IN THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND

[2011] NZERA Auckland 384
5344106

	BETWEEN	IAN SIGGLEKOW Applicant
	AND	WAIKATO DISTRICT HEALTH BOARD Respondent

Member of Authority:	Rachel Larmer
Representatives:	Anamika Singh, Counsel for Applicant Amy Tiatia, Advocate for Respondent
Investigation Meeting:	22 June 2011 at Hamilton
Submissions Received	27 June 2011 from Applicant 30 June 2011 from Respondent
Determination:	07 September 2011

DETERMINATION OF THE AUTHORITY

A. Waikato District Health Board's dismissal of Mr Ian Sigglekow was unjustified.

B. Mr Sigglekow contributed to the situation which gave rise to his personal grievance.

C. Waikato District Health Board ("WDHB") is ordered to pay Mr Sigglekow:

(i) $3,461.55 for lost remuneration;
(ii) $2,000.00 as distress compensation.

D. Costs are reserved.

Employment relationship problem

[1] Mr Sigglekow's claim against Waikato District Health Board ("WDHB") came to the Authority as an interim reinstatement application. By consent, the parties agreed that an early substantive investigation should be held instead of an interim reinstatement hearing.

[2] Mr Sigglekow alleged he had been unjustifiably dismissed from his position as a Registered Nurse ("RN") in the WDHB Forensic Psychiatric Service. He sought reinstatement, compensation, interest, and costs.

[3] WDHB summarily dismissed Mr Sigglekow on 21 April 2011. It said dismissal was justified because Mr Sigglekow had engaged in serious misconduct on 13 January 2011, namely:

(a) Leaving his shift early without prior notification or authorisation; and

(b) Sleeping whilst on duty.

Work environment

[4] The WDHB Mental Health Addiction Service ("MHAS") provides a portfolio of specialist mental health and addictions services which includes the Regional Forensic Psychiatric and Rehabilitation Service ("RFPRS").

[5] The RFPRS cares for individuals who have a mental disorder which has led to criminal offending. On the WDHB Hamilton campus, RFPRS has a secure in-patient service (the Henry Rongomau Bennett Centre) and two integrated on site rehabilitation houses (Puna Taunaki and Puna Whiti). Mr Sigglekow worked in Puna Whiti.

[6] Puna Whiti is a small rehabilitation ward for mental health patients. It contains five bedrooms, a common lounge, a small TV lounge, and is akin to a home environment. Five male clients reside in Puna Whiti. They are all detained by Court order and two are held as Special Patients (i.e. patients who have committed a serious crime, who have been detained by Court order and are recorded on a special register kept by the Ministry of Health).

[7] Puna Whiti's five residents are classified as medium to low risk and all are required to take regular medication. Although the residents are generally in a stable mental state, they all have well documented histories of violence, crime, and mental health issues. Their criminal charges range from arson to causing harm to themselves or others, including grievous bodily harm, attempted murder, or murder.

[8] The residents of Puna Whiti have been within RFPRS for a long time and have followed the pathway from forensic acute admission through to a final stage of minimum security rehabilitation, as a resident of either Puna Whiti or Puna Taunaki. Although the risk level when residents reach Puna Whiti is considered low, alcohol or drug use can increase the risk immediately, so vigilance is always required.

[9] Puna Whiti and Puna Taunaki are staffed 24/7 by RNs and Psychiatric Assistants ("PAs") who work a roster comprising of three shifts:

(a) A Shift (night shift): 2300 hours to 0735 hours;

(b) B Shift (day shift): 0700 hours to 1600 hours;

(c) D Shift (evening shift): 1500 hours to 2335 hours.

[10] D Shift is the shift when there are more likely to be problems, so at least one RN and one PA are always rostered to work in each unit in the evening.

[11] The RN is required to administer medication and to monitor the mental state of and risk to the residents. The RN is also responsible and accountable for the care provided by the PA. The PA's function is to support the RN in carrying out their duties and to provide assistance to the residents with tasks, such as their household cleaning duties.

Mr Sigglekow's health issues

[12] Mr Sigglekow was a RN who had been nursing since 1993. He had been employed by WDHB since 1997, principally in the area of mental health services. He described himself as a "*psych nurse*" and said he had 15 years' experience in the forensic service (mental health).

[13] Mr Sigglekow suffered a heart attack on 16 October 2010 and was admitted to Waikato Hospital. He was discharged on 4 November 2010 and convalesced at home between 4 and 19 November 2010. On 19 November 2010, he was readmitted to hospital for one night following chest pain and convalesced at home between 20 November and 12 December 2010.

[14] On or around 7 December 2010, Mr Sigglekow called his line manager Amanda Lewis about returning to work. Ms Lewis as the Charge Nurse Manager MHAS is responsible for Puna Whiti, Puna Taunaki, and Ward 37. She told Mr Sigglekow he would need medical clearance before he could return to work.

[15] On or around 10 December 2010, Ms Lewis received a medical report from Mr Sigglekow's General Practitioner ("GP") which was dated 7 December 2010 and which stated that he was fit to undertake a gradual return to work by working four hours a day for his first roster, then six hours a day for the following roster, then full time.

Mr Sigglekow's return to work

[16] Ms Lewis facilitated Mr Sigglekow's return to work at Puna Whiti. She reorganised the roster around his GP's return to work proposal and she rostered another RN to work with Mr Sigglekow from 14-24 December 2010, so he had additional support immediately available to him if required.

[17] For his first roster, which ran from 14-19 December 2010, Mr Sigglekow worked four hour shifts. After monitoring Mr Sigglekow, Ms Lewis was concerned he would not manage an increase to six hour shifts the following week. so she and Mr Stuart Erwin, Health & Safety Adviser, arranged to meet with Mr Sigglekow on 20 December 2010.

[18] Mr Sigglekow was given advance notice of the meeting, advised of the right to have a support person, and informed the purpose of the meeting was to discuss his health requirements as they related to his return to full time return to work.

[19] At the meeting on 20 December 2010, Mr Sigglekow was asked about his state of health and how he had been managing four hour shifts. He insisted he felt fit and

asked to increase his hours of work to eight a day. Ms Lewis was reluctant to allow that, so after some discussion it was agreed he would trial six hour days and then assess his situation.

[20] After the meeting Mr Erwin prepared a Health Management Plan ("HMP") which recorded what had been agreed about Mr Sigglekow's return to work namely:

(a) Week 1 – 13th – 17th December – 4 hours per day;

(b) Week 2 – 20th – 24th December – 6 hours per day;

(c) Week 3 – 27th – 31st December – 8 hours per day;

(d) Week 4 – normal working hours.

[21] Ms Lewis said she kept an eye on Mr Sigglekow from 20-31 December 2010 and offered him reduced hours or further time off on several occasion and also encouraged him to ask for help if necessary. Mr Sigglekow told her he was fine and that he was fit to work.

25 December 2010 incident

[22] Up until 24 December 2010 Ms Lewis had rostered an extra RN to work alongside Mr Sigglekow, so the extra RN could take over his duties if he felt he was not coping. On 21 December 2010 Ms Lewis asked Mr Sigglekow if he was comfortable being the only RN to work the D Shift on 25 December 2010. He would have a PA rostered on with him as normal and only two patients would be in residence. Mr Sigglekow agreed he was happy with that.

[23] On or around 26 December 2010, Ms Diane Metekingi, Associate Charge Nurse, informed Ms Lewis that Mr Sigglekow had left his 25 December 2010 shift early, without completing the requisite hand-over. This was discovered when the Puna Taunaki RN visited Puna Whiti at 21.30 hours and found Mr Sigglekow had left without informing her and without leaving her the keys to the Puna Whiti medication cupboard.

[24] The Puna Taunaki RN completed an incident report which was passed to Ms Metekingi. Ms Metekingi discussed the 25 December 2010 incident with

Mr Sigglekow on 31 December 2010 but it was not dealt with as a disciplinary concern. No notes were taken of this discussion and the only record of it is in the incident report form.

25 December 2010 incident report form

[25] Ms Metekingi completed the "*manager's comment*" section on the form by recording the cause of the incident was:

> *"[Mr Sigglekow] Had gone home early without working out his full D shift. Had not informed RN at Puna Taunaki and had not taken keys across the road to Puna Taunaki."*

[26] Under the section "*actions taken/to be taken to minimise risk or prevent recurrence of this incident"* Ms Metekingi had recorded on 3 November 2011:

> *"[Mr Sigglekow] Informed that this was unacceptable. Asked to always communicate with Puna Taunaki RN if needing to leave. Timesheet adjusted accordingly."*

[27] Ms Metekingi passed the completed incident form to Rachael Aitchinson, Service Manager for Puawai, The Midland RFPRS to add the "*service manager comment*". Ms Aitchinson recorded "*This is currently under further investigation*", and she dated the form 24 January 2011.

Information given to Ms Lewis about Mr Sigglekow sleeping on duty

[28] On 2 January 2011 Ms Lewis told Mr Sigglekow she had received reports that Puna Taunaki staff had twice found him asleep when they had visited Puna Whiti. Ms Lewis said Mr Sigglekow accepted that he had been sleeping and said he was very embarrassed about it. Ms Lewis said she talked about the importance of role modelling for the residents and asked Mr Sigglekow if he required further time off or reduced hours, but he was adamant that he did not.

[29] Ms Lewis said the staff who told her about Mr Sigglekow sleeping on duty were not prepared to make a formal complaint, so she addressed the matter by having an informal discussion with Mr Sigglekow instead of commencing a disciplinary process.

[30] Ms Lewis did not take notes of her discussion with Mr Sigglekow but she did refer to it in an email she sent to Ms Metekingi on 2 January 2011. The purpose of her email was to leave Ms Metekingi with work instructions in preparation for Ms Lewis' departure on annual leave. Ms Lewis' email stated (amongst other things):

> *"Ian – spoke to him tonight about sleeping – told him Taunaki staff had come over twice and found him asleep. He accepted it and said he was embarrassed."*

[31] Ms Lewis did not refer the incident to Ms Aitchinson and no incident report was completed. Ms Lewis did not mention these allegations again until the middle of the disciplinary meeting.

7 January 2011 resting incident

[32] On 7 January 2011 Ms Metekingi visited Puna Whiti at around 16.00 hours and found Mr Sigglekow stretched out with his feet up on the couch and a pillow under his head. Ms Metekingi said he sat up quickly when she appeared.

[33] Ms Metekingi did not do anything about this incident. She did not express any concern to Mr Sigglekow, she did not report it to her manager Ms Lewis, and she did not complete an incident report. This incident was raised for the first time in Ms Metekingi's witness statement to the Authority. It did not form part of the disciplinary process.

13 January 2011 – disciplinary incident

[34] It is the events on the evening of 13 January 2011 which caused WDHB to dismiss Mr Sigglekow.

[35] That evening, Ms Metekingi received a text from Ms Robyn McQuiod-Rink (an off duty RN from Puna Taunaki) which reported Mr Sigglekow had left work early leaving Ms Mara Varga (the PA) on her own in Puna Whiti and that Ms Varga was apparently upset with Mr Sigglekow.

Investigation of 13 January 2011 incident

[36] Ms Metekingi met with Ms Varga on 14 January 2011 and said she could not do anything unless Ms Varga formalised her complaint.

[37] On 14 January 2011 Ms Metekingi also met with Ms Erina Morrison, Clinical Nurse Director ("CND") within MHAS. Ms Metekingi told Ms Morrison that Mr Sigglekow had been seen sleeping on 13 January 2011; he had left work early without notifying another RN; and he had left the keys to the drug cabinet with a PA before leaving his shift early.

[38] Ms Morrison advised Ms Metekingi that there were potential breaches of the NZNC nursing code of conduct; NZNC nursing competencies; and organisational expectations and code of conduct. Ms Morrison emailed Ms Metekingi her views on the incident, and she copied her email to Peter Astwood, Human Resources Consultant and Ms Aitchinson. Ms Morrison's email concluded:

> *"That these behaviours may or may not be a consequence of recent medical illness is a separate issue to be investigated by health & safety, and I Sigglekow's medical treating team."*

[39] No other investigation was undertaken about this or any of the similar preceding incidents.

Written complaint

[40] Ms Varga provided a written complaint on 17 January 2011 and the same day Ms McQuiod-Rink also provided a written statement of the discussion she had had with Ms Varga on 13 January 2011.

[41] Ms Varga's complaint recorded that Mr Sigglekow:

(a) Was not doing his share of duties;

(b) "*Was sleeping in full view of the clients*";

(c) Was interacting with the clients by snapping at them;

(d) Had told her she was OCD (meaning she had obsessive compulsive disorder) when she remonstrated with him about his use of foul language;

(e) Told her that he was really tired and said: *"You don't mind if I go home early tonight do you?"*

(f) Was not helping with the shift duties and had a bad attitude so when he asked if she minded if he went home early she told him, "*No, go home"*.

[42] Ms Varga said that Mr Paul Fuller, the RN from Puna Taunaki arrived at Puna Whiti to collect notes from the printer but that Mr Sigglekow left without doing a hand-over to Mr Fuller and without handing him the keys to the medicine cupboard. She said she asked Mr Fuller to wait while she finished her case notes, so he could countersign them for her, and she passed Mr Fuller the medicine cupboard keys to Puna Whiti before he returned to Puna Taunaki.

[43] Ms McQuoid-Rink's written statement recorded:

> *"I enquired as to how her* [Ms Varga's] *shift had been going. This was a supportive measure due to the difficulties Mara and myself had been experiencing when working with registered nurse Ian Sigglekow, namely being idle and sleeping at work.*
>
> *Mara sounded stressed over the phone and said it had not been a good night. She stated that Ian had been asleep most of the duty and when he was awake he was argumentative and sarcastic. He had gone home early leaving Mara on her own. She was alone at the time I spoke to her."*

[44] Neither Ms Varga nor Ms McQuiod-Rink were questioned about the information they had provided.

ACNM incident report

[45] On 17 January 2011, Ms Metekingi filled out an Associate Charge Nurse Manager ("ACNM") Staff Incident Report about the 13 January 2011 events which noted the prior incident of Mr Sigglekow leaving early and not following correct handover procedures on 25 December 2010.

[46] Ms Metekingi's report about the 13 January 2011 incident stated:

> *"All staff and residents have been aware that Ian has suffered a serious illness through September, October and November of 2010. On his return to work he commenced on reduced hours for one week. Everyone was more than happy to support him through this time. However, as the weeks have passed Ian has appeared to be more irritable, less interactive with the residents, sleeping for at times, long periods of time. He is constantly reminding his female colleagues on shift that he has a serious illness and they need to look after him. His*

> *work performance has been less than adequate and basic nursing protocols and procedures are not being met."*

[47] Ms Metekingi then gave some examples of the protocols and procedures that she believed were not being met by Mr Sigglekow. This included *"sleeping in full view of all residents and staff"* and entering in the case notes that a resident had a "*good night*" when the RN on duty with Mr Sigglekow had to give the resident medication, which Mr Sigglekow had missed due to his sleeping on duty. Ms Metekingi did not identify what her reference to "*sleeping for at times, long periods of time"* referred to.

[48] Ms Metekingi's report and the statements from Ms Varga and Ms McQuoid-Rink were forwarded to Ms Aitchinson. Ms Metekingi was not questioned about the content of her report, about the statements she had received from Ms Varga and Ms McQuoid-Rink, or about her discussions with Ms Morrison.

Disciplinary allegations

[49] Ms Aitchinson took advice from Ms Morrison about the seriousness of the incident and whether it raised any nursing competency issues. There is no record of either the advice given or the date on which it was provided.

[50] However, it is clear that after receiving advice from Ms Morrison, Ms Aitchinson concluded that Mr Sigglekow's actions were of a serious nature. She drafted a disciplinary letter containing allegations of serious misconduct, which she forwarded to HR to finalise and attach the accompanying documentation. Because Ms Aitchinson was beginning a period of leave the following day, she asked Ms Eileen Hughes, Service Manager for Adult Mental Health Services, to sign the disciplinary letter once it had been finalised.

[51] The disciplinary letter dated 27 January 2011 scheduled a disciplinary meeting on 2 February 2011 to discuss three allegations of serious misconduct. It stated:

> *"It is alleged that on 25 December 2010 and again on 13 January 2011:*
>
> *1. You left the work site, Puna Whiti during your rostered shift without prior notification or authorisation and did not return for the remainder of your rostered shift.*

2. *Prior to leaving the work site you left keys which enable access to the drugs, in a drawer under the control of a psychiatric assistant and did not complete the requisite hand over protocols.*

3. *You spent a period of your duty asleep."*

[52] Enclosed with the disciplinary letter were:

(a) WDHB's performance management and discipline policy;

(b) Ms Metekingi's ACNM incident report dated 17 January 2011;

(c) Ms Varga's written complaint dated 17 January 2011;

(d) Ms McQuoid-Rink's statement dated 17 January 2011.

Attempts to arrange disciplinary meeting

[53] The scheduled disciplinary meeting did not proceed on 2 February 2011. Mr Sigglekow advised Ms Lewis he required more time to organise representation, so it was rescheduled to 11 February 2011. On 5 February 2011, Mr Sigglekow had an accident at home in which he injured his heel so was off work on ACC.

[54] A further disciplinary meeting was scheduled for 1 April 2011, but that did not proceed because Mr Sigglekow said his union representative was unable to attend. Another disciplinary meeting was scheduled for 7 April 2011, but that did not go ahead because Mr Sigglekow said he was not well enough to attend because he had been admitted to Waikato Hospital on 30 March 2011 with chest pains and discharged on 1 April 2011.

[55] A fifth disciplinary meeting was scheduled for 15 April 2011, but that did not proceed because Mr Sigglekow advised WDHB the day before the meeting that his lawyer was unable to attend. WDHB tried to reschedule the meeting for 19 April 2011 but was again told Mr Sigglekow's lawyer was unavailable.

[56] The disciplinary meeting was finally held on 21 April 2011.

Disciplinary meeting

[57] Ms Aitchinson (Service Manager), Ms Lewis (Charge Nurse Manager), Ms Morrison (Clinical Nurse Director), Ms Ami Tiatia (Employee Relations Consultant), Mr Sigglekow's lawyer Simon Scott, Mr Sigglekow, and his friend Chrissy Rogers all attended the disciplinary meeting on 21 April 2011. Ms Aitchinson was the decision maker and she led the meeting.

[58] At the outset of the meeting Ms Aitchinson advised (in response to Mr Scott's question) that the reference in the disciplinary letter to 25 December 2010 had been provided as background information only and it did not give rise to any disciplinary allegations. Ms Aitchinson clarified that the disciplinary concerns related solely to events on 13 January 2011.

Mr Sigglekow's response to the allegations

First allegation – leaving shift without prior notification/authorisation

[59] Mr Sigglekow said he left his shift early because he felt sick. He stated he had felt unwell, short of breath, and as if he was going to have a further heart episode. He said he felt scared and was in pain so decided it was best for him to go home and relax. He said he advised Ms Varga and Mr Fuller that he was leaving his shift before he did so.

[60] WDHB's witnesses told me Mr Sigglekow had also told them during the disciplinary meeting that he was so sick that night he did not know if he was going to leave in an ambulance or whether he could walk out.

Second allegation – left keys under the control of the PA and did not complete hand over protocols

[61] Mr Sigglekow said that he had told Mr Fuller he was leaving and he had given Mr Fuller the keys to the Puna Whiti medicine cupboard before he left. He said he had slid the keys over to Mr Fuller who happened to be at Puna Whiti using the printer around the time Mr Sigglekow was leaving. Mr Sigglekow also said that before he left that night he had asked Ms Varga if she was happy for him to leave early, and she had agreed she was.

[62] Mr Sigglekow considered that because he had left the keys under the care and supervision of Mr Fuller he had made a genuine attempt to get things sorted before he had left his shift.

Third allegation – sleeping on duty on 13 January 2011

[63] Mr Sigglekow denied sleeping on duty but admitted "*resting*". He said the difference between resting and sleeping was that when resting you could immediately respond but when sleeping you could not be roused. Mr Sigglekow considered that resting in the workplace during a shift was an acceptable and normal practice for an RN in his position.

Adjournments during disciplinary meeting

[64] There were two adjournments during the disciplinary meeting.

[65] During the first adjournment WDHB discussed Mr Sigglekow's explanation and Ms Lewis phoned Mr Fuller to see what he could recall. Mr Fuller was involved in a work-related incident about 10 years ago which left him with a head and brain injury that affects, among other things, his mid to long term memory. Mr Fuller told Ms Lewis that he could not remember anything.

[66] When the meeting resumed Ms Aitchinson asked Mr Sigglekow some questions about his response and also explained that Mr Fuller had been contacted but did not recall anything.

[67] During this part of the meeting, Mr Sigglekow's friend, Ms Rogers, made a statement in support of him which said that she had worked with him for six years and had observed that he had a good relationship with the clients and had their welfare at heart.

[68] There was then a second adjournment during which WDHB discussed Mr Sigglekow's responses to each allegation and formed its conclusions on the allegations and outcome.

Advice from Clinical Nurse Director

[69] Ms Morrison participated in the disciplinary meeting in order to provide WDHB with professional nursing advice on whether Mr Sigglekow's actions had breached the New Zealand Nursing Council ("NZNC") Competencies for RNs and/or the NZNC Code of Conduct for Nurses. Ms Morrison was fully involved in the discussions which occurred during both adjournments.

[70] During the first adjournment Ms Morrison raised her professional concerns about a nurse sleeping or resting on duty and said both scenarios were unacceptable because they created significant risk for both residents and staff. That was not put to Mr Sigglekow to respond to.

[71] Ms Morrison also asked why Mr Sigglekow, if he was as sick as he said he was, did not seek support from either the staff on site, the after hours duty manager, 777, or the hospital's emergency department if he was so severely ill. She queried why, if Mr Sigglekow believed he was about to have a heart episode and was unsure if he would have to leave work in an ambulance, he would drive himself home where he lived alone. These queries were not put to Mr Sigglekow to respond to.

[72] During the second adjournment Ms Morrison said Mr Sigglekow had breached recognised standards of professional practice and competencies because he had left an unregulated health worker (Ms Varga) in charge of patients with a history of high and complex needs. Ms Morrison strongly believed Mr Sigglekow's actions on 13 January 2011 had significantly compromised patient safety and wellbeing. Those views were not put to Mr Sigglekow to respond to.

[73] Ms Morrison advised Ms Aitchinson Mr Sigglekow's actions had breached;

(a) Four of the NZNC Competencies for Registered Nurses; and

(b) Two of the Principles of the NZNC Code of Conduct for Nurses.

[74] These alleged breaches were never put to Mr Sigglekow to respond to.

[75] Ms Morrison said Mr Sigglekow's responses regarding the risk that arose from his actions made her extremely concerned about his practice. She said that she felt

that his stated belief that resting with his eyes closed while on duty was an acceptable practice demonstrated an underlying attitude that could not be changed or rehabilitated by further training or performance management. She therefore advocated dismissal as the appropriate outcome. This view was not put to Mr Sigglekow to respond to.

[76] Ms Morrison also told me the disciplinary meeting was disjointed and it ended so quickly she did not have an opportunity to speak. She suggested that was why her concerns had not been put to Mr Sigglekow.

Disciplinary outcome

WDHB's consideration of explanation to first allegation

[77] Ms Aitchinson believed that Mr Sigglekow's representation about how unwell he was changed over the duration of the meeting. His lawyer initially stated he had some breathing issues and felt unwell, and then Mr Sigglekow later said he was so unwell he was not sure whether he would have to leave work in an ambulance. That apparent change in the explanation was not put to Mr Sigglekow to respond to.

[78] Ms Aitchinson said there was nothing in Ms Varga's complaint which indicated that Mr Sigglekow was so severely ill that it was potentially a life and death situation. She noted that, apart from leaving work early, Mr Sigglekow had not taken any other action such as calling, or asking Ms Varga to call, the emergency medical team to the house. Mr Sigglekow had written in the diary before leaving work and he had driven himself home, where he lived alone. Ms Aitchinson concluded these were not the actions of a man so severely ill he thought he might end up in an ambulance.

[79] Ms Aitchinson concluded that Mr Sigglekow could have provided notification and obtained authorisation prior to leaving the workplace before leaving Ms Varga in sole charge of the five male patients in the unit that evening, but did not do so. Ms Aitchinson decided the first allegation had been established.

WDHB's consideration of explanation to second allegation

[80] Ms Aitchinson concluded it was difficult to tell from the evidence available exactly how Mr Fuller had taken possession of the keys to the drug cabinet. She

therefore decided to give Mr Sigglekow the benefit of doubt and concluded this allegation had not been established.

WDHB's consideration of explanation to third allegation

[81] Ms Aitchinson concluded that Mr Sigglekow had been sleeping on duty. She believed sleeping at work was unacceptable and that there was no area of nursing practice where "*resting with your eyes shut"* was an acceptable way of completing the responsibilities of an RN.

[82] Ms Aitchinson considered it critical for a forensic mental health RN to remain alert and attentive so they could deal immediately with any issues that arose. She concluded that Mr Sigglekow's sleeping whilst on duty was negligent and posed a risk to himself and others. Ms Aitchinson concluded the third allegation had been established.

Communication of disciplinary findings

[83] After a second adjournment the disciplinary meeting resumed. Mr Sigglekow was first asked if there was anything else he wanted to add in response to the allegations, and he clarified that there was not. Ms Aitchinson then outlined her findings in respect of each of the allegations and provided her reasoning.

Disciplinary sanction

Mr Sigglekow's submissions on sanction

[84] After Ms Aitchinson had informed Mr Sigglekow of her findings in respect of each disciplinary allegation, he was invited to provide submissions on the proposed sanction for the two allegations that had been substantiated.

[85] Mr Sigglekow's response was that he was "*not guilty*" of the allegations. Mr Scott stated WDHB had not supported Mr Sigglekow's return to work as far as his health issues were concerned.

New information

[86] Ms Lewis disputed Mr Scott's statement about a lack of support and explained the measures that had been put in place to support Mr Sigglekow. It was at this point the disciplinary meeting derailed. In the context of discussing what she had done to support Mr Sigglekow's return to work, Ms Lewis announced she had heard "*Mr Sigglekow had been nodding off whilst at work*", so she had arranged to spend some time with him in order to support him with his return to work.

[87] Understandably Mr Scott immediately wanted to know who had made that allegation. Ms Lewis said patients had mentioned it to her and she had spoken to Mr Sigglekow about it at the time. As an aside I note Ms Lewis' email to Ms Metekingi on 2 January 2011 stated that "*staff*" (not patients) had told her they had twice seen Mr Sigglekow asleep (not nodding off).

[88] Mr Sigglekow initially denied any knowledge of that conversation but when Ms Lewis reminded him she had raised sleeping on duty with him on 2 January 2011, he accepted that he vaguely recalled a conversation with her about that. He was not asked to clarify what he did recall and Ms Lewis was not asked to explain what she believed had been discussed.

[89] Upon hearing Ms Lewis' disclosure, Mr Scott demanded the meeting be stopped on the basis WDHB had information which had not been disclosed to Mr Sigglekow. Ms Tiatia replied that all relevant information had been provided and that Mr Sigglekow could request his health and safety records if he wanted documentation regarding his return to work.

[90] Mr Scott then apparently attempted to leave the meeting after exchanging cross words with WDHB. It was agreed at this point that the decision to dismiss would be issued to Mr Sigglekow in writing via Mr Scott.

Reasons action short of dismissal discounted

[91] Ms Aitchinson said she had considered whether a final written warning and a performance management plan should be imposed instead of dismissal but decided

that would not be appropriate because it would not manage Mr Sigglekow's attitudes or beliefs, which she considered were contrary to fundamental nursing practice.

[92] She believed Mr Sigglekow:

(a) Knew the process for an appropriate hand over but had not followed it;

(b) Had compromised the safety of the patients;

(c) Had not acted in accordance with Nursing Council competencies;

(d) Had breached WDHB's code of conduct;

(e) Was experienced enough to know his actions fell significantly below what was expected and required of an RN with his experience;

(f) Had been flippant about resting on duty;

(g) Believed he could leave as and when he individually determined.

[93] Ms Aitchinson concluded that sleeping on duty and leaving patients without a RN was a very serious matter. She felt Mr Sigglekow held beliefs, in terms of the actions he had engaged in and the responses he had given to WDHB's concerns, which were not consistent with the role, authority, or accountability of an RN. She never raised her concerns about this with Mr Sigglekow.

[94] Ms Aitchinson reflected on Ms Morrison's advice and concluded that Mr Sigglekow's attitudes and beliefs were contrary to fundamental nursing practices which was why she did not believe that a final written warning together with a performance management plan was appropriate. Ms Aitchinson never shared Ms Morrison's views with Mr Sigglekow.

[95] Ms Aitchinson said she considered whether Mr Sigglekow's actions were the result of his ill health but concluded they were not. Ms Aitchinson said Mr Sigglekow and his medical practitioner had confirmed he was fit for work and she believed he had been supported appropriately during his return to work.

[96] Ms Aitchinson did not take any steps to investigate issues around his health and return to work, instead relying on the fact he was back at work full time to

establish that Mr Sigglekow was fully fit to undertake his normal duties and had no ongoing health issues.

[97] Ms Aitchinson said that Mr Sigglekow had been offered support and time off after his medical event and there had been ample opportunity for him to raise any medical problems with WDHB prior to the 13 January 2011 incident. Mr Sigglekow had declined offers of further assistance, including additional time off or shorter shifts, and he had insisted that he was better to be at work.

[98] Ms Aitchinson considered Mr Sigglekow had been informed of expectations following a similar incident which had occurred on 25 December 2010 when he left the unit and patients in the care of a PA. She did not make any inquiries to determine what Mr Sigglekow had been told in response to that incident. Nor did she evaluate the 25 December 2010 incident form which appeared to set different requirements for leaving a shift early from what Ms Aitchinson believed applied.

[99] Ms Aitchinson said that her trust in Mr Sigglekow had been severely compromised by the actions he took on 13 January 2011 and also by the lack of concern he displayed about the incident and his actions. For all these reasons she concluded action short of dismissal was not appropriate.

Performance Management Disciplinary Policy

[100] The WDHB Performance Management and Discipline Policy sets out the factors that must be considered where an employee's employment is terminated. I am satisfied Ms Aitchinson appropriately considered all of the relevant factors, namely:

(a) Nature of the act – she concluded that Mr Sigglekow had engaged in serious misconduct;

(b) Gravity of the act – she considered that there was a risk to staff and patients and was particularly concerned about the impact on special patients when left in the unit with only a PA present;

(c) Consequences of the act – she was concerned that Ms Varga had been left alone and she considered this posed a significant risk to her and others if an incident had occurred;

(d) Employment history – she noted Mr Sigglekow had no previous warnings, so was entitled to credit for that;

(e) Whether Mr Sigglekow had admitted to the circumstances of the allegation – she concluded he had not done so;

(f) Whether Mr Sigglekow had displayed insight with regard to the appropriateness of his actions – she decided he had not done so.

[101] After applying this policy, Ms Aitchinson ultimately decided that termination of Mr Sigglekow's employment was the appropriate outcome. However, before implementing her decision, she spoke with her direct line manager, Mr Jeff Bennett, and he told her he supported her decision to dismiss Mr Sigglekow. It was unclear what information Ms Aitchinson conveyed to Mr Bennett or why he supported her decision to dismiss. Mr Sigglekow was never advised that Mr Bennett would be, or had been, involved in the decision to dismiss him and it was not clear what influence Mr Bennett had on the outcome.

Dismissal letter

[102] Ms Aitchinson prepared the dismissal letter on 21 April 2011 which stated:

> *"I do not accept your explanations to allegations one and three […] and consider these allegations have been substantiated.*
>
> *[…]*
>
> *I have decided your actions in respect of allegation one and three represent a disregard to WDHB policy. As a result, the necessary trust and confidence required in your position and in the employment relationship is lost. I have therefore decided to summarily dismiss you from your employment with WDHB effective immediately."*

Relevant Law

New s103A justification test

[103] The statutory justification test has recently been amended. On 1 April 2011 s.103A was substituted by s.15 of the Employment Relations Amendment Act 2010. The new justification test came into effect on 1 April 2011.

[104] Mr Sigglekow was dismissed on 21 April 2011, so justification of his dismissal falls to be determined under the new justification test. This is the first case I am aware of in which the Authority has had to consider the new s103A justification test in respect of a substantive matter.

[105] The new s103A now states:

> ***"103A Test of justification***
>
> *(1) For the purposes of s.103(1)(a) and (b), the question of whether a dismissal or an action was justified must be determined, on an objective basis, by applying the test in subsection (2).*
>
> *(2) The test is whether the employer's actions, and how the employer acted, were what a fair and reasonable employer could have done in all the circumstances at the time the dismissal or action occurred.*
>
> *(3) In applying the test in subsection (2), the Authority or the Court must consider –*
>
> *(a) Whether, having regard to the resources available to the employer, the employer sufficiently investigated the allegations against the employee before dismissing or taking action against the employee; and*
>
> *(b) Whether the employer raised the concerns that the employer had with the employee before dismissing or taking action against the employee; and*
>
> *(c) Whether the employer gave the employee a reasonable opportunity to respond to the employer's concerns before dismissing or taking action against the employee; and*
>
> *(d) Whether the employer genuinely considered the employee's explanation (if any) in relation to the allegations against the employee before dismissing or taking action against the employee.*
>
> *(4) In addition to the factors described in subsection (3), the Authority or the Court may consider any other factors it considers appropriate.*
>
> *(5) The Authority or the Court must not determine a dismissal or an action to be unjustifiable under this section solely because of defects in the process followed by the employer if the defects were –*
>
> *(a) Minor; and*
>
> *(b) Did not result in the employee being treated unfairly."*

Submissions

[106] Ms Singh's submissions did not refer to justification at all, so they did not provide the Authority with any assistance as to how it should be applied to

Mr Sigglekow's dismissal. Ms Tiatia acknowledged the new justification test, but did not provide any submissions on how it should be applied.

Requirements of the new test

[107] I find the new test requires the Authority to:

(a) Consider justification objectively[1] i.e. from the view of a neutral observer[2] or in a dispassionate or disinterested manner[3];

(b) Focus its inquiry on the employer's conduct[4];

(c) Consider substantive justification by assessing;

(i) the employer's actions i.e. substantive justification (what the employer did/the outcome and the grounds for it/the merits of the employer's conclusions of fact)[5]; and

(ii) how the employer acted i.e. procedural fairness (the process it used in arriving at its outcome)[6];

(d) Apply the standard of a notional hypothetical fair and reasonable employer to the conduct of the actual employer[7];

(e) Assess justification at the time the dismissal (or other action) occurred[8];

(f) Consider all of the circumstances at the time the dismissal (or action) occurred.[9] This will include but is not limited to:

(i) The employer's actions and reactions[10];

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1 Section 103A(1) ERA
2 *Air New Zealand Ltd v. Hudson* [2006] ERNZ 415 (para.13)
3 *X v ADHB* [2007] ERNZ 66 (para.96)
4 Section103A(2) ERA and *X v ADHB* supra (para 97)
5 Supra
6 Supra
7 Ibid 2 and *X v ADHB* ibid 3 (para 97)
8 Ibid 3
9 Supra
10 Ibid 2

(ii) The circumstances in which the misconduct arose[11];

(iii) The employer's business circumstances[12];

(iv) The employee's personal circumstances[13];

(g) Specifically consider each of the factors in s103A(3), namely whether:

(i) Having regard to the employer's resources, its investigation was sufficient;

(ii) The employer raised its concerns with the employee;

(iii) The employee was given a reasonable opportunity to respond;

(iv) The employer considered the employee's explanation (if any);

(h) Identify and then consider other appropriate factors such as:

(i) Good faith requirements[14];

(ii) Contractual obligations (express, incorporated, implied)[15];

(iii) Whether the employer's expectations were made clear to the employee[16];

(iv) Conduct of the parties[17];

(v) History of the employment[18];

(vi) Nature of the industry and its customs and practice[19];

(vii) Nature and quality of resources available to the employer, including access to specialist HR advice[20];

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11 *Wellington Road Transport Industrial Union of Workers v. Fletcher Construction* [1983] ACJ 653, 666; *Hudson* ibid 2 (para.142)

12 Supra

13 Supra

14 Ibid 3 and *Air New Zealand Ltd v. V* [2001] ERNZ 185

15 Ibid 3

16 *Chief Executive of Department of Inland Revenue v. Buchanan* [2005] ERNZ 767

17 Ibid 11

18 Supra

19 Supra

20 *The Chief Executive of The Department of Corrections v Tawhiwhirangi* [2007] 1 ERNZ 610, (para 11)

(viii) Industrial practice, which involves some consideration of the social and moral attitudes of the community[21];

(ix) Statutory or public interest obligations on the employer[22];

(x) Relevant policies, procedures, and other non-contractual employment documentation[23];

(xi) Size of workplace and number of employees involved[24];

(xii) Whether significant conclusions, including tentative ones, were articulated to the employee[25];

(xiii) Disparity of treatment;

(xiv) Compliance with statutory good faith requirements[26];

(xv) The objects of the Act, in particular s.3 and s.101, maybe taken as a guide to the standards which apply to a fair and reasonable employer[27];

(xvi) The established judge made law of personal grievances[28];

(xvii) Mitigating factors[29];

(i) Assess the nature of any process defects to determine:

(i) Whether they were minor only, and if so;

(ii) Whether or not they resulted in any unfairness to the employee.

[108] Because the Authority is required to consider the employer's actions at the time the dismissal occurred that means that if relevant information comes to light

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21 Ibid 11
22 Ibid 20 (para 11)
23 Ibid 3
24 Ibid 20 (para 11)
25 Ibid 3 (para 153)
26 Section 4 ERA; *X v ADHB* ibid 3 (para 100)
27 Ibid 15 and ibid 2 (para 129)
28 Ibid 3
29 *Fuiava v Air New Zealand Ltd* [2006] ERNZ 806; *Angel v Fonterra Co-Operative Group Ltd* [2006] ERNZ 1080

later, or the employer subsequently discovers new conduct that may have given grounds for dismissal, then does that not affect justification, although it may be relevant to remedies.[30]

[109] The employer's decision is still subject to proper, objective, and independent scrutiny as it was previously. The new justification test in a disciplinary context still encompasses the employer's investigation, its decision about whether misconduct or serious misconduct has occurred, and the ultimate outcome or sanction[31].

[110] The employer's actions at each of these stages must still be scrutinised, although the Employment Court in *Hudson* warned that should not be done in a mechanical way because the lines between each of these stages are often blurred.[32]

[111] In a case such as this when misconduct is not admitted, the Authority's inquiry is into whether, after conducting a full and fair investigation, the employer had an honest belief, based on reasonable grounds that the employee had engaged in misconduct or serious misconduct.[33]

[112] Section 103A requires the Authority to examine whether the actions of the employer which led to its purported honest belief that serious misconduct had occurred were reasonable. In doing so the standards of a notional employer must be applied to the conduct of the actual employer.[34]

[113] The factors in s.103A(3) which must be considered by the Authority or Court when applying the test in s.103A(2) are consistent with widely recognised principles of procedural fairness and natural justice. Failure to comply with these factors may result in the employer being unable to justify its actions and how it acted.

[114] The factors which must considered under s.103(3) are mandatory, but not exclusive. Section 103A(4) allows the Authority to "*consider other factors it thinks appropriate*" so that will also inform the objective assessment of the employer's actions and how it acted.

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30 Ibid 3 (paras. 98 and 99)
31 Ibid 14
32 Ibid 2 (para.133)
33 *Airline Stewards & Hostesses of NZ IOUW v Air New Zealand* (1983) ERNZ Sel Cas 10
34 Ibid 3 (para 97)

[115] The nature of any procedural defects must be assessed under s.103A(5) to determine whether they were minor defects, and if so, whether or not they resulted in the employee being treated unfairly. Minor procedural defects which do not result in unfairness to the employee will not result in a dismissal or action being unjustified solely because of process defects.[35]

"Could" vs "would" distinction

[116] The new justification test has substituted the word "*would*" for "*could*".[36]

[117] The Employment Court in *Air New Zealand Limited v Hudson*[37] held that, in the context of considering justification of dismissal, the Court of Appeal's use of the word "*could*" in *W&H Newspapers v Oram*[38] widened the range of misconduct responses open to an employer.

[118] In *Hudson* the difference between "*could*" and "*would*" was explained as:

> *"The difference between whether a person is able to respond in a certain way or whether a person who is able to respond would actually respond in that way."*[39]

[119] I consider the new test means that both process and substance issues are to be assessed in light of whether a fair and reasonable employer was able to respond to the situation in the particular way the actual employer did. If so, the actual employer's actions will meet the requirements of s.103(2) of the Act, if not then the actual employer's actions will fall short of the standard required.

[120] My view is that the previous s103A justification test did not prevent employers from having recourse to a range of possible disciplinary options, but it did involve evaluating the employer's choice against the objective standard of: "*what would a fair and reasonable employer have done in all the circumstances?*"[40]

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35 Section 103A(5) ERA
36 Section 103A(2) ERA
37 Ibid 2 (para.435)
38 [2000] 2 ERNZ 448 (para 32)
39 Ibid 2 (para 139)
40 Supra

[121] The Authority must still judge the employer's actions against the objective standard of a fair and reasonable employer, but the standard to be applied is what the Authority concludes a fair and reasonable employer in the circumstances of the actual employer could have decided and how those decisions could have been made. The actual employer's actions are now to be assessed against the standard of what a fair and reasonable employer could have done in all the circumstances.

Application of justification test

[122] Mr Sigglekow denied engaging in the misconduct for which he was dismissed. The new justification test required WDHB to show it carried out a full and fair investigation which disclosed conduct a fair and reasonable employer could regard as serious misconduct. Whether a full and fair investigation has been conducted will be considered in light of the factors in s.103A(3); statutory good faith requirements[41], and longstanding natural justice principles. WDHB must also then establish that dismissal was a response that could be taken by a fair and reasonable employer in all the circumstances at the time dismissal occurred.

Consideration of s.103A(4) factors

Was there a sufficient investigation, given WDHB's resources?

[123] WDHB is an employer with considerable resources at its disposal. It had in house HR expertise available which it accessed from the outset. WDHB also involved its legal advisor at an early stage, and she attended the disciplinary meeting. The incident Mr Sigglekow was disciplined for occurred on 13 January 2011 and his disciplinary meeting was not held until 21 April 2011. WDHB clearly had sufficient time and resources to undertake a proper investigation.

[124] The allegations were serious ones that put Mr Sigglekow's ongoing employment in jeopardy. Mr Sigglekow was a very experienced psych nurse and a long serving WDHB employee who had a clean disciplinary record. At the time of the incident, Mr Sigglekow had only just returned to work after a lengthy period away due to a significant illness. Ms Metekingi's ACNM incident on 17 January indicated Mr Sigglekow's performance after his return to work had deteriorated, in

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41 Section 4 ERA

circumstances which suggested that deterioration in performance was linked to his recent health issues.

[125] These circumstances indicated that a thorough investigation was necessary and appropriate which WDHB, with its considerable resources, was well placed to do.

[126] I find WDHB's investigation was insufficient. It was not a full or fair investigation. The decision-maker, Ms Aitchinson, had material available to her that obviously indicated further inquiries and investigation was required. WDHB failed to act fairly and reasonably by not properly investigating its concerns

[127] I consider a fair and reasonable employer, in order to conduct a full and fair investigation, needed to have inquired into:

(a) Why no disciplinary action had been taken over the 25 December 2011 incident when WDHB now intended to treat similar but less serious conduct (the 13 January 2011 incident) as serious misconduct;

(b) Why no disciplinary action had been taken over previous information Mr Sigglekow had been seen sleeping on duty when WDHB now intended to treat the allegation of sleeping on 13 January 2011 as serious misconduct;

(c) Ms Lewis' email to Ms Metekingi on 2 January 2011 which recorded that:

(i) Staff had twice seen Mr Sigglekow sleeping on duty;

(ii) Ms Lewis had spoken to him about that;

(iii) Mr Sigglekow admitted he had been sleeping on duty and was embarrassed about it.

(d) Why no disciplinary action had been taken over the allegation in Ms Metekingi's report on 17 January 2011 that Mr Sigglekow had made incorrect patient notes because he had not known that a patient had been medicated by another RN because he (Mr Sigglekow) had been sleeping on duty when WDHB now intended to treat the

13 January 2011 sleeping on duty allegation as serious misconduct despite it being less serious than the incident Ms Metekingi referred to;

(e) Why no disciplinary action was taken about Ms Coll's report that she saw Mr Sigglekow sleeping on duty on 20 January 2011 when WDHB intended to treat the allegation of sleeping on duty on 13 January 2011 as serious misconduct;

(f) Why suspension was not considered in light of Ms Morrison's view that Mr Sigglekow's actions on 13 January 2011 posed a serious risk to himself, other staff, and patients. The fact he was allowed to continue working as normal is inconsistent with Ms Morrison's view that his practice was unsafe and posed a risk to others. That inconsistency needed to be properly examined by Ms Aitchinson;

(g) What WDHB policy Mr Sigglekow had allegedly breached and what specific breaches were alleged to have occurred;

(h) What procedure had to be followed if a sole RN on duty in Puna Whiti or Puna Taunaki had to leave their shift early;

(i) Why Ms Metekingi's comments in the report on the 25 December 2010 incident appeared to instruct Mr Sigglekow to follow a different process for leaving early than the authorisation and notification process WDHB believed applied;

(j) What (if anything) had been communicated to all staff about authorisation and notification requirements if they had to unexpectedly leave their shift early;

(k) What (if anything) had been communicated to Mr Sigglekow about authorisation and notification requirements if he had to leave work early, particularly if he was the sole RN on duty;

(l) Whether the 13 January 2011 incident was a health (i.e. medical incapacity) issue rather than a misconduct (i.e. disciplinary) issue;

(m) Whether the concerns arising from the 13 January 2011 incident involved performance rather than misconduct issues;

(n) What had been done in response to Ms Morrison's email of 14 January 2011 which correctly identified the need to investigate whether Mr Sigglekow's behaviour on 13 January 2011 was a consequence of ill health;

(o) What clinical practice issues Ms Morrison believed had arisen as a result of the 13 January 2011 incident and why;

(p) What Ms Morrison meant in her email of 14 January 2011 when she said she considered Mr Sigglekow had breached the "*RN Code of Conduct, NC competence to practice and WDHB organisational expectations of employment conduct*". In particular, what were the specific breaches and what specifications did she consider were in breach;

(q) What Mr Fuller recalled about the events on 13 January 2011. He should have been spoken to on 14 January 2011 or as soon thereafter in light of WDHB's knowledge of his mid-long term memory problems. If he had been spoken to immediately it was likely he could have recalled what had occurred;

(r) Whether Mr Sigglekow's health had deteriorated subsequent to his GP's certificate of 10 December 2010 and if so, whether Mr Sigglekow's managers were aware or should have been aware of that;

(s) Whether Mr Sigglekow had been fully fit to undertake his normal fulltime duties at the time the 13 January 2011 incident occurred;

(t) The nature of Mr Sigglekow's recent health issues and in particular what if any issues that presented in terms of his work requirements. Such inquiries would include what, if any, arrangements were in place

if he became unwell or was not coping during a shift when he was the only RN on duty;

(u) The details of Mr Sigglekow's return to work plan, the assistance that had been given to him, and whether his return to full time duties had been properly supported and monitored;

(v) What if any instructions Ms Metekingi had given Mr Sigglekow in response to the 25 December 2010 incident;

(w) What Ms Varga's belief Mr Sigglekow had been *"sleeping in view of the patients"* was based on;

(x) Ms Varga's response to Mr Sigglekow's explanation he had briefly rested with his eyes closed because be became unwell during his shift and was trying to compose himself;

(y) Whether Ms McQuoid-Rink had personally experienced Mr Sigglekow sleeping at work (and if so when) or whether she was merely repeating what Ms Varga had told her about the evening of 13 January 2011;

(z) Ms Coll's written statement because it alleged she had seen Mr Sigglekow asleep at work on 20 January 2011 and that he had appeared, *"limp"*, *"vague and unaware of his surrounding"* *"unfocussed and unwell*". This was relevant firstly to his health issues and secondly to why no disciplinary action had been taken over that sleeping allegation;

(aa) What Ms Metekingi's comment in her 17 January 2011 report that Mr Sigglekow had been *"sleeping for at times, long periods of times"* was based on;

(bb) The medical report dated 3 February 2011 (provided after he was given the disciplinary letter) stated Mr Sigglekow's convalescence was likely to extend over a long period of time during which he would need support and may need to finish shifts early or take time off because

that information suggested he may not have been fully fit to work as the only RN on duty at the time the incident occurred;

(cc) The deteriorating performance issues identified by Ms Metekingi that had arisen since as a result of Mr Sigglekow's return to fulltime duties and to what (if any) extent these were linked to his recent health problems;

(dd) What Ms Lewis was referring to when she told the disciplinary meeting patients had told her they had seen Mr Sigglekow *"nodding off"* whilst on duty;

(ee) Ms Lewis' email to Ms Metekingi that staff had reported seeing Mr Sigglekow sleeping on duty twice and that he had accepted that and was embarrassed;

(ff) What Ms Lewis had previously discussed with Mr Sigglekow about reports that he had been sleeping on duty.

[128] None of these inquiries was onerous and could have been easily undertaken with the time and resources WDHB had available. I find that WDHB's failure to make any inquiries into the above matters resulted in an inadequate and insufficient investigation. That meant WDHB did not have the full picture so it was unable to properly evaluate all relevant information. This meant it disciplined and dismissed Mr Sigglekow without being aware of all the circumstances.

Did WDHB raise its concerns with Mr Sigglekow before dismissing him?

[129] Although Ms Aitchinson dismissed Mr Sigglekow because she considered his actions had breached NZNC requirements regarding competencies for RNs, that was never raised with him. The disciplinary letter did not refer to NZNC requirements and these were not discussed with Mr Sigglekow during the disciplinary meeting.

[130] Ms Morrison provided detailed information to Ms Aitchinson about what she considered to be serious breaches of the NZNC Code of Conduct and Competencies for Nurses, but that was never shared with Mr Sigglekow, so he had no opportunity to respond to her specific concerns.

[131] Ms Morrison and Ms Aitchinson both believed Mr Sigglekow held beliefs which were inconsistent with his role as a RN and which made action short of dismissal inappropriate. These concerns were critical to the decision to dismiss him but they were never put to him, thereby depriving him of an opportunity to respond to them.

[132] The dismissal letter referred to a breach of WDHB policy, but Mr Sigglekow was never told what policy WDHB believed he had breached or why.

[133] I find that WDHB did not raise key concerns with Mr Sigglekow which were fundamental to its decision to dismiss him.

Was Mr Sigglekow given a reasonable opportunity to respond to WDHB's concerns?

[134] Mr Sigglekow did not have an opportunity to respond to any of the concerns I refer to above because WDHB had not raised those with him. He was therefore unable to respond to whether or not he held the beliefs WDHB attributed to him. He was also unable to respond to whether those beliefs, if held, made action short of dismissal inappropriate.

Did WDHB genuinely consider Mr Sigglekow's explanation?

[135] Mr Sigglekow denied sleeping, but admitted resting on the couch with his eyes closed in an attempt to compose himself because he was ill. He said he believed his actions were consistent with his doctor's advice to rest when necessary.

[136] Mr Sigglekow said that after a short time he decided he would be better off at home, so he made arrangements with Ms Varga and Mr Fuller to leave his shift early. Mr Sigglekow said he followed procedure because he notified the Puna Taunaki RN (Mr Fuller) he was leaving early and handed him the keys to the Puna Whiti medicine cupboard which is what he said Ms Metekingi had told him to do when she spoke to him about the 25 December 2011 incident.

[137] By the time Mr Sigglekow provided this explanation on 21 April 2011 Mr Fuller, because of his head injury, had lost his memory of the events of 13 January 2011. Ms Varga's written statement just said that Mr Sigglekow had told her he was "*really tired*" and that she was annoyed with him "*sleeping in full view of the clients*".

[138] Ms Varga's statement did not contain sufficient detail to enable WDHB to understand why she believed Mr Sigglekow had been sleeping and it did not say anything about Mr Sigglekow becoming ill during the shift. Nor did it address the circumstances of the purported handover to Mr Fuller. Without making further inquiries of Ms Varga, WDHB did not have sufficient information to enable it to properly assess Mr Sigglekow's explanation.

[139] Ms McQuoid-Rink's statement on the face of it was hearsay, so it would have been unreasonable for it to have preferred that over Mr Sigglekow's direct evidence of events.

[140] Ms Aitchinson rejected Mr Sigglekow's explanation to the first allegation because she believed Mr Sigglekow knew he was required to notify and/or seek authorisation from a manager before leaving early. However, that was not a finding a fair and reasonable employer could have made based on the evidence available at the time because it contradicted the instruction Ms Metekingi had recorded in her report on the 25 December 2010 incident. Ms Aitchinson must have been aware of that instruction because Ms Metekingi's report had been sent to her and she had signed it.

[141] I find WDHB did not genuinely consider Mr Sigglekow's explanation because:

(a) It did not question him about the circumstances of his admitted *"resting"* so it was not in a position to assess the seriousness or otherwise of his conduct;

(b) It did not follow up issues that arose out of his explanation (such as why Ms Varga believed he was sleeping on duty);

(c) It ignored its own information which supported his explanation (the 25 December incident report about the procedure he had to follow if he went home early).

Consideration of other appropriate factors under s103A(4)

Did WDHB comply with its good faith obligations?

[142] A fair and reasonable employer would comply with its statutory good faith obligations.[42]

[143] Section 4(1A)(c)(i) required WDHB to provide Mr Sigglekow with access to information relevant to the continuation of his employment and s.4(1A)(c)(ii) required WDHB to give him an opportunity to comment on the information before it decided to dismiss him.

[144] WDHB breached its good faith obligations because it failed to provide him with information relevant to its concerns, thereby depriving him of an opportunity to comment on all relevant information before he was dismissed. I discuss this information below.

(i) Ms Lewis' information about previous sleeping on duty incidents

[145] At the end of the disciplinary meeting Ms Lewis raised for the first time that patients had told her Mr Sigglekow had been seen "*nodding off*" at work. This was unexpectedly sprung on Mr Sigglekow and when his representative asked for disclosure of the information Ms Lewis' comment was based on, it was not provided. Ms Lewis just said she had discussed the patients' complaint with Mr Sigglekow on 2 January 2011.

[146] I consider that comment by Ms Lewis was misleading because her email of 2 January 2011 recorded that it was staff from Puna Taunaki who had twice seen Mr Sigglekow sleeping on duty. The information was different because on one account by Ms Lewis said patients had seen Mr Sigglekow nodding off whilst her other account said staff had twice seen Mr Sigglekow sleeping.

[147] New allegations from Ms Lewis that Mr Sigglekow had been seen sleeping on duty before the 13 January 2011 incident were highly prejudicial. They were also likely to have influenced Ms Aitchinson because this reference was included in the notes she made regarding her view of the disciplinary meeting.

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42 Ibid 3 (para 102)

[148] Not only was the detail of Ms Lewis' allegations not provided, but the manner in which the issue was raised meant Mr Sigglekow did not have a genuine opportunity to properly respond to it. WDHB ignored Mr Scott's concerns and proceeded to dismiss Mr Sigglekow without first disclosing the full details of the matter(s) Ms Lewis had referred to.

(ii) 25 December 2010 incident report

[149] Ms Aitchinson had a copy of the 25 December 2010 incident report which appeared to support Mr Sigglekow's view of the procedure he was required to follow if he left work early. The incident report was never disclosed to Mr Sigglekow, so he was unable to comment on it. That was a serious omission because it supported his explanation.

(iii) Ms Morrison's views on professional issues

[150] Ms Morrison sent an email to Ms Metekingi, (copied to Ms Aitchinson) on 14 January 2011 which stated that Mr Sigglekow's conduct on 13 January 2011 was unprofessional. That was never disclosed to him, so he could not comment on it.

[151] Ms Morrison's advice on 14 January 2011 was that Mr Sigglekow had clearly breached the:

(a) RN code of conduct,

(b) NZNC Competence to Practice; and

(c) WDHB's organisational expectations of employment/conduct.

[152] Mr Sigglekow was never told about Ms Morrison's views, nor was he given any of the above documents to comment on.

[153] Ms Aitchinson took additional advice from Ms Morrison before she decided to proceed with disciplinary action. However, there is no record of what Ms Morrison's advice was or when it was given and Mr Sigglekow was never told what Ms Morrison's view had been.

[154] During the adjournments to the disciplinary meeting, Ms Morrison provided very strong views about Mr Sigglekow's conduct and the professional issues it presented, but Mr Sigglekow was never made aware of that, so he did not have an opportunity to comment on Ms Morrison's adverse view of him.

Did WDHB make its expectations clear to Mr Sigglekow?

[155] I find that WDHB did not make its expectations clear to Mr Sigglekow prior to dismissing him. It led him to believe that the procedure he adopted when he left work early was acceptable and it impliedly condoned his resting/sleeping at work by failing to take appropriate remedial action over previous instances of resting/ sleeping on duty.

(iv) Authorisation and notification procedure when leaving early

[156] WDHB's position was that Mr Sigglekow had to get authorisation from, and notify, a manager before he could leave work early and that he should have known that. WDHB was unable to produce any evidence to show that expectation had been communicated either to its staff or to Mr Sigglekow. WDHB's position was that Mr Sigglekow should have just known that without specifically being told.

[157] I do not accept that view because Ms Metekingi's comments in the 25 December 2010 incident record that she told Mr Sigglekow that if he had to leave early he had to notify the Puna Taunaki RN and give them the keys implied that was the procedure he had to follow. That is what he did on 13 January 2011.

[158] Although Ms Metekingi specifically spoke to Mr Sigglekow about her concern over the manner in which he had left work early on 25 December 2010, she did not tell him he had to get authority from and notify a manager before he left a shift early. If that really was WDHB's policy then Ms Metekingi, as Mr Sigglekow's manager, should have raised that with him and it should have been noted in the report in the remedial action section. Ms Metekingi accepted she had never specifically told Mr Sigglekow he had to contact a manager before leaving early.

[159] I find that WDHB had led Mr Sigglekow to believe that the actions he took when leaving early on 13 January 2011 were appropriate.

(v) Sleeping at work

[160] In addition to the 13 January 2011 allegation, WDHB managers were aware of at least five (and possibly many more) other instances when Mr Sigglekow had allegedly been seen sleeping or resting on duty:

(a) Staff from Puna Taunaki told Ms Lewis they had twice seen Mr Sigglekow sleeping on duty. Ms Lewis briefly mentioned that to Mr Sigglekow on 2 January 2011 but nothing was done to make him aware such behaviour was unacceptable and could potentially result in summary dismissal;

(b) Ms Lewis in the disciplinary meeting said patients had told her they had seen Mr Sigglekow *"nodding off"* at work but there was no evidence any action had been taken over that disclosure;

(c) Ms Metekingi's report on the 13 January 2011 incident referred to a prior instance when Mr Sigglekow's sleeping on duty had resulted in him missing a patient's medication. However, nothing was ever done about that, which suggested WDHB did not view it as a serious concern at the time;

(d) Ms Metekingi's report noted that since Mr Sigglekow had returned to work he *"has […] been sleeping for at times, long periods of time"*. This suggested Mr Sigglekow had a prior history of sleeping on duty which had not been addressed;

(e) Ms McQuoid-Rink's statement suggested she may have had personal experience of Mr Sigglekow sleeping on duty, but that was not followed up by WDHB;

(f) Ms Aitchinson had Ms Metekingi's information before she drafted the disciplinary letter, but the information about sleeping (outside of the 13 January 2011 incident) was not pursued as a disciplinary concern;

(g) Ms Metekingi told Ms Varga when she spoke to her on 14 January 2011 that she would not take any action about the 13 January 2011

events without a written complaint. If WDHB had viewed sleeping on duty as seriously as it told me it did, then it should have been prepared to raise that (even if it did not make it a disciplinary matter) with Mr Sigglekow regardless of whether it had received a formal complaint;

(h) On 7 January 2011 Ms Metekingi saw Mr Sigglekow stretched out with his feet up on a couch and a pillow under his head when he was on duty, but she did not do anything about it. She did not raise it with Mr Sigglekow. She did not mention it to her manager. She did not put it in her report on the 13 January 2011 incident (although her report did refer to another sleeping on duty incident). She did not tell Ms Aitchinson about it once she knew disciplinary action had been commenced against Mr Sigglekow for sleeping on duty. Mr Sigglekow knew Ms Metekingi had seen him lying on the couch because he jumped up when she disturbed him, but there were no consequences or repercussions for his actions which implied such conduct was not viewed as serious misconduct at that time;

(i) Ms Coll provided a written statement dated 21 January 2011 (i.e. before the disciplinary letter was prepared) which alleged she had seen Mr Sigglekow sleeping on duty on 20 January 2011. This statement was available to Ms Metekingi and Ms Aitchinson, neither of whom did anything about it. It did not give rise to any disciplinary concerns despite the sleeping allegation being more detailed and therefore more credible than the allegation Ms Varga made in her statement of 17 January 2011.

[161] The complete failure by WDHB to properly address any of these other instances of alleged sleeping on duty implied it did not consider resting/sleeping on duty to be a disciplinary concern much less examples of serious misconduct.

Did WDHB comply with its own policies or procedures?

[162] WDHB's Performance Management and Discipline Policy dated 16 February 2009 required that:

"Prior to disciplinary action being taken, a fair and reasonable preliminary investigation into the event/incident should be completed.

The investigation should endeavour to include:

- *Collection and recording of witness statements (if applicable);*
- *Verification of records and facts (if possible);*
- *Advice from a suitably qualified professional when it is relevant to the matter being investigated*
- *Copy of the incident form(s)*

***No disciplinary action is to be decided upon, or taken, before the relevant facts have been evaluated and appropriate people involved**."*

[163] A fair and reasonable employer would comply with the standards it set itself. WDHB did not do so because:

(a) There was no actual investigation;

(b) Ms Varga and Ms McQuoid-Rink were merely asked to provide written complaints, but they were never questioned about the information they provided;

(c) Mr Fuller was not questioned at the time of the incident despite him being a critical witness;

(d) Ms Morrison's advice to Ms Aitchinson was not recorded;

(e) The information in Ms Metekingi's two incident reports was not evaluated;

(f) Ms Lewis was not interviewed;

(g) Ms Metekingi was not interviewed;

(h) Nothing was done to investigate Mr Sigglekow's health issues before Ms Aitchinson decided to take disciplinary action.

[164] WDHB therefore cannot have evaluated the relevant facts before commencing disciplinary action, as its policy required it to do. Accordingly, I find that WDHB breached its Discipline Policy.

Did WDHB properly consider Mr Sigglekow's personal circumstances?

[165] I find that Mr Sigglekow's personal circumstances were not properly considered because Ms Aitchinson made no attempt to evaluate his health situation as it related to his work responsibilities as a RN.

Did WDHB act consistently regarding the same or similar incidents of alleged serious misconduct?

[166] A fair and reasonable employer would treat the same or similar conduct consistently or if it intended to change its previous approach (say by enforcing conduct it had previously permitted or turned a blind eye to) then it would inform employees of that before it took disciplinary action against them.

[167] WDHB did not view Mr Sigglekow's departure from work early without telling anyone and without securing the keys to the Puna Whiti medicine cupboard on 25 December 2010 as sufficiently serious to warrant any disciplinary action. It was therefore inconsistent for it to view his actions on 13 January 2011 (when he told the Puna Taunaki RN he was leaving and passed him the keys), which were much less serious, as such.

[168] Although WDHB managers had information that Mr Sigglekow had allegedly slept on duty on a number of occasions it did not pursue any of these allegations as disciplinary concerns. It was therefore inconsistent for it to treat the allegation on 13 January 2011 (which was less serious than at least two of the other sleeping allegations) as serious misconduct without first notifying him that sleeping on duty would be viewed as serious misconduct.

[169] This inconsistency in approach and WDHB's categorisation of less serious behaviour as serious misconduct when more serious behaviour had not been viewed as a disciplinary concern is something Ms Aitchinson should have considered and addressed as part of her 13 January 2011 disciplinary process. However, she did not do so, which I find was unfair and unreasonable.

[170] I find a fair and reasonable employer could not have pursued disciplinary action against Mr Sigglekow before it had made it clear to him that behaviour which it had previously tolerated would in future be treated as serious misconduct, which may put his ongoing employment in jeopardy.

Did WDHB properly deal with highly prejudicial information fairly?

[171] I consider the manner in which WDHB considered highly prejudicial information was unfair to Mr Sigglekow. Ms Aitchinson was in receipt of the following highly prejudicial information:

(a) Ms Lewis' disclosure that she had been told patients had seen Mr Sigglekow nodding off prior to the 13 January 2011 incident;

(b) Ms Lewis' email that staff had twice seen Mr Sigglekow sleeping on duty and he had admitted it and was embarrassed;

(c) Ms Coll's statement she had seen him sleeping on duty on 20 January 2011 (i.e. after the 13 January 2011 incident).

[172] This prejudicial information had not given rise to any disciplinary allegations but it was information the decision-maker must have considered during the disciplinary process. It is artificial to expect Ms Aitchinson to have put this information out of her mind, and there was no evidence she did so.

[173] It was unclear how this prejudicial information impacted on her decision-making because:

(a) The allegations in the disciplinary letter related to 13 January 2011 only;

(b) Ms Aitchinson made it clear at the beginning of the disciplinary meeting she was only concerned with the 13 January 2011 incident;

(c) The dismissal letter also specifically referred to the 13 January 2011 incident only.

[174] I consider Ms Aitchinson should have informed Mr Sigglekow about how she intended to deal with this prejudicial information and what if any influence it was going to have on the allegations she had to decide. For example:

(a) If it played no part in her decision making she should have said that;

(b) If she considered the information was irrelevant or unreliable so she intended to ignore it then she should have told Mr Sigglekow that;

(c) If she considered it was similar fact evidence which made the sleeping allegation on 13 January 2011 more likely to be true then she should have specifically put that to Mr Sigglekow to respond to.

Consideration of whether procedural defects were minor and not unfair to Mr Sigglekow

[175] Any decision must still be found to be justifiable if the sole defects in the process were minor and did not result in the employee being treated unfairly.[43]

[176] I consider that WDHB failed to:

(a) Comply with its good faith obligations[44];

(b) Sufficiently investigate its concerns;

(c) Raise all of its concerns with Mr Sigglekow;

(d) Give Mr Sigglekow a reasonable opportunity to respond to each of its concerns;

(e) Genuinely consider Mr Sigglekow explanation;

(f) To comply with its own policy;

(g) Properly consider all relevant information, including Mr Sigglekow's personal circumstances;

(h) Treat similar or the same conduct consistently;

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43 Section 103A(5) ERA

44 Section 4(1A)(c)

(i) Inform Mr Sigglekow of its expectations regarding the behaviour it dismissed him for.

[177] I find none of these defects were minor and they all resulted in Mr Sigglekow being treated unfairly. Accordingly, s.103A(5) of the Act does not prevent me from finding Mr Sigglekow's dismissal was unjustified.

Dismissal unjustified

[178] I find that Mr Sigglekow's dismissal for serious misconduct was unjustified.

[179] A fair and reasonable employer could not have concluded that Mr Sigglekow had engaged in serious misconduct, or that summary dismissal was an appropriate response to the concerns that had been raised with him, based on the information that was available to WDHB at the time it decided to dismiss him.

[180] A fair and reasonable employer in WDHB's position could not have dismissed Mr Sigglekow because its investigation was so flawed it did not have reasonable grounds for its conclusion (on the evidence available at the time) that he had engaged in serious misconduct.

[181] The only hearsay evidence it had of Mr Sigglekow sleeping on duty was in Ms Varga's statement and the factual basis of her comment about that was unknown. I also find that the evidence WDHB had did not support its view that Mr Sigglekow had to get authorisation from a manager and notify a manager he was leaving early.

[182] WDHB cannot justify its actions and how it acted because it failed to properly investigate its concerns; it breached well recognised natural justice requirements; it breached its statutory good faith obligations; it breached its Performance Management and Discipline Policy; and it treated less serious conduct more harshly than it had previously treated the same or more serious instances of similar behaviour. It also breached every one of the statutory procedural fairness obligations identified in s103A(3) of the Act

[183] I find that WDHB's reasoning was not logical or reasonable based on the information it had available to it. WDHB did not have reasonable grounds for believing serious misconduct had occurred. WDHB did not have clear evidence upon

which a reasonable employer could safely conclude serious misconduct had occurred. I find WDHB had not carried out reasonable inquiries which could have entitled it to reasonably conclude, on the balance of probabilities, that Mr Sigglekow had engaged in serious misconduct.

Remedies

Reinstatement

[184] Mr Sigglekow sought reinstatement.

[185] Neither party referred to the fact that s.125 of the Act was substituted on 1 April 2011 by s.16 of the Employment Relations Amendment Act 2011. This means that reinstatement is no longer the primary remedy. Section 125(2) now provides that the Authority may provide for reinstatement *"if it is practicable and reasonable to do so"*. Reinstatement is now just one of a selection of remedies the Authority may exercise its discretion to award in order to achieve justice between the parties.

[186] I decline to reinstate Mr Sigglekow. Not only is reinstatement not practicable or reasonable in the circumstances of the case, but I also consider reinstatement is not an appropriate remedy given the level of Mr Sigglekow's contribution to the situation which gave rise to his unjustified dismissal.

[187] When Mr Sigglekow filed his interim reinstatement application, he was informed (by Member Anderson[45]) that medical evidence would be required to support his claim for reinstatement. Once the matter was transferred to me, I reiterated that medical evidence would be as required in support of the remedies claimed.

[188] No such medical evidence was ever forthcoming. The most recent medical information I had was a certificate from Mr Sigglekow's GP dated 20 April 2011 which was provided to clear him to return to work so the disciplinary meeting could be held on 21 April 2011. This stated that Mr Sigglekow was fit to return to work for reduced hours, with the recommendation that he work four hours a day for several weeks with a gradual increase in hours *"as he is able"*. There was no current medical

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45 Member Anderson dealt with the urgent interim reinstatement application

evidence about Mr Sigglekow's diagnosis or prognosis or what, if any, of his normal duties he would be fit to undertake were he to be reinstated.

[189] During the investigation, Mr Sigglekow admitted he had still not been cleared to return to full time work but expressed his belief that he would gradually be able to return to his normal full time duties over an unspecified period of time. There was no evidence about how or when that could occur.

[190] I acknowledge that if Mr Sigglekow were to be reinstated he could be put on sick leave until his health issues had been properly investigated or until he had been medically cleared to return to his normal duties. So his current ill health is not determinative of the reinstatement issue.

[191] Even if Mr Sigglekow was medically cleared to return to work (and that has not yet occurred), I would still be concerned that he may not be open and communicative with WDHB if he was experiencing health problems. When he last returned to work Mr Sigglekow maintained (at least to management) that he was fine and did not need any assistance when the evidence I heard strongly suggested that was not the case.

[192] I consider that Mr Sigglekow did not manage his own health appropriately. He was under considerable financial pressure to work, because that is his only income, so I am concerned there is a real risk he would again be reluctant to inform WDHB of any new or ongoing health issues if that could impact on his hours of work.

[193] WDHB need to have at least one RN on duty at each unit at all times. The nature of Mr Sigglekow's role meant that if he was reinstated WDHB would probably have to roster another RN on duty with him to provide cover in case he had to rest during a shift or leave work early. That is an onerous obligation which I am not satisfied is warranted.

[194] Mr Sigglekow's medical certificate dated 3 February 2011 stated that he would need ongoing support and may have to leave work early. This advice would present practical problems for WDHB because it would have to ensure appropriate RN cover was in place for the duration of Mr Sigglekow's shift. Whilst WDHB did

pay for a second RN from 14-24 December 2010, I consider it unreasonable for it to have to incur such additional cost on an ongoing basis if Mr Sigglekow were to be reinstated.

[195] Another complicating factor which makes reinstatement impractical is that Mr Sigglekow does not hold a current practising certificate. I note that it was not up to WDHB to obtain his annual practising certificate for him because it is always up to the individual health practitioner to ensure they have made the necessary arrangements for a current practising certificate. Whilst I could make reinstatement conditional upon Mr Sigglekow obtaining a current practising certificate, I do not consider it appropriate to exercise my discretion to do that in light of all the circumstances of this matter.

[196] It was Mr Sigglekow's obligation to ensure that he maintained a current practising certificate but he has not done so. He told me he did not have a practising certificate because he has not worked the required hours to enable him to obtain one. Because of that, Mr Sigglekow is likely to face some difficulties in obtaining a new practising certificate.

[197] Mr Sigglekow's training record is such that he does not have sufficient hours to enable him to automatically get his annual practising certificate back. He is therefore required to apply to the Nursing Council for a new practising certificate, and whether he is given one is a Nursing Council (not WDHB) decision. I accept Ms Morrison's evidence that WDHB cannot employ Mr Sigglekow in the role he holds if he does not have an annual practising certificate.

[198] Mr Sigglekow accepted that he would have to explain to the Nursing Council why he did not have sufficient hours to obtain an annual practising certificate. Prior to his dismissal he had been practising under special clearance by the Nursing Council in order to get his practising hours up. Mr Sigglekow was unsure whether he would be eligible for another special clearance from the Nursing Council, but he told me he considered it unlikely.

[199] After carefully weighing all of the evidence I determine that reinstatement is not an appropriate remedy in this case. Mr Sigglekow engaged in blameworthy conduct by not managing his health issues appropriately, by asserting to WDHB that

it was appropriate for a RN to rest with their eyes closed whilst on duty, and by sleeping on duty in circumstances which puts others at risk. I find that his culpable actions mean it would be inappropriate to return him to the workplace given the nature of his working environment.

Mitigation

[200] Mr Sigglekow was under an obligation to mitigate his loss by all available means, until his grievance was resolved regardless of the remedies he was seeking[46]. Failure by an employee to take adequate steps to mitigate their loss will break the chain of causation because such loss may then be attributable to the failure to seek alternative employment, not to the unjustified dismissal.

[201] Mr Sigglekow admitted he had not taken any steps to mitigate his loss. By the time his matter was heard, Mr Sigglekow had been out of work for nine weeks. Whether there was a causal link between his personal grievance and the remuneration he has lost is a matter of fact and degree.

[202] I find that only six weeks of his lost remuneration can be attributed to his unjustified dismissal, with the remainder of his loss being due to his failure to take any steps to secure alternative employment or remuneration. Mr Sigglekow did not say he was unfit to seek work, he said most of his time had been spent preparing for mediation which was held on 27 May 2011 and then for the Authority's investigation held on 27 June 2011.

[203] I consider Mr Sigglekow's total failure to take any steps to mitigate his loss breaks the chain of causation, so the full nine weeks' lost remuneration is not all attributable to his personal grievance. I consider it reasonable to attribute six weeks' lost remuneration to his dismissal with the other three weeks' lost income being due to his failure to take any steps to mitigate his loss.

Lost remuneration

[204] Mr Sigglekow has claimed full lost remuneration from 21 April to 22 July 2011 of $10,384.65 ($1,153.85 per week x 9 weeks).

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46 *Jenkinson v. Ocean Gold (NZ) Ltd* [2010] NZEMPC 102 (para.80)

[205] I have found that Mr Sigglekow has only lost six weeks' remuneration as a result of his unjustified dismissal.

[206] I also find he is not entitled to full wages for the period he has claimed because he was not medically fit to work full time. The most recent medical certificate in April 2011 only cleared Mr Sigglekow to work four hours per day. I therefore determine that he is entitled to $576.92 per week which represents the four hours per day he could have worked if he had not been dismissed.

[207] WDHB is ordered to pay Mr Sigglekow lost remuneration under s.128(2) of the Act of $3,461.55 (i.e. 6x $576.92).

Distress compensation

[208] Mr Sigglekow sought $20,000 compensation under s.123(1)(c)(i) for his humiliation, loss of dignity, and injury to feelings. Mr Sigglekow's evidence in support of this claim was that he had *"been feeling down, unhappy and generally stressed out"* and that he believed his reputation and credibility had been damaged.

[209] Whilst Mr Sigglekow has no doubt been upset by his unjustified dismissal, an award of distress compensation must be limited to the effects of the dismissal on him. It cannot to be used to punish or express disapproval of WDHB's actions. The evidence did not support a more than a minimal award of distress compensation.

[210] I order WDHB to pay Mr Sigglekow $2,000 under s.123(1)(c)(i) of the Act.

Contribution

[211] Having determined that Mr Sigglekow has a personal grievance, I am required under s.124 of the Act, when deciding the nature and extent of the remedies, to:

(a) Consider the extent to which the employee contributed towards the situation that gave rise to his personal grievance; and

(b) If required, reduce remedies accordingly.

[212] For remedies to be reduced, I must find that Mr Sigglekow engaged in blameworthy conduct.

[213] I had evidence available to me at the hearing which WDHB did not have at the time of its dismissal. Whilst this subsequently discovered evidence is not relevant to justification (which must be assessed at the time of the dismissal[47]), it is relevant to contribution.[48]

[214] The sleeping on duty allegation only related to the 13 January 2011 incident. Whilst there were other sleeping allegations, those had not given rise to any disciplinary concerns. In terms of contribution, I must put these other concerns about Mr Sigglekow sleeping on duty to one side because none of these other incidents were established on the balance of probabilities because they were never investigated. Accordingly, the evidence presented at the hearing of these incidences was limited. I have viewed the other references to Mr Sigglekow sleeping on duty as unsubstantiated allegations.

[215] I cannot reduce remedies on the grounds of contribution for conduct which has not been established on the balance of probabilities. The evidence of the other sleeping allegations was insufficient to meet that standard. However, I did hear sufficient evidence to enable me to conclude that the allegation Mr Sigglekow had been sleeping on duty on 13 January 2011 was more likely than not to be true.

[216] It is important to recognise that I had evidence that was not available at the disciplinary meeting, namely details about the nature of Mr Sigglekow's admitted resting on duty and evidence about why Ms Varga believed Mr Sigglekow had been sleeping and not just resting his eyes because he was sick. If WDHB had conducted a proper investigation it would have had that evidence at the time of its disciplinary meeting.

[217] Because of its fundamentally deficient investigation WDHB, at the time it decided to dismiss Mr Sigglekow, had insufficient evidence from which it could reasonably form the view that he had been sleeping. As a result of questioning Mr Sigglekow and Ms Varga during the hearing I was in position to form a view on the merits of the sleeping on duty allegation.

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47 Section 103A(2) ERA

48 *Salt v Fell* [2008] ERNZ 155 CA

[218] Ms Varga told me a resident complained to her that they could not use the lounge because Mr Sigglekow was sleeping in there. Ms Varga went to have a look and saw Mr Sigglekow had turned out the lights in the residents' lounge, he had pulled the door partially closed, he had pushed two soft chairs together and was lying in them, he had his eyes closed and he did not respond to her attempts to rouse him by calling his name and speaking to him.

[219] I also received further evidence during the hearing from Mr Sigglekow about how he had been "*resting*" than WDHB obtained during its disciplinary process. Mr Sigglekow admitted doing to what Ms Varga had described above but he said he was resting his eyes not sleeping.

[220] If Mr Sigglekow had just been resting his eyes I consider he would have been aware that at least one of the residents wanted to use the lounge to watch TV. It is also likely he would have responded to Ms Varga's attempts to communicate with him.

[221] I also consider the environment Mr Sigglekow created was consistent with someone who intended to sleep. The chairs were pulled together, he was reclined with his feet up, he had dimmed the lights and pulled the door partially shut. This strongly suggested Mr Sigglekow did more than fleetingly close his eyes whilst remaining fully aware of his surroundings.

[222] That evidence satisfied me on the balance of probabilities that Mr Sigglekow had been sleeping on duty on 13 January 2011. With his considerable experience, he should have known that was unacceptable. This was highly blameworthy conduct because the nature of his work environment meant his sleeping on duty created unnecessary risk for the Puna Whiti residents and for the PA on duty with him.

[223] I also consider that Mr Sigglekow's attitude and responses during the disciplinary meeting to the effect that he considered it appropriate for an RN to rest with their feet up and their eyes closed whilst on duty lead Ms Aitchinson to conclude action short of dismissal was not appropriate.

[224] I find that is also blameworthy conduct because if Mr Sigglekow had demonstrated an understanding of WDHB's concerns or if he had accepted that it was

unacceptable for a RN to rest and/or sleep whilst on duty he may not have been dismissed. His failure in this regard can therefore be viewed as contributing to the situation which gave rise to his dismissal.

[225] Mr Sigglekow must also shoulder considerable blame for failing to properly manage his health difficulties. Notwithstanding that, I simply did not have sufficient evidence before me to entirely discount the possibility that Mr Sigglekow's health issues and return to work had not been handled appropriately.

[226] I was concerned that Ms Lewis observed Mr Sigglekow was not coping with his four hours per day shifts over the 14-24 December 2010 period, but nevertheless (due to pressure from Mr Sigglekow) allowed him to increase his hours. She knew by 2 January 2011 that he had allegedly been seen sleeping on duty but failed to take that opportunity to have him medically assessed or to make proper and necessary inquiries into the current state of his health. That was a serious failure of her management responsibilities.

[227] Likewise, Ms Metekingi and Ms Aitchinson both failed to follow up information that suggested Mr Sigglekow may not be fit to be at work. I consider WDHB closed its eyes to the information it had which suggested Mr Sigglekow was still experiencing health difficulties and instead improperly relied on his inaccurate self reporting that he was absolutely fine.

[228] In terms of Mr Sigglekow's culpability, it was also unclear how long he had been sleeping for and I acknowledge he did in fact leave his shift early because he said he had become very unwell. I am therefore prepared to give Mr Sigglekow the benefit of the doubt around his health issues and the circumstances involved with his sleeping on duty by declining reinstatement but not reducing his other remedies.

Interest

[229] Mr Sigglekow claimed interest. However, I decline to exercise my discretion to award interest pursuant to clause 11, Schedule 2 of the Act because of Mr Sigglekow's contribution to the situation that gave rise to his grievance.

Outcome

[230] WDHB is ordered to pay Mr Sigglekow:

(a) $3,461.55 as lost remuneration under s.128(2) of the Act; and

(b) $2,000 as distress compensation under s.123(1)(c)i) of the Act,.

Costs

[231] Mr Sigglekow as the successful party is entitled to a contribution towards his legal costs. The parties are encouraged to agree costs between them. If that is not possible, costs will be resolved by way of an exchange of memoranda.

[232] Mr Sigglekow has 14 days within which to file a costs memorandum, WDHB has 14 days within which to respond, and Mr Sigglekow has a further 7 days within which to file reply. Departure from this timeframe requires the prior leave of the Authority.

[233] In order to assist the parties to resolve costs themselves, I can indicate that (subject to the parties' submissions and in the absence of a without prejudice except as to costs offer), I am likely to adopt the Authority's usual daily tariff approach to an award of costs.

Rachel Larmer
Member of the Employment Relations Authority