and appeared normal. X was motivated to finish his breakfast. Despite that, Ms Johnstone and Y performed checks such as squeezing their fingers and checking his pupils and pulse. When Ms Johnstone asked Y if X should go to work, Y asked X what he wanted to do. X said he wanted to go to work (at the marae). Ms Johnstone says she went along with that choice - she couldn't think of a reason why X should not go. X could be challenging when his choice was overridden. There is a dispute about whether Y told Ms Johnstone X was unconscious.

[19] Because of what had happened, Ms Johnstone later called a doctor to make an appointment for that day. Y would hand over to the marae what had happened and contact their manager Ms Stewart.

[20] At 8.51 a.m. Y messaged Ms Stewart:

> … [X] collapsed off his chair this morn during breakfast was rigid and unconscious for around ten seconds when he came around looked confused .but recovered ok and back to breakfast and looks OK now .thought I better let u know.

[21] Ms Stewart says she did not immediately open and read the message as the banner on her phone showed only the start of the message about a WOF for a vehicle. Once she read it, she contacted Ms Johnstone.

[22] Ms Stewart provided a file note dated 2 May 2023 compiled from notes she says she recorded on the day but were later discarded. She acknowledges her file note contains more detail than her notes did. Among other things, Ms Stewart's file note recorded that she spoke with Ms Johnstone that morning and that when asked what happened, Ms Johnstone said "[X] passed out and started eating his breakfast again and wanted to go to work but I've made a doctor's appoint for him at 1.30pm today." When asked why X had gone to work, Ms Johnstone said he wanted to and seemed fine. Ms Stewart asked if it was common for X to have fainting spell seizures and Ms Johnstone said no. Ms Stewart asked Ms Johnstone to stay on shift a bit longer, but she said she couldn't and had to go and that Ms Stewart would need to talk to Y.

[23] The diary note for 27 April 2023 has an entry in it at the top from Y saying:

> [X] while having breakfast had a blackout, was on the floor face down & rigid, for about ten seconds, eyes opened up, looked confused when up, why am i on floor looked ok sat back on seat & carried on breakfast.

[24] After this entry Ms Johnstone wrote "[X] was alert and fully conscious … Practice Nurse advises [X] needs/or it would be good he is seen today. Cara informed – appointment made."

[25] Regrettably, at the marae, X had two fainting episodes and vomited. An ambulance was called. X was subsequently hospitalised and nearly died. Due to an underlying heart condition a pacemaker was put in.

[26] Days later X's family withdrew X from ZXY's care because of the incident.

[27] Neither Ms Johnstone nor Y submitted an incident report until later. Ms Johnstone dated her report 2 May 2023. Y dated his 15 May 2023.

[28] ZXY was required to submit a report to Whaikaha / Ministry of Disabled People.

What did the reports say?

[29] The incident report provided by Y recorded that:

(a) Immediately before the incident, X returned to his seat after taking his toast plate to kitchen.

(b) When X went to sit back down, he missed the seat and rolled on to his front.

(c) Y responded by rushing over, called out to Ms Johnstone, giving X a shake, and putting his hand on his shoulder. X looked up at him, somewhat confused.

(d) Y helped X onto his chair and asked what happened? X put his hands up to gesture "I don't know."

(e) Y asked if X was feeling OK or felt sore anywhere, to which X nodded no to any pain.

(f) Y did some other checks such as "squeeze my fingers" (both the same).

(g) Ms Johnstone was also involved and discussed what Y had seen, and agreed to closely observe for any symptoms of what happened, checked medical history for any pre-existing condition, no history of epilepsy etc.

(h) X carried on with his usual morning routine, finished his breakfast, got up to get a shaver, put Weet-Bix back on bench etc.

(i) Y asked X again if feeling OK and got a thumbs up.

(j) Y asked X if he wanted to go to the marae - X nodded yes.

(k) Y text Ms Stewart at 8:50am and took X to the marae but took extra time to hand over and inform them to keep a close eye on him because of what happened.

(l) While dropping off X to the marae Ms Johnstone rang the doctor's nurse to get advice - appointment made for 1:45pm.

(m) At 11:19am Y got a call from Ms Stewart to go to the marae as X had another turn and ambulance was on its way.

[30] Ms Johnstone's incident report recorded that:

(a) Immediately before the incident X was having his breakfast, he had got up, made his bed, had his medication, looked happy and well.

(b) Ms Johnstone walked into the dining room and saw X getting up to sit in his chair. Y was supporting him and said X fell off his chair.

(c) Ms Johnstone observed X's eyes were open, he sat down on his chair, and immediately started eating. He was alert and looked normal.

(d) Ms Johnstone asked Y what had happened and he and her discussed with X was he feeling okay. X indicated he was. They asked if X wanted to stay home. X was clear he wanted to go to his work placement. Ms Johnstone did not want to go against X's choice but they made it clear he could stay home as he had fallen on the floor.

(e) Ms Johnstone did not know what had caused the incident. Y and Ms Johnstone discussed what Y had seen (he had seen the whole episode - ten seconds he said in total). Could have been epilepsy.

(f) Ms Johnstone tried to take X's pulse but couldn't feel it.

(g) Y got X's file out. Ms Johnstone knew X had no previous epilepsy and other things.

(h) Y was to take X to work and inform marae staff.

(i) Ms Johnstone rang X's GP rooms and was able to talk to a registered nurse and ask for advice given they did not know what had happened.

(j) Ms Johnstone described what Y had told her and what she had seen including that X on resuming his breakfast was conscious and alert and seemed to be as though nothing had happened and was behaving as normal and wanted to go the marae even though offered to stay home. The nurse advised that X should see a GP that day and gave an appointment time of 1:30pm (she thought).

(k) Ms Johnstone rung Ms Stewart immediately to inform her of this. Y had taken the role of informing Ms Stewart as he had seen the incident from the lounge and more than Ms Johnstone.

(l) Ms Stewart was going to organise for another staff member to take X to the GP appointment as Ms Johnstone was rostering off at 10am.

[31] Ms Knowles completed a critical incident reporting form recording that:

(a) the primary category of critical incident was neglect of a disabled person with a secondary category of hospitalisation of a disabled person.

(b) X passed out while eating breakfast. He became rigid and unconscious for ten seconds.

(c) X went to his place of work and by 11am had passed out twice and vomited. An ambulance was called, and he was taken to hospital. A pacemaker was put in.

(d) Factors that may have contributed to the event were staff not following policy and procedure, not calling an ambulance at breakfast time, or referring to management for support and advice at the time.

(e) The report recorded that disciplinary processes were being followed with staff members.

[32] In response to questions about the report, Ms Knowles acknowledged her Quality Manager had written it and she had signed it. She could not recall the exact detail (a copy of the report was provided after Ms Knowles gave evidence). When asked about what might be in it, Ms Knowles suggested ZXY may have needed to be more comprehensive with training on when to call an ambulance (although it was already quite comprehensive, and it was "common sense"). Ms Knowles could not recall if any policies and procedures were updated because of the incident. When the written report was provided, it did not include comments about these things.

What do the employment documents say?

[33] The individual employment agreement dated April 2022 between ZXY and Ms Johnstone (Agreement) recorded that in the event of establishing serious misconduct or gross negligence, ZXY could terminate Ms Johnstone's employment

without notice. It could also suspend her on pay pending an investigation into any suspected serious misconduct or gross negligence involving her.[1]

[34] In relation to policies, the Agreement required Ms Johnstone to familiarise herself with and comply with ZXY's rules, policies and procedures.[2]

[35] The job description records that the residential support worker is responsible for the care, support and community integration of residents living within their home. Key tasks include following written emergency procedures in relation to fire safety, resident health, accidents and civil emergency.

[36] A document called "Code of Conduct / Ethical Standards" does not define misconduct or serious misconduct. It sets a series of standards expected for which someone who breaches them could be subject to disciplinary action. It does not set out a process for disciplinary matters.

[37] ZXY attached the code of conduct and several other policies it considered relevant. It was unclear if and how ZXY relied on these policies except for the Adverse Event Reporting policy that required an incident report to be completed when any adverse event occurred in the house (including accidents, near misses or injuries to a person such as falls), and that a manager/director should be notified of all serious incidents as soon as possible when they occur and an incident report to be made available to the manager within 24 hours of the incident.

[38] There was no written policy on when to call an ambulance.

[39] ZXY provides regular training such as first aid. Ms Johnstone had completed a refresher first aid course the week prior to the incident occurring. Among other things Ms Johnstone had recalled her ABC (or as she later conceded, ABCC). For her the "C" meant she would have called an ambulance if she had known that X was unconscious (C standing for consciousness).

[40] When asked about any policy or training on when to call an ambulance, Ms Stewart said she had covered this in monthly training sessions with staff. It was

[1] Clause 16.
[2] Clause 3.4.

unclear when this may have occurred, possibly in prior months. No records were provided.

[41] Ms Knowles confirmed that training on when to call an ambulance was informal. Staff were told never to be afraid to call an ambulance. ZXY has a monthly subscription with St John for houses to call an ambulance. Staff are also told not to hesitate to go to the GP to seek advice. Ms Knowles noted there needs to be an element of common sense applied by staff about when to call an ambulance. She was of the view that with or without losing consciousness, the situation with X clearly required calling an ambulance.

Suspension

[42] Following the incident, Ms Johnstone worked as usual.

[43] At work on 2 May 2023, Ms Stewart met with Ms Johnstone to suspend her. Ms Stewart read a script to Ms Johnstone with Ms Knowles on the phone. An email from Ms Knowles to Ms Johnstone dated 3 May 2023 records what was said.

> We are going to have to conduct a formal disciplinary investigation of the conduct of both you and [Y] on Thursday. We think from what we understand so far that there is a basis for serious misconduct allegations to be made around the following issues that warrant proper investigation:
>
> - The apparent failure to observe [X]'s choking risk care plan as we understand that the incident occurred after [X] had begun to have his breakfast without supervision and he was apparently found rigid and unconscious,
> - The apparent failure to assess the potential seriousness of the situation on the basis that [X] was keen to resume eating being treated as an indicator that the issue, whatever it was, had passed (despite [X]'s known disability providing strong driver to eat) and because [X] wanted to go to work at the Marae (when he was not in a position to make a reliable assessment of the situation himself).
> - The apparent failure to call an ambulance,
> - Failure to fill out an incident report
> - Failure to contact a manager as soon as possible
> - Exposing a resident to unnecessary health risks.
> - Concerns from [X]'s family over his level of care resulting in withdrawing him from our care.
>
> These issues potentially support serious misconduct allegations of gross dereliction of duty and failing to follow proper practice, and damage to the business reputation as a result.
>
> Because these allegations are so serious and involve safety issues we think it is appropriate to suspend you on pay pending a formal disciplinary meeting where suspension will be

reviewed. We refer to clause 16.1.4 of your employment agreement that provides that *We may suspend you on pay pending an investigation into any suspected serious misconduct or gross negligence involving you*.

You are entitled to comment on this proposal to suspend and I invite you to do so now. If you agree accept the proposal, I will send you home from your rostered shift on pay. Otherwise I will take further advice before making a decision on the issue.

I will confirm this discussion in writing and you can expect to receive a formal letter setting out allegations together with a summary of all information relied upon from investigations to date and an invitation to meet shortly. You will be entitled to representation for this part of the process.

[44] Eager to make things easier for ZXY, Ms Johnstone agreed to the suspension. Ms Knowles and Ms Stewart recalled Ms Johnstone was contrite, apologetic and understanding of their situation at that time.

Disciplinary Process

[45] Following further investigation, ZXY wrote to Ms Johnstone in a letter dated 12 May 2023 notifying her of a disciplinary meeting and convening a formal disciplinary meeting to hear her responses to allegations of serious misconduct. The letter provided further information and background including the following:

> This matter first came to [Ms Stewart's] attention following the discovery of a text message received by [Y] which she then followed up with a telephone call and further inquiries. Matters came to a head when our resident [X] fell ill at the Marae and had to be taken to the hospital by ambulance.
> Our initial inquiries following these events highlighted a number of serious issues about the level of care provided by you and [Y] to [X] that morning and your apparent failure to follow our policies and procedures with the result that [X] was placed at serious risk of harm. As a result, his family has withdrawn [X] from our care. This is the first time such an action has been taken by a family of one of our residents in over 25 years of being in business. You provided an incident report and we have since also received an incident report and a supplementary report from staff at the Marae concerning the events. By way of further background, I note that you had attended a first aid course approximately a week prior to the incident and that you did not complete an incident report until requested by [Ms Stewart] sometime after the events unfolded.

[46] The letter listed the documents provided including policies and reports. It referred to the issues outlined in the suspension letter. It then listed specific allegations of serious misconduct and outlined the process as follows:

> 1. It is alleged that you acted on 27 April 2023 in your support and care of the resident [X] with a gross dereliction of duty by failing to ensure that [X] was supervised while eating his breakfast and by allowing [X] to finish his breakfast and go to work at the Marae instead of intervening and calling an ambulance for [X], as well

as by failing to contact [Ms Stewart] as your manager as a matter of urgency and completing an incident report as soon as possible;

2. It is alleged that your apparent neglect of a resident's needs as set out has resulted in the withdrawal of a client from our care and likely damage to our reputation.

It is acknowledged that you are not solely responsible for the matters that are the subject of this investigation, and we advise that your co-worker who had overlapping responsibility will also be investigated upon his return from holiday. The issue of the extent of your apparent culpability in the incident will be assessed as part of the investigation.

These matters are all considered very serious, and if established would suggest that you cannot be trusted to perform key parts of your role in accordance with company standards and instructions and that you may not be trusted to look after our residents with the required level of care presenting a serious health and safety risk to the client. I have not drawn any conclusions about your alleged behaviour and look forward to hearing your full explanation in response to these allegations.

You need to know that your employment may be at risk if you cannot provide me with a satisfactory explanation in response to the allegations.

[47] On 19 May 2023, ZXY met with Ms Johnstone who was represented by Mr Hope. Ms Knowles, the decision maker for ZXY, was supported by Ms Stewart.

[48] The Authority had the benefit of a transcript and audio recording of the meeting. Although there does not appear to be any dispute about what was said at the meeting, the parties differ about what conclusions can reasonably be reached.

[49] During the meeting Ms Johnstone covered in detail the events from her perspective. Key points included that:

(a) Y was watching X eating his breakfast at the time of the incident, consistent with the choking risk management plan.

(b) Ms Johnstone did not see what happened with X that caused him to be on the ground. She relied on what Y told her happened which included that X had missed his chair, lain "sort of rigid" and looked confused.

(c) Y was helping X back into his chair when she got to the dining room.

(d) Y did not tell her that X was unconscious. This was an important consideration for her in not thinking to call an ambulance at the time.

(e) X was smiling, alert, communicating, and hooked into his Weet-Bix (when sometimes he requires prompting).

(f) Ms Johnstone checked his pulse and pupils, both of which were inconclusive.

(g) Y asked X if he wanted to stay home or go to work. X wanted to go to work. This occurred before Ms Johnstone and Y had a chance to discuss it and she went along with Y's judgment on that.

(h) It was agreed Y would contact Ms Stewart to tell her what happened and handover to the Marae; Ms Johnstone would ring for medical advice.

(i) Ms Johnstone rang the GP's room and spoke to a nurse. She told the nurse what had happened and said she did not know what had caused it and wondered whether it could be epilepsy or something else. The nurse wanted to see X that day and an appointment was made.

(j) The incident and what followed all happened within a short time.

(k) Ms Johnstone had rung an ambulance for X before when he had been choking and noted she would ring an ambulance if she felt she needed to or knew to (but she did not think she needed to at the time of the incident).

(l) Ms Johnstone acknowledged she did not write an incident report within 24 hours and put her hand up for that. At the investigation meeting Ms Johnstone said a prior manager had a practice of co-signing reports and that she anticipated co-signing Y's report because he had seen what happened.

(m) Ms Johnstone apologised, referred to the incident as being "… the worst thing that's ever happened in my working life," and that what ZXY does for people means everything to her and she was proud of it.

(n) Ms Knowles highlighted inconsistencies with what Ms Johnstone said and records such as Y's entry in X's diary and Y's text message.

(o) Ms Knowles said she felt like Ms Johnstone was trying to blame it all on Y, which was denied and explained as her trying to give her account of events.

(p) It was acknowledged in hindsight that not calling an ambulance and allowing X to go to work was not the right decision, but that Ms

Johnstone did the best she could with what she knew at the time and had behaved responsibly in ringing the GP's rooms and seeking a medical assessment and appointment.

(q) When Ms Knowles asked what Ms Johnstone would do now with the benefit of hindsight, Ms Johnstone said "Absolutely ring the ambulance at any point. Ring [Ms Stewart] straight away. I would have had [Ms Stewart] in before I said to Y should we keep him at home."

(r) Ms Knowles indicated she would speak with Y about his account of what happened because his incident report was "pretty scant."

(s) Ms Johnstone encouraged this and observed Y had said different things to different people.

(t) Ms Knowles noted she was not in any position to be making a decision because of "massive holes" in the investigation.

[50] The meeting was left on the basis that there would be further investigations, although it was unclear whether there would be a further meeting. Subsequently it is clear that Ms Johnstone and Mr Hope thought there would be.

[51] On 26 May 2023 Ms Knowles wrote a letter to Ms Johnstone:

> **Provisional outcome of disciplinary meeting**
>
> Dear [Ms Johnstone]
>
> Further to our meeting Friday 19 May 2023, I write to confirm my findings from the investigation and the provisional outcome in terms of a proposed penalty before I reach a final decision. Since meeting with you I have conducted a disciplinary meeting with your colleague [Y] and considered what he has said where relevant, particularly in relation to the choking care plan issue as this issue depended on knowing [Y]'s whereabouts exactly when [X]'s breakfast incident occurred.
>
> **Findings in relation to the specific allegations of serious misconduct**
>
> 1. It was alleged that you acted on 27 April 2023 in your support and care of [X] with a gross dereliction of duty. There were a number of elements to this allegation including:
>
> - The apparent failure to observe [X]'s choking risk care plan as we understand that the incident occurred after [X] had begun to have his breakfast without supervision and he was apparently found rigid and unconscious. Following investigation, I am satisfied that [Y] did in fact provide supervision at the relevant time and that [X]'s choking risk care plan was in fact observed on the occasion in question;
> - The apparent failure to assess the potential seriousness of the situation on the basis that [X] was keen to resume eating being treated as an indicator that the issue, whatever it was, had passed (despite [X]'s known disability providing a strong driver to eat) and because [X] wanted to go to work at the Marae (when he was not in a

position to make a reliable assessment of the situation himself). I am satisfied that this element of the allegation has been established. It appears that neither you nor [Y] acted appropriately and that no proper judgement was exercised with the result that [X] was endangered by a dereliction of duty. I am particularly concerned that even after the event you apparently regarded your action in allowing [X] to go to the Marae instead of calling an ambulance and facilitating a medical assessment as an appropriate level of care by you. It was never appropriate for you to rely on [X]'s feedback in determining the seriousness of the situation;

- The apparent failure to call an ambulance. This is an accepted fact. It was not acknowledged by you that this was the required procedure until you were pressed on the issue by me in our meeting. Your reluctance to accept the obvious failure became apparent in your conversation with other staff and this was illustrated to me in our meeting;
- Failure to fill out an incident report. You did not complete an incident report until you were asked to do so by [Ms Stewart] on 1 May, by which time you were aware that a disciplinary process was underway.
- Failure to contact your manager as soon as possible. In keeping with the inexplicable lack of appreciation of the seriousness of the situation you did not immediately seek to contact your manager but appear to have been content for [Y] to send a text to [Ms Stewart] after some delay. You were both on shift together and had an equal responsibility to ensure this occurred.
- Exposing a resident to unnecessary health risks. [X] passed out at the Marae and was a genuine medical emergency case with his emerging heart problem requiring critical care intervention at the hospital.

I confirm that the elements of dereliction of duty have been established apart from one element relating to the choking care plan. The allegation has been established and the behaviour is regarded as serious misconduct.

2. It was alleged that your apparent neglect of a resident's needs as set out had resulted in the withdrawal of a client from our care and likely damage to our reputation. This in fact occurred and I consider that your dereliction of duty was a significant contributor to this outcome.

I confirm that this allegation of serious misconduct has been established. It is acknowledged that you are not solely responsible for these matters. Given that you and [Y] are both very experienced staff sharing a shift, it is difficult to separate you both in terms of attributing responsibility for the failures identified. Your classification of [Y] as the first responder unfortunately appears to be an attempt to pass on your shared responsibility to [Y].

Provisional Outcome

These matters are all considered very serious and potentially justify an outcome of dismissal. I am particularly concerned over your apparent attempts to shift responsibility to [Y] as "first responder" when you are both very experienced support workers with a joint responsibility on the shift. I am also very concerned that you have been slow to acknowledge the extent of your dereliction of duty as apparently evidenced in your discussions with other staff and with me in our meeting. These events are also particularly disappointing when you had only recently completed your first aid refresher course a week prior to the incident. I consider these matters to be aggravating features that raise serious questions about your judgment and whether I can trust you to take the required care to perform key parts of your role in accordance with company standards and instructions. I am concerned that you cannot be trusted to look after our residents with the required level of care to avoid exposing a resident to serious health and safety risks.

> The stakes are very high for our residents and unfortunately, I do not think I can trust you again to perform your role with the diligence and care that your role demands. I am extremely disappointed that I feel this way about you given your long service for the company. I am unfortunately tending to the view that the appropriate outcome is that you are summarily dismissed for the serious misconduct identified above, after taking all the circumstances into account.
>
> *Before I finalise my decision, I am allowing you the opportunity to make any further submissions by 5pm on Monday 29 May 2023 whereupon I will communicate my decision in writing.*

[52] Upon receipt of the provisional outcome that day, Mr Hope emailed and requested an extension of four days to allow for more than one business day for a response, particularly given the severity of the proposed outcome. Ms Knowles agreed to a further 24 hours and noted the response need not be lengthy given it required feedback on proposed penalty only. Mr Hope responded reiterating his request noting the timeframe's unacceptability particularly considering his understanding they had adjourned the meeting for Ms Knowles to seek further information and they received no update nor invitation for a further meeting. He also noted Y had received a final written warning and signalled a grievance would be raised if dismissal resulted.

[53] Mr McGinn responded on behalf of ZXY by email on 29 May 2023:

> I have been briefed on the process undertaken by my client. Following the meeting with [Ms Johnstone] it seems the only issues of contention were the circumstances of supervision at the time [X] was found, which as been resolved with no finding of fault on that aspect, and secondly, the comments reported by other staff on what [Ms Johnstone] said to them after the event which your client refuted.
>
> My client has reviewed that conflicting evidence which is peripheral to the central allegations concerning dereliction of duty. You will see my client has made findings to the effect that your client has attempted to shift blame to [Y] rather than share responsibility. My client has also noted that your client did not consider matters were sufficiently serious at the time to justify her completing an incident report as required which is consistent with the description of the accounts given by other staff about what she said in the days following the event.
>
> [Y]'s outcome was different to that proposed for [Ms Johnstone] because [Y]'s acceptance of responsibility allowed my client to consider that the relationship could be repaired. If my client concludes that your client was not willing to accept responsibility for her part in the events then that may well justify a different outcome. I suggest that you focus on providing feedback on penalty rather than try to take technical points at this stage. Is there a reason why you cannot do so by 5:00pm tomorrow?

[54] Mr Hope responded on 30 May 2023 noting his commitments including bargaining and that although they would provide a written response, requested a further meeting to present the response that Friday. Mr McGinn responded on 31 May 2023 saying ZXY would only agree to a meeting that Friday if Ms Johnstone agreed to be on leave without pay after 5:00pm (the initial extension). If not, then ZXY required any submission by 5:00pm that day, after which time it would make a final decision. Mr Hope responded confirming they would do the latter but reiterated the request for a follow up meeting on Friday. Mr McGinn said ZXY would consider the response received to determine whether it was appropriate to meet again that Friday. Mr Hope submitted a letter by email at 6:30pm that day.

[55] Mr Hope's letter dated 31 May 2023 materially said:

> At an investigation meeting held 19 May 2023, [Ms Johnstone] verbally presented her account of events as they transpired on 27 April 2023. In this account, Gay described what she witnessed during breakfast time with [X] and the actions both her and [Y] took in response to this. It has been established that the necessary course of action was not taken at the appropriate time, which ultimately put a client at risk and led to them being removed from [XZY]'s care.
>
> You acknowledged that [Ms Johnstone] was not solely responsible for these matters, but express concern at "[Ms Johnstone]'s apparent attempts to shift responsibility to [Y] as 'first responder'. On the morning the incident occurred, it was agreed that [Y] would keep an eye on [X] eating breakfast while [Ms Johnstone] tidied up in the kitchen (which was out of view of [X]). This meant that [Y] was witness to [X] falling off his chair onto the ground. It was not [Ms Johnstone]'s intention to imply that [Y] was 'first responder' and therefore held the responsibility to act, but that [Y] witnessed more of the events unfold and was first to attend the scene.
>
> To be clear, [Ms Johnstone] does not view her role as in any way subservient to [Y]'s and she accepts that they both share equal responsibilities as carers. [Ms Johnstone] and [Y] have worked effectively as a team for over a decade. She has the utmost respect for [Y], his judgment, and their working relationship, which is why she accepted [Y]'s immediate assessment of the situation. She did, however, take further measures such as arranging a medical assessment for [X] and informed [Ms Stewart] of this.
>
> Both [Ms Johnstone] and [Y] acted in accordance with the knowledge they had at the time. [Ms Johnstone] has previously called an ambulance for [X] during a choking incident and accepts that the same course of action should have been followed given the events that later occurred at the marae. She deeply regrets not calling an ambulance or immediately calling [Ms Stewart] to inform her of what had happened at breakfast. She accepts culpability for her inaction.
>
> The care and wellbeing of [X] and all clients at [ZXY] is of paramount importance to [Ms Johnstone]. This incident has left her distraught and with deep regret. [Ms Johnstone] is extremely proud of the work she performs as a carer for [ZXY] and highly values the services the organisation, its management, and its carers provide to the

disabled community. [Ms Johnstone] is committed to her role and has always strived to do her best by [ZXY] and the people it cares for.

Given the service [Ms Johnstone] has provided to [ZXY] over the past twenty-one years, and her longstanding working relationship with you, we feel it appropriate to reconvene to discuss in person your concerns regarding trust and confidence in [Ms Johnstone]'s ability to perform her role. I have availability on Friday 2nd June to attend as [Ms Johnstone]'s union representative.

[56] Ms Knowles dismissed Ms Johnstone in her letter to her dated 1 June 2023:

Further to my letter of 26 May 2023 I have now had an opportunity to consider [Mr Hope]'s letter of 31 May 2023 on your behalf, responding to my letter. I have taken careful note of the key points from [Mr Hope]'s letter, and I have also once again reviewed all the information from the investigation, including the recording of our meeting on 19 May 2023.

Unfortunately, I cannot accept the assertion that you did not attempt to shift responsibility to [Y] in your explanation. This was clearly what you did attempt to do on my interpretation of your explanation in the meeting when I replayed the recording. You repeatedly referred to [Y] as being first on the scene and the first responder and that you were relying on [Y]'s report of what had happened. You stated, "he was the one who made the judgment and I went along with it." You also stated "I didn't have a lot of input" into the decision for [X] to go to the Marae.

You repeatedly emphasised to me in our meeting that you did not know that [X] had become unconscious which I interpret as you attempting to explain why you did not think the incident warranted an ambulance to be called, even though it is clearly now accepted that an ambulance should have been called in the circumstances that you described in our meeting.

What I have found on a review of the evidence and particularly [Ms Stewart]'s file note of events is that [Y] reported in his text to [Ms Stewart] on the morning of the incident that *"[X] collapsed off his chair this morn during breakfast was rigid and unconscious for around ten seconds when he came around looked confused but recovered ok and back to breakfast and looks OK now*". In addition, [Ms Stewart] noted that on the day in question "Was not alerted to the text from [Y] until seeing it and immediately calling the house at approx. 9.15am and spoke with [Ms Johnstone]. I asked what had happened and [Ms Johnstone] said *"[X] passed out and started eating his breakfast again and wanted to go to work but I've made a doctors appoint for him at 1.30 pm today."*

In my view you were well aware that [X] fell unconscious during the incident. I consider your understatement of this issue to be an aggravating feature in this case along with your reported reaction to the situation as depicted in the accounts to [A] and [B]. I consider that once you saw [Y]'s statement you saw an opportunity to "throw him under the bus."

Unfortunately, the tenor of the matters raised in [Mr Hope]'s letter, while they read well and are designed to restore trust, are in stark contrast to the matters I have noted above. If you have now changed your attitude, I consider that to be too little, too late. All trust is gone.

> **Outcome**
> My final view on this matter is that the appropriate outcome is that you are summarily dismissed for the serious misconduct previously detailed, effective immediately. I regret being in a position to have to make this decision after your 21 years of service and positive work history. In recognition of those matters I am prepared to give you the opportunity to tender your resignation effective as at 5:00 pm 31 May 2023. If you wish to take this opportunity, I will need to receive confirmation of your resignation in writing by 5:00 pm today. I am also prepared to meet with you and [Ms Stewart] to enable us to say our goodbyes in person without representatives involved if you would like to take up that opportunity.

[57] Ms Johnstone did not take up the offer of a retrospective resignation after being dismissed. A personal grievance was raised by way of letter dated 9 June 2023 and responded to by way of letter dated 30 June 2023.

Unjustified Dismissal?

[58] The Authority must determine the question of whether ZXY can justify its dismissal of Ms Johnstone on an objective basis, applying the test of justification: whether ZXY's actions, and how it acted, were what a fair and reasonable employer could have done in all the circumstances at the time it dismissed Ms Johnstone.[3]

[59] In applying the test of justification, the Authority must consider the following four factors:

(a) Whether (having regard to resources), ZXY sufficiently investigated the allegations against Ms Johnstone before dismissing her;

(b) Whether ZXY raised its concerns with Ms Johnstone before dismissing her;

(c) Whether ZXY gave Ms Johnstone a reasonable opportunity to respond to its concerns before dismissing her; and

(d) Whether ZXY genuinely considered Ms Johnstone's explanation (if any) to the allegations before dismissing her.

[60] The Authority may consider other factors as appropriate.

[3] Act, s 103A.

[61] The Authority must not determine Ms Johnstone's dismissal was unjustified solely because of minor procedural defects by ZXY that did not result in her being treated unfairly.

[62] The duty of good faith requires parties to deal with each other in good faith - it includes not indirectly doing anything likely to mislead or deceive the other.[4] The duty expressly requires an employer proposing to make a decision that may adversely impact an employee's ongoing employment, to provide access to information relevant to that decision, and an opportunity to comment on that information before deciding what to do.[5]

What is Serious Misconduct?

[63] The Court of Appeal has described the kind of conduct that will justify summary dismissal in broad terms:[6]

> Definition is not possible, for it is always a matter of degree. Usually what is needed is conduct that deeply impairs or is destructive of that basic confidence or trust that is an essential of the employment relationship. In the context of a personal grievance … questions of procedure and substantive fairness are also relevant. In the end, the question is essentially whether the decision to dismiss was one which a reasonable and fair employer would have taken in the particular circumstances.

[64] Isolated incidents of carelessness can justify a finding of serious misconduct although context is key:[7]

> … even one-off acts of inadvertence, oversight or negligence can, depending on the overall circumstances, amount to serious misconduct justifying dismissal. The Court is to stand back and consider the factual findings and evaluate whether a fair and reasonable employer would characterise that conduct as deeply impairing, or destructive of, the basic confidence or trust essential to the employment relationship, thus justifying dismissal. What must be evaluated is the nature of the obligations imposed on the employee by the employment contract, the nature of the breach that has occurred, and the circumstances of the breach. Thus, a careless act can lead to dismissal for serious misconduct, but the matter needs to be considered in light of all the circumstances and ultimately must revert back to the primary consideration to be made under s 103A of the Act.

---

[4] Act, s 4(1).
[5] Act, s 4(1A)(c).
[6] *Northern Distribution Union v BP Oil New Zealand Limited* [1992] 3 ERNZ 483 at [487].
[7] *Hines v Eastland Port Limited* [2018] NZEmpC 79 at [78].

[65] The Employment Court has commented on the problematic nature of carelessness as serious misconduct where consequences are considered:[8]

> The classification of serious misconduct becomes more problematic where an employee acts out of ignorance, carelessness, or accident but causes serious or potentially serious consequences for the employer or the employer's business. In evaluating whether an employer is justified in believing that such an act has caused the irreparable breakdown of the employment relationship, the Court has to objectively assess whether it was the *consequences* of the employee's action which have led the employer to conclude that there was serious misconduct or whether it was the *actions* or omission of the employee that were so serious.
>
> …
>
> In *Makatoa v Restaurant Brands (NZ) Ltd* the Court stated:
>
> > The mere fact that consequences are very serious does not mean that the act which produced or contributed to those consequences necessarily amounts to serious misconduct. That kind of misconduct will generally involve deliberate action inimical to the employer's interest. It will not generally consist of mere inadvertence, oversight, or negligence however much that inadvertence, negligence, or oversight may seem an incomprehensible dereliction of duty.
>
> With respect, the last four words may have overstated the position. If the behaviour has got to the point of dereliction of duty then that must come close to or even amount to serious misconduct. The word dereliction includes an element of shame and impliedly a deliberate failure to fulfil the required duty.
>
> Where an employer investigates an employee's failure to adhere to a policy or code of conduct, it has to assess whether the employee's failure to comply was because of inadvertence, oversight, or negligence or whether it was done deliberately in the knowledge that it was wrong. If the employee did not have knowledge of the relevant policy or rule, a fair and reasonable employer should find out whether that was the fault of the employee for ignoring or failing to take proper care to be familiar with the policy, or whether there was genuine room for misunderstanding as to what the policy meant. That is not to say that it is necessary for an employer to be satisfied that an employee who breaches policy or a code of conduct has done so deliberately in the sense of having mens rea or criminal intent (an approach firmly rejected in the *Hepi* case) but it is bound to investigate fully to establish why it occurred.

[66] An employer must have a reasonable basis for concluding serious misconduct has occurred. The Authority will look at the information known to an employer at the time of its conclusions, and anything relevant that ought to have been available to it following proper inquiry.[9]

[67] It is clear from the authorities that a gross dereliction of duty could amount to serious misconduct. However, the Authority must be satisfied ZXY had a sufficient and

---

[8] *Angel v Fonterra Co-operative Group* [2006] ERNZ 1080 at [78] to [81] (numbering and footnotes omitted).

[9] *Ritchies Transport Holdings v Merennage* [2015] NZEmpC 198 at [78].

reliable basis for upholding that allegation, and that ZXY's decision that what occurred amounted to serious misconduct justifying summary dismissal, and how it went about it, were what a fair and reasonable employer could have done in all the circumstances.

Consequences or Conduct?

[68] I find ZXY placed an unfair emphasis on the consequences of what occurred, rather than the conduct of Ms Johnstone, when assessing its seriousness. I do not consider a fair and reasonable employer could have in all the circumstances concluded Ms Johnstone's conduct was serious misconduct.

[69] At the outset, the consequences coloured ZXY's views. Ms Knowles acknowledged in her evidence that what caused her to consider the matter to be serious misconduct was that X nearly died. In addition, she said X was taken away from ZXY, the incident caused harm to XYZ's reputation, and there could have been a complaint to the Ministry of Health with very serious consequences. The consequences became the lens through which Ms Knowles saw what Ms Johnstone did or did not do, despite what Ms Johnstone says she knew at the time and what she would have done with the benefit of hindsight. I find this approach prevented Ms Knowles from genuinely considering the explanations provided by Ms Johnstone about what had happened and what she knew (or did not know) at the time. Ms Knowles' views of the seriousness of the matter given the consequences, including the reporting required, weighed on her mind during the disciplinary meeting. For example, she commented "I just can't get past that you didn't call an ambulance" and referred to the difficulties facing ZXY because of what happened. This disproportionately affected how ZXY framed the allegations and reached its decision that serious misconduct had occurred.

[70] Consistent with that focus on consequences, the second allegation almost exclusively focussed on what followed i.e. ZXY's view that the concluded gross dereliction of duty resulted in X's family withdrawing him from ZXY's care, and likely damage to the organisation's reputation (although in evidence it was acknowledged that through careful management, ZXY's reputation had emerged intact).

[71] I do not doubt the significance and seriousness of the situation that followed the incident including the impact on X and his family. However, in a disciplinary process it is important to distinguish between what the consequences were and what Ms

Johnstone did (or did not do) with the information she had at the time. Regrettably, Ms Knowles' focus on consequences seemed to result in what I consider were unreasonable rejections of what Ms Johnstone explained about the circumstances and led to later (in my view unfair) conclusions about Ms Johnstone engaging in serious misconduct, and the decision to dismiss.

Conscious or Unconscious?

[72] I find ZXY unfairly relied on a finding that Ms Johnstone knew X was unconscious at the time of the incident. It was clear from the disciplinary meeting Ms Johnstone said she did not know X was unconscious when deciding whether to send X to work and why she did not think to call an ambulance. ZXY did not refer to Ms Johnstone's perceived knowledge about this issue in the provisional outcome letter but did when it dismissed her. ZXY concluded Ms Johnstone's understatement of this issue was an aggravating factor justifying dismissal. It appears ZXY had concluded Ms Johnstone knew X was unconscious because Y told her that immediately after the incident.

[73] I do not consider a reasonable employer could conclude Ms Johnstone knew X was unconscious at the time of the incident. ZXY seemed to think Ms Johnstone knew based on Y's diary note and text message and Ms Stewart's notes about a conversation with Ms Johnstone after the incident during which she said X passed out. These records were all made after the incident and after the decision to send X to the marae had already been made. They do not record what Y told Ms Johnstone about the incident.

[74] A further factor reinforcing my view is that Ms Knowles in her provisional outcome letter referred to speaking with Y and relying on what he said (where relevant) but did not elaborate on what Y had said (about what he said he had told Ms Johnstone after the incident and whether he had told her X was unconscious). ZXY considered Ms Johnstone's stance she did not know to be significant. ZXY should have asked Y about that as part of the investigation and provided that relevant information to Ms Johnstone. If for example, Y confirmed he had not told Ms Johnstone that X was unconscious, then that would tend to support Ms Johnstone's claim she did not know and cast doubt on the reliability of the finding ZXY subsequently made that Ms Johnstone did know. Ms Johnstone said she considered it significant Y's incident report did not refer to telling

her X was unconscious, emailing in response to a copy that it had "saved her bacon." ZXY concluded Ms Johnstone had seen an opportunity to shift responsibility to Y.

[75] In these circumstances, failing to further investigate, or failing to provide relevant information about what Y said he had told Ms Johnstone, were procedural flaws that were more than minor and impacted materially and unfairly on the conclusion Ms Johnstone knew X was unconscious and ultimately the decision to dismiss.

Policy Factor

[76] A further aspect of the incident that appears to remain un-investigated by ZXY is the extent to which a misunderstanding about what policy required contributed to what happened. Ms Johnstone did not know at the time of the incident that ZXY considered she was required under its policies and procedures to call an ambulance based on what she understood had happened. It is significant in my view that there was no written policy guiding staff on when to call an ambulance (as opposed to calling the GP rooms). Ms Knowles relied on staff knowing this as a matter of common sense and ZXY effectively dismissed Ms Johnstone for lacking that common sense.

[77] Relying on an informal policy and common sense was problematic, particularly when ZXY relied on a failure to follow that approach in dismissing Ms Johnstone. The policy and procedures were not as clear as ZXY says. Ms Knowles indicated that one of the actions that could have been taken after the incident was that there could be more training and clarity on this. ZXY had two employees, both of whom were very experienced, who at the time did not consider it was necessary to call an ambulance, indicating there was a gap between what ZXY thought its policy was and practice.

[78] In any case, I do not consider calling an ambulance was as obvious as ZXY says. Both Y and Ms Johnstone did not think to call an ambulance given what they had observed and based on their knowledge of X and history working with him and his "normal." Even the nurse Ms Johnstone called made an appointment for later that day and did not suggest calling an ambulance. I find hindsight unfairly informed ZXY's conclusion there was an obvious need to call an ambulance that Ms Johnstone had negligently failed to recognise, and ZXY did not investigate the extent to which any gaps in its policy, procedures and practice could have contributed to what happened.

All the Circumstances

[79] The provisional outcome letter finding serious misconduct and proposing a penalty of summary dismissal listed five factual findings supporting its conclusion the first allegation of "gross dereliction of duty" was established:

(a) Ms Johnstone's failure to assess the potential seriousness of the situation including because X was keen to resume eating (despite X's disability providing a strong driver to eat) and said he wanted to go to work (when he could not make a reliable assessment himself). Relying on feedback from X in determining the seriousness of the situation was considered inappropriate.

(b) Ms Johnstone's failure to call an ambulance. Ms Knowles noted Ms Johnstone was reluctant to accept calling an ambulance was the "required procedure"' and her obvious failure to do so.

(c) Ms Johnstone's failure to fill out an incident report until asked to do so by Ms Stewart.

(d) Ms Johnstone's failure to contact her manager as soon as possible – instead relying on Y and being seemingly content for him to send a text message after some delay.

(e) Exposing a resident to unnecessary health risks – X had passed out at the marae and was a genuine medical emergency case with an emerging heart problem requiring critical care intervention at the hospital.

[80] The crux of the matter seems to be that ZXY thought Ms Johnstone failed to immediately call an ambulance and call her manager after the incident, because she negligently failed to appreciate how serious the situation was. However, that did not take into consideration what Ms Johnstone knew at the time when assessing the appropriateness of the steps she did take after recognising medical advice was required.

[81] At the time of the incident Ms Johnstone says she did not know X had an underlying heart condition. Although in her evidence Ms Stewart referred to a history of a heart murmur and a statement from a staff member after the incident referring to known heart problems, it did not appear to be in any records prior to the incident. The

suggested history was inconsistent with Ms Johnstone's prior knowledge of accompanying X to doctors' visits where no heart issues arose, and her knowledge of X's medical records at the time. Given these circumstances, it could not have reasonably been known to Ms Johnstone prior to the incident that X had an underlying heart condition.

[82] What did Ms Johnstone know when decisions were made? Less than what she knew afterwards:

(a) As noted above, Ms Johnstone did not know X had an underlying heart condition (it appeared nobody knew that prior to the incident).

(b) She had not seen X fall, but had observed he was alert, conscious, happy and otherwise normal and motivated to eat his breakfast and go to work.

(c) Ms Johnstone relied on what Y told her happened, which was that X was "sort of rigid" and may have missed or fallen off his chair but it was unclear why.

(d) X did not have any known history of epilepsy or other issues that would have caused concern.

(e) Ms Johnstone did not observe anything else that indicated something more was wrong with X, including the checks they had performed.

[83] Ms Johnstone had not relied solely on feedback from X when making decisions – it was part of the picture. Recognising something of concern had happened and that medical advice was needed, Y contacted Ms Stewart and the marae to let them know what happened, and Ms Johnstone contacted the GP's rooms for advice and an appointment. This is not a case where warning signs were ignored. Based on what Ms Johnstone knew of the situation at the time and calling on her recollections of her recent first aid training, she did the best she could in the circumstances.

[84] ZXY appeared to conclude Ms Johnstone should have called an ambulance because of Y's comment about rigidity and that X may have fallen off his chair. From Ms Johnstone's perspective, it was not obvious that an ambulance should have been called because she considered unconsciousness to be key and did not know X had been. ZXY could not point to any written policy or record of training that an ambulance

should have been called. It relied on staff knowing it was a "common sense" thing to do. It was with the benefit of hindsight and the opinions of others who knew what happened after the incident that this was "common sense." To assess Ms Johnstone's actions at the time of the incident, with hindsight, was not fair.

[85] Ms Johnstone did not knowingly fail to call an ambulance thinking she should have. It is difficult to see how a fair and reasonable employer could view what happened as a "gross dereliction of duty" which implies a deliberate action or inaction on Ms Johnstone's part in the knowledge that what she did was wrong. I do not accept she did.

[86] The conclusions also did not consider that although Ms Johnstone did not fill out an incident report within 24 hours as required by policy, she had felt overwhelmed by events and eventually did complete this upon request by Ms Stewart. Further, Ms Johnstone's delay was partly based on a misunderstanding she could co-sign Y's report, based on prior management practice.

[87] In addition, there appeared to be little if any weight given in the decision-making process and outcome to other relevant factors such as Ms Johnstone's prior practice of having called an ambulance for X and her nearly 21 years unblemished employment record with ZXY. Offering an opportunity for Ms Johnstone to retrospectively resign after the decision to dismiss because of her prior service indicates this was not meaningfully considered.

Unjustified Dismissal

[88] Having considered the factors under s 103A of the Act and the circumstances in this case, I find ZXY's dismissal of Ms Johnstone and how it went about it were not what a fair and reasonable employer could have done in all the circumstances.

What (if any) remedies should the Authority award Ms Johnstone?

[89] Where the Authority determines an employee has a personal grievance, it may provide for one or more remedies under s 123 of the Act. Ms Johnstone has sought compensation and wages lost because of her grievance.

Compensation

[90] Ms Johnstone seeks an award of compensation that is at or near $50,000.

[91] Ms Johnstone says she hugely lost confidence in herself because of her dismissal. She says the feeling of losing her job felt like being assaulted. She loved her work and felt distressed to lose her job for alleged negligence.

[92] Ms Johnstone produced two documents dated 14 March 2024 and 9 May 2024 from her doctor of 25 years. Her doctor says Ms Johnstone has suffered a huge amount of stress because of her dismissal the prior year. Her doctor records having seen Ms Johnstone on 18 May 2023 feeling anxious about her actions being questioned in a work situation. After that she became highly stressed and anxious and was eventually terminated. The earlier document records symptoms such as anxiety, palpitations, and nausea. The later document also records panic attacks, poor sleep, and loss of appetite.

[93] After considering the evidence, what has been awarded in other cases and trends generally,[10] I award Ms Johnstone $25,000 under section 123(1)(c)(i) of the Act.

Lost wages

[94] Ms Johnstone says she has been unable to work since her dismissal. At the time of the investigation meeting in late September 2024, it had been more than 12 months.

[95] Prior to being dismissed, Ms Johnstone had asked about her sick leave entitlements with a view to planning surgery for medical conditions she had. She says she had surgery in mid-June 2024 which has resulted in her being unable to drive due to recovery times. There is also an ACC certificate that shows Ms Johnstone had different surgery on 6 July 2023. Because of this Ms Johnstone qualified for earnings related compensation from ACC and was unfit for work from 6 July 2023 until 5 September 2023. Ms Johnstone says her health complications since her dismissal have meant she was unable to seek work.

[96] The document dated 9 May 2024 from her doctor. These documents were largely similar except the later one included a sentence saying Ms Johnstone's symptoms prevented her from being able to apply for new positions as she felt anxious about difficulties coping with an interview or being in a job until she had cleared her name.

[10] Such as *GF v Comptroller of the New Zealand Customs Service* [2023] NZEmpC 101 at [161] to [162].

[97] Although there is some evidence of a link between Ms Johnstone's extended unemployment and the effects of her dismissal, there is uncertainty about the extent to which this was and whether Ms Johnstone could have worked due to her underlying medical conditions (rather than symptoms caused by her dismissal). In these circumstances I do not consider it appropriate to exercise my discretion to order more than three months remuneration under s 128 of the Act.

[98] I order ZXY pay Ms Johnstone three months ordinary time remuneration.

Contribution?

[99] Ms Johnstone did not contribute to the situation giving rise to her grievance in terms of section 124 of the Act.

Summary of Orders

[100] I make the following orders:

(a) ZXY is to pay Ms Johnstone $25,000 compensation; and

(b) ZXY is to pay Ms Johnstone three months' wages.

[101] If the parties are unable to agree on the amount in paragraph [100] (b) then leave is granted to ask the Authority to do so.

Costs

[102] Costs are reserved. The parties are encouraged to resolve any issue of costs between themselves.

[103] If the parties are unable to resolve costs, and an Authority determination on costs is needed, ZXY may lodge, and then should serve, a memorandum on costs within 28 days of the date of this determination. From the date of service of that memorandum Ms Johnstone will then have 14 days to lodge any reply memorandum. On request by either party, an extension of time for the parties to continue to negotiate costs between themselves may be granted.

[104] The parties can anticipate the Authority will determine costs, if asked to do so, on its usual "daily tariff" basis unless circumstances or factors, require an adjustment upwards or downwards.[11]

Lucia Vincent
Member of the Employment Relations Authority

[11] For further information about the factors considered in assessing costs see: www.era.govt.nz/determinations/awarding-costs-remedies/#awarding-and-paying-costs-1