New Zealand Employment Relations Authority Decisions

Thow v Canterbury District Health Board (Christchurch) [2016] NZERA 418; [2016] NZERA Christchurch 151 (6 September 2016)

Last Updated: 1 December 2016

Attention is drawn to the order prohibiting publication of certain information

IN THE EMPLOYMENT RELATIONS AUTHORITY CHRISTCHURCH

[2016] NZERA Christchurch 151
5582941

BETWEEN	RONALD THOW Applicant	
A N D	CANTERBURY HEALTH BOARD Respondent	DISTRICT

Member of Authority: Helen Doyle

Representatives: Jeff Goldstein and Linda Ryder, Counsel for Applicant

Penny Shaw, Counsel for Respondent

Investigation Meeting: 19 April and 13 May 2016 at Christchurch

Submissions Received: 13 May 2016 and 12 July 2016 from both parties

22 July 2016 from the Respondent and 25 July 2016 from the Applicant

Date of Determination: 6 September 2016

DETERMINATION OF THE AUTHORITY

A CDHB did not breach its contractual obligations to Ronald Thow. B There is an adequate explanation for the disparity of treatment.

C I have found a breach of the duty of good faith to be responsive and communicative on the part of CDHB but it is not a situation where an award of a penalty should be made.

D Costs are reserved and I encourage the parties to see if agreement can be reached.

Employment relationship problem

[1] Ronald Thow suffered a heart attack on 4 April 2015. He says that he was medically cleared to work from 18 May 2015 but his employer Canterbury District Health Board (CDHB) would not allow him to return to his role as a Behavioural Support Facilitator (BSF) and he was then placed under considerable financial pressure and stress. His sick leave was exhausted.

[2] Mr Thow lodged an interim injunction application on 21 September 2015 for orders that he return to work immediately on the terms in his medical certificate dated

31 August 2015 and on his current terms and conditions of employment. The parties attended mediation but the matter remained unresolved.

[3] At the start of the investigation meeting for the interim injunction application on 16 October 2015 the Authority was advised by counsel that orders could be made by consent in relation to the application for an interim injunction.

[4] The orders made by the Authority are contained in determination *Thow v CDHB* [2015] NZERA Christchurch 156 and provide amongst other matters that Mr Thow would return to work on Monday, 19 October 2015 at 10am and he would be provided with full time suitable alternative administration duties. There was agreement by Mr Thow to a medical assessment with a cardiologist. It was agreed that Mr Thow would remain on alternative duties until 31 March 2016 or when he was assessed as being fit to undertake the measures sometimes used to physically restrain patients (restraints), whichever was the earlier. There was a date for the substantive investigation meeting recorded in the consent determination of 19 April 2016.

[5] Mr Thow was medically cleared to undertake restraints from 4 April 2016 and at the time of the substantive investigation had returned to

his BSF role.

[6] Mr Thow says the earlier refusal by CDHB to allow him to return to work on

18 May 2015 was in breach of express and/or implied contractual obligations and that CDHB had failed to meet its good faith obligations under s 4 of the Employment Relations Act 2000 (the Act). There was a further claim that CDHB had facilitated the return of other staff members but had refused and/or failed to offer options to Mr Thow.

[7] CDHB says that Mr Thow could not have returned to work in his BSF role in the Assessment Treatment and Rehabilitation (AT&R) unit which is a part of the Specialist Mental Health Service (SMHS) at Hillmorton Hospital because his role required him to be able to safely and effectively restrain patients and he was not medically cleared to do that. It says that returning to work without that clearance meant he put himself, patients and colleagues at risk and that it does not have an obligation in those circumstances to provide work or an income to Mr Thow.

[8] The statement of problem was not amended for the substantive investigation. The orders sought by the applicant in the statement of problem are as follows:

(a) A permanent order that Mr Thow immediately be allowed to return to work on the terms set out in his medical certificate dated 31 August

2015 and on his current terms and conditions of employment;

(b) Reimbursement for lost wages and other contractual benefits from

18 May 2015 to the date of his return to work in an alternative role on

19 October 2015 quantified as a total of 22 weeks without income in the sum of $27,745.30;

(c) Damages for lost enjoyment of life;

(d) A penalty for breach of the employment agreement;

(e) A direction that the penalty be paid to Mr Thow under s 136 of the Act; (f) Interest; and

(g) Costs.

[9] Some discussion took place at the start of the substantive investigation meeting about the issues before the Authority. Mr Thow has returned to his original position and is medically cleared to undertake restraints so the first order sought above is no longer required.

[10] Ms Shaw was concerned by Ms Ryder's suggested expansion of the issues to include personal grievances raised but not pleaded as there had been no notice to CDHB that the matter was other than a breach of contract claim and she had prepared on that basis.

[11] The Authority put options to the parties to either adjourn the matter to enable personal grievance claims which had been raised to be pleaded by way of an amended statement of problem or to proceed on the basis of the breach of contract claim.

[12] Counsel agreed that the matter would proceed on the second basis outlined. The Authority agreed to hear evidence about alleged disparity of treatment because that had been specifically pleaded. In respect of the disparity issue there was no specific claim for any compensatory remedies. I shall deal with the issue of any remedies in relation to disparity of treatment if I get to that point.

Prohibition from publication

[13] By agreement the Authority makes the following order about prohibition from publication. I order, under section 10 (1) of Schedule 2 to the Act, that the evidence about Mr Thow's medical condition beyond what is referred to in this determination is not to be published.

The issues

[14] The issues for the Authority to determine are as follows:

(a) What contractual terms and conditions of employment are alleged by

Mr Thow to have been breached by CDHB?

(b) Is the content of the Health Safety and Wellbeing Policy (the policy) a contractual term and condition of Mr Thow's employment?

(c) Is the content of the Health Safety and Wellbeing Management System (the management system) a contractual term and condition of Mr Thow's employment?

(d) Did CDHB breach a contractual obligation by not allowing Mr Thow to return to work from 18 May to 19 October 2015?

(e) Was Mr Thow required to undertake restraints in his BFS role and was that a significant part of his role?

(f) Was the CDHB contractually required to consider alternative roles or return to work on a restricted basis?

(g) If there was a breach of the contractual terms and conditions of employment, did that breach cause Mr Thow loss for which he should receive an award of damages?

(h) Was there disparity in the treatment of Mr Thow and other employees in similar circumstances?

(i) If there was then what remedies should flow from that in circumstances as described above?

(j) Was there a breach of good faith?

(k) If there was a breach of good faith then should a penalty be imposed on CDHB for breach of the employment agreement and should that penalty be paid to Mr Thow?

(l) If there are awards made, should they attract interest?

What terms and conditions of Mr Thow's employment are alleged to have been

breached?

[15] Ms Ryder submits CDHB breached the following terms and conditions of employment:

(a) A failure to implement and adhere to the Health Safety and Wellbeing

Policy;

(b) A failure to adhere to the Health Safety and Wellbeing Management

System;

(c) The failure to return Mr Thow to his BSF role without requiring him to undertake restraints in accordance with his position description.

[16] If an employee is cleared as medically fit to return to work after a period of sick leave and is not permitted to return to work then that could be a breach of a contractual obligation to provide work and/or payment. The obligation to provide work, as Ms Shaw submits, has been recognised as existing in garden leave circumstances described by the Court of Appeal in *Ogilvy & Mather (NZ) Ltd v*

*Turner*1 and by the Employment Court in *McAulay v Sonoco New Zealand Limited.*2

The situations discussed in those cases have some relevance although are not on all fours with this matter because Mr Thow did not receive payment whilst away from the workplace.

[17] The more challenging issue in this case is whether the contents of the policy and management system are contractual terms and conditions of employment. I asked for and received further helpful submissions on that question.

[18] What must be established in a breach of contract claim is succinctly put by Judge Colgan as the Chief Judge was then in *Jensen v Attorney-General sued in respect of the Chief Executive of the Department of Corrections.*3 The Judge stated that the claim in that case was not a personal grievance where questions of fairness and reasonableness of the employer's actions are at issue and that the grounds open to [Ms Jensen] were narrower. He stated:

...To succeed in her claim, she must establish the existence of contractual rights and obligations and a breach of these by the employer, together with recognised consequential losses...

[19] It is appropriate in identifying contractual rights and obligations to start with the collective agreement and any changes to terms and conditions when Mr Thow went to work at AT&R.

[20] Mr Thow's position at the material time was under the coverage of a multi- employer collective agreement (the collective agreement) between a number of DHBs and the New Zealand Public Service Association Incorporated (PSA) deemed to come into force on 27 October 2014 and to expire on 30 April 2015.

[21] Clause 22 of the collective agreement provides the following about policies and procedures:

22.1.1 All employees covered by the Agreement shall comply with the employer's policies and procedures in force from time to time, to the extent that such policies and procedures are not inconsistent with the terms and conditions of this Agreement.

1 [1995] 2 ERNZ 389

2 [1998] NZEmpC 68; [1998] 2 ERNZ 225

3 [2003] ERNZ 36 at [11]

22.1.2 The union will be consulted regarding any additions/amendments to those policies and procedures, where such additions/amendments have a material effect on employees' conditions of employment. Failure to consult shall not void any additions/amendments.

[22] Clause 15 of the agreement is headed Health & Safety and provides amongst other matters that the employer and employees shall comply with the provisions of the Health and Safety in Employment Act 1992 and subsequent amendments and that the parties agree that employees should be adequately protected from any safety and health hazard arising in the workplace. Clause 15.4 provides "Attention is also drawn to the employer's policies and procedures on health and safety".

[23] Before Mr Thow went to work at AT&R he received a letter dated 3 October

2014 formally confirming his transfer to the position of BFS at SMHS effective from

3 November 2014. There was reference in the letter to the location Mr Thow would work in but the right was reserved to request Mr Thow to work in other areas of CDHB. The hours of work were to be 80 per fortnight with his manager to determine the arrangement of the hours consistent with Mr Thow's employment agreement and the hours/roster worked at the department. The remuneration was specified in the letter and it was stated that all other terms and conditions remained the same.

The policy

[24] The policy and management system were provided for the first time to the Authority with Mr Thow's statement of evidence for the substantive matter. They were not specifically referred to in the statement of problem.

[25] The policy is contained in three pages with an issue date of 9 July 2014 to be reviewed on 29 August 2015. It is authorised by the Chief Executive Officer CDHB David Meates and referred to as owned by the Health and Safety and Wellbeing Manager.

[26] The policy is that CDHB provides and maintains the management system for the organisation. The audience/scope of the policy is wide and includes managers, staff, visiting staff, volunteers, students and contractors. There are references to

relevant legislation, handbooks, standards and guidelines. The management system the policy develops and maintains includes a number of processes including employee and union consultation and participation in health, safety and wellbeing processes. There is a process under Rehabilitation that Ms Ryder places reliance on: "Ill or injured employees are assisted to remain at work, or return to work as soon as practicable".

The management system

[27] The management system is a substantial document. Some of the pages from

2 – 29 as attached to Mr Thow's statement of evidence show they are authorised by the Health and Safety Manager with a date of October 2015 and the remaining pages from 30 – 56 show they are authorised by the Health and Safety Manager with a date of July 2014. Emphasis was placed by Ms Ryder on the systems in section 9 which is about injury management and rehabilitation and is contained on pages 35 – 39 of the management system.

[28] Section 9 provides at the outset that CDHB is committed to providing a proactive injury management and rehabilitation programme for its employees to assist with return to work following an injury or illness, work or non-work related. It provides that CDHB uses a case management system and early intervention and that where an employee is unable to return to their normal work duties and hours a return to work programme may be implemented and that suitable alternative duties may be required.

[29] There was also reference to documents at page 101 and 102 attached to Mr Thow's statement of evidence. Page 101 is a referral to occupational health information for employees and page 102 is a referral to occupational health information for line managers. For completeness, and if it suggested otherwise, I do not consider these information sheets to be contractual terms and conditions of employment.

Are the contents of the policy and management system express terms and conditions of Mr Thow's employment agreement?

[30] Ms Ryder submits that the policy and management system are express terms of the employment agreement by virtue of clauses 22 and 15 of the employment agreement and by virtue of Mr Thow's job description. She submits that the parties

have expressly agreed that all employees covered by the collective agreement are bound by the policies and procedures.

[31] Both counsel referred to the Employment Court judgment in *Cuttriss v Carter Holt Harvey Limited.4 Cuttriss* concerned an unjustified action claim about whether a discontinued retirement policy was a term of the employment agreement. Judge Travis stated at [40] as below:

As a general proposition, supported by the authorities to which I have referred, unless a policy document such as KSP433 and the other policies contained in the manual are incorporated by reference in the applicable employment agreement, they would not be expressly binding.

[32] Judge Travis stated further at [42] as below:

Matters contained in policy manuals, which were fairly and reasonably promulgated could for the basis of lawful and reasonable instructions and govern the practices of the workplace. They could also be determinative of actions taken by the employer if those actions were inconsistent with the promulgated policy. However, that did not automatically raise them to the status of contractual terms in the absence of agreement expressed or implied by their incorporation in the employment agreement. In the present case the policies were to form part of the terms of employment by clause 16 of the 2003 agreement. However, the defendant had reserved the right to change those policies to meet operational needs or changed circumstances, providing that did not override terms expressly set out in the agreement. The retirement policy was not such a term.

[33] The policy and the management system in this case seem to have been unilaterally promulgated by CDHB rather than the subject of negotiation and agreement between the parties as part of the collective agreement. Clause 22.1.1 of the employment agreement refers to employees complying with the policies in force from time to time as long as they are not inconsistent with the collective agreement.

Whilst the union is to be consulted under clause 22.1.2 regarding additions/

4 [2007] ERNZ 233

amendments where they have a material effect on the employees' conditions of

employment the failure to do so shall not void any addition or amendment.

[34] The content of the policy and management system are updated and amended from time to time. At the bottom of each page of the policy there is reference to the latest version of the document being available on the intranet/website only and that printed copies may not reflect the most recent updates. The management system has different dates at the conclusion of the first and second section and places an emphasis on ongoing review.

[35] Mr Thow's position description Ms Ryder submits is also an express term of the employment agreement. She submits that it sets out key

performance objectives which include complying with health and safety legislation and organisational policy and procedures, practicing in accordance with CDHB polices and procedures and the code of conduct and she places emphasis on the requirement to take an active role in the CDHB's rehabilitation plan to ensure an early and durable return to work. The position description though is expressed to be a guide and provides it "will vary from time to time and between services and/or units to meet changing service needs".

[36] Ms Ryder, in respect of clause 15 of the employment agreement, refers to the Employment Court judgment in *French v Chief Executive of the Department of Corrections.5* It was found in *French* adherence to the Health and Safety in Employment Act 1992 (HSEA) was expressly incorporated into the employment contract and from that it was inferred there would be compliance with those obligations [health and safety] in policies and procedures as part of the obligation to

comply with the Act. Mr Thow's claim is a different one and the wording in the

collective agreements is different. This matter is distinguishable from *French.*

[37] The contents of the policy and management system documents could be considered in a personal grievance as to whether the employer's conduct toward Mr Thow from 18 May was fair and reasonable. Ms Shaw accepts in her submission that an employer has an obligation to follow its policies and failure to do so may give

rise to a claim for unjustified action.

5 [2002] NZEmpC 214; [2002] 1 ERNZ 325

[38] I do not however conclude that the contents of those documents are contractual and include express terms and conditions of employment which if breached entitle Mr Thow to damages.

[39] The alleged breach of contract that remains is that CDHB did not allow Mr Thow to return to his BSF role from 18 May 2015 without the need to undertake restraints.

Background against which the allegation of breach is to be considered

[40] When Mr Thow commenced employment with CDHB as a BSF in June 2008 he was employed within the Intellectual Disability Community Team (IDCT) that delivered behaviour support services to individuals with an intellectual disability and challenging behaviours.

[41] In August 2013 the Ministry of Health who had been reviewing the behaviour support service specification advised CDHB that it would be tendering the service and its preferred provider was one national organisation. The tender offer from CDHB was not successful and in February 2014 there was advice that the service would close in six months.

[42] In March 2014 employees of IDCT including Mr Thow were advised that the proposal for continuance of the contract for the behavioural support services was unsuccessful and redeployment options would be investigated for all employees. At that time there were seven BSFs in the team.

[43] When final decisions were made about where the BSFs would be placed there were only two positions available in AT&R. Catherine (Cate) Kearney is employed by CDHB as the Service Manager for Canterbury Regional Forensic Service, and Intellectually Disabled Person's Health Service in the Specialist Mental Health Service (SMHS). This includes Service Manager responsibility for AT&R.

[44] Ms Kearney by letter dated 3 October 2014 confirmed Mr Thow's transfer to the duties at AT&R in the positon of BSF from 3 November 2014. He commenced in AT&R on 3 November 2014. There are only three BSF positions at CDHB. Two are in the AT&R unit. One of these is Mr Thow's. In addition to those two positions the other BSF employed by CDHB is in the community team and there is no requirement for the person in that position to be restraint trained.

[45] After Mr Thow's heart attack he underwent surgery and following his discharge from hospital had a number of telephone conversations with his unit manager, Carol Cox every week to ten days.

[46] On 11 May 2015, Mr Thow attended his general practitioner Dr Chima. Dr Chima provided a medical certificate that provided in his opinion Mr Thow was medically fit to return to work on 18 May 2015 as long as he is not involved in restraining patients.

[47] On 22 May 2015 Ms Kearney telephoned Mr Thow and asked him to undertake an external occupational health assessment. Mr Thow signed a referral to Occupational Health CDHB (OH) and consent document on 22 May 2015. There had also been some discussion about a sick leave advancement to Mr Thow and communication took place about a 10 day advance of sick leave which had been exhausted.

[48] Melanie Vink, a CDHB occupational health nurse became involved in the process. Ms Vink communicated with Mr Thow by email and with Ms Kearney before she made an external referral to Dr Monica Ford from Occupational & Environmental medicine on 2 June 2015.

[49] On 2 June 2015 Ms Vink attached to the letter to Dr Ford a copy of the referral to occupational health, a copy of Mr Thow's position description, a copy of the medication Mr Thow was taking on discharge from hospital, a copy of Dr Chima's medical certificate dated 11 May 2015 and a copy of an email from Mr Thow to Ms Vink dated 29 May 2015 which set out amongst other issues that the primary issues of medical concern for him and his GP are patient restraint and assault by patients which he stated were comparatively frequent.

[50] On 30 June 2015 Mr Thow attended an appointment with Dr Ford for a clinical assessment. There was some delay in securing an appointment with Dr Ford but there was no evidence to support that the timing of that appointment was a matter within the control of CDHB.

[51] On 15 July 2015 a written report was provided to Ms Vink which provided that Mr Thow was currently fit for his BSF role as outlined in his position description. His cardiologist also supported a return to usual work activities. It was noted in the report that the consultant cardiologist did not express concern with Mr Thow

undertaking full duties including patient restraints although his medication meant it would be prudent to restrict involvement in restraints

for about another 6 weeks. That would be until 25 August 2015.

[52] On 3 August 2015 Ms Kearney received a letter from Ms Vink advising that Mr Thow was currently fit for his role as a BSF and his specialist supported a return to usual work activities. A gradual return to work was suggested to assist with confidence and reduce undue fatigue.

[53] On that same day Ms Kearney sent an email to Mr Thow, Ms Cox and Human Resources Adviser, Louis Van Rensberg, advising that it was "great news" Mr Thow was fit to return to work and that in addition to the letter from Ms Vink a medical certificate from Mr Thow's doctor confirming fitness and hours to be worked was required. Ms Kearney in her subsequent emails usually copied in the above people as did Mr Thow. For ease of reading and because it is unnecessary to do so I will not repeat all the recipients of the various emails again.

[54] Ms Cox sent Mr Thow an email on 12 August advising that she was hoping to talk to him that week to make arrangements regarding a return to work but had had no luck contacting him. Ms Cox noted that the external assessment had been completed which states a return to normal duties but with a gradual return starting with reduced hours. Ms Cox repeated the request for a final medical certificate from Mr Thow's general practitioner with clearance. Ms Cox noted that she would like to proceed with the return to work plan and wanted a call as soon as possible to make arrangements and that she looked forward to having Mr Thow back on board.

[55] Mr Thow questioned in an email to Ms Kearney dated 17 August 2015 the request for a medical certificate and said that it would be useful to know what it could contribute that was not already covered by the external assessment process. He wrote that he understood the external assessment process outcomes were fairly definitive and used to draft a plan to return to work. He also noted that after an attack by a patient some months earlier when he returned to work from ACC he was told there were no light duties in AT&R. He wrote that he was now "given to understand that there are actually staff on light duties" and that he looked forward to seeing a plan to return to work developed and moving forward.

[56] Ms Vink sent an email to Mr Thow and advised that Ms Kearney did require a medical certificate for him to return to work and then the recommendations by the OH Physician could be put into action. On 25 August 2015 Ms Kearney sent a further email to Mr Thow advising that she was keen for Mr Thow to return to work and asked for a medical certificate.

[57] On 26 August 2015 there were several emails. In the first Mr Thow attached a medical certificate and stated that he awaited advisement of a return to work plan. Ms Kearney emailed Mr Thow and noted that what was provided was not a new medical certificate but was the May medical certificate. She suggested that Mr Thow see his general practitioner as soon as possible to send through a current medical certificate. Mr Thow explained to Ms Kearney in an email by reply that it was a new medical certificate and that Dr Chima considered the same medical conditions to be valid as in May. Mr Thow mentioned again in his email that some staff operate within the unit and are not involved in physical duties or restraint and other staff are off restraint and on light duties or seconded to other roles. He wrote that he was confident that a return to work plan could be developed.

[58] On 27 August 2015 by email Ms Kearney advised that the medical certificate submitted did not match the OH assessment which cleared him for a return to usual work activities which included restraint. She asked for a medical certificate that matched the OH assessment with a current date.

[59] On 1 September 2015 Ms Ryder sent an email to Ms Kearney with a letter attached dated 30 August 2015. Ms Ryder wrote amongst other matters that Mr Thow's position description did not include any requirement to restrain patients and there were no grounds for preventing him from undertaking his duties as a BSF. Ms Ryder attached a further medical certificate from Dr Chima dated 31 August 2015 that stated amongst other matters that Mr Thow was seen and examined by him on

31 August 2015 and is his opinion medically fit to return to work on 31 August as long as he is not involved in restraining patients.

[60] Ms Ryder requested in her letter written confirmation by 4 September 2015 that Mr Thow could return to work from Monday 14 September 2015 on a graduated basis over three weeks otherwise she would seek an interim injunction. A disadvantage grievance and disparity of treatment was raised in the letter and a breach of good faith for not responding to Mr Thow's concerns.

[61] Proceedings were then lodged with the Authority for the interim injunction on

21 September 2015 and Mr Thow commenced alternative administrative roles from

19 October 2015 by agreement at CDHB.

Was Mr Thow required to undertake restraints as part of his duties?

[62] Mr Thow says that the medical certificate dated 11 May 2015 from Dr Chima cleared him as fit to return to work from 18 May 2015 provided he was not involved in restraining patients. He says that he was not contractually required to undertake restraints although he accepts that he was undertaking restraints leading up to his period of sick leave.

[63] Paul Kelly is employed by CDHB as Nurse Consultant. AT&R is one of the areas in which he provides professional leadership and oversight in his role. Mr Kelly gave evidence that all staff in an inpatient area working in a roster are expected to be restraint trained and if they are in a clinical area and cannot safely restrain then they compromise their colleagues' safety and place themselves at risk of an assault. Mr Kelly said that if Mr Thow could not undertake restraints then he would not be able to work "on numbers" working with patients in the locked patient area which is

75% of his role. The remaining 25% of Mr Thow's time is spent "off numbers"

which enables him to undertake paper work and other non-patient duties.

[64] Mr Thow is correct that there is no reference to a requirement to undertake restraints in his position description and in his role within the IDCT he was not required to be restraint trained. Mr Kelly did not understand there to be a reference for nurses at CDHB in their position

description to undertake restraints either. Ms Ryder in final submissions directed the Authority to the second bullet point on page three of the nurses position description which provides; "that the nurse acts appropriately to protect oneself and others when faced with unexpected patient responses, confrontation, personal threat or other crisis situation". Further on page 5 bullet point 8; "Acts as a resource for area specific responsibilities e.g. CPR Instructor, IV Assessor or other area of designated responsibility or expertise".

[65] I find the new model of care proposal for AT&R dated 6 June 2014 which is attached to the statement in reply and was subsequently finalised relevant. The key issues leading to that proposed new model of care for AT&R were chronic nursing shortages, high rates of assault and seclusion use, concerns for patient and staff safety

and low morale amongst the team. The new model of care proposed for the unit was to utilise evidence based approaches to positive behaviour modification and provide positive engagement in occupational and rehabilitation for AT&R service users.

[66] Materially it was proposed that nursing vacancies be converted to BSF and Occupational Therapist FTE and amongst other matters that BSFs work under the direction and delegation of the nursing line on a daily basis whilst under the supervision of psychology in regard to implementation of the behaviour plans. BSFs it was proposed would carry a clinical caseload and be trained in calming and restraint. It is important to record that BSFs in AT&R replaced some nursing FTEs. The proposal was provided for feedback to Mr Thow along with other BSFs at CDHB. A submission was duly made in response to the proposal by Mr Thow and other BSFs.

[67] On 4 August 2014 the proposal to change the model of care in AT&R was finalised and the two new positions for BSFs were identified as redeployment options for IDCT employees. Mr Thow was subsequently redeployed to one of the two new BSF vacancies in AT&R.

[68] Ms Ryder submits that Mr Thow was not advised that he was obliged to undertake restraints before he commenced his role at AT&R. Looking at the matter objectively I am satisfied from the proposal which was subsequently finalised that it was the intention of CDHB before Mr Thow was redeployed that BSFs in AT&R would be trained in calming and restraint techniques.

[69] As Ms Shaw submits the intent of the position description is "to provide a representative summary of the major duties and responsibilities performed by staff in this job classification. Staff members may be requested to perform job related tasks other than those specified". The position description is a guide only and expressed to vary from time to time.

[70] There is no dispute that Mr Thow was trained in restraint from late 2014 and undertook restraints as a part of his role up to the time of his heart attack. Ms Ryder placed some emphasis on the date that Mr Thow undertook restraints from and whether there had been a long enough period to conclude they were part of his duties.

[71] Mr Thow advised Ms Vink on 29 May 2015 by email that the primary issues of medical concern for him and Dr Chima are patient restraint and assault and he

noted that unfortunately these were comparatively frequent. Dr Ford in her report stated that "Mr Thow is required to undertake restraints" and set out in some detail what that involved from her discussion with Mr Thow at the time of his appointment. Other non-nurse positions at AT&R are restraint trained such as the current occupational therapist and the AT&R social worker as well as health care assistants.

[72] I agree with Ms Shaw's submission that there is case law to support the principle that the duties in a position description cannot be considered as exhaustive and definitive without an employer having the ability to require an employee to perform other tasks.6

[73] Ms Ryder submits that mandatory training for CPR and fire and emergency do not extend to a contractual obligation to perform those duties. I did not hear evidence about the reason for that training or any obligation following it to perform those duties. I did hear evidence about restraint training. It was undertaken so that staff in a patient area could lead or participate in restraints of patients when required. The need for restraint can arise when a patient assaults or attempts to assault another patient or a staff member. Attempts to de-escalate situations without the need for restraint will be made but the evidence supports this is not always successful and restraints are still undertaken.

[74] The doctor and psychiatrist do not typically participate in a restraint but they are not based in the AT&R unit. The restraint training for psychologists was postponed in 2015 to enable them to seek advice from their professional body but Ms Kearney said that advice has now been received and psychologists working in inpatient areas will undertake restraint training in 2016. Mr Kelly gave evidence that all other staff working in an inpatient setting need to be able to restrain. I find that restraint was one of the duties Mr Thow undertook at AT&R and it was a duty that was of concern to him and his doctor after his heart attack. Restraints can be physically demanding.

[75] It was not a breach of contract for CDHB to take into account in assessing

Mr Thow's fitness to return to work that he was not to undertake full duties as a BSF

which included restraints.

6 *Group Rentals NZ Limited v Canterbury Clerical Workers IOUW* (1987) NZILR 255

[76] Ms Ryder submits that if I got to this point then Mr Thow's involvement in restraining patients was so minimal that it could easily have been accommodated by other staff.

Are restraints a minimal part of the duties?

[77] Mr Thow said that there was a need for restraint in AT&R every 7 to 10 days. [78] Mr Kelly in his evidence said that he was aware of restraints that took place in

the areas he had oversight of because he signs off on them. Mr Kelly explained that restraints are frequent in AT&R. He said in his evidence that the week before the investigation meeting in April 2015 there had been 7 attempted assaults in the AT&R unit.

[79] In her affidavit Ms Kearney stated that AT&R is a secure facility for individuals with severe behavioural disturbance and individuals

receiving compulsory inpatient treatment under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. The AT&R unit meets the Ministry of Health's secure matrix for a secure hospital facility. The unit is locked 24 hours a day and has secured exits, windows and strengthened walls to prevent restricted patients leaving the facility. The staff offices in the AT&R unit are secured from patients.

[80] There was agreement that the need for restraint occurred even if there was a dispute as to how regularly restraints were carried out and what the percentage of planned and unplanned restraints was. Ms Kearney's evidence was that whilst gains have been made in the AT&R unit due to the new model of care it still remained an area where more restraints occur than any other hospital unit. Further that the unit has the most physical assault injuries of any CDHB units.

[81] I find the evidence establishes a degree of unpredictability with restraints that may not present itself in another case about fitness to return to work. Restraints require at least three trained staff to be undertaken safely although more may be required and there may be an urgent need for other staff which is less effectively met by staff running from another unit when delay could present a level of increased risk.

[82] Five staff are rostered to a morning shift and 4.5 for an afternoon shift. There are some staff "off numbers" in the unit who are required to be available for restraint if needed. There is an alarm which can alert other staff outside the building so they

can run to AT&R and assist but that can take a minute or so. Mr Kelly said that a lot could occur in the interim. and that it was preferable that staff who are involved in the restraint are familiar with the patient, their behaviour and restraint minimisation plan.

[83] Assaults are also a risk factor in AT&R. The other BSF at AT&R had been assaulted by a patient in July 2015 and could not have patient contact for a number of weeks because of injuries sustained.

[84] There was some risk to Mr Thow if he was to be return to the BSF role and undertake restraints or if he was exposed to the possibility of an assault. A situation could develop where the danger to other staff or patients was such that Mr Thow felt he could not stand back from a restraint. CDHB had obligations to Mr Thow to keep him safe from harm until he was medically cleared to undertake full duties as well as obligations to its other staff and patients to ensure that there was sufficient trained staff available to minimise risk to in the event of a restraint situation. I do not find the evidence supports restraints are a minimal part of the duties.

[85] Ms Ryder submits that Mr Thow could have worked the 25% of his role "off numbers" or that he could have undertaken the other BSF's off number part of her role increasing his potential work to 50%. The evidence supported that if Mr Thow returned and did not do restraints then he would be supernumerary and CDHB would have to pay for a nurse to be employed in his place. I do not find any contractual obligation that the CDHB provide work on that basis.

[86] For completeness the other BSF who worked in AT&R sustained an injury following an assault by a patient on 8 July 2015. She was on non-patient contact from

8 July until 21 September 2015 so any adjustment to duties between the BSFs would have been restricted to either side of those dates. Before 8 July 2015 Mr Thow and CDHB were waiting for the medical report from Dr Ford. From 19 October 2015

Mr Thow worked in administrative roles and aside from any graduated return worked full time and was paid his usual salary.

[87] Mr Thow was not I find fully medically cleared for the BSF role until 4 April

2016 at which point he was permitted to return to that role and undertake restraints.

[88] I do not find that CDHB was in breach of its obligations by not permitting

Mr Thow to return to his BSF role without the need to undertake restraints.

[89] CDHB under its policies shows a commitment to its staff by working with them to return to work as soon as possible after illness and injury. That may include alternative duties. There was some unfortunate delay in this case in obtaining the external medical assessment and report but I do not find that delay was within the control of CDHB. I do not find obtaining an external medical assessment a breach of, or inconsistent with, the contractual obligations of CDHB. As at 3 August 2015

CDHB, based on Dr Ford's medical report, concluded Mr Thow would be able to return to work at AT&R with a gradual start and the email exchanges at that time were focussed on obtaining a medical certificate in line with Dr Ford's report. The medical certificate from Dr Chima dated 31 August did not however clear Mr Thow to undertake restraint of patients.

[90] There were then 7 weeks between 31 August and 19 October 2015 before Mr Thow commenced an alternative role. Ms Kearney did explore after 31 August whether the other BSF in the community setting would be prepared to undertake Mr Thow's role and Mr Thow undertake the community BSF role but that was not viable. Administrative/secretarial vacancies were then considered and one found as at

19 October 2015. Those roles are not at an equivalent remuneration level to Mr Thow's BSF role however Mr Thow was paid at his existing salary level until cleared to work back at AT&R in April 2016.

[91] Mr Thow was concerned about delay and the time he was without an income. I am not however satisfied that CDHB was contractually obliged to offer light or alternative duties to Mr Thow in circumstances where it concluded he was not cleared medically to undertake the requirements of his BSF position.

Was there disparity of treatment of Mr Thow?

[92] Mr Thow considered that he was treated differently to other employees in the same situation that he was in. The Authority heard about two employees in some detail.

[93] The first was the other BSF at AT&R who has been referred to earlier. She had no patient contact for a number of weeks after being assaulted by a patient so was undertaking light non-contact clinical duties as part of her rehabilitation in AT&R. Ms Kearney said that CDHB is

in an ACC partnership programme and is an ACC accredited employer. She said that CDHB employs workplace rehabilitation advisors

to facilitate return to work plans and financial support is available through the programme so the BSF was working effectively supernumerary until her recovery. The funding was not available in a situation such as Mr Thow's.

[94] The second employee was a registered nurse who suffered a heart attack at about the same time as Mr Thow. He was also unable to undertake restraints and was redeployed to a community registered nurse vacancy. He did not return to light duties or non-patient contact duty which is similar to the approach taken with Mr Thow.

[95] In *Chief Executive of the Department of Inland Revenue v Buchanan* the Court of Appeal7 set out three issues to be considered in relation to the question of disparity of treatment:

a. Is there disparity of treatment?

b. If so is there an adequate explanation for the disparity?

c. If not, is the dismissal justified, notwithstanding the disparity for which there is no adequate explanation?

[96] The cost of the return to work plan for the other BSF which did involve non- patient contact duties was met by the provider. The provider through its advisors facilitated a return to work plan as it saw fit in circumstances where there was a work related injury. There was no additional cost for that return to work plan to CDHB.

[97] There is, I accept, more opportunities for transferring a nurse because that is one of the largest occupational groups employed by CDHB and they are trained for the role which no doubt had the same or similar rates of remuneration wherever the role was undertaken. There were only three BSF positions and a transfer was not as easily identifiable at an early stage or available as with the nursing positions.

[98] I find that there was an adequate explanation for the disparity of treatment and no remedies flow as a result from that claim.

7 [2005] NZCA 428; [2005] ERNZ 767; (2006) 7 NZELC 98,153 (CA) at para [45]

[99] The claim that there has been a breach of good faith is a failure on the part of

CDHB to respond to concerns raised by Mr Thow in his emails dated 17 and 26

August 2015. Ms Ryder submits that the failure was intended to undermine the employment relationship and a penalty should be awarded under s 4A of the Act.

[100] On 17 August Mr Thow in an email sent to Ms Kearney and others referred to two situations where he had been advised there were no light duties but understood that staff were currently on light duties. On 26 August Mr Thow again referred to other staff off restraint and other physical duties or seconded to other positions following medical/accident issues.

[101] I accept those issues were of concern to Mr Thow because he felt he was being treated differently. The tone of his emails began to change at or about that time.

[102] I find that Ms Kearney focussed in her responses to Mr Thow at that time to getting a medical certificate that was in line with Dr Ford's report so that Mr Thow could return to work. The concerns Mr Thow raised about how other staff injured or unwell were dealt with were not answered and matters very quickly thereafter went down a legal path.

[103] Parties to an employment relationship are required to be responsive and communicative and I find there was a breach of good faith at that time by CDHB to respond to Mr Thow's concerns and to explain the difference for the treatment of others balancing confidentiality of those staff in doing so.

[104] I do need to be satisfied that the failure was intended to undermine the employment relationship for an award of a penalty under s 4A of the Act. I am not satisfied that the breach of the duty of good faith was intended to undermine the employment relationship. Rather I find it more likely having heard from Ms Kearney that she focussed instead on a medical certificate clearing Mr Thow for work which would enable him to return to work. This is not a situation where I find a penalty should be awarded.

[105] I reserve the issues of costs. I would encourage the parties to see if agreement can be reached.

Helen Doyle

Member of the Employment Relations Authority