**IN THE EMPLOYMENT COURT OF NEW ZEALAND**
**AUCKLAND**

**I TE KŌTI TAKE MAHI O AOTEAROA**
**TĀMAKI MAKAURAU**

**[2019] NZEmpC 34**
**EMPC 278/2016**

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| IN THE MATTER OF | a challenge to a determination of the Employment Relations Authority |
| BETWEEN | LYNDA MARIE EMMERSON<br>Plaintiff |
| AND | NORTHLAND DISTRICT HEALTH BOARD<br>Defendant |

Hearing: 1, 3, 5, 15, 16, 17, 18, 19, 23, 24, 25 and 26 October 2018

Appearances: S Henderson and C Martin, counsel for plaintiff
S Hornsby-Geluk, counsel for defendant

Judgment: 28 March 2019

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## JUDGMENT OF JUDGE B A CORKILL

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## Introduction

[1] A medical practitioner claims she was badly mistreated by her hospital employer, and then wrongfully dismissed. She seeks substantial remedies.

[2] Her employer vigorously denies all her assertions, stating it acted in a fair and reasonable way at all times, and that the employee's claims are all misconceived; further, if the Court were to get to the point of considering remedies, these should not

be awarded in light of her egregious misconduct; at best, only modest awards would be justified.

## Background

*Overview of facts*

[3] Dr Lynda Emmerson[1] worked as a junior doctor for the Northland District Health Board (NDHB) from 2012 until 2015. For much of this time, she worked on the Tumanako Inpatient Unit (the Unit). It provided mental health care for adult inpatients, at Whangarei Hospital.

[4] Dr Emmerson did well on the whole as a house officer when working in the Unit in 2014. On becoming a registrar in the same Unit in December 2014, problems arose.

[5] First, there was an issue as to the adequacy of her supervision and how she was treated by NDHB as a registrar in training. She also considers she was bullied and that there are related health and safety issues.

[6] Then, issues arose as to the circumstances in which she had written prescriptions for her partner.[2] After conducting a disciplinary process, NDHB concluded she was in serious breach of the standards which it, and the regulatory authority responsible for medical practitioners, the Medical Council of New Zealand (MCNZ), required of her. She was also found to have misappropriated the final prescription which she wrote. She was accordingly dismissed on the grounds of serious misconduct in May 2015.

[7] In the aftermath of the dismissal, a variety of events occurred, some of which are relevant to this case.

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1 I refer to her by the epithet of Dr, as she was throughout the events reviewed in this judgment. A registered health practitioner is entitled to be so addressed. As will become evident, her registration was subsequently cancelled, and currently she is not entitled to be so addressed.

2 There is a permanent order of non-publication of name for Dr Emmerson's partner: minute of 1 October 2018.

[8] As a result of a complaint by a senior NDHB doctor to MCNZ, its Health Committee considered whether she was fit to practice on the basis of prior use of methamphetamine and cannabis. In September 2015, it recorded her as having stated that she had become abstinent from such use; it accordingly proposed conditions to enable her to resume practice.

[9] However, the prescribing issues, and then the personal issues of drug use, came before a Preliminary Conduct Committee (PCC), which determined that a disciplinary charge should be placed before the Health Practitioners' Disciplinary Tribunal (the HPDT). That charge related to the prescribing of medicine to family and friends, to personal drug use, and to an assertion that Dr Emmerson had misled or attempted to mislead the PCC in relation to the full extent of her drug use.

[10] In May 2017, the HPDT found that the allegations of professional misconduct were made out and determined that Dr Emmerson's registration should be cancelled.[3]

[11] Prior to this, in November 2015, Dr Emmerson issued defamation proceedings against two of the senior doctors, with whom she had engaged as an employee, Dr M and Dr N. The Court understands that this claim came on for trial in November 2017; but was then adjourned part-heard.

[12] Finally, I record that Dr Emmerson raised four personal grievances which were investigated by the Employment Relations Authority (the Authority) in January and July 2016; the determination was issued in September 2016.[4] Dr Emmerson's assertions as to both disadvantage and dismissal grievances were all dismissed.

[13] In November 2016, a de novo challenge of the Authority's determination was filed in this Court.

*The challenge*

[14] Dr Emmerson raised four causes of action. In summary, as pleaded, they are:

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3 *A Professional Conduct Committee appointed by the Medical Council of New Zealand v Emmerson* 887/Med16/358P.

4 *Emmerson v Northland District Health Board* [2016] NZERA Auckland 322.

a) That she suffered unjustified disadvantage because NDHB failed to comply with the standards of training, and in particular supervision, required by the Royal Australian New Zealand College of Psychiatrists (the College), as described in applicable regulations. Specifically, these requirements included an obligation on her supervisor, Dr M who was Clinical Head of the department with which she worked, to provide at least one individual educative session with her each week, which did not occur between 8 December 2014 and 2 April 2015, causing significant disadvantage.[5]

b) A second claim of unjustified disadvantage is that Dr Emmerson was subjected to continuous bullying and intimidation from Dr M. Dr Emmerson relies on multiple interactions with Dr M which she says occurred between December 2014 and April 2015. Recognising that this personal grievance may be out of time, she also asserts that there are exceptional circumstances justifying the grant of leave for raising the personal grievance, after the expiration of the 90-day period within which a personal grievance should be raised.

c) The third assertion of unjustified disadvantage is that there was a failure to provide a safe working environment, because Dr M criticised, demeaned and confused Dr Emmerson on a daily basis. A range of alleged abusive behaviours are alleged to have occurred from December 2014 to April 2015.

d) Dr Emmerson asserts that she was unjustifiably dismissed, in that the decision to dismiss was not justified substantively, and the process leading to such a conclusion was flawed. She asserts that Dr M and Dr N, a Consultant Psychiatrist involved in management of mental health services at NDHB, unduly influenced the process of termination and there were numerous procedural defects. She says the outcome of

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5 There are interim orders on non-publication of name of two doctors referred to in this judgment, who are therefore referred to as Dr M and Dr N: minute of 1 October 2018. The question of whether these orders should be made permanent has yet to be considered.

dismissal was disproportionate to her actions and failed to take into account the future impact on her career in medicine.

e) It is pleaded that substantial remedies should be awarded for these breaches.

[15] For its part, NDHB states in response:

a) The applicable standards of training and supervision were not breached; nor was Dr Emmerson disadvantaged. In any event, many or all of the issues relating to this claim occurred outside the required 90-day timeframe for raising a personal grievance, and there are no exceptional circumstances that would justify the delay.

b) It denies that there was any bullying conduct by Dr M; again, it asserts there was not compliance with the required 90-day timeframe for raising a personal grievance, and that there are no exceptional circumstances that would justify the delay.

c) NDHB denies that there was a failure to provide a safe working environment in the respects asserted and says that many or all of the issues raised occurred outside the required 90-day timeframe for raising a personal grievance.

d) With regard to the dismissal grievance, NDHB pleads that each of the allegations raised by Dr Emmerson lack foundation, and in summary NDHB took steps with regard to Dr Emmerson's serious misconduct, both substantively and procedurally; and that dismissal was an option open to a fair and reasonable employer in all of the relevant circumstances.

e) The remedy claimed is excessive in the circumstances.

**First, second and third causes of action**

*Brief chronology – introductory matters*

[16] Dr Emmerson graduated in 1996 with two undergraduate degrees in commerce and law. She then practiced law in Whangarei for eight years. In contemporaneous documentation, she said the majority of her practice was in family law.

[17] Against that background, she decided to study medicine via the University of Otago; she attended the medical school in Dunedin for two years, then the Wellington School of Medicine for two years, completing her intern year at Whangarei Hospital.

[18] As part of her final training year, she spent a month working at the Unit. It was in this period that her interest in the treatment of mental illness developed. She gained a distinction in the psychiatry component of her degree in 2012. She successfully applied for a house officer's role and began work as such with NDHB in November 2012. She started in general surgery, and then undertook two three-monthly rotations in general medicine, followed by one in orthopaedics.

[19] On 27 November 2013, she was granted General Scope Registration by the MCNZ.

*House officer: February to December 2014*

[20] In her second year as a house officer, she undertook a nine-month rotation in psychiatry which commenced in February 2014, in the Unit. The inpatient ward contained 24 beds;[6] at times, patient demands increased patient numbers up to 27. A sub-acute unit provided care for a further five patients. At times, work in the Unit was demanding having regard to a range of issues arising from mental unwellness; some patients had a propensity for violence, addiction to drugs, dysfunctional relationships; and many had challenging socio-economic backgrounds.

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6 As described in a report written by Dr Emmerson in late 2014; in her evidence, however, she said there were 23 beds.

[21] Early in her clinical placement on the Unit, Dr Emmerson became interested in conducting a particular project as to the physical health of patients. It took place because of concerns she held as to:

- paucity of documentation following a house officer seeing a patient;
- perceived inadequacies as to a policy and process for the administration of anti-psychotics such as Clozapine;
- lack of formality in ordering and reviewing tests for patients;
- incorrect recording and management of abnormal results; and
- appropriate handovers in relation to the physical health of patients.

[22] These concerns related to how patients' physical health needs would be handled, as distinct from their mental health needs. Dr M considered there was room for improvement in how those needs might be handled, so she supported the project.

[23] In March 2014, Dr Emmerson separated from her then partner; she said he started using methamphetamine for a short period. She told Dr M about the separation and her partner's behaviour. Dr M said she was also told about his anger issues.

[24] In about April or May of 2014, Dr Emmerson was observed by Dr M to be attending work in a state where she was unfit to work. She was slurred in her speech and seemed unaware of how she presented. She was told to go home. The next day, she returned much improved. She was alert, stable on her feet and aware of her surrounds. She told Dr M that she had previously suffered a significant head injury, which caused her to become dizzy and disoriented if she suffered even a slight knock to the head, as had occurred.

[25] There is a dispute as to whether the two discussed a question as to whether Dr Emmerson was using drugs. Dr Emmerson denied personal drug use. Dr M said she was not entirely persuaded by the denials but gave her the benefit of the doubt and let the matter lie.

[26] Ms Jo Wilkins was a General Focus Nurse working in the Unit.[7] Her role was to support and coordinate the house officers' physical health work. Initially, Ms Wilkins and Dr Emmerson worked well together, but their relationship deteriorated. It appears the review of patients' physical health needs undertaken by Dr Emmerson created friction.

[27] Ms Wilkins shared her concerns with Dr M and the Acting Unit Manager, Ms Donna Kiwikiwi; she complained about the way she was being treated by Dr Emmerson. She requested a change in role. However, Ms Wilkins did not wish to formalise her concerns by making a complaint.

[28] Dr M said she met with Dr Emmerson, who claimed to have no idea why the issues had been raised. Dr Emmerson says there was no such meeting; and that her interactions with Ms Wilkins reflected what she had been told to say and do by Dr M. Dr M says there may have been discussions as to how particular tasks were to be handled, but in any event, communication between Dr Emmerson and Ms Wilkins should have been handled in a more professional and sensitive way.

[29] In the result, Dr M did not think either party could be held more responsible than the other for the breakdown of the relationship. Ms Wilkins moved to another role in August 2014 so that some of the administrative functions formally undertaken by her became Dr Emmerson's responsibility.

[30] Dr Emmerson referred to several situations which it appears were intended to suggest there was a culture of sloppy boundaries. She said that from July 2014, she provided legal assistance to some of Dr M's family members. There is a dispute as to whether this was volunteered or requested. The main point, however, is that the legal assistance was significant, and Dr M now accepts in hindsight that she made an error of judgment in allowing Dr Emmerson to provide the advice. One issue related to a potential family protection claim. Dr Emmerson drafted appropriate letters, telling family members they could easily manage without a lawyer, and stating that if they were happy with the arrangement, she would provide informal assistance. It is obvious that legal costs were saved.

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7 She was also described as a Physical Health Nurse.

[31] With Dr M's knowledge, legal assistance was also provided to a senior colleague on the ward.

[32] On another occasion, Dr M asked Dr Emmerson to give advice as to the interface between the mental health legislation, and the provisions of an enduring power of attorney; this avoided the instructing of a Board lawyer. Then, Dr M was advised by Dr Honeyman, a NDHB psychiatrist, that it was inappropriate for a house surgeon to provide legal advice, as there was a potential for a perceived conflict of interest, and this was not her job.

[33] I find that Dr M did rely on Dr Emmerson to provide legal advice in light of her previous experience as a lawyer, and that this was beyond the scope of her terms of employment.

[34] Dr Emmerson also provided assistance to Dr M when she acquired an iPad. There is a dispute as to whether this was requested or volunteered; again, Dr Emmerson was not required to give this assistance, but Dr M accepted the assistance.

[35] Another issue about which there is a dispute relates to an assertion by Dr Emmerson that she was asked by Dr M to look at the medical records of the latter's family members, which she said happened on several occasions. Dr M denies this assertion in part, although she accepted that on one occasion, Dr Emmerson did look up her father's medical records. Dr Emmerson said she offered to do this because it may not have been appropriate for Dr M to do so herself. Dr M said she allowed Dr Emmerson to do this but did not direct her to do so; nor was any concern expressed at the time. On the evidence, the only person who would have had any interest in these records was Dr M; she was the senior doctor involved, and it is more likely than not she approved the accessing of medical documents by Dr Emmerson.

[36] All of these incidents suggest that there was a reasonably close association between Dr Emmerson and Dr M.

[37] In mid-2014, there was a discussion when Dr M told Dr Emmerson of an instance where she had taken a tablet of Diazepam from a ward dispensary for her father in a one-off emergency situation. Dr Emmerson said that as a result of this conversation, and of practices she had observed in the Unit, she was left with the view that treating or prescribing to those close to a practitioner was a "grey area", but it was a matter for individual judgement.

[38] Dr M said she referred to this example to demonstrate why treating those close to a health professional was not appropriate. In her father's case, she was obliged to take detailed follow-up actions, which included disclosure to multiple individuals, clinical review, independent enquiry and the immediate referral of her father to his own clinician. This issue later became relevant to the circumstances which gave rise to Dr Emmerson's dismissal and will be discussed further when considering those issues.

[39] Dr M said that by late August 2014, she had received two complaints about Dr Emmerson. The first concerned Ms Wilkins, as already outlined. The second related to a concern raised by another nurse, Ms Carmen Fleming; she said she had asked Dr Emmerson to attend to a patient issue, but this had not occurred. Dr M said that when she raised the issue with Dr Emmerson, she demonstrated no understanding as to how she may have contributed to the situation. For her part, Dr Emmerson denied the incident, or that the criticisms were put to her.

[40] Dr M said that by late August 2014, when it was necessary for her to prepare one of the several evaluation forms for Dr Emmerson, she was concerned about the two complaints she had received. She said she took these into account with regard to several of the ratings in the evaluation form. These were initially recorded as being "Meets Expectation, Consistent with performance generally observed for this level of experience". However, Dr Emmerson was provided with a copy of the draft so as to provide feedback on the provisional assessment. She emphasised that she had provided good patient care generally, had done a lot of work in the Unit, and continued to be passionate about her practice. As a result, Dr M amended the evaluation and signed it off, noting:

Extremely competent HO
Will be an asset to psychiatry
Self-motivated, disciplined
Confident in decisions
Excited by processes developed

[41] On 24 September 2014, Dr M completed a reference for the College, supporting Dr Emmerson's application to undertake training as a psychiatrist. Again, there was a positive assessment, although she recorded a perceived weakness that Dr Emmerson took people at face value and that she was prone to being gullible.

[42] Dr N also completed a reference for trainee selection, to be sent to the College. She also noted that Dr Emmerson had been competent and hardworking, often staying late. She went on to state that Dr Emmerson might have difficulties with overworking and would need to be mindful of maintaining boundaries as to her time. She was assessed as being a good applicant for the training scheme.

[43] Finally, Dr McIlhinney also provided a positive reference for Dr Emmerson. He highlighted a minor issue, which was about taking on too much work rather than delegating. He gave her high scores.

[44] On 2 October 2014, Dr M formally requested an extension of Dr Emmerson's role as house officer, from 24 November 2014, for two weeks. The proposal emphasised a number of Dr Emmerson's positive contributions, particularly the systems she had developed for the Unit which it was acknowledged were not within her current job description and had been undertaken in addition to usual duties. It was stated that new house officers would commence on 24 November 2014, and the changes on which Dr Emmerson had been working would need to be implemented, "so that these then become imbedded (does not require change of JD)". She went on to state that Dr Emmerson would develop a briefing paper for Dr Roberts, the Chief Medical Officer, to address "the interface issues" and meet with him to discuss the issues and implications for the organisation if the physical health issues she had identified were not addressed. This extension was approved by Mr John Wade, the Group Manager of Mental Health and Addiction Services, on 7 October 2014.

[45] On 14 November 2014, Dr M completed the final evaluation form for Dr Emmerson's rotation, covering the period August to November 2014. Her performance was rated, in all respects, as exceptional, which was defined as: "Performs as a much higher level than that generally observed". In her comments, Dr M stated:

> [Dr Emmerson] has performed at an exceptional level, undertaken projects to improve service processes, developed a research database that will inform future developments. She has clarified HO job description, developed important relationships with general hospital and internal staff.

*Dr Emmerson's role as a registrar from December 2014*

[46] Dr Emmerson commenced work as a psychiatric registrar on 8 December 2014. She told the Court that the extent of her orientation from Dr M was the instruction "follow me and do the mental states". Dr M said this was "entirely untrue". She said Dr Emmerson spent a significant amount of time with her seeing patients and discussing services available to them and so forth. This was, she said, orientation. I find, however, there was no formal orientation from Dr M, perhaps because it was assumed Dr Emmerson was already familiar with the routines and practices in the Unit.

[47] An incident involving a senior house officer, Dr Ei Ling Loo, occurred very soon after Dr Emmerson started in her new role. A patient was about to be discharged, and issues arose as to the extent of review which was required at that point. Dr Emmerson said that Dr Loo was resistant to undertaking the required tasks – as set out in the physical health report – so it was necessary to obtain Dr M's support for this to be done. She said Dr M told her to tell Dr Loo she was expected to do the requested task. She reiterated the request; Dr Loo refused.

[48] Almost immediately, on 9 December 2014, Dr Loo wrote to the Resident Medical Officers' Manager at the hospital; she requested a change of an anticipated run allocation as a house officer working in psychiatry from February 2015 to May 2015. She said that she had concerns regarding the recent protocols that had been put in place for house officers, which raised issues as to over-investigation of patients with blood tests and unnecessary patient reviews that were capable of being counterproductive in terms of patient care and safety; and that her relationship with

Dr Emmerson had become, almost immediately, challenging. She said she had been told not to question the protocols Dr Emmerson had developed, but to comply with them. One of her concerns was that such requirements cut across her ability to exercise her judgement as a doctor on patient issues.

[49] Management attempted to address these concerns promptly. Dr Loo was told that her comments regarding the new protocols were helpful, and that these were in draft form only; she was encouraged to reconsider the possibility of working as a house officer in psychiatry; and she was reassured that she should use her own clinical judgement. Dr Emmerson was told that clear boundaries needed to be maintained as a registrar, and that Dr Loo, as a house officer, did not report to her as a registrar.

[50] On 15 December 2014, a copy of Dr Loo's complaint was sent to Dr Emmerson, together with advice from Dr N that she would be conducting an investigation. An investigation meeting took place on 19 December 2014. It was attended by Dr Emmerson, Dr N and Dr M as her supervisor pursuant to the training requirements of the College. According to a letter Dr N wrote soon after, the subject matter of the meeting was Dr Emmerson's communication style.

[51] Dr N appears to have emphasised the importance of constructive communications with colleagues. For her part, Dr Emmerson appears to have emphasised that the circumstances of her interaction with Dr Loo involved an issue of patient care which should not be compromised.

[52] In evidence, Dr Emmerson said that she was disappointed Dr M had not been prepared to acknowledge at the meeting that it was she who instructed her to approach Dr Loo with a request to complete the documentation, based on the terms of the recently developed protocol. She said Dr M "threw me under the bus".

[53] In a subsequent letter, sent by Dr N to Dr Emmerson on 23 December 2014, reference was made to various aspects of the discussion at the meeting. She made several comments as to the context of the relevant exchange with Dr Loo. She said that passion for patient outcomes may have impacted on communication between herself and Dr Loo. The importance of engaging with staff in a way which understood

any resistance they may have to change, as well as acknowledging any responses they might have, was emphasised. Self-awareness in a psychiatrist was also referred to. Dr N also acknowledged that the transition from house officer to a registrar's role was a time of significant change. She concluded by stating that, as the investigation had been stressful, it was not necessary to take the matter any further. However, she encouraged Dr Emmerson to explore the issues summarised with Dr M in a "Supervision framework".

[54] Dr Emmerson said that within days of the meeting, Dr M informed her that it would no longer be necessary to undertake formal supervision. This was because supervision was in effect occurring when attending patients, with the opportunity for educative discussion to take place. The supervision was that she was observing an important clinical interaction. I will discuss further the question as to whether Dr M told Dr Emmerson there would be no individual supervision, shortly.

[55] By this time, Dr Emmerson had, with some effort, completed her physical health report and had provided it to Dr M; the latter, however, had not read the document in its entirety, although she said she did not ignore or disregard it. I find that she was not fully familiar with its content at that stage.

[56] I also note that, whilst Dr M had originally envisaged that the recommendations of Dr Emmerson's report were to be "embedded" into use when the incoming house surgeons commenced their rotations in December 2014, because of the difficulties that had arisen, those recommendations became a set of draft proposals. Dr N said that some elements of the project were continued thereafter, and some were not. A key driver for this change of emphasis related to the ability to retain house officers without overworking them. A related issue was that a physical health nurse had previously the responsibility to perform this work up until August 2014; but by the time these events occurred, there was no longer such a resource.

*January 2015*

[57] In an email sent on 6 January 2015 by Dr Roberts to Dr M and Dr N, he said he had met with Dr Loo who stated she had found working with Dr Emmerson very difficult, not least because of the workload arising from the project, which she found

impossible to address within working hours. A second house officer who had recently commenced a rotation on the Unit, Dr Tamara Birchall, was also reported as struggling to complete the work required by the templates Dr Emmerson had developed. Not only was there now reduced nursing support for the house officer because Ms Wilkins had left her position, there was also an increased workload for the house officers. In Dr Roberts' view, this had led to Dr Birchall feeling overwhelmed.

[58] Dr Roberts said he felt sure Dr Emmerson was trying to act in the best interests of patients, but he thought she needed clearer guidance regarding this work. He also said that a number of people had spoken to him off the record about Dr Emmerson's behaviour towards junior doctors and some members of nursing staff. He had been told that her behaviour was bullying and intimidatory, although without a formal complaint, he was unable to investigate such claims.

[59] These issues continued to be the subject of discussion between those managing this issue for the remainder of January, including whether a nurse's position could be re-established to undertake a physical healthcare role in the Unit, and whether Dr Loo would in light of the steps which had been taken to deal with her concerns, be prepared to work in the Unit either on a psychiatry run or as a relief house officer from time to time.

[60] In summary, the events that arose from Dr Loo's concerns as to the physical needs project were significant. They had at least three consequences.

[61] The first related to the fact that normally a house officer would be able to take advice and consult with a registrar; it was made clear to Dr Emmerson that this would not happen, at least as far as Dr Loo was concerned.

[62] Second, there was concern as to recruitment of a house officer for the second quarter of 2015, since Dr Loo was adamant she would not take up the psychiatric run at the Unit to which she had been initially allocated.

[63] Third, Dr M said that she became frustrated with all the house officers and junior doctors on the Unit, and the difficulties that arose in trying to obtain a house

officer to cover the needs of the Unit. She said that as a result, she became "more formal" towards all of the junior doctors at that time.

[64] As far as her interactions with Dr Emmerson were concerned, Dr M said that between 22 December 2014 and 27 March 2015, the two spent on average four hours a day, four days a week, jointly seeing patients and discussing issues as they arose. She emphasised that ward discussions with a junior registrar were particularly important, since in her view psychiatric training was based on an apprenticeship model. Her approach to supervision was designed to immerse Dr Emmerson into psychiatry, initially through observation and being present with her for extended periods of time on the ward.

[65] She also said some nine individual supervision meetings occurred. But she did not formally record the content of these until late March 2015. She said that, in these sessions, she discussed training topics and clinical issues.

[66] For her part, Dr Emmerson says that from December 2014 to March 2015, she worked with Dr M, seeing patients in the Unit, but under circumstances that were increasingly difficult. It was her evidence that individual supervision sessions did not take place as they should have. There was, she said, one interrupted individual meeting with Dr M in mid-December 2014; but that Dr M told her later in that month that it was no longer necessary to undertake formal supervision; this was because the questions Dr Emmerson asked about a patient concerning his or her management were the equivalent of supervision.

[67] Dr Emmerson said that soon after becoming a registrar, Dr M began to actively undermine her, to the point where she was intimidated, humiliated and belittled constantly in front of other staff, and in private. She gave evidence of a number of interactions with staff and patients, which she said demonstrated not only that she was not being supervised properly, but that there was a constant changing of the goal posts so that what she was told was correct one day was wrong the next. She said she became exhausted and worried about her work; she said she suffered sleep deprivation, weight loss, and diminished confidence in her abilities.

[68] Others noticed a change. Ms Maryanne Rata, a nurse at the Unit, observed Dr M and Dr Emmerson were not getting on, and that there was friction between them. She said that Dr Emmerson was being "squashed", "silenced" and "muffled". She said there was a "cold edge" to Dr M's conversations with Dr Emmerson. Ms Yasmin Oxton, another nurse at the Unit, said there was a tension between the two, and that Dr M "sounded really frustrated" with Dr Emmerson. Ms Oxton noticed Dr Emmerson had lost weight, but also understood Dr Emmerson was suffering relationship issues at the time. Dr Cole who had worked previously in the Unit with both Dr M and Dr Emmerson as a registrar, said that at weekly multi-disciplinary team meetings in early 2015, Dr Emmerson appeared stressed and tired and that she and Dr M were talking less and seemed "disinterested in each other".

[69] Dr Vernon Reynolds, a psychiatrist, was responsible for meeting from time to time with psychiatric registrars for group psychotherapy supervision as an aspect of their training programme. At such a meeting on 23 February 2015, Dr Emmerson raised problems which she said she was experiencing in her supervision relationship with Dr M.

[70] Much later, when NDHB was conducting an investigation process, Dr Reynolds referred to Dr Emmerson's concerns as discussed at the February meeting. He recalled she had said her relationship with Dr M had become "extremely dysfunctional". She had raised serious concerns as to boundaries, team work, clinical supervision, communication and pastoral support.

[71] Dr Reynolds told the Court that the group canvassed options for dealing with the situation, including discussing these issues with Dr M, or seeking assistance from the training facilitator at NDHB, Dr N, or from the external training director, Dr Felicity Plunkett. However, Dr Emmerson indicated she would try to address the issues herself, using an upcoming mid-run evaluation as an opportunity for discussion.

[72] After this meeting, Dr Cole told Dr Emmerson that confronting Dr M would not be appropriate, as it could lead to an argument; rather, Dr Emmerson should look at ways of rebuilding the relationship.

*Review of supervision arrangements for Dr Emmerson*

[73] On 17 March 2015, Dr N met with the heads of each Mental Health Service within NDHB. Such meetings were held monthly so attendees could provide an update on progress in their particular service and seek senior psychiatrist peer support and feedback on any issues of concern.

[74] At the March meeting, Dr M raised concerns about Dr Emmerson. These were discussed briefly. She said that the main issue was Dr Emmerson's inconsistency in performance. She said this made it difficult to know how to grade Dr Emmerson for her three-monthly review: should Dr Emmerson be scored according to her best performance or her worst performance?

[75] The view was taken that patient safety was paramount, and it was therefore prudent to score her at her worst, so she would be encouraged to persistently perform at a higher standard.

[76] One of the other psychiatrists said he had noted some concerns in terms of Dr Emmerson's rigidity, inability to take feedback and tendency to over-investigate. Also discussed was the possibility that another psychiatrist take over Dr Emmerson's supervision so as to provide another opinion on her performance. However, that possibility was not pursued.

[77] On 18 March 2015, Dr N met Dr Emmerson for a routine three-monthly meeting, the purpose of which was to obtain feedback on her training thus far. Dr N, who prepared a brief note of the meeting, said she recalled Dr Emmerson stating she was pleased to be working on the Unit, and that for the purposes of the next six-month rotation from June 2015, she wished to continue working with Dr M as a supervisor rather than another psychiatrist. Dr N said she asked Dr Emmerson whether she had completed any work-based assessments (WBA) as required by the College; these were structured tasks that a trainee presented to or completed with their supervisor. Dr Emmerson said she had not received formal one-on-one supervision meetings for this purpose.

[78] On this topic, Dr Emmerson said the issue of supervision was not discussed in connection with WBA requirements; rather, she told Dr N she was not receiving formal supervision at all. I accept this was the thrust of the conversation, since it is consistent with the previous concerns she had expressed to colleagues in late February 2015.

[79] In any event, Dr N said she would discuss the issue with Dr M. Dr N also stated that there was nothing in Dr Emmerson's manner which indicated she was concerned about Dr M's approach towards her or treatment of her; at the time, she recorded that Dr Emmerson was over-confident.

[80] The next day, Dr N raised the supervision issue with Dr M. In her evidence, Dr N said that Dr M stated one-on-one sessions occurred when they attended Dr M's patients.

[81] A few days later, on 24 March 2015, there was to be a meeting of accredited supervisors with Dr N. Dr M prepared notes for the purposes of this meeting, summarising concerns she had about Dr Emmerson.

[82] The concerns which were identified by Dr M were soon after recorded in an email sent on 27 March 2015 by Dr N to Dr Plunkett, who represented the interests of the College. They included fluctuating functioning, poor initiative, difficulty taking advice, over-investigation, undue rigidity, and poor personal appearance.

[83] Dr Plunkett responded on the same day. She asked whether there were causes which may need addressing and raised the possibility of a performance management strategy. She suggested that a detailed grading of performance should be undertaken so as to identify targets which should be met over the following three months. Feedback should be placed in writing, as should those targets. These should be reviewed at the end of the three-month period. There would also be an emphasis on passing outstanding WBAs. If need be, a formal performance improvement plan might have to be considered.

[84] Dr M says that as a result of the advice given by Dr Plunkett, she decided to document supervision in an attempt to clarify specific concerns that could

subsequently be addressed. She said she also commenced using a detailed scoring system to grade Dr Emmerson's performance with a view to providing feedback on any deficits which were identified. It was her plan to monitor Dr Emmerson's progress and to provide feedback more formally than had occurred previously, then review all of this at the end of the run in June 2015. She told the Court it was her aim to assist and support Dr Emmerson to achieve her training requirements so that she could pass her run requirements.

[85] This plan was not communicated to Dr Emmerson at this stage. Dr M said that there needed to be a joint meeting for this purpose, involving herself, Dr N and Dr Emmerson. She recognised that Dr Emmerson would find the possibility of a remediation plan difficult. She herself had a period of leave coming up; shortly before taking that, the meeting would take place to enable discussion of the particular concerns, and a clear process to address these. Whilst Dr M was on leave, Dr McIlhinney would work with Dr Emmerson on some work-based assessments, as required for College training. She said this would provide support and reassurance to Dr Emmerson. Dr M also said that the plan could not be properly formulated until time had been spent in one-on-one supervision.

[86] The first of the supervisory sessions occurred on 1 April 2015. It appears to have been triggered by an event which had recently occurred when a patient in the acute Unit had taken leave with a person who was not authorised to accompany her; the patient then became absent without leave. The patient's family was very distressed. The patient was located several days later and returned to the hospital.

[87] Dr M met Dr Emmerson in supervision the following day for two and a half hours. There was a discussion as to how Dr Emmerson had reached the clinical decision to grant leave. Although denied by Dr Emmerson, Dr M considered contributing factors were a failure to actually see the patient, to review clinical notes, to note a previous risk assessment, and to review leave forms. She considered Dr Emmerson had appeared not to understand the risks involved. These factors were recorded in the comprehensive note which Dr M prepared, following the session of supervision. She also recorded four specific areas on which Dr Emmerson would work as a result of the incident and the supervision session that followed it, including the

completing of comprehensive mental state examinations, familiarising herself with electronic documents, knowing which documents should be reviewed for patients when on call to assist with clinical decisions, and taking more initiative for her own learning.

[88] Dr M said that on 3 April 2015, she completed an In-Training Assessment (ITA) form about Dr Emmerson. The purpose of the form was to identify and provide feedback on the trainee's strengths and weaknesses, as well as their progress at a mid-point of the rotation.

[89] A number of Dr M's assessments fell within the "inconsistently met" category of expectations. She also noted the fact that she would be meeting with Dr Emmerson together with Dr N to discuss concerns and a process for addressing them.

[90] Dr M recorded that the areas for further development were "Fluctuating mental state leading to inconsistent performance, unable to trust decision making – Need to clarify the reason for fluctuation before we can develop a robust plan".

[91] Dr Emmerson completed some of the form, a part which recorded that the supervision requirements required by the College had been met. Dr Emmerson did not, however, countersign that part of the form which confirmed she had sighted Dr M's assessment, and that she had discussed that with the supervisor. Dr Emmerson said that her acknowledgment of supervision having been properly given was made because this was the path of least resistance and the only way she was going to be able to complete the year without there being adverse consequences. She also said that she downloaded the form on 6 April 2015, completed it in part as just described, and then gave it to Dr M. I will return to these issues shortly.

[92] There was a further supervision session on 7 April 2015 during which the circumstances of the patient who had been discussed the previous week were reviewed, and there was a discussion as to the diagnosis of a further patient. A relatively brief record of this session was made by Dr M.

[93] A yet further session took place on 13 April 2015, where again a range of patient-centred topics were discussed. In her note of the meeting, Dr M recorded five matters on which there needed to be more focus by Dr Emmerson; however, she also noted improvements, such as the fact that Dr Emmerson was dressing more appropriately, was more alert, and had completed relevant summaries although with prompting. She also recorded that Dr Emmerson worked better when under direct supervision, which was to be contrasted to the relatively autonomous role she had as a house officer when information she provided was accepted as fact, she had managed her own time, and she had obtained tests which she wanted and convinced others they were needed. She observed that she did not think Dr Emmerson coped well with restrictions.

[94] The fourth supervisory session took place on 15 April 2015. This session was covertly recorded by Dr Emmerson. The parties agreed that a transcript of the recording should be placed before the Court, as was an audio file to which I have listened. The handwritten note made by Dr M of this session is brief.

[95] It is evident from the transcript that a free-ranging conversation was held as to the behaviours of various patients. Dr Emmerson says that in this conversation, Dr M described in detail her knowledge and "involvement" in gangs, as well as that of her family. She said that in this meeting, and in a conversation which occurred on the previous day, Dr M subtly reminded her that she had the ability to effect "gang retribution".

[96] She also said that the one-on-one meetings were the "most unpleasant hours of my life", where she would "be berated and told off for things that I didn't even know I'd done".

[97] The events summarised in this section provide the context for the first three causes of action. I will summarise later those events which are relevant to the fourth cause of action.

## Credibility

[98] There are sharp differences of account between Dr Emmerson on the one hand and Dr M on the other, so it is necessary to examine the credibility of their evidence in some detail. Since it is asserted that Dr N acted in concert with Dr M, I will also assess the reliability of her evidence.

[99] In undertaking this exercise, the Court must carefully evaluate all the evidence, looking for inconsistencies between witnesses, and whether there are any external indications which can assist in a determination as to what actually occurred. All elements of the evidence have to be evaluated in a common-sense way. A finding of credibility is unlikely to be based on one aspect to the exclusion of all others, and will instead need to be based on all factors by which it can be tested in the particular case.[8] The demeanour of witnesses when giving evidence is unlikely to be determinative, because there are well recognised difficulties when assessing credibility through demeanour alone. Important are contemporary materials, objectively established facts and the apparent logic of events.[9]

[100] Other factors to be considered are that the evidence relates to events that occurred some years ago, so it is natural for parties to emphasise matters of self-validation and minimise factors that reflect less credit on their behaviour. Mounting indignation with the other side's behaviour could also cloud the issues. As it was put in one case, the act of giving evidence can on occasion be unhelpful to the court if overtaken by the trade of blame; witnesses may well have convinced themselves of the respectability of their respective positions. Finally, people do not behave in a consistent way; they may behave badly one day and correctly the next, or vice versa; in these circumstances, no reliable inference necessarily flows from either inappropriate, or, for that matter, appropriate, behaviour.[10]

[101] In light of these well established principles, I make the following observations regarding, first, Dr Emmerson's evidence:

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8 *Faryna v Chorny* [1952] 2 DLR 354 (BCCA), at [8]-[9].
9 *Onassis v Vergottis* [1968] 2 Lloyd's Rep 403 (HL) at 431 per Lord Pearce.
10 *Xu v McIntosh* [2004] 2 ERNZ 448 (EmpC) at [26].

a) She was ready to assume the worst on the part of Dr M at all times; as a result, on some matters, allegations about Dr M were overstated. For example, she asserted that a document prepared by Dr M was dated 3 December 2014 because it had the number three placed over the number 12. It referred adversely to events which had occurred well after that date. Dr Emmerson concluded it must have been fabricated after the event. It transpired that Dr M had prepared the document not in December 2014, but in March 2015, which was the third of 12 months of that year. It had been prepared by her in that month to speak to her colleagues regarding concerns she had about Dr Emmerson. Dr Emmerson's assertion was misconceived.

b) Dr Emmerson believed that the ITA recorded by Dr M at the time as having been completed by her on 3 April 2015, was also a fabrication; she pleaded that it was completed after 24 April 2015. She said the form in question had not come into existence by 3 April 2015 and she said she herself downloaded the form a few days later and completed part of it before providing it to Dr M. The photo shot on which she relies for this evidence is not dispositive of this issue. There are other explanations, such as a prior download followed by a deletion of her pdf file.

An examination of the document suggests Dr M undertook a balanced review. She assessed Dr Emmerson as almost meeting or sometimes exceeding expectations in 20 areas, with inconsistencies in meeting expectations in 13 areas. She described Dr Emmerson's performance as "Fluctuating mental state leading to inconsistent performance": sometimes very good and at other times poor. Dr M expressed this opinion consistently in this period, including to the College. All of this suggests the document accurately reflected the views Dr M held at the time, and that it was prepared when she said it was. Nor was it explained why she would need to complete a false document, although it may have been advanced to suggest the contention that Dr M – and Dr N – connived to have her dismissed. I will consider this assertion later, but

at this stage, I find that the document being fabricated well after the event is not plausible.

c) Dr Emmerson told the Court that she had been threatened with "gang retribution"; she acknowledged that such threats had not been made explicitly, but sufficient reference had been made by Dr M, she said, with regard to members of her family who were associated with gangs as to justify her in concluding she was being threatened. She said this led her to covertly recording an individual supervision session which occurred on 15 April 2015. As noted earlier, a transcript of the session was before the Court, as well as an audio file to which I have listened.

The conversation between Dr Emmerson and Dr M was somewhat unstructured, with both parties referring mainly to the challenges of correct diagnosis, the obtaining of relevant information from patients and their families, and from time to time, the giving of advice by Dr M as to how to deal with such issues – just as she had in previous recently held sessions of supervision. There was a relatively brief discussion between the two as to gang behaviour, including by Dr M with regard to her family members; but there was no evidence of any serious dispute or disagreement between the two which could possibly have provided a basis for a conclusion that these remarks amounted to a threat to Dr Emmerson of gang retribution. Nor was the tone of the language used by Dr M given in a threatening fashion.

At that stage, the only complaint Dr Emmerson had made to management regarding Dr M related to one-on-one supervision. Whilst Dr M was aware of this, it is inherently improbable that this would have led to Dr M making an implied threat of physical violence.

It is more likely that the session was recorded by Dr Emmerson because she had concerns as to the adequacy of her supervision, which she knew needed to be discussed at the mid-point of the rotation.

d) Another area of unreliability relates to drug use. Dr Emmerson told the Court she had "occasionally" used cannabis, and in evidence denied being a "regular user". However, when it was put to her she had told the High Court in the defamation trial that she smoked cannabis every three weeks between 2002 and 2008 when she was a lawyer, she said "I don't recall that but if it's in the transcript I must have said it".

There were also variations in her evidence as to when she had used methamphetamine. In the context of information that she provided in an email to the Health Committee, and during the hearing to this Court, she said she had used this drug on approximately six occasions in total between January 2013 to April 2015; she preceded this statement by stating she had used it that year and on Easter Saturday. This statement was made notwithstanding the fact that at the time she was in possession of a drug test which suggested there was no such use between 18 February and 19 May 2015. Later, she relied on the negative result for methamphetamine, asserting that her earlier statement that she used the drug on Easter Saturday 2015 must have been incorrect.

She told the Court her partner's use of the drug was restricted to three weeks after a separation in early 2014; yet in a written statement she provided to the PCC in December 2015, she stated that he had used methamphetamine "on and off for around 6 weeks". These variations in account on such an important topic were quite unsatisfactory. Generally, Dr Emmerson attempted to minimalise her personal drug use when giving evidence.

e) In the course of describing the events concerning the prescribing of a controlled drug to her partner, Dr Emmerson told the Court that on the day in question when she had gone home to see her partner who had hurt his back, he was still in pain. She said she tried to call Dr M to ask her what to do; she was not available, so she consulted a text book she had at home, and then did what she thought was right. Later, on the day on which Dr Emmerson gave this evidence to the Court, she said she

realised her evidence had been misleading. This was, she said, because Dr M was on leave on the day in question, and so she did not try to contact her. Although Dr Emmerson told the Court this was merely an inadvertent mistake in the giving of her evidence, it reinforces the need to assess Dr Emmerson's evidence with considerable care.

f) There were other discrepancies. Dr Emmerson told the Court that she was supposed to receive supervision for a total of five hours per week. This was not accurate, since the applicable regulations of the College prescribed four hours' supervision per week.

She told the Court that she felt comfortable by the start of 2015, but then recorded a series of events suggesting she was not, from mid-December 2014 onwards.

She referred to many events, particularly those involving Dr M and Dr N, in pejorative terms.

[102] In summary, aspects of Dr Emmerson's evidence were exaggerated and at times unreliable. A difficulty is that Dr Emmerson has given written accounts of these events on several occasions (for example in correspondence with the Health Committee of MCNZ, the PCC, and to the MCNZ itself); and she has given evidence in defended hearings on three previous occasions.[11] She has persuaded herself that she is a victim, that the account she now gives is entirely correct and that in summary, Dr M and Dr N were the root of all her problems.

[103] The witnesses she called supported some aspects of her evidence, but the secondary evidence does not corroborate her more extreme assertions.

[104] There are elements of Dr M's evidence which are also unreliable:

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[11] In the disciplinary proceedings before the Health Practitioners' Disciplinary Tribunal, the Authority and in the defamation proceedings before the High Court.

a) She frequently minimalised aspects of Dr Emmerson's performance, to an extent which was not justified, and which if accepted would have placed Dr Emmerson in a generally poor light. This is particularly true of Dr Emmerson's period as a house officer; her evidence as to Dr Emmerson's performance in that period is in stark contrast to the very positive assessments she made of Dr Emmerson at the time, both for internal performance purposes and for the purposes of recommendation to the College that she be accepted for training.

b) I refer to several examples. Dr M was insistent that Dr Emmerson had volunteered the giving of legal advice, and that it had never been sought by her, no doubt to explain why such an interaction had occurred between a junior and a senior doctor. As noted earlier, this was not necessarily the case, there being, for example, an email exchange between Dr M and Dr Honeyman, who made it clear that at least for DHB purposes it had been inappropriate for Dr M to have requested legal advice from Dr Emmerson on a particular point concerning enduring powers of attorney.

c) Dr Emmerson said that she had made a particular effort with regard to the physical health project. She said Dr M appreciated the significance of her work and that she was supportive of the project. That this was the case was evident, for example, in Dr M's email of 2 October 2014 when she requested an extension of the house officers' role for two weeks, so as to implement changes from the project on which Dr Emmerson had been working, and "to embed these changes". In this email, she acknowledged that the project had been undertaken over and above normal duties to address clinical/organisational risks.

In contrast, when giving her evidence to the Court, Dr M minimalised these efforts. For example, she said that the hours worked by Dr Emmerson were not excessive and that she was not coerced to work overtime.

There is other, more reliable, evidence. Dr Cameron Cole, a registrar working in the Unit at the time, confirmed that Dr M and Dr Emmerson often stayed after hours to discuss cases and to undertake this quality improvement work.

Dr N provided a referee's report to the College in September 2014; she referred to the risk of Dr Emmerson overworking and needing to be mindful as to her "boundaries with time". Dr McIlhinney said in a similar report that there were no glaring weaknesses, but that she would perhaps take on too much rather than delegate.

The contemporaneous evidence suggests that Dr Emmerson's efforts did involve significant overtime and were appreciated by senior colleagues. Dr M was slow to acknowledge these realities when giving evidence.

d) A further issue which requires an assessment of Dr M's credibility relates to the manner in which she responded to the complaint made by Dr Loo about the requirements of the physical health project, and about Dr Emmerson, clearly caused concern within management. Dr M began to distance herself from Dr Emmerson's work. At the disciplinary meeting convened by Dr N and Dr M with Dr Emmerson, the focus was on Dr Emmerson's communication skills with Dr Loo. Whilst that may well have been appropriate in the circumstances, what is striking is the absence of acknowledgment of the positives of the project which she had previously supported, and in which she had been partially involved. Before these events occurred, she had been impressed by Dr Emmerson's work and had assessed her as being "exceptional". Following Dr Loo's complaint, this assessment was recast. By late March 2015, she said Dr Emmerson, when working as a house officer, did not have a direct line of accountability; she had worked independently and did not have as much contact with her as occurred when Dr Emmerson became a registrar. Dr M was attempting to suggest she had not been involved in the project in any significant way. I am satisfied from the evidence that she was.

e) Colleagues who gave evidence about Dr M referred to her strong personality, and the fact that she could be assertive, direct and robust. That was evident in her answers on many of the matters about which she was asked in evidence and affected the reliability of her testimony. She also became defensive, often stating she could not recall particular details about circumstances which might have been contrary to her interests.

f) Many of the interactions about which evidence was given to the Court were not documented by Dr M as supervisor at the time. They must accordingly be approached with some care – particularly her evidence as to the nature of supervision.

[105] Having regard to these and other aspects of Dr M's evidence, I consider that her reliability as a witness has also been influenced by subsequent events. She was significantly affected by the circumstances which gave rise to the disciplinary investigation, believing that she herself might be at risk of gang retaliation. She was then required to deal with a detailed complaint made about her by Dr Emmerson to MCNZ, following which she told her colleagues that Dr Emmerson was suffering a "narcissistic wound" and said that "she remains fixated on me". She has also been cited as a defendant in Dr Emmerson's defamation proceedings in the High Court, which she is defending together with Dr N. She gave evidence for NDHB to the Authority's investigation meeting. By the time she gave her evidence to the Court, her evidence had become defensive, as discussed. This factor must also be considered when reviewing her evidence.

[106] Finally, I refer to the evidence given by Dr N. I am satisfied that she was a reliable witness. She made fair concessions. As I will amplify later, she became very concerned as to Dr Emmerson's conduct, and expressed forceful views in that regard; but those strong views did not, in my opinion, detrimentally affect the accuracy of her account of the events which took place up to mid-April 2015, the focus of the first three causes of action. Furthermore, for reasons which I will explain later, her longstanding professional relationship with Dr M did not impact on the reliability of her testimony.

## 90-day issues regarding Dr Emmerson's disadvantage claims

[107] NDHB pleaded that a number of the events relied on by Dr Emmerson for the purposes of her disadvantage claims occurred outside the 90-day period which preceded the raising of her personal grievances.

[108] Notification of her disadvantage grievances was first given in a letter sent by her counsel, Mr Jackson, on 25 May 2015. Although Mr Jackson referred in passing to the fact there was a training issue at a disciplinary meeting held on 14 May 2015, no separate complaint was developed on that occasion which could have led to NDHB becoming aware that Dr Emmerson raised a disadvantage grievance on that date.

[109] In this case, then, an issue arises with regard to events that occurred before 25 February 2015. Mr Henderson confirmed that for the purposes of the first three causes of action, reliance was being placed on events which occurred from 8 December 2014, when Dr Emmerson became a registrar.

[110] From a legal perspective, the Court must consider the provisions of s 114 of the Act. It relevantly provides:

> **114 Raising personal grievance**
>
> (1) Every employee who wishes to raise a personal grievance must, subject to subsections (3) and (4), raise the grievance with his or her employer within the period of 90 days beginning with the date on which the action alleged to amount to a personal grievance occurred or came to the notice of the employee, whichever is the later, unless the employer consents to the personal grievance being raised after the expiration of that period.
>
> (2) For the purposes of subsection (1), a grievance is raised with an employer as soon as the employee has made, or has taken reasonable steps to make, the employer or a representative of the employer aware that the employee alleges a personal grievance that the employee wants the employer to address.
>
> ...

[111] The main possibility which must be considered is whether events which occurred in the period 8 December 2014 to 25 February 2015 were part of a related

and continuous cause of action, this being an issue of fact and degree. As it was put by former Chief Judge Colgan in *Premier Events Group v Beattie*:[12]

> ... one raising of a personal grievance should be sufficient to cover one related and continuous cause of action, providing the events complained of outside the 90 days all relate to events contained within the 90-day period and form a course of related conduct.

[112] I now turn to consider each cause of action in light of these principles.

*90-day issues as to first cause of action*

[113] Mr Henderson submitted that the failure to provide proper supervision required an assessment of a continuous course of related conduct over the period 8 December 2014 to 1 April 2015, the date from which there is no doubt that individual supervision occurred. He submitted that instances of that failure which occurred prior to 25 February 2015 should be taken into account.

[114] Ms Hornsby-Geluk submitted that Dr Emmerson's case proceeded on the basis that Dr M said shortly after the meeting on 19 December 2014, which related to Dr Loo's complaint, that "we no longer need to do formal supervision". She argued that late December was therefore the point at which the 90-day period commenced for the purposes of this grievance. She said that although Dr Emmerson discussed her concerns as to supervision with her peers at a registrars' meeting on 23 February 2015, as a result of which she said she needed to raise the matter with Dr M directly, she did not do this which meant this event was not relevant to timing issues. In reference to Dr Emmerson's meeting with Dr N on 18 March 2015, Ms Hornsby-Geluk submitted that no significant dissatisfaction was expressed; nor was there a request for any particular action to be taken. Thus, it could not be concluded that this conversation amounted to the raising of a personal grievance.

[115] I am satisfied that this particular personal grievance was raised within 90 days, for two reasons.

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[12] *Premier Events Group v Beattie (No 3)* [2012] NZEmpC 79, [2012] ERNZ 257 at [20].

[116] First, I accept Mr Henderson's point that the grievance is based not on an assertion that there was an outright refusal to provide formal supervision, as notified on a particular date, but that there was an ongoing failure to do so. It is apparent from the contemporaneous evidence that Dr Emmerson's concerns as to supervision centred not on the fact that Dr M had made a particular statement that there was no need to conduct formal supervision, but on the fact that formal supervision was not being provided on an ongoing basis; this was the substance of her discussion with Dr Reynolds and the other registrars, on 23 February 2015.

[117] Accordingly, the elements of the cause of action are plainly based on a continuous course of conduct.

[118] Second and alternatively, I am satisfied that the concerns were raised with sufficient particularity in the conversation Dr Emmerson had with Dr N on 18 March 2015. I find that the question of one-to-one supervision was referred to by Dr Emmerson. She understandably wanted the matter addressed by NDHB, because it was an essential pre-requisite of the College requirements. It is evident Dr N recognised the importance of the issue, first because she recorded it in her handwritten note, and second because she immediately raised the matter with Dr M.

[119] There is no particular form of words for raising a complaint or concern that constitutes the raising of a personal grievance. What is important is that the employer is made sufficiently aware of the problem as to be able to respond as the legislative rule requires.[13]

[120] Here, Dr N obviously knew an important concern had been alluded to which had to be sorted out for the employee. As just noted, that is what she did. I find NDHB was made sufficiently aware of a problem as to lead to the conclusion that a grievance was being raised which Dr Emmerson wanted her employer to address.

[121] The first cause of action does not, therefore, fall foul of the 90-day requirement.

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[13] *Creedy v Commissioner of Police* [2006] ERNZ 517 (EmpC) at [31]-[36]. This case was overruled on appeal but not on this point: *Commissioner of Police v Creedy* [2007] NZCA 311, [2007] ERNZ 505; *Creedy v Commissioner of Police* [2008] NZSC 31, [2008] 3 NZLR 7, [2008] ERNZ 109.

*90-day issues as to second and third causes of action*

[122] The bullying and health and safety causes of action were first raised in the letter sent by Dr Emmerson's lawyer to NDHB on 25 May 2015.

[123] Mr Henderson submitted that the events relied on should be considered as a continuous course of conduct.

[124] The first amended statement of claim did not provide particulars of the asserted "continuous bullying and intimidation from Dr M". However, in closing submissions, a consensus emerged that Dr Emmerson had provided evidence of some 17 alleged unjustified actions in respect of the period 8 December 2014 to 25 February 2015; and a further seven for the period 25 February 2015 to 21 May 2015. These relate to both the second and the third causes of action.

[125] I am satisfied that the matters relied on by Dr Emmerson, which she says occurred before 25 February 2015, qualify for consideration.

[126] Those events are part and parcel of what Dr Emmerson asserts was a significant change of attitude towards her by Dr M after 8 December 2014 when she became a registrar, and which resulted in a range of adverse consequences. The common theme of the conduct complained about is summarised in Dr Emmerson's first amended statement of claim when she says that Dr M subjected her to continuous bullying and intimidation. This broad allegation was intended to relate to Dr M's interactions with her on numerous occasions over several months, before and after 23 February 2015.

[127] I find the allegation is one of continuous conduct, and that the pre-25 February 2015 events are causally connected to the post-25 February 2015 events.

[128] I conclude that the second and third causes of action involve disadvantage grievances which were raised within 90 days.

[129] Whether any of the three grievances are made out is an entirely different question, to which I shall come shortly. It suffices to say at this stage that Dr M strongly asserted that her behaviour was appropriate at all times.

[130] Given these conclusions as to timing, it is unnecessary to consider whether there are exceptional circumstances under s 114(3) of the Act with regard to the second cause of action, as pleaded.

## First cause of action: failure to provide supervision and training

*Unjustifiable action?*

[131] Dr Emmerson's first amended statement of claim alleged that there were breaches by NDHB of the requirements set by the College for training in two respects. The first was the failure to provide Dr Emmerson with a written job description. In closing, Mr Henderson accepted that this particular allegation had not been proven.

[132] Secondly, it was alleged that NDHB had breached the standards imposed by the College for proper supervision of a trainee.

[133] These requirements were expressed in regulations published by the College in 2012 as follows:

> **4.5 Supervision**
>
> 4.5.1 General Supervision Time Requirements
>
> > As specified in the Policy and Procedure on Supervision ... clinical supervision of trainees must be maintained at a minimum of 4 hours per week over 40 weeks for full-time trainees.
> >
> > Of these hours, a minimum of 1 hour per week must be individual supervision of a trainee's current clinical work. While this hour is required in full for all trainees, the other 3 hours of supervision must be on a pro-rata basis (minimum) for part-time trainees.
>
> 4.5.2 Stage 1 – specific Supervision Requirements
>
> > Additionally, of the 4 supervision hours per week, at least two hours per week must be closer supervision outside ward rounds and case review meetings for Stage 1 trainees.
>
> ...

[134] In closing, Mr Henderson made it clear that the essence of the claim was not that Dr Emmerson received no supervision at all, but that she did not receive the required one-to-one supervision meetings described in the regulations. This was a proper concession because there is ample evidence that Dr Emmerson spent a

considerable amount of time with Dr M each day in the ward undertaking clinical assessments of patients, except when Dr M was away. Indeed, Dr Emmerson accepted this was the case.

[135] The central issue is to do with the nature of the individual supervision given by Dr M.

[136] Dr Emmerson stated that Dr M was away for much of December, meaning that there was in reality little supervision in that month for that reason. She said that the situation did not improve when Dr M was available in the months of January to March 2015. I am satisfied that the assertion as to extended absences of Dr M in December 2014 were exaggerated, having regard to the extent of Dr M's involvement in the events which followed the complaint made by Dr Loo.

[137] As discussed earlier, Dr M took the view that Dr Emmerson should learn by observing ward interactions. She said that she and Dr Emmerson spent on average four hours a day, four days a week jointly seeing patients, discussing issues as they arose.

[138] But she also stated that there were individual supervision sessions on eight dates between 22 December 2014 and 27 March 2015 (two of those sessions, she said, were on 27 March 2015); although she says she recorded these dates at the time in her journal, no record of what was discussed in those sessions was made. From 1 April to 15 April 2015, there were four private sessions with Dr Emmerson which, it was accepted, fulfilled College requirements. In each of those instances, Dr M prepared a handwritten note.

[139] Dr M said that at all the individual sessions, those that were not minuted and those that were, she discussed Dr Emmerson's training requirements, resources and clinical issues, but also mental health services in general, the move from institutionalised care to community care, significant Ministry of Health documents that guide the delivery of mental health services, and the role of non-government organisation providers in that regard. She said they discussed the acute psychiatric care spectrum and the role of respite providers. They also referred to the mental health

legislation and the ethical challenges associated with its use, and the importance of understanding team dynamics and not getting involved in "ward gossip". She also said that Dr Emmerson raised issues in supervision to do with her partner, including whether he was stable, was using drugs and/or was dangerous.

[140] In her evidence, Dr Plunkett explained that "supervision" is a broad term which encompasses a range of training activities. This would include observational ward rounds and attendance at case review meetings. It would also include closer supervision, particularly individual one-on-one private sessions. These sessions provided an opportunity to discuss a range of issues. They could, she said, include clinical matters if the supervisor in training agreed, but otherwise other topics such as the particular challenges the trainee may be experiencing, or even personal issues. As I shall elaborate later, she said the purpose of the supervision was to provide a reasonable level of support for registrars who were starting out.

[141] I am not satisfied that individual one-one-one supervision occurred between December 2014 and March 2015 for several reasons:

a) I do not accept that the list of eight dates between December 2014 and March 2015 given by Dr M establishes that weekly individual supervision occurred throughout the period. The list itself does not confirm one day in each week was devoted to that activity; it refers only to sessions in seven of 16 weeks.

   The list of dates given to the Court varies from a similar list given to MCNZ. Dr M told the Court that on 27 March 2015, there were two sessions (one of one hour and one of two hours). She told MCNZ in a letter of 4 August 2015 there was one session on that day (two hours). The journal which Dr M said she had used was not available to the Court. She also said that it was a long time ago since these events occurred, and she could not recall the specifics; but she said her account accorded with her normal practice. I find that, at best, this may have been a list of intended dates for one-to-one supervision, an "action list" of dates when it was intended individual supervision could occur.

b) In December 2014, the emphasis as far as Dr M was concerned was on the complaint made by Dr Loo about Dr Emmerson, and the issues which had become apparent regarding the physical health project. This became a significant focus, which resulted in supervision not taking place as it should have and as may have been intended.

c) On 23 February 2015, Dr Emmerson reported the fact that she was not receiving supervision from Dr M when she met other registrars, and significantly, Dr Emmerson was understood as stating that a dysfunctional relationship had developed between Dr M and herself. Other witnesses confirmed this as described above. I accept that this was an accurate description since the secondary witnesses had no reason to give an inaccurate assessment. I find the relationship between Dr Emmerson and Dr M had deteriorated as a result of the fallout from Dr Loo's complaint. Dr M was frustrated and became more formal. Not only did she distance herself from the project, she distanced herself from Dr Emmerson. Communication decreased, even on the ward. In this context, Dr M chose not to meet with Dr Emmerson privately for individual sessions, until the issue was raised with her by Dr N.

d) In any event, Dr M considered the individual sessions were not as important as was the process of observation on the ward. Where an opportunity for clinical observation arose, this was preferred. Dr M said she regarded observation on the ward for four hours a day as being more important than any time away from the ward discussing "how you do it". But this was not consistent with the expectations of the College.

e) The supervisory meetings which took place from early April 2015 were compliant with the requirements of the College; as the record made at the time by Dr M confirms, they provided a proper opportunity for reflection on the various activities in which Dr Emmerson was engaged as a registrar, of her reaction to those activities, and for an educative response to be given by Dr M where appropriate. This had not occurred previously.

f) I consider that Dr M's evidence that extra opportunities were given to observe in a clinical setting were no more than the obligation to do so, as described in the requirements of the College for first-year students.

g) To be contrasted with the foregoing points is Dr Emmerson's acknowledgment in the mid-rotation ITA form that all supervisory sessions had occurred.[14] Having regard to her reasons for making that statement, I find that it was not intended to be accurate, and it was not.

[142] I am satisfied that individual supervision of Dr Emmerson as a registrar, was a condition of Dr Emmerson's employment, which did not in the period under review take place according to the requirements of the College.

*Disadvantage?*

[143] The next question is whether the absence of individual supervision meant that Dr Emmerson was disadvantaged.

[144] There are two elements to this, which are intertwined. The first relates to the professional consequences of a lack of individual supervision, and the second relates to the personal consequences. I deal with each.

[145] Dr Plunkett was clear that the purpose of one-on-one supervision for registrars starting out was to provide a reasonable level of support to them. She said that such supervision was intended to be "fairly intensive". Its purpose was to ensure that there was space in a busy working week where there could be some kind of thoughtful consideration of issues which might otherwise be lost during busy clinical activities. It was for this reason that this particular activity was known as the "college hour" or as "educational supervision". It would enable a trainee to discuss any difficulties they were having adjusting to training, coping with workload, balancing personal lives, discussing upcoming examinations, and specific workplace-based assessments, as well as an opportunity for discussing ethical questions.

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[14] Above at [101](b).

[146] Dr Plunkett went on to say that if she had become aware one-on-one supervision was not occurring for a registrar within two or three months of the commencement of a run, she would regard that fact as being serious. Further, if she was aware that there was a dysfunctional relationship between trainee and supervisor, she would also regard that as a serious matter, since it would definitely cause problems.

[147] In light of these requirements and observations, I find:

a) Dr Emmerson did not receive the education and support which should have been available to her so that she could develop as a registrar.

b) I am not satisfied, in the particular circumstances, that the supervision which was available to Dr Emmerson in this period was an effective substitute for the intense and educative one-on-one supervision she should have been receiving.

c) At the disciplinary meeting held with Dr Emmerson following Dr Loo's complaint on 19 December 2014, several issues were discussed. The first related to appropriate communication between Dr Emmerson as a registrar and Dr Loo as a house officer. Another was the fact that Dr Emmerson was suffering difficulties with the transition from house officer to registrar. Also discussed was the appropriate standard of physical care for patients, a problem which was at the centre of the physical health project. Dr N said that these were all matters which should be explored in a supervision framework. Notwithstanding this express prompt from Dr N who was the facilitator with some responsibility for the training of registrars such as Dr Emmerson, the intended supervision did not occur.

d) Although appropriate individual supervision took place on four occasions in April 2015, that does not mitigate the absence of such supervision earlier. The short point is that in four months employment as a registrar, during which Dr Emmerson was at the heart of a significant controversy concerning her physical health project, she had not been

adequately supported in dealing with that issue, and in dealing with her transition from house officer to registrar.

e) As I shall discuss more fully shortly, Dr M became very critical of Dr Emmerson's fluctuating performance. That was precisely the sort of issue that was capable of identification in individual supervisory sessions.

f) Ms Hornsby-Geluk argued that the mid-run ITA was never finalised, so that it could not be shown that Dr Emmerson had established she was disadvantaged for College purposes by these problems. Given the evidence of Dr Plunkett that this requirement not being fulfilled would have been a matter of concern to her, I find that there was disadvantage for the purposes of Dr Emmerson's claim. What might have occurred with the College, subsequently, can only be a matter of speculation.

g) She also argued that Dr Plunkett was of the view that had she been aware supervision had not occurred adequately, she would have stepped in to ensure that the registrar's place on the training programme or their run as a whole was not compromised. That would have involved a remediation plan. Again, the Court must focus on what did occur, and not on what might have occurred. I am satisfied that the disadvantage to Dr Emmerson was sufficiently serious as to qualify for the purposes of her statutory claim.

[148] I turn now to consider the personal consequences. After Dr Emmerson became a registrar, her presentation at work changed. Whereas as a house officer she had been energetic and positive, this was no longer evident when she became a registrar. She told her colleagues she was not sleeping well. She was losing weight, and she did not necessarily dress appropriately.

[149] These significant effects were in my view catalysed by a number of factors, including:

a) The transition from her being a respected senior house officer to the challenges of being a junior registrar. Dr M herself referred to this transition in one of the supervised sessions which took place in April 2015, stating that whereas she had been at the top of her game when training as a house officer, she had "come back down to the bottom again" as a registrar. Dr Emmerson agreed with this statement, saying that she was in effect having to be retrained. Ms Rata observed the same dynamic.

b) It is clear from emails that passed between staff that there were in this period very demanding clinical challenges for staff at times. Such crises were regarded by them as being both physically and emotionally demanding. They obviously caused stress to those involved, including Dr Emmerson.

c) Dr Emmerson had separated from her partner for a period in the first half of 2014, which had caused her distress. However, she was still involved with him in early 2015, although the specifics were not explained. Ms Oxton, when giving evidence as to Dr Emmerson's changed physical appearance, said she had understood from Dr Emmerson in early 2015 that she was still undergoing relationship issues. She also referred in supervision to such problems. On the balance of probabilities, I accept this was the case in the first quarter of 2015.

d) The complaints made by Dr Loo and Dr Birchall both as to communication issues with Dr Emmerson, and as to what they regarded as extra workload arising from the physical health project were ongoing in this period; the evidence suggests that these circumstances caused significant stress for Dr Emmerson.

e) In addition, the inadequacy of supervision caused stress for Dr Emmerson.

[150] I conclude that the issues concerning one-on-one supervision did impact on Dr Emmerson professionally, as well as personally. But in considering the extent of the personal effects, it is necessary to acknowledge that there were a range of other impacts, as just described, which were not directly related to the failure to provide one-on-one supervision.

*Conclusion as to first cause of action*

[151] It was the DHB's responsibility, through the arrangements as to supervision which were put in place by NDHB as employer via Dr M, to ensure that the obligations as prescribed by the College for junior registrars would be respected. As Dr Plunkett confirmed, the direct responsibility for this fell on Dr M, albeit subject to Dr N's oversight. Whatever Dr M may have thought as to Dr Emmerson's performance in the early stages of her registrar's training, it was nonetheless her responsibility to provide educative supervision and support. That did not occur. Dr N did not realise in early 2015 that the necessary supervision was not being provided. I am satisfied that a fair and reasonable employer could not have allowed this to occur, and that Dr Emmerson has established this disadvantage grievance.

## Second and third causes of action: bullying/failure to provide safe working environment

[152] It is appropriate to deal with these two causes of action together.

[153] Dr Emmerson pleaded that she was subjected to continuous bullying and intimidation from Dr M; she asserted that the mistreatment increased over the five months prior to her dismissal. She went on to state that NDHB knew or should have known of the "bullying/mistreatment", and that it permitted this to occur. It was alleged that Dr Emmerson complained about the bullying at the meeting with colleagues on 23 February 2015 and that the issue was common knowledge on the ward.

[154] Dr Emmerson asserted that NDHB had a duty to provide her with a safe working environment, and failed to do so, as a result of which she was bullied and demoralised, which caused harm to her health. In support of the allegation, it was

asserted Dr M had criticised, demeaned and confused Dr Emmerson on a daily basis. The alleged adverse behaviour included:

- Threatening Dr Emmerson with retribution by the Black Power gang;
- using her position to require Dr Emmerson to complete legal work for her and her family without compensation;
- requiring Dr Emmerson to work excessive hours;
- requiring Dr Emmerson to work overtime on a daily basis without compensation;
- subjecting Dr Emmerson to humiliating and intimidating behaviour on a daily basis, designed to impact on performance and confidence;
- failing to provide Dr Emmerson with any orientation; and
- isolating Dr Emmerson from senior management and various peers.

*The principles to be applied in each instance*

[155] NDHB had a Disciplinary Policy for managing unacceptable behaviour in the workplace. It defined bullying in this way:

> Bullying in the workplace is repeated, unwanted, unwarranted behaviour that a person finds offensive, intimidating and/or humiliating so as to have a detrimental effect upon a person's dignity, safety, wellbeing and functionality.

[156] This term is used in a context where it is plain that the issue is whether any behaviour so complained about is "unacceptable"; that is, not satisfactory or allowable according to a yardstick of what is fair and reasonable.

[157] Behaviour which would be unlikely to cross the threshold for the purposes of this particular definition of bullying might include legitimate criticisms regarding work performance if expressed appropriately, justified discussion as to legitimate concerns or conflicts in the workplace, and relatively insignificant incidents where there may have been miscommunication or misunderstanding. Such interactions may be unwanted and even humiliating in the eyes of the employee, but these are not

necessarily unwarranted. The issue is one of fact and degree. I also note the assessment should not be made on a hindsight basis.

[158] No particular legal framework was relied on for the purposes of the health and safety claim.

[159] Generally, an employer has a legal responsibility to take all reasonable steps to prevent harm to an employee which it foresaw or should reasonably have foreseen at the time: *Attorney-General v Gilbert*.[15] The Court of Appeal confirmed that the relevant obligations are spelt out in some detail in the health and safety legislation – at the time this was the Health and Safety Employment Act 1992;[16] the replacement statute did not take effect until 2016.[17] That court went on to acknowledge that the duty to take reasonable steps to maintain a safe workplace is also a term now implied by common law into employment contracts, in recognition of their special nature.

[160] The following passage summarises the conclusions of the court:[18]

> ... The standard of protection provided to employees by the Health and Safety in Employment Act is however a protection against unacceptable employment practices which have to be assessed in context. That is made clear by the definition of "all practicable steps". What is "reasonably practicable" requires a balance. Severity of harm, the current state of knowledge about its likelihood, knowledge of the means to counter the risk, and the cost and availability of those means, all have to be assessed. Moreover, under s 19 the employee must himself take all practicable steps to ensure his own safety while at work. These are formidable obstacles which a potential plaintiff must overcome in establishing breach of the contractual obligation. Foreseeability of harm and its risk will be important in considering whether an employer has failed to take all practicable steps to overcome it. These assessments must take account of the current state of knowledge and not be made with the benefit of hindsight. An employer does not guarantee to cocoon employees from stress and upset, nor is the employer a guarantor of the safety or health of the employee. Whether workplace stress is unreasonable is a matter of judgment on the facts. It may turn upon the nature of the job being performed as well as the workplace conditions. The employer's obligation will vary according to the particular circumstances. The contractual obligation requires reasonable steps which are proportionate to known and avoidable risks.

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15 *Attorney-General v Gilbert* [2002] 2 NZLR 342, [2002] 1 ERNZ 31 (CA) at [92].
16 Health and Safety in Employment Act 1992, ss 2-7.
17 Health and Safety at Work Act 2015, s 2.
18 At [83].

[161] I apply these guiding principles for the purposes of the health and safety claim advanced in the present case.

*Analysis in each instance*

[162] I alluded earlier to the summary of alleged unjustified actions which the parties agree are the matters which the Court should consider for present purposes.[19] In essence, Dr Emmerson asserts that there were multiple situations where she now claims Dr M bullied and intimidated her. She said she was often ridiculed, was "ripped into", blamed for adverse events, given inconsistent instructions, and was threatened. She said that as a result she became ill, lost weight, did not want to attend work, was confused and upset, and lost confidence in her abilities.

[163] In assessing the many incidents to which she referred, the Court must consider not only Dr Emmerson's perceptions, but those of Dr M, and of the various secondary witnesses who were called.

[164] As recorded earlier, Dr Reynolds said that although he understood there was a dysfunctional relationship, Dr Emmerson had not described the problem as one of bullying.

[165] Dr Cole said there was no complaint of yelling or mistreatment – rather, Dr Emmerson and Dr M were not getting on and were "disinterested in each other".

[166] Ms Oxton described a conversation which took place between Dr M and Dr Emmerson in a nurses' station, which in her view should have been held in private. She told Dr M as much. The problem was, she said, that Dr M was frustrated in her communications with Dr Emmerson, and not that she was bullying her.

[167] Ms Rata said that on one occasion, Dr Emmerson left a private meeting involving Dr M and a patient and her family, seeming "muffled" or "squashed"; there had apparently been a difference of opinion over a clinical issue. She said that at times

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19 Above at [124].

– and it was not clear when - Dr M was unprofessional in her communications with Dr Emmerson.

[168] For her part, Dr M made it clear that the complaints lodged by two house officers as to the demands of the physical health project, and consequential workforce issues including the fact there was no nurse to deal with physical need issues, were of significant concern to her. As mentioned, she said that as a result she became more formal towards not only Dr Emmerson, but all the junior doctors, with whom she was frustrated. She also found Dr Emmerson's fluctuating work performance difficult.

[169] The context for these dynamics was a high-pressure work environment. I referred earlier to mails exchanged between staff members which suggest that there were also, at times, significant workplace demands which arose from high patient numbers and the intensity of care required by them. These factors created significant stress for staff, at all levels.

[170] I find that on the balance of probabilities, at the heart of the issues which arose between Dr M and Dr Emmerson was a relationship problem. At times, their communications with each other were completely professional, but at other times they were not.

[171] As already discussed, there were a range of factors which affected Dr Emmerson. Upon becoming a registrar, she no longer had autonomy over her work. She was in a position where she had to accept direction and instructive criticism. She was subject to greater scrutiny than when she was a house officer. She was upset over the fallout of the issues concerning the physical health project. She realised she was not getting individual supervision. All these factors affected her health and performance.

[172] The circumstances have to be evaluated dispassionately. I am satisfied that Dr Emmerson has exaggerated many of the interactions she had with Dr M.

[173] Many of these were difficult, and perhaps challenging, but they did not amount to bullying.

[174] This is not to diminish the potential significance of such allegations. There is huge international literature on the topic of bullying of junior doctors by senior doctors, a product of the significant power imbalance that can occur.[20] However, the multifactorial complexities which occurred in this case do not qualify for such a description.

[175] The related allegations that interactions with Dr M breached health and safety standards are also not made out. I am not satisfied that Dr Emmerson's personal safety was imperilled so it could be said NDHB breached its statutory obligations.

[176] The second and third causes of action are accordingly dismissed.

## Fourth cause of action: unjustified dismissal

[177] The fourth cause of action relates to Dr Emmerson's claim that she was unjustifiably dismissed, on substantive and procedural grounds. Although these were extensively pleaded in the first amended statement of claim, having regard to the evidence which was led, and the submissions made on her behalf, the key grounds she raised were:

a) NDHB failed to adequately investigate the disciplinary matters it raised, including her explanation for the conduct under review.

b) NDHB failed to comply with its own policies.

c) NDHB failed to take into account relevant considerations such as the impact of dismissal on Dr Emmerson as a trainee registrar, and her overall excellent record. The decision to dismiss was disproportionate and unfair.

d) NDHB's decision to dismiss was infected by the views of persons who were not authorised to be involved in the decision, particularly Dr N and

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[20] See for example Lyn Quine "Workplace bullying in junior doctors: questionnaire survey" (2002) 324 BMJ 878; Lyn Quine "Workplace Bullying, Psychological Distress, and Job Satisfaction in Junior Doctors" (2003) 12 Camb Q Health Ethics 91; Elisabeth Paice and others "Bullying among doctors in training: cross sectional questionnaire survey" (2004) 329 BMJ 658.

Dr M; and it was influenced by a range of very serious allegations which were initially raised, but not then pursued.

e) There were multiple flaws in the process which was adopted.

[178] NDHB contests each and every one of these allegations. In summary, its position is:

a) It investigated the serious allegations thoroughly.

b) There was no pre-determination; a duly authorised decision-maker made the decision to dismiss; and it put extraneous allegations to one side.

c) Dismissal was in all the circumstances the response that a fair and reasonable employer could have taken.

[179] Each party's contentions will be reviewed in detail later. It is first necessary to set out the somewhat complex chronology which gave rise to the investigation conducted by NDHB, then the disciplinary process it followed, including its ultimate decision to dismiss.

## Chronology

*The prescribing of controlled drugs by Dr Emmerson to her partner*

[180] The disciplinary process primarily focused on events which occurred on 20 April 2015, when Dr Emmerson prescribed controlled drugs for her partner.

[181] Three days previously, her partner had hurt his back whilst working. Dr Emmerson said that although she encouraged him to attend the emergency department of the Whangarei Hospital, he was reluctant to do so and attempted to manage his pain using DHC and tramadol. She said that until late 2013, he had attended a GP on a reasonably regular basis, who had prescribed pain relief to control ongoing and deteriorating back pain. She said that on one occasion he had an acute flare-up, and was given a combination of m-Elson and sevredol, which assisted.

M-Elson is a long acting form of morphine sulphate. Sevredol is an immediate release form of morphine sulphate. Morphine sulphate is a Class B controlled drug under the Misuse of Drugs Act 1975.

[182] The GP ceased practice at the end of 2013. Ms Emmerson's partner did not like other doctors in the practice and was reluctant to see any of them. He was also angry and distrusting of the medical profession as a whole as a result of events concerning his father which had occurred in 2013. Despite being encouraged by Dr Emmerson to see a GP in April 2015, he refused to do so.

[183] Dr Emmerson says she was worried about her partner at lunchtime on 20 April 2015 and went to check on him at his house. She found he was still in bed and in pain. She said she undertook a full assessment and documented her findings on her laptop. It was her view he needed stronger pain relief for an acute flare-up but was unsure how to go about prescribing morphine for him, as his GP had done previously. She said that Dr M was away, so she could not discuss the issue with her.

[184] What happened next was at the heart of the allegations which NDHB investigated. The following accounts are given by Dr Emmerson to those investigating the issues and as provided by two nurses involved in the incident.

[185] Dr Emmerson returned to the Unit, asking Ms Petra Rozijn, a registered nurse, if there were controlled drug scripts. She said she wished to use one for a patient, her partner. Nearby was a controlled and secure drugs room. The controlled drugs cupboard was locked; the keys were located in the nursing station.

[186] Dr Emmerson and Ms Rozijn attended the room. Dr Emmerson took a prescription for prescribing controlled drugs and recorded in the register the date and this entry: "1 x To Sub acute". Later, she said that she had heard someone mention something about sub-acute and without thinking handwrote the word "sub-acute" in the drug register, which she then immediately crossed out. There was a dispute as to when the crossing out occurred.

[187] Dr Emmerson said they then went to the nearby nurses' station. She took the controlled drug register with her. She said that she and Ms Rozijn were unsure how to complete the register, although Ms Rozijn said in her statement that Dr Emmerson proceeded to the nurses' station apparently to look up the "Sub acute patient's [NHI] number". Dr Emmerson said because she was unsure how to complete the register, as was Ms Rozijn, she asked a second nurse what to do, who was also unsure. She then spoke to the Acting Clinical Nurse Specialist, Ms Cayla Timperley, who entered the nurse's station. She told her that she and Ms Rozijn had just signed a controlled drug prescription form. Dr Emmerson then added her partner's NHI number, but not his name and address as was required in the register.

[188] Although Dr Emmerson told Ms Rozijn that the script was being written for her "husband", it was not understood by her, or the other nurses involved, that he was not a patient. NDHB also had to consider the question of when the word "Sub acute" was deleted, and whether the NHI number was written in such a way as to be illegible so as to obscure the identity of the person for whom the prescription was being written.

[189] Dr Emmerson's partner uplifted the medication from a pharmacy on 20 April 2015; the repeat prescription was filled on 29 April 2015.

[190] The issues which arose from these events included:

a) the accuracy of Dr Emmerson's account;

b) her belief that she could provide the prescriptions to a close family member having regard to her understanding of MCNZ Standards, and what she had observed and been told at NDHB;

c) why she did not seek the assistance of a colleague; and

d) whether there was a prescribing culture in NDHB which allowed for the possibility of prescriptions being given to family members.

*Concerns raised by three nurses*

[191] On the morning of 23 April 2015, Ms Timperley was asked to speak to three nurses who had concerns about Dr Emmerson. All three were upset.

[192] She then told Dr M that the nurses were refusing to start their duty at 2.30 pm until they had spoken to her about their concerns. She and Ms Timperley met with the three for about an hour. Dr M took a handwritten note of the issues they were raising.

[193] One of the three nurses, Ms Blair, told the Court that the note which was before the Court was fabricated. I do not accept this evidence. The note is completely consistent with evidence from multiple witnesses as to the surrounding events.

[194] The concerns were then escalated. Dr M and Ms Timperley met briefly with the Acting Manager of the Unit, Ms Kiwikiwi, because the nurses were saying they did not want to go on duty. Then they spoke to Dr N, who in turn spoke to Dr Roberts.

[195] Following these events, Dr N sent an email to Mr Wade. The email briefly summarised the above steps, and then set out the concerns which had been raised, as follows:

> ...
>
> 1. One nurse stated that Dr Emmerson had said that if tested, she would fail a drug urine test on marijuana, benzodiazepines, methamphetamine and heroin
> 2. She stated that Dr Emmerson told her that one morning when she opened her diary in the handover meeting there was a "point bag" inside that she stated came from her partner
> 3. Dr Emmerson stated that her boyfriend had three weeks earlier been abducted because of a drug deal that had gone wrong and that he had taken her [eftpos] card and emptied her bank account
> 4. Dr Emmerson prescribed a nurse ondonsetron maxalon and immovane without the nurse asking for this
> 5. Dr Emmerson gave another nurse a script of lorazepam for long distance travel
> 6. Dr Emmerson asked nursing staff to sign out a controlled drug script for a patient who was not on the Tuamanko ward saying it was for a patient in the general hospital
> 7. Dr Emmerson offered staff at an evening handover prescriptions after a particularly stressful night
> 8. Dr Emmerson has accessed concerto without their permission to enable her to write scripts and arrange an [X-ray] for another named staff member

9. She has asked particular nurses whether she is "being paranoid" or "over the top"
10. She has told staff members she has bipolar affective disorder and her records on JADE
11. Dr Emmerson was absent from work for a period of time on 22.4.2015 and the nursing staff were unable to contact her. There has been several incidents of being away from the ward
12. Nursing staff are afraid to formalise the situation. One staff member has a daughter currently in prison on drug charges and the staff member has rung her daughter who has advised there are issues of risk from Dr Emmerson's partner because of his drug use

...

*Management's reaction*

[196] Mr Wade determined that the 12 concerns were serious matters that required investigation. He took advice from Mr Mark Stroud, Human Resources (HR) Advisor. Between them, they determined that on their face the allegations needed to be raised urgently with Dr Emmerson. The possibility of suspension was discussed.

[197] It emerged that Dr Deborah Powell, National Secretary for the New Zealand Resident Doctors' Association, would be at the hospital the following day; it was suggested to her that she might wish to be available to support Dr Emmerson at a meeting which would take place early on 24 April 2015. It appears she agreed, because she in fact made herself available.

[198] On 24 April 2015, Dr Emmerson was attending a morning handover meeting. She was unaware of any of these developments. Mr Wade asked to speak with her privately. This occurred: he asked her to accompany him to a meeting with HR, to which she agreed. Mr Stroud and Dr Powell were waiting for the meeting to commence. Dr Emmerson says she was told that Dr Powell had been briefed, and that NDHB had arranged for her to be at the meeting as her representative. She said she did not know who Dr Powell was.

[199] At the meeting, Mr Wade outlined the concerns that had been raised. Dr Powell asked for relevant documents, including a copy of Dr Emmerson's personal file, and queried whether there were any current performance concerns, a question that was not immediately answered. Amongst other comments Dr Powell made was the statement that the Unit was well known to be a stressed environment, and comments made by

Dr Emmerson had to be understood in that context. She said that the group of nurses, whose names were not given, may have spoken together and formed a view based on gossip rather than fact. More details would be needed before a full response could be given.

[200] It had initially been considered by Mr Wade that Dr Emmerson would need to be suspended on pay whilst investigations were undertaken. He said that the statement allegedly made by Dr Emmerson that she would fail a drug test, suggested potential impairment. Dr Powell said that for this assertion to have weight, the concerns as to drugs would need to be related to concerns about performance. She said that currently there were none.

[201] Dr Emmerson spoke privately to Dr Powell, who then proposed that Dr Emmerson be placed on special paid leave, a proposal to which Mr Wade agreed. It was tentatively agreed that the parties would meet again on 1 May 2015 to discuss the allegations.

*Reluctance of nurses to provide statements*

[202] There were then two meetings with the three nurses involved. The first on 24 April 2015, involved the nurses meeting Dr N, Ms Kiwikiwi and Ms Timperley. The second on 28 April 2015, involved the nurses, and their Public Service Association representative, Mr Mark Fury, meeting Mr Wade. In both meetings, the possibility of the nurses providing statements for use in an investigation of Dr Emmerson's conduct was discussed. Although it appears some statements had been prepared, the nurses were most reluctant for these to be used. Dr N and Dr Wade told the Court the nurses were genuinely fearful and anxious as to possible retribution from Dr Emmerson's partner and from Dr Emmerson herself.

[203] Mr Wade took advice. In light of the reluctance of the nurses to provide statements, and the fact that the sixth allegation was considered the most serious one and the only one which was possible of verification without significant involvement of nursing staff, he decided to investigate that allegation only.

[204] Late that day, Dr Chamberlain, the Chief Executive of NDHB, was told of these events; it was subsequently recorded by Mr Stroud that he was "initially quite annoyed" that Dr Emmerson had been placed on special paid leave, expressing the view to the head of HR that she should be suspended without pay. I place this information to one side, since there is no evidence that this opinion played any part in the events which followed.

*Dr M's concerns*

[205] On 27 April 2015, Dr M wrote to Dr N. Before referring to the contents of her email, I record Dr M's evidence to the Court that following her meeting with the three nurses on 24 April 2015 and the provision of various concerns which included the possibility of Dr M being at risk, she went to see a cousin who lived in Whangarei and asked whether she should be concerned for her safety, having regard to the identity of Dr Emmerson's partner. She said that her cousin told her she should be. She made a brief note to this effect and told Dr N of her concerns.

[206] Dr N said that within a very short time, she knew Dr M was "very scared". Accordingly, Dr M, in her email to Dr N of 27 April 2015, referred to information she said she had been given by Dr Emmerson as to the use of drugs by both Dr Emmerson and her partner. She referred to circumstances that had arisen in 2014 where he had used methamphetamine, and there had been an episode of domestic violence involving the Police. She said that in supervision some four to six weeks previously, Dr Emmerson had told her she was still in a relationship with a partner and they had not separated. She had said he was no longer using methamphetamine but that he smoked heroin. Dr Emmerson had reassured her that she was safe, and committed to the personal relationship, irrespective of drug use and associated lifestyle. She also said that she thought Dr Emmerson had an in-depth knowledge of the local drug scene, often describing specific substances such as heroin and methamphetamine and the range of ways these substances were used. She also knew of local methamphetamine dealers.

*Next steps*

[207] On 27 and 28 April 2015, Dr N emailed Dr Plunkett as to whether it would now be appropriate for Dr Emmerson to attend teaching with the College. She also forwarded to Mr Wade and Mr Stroud the emails which had passed between herself and Dr Plunkett in late March, regarding the serious performance concerns and performance plan which Dr Plunkett had developed. Dr N also took steps to review the prescribing which had occurred on 20 April 2015, as I shall describe shortly.

[208] The Professional Leader of Mental Health and Addiction Nursing, Ms Jane Simperingham, commenced interviews of nurses with regard to the prescribing on 29 April 2015.

[209] On 29 April 2015, Mr Jackson advised Mr Wade that he had been briefed for Dr Emmerson. He formally requested advice of the allegations in writing, and a deferment of the meeting which had been proposed for 1 May 2015.

*Dr N's investigations*

[210] Dr N reviewed the Controlled Drugs Register in the Unit. She identified the entry made on 20 April 2015 by Dr Emmerson. She noted that the script had originally contained the words "1 x To Sub acute", which were understood to mean that the script was to be issued to a patient in the Mental Health Sub-Acute Unit.

[211] She reviewed the controlled drug prescription pad and was able to identify the prescription number for the entry made on 20 April 2015. She then contacted a particular pharmacy and was able to track down the prescription form itself, because it had by then been filled there. She established that the prescription had been dispensed on 21 April 2015. The prescription recorded Dr Emmerson's partner's address, which was also Dr Emmerson's address.

[212] She also contacted the Ministry of Health, who advised her that on occasions between June 2014 and 20 April 2015, Dr Emmerson had prescribed her partner a range of controlled drugs, including tramadol, DHC, morphine, sevredol and diazepam. She was also told that Dr Emmerson had prescribed for her partner's

mother a synthetic opiate, tramadol and antibiotics. I interpolate that a summary of this prescribing was soon after made available by Dr Emmerson to those investigating.

[213] Dr N also wrote to MCNZ at the same time, a step which had been recommended by Dr Roberts. She summarised the concerns of the nurses which related to inappropriate prescribing, allegations that she was a drug user, and had openly spoken about her partner being a drug abuser, She said she had spoken to personnel from the Audit and Compliance Unit of the Ministry of Health who had confirmed that on several occasions between June 2014 and April 2015, Dr Emmerson had prescribed her partner a range of controlled drugs, including tramadol, DHC, morphine, sevredol and diazepam. She described the steps that had been taken with regard to Dr Emmerson, and said she was concerned that she posed a clinical risk and that she may have script pads and still be able to prescribe.

*Letter to Dr Emmerson describing the allegations which would be investigated*

[214] On 29 April 2015, Mr Wade wrote to Dr Emmerson via Mr Jackson stating that the list of concerns had now been revised, and the only allegations being pursued were:

> ...
>
> - On 20 April 2015 without authority you obtained a controlled drug script from the register in the Inpatient Unit and recorded a script for "1 x To Sub acute" with other writing unidentifiable and then signed the register.
>
> - On the same day you completed a controlled drug prescription form 6883961 in the name of the patient [name of Dr Emmerson's partner given] with the residential address of [address given]. The script prescribed a range of controlled drugs as detailed on the attached copy.
>
> - On or about 21 April 2015 the script was filled by Kensington Pharmacy (copy attached) and we now understand that the patient is your partner and that you reside jointly at the residential address listed on the script.
>
> - Sometime after filling the controlled drugs register you returned to the register and crossed out the initial entry "Sub Acute" (under the name of the patient or resident) and added what appears to be an illegible NMPI number in the same coloured ink as the original entry.
>
> ...

[215] Mr Wade went on to say that issues accordingly arose under NDHB's Code of Conduct (the Code) and Disciplinary Policy. He also referred to the obligations

contained in guidance issued by MCNZ in April 2010, "Good Prescribing Practice", which relevantly stated:

> 5. Avoid writing prescriptions for yourself or those with whom you have a close personal relationship. It is never appropriate to prescribe or administer drugs of dependence or psychotropic medication to yourself or someone close to you.

[216] He referred to a second statement issued by MCNZ as to the responsibility of doctors when prescribing drugs of abuse, and to s 24 of the Misuse of Drugs Act 1975. Attached to the letter was a copy of the Controlled Drugs Register containing Dr Emmerson's entry and the prescription she had completed.

[217] In response to this letter, Mr Jackson wrote to the lawyer who had been instructed for NDHB, Mr David Grindle, to discuss arrangements for the investigation meeting which was to take place. He requested a copy of Dr Emmerson's personal file.

[218] It was on this day that Dr Emmerson's partner presented the 20 April 2015 prescription, for refill purposes.

*Investigation meeting*

[219] An investigation meeting was held at Mr Grindle's office on 6 May 2015. Both sides were legally represented. Dr Emmerson was questioned closely on the misprescribing issue as described earlier.[21] She said that her partner was now in the care of a particular medical centre, and that he was not dependent on controlled drugs. Mr Jackson stated that Dr Emmerson thought she could provide the prescriptions, and in that context, the schedule of prescriptions which Dr Emmerson had written both for her partner and her partner's mother was volunteered.

[220] Mr Jackson also said there had been a high level of performance throughout Dr Emmerson's time in the Unit. Mr Wade told the Court that he had been advised by Dr N that Dr M had signed a performance appraisal for Dr Emmerson on 3 April 2015 which did not support that view. He knew this had not been seen by Dr Emmerson to

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[21] Above at [180]-[189].

that point. Consequently, when Mr Jackson referred to Dr Emmerson's performance, he showed the performance appraisal to them. There is no evidence that they were provided with a copy or that they had a proper opportunity to consider it. However, he said that Dr Emmerson's work performance did not become part of the investigation; he said the topic was touched on merely to correct Mr Jackson's statement.

[221] A further meeting was scheduled for 13 May 2015.

*Events: 6 – 15 May 2015*

[222] On 7 and 8 May 2015, Dr N wrote to Mr Stroud, but also Mr Wade, Dr Roberts, Mr Tito (General Manager, Maori Health and Mental Health and Addiction Services, to whom Mr Wade was accountable) and Mr Grindle, expressing her views to what had occurred. In one of her emails she referred to Dr Emmerson's conduct as being "seriously inappropriate behaviour with multiple prescriptions for her partner". She said that in no circumstances could this be appropriate, having regard to relevant guidelines of MCNZ.

[223] Later that day, in a further email to those investigating, Dr N emphasised that it was important NDHB did not accept the contention Dr Emmerson was in a doctor/patient relationship with her partner, who was not being seen as a mental health client by her within her role as a mental health doctor. The various assertions she had made were irrelevant; what she had done was "irrefutably serious misconduct".

[224] An issue then arose as to whether Mr Wade held the appropriate delegation from Mr Tito to dismiss. Over the course of the next few days, it was decided that Mr Tito would have to be the decision-maker. Mr Wade was frustrated by this turn of events; it was his view that Mr Tito should have been leading the process from the start, convening the meetings which were taking place with Dr Emmerson.

[225] On 12 May 2015, Mr Grindle wrote to Mr Jackson summarising the information that had been provided at the investigation meeting and advising that NDHB had reached the conclusion Dr Emmerson's misprescribing conduct constituted a breach of MCNZ statements, as well as the implied terms of her

employment agreement to conduct herself in the best interests of NDHB. He said that the relevant expectations were also set out in Cole's Medical Practice in New Zealand (Cole's).[22] That volume described the legal regulatory and professional ethical conduct requirements that are expected of registered medical practitioners, as established by law or relevant statements by MCNZ as the regulatory authority.[23]

[226] Mr Grindle stated that it was believed Dr Emmerson's behaviour constituted serious misconduct, and that there were a range of possible sanctions "up to and including the possibility of summary dismissal". There would therefore be a disciplinary investigation, and for that purpose, a meeting was proposed for 14 May 2015 at 11.40 am.

[227] On 13 May 2015, Dr N sent an email to the various persons with whom she had been communicating previously as above, stating she was "very concerned to hear that the plan of Dr Emmerson's employment being terminated this week was no longer happening because of concerns expressed at the executive meeting". She went on to say that she understood the concerns expressed were because of organisational risk from other doctors prescribing for family members. She said she wished to express strongly the clinical risk which NDHB would face if it did not appropriately address the "serious and dangerous behaviour of Dr Emmerson". In that regard, she referred to the following concerns about Dr Emmerson:

- she had failed her mid-run assessment because of erratic behaviour;
- there were suspicions that her behaviour in the workplace was affected by substances;
- she had prescribed benzodiazepines for her partner who had criminal convictions;
- staff were intimidated and therefore unwilling to formalise complaints;

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22 Ian St George (ed) *Cole's Medical Practice in New Zealand* (12th ed, eBook, Medical Council of New Zealand, 2013).

23 Ian St George, above n 22, at 3.

- the nature of the medications that she charted were clear drugs of abuse on multiple occasions;

- she used a controlled drugs script from the Unit with a fraudulent entry; and

- she had tried to justify her behaviour stating she was in a doctor/patient relationship with her partner, showing a blatant disregard for the ethics and nature of a doctor/patient relationship.

[228] Dr N went on to say that it was possible Dr Emmerson may in the future come under scrutiny from the Police having regard to her lifestyle, and that there would be more detailed investigations by the MCNZ. She said NDHB needed to prioritise clinical safety.

[229] Significantly, she also said that she and other senior psychiatrists would have no trust in working with Dr Emmerson and would be unwilling to provide her with any supervision or support were she to work in mental health.

[230] Dr N told the Court that this was a summary of her concerns with which those investigating were already very familiar. Mr Wade responded to Dr N, and the other recipients of her email, thanking her for her comments, and stating that all her points were acknowledged.

[231] Dr Roberts also expressed the view to Mr Wade, Mr Tito and Mr Stroud, as well as other senior colleagues, that there was a significant difference between prescribing drugs with addictive potential for family members, and prescribing drugs that did not have that potential. He said one was forbidden except in circumstances of urgent and unexpected need when it would be allowed, but only until another doctor becomes available to take over care; and the other was discouraged. He said Dr Emmerson had prescribed huge quantities of drugs with addictive potential, and many of them were actually controlled.

[232] On 14 May 2015, Mr Stroud forwarded to Mr Tito, now involved as decision-maker, a copy of the documents relating to the investigation of Dr Emmerson.

Following receipt, Mr Tito responded by stating he had particularly noted Dr N's emails of 7 and 8 May 2015, and that he believed "these arguments are irrefutable". He would be discussing this with others involved.

[233] On the same day, Dr N emailed Mr Tito and Mr Wade suggesting that Dr Emmerson had made inappropriate allegations to the effect that Dr M and Dr Cole had inappropriately prescribed for family members. She said that she was aware of one instance where Dr M had obtained medication for her father on an emergency basis, about which she had then given advice to senior colleagues, including Dr N. She said there was full transparency, and this was not a disciplinary matter. She also said that there had been no inappropriate prescribing as far as Dr Cole was concerned. Mr Tito responded stating that NDHB would not be investigating these allegations; he regarded them as irrelevant to the matters that were under discussion.

*Disciplinary meeting: 14 May 2015*

[234] The second disciplinary meeting was held with the same attendees as had participated in the first such meeting, along with Mr Tito. Although the minutes of the meeting did not record that Mr Tito was now the decision-maker, I accept that Mr Grindle stated this was the case at the meeting for several reasons. In emails sent a few days later by Mr Stroud, he said Mr Grindle had introduced Mr Tito as "the lead decision-maker at the disciplinary meeting". The fact was confirmed in the next letter sent to Mr Jackson on 19 May 2015, which tends to confirm that it was information which had already been conveyed. In any event, he was the most senior member of NDHB's management present at the meeting.

[235] A copy of type-written minutes of the meeting of 14 May 2015 was introduced in evidence. I find that Mr Stroud prepared these well after the event, and they may not in fact have been made available to Mr Tito and others in a timely way. They also contain an error, because although they purport to relate to the meeting of 14 May, they refer to a letter sent by Mr Grindle on 19 May 2015. I find this was obviously a mistake and that it is likely the minutes were prepared after that date and when the letter of 19 May 2015 had in fact come into existence. The error is not one of any material significance, particularly as the two members of management who were still

actively involved, Mr Wade and Mr Tito, were present, and there was an appropriate follow-up letter setting out what took place from Mr Grindle to Mr Jackson.

[236] At the meeting, reference was made to the applicable professional standards as to prescribing by Mr Wade. In the course of the discussion which followed, Mr Jackson said that it was clear Dr Emmerson thought she was entitled to prescribe the medications. Ms Emmerson explained what she knew about correct prescribing, as originally taught at Otago University; she also referred to occasions of informal prescribing, as observed or explained to her when she was a house officer.

[237] Although Mr Jackson had said at the previous meeting that Dr Emmerson recognised she should not have proceeded as she did, on this occasion, he said that it was not accepted that Dr Emmerson knew that what she was doing was wrong or was a flouting of MCNZ's guidelines. He said that Dr Emmerson had explained what her clinical assessment of her partner had been, and his reluctance to attend a GP.

[238] There was further discussion on these issues, particularly as to Dr Emmerson's understanding of the applicable guidelines. Dr Emmerson said she could vaguely recall MCNZ standards, but not that she had ever looked them up. She said she had read Cole's extensively, apparently a reference to the 2009 edition.

[239] The meeting concluded with Mr Grindle stating that the issues were very serious and that the matter would need to be considered further. Further feedback would be provided prior to the next meeting.

[240] Later that day, there was an exchange between Dr N and Dr Reynolds. He sent an email to Dr N describing his understanding as to the difficulties which had arisen with Dr M earlier in the year. He queried whether in those circumstances it would be appropriate for Dr M to take on another supervisory relationship. Dr N responded by stating that the matters which were the subject of the disciplinary investigation had nothing to do with her supervisory relationship with Dr M. She said the latter had not initiated the process or been involved in it. Dr N's exchange with Dr Reynolds was not forwarded to Mr Tito, Mr Wade or Mr Stroud.

*Mr Tito's conclusions*

[241] The next day, on 15 May 2015, Mr Tito recorded that he had spoken after the meeting of the previous day with both Dr Roberts and Dr N to advise them of the outcome of the meeting. He said they were adamant that the guidelines, as promulgated by MCNZ and as recorded in Cole's, were undeniably linked with doctors' training, and that every doctor would be well aware of these. He told Mr Stroud he was confident and convinced that Dr Emmerson was well aware of her professional and ethical obligations as to prescribing. He considered the allegations and description of a prescribing culture among doctors at NDHB to be irrelevant.

[242] He then said that there was sufficient evidence to make a determination, and that Mr Grindle should be instructed to prepare a letter laying out the case and determining that Dr Emmerson be dismissed. Dr N, Dr Roberts and Mr Wade all indicated agreement to this conclusion.

[243] On 19 May 2015, Mr Grindle wrote to Mr Jackson, summarising the information which had been provided by Dr Emmerson. He stated that NDHB did not accept that the reasons given by her for not complying by MCNZ statements and standards were valid. With regard to the two occasions where Dr Emmerson said others had potentially breached NDHB's medication prescribing policy, he said the organisation would conduct its own process; but did not believe that, if proven, this could provide evidence of a culture, nor could it excuse responsibility for Dr Emmerson's own conduct. He then said that NDHB had concluded:

- Dr Emmerson had failed to meet her professional responsibility to understand the guidelines provided in both Cole's and in MCNZ's standards.

- Prescribing controlled drugs to her partner was a breach of both, and the fact that she had been doing so for over a year was an aggravating factor.

- She had breached NDHB's medication prescribing policy, which referenced the MCNZ's standards with regard to good prescribing practice of 2010.

- She had misappropriated hospital property, namely the script she had filled, in circumstances where she knew or ought to have known that the use of such scripts was not for administering drugs to non-patients who are relations.

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

[244] Mr Grindle went on to state that the employer's preliminary view was that a sanction by way of summary dismissal should occur. He concluded the letter by inviting Mr Jackson to engage with him in regard to that proposal. He said that if need be, NDHB would be willing to meet for a further occasion, either on 20 or 22 May 2015. If no meeting was arranged, the right to formalise the proposal was reserved. This letter was forwarded by email to Mr Jackson, at 3.35 pm.

[245] There were various other communications that day as to the process which would be followed. First, after receiving Mr Grindle's letter, Mr Jackson phoned him. He said he told him that he may wish to have a meeting either at 11.00 am on 20 May, or on 22 May 2015. Mr Grindle caused enquiries to be made as to the availability of management personnel to attend such a meeting, which was confirmed via Mr Stroud.

[246] Later that day, Mr Jackson emailed Mr Grindle, stating he was seeing Dr Emmerson at 10.00 am the next day; he proposed a meeting to follow at 11.30 am.

[247] Also, in the course of 19 May 2015, Dr N and Dr Honeyman discussed with Mr Wade the question of whether it would be appropriate to allow Dr Emmerson the opportunity to resign. In a subsequent email, Dr Honeyman said that she was shocked that such a possibility would be considered, because to do so would not be ethical. She said that the issue was one of serious professional misconduct, and that NDHB needed to be staunch about that. The Chief Medical Officer/Clinical Director needed to be involved.

[248] On 20 May 2015, Dr Roberts responded to Dr N and Dr Honeyman, copying in others. He said his focus had been to protect patients, staff, but also Dr Emmerson's concerns. He had accordingly recommended early notification to MCNZ so that her

practice could be curtailed or very closely supervised. He also recommended she not be allowed to work during the initial investigation. He had tried to protect staff by recommending Police involvement at an early stage, and by trying to ensure there was adequate support for staff. As regards protecting Dr Emmerson, he said he did not believe she was "an intrinsically bad person". Rather, he believed she had acted under duress from a partner who was a deeply flawed person with many deeply unpleasant character traits. He said that Dr Emmerson should have the option "to act honourably" by being provided with an opportunity to recognise the problem she had caused, as well as her unacceptable behaviour, and then be offered the opportunity of stepping down from her position. Dismissal would more likely demonstrate a lack of compassion.

[249] Later, Dr Roberts clarified his position. He said NDHB would be acting reasonably if Dr Emmerson was dismissed, and it would be acting compassionately if it allowed Dr Emmerson an opportunity to resign before taking that step. These exchanges were copied to Mr Tito and to Mr Wade, amongst others.

[250] Also, early that morning, Mr Jackson wrote to Mr Grindle, stating that as the decisions Dr Emmerson would have to make would have great significance to her, could the meeting be postponed until 11.00 am on 22 May 2015.

[251] Emails exchanged internally suggest that there was a reluctance to delay the process. Mr Stroud, for example, acknowledged that there was a desire to bring the matter to an end. Mr Tito told the Court that he was anxious to resolve the issue, as the investigation had been underway for some time. Mr Stroud told Mr Grindle, therefore, that there was a preference to proceed that day.

[252] Mr Stroud also said that if there was delay, Dr Emmerson may become disruptive to others. Mr Tito said that his view was that resolution of the matter was the paramount consideration; any disruption, as referred to by Mr Stroud, was a background factor.

[253] A telephone conversation then took place between Mr Grindle and Mr Jackson approximately 20 minutes after the time which had originally been mooted for a

meeting, 11.30 am. The two lawyers discussed the pros and cons of NDHB's decision that serious misconduct had occurred. In the course of the conversation, Mr Jackson also said that Dr Emmerson would be meeting with MCNZ representatives on 8 – 9 June 2015, and asked that the employment investigation be adjourned, to be reconvened following that meeting. Not to do so, he said, would usurp the role of MCNZ. Mr Jackson also asked for NDHB's response to the points he had made during the call. No reference was made during the meeting to the possibility of a meeting being held on 22 May 2015, the date which had previously been suggested for doing so. Mr Grindle concluded that the exchange which had taken place between the lawyers had obviated the necessity for a further meeting.

[254] Mr Grindle told the Court, with reference to brief notes he took of the meeting, that at no time was any mention made of a Facebook posting by Dr Emmerson, which it had been asserted was relevant to a concern about disruption. Mr Tito said he was unaware of this Facebook posting.

[255] The telephone conversation took place in the presence of Mr Tito and Mr Stroud, but Mr Grindle then advised them as to its content, since they had heard only one side of the conversation.

[256] Mr Grindle was then instructed to prepare a letter responding to the various points which had been discussed in the telephone call between the lawyers.

[257] In responding to those points, Mr Grindle said that:

a) The employer did not accept that Dr Emmerson wrote "Sub acute" because someone in the background had mentioned those words; rather, it considered Dr Emmerson had been trying to mask the actual details of the controlled drug script recipient.

b) The 2009 edition of Cole's had been superseded, by the time of the events in 2015. There was an obligation on practitioners to stay current. The investigation conducted by NDHB had concluded that practitioners needed to be cognisant of MCNZ requirements.

c) Dr Emmerson knew, or ought to have known, that the controlled drugs scripts contained within the Unit were for hospital business use only; these were not for personal use.

d) The prescribing to persons other than patients by Dr M and Dr Cole had been examined initially, and there were considerable differences in those cases, principally the fact that there had been appropriate clinical discussion with a senior doctor in each case.

e) Implied and actual terms of employment were referred to. Dr Emmerson's prescribing for 14 months without the knowledge of her employer to her partner contrary to MCNZ standards was a breach of good faith obligations. Dr Emmerson was required to adhere to the employer's practices and procedures. Examples were set out in the Disciplinary Policy as to what constituted serious misconduct for various behaviours. These included a deliberate breach of the organisation's policies, a deliberate breach of statutory requirements, and the unauthorised use and/or removal of the property of the organisation. Improper conduct in an official capacity could also constitute serious misconduct. Nor was it appropriate for an employee to bring the organisation into disrepute. Consideration of these obligations led to a conclusion that Dr Emmerson had breached actual and implied terms of her employment, which required her to conduct herself in the best interests of NDHB.

[258] Mr Grindle ended the letter by stating that NDHB maintained that the proposed course of action was the correct one and proposed to formalise the summary dismissal at the close of business on 21 May 2015. The letter was emailed to Mr Jackson at 8.45 am that morning. He responded by stating that the position of NDHB was noted but not accepted; he also noted that Dr Emmerson would be formally dismissed at the close of business that day.

[259] NDHB's decision to dismiss Dr Emmerson was recorded by a further letter sent that day to Mr Jackson, which he duly acknowledged.

*Relevant legal principles as to justification*

[260] Section 103A of the Act provides that the question of whether a dismissal or an action was justified must be determined on an objective basis by applying the test in subs 2 which provides:

> **103A Test of justification**
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> …
>
> (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.
>
> …

[261] The section goes on to stipulate four factors which the Authority or Court must consider namely:

> …
>
> (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.

[262] The Court may consider any other factors it thinks relevant.[24] It cannot determine that a dismissal or an action is unjustifiable solely because of defects in the process followed by the employer if the defects were minor and did not result in the employee being treated unfairly.[25]

[263] It is not for the Court to substitute its decision for what a fair and reasonable employer could have done in the circumstances, and how such an employer could have done it. In *Angus v Ports of Auckland Ltd*, it was emphasised there may be a range of

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[24] Employment Relations Act 2000, s 103A(4).
[25] Section 103A(5).

responses open to a fair and reasonable employer, and that the Court's task is to examine objectively the employer's decision-making process and determine whether what the employer did, and how it was done, were steps which were open to a fair and reasonable employer.[26]

[264] The Court of Appeal emphasised this point in *A Ltd v H.*[27] It said:[28]

> [46] It is apparent that the effect of the statute is that there may be a variety of ways of achieving a fair and reasonable result in a particular case. As the Court in *Angus* observed, the requirement is for an assessment of substantive fairness and reasonableness rather than "minute and pedantic scrutiny" to identify any failings.

[265] Dicta of the Court of Appeal in an earlier case, that of *Air Nelson Ltd v C,* is also of assistance:[29]

> [19] Section 103A requires the Court to undertake an objective assessment both of the fairness and reasonableness of the procedure adopted by [the employer] when carrying out its inquiry and of its decision to dismiss [the employee]. Within that inquiry into fairness and reasonableness the Court is empowered to determine whether [the employer] had a sufficient and reliable evidential basis for concluding that [the employee] had been guilty of misconduct.

[266] An issue which can arise in cases such as the present relates to the professional consequences of a termination of employment, which can be very significant. In *Lewis v Howick College Board of Trustees*, the Court said:[30]

> [5] As in the cases of other professional employees whose very livelihoods are affected by a dismissal from employment, the consequences for a school teacher of dismissal for misconduct or incompetence and especially, as in this case, a summary dismissal for serious misconduct, affect not only that employment relationship. Whereas many other dismissed employees have opportunities to seek alternative employment within their fields of experience and for which they are qualified, teachers (and others) must also be professionally registered to practise. Dismissals of teachers (and a range of lesser sanctions in employment) trigger automatically a vocational or professional registration investigation. As with many other professions there is little, if any, opportunity for employment in New Zealand without registration. An employer dismissing a teacher is bound by law to advise the

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26 *Angus v Ports of Auckland Ltd (No 2)* [2011] NZEmpC 160, [2011] ERNZ 466 at [36] – [44].
27 *A Ltd v H* [2016] NZCA 419, [2017] 2 NZLR 295, [2016] ERNZ 501.
28 (Footnotes omitted).
29 *Air Nelson Ltd v C* [2011] NZCA 488, (2011) 8 NZELR 453.
30 *Lewis v Howick College Board of Trustees* [2010] NZEmpC 4, [2010] ERNZ 1. See also *Edwards v Board of Trustees of the Bay of Islands College* [2015] NZEmpC 6, [2015] ERNZ 437 at [15]; *Campbell v Commissioner of Salford School* [2015] NZEmpC 122, [2015] ERNZ 844 at [120].

> Teacher Registration Council. As in this case, it can be expected that there will be a level of inquiry into the teacher's fitness to be registered in light of the circumstances of the dismissal and other relevant considerations. So the effect of the dismissal of a teacher is especially significant. Put simply, allegations of misconduct or incompetence place teachers (and other similarly registered occupations) in double jeopardy of their livelihoods.
>
> [6] Accordingly, employers of teachers must act to a high standard when their decisions can have these consequences. So, too, independent courts and tribunals considering the justification for dismissals of teachers must be conscious of that consequence and the corresponding need to examine such cases with great care. It is an onerous responsibility that the legislation has placed on boards of trustees as employers who are very much part-time, nominally remunerated, and, for many board members, without appropriate expertise either in the teaching profession or employment relations. It is important, in these circumstances, that boards of trustees as employers take and follow correct professional advice and that they are advised independently and dispassionately on education matters by the school's professional leader, its principal, who must be ex officio a member of the Board.

[267] This principle is of broad application to employees who are required to be registered to practice, such as health professionals, as was accepted by Judge Couch in *De Bruin v Canterbury District Health Board*.[31] I accept Mr Henderson's submission that by natural extension the dicta cited in *Lewis* applies in the present circumstances. Accordingly, NDHB was required to act to a high standard when making decisions that could have far-reaching professional consequences for Dr Emmerson.

[268] A related point is that the fact there is serious misconduct does not mean that dismissal will automatically be justified. In *Auckland Provincial District Local Authorities Officers IUOW v Northland Area Health Board*, the Court stated that the correct approach involved two steps.[32] First, there must be a determination that the conduct in question is capable of amounting to serious misconduct. If this requirement is satisfied, the second step is to consider whether dismissal is warranted in all the circumstances of the case. The Court explained that the availability of dismissal as an option is not decisive. More recently, former Chief Judge Colgan stressed that there may be circumstances where consideration needs to be given to alternative outcomes

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31 *De Bruin v Canterbury District Health Board* [2012] NZEmpC 110, [2012] ERNZ 431 at [66].

32 *Auckland Provincial District Local Authorities Officers IUOW v Northland Area Health Board* [1991] 2 ERNZ 215 (LC) at 222.

under the relevant conduct policies which may have contractual force. In *Secretary for Justice v Dodd,* the Court stated:[33]

> Although serious misconduct, even what is effectively a single incident thereof, may usually constitute good grounds for a justified dismissal, that does not follow necessarily in every case. As the judgment of the full Court in *Air New Zealand Ltd v V* confirms, the test for justification does not only apply to the employer's decision that there was serious misconduct leaving the consequences of this entirely to the employer. Section 103A requires the Court (and the Authority) to apply the objective fair and reasonable employer test also to the employer's decision about the consequences of serious misconduct, in this case summary dismissal.

[269] Although these comments were directed to the previous test of justification ("what a fair and reasonable employer *would* have done in all the circumstances"), in my view, they apply equally to the current version ("what a fair and reasonable employer *could* have done in all the circumstances").

[270] Clause 7 of the Disciplinary Policy is consistent with this case law. It made it clear that dismissal was a serious matter "which should occur only when the organisation is satisfied there is no other appropriate means of resolving the situation"; it imposed an express obligation to address this issue.

[271] The MECA which covered Dr Emmerson's role stated that any termination would be in accordance with the employer's policies and procedures. Clause 7 of the Disciplinary Policy thus had contractual force.

*Other provisions in NDHB's Code of Conduct and Disciplinary Policy*

[272] It is necessary to consider these documents more fully, for the purposes of reviewing the process undertaken by NDHB.

[273] The Disciplinary Policy described the processes for investigating a misconduct matter, and for then undertaking a disciplinary process.

[274] It contained a cross-reference to a separate document, the Code, which it stated established the standards of behaviour expected of employees; it also defined minor

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[33] *Secretary for Justice v Dodd* [2010] NZEmpC 84, [2010] 7 NZELR 578 at [121] (footnotes omitted).

and serious misconduct. It went on to state that the examples given in the Code were not exhaustive, because it is not possible to foresee every possible situation of misconduct.

[275] The Code itself described minor misconduct as behaviour that would generally lead to disciplinary action being invoked. Meanwhile, serious misconduct was behaviour that would lead to disciplinary procedures being invoked, including the possibility of termination of employment/summary dismissal. The Code stated that in distinguishing between the two, regard should be given to the consequences and/or risks to which the misconduct exposes the organisation, including its patients and staff.

[276] Returning to the Disciplinary Policy, examples of minor and serious misconduct were given in an appendix. Although some of these required deliberate conduct before a finding of serious misconduct could be made, others did not; intention was thus not necessarily a prerequisite.

[277] General principles under the Disciplinary Policy included one relating to fairness. The degree of discipline had to relate to the nature of the offence; regard was to be given to a range of factors, including the seriousness of the problem and/or issue, the employee's work history, any relevant extenuating or mitigating factors, in which case it would be imperative the employee was given an opportunity to explain his or her side of the story.

[278] Turning to grounds for disciplinary action, a generic definition of misconduct was given, to the effect that it comprised unacceptable or irresponsible actions or omissions. A cross-reference was provided to an appendix outlining actions that could constitute minor or serious misconduct, but the list was not to be regarded as exhaustive.

[279] The Disciplinary Policy went on to describe the necessity for a careful and thorough investigation in respect of each allegation of misconduct or poor performance, particularly if disciplinary action may result.

[280] Then the Disciplinary Policy referred to outcomes, including dismissal. I have already referred to the fact that NDHB needed to be satisfied there were no other appropriate means of resolving the situation. The Disciplinary Policy relevantly stated no dismissal may be effected without discussion with the HR department and consultation with the Chief Medical Officer.

[281] In short, as would be expected in an organisation of this kind, NDHB had a comprehensive Disciplinary Policy, which needed to be considered together with its Code.

*Analysis*

[282] In this section, I will consider the key conclusions which were reached by NDHB in the disciplinary process, first with regard to the alleged misprescribing, and second with regard to the alleged misappropriation of a prescription. I will go on to consider the mitigating factors raised by Dr Emmerson in the course of the process, and finally assess whether a fair and reasonable employer could have concluded that the circumstances amounted to serious misconduct. Finally, I will consider the separate issue as to whether the dismissal was justified.

*The misprescribing allegation*

[283] It is not disputed that Dr Emmerson did prescribe Class B drugs of dependence to her partner, namely m-Elson and sevredol, both of which are morphine-based medications.

*The applicable standards*

[284] In assessing the standards required of medical practitioners when prescribing, the advice given to Mr Tito was that these were set out in two publications issued by MCNZ, both of which were amended from time to time. Also relevant was NDHB's own prescribing policies.

[285] During the disciplinary meeting, Dr Emmerson had said her prescribing was justified having regard to her understanding of the applicable standards as set out in the 2009 edition of Cole's, and her training at medical school. She had said her actions accorded with the following statement in Cole's:

**Providing care to those close to you**

> 7. Wherever possible, avoid providing medical care to anyone with whom you have a close personal relationship. The Council recognizes that in some cases providing care to those close to you is unavoidable. However, in most cases, providing care to friends, those you work with and family members is inappropriate because of the lack of objectivity and possible discontinuity of care.

[286] A footnote to this statement referred to the June 2007 guidance of MCNZ. In that document, it was stated that prescribing psychotropic medication for family members "should be avoided".

[287] For its part, NDHB relied on its Medication Prescribing Policy. The version which was current at the time of the 2015 events had been issued in October 2014 and relevantly stated:

> 4. Avoid writing prescriptions for yourself, colleagues or those whom you have a close personal relationship unless a therapeutic relationship has been established.

[288] Mr Grindle's letter of 19 May 2015 stated that this obligation referred to a 2010 MCNZ standard; this document was issued by MCNZ in April of that year and relevantly stated:

> 5. Avoid writing prescriptions for yourself or those with whom you have a close personal relationship. It is never appropriate to prescribe or administer drugs of dependence or psychotropic medication to yourself or someone close to you.

[289] Although express reference was not made in the Medication Prescribing Policy to that particular standard, that was nonetheless the expectation of MCNZ as from that date.

[290] In the 2013 edition of Cole's, MCNZ's position was this:[34]

**Providing care to yourself or those close to you**

> 11. Other than in exceptional circumstances you should not provide medical care to yourself or anyone with whom you have a close personal relationship.

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[34] Refer to MCNZ's statement on "Providing care to yourself and those close to you"; the footnote does not provide a date for that document, but the most recent publication of that guidance was the document of 2010.

[291] In summary, MCNZ expectations became more prescriptive after 2009. From April 2010, it was clear that it was "never appropriate" to prescribe or administer drugs of dependence or psychotropic medication to someone close to a medical practitioner. NDHB's Medication Prescribing Policy was not as clear as it might have been, but it obviously had to be understood in light of MCNZ guidance for medical practitioners. And there is no evidence that Dr Emmerson had regard to the language of NDHB's Medication Prescribing Policy at the time of the prescribing.

[292] NDHB assessed Dr Emmerson's prescribing according to the more prescriptive criteria which had applied since April 2010, to the effect that it was never appropriate to prescribe or administer drugs of dependence or psychotropic medication to someone close to a medical practitioner.

*Advice given to Mr Tito*

[293] Mr Tito took advice on this matter, as he was required to do under the Disciplinary Policy, from Dr Roberts. That advice was clear. He said Dr Emmerson had prescribed "huge quantities of drugs with addictive potential and many of them are actually controlled". The latter part of this statement was a reference to the fact that controlled drugs had been prescribed to Dr Emmerson's partner not only in April 2015, but also in June 2014. It will be recalled Dr Roberts made a clear distinction between prescribing controlled drugs without addictive potential for family members and prescribing those that did have such a potential. The preliminary decision letter of 19 May 2015 confirmed Mr Tito had taken this advice.

[294] That letter did not refer to the fact that Mr Tito had also received extensive advice from Dr N. Her views were strongly expressed in emails she sent during the investigation process on 7 and 8 May 2015. As already mentioned, in one of those emails, she stated that the totality of prescribing to Dr Emmerson's partner amounted to "seriously inappropriate behaviour". Shortly before the meeting which Mr Tito attended on 14 May 2015, Mr Tito said the arguments she presented in those emails were "irrefutable".

[295] On 13 May 2015, she reiterated her views, including the opinion that there was a clinical risk to NDHB if it did not appropriately address the "serious and dangerous

behaviour" of Dr Emmerson. On this occasion, she referred to the further concerns which had been expressed initially by the three nurses, but not investigated. She went on to say that she and other senior psychiatrists would not have trust if required to work with Dr Emmerson and would be unwilling to provide her with any supervision or support.

[296] After the disciplinary meeting of 14 May 2015, Mr Tito confirmed in an internal email that he had discussed what occurred at that meeting with Dr N and Dr Roberts so as to advise them of its outcome. He recorded that they were adamant as to their views as to prescribing. He concluded that there was sufficient evidence to determine Dr Emmerson had seriously breached NDHB's Code.

[297] It is necessary to consider the role which the views of Dr N and Dr Roberts played in Mr Tito's decision-making. It is obvious Dr N had very strong views on all the matters that had been raised. I have considered the question as to whether her views about the misprescribing which was investigated, were influenced by the allegations which were not investigated, particularly issues as to drug use. Did Mr Tito receive advice that was distorted by matters which should have been irrelevant for the purposes of the misprescribing allegations?

[298] Although this issue will have implications for later aspects of this cause of action, I am satisfied that Dr N's views on the misprescribing issue were consistent with the views expressed on the same topic by Dr Roberts. Mr Tito was required under the disciplinary policy to consult with him as the Chief Medical Officer. His opinions were not expressed in strident terms. He had expressed views about the wider context, including the fact he thought Dr Emmerson had acted under duress; but his views as to the obligations in respect of prescribing were well grounded in the standards prescribed by MCNZ, and that MCNZ expected all medical practitioners to keep up to date on such important obligations. I conclude, therefore, that it was fair and reasonable for Mr Tito to accept the opinions given as to misprescribing by both Dr Roberts and Dr N.

*Mitigating matters*

[299] During the disciplinary process, Dr Emmerson argued that her understanding about misprescribing to family members was influenced by several factors. One of these related to what she had been told at university, when attending an ethics tutorial on prescribing to those close to a practitioner.

[300] She told the Court that it was clear that while prescribing to family members was not the best practice, it was not forbidden. What a practitioner would need to do in such a situation was to act professionally, undertaking a proper examination and taking notes. However, the PowerPoint presentation produced to the Court relating to the university lecture, which Dr Emmerson said she recalled, made a direct reference to the relevant MCNZ standard which stated that certain specific situations when treating family members "should be avoided"; that standard included prescribing psychotropic medications.

[301] This explanation, however, differs from what she told the employer at the disciplinary meeting which took place on 14 May 2015, where it is recorded that while studying at Otago University, medical students had learned about Cole's, but not MCNZ standards. A relevant matter of context is that the tutorial/training also pre-dated the several years of practical experience Dr Emmerson had as a registered medical practitioner.

[302] Dr Emmerson also said that in mid-2014, she told Dr M that she struggled with what she was supposed to do when staff approached her for scripts or treatment. She had described how it was commonplace for nurses to approach the house surgeon seeking scripts. Dr M had told her this it was a grey area in medicine and a difficult thing to manage, but it was her decision whether or not she assisted nurses in this way. Dr Emmerson went on to refer to a situation Dr M had alluded to, where she had written a prescription for her father.

[303] Dr Emmerson's understanding was that this incident involved Dr M taking her father to the emergency department of the hospital because of sleep issues; she became upset when adequate treatment was not given. She had thus driven across the carpark, entered the Unit and taken some diazepam from the medication room, which she felt

was the only way to treat him. Dr M had said she was worried that cameras had been installed in the area and that she was going to be blamed for a trend of missing diazepam. For this reason, she told the charge nurse what she had done. This account implied that Dr M had acted in a somewhat cavalier fashion with regard to prescribing.

[304] Dr M herself explained the circumstances. It was correct she had taken her father to the emergency department. This was on a Saturday. He was discharged but did not improve. Accordingly, the next day, by which time her father had not slept for more than 48 hours, she attended the ward and explained to the charge nurse she required one 5mg tablet of diazepam, explaining the rationale. The next day, which was a Monday, she had explained what she had done and why to the manager of the Unit, and the clinical director. Then, she sought advice from a psycho-geriatrician and based on that advice arranged for a geriatrician to arrange an urgent private assessment of her father.

[305] It was her evidence that she raised the example to demonstrate why treating those who were close to you was not appropriate and that there were necessary follow-up actions.

[306] Since Dr M was describing a situation in which she herself had been involved, I prefer her evidence as to what occurred. Moreover, evidence from others confirmed that Dr M had given this account at the time. I do not accept Dr Emmerson's evidence that Dr M had disclosed what had occurred because she was concerned the events may have been captured on camera.

[307] Dr Emmerson also said that when she was a house officer, Dr Cole had described a recent illness where he had written scripts for himself for several antiemetics, Imodium and antibiotics.

[308] For his part, Dr Cole could not recall this when giving evidence, although he did say there may have been some instances when he had gone overseas and prescribed an anti-nausea pill or sachets for diarrhoea. He went on to say that it was not unheard of for doctors to prescribe for friends, family and nurses, for instance where such a person was to travel. However, he said that was a rather different situation from one

where a controlled drug would be prescribed. He did not recall Dr M stating that this was a grey area in medicine.

[309] Turning to what was said about these matters in the disciplinary process, Dr Emmerson is recorded as having referred to these issues at the meeting of 14 May 2015. She said that what she had been told by Dr M and Dr Cole had given her the distinct impression that the writing of scripts for family members was permissible.

[310] Later that day, Dr N told Mr Tito and Mr Wade she was very concerned to hear Dr Emmerson had been making allegations that Dr M and Dr Cole had inappropriately prescribed for family members. She outlined her understanding as to what had occurred when Dr M obtained medication for her father. She said at the time the situation was brought to her attention and to a relevant general manager. The situation was one that had occurred on an emergency basis. Another medical practitioner had then been involved in providing an urgent home visit review of Dr M's father. Dr N also said that Dr Cole was an excellent registrar, and that she was unaware of any inappropriate prescribing.

[311] Mr Tito responded to Dr N, stating that these matters would not be investigated. However, in Mr Grindle's letter of 19 May 2015, it was stated that NDHB would conduct its own processes with regard to the allegations, but did not believe, if proven, they provided evidence of an inappropriate culture, or one which could excuse liability. I find that in essence, NDHB concluded the circumstances as described were very different from the prescribing of a controlled drug, not for the first time, to a doctor's partner.

[312] Some evidence was led from a previous employee which suggested that prior to 2010 there had been a more permissive environment with regard to doctors treating nurses. However, that doctor told the Court she thought the practice had stopped. I find that this evidence does not assist on this issue, since it was at about this time that the guidance from MCNZ became more prescriptive. Furthermore, the direct evidence from Dr Roberts was that there was no permissive or lax prescribing culture either within the Unit, or elsewhere within NDHB, as at 2015.

*Mr Tito's conclusions*

[313] Mr Tito did not accept Dr Emmerson's explanation that she was unaware of the up-to-date standards. He concluded that these were understood by all "reasonable practitioners" to be the applicable standards and best practice for persons in Dr Emmerson's position.

[314] To some extent, this involved a credibility finding. Mr Tito told the Court Dr Emmerson's account involved a "falsehood". He said that she knew through her training, and her writings, there were obligations upon doctors to remain current with practice standards.

[315] Mr Tito's reference to "writings" was to the comprehensive report Dr Emmerson had prepared about the physical health of patients. In that document, she referred variously to Cole's, as well as statements of MCNZ. For instance, she stated:

> The Medical Council of New Zealand provides clear guidelines in respect of medical practice in New Zealand. It is the responsibility of competent doctors to be familiar with "Good medical practice" and to follow the guidelines it contains. The Health Practitioners' Disciplinary Tribunal, the Council's Professional Conduct Committee and the Health and Disability Commission (sic) may use this publication as a standard by which to measure professional conduct.

[316] I find that a fair and reasonable employer could have reached the conclusion that Dr Emmerson was well aware of her prescribing obligations, and that her statement she had mistakenly relied on an out-of-date edition of Cole's was incorrect.

[317] Standing back, I am satisfied that the advice received by Mr Tito as to the seriousness of the prescribing was reliable; and that a fair and reasonable employer could have accepted that advice and concluded that Dr Emmerson either did or should have been well aware of the applicable standards, which were breached.

*Misappropriating a controlled drug prescription form*

[318] NDHB concluded that there was misappropriation of hospital property, and that Dr Emmerson either knew or ought to have known that hospital scripts were not for administering drugs to non-patients who were relations.

[319] NDHB operated a policy "Controlled Drugs: Management Outside Pharmacy". It provided that all persons involved with controlled drugs, which included the completion of a drugs register and prescription forms, were required to adhere to the provisions of the policies.

[320] One such provision was a prohibition on the cancelling, altering or obliteration of any entries in the controlled drugs register. Further, blank controlled drug prescription forms were to be used only for controlled drugs for discharge or for patients in an outpatient clinic only.

[321] The policy also required that a patient's name, as well as their NHI number, were to be documented.

[322] In the course of the investigation, Dr Emmerson was asked why she had written the words "1 x To Sub acute" in the controlled drugs register, when her partner had never been a patient of the Unit; the word "Sub acute" implied that the medications were being prescribed for a patient in the sub-acute unit. Then the word was deleted. The next difficulty was that Dr Emmerson's partner's name was not recorded in the register, only a somewhat blurred NHI number. Dr Emmerson explained to those investigating how and why those entries were made.[35]

[323] In his letter of 19 May 2015, Mr Grindle stated that the employer did not accept the explanation as to why the word "Sub acute" had been written on the controlled drugs register. The way in which Dr Emmerson had filled out the Register suggested that she was deliberately trying to mask the actual details of the script's recipient.

[324] This conclusion was first referred to expressly in the penultimate letter of 19 May 2015; there was thus an opportunity for Dr Emmerson to address the employer's view of the matter. That did not happen. The conclusion was reiterated in the final letter of 21 May 2015.

[325] I find it was one which could have been reached by a fair and reasonable employer.

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[35] Above at [181]-[189].

*Campaign by Dr N and Dr M to terminate Dr Emmerson's employment*

[326] Dr Emmerson, in her first amended statement of claim, asserted that there were "clandestine actions" on the part of Dr N and Dr M, which was an aspect of a campaign to terminate her employment. In her evidence, she said the two doctors had "connived and contrived" from at least March 2015 to have her dismissed.

[327] To support this allegation, Dr Emmerson said evidence had been fabricated. Several examples were given. She asserted that the file note prepared by Dr M of her conversation with three nurses, which gave rise to the 12 allegations that were forwarded to Dr N and then members of management, involved the fabrication of evidence by Dr M.

[328] Ms Rata gave evidence to the Court and supported this allegation. She said Dr M's file note was "a lie". However, as I indicated earlier, I found her evidence to be wholly unreliable; it contradicted the evidence of others who were involved in the process which gave rise to Dr M's file note, Dr N's contemporaneous email to management, and the several conversations which then took place involving the nurses, as well as that of Mr Wade. There is overwhelming evidence that the original allegations made by the nurses as recorded in Dr M's handwritten note were correctly understood by management.

[329] I referred earlier to another example: Dr Emmerson's assertion that a document which Dr M prepared in March 2015[36] was also fabricated. I found that Dr Emmerson's theory about this was also misconceived.

[330] Similarly, she believed the performance appraisal document, dated by Dr M on 3 April 2015, was in fact prepared by her sometime after 24 April 2015, and backdated. Again, I have found this was not the case.

[331] Finally, I observe that Dr M was not involved directly in the disciplinary process. It is the case that Dr M and Dr N had worked with each other for many years and had some social contact. But I am not satisfied that these factors influenced the

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36 Above at [101](a).

opinions they gave in the disciplinary process. In particular, Dr N's strong views were her own, genuinely held.

[332] Dr N was somewhat defensive when it was suggested to her that Dr M might not take on another supervisory relationship[37] or that she might have infringed standards relating to prescribing to family members.[38] These reactions may have stemmed from her close association with Dr M, but were not an aspect of a concerted campaign between two doctors.

[333] I do not accept the assertion that Dr N was involved in "clandestine actions" in concert with Dr M. These assertions are not relevant, then, to the Court's assessment as to whether a conclusion as to serious misconduct was justified.

*Second step*

[334] It is next necessary to consider the issue to which I referred earlier, whether NDHB met its obligation to ensure it was satisfied there was no other appropriate means of resolving the situation.[39]

[335] In the course of the various disciplinary meetings, and in the letters sent by Mr Grindle, there is no confirmation that this mandatory consideration of alternative outcomes had been considered, and, if considered that it had been ruled out, and if so, why.

[336] Mr Tito told the Court that "the wrong was irrefutable"; he also said that no alternative outcome was considered.

[337] The contemporaneous evidence confirms that relevant factors pertaining to this step were not raised with Dr Emmerson. Mr Grindle's penultimate letter, sent at the stage when a fair and reasonable employer could be expected to set out outcomes, focused only on the misprescribing and misappropriation allegations. The final

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37 Above at [240].
38 Above at [310].
39 As discussed earlier at [268]-[271].

decision-letter of 21 May 2015 again focused on these topics. Mr Tito's brief reference to the "final step", as contained in his email of 15 May 2015, was not referred to at all.

[338] There are several issues indicating that this step was not undertaken adequately, or transparently.

[339] The first is that the 11 allegations which had originally been made, and which NDHB said it would not investigate, remained live. Dr N was clearly concerned about these. Her emails alluded to them. I have also concluded that this factor influenced her views when she said that none of the psychiatrists working in mental health at NDHB would be prepared to work with Dr Emmerson in the future.

[340] Dr N's reference to the views of senior doctors included, I do not doubt, her awareness that Dr M was concerned about Dr Emmerson's behaviour. Dr M had told Dr N that following her conversation with her cousin, she became concerned for her personal safety having regard to the identity of Dr Emmerson's partner. She also said she knew Dr M was very scared. So were nursing staff, to the point that they were not prepared to formalise the concerns that they originally expressed in writing.

[341] Dr Roberts touched on the same issue when discussing the outcome of either dismissal or resignation.[40]

[342] These facts were known to Mr Wade, who was initially involved in the process that followed the raising of these concerns; and by Mr Tito since, as noted, Dr N referred to them in email communications which he received. As Mr Henderson put it, there was an elephant in the room: the uninvestigated allegations to which credence was given.

[343] I find that the existence of these concerns reinforced the conclusion that Dr Emmerson had to be dismissed. I accept Mr Henderson's submission that alternative outcomes could not be properly assessed without the unresolved allegations being investigated.

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[40] Above at para [248]-[249].

[344] Ms Hornsby-Geluk also referred to this issue. She said that had the plaintiff not been dismissed, it was "highly likely" that NDHB would have come back to the "unresolved allegations" and conducted a further investigation into them.

[345] It was not submitted that any one or more of the unresolved allegations would have been established. Most of them concerned prescribing to others, apart from the first which related to personal drug use. It related only to an alleged statement about personal drug use, not the fact of such use. There was no evidence from NDHB witnesses, or submissions, that Dr Emmerson's drug history, as became evident later, would have been revealed in any detail. In these circumstances, the Court cannot speculate as to what would have occurred had an investigation of the nurses' concerns taken place.

[346] If the allegations were in fact substantiated, they may well have supported a conclusion of dismissal; but if they were not, the underlying concerns could have been addressed by a fair and reasonable employer. Mr Henderson submitted that there were other options which would have allowed a junior doctor to remain in employment, such as the removal of the authority to prescribe, and appropriate education. I express no view as to whether these steps would have been appropriate, since there is no evidential foundation for reviewing such possibilities.

[347] However, this factor is sufficient to reach a conclusion that a fair and reasonable employer could not have failed to take appropriate steps to satisfy itself that there were no other appropriate means of resolving the situation.

[348] There was also a second difficulty. It related to the information possessed by Mr Tito as to Dr Emmerson's performance. All he had was the partially completed document prepared by Dr M on 3 April 2015. I am not satisfied that Dr Emmerson was provided with a copy of this document; moreover, she was not invited to comment on its contents if it was to be relevant at the final stage of the disciplinary process. Reference was made in the document to a "robust plan" being formed to address areas relating to Dr Emmerson's further development. As noted earlier, a remediation plan had been discussed with Dr Plunkett. Dr M and Dr N said they were working towards

the implementing of such a plan. There is no evidence that any of this was known to Dr Emmerson.

[349] Mr Tito was left with a brief and negative view of Dr Emmerson's work performance on the basis of the incomplete mid-rotation assessment.

[350] Nor is it apparent he was aware of the very positive assessments which had been made of Dr Emmerson as a house officer, the genesis of the report she prepared, and the sequel to that which resulted in complaints being made about it and her.

[351] The Disciplinary Policy stated that the degree of discipline should be related to the nature of the offence. As explained earlier, a relevant factor was the employee's work history; this entailed consideration of how long the employee had worked for the organisation, and the quality of the employee's performance and conduct.

[352] Mr Tito said that Dr Emmerson's employment history, including her length of service and her "overall performance during that time," were taken into account when determining if dismissal was the appropriate outcome. He told the Court that once he had made the decision that serious misconduct had occurred, he turned his mind to the broader issues. He said that she did not have a long employment record with NDHB, and her performance had been varied. He viewed these factors as neutral, as opposed to factors that may have mitigated her actions.

[353] However, Mr Tito acknowledged the performance history and issues were never disclosed or discussed with Dr Emmerson. In the result, the complexities of her employment history were not properly understood by Mr Tito.

[354] I find a fair and reasonable employer could not have proceeded to dismissal without considering whether there were alternatives short of dismissal. That required an investigation of the untested 11 assertions made by the nurses, and it required a proper understanding of Dr Emmerson's employment history. These were obviously matters which required full discussion with Dr Emmerson. This did not occur. I also find that this was because of the concerns which had been expressed by Dr N that neither she nor other senior psychologists would have trust in working with

Dr Emmerson and would be unwilling to provide her with supervision or support if working in mental health.

[355] The consideration of the "final step" by Mr Tito was insufficiently brief. A fair and reasonable employer could not have given such limited consideration to alternatives, in light of the mandatory obligations of cl 7 of its Disciplinary Policy.

*Procedural issues*

[356] A plethora of alleged procedural flaws with regard to the NDHB investigation were pleaded. Some of these were not pursued. In deference to the fact that the parties dealt with some of these in evidence, I refer to the main concerns of that nature that were raised. As will be seen, I am satisfied that either they did not occur; or they were minor and did not result in unfairness.

*Ambush at the outset?*

[357] It was submitted that Dr Emmerson was ambushed at the first meeting, when she was faced with 12 allegations, only one of which was subsequently pursued; and because a representative was in effect imposed on her by the employer.

[358] I am satisfied the raising of the full set of concerns with Dr Emmerson and the way this was done was a step that a fair and reasonable employer could have taken.

[359] Plainly, NDHB had an obligation to raise such significant matters with its employee. I do not accept that the emotive language used by Dr Emmerson to describe the way in which Mr Wade asked her to accompany him to the meeting is accurate. I accept Mr Wade's account. But I also accept it was appropriate for NDHB to speak to Dr Emmerson promptly, given the range and seriousness of the allegations that it was obliged to consider. Nor was it unreasonable for her to be told that she should not discuss the issues with any other employees, given the nature of the concerns that had been raised.

[360] Whilst it was somewhat unusual for the employer to have arranged a representative, I find that Dr Powell's representation was a defect that did not result in unfairness or prejudice to Dr Emmerson.

*Mr Tito's role*

[361] Initially Mr Wade investigated the concerns which had been raised, with Mr Tito being kept appraised of the steps that were being taken, although as he told the Court, he was not necessarily "across the detail" to the extent that Mr Wade was. Mr Tito also accepted that at the time when he formally assumed the role of decision-maker – likely after the letter of 20 May 2015 had been sent which was authorised by Mr Wade – there was "confusion as to the boundaries between the two of them". However, I have found that it was made clear Mr Tito was the decision-maker thereafter.

[362] It is arguable that it would have been desirable for Mr Tito to have led the investigation from the outset in the particular circumstances. That he did not may have contributed to the issues I identified earlier. But this problem should not be regarded as a separate flaw justifying a discrete finding of procedural unfairness.

*Was Dr Emmerson given an adequate opportunity to respond?*

[363] Dr Emmerson was represented by an experienced lawyer throughout the investigative process. Letters were sent at each stage of the process from NDHB's lawyer. These indicate a transparent process where the employer spelt out its primary concerns at each stage. Subject to the failure to expressly consider an alternative outcome which has already been discussed, I am satisfied there were no additional matters that were not raised, or in respect of which Dr Emmerson was not given a reasonable opportunity to respond.

*Provision of documents*

[364] Dr Emmerson contends that she was not provided with all relevant documents, including minutes of the meetings she attended. This appears to have been the case in part, but I have found the letters sent by NDHB's lawyer accurately summarised the primary concerns of NDHB at the various stages of the investigation process, subject to the one matter of which I have been critical. I do not consider there was a procedural flaw with regard to the provision of information.

*Refusal to meet on punitive grounds*

[365] Dr Emmerson said her lawyer received a telephone call the day following the 19 May 2015 preliminary decision letter, cancelling an intended meeting because of a Facebook post, and that this was a punitive step. This was denied by Mr Stroud, Mr Wade and Mr Grindle.

[366] The issue was not referred to in correspondence from Dr Emmerson's lawyer at the time, nor in her letter raising a personal grievance. Significantly, Mr Jackson was not called to support the allegation. In any event, Mr Tito said that he did not learn about the Facebook post in question until after the dismissal on 2 June 2015.

[367] I also note that in Mr Grindle's first letter of 21 May 2015, Mr Jackson was told that NDHB proposed to formalise its view at the close of business that day. Mr Jackson acknowledged receipt of that letter, without protesting that there should be a further meeting. The final step that day was the formalising of the employer's decision.

[368] In all these circumstances, I find that the intended meeting was not cancelled.

*Pre-determination*

[369] Dr Emmerson pleaded that, at the behest of Dr N and Dr M, there was a determination on the part of the employer to ensure Dr Emmerson would be dismissed.

[370] I have already found that there were no clandestine activities between Dr N and Dr M.

[371] I have also considered the impact of Dr N's strong views on the decision-making process. I have found that those views contributed to the failure to consider alternative outcomes. That was the real problem. In my view, the ultimate decision is not appropriately characterised as having been pre-determined; rather, it involved the decision-maker being influenced by irrelevant matters and failing to take into account relevant matters.

*Conclusion as to fourth cause of action*

[372] Dr Emmerson was unjustifiably dismissed, because inadequate consideration was given to outcomes other than dismissal. That decision was accordingly not one which a fair and reasonable employer could have taken in all the circumstances. The fourth cause of action is established.

## Remedies

*Overview of parties' positions*

[373] In relation to the disadvantage grievance relating to inadequate supervision, Dr Emmerson sought $50,000 for humiliation, loss of dignity and injury to feelings, and penalties. In relation to her claim that she had been unjustifiably dismissed, Dr Emmerson sought lost wages for 23 months, unpaid overtime, special damages of $50,000 for "loss of government bond in relation to working in a hard-to-staff area and hard-to-staff speciality", an order for compensation for humiliation, loss of dignity and injury to feelings, and penalties for breach of obligations.

[374] In her original statement of claim, Dr Emmerson also sought an order for reinstatement. Although this was not pursued, having regard to the fact that her registration had been cancelled, the HPDT recorded that it could envisage a situation where Dr Emmerson might be able to obtain re-registration in time.[41]

[375] Mr Henderson submitted that if the only impediment to reinstatement was re-registration, then this could be recorded in the Court's judgment. In my view, it would be inappropriate to make any findings at all on reinstatement when the issue was not live at the hearing. A hypothetical assessment by the Court is not appropriate.

[376] Turning to the position of NDHB as to remedies, it was submitted by Ms Hornsby-Geluk:

a) It would not be just and equitable in the circumstances for Dr Emmerson to be awarded any remedies for the dismissal grievance, having regard

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41 *Professional Conduct Committee v Emmerson,* above n 2, at [104].

to egregious misconduct on her part, not only because of the misprescribing and misappropriation findings made by NDHB, but also in light of later discovered misconduct, namely serious personal drug use.

b) Were the Court not to accept this submission, there would nonetheless be a range of factors to take into account in fixing remedies which would mean these could only be minimal, at best. A similar submission applied to compensation for the disadvantage grievance.

*Authorities as to zero awards*

[377] It is first necessary to consider NDHB's primary submission, which is that no remedies should be awarded with regard to the dismissal grievance, having regard to conduct which NDHB says was egregious.

[378] There are two authorities relevant to this allegation. In *Xtreme Dining Ltd v Dewar*, a full Court expressed the view that it may not be just or equitable to award remedies under s 123 of the Act, where the employee has engaged in disgraceful conduct.[42] It stated:[43]

> ... when there is misconduct which is so egregious that no remedy should be given, notwithstanding the establishing of a personal grievance, the Authority or Court may take that factor into account in its s 123 assessment in a manner that conforms with "equity and good conscience". The absence of a remedy in rare cases, notwithstanding the establishing of a personal grievance may be appropriate. The Court of Appeal reached this conclusion where there is disgraceful misconduct discovered after a dismissal. We consider that this statutory scheme allows for the same outcome in other instances where, for example, there has been outrageous or particularly egregious employee misconduct.

[379] In this passage, the reference to dicta of the Court of Appeal was to that contained in *Salt v Fell*.[44]

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42 *Xtreme Dining Ltd v Dewar* [2016] NZEmpC 136, [2016] ERNZ 628.
43 At [216].
44 *Salt v Fell* [2008] NZCA 128, [2008] 3 NZLR 193, [2008] ERNZ 155.

[380] In that instance, the majority stated:[45]

> ... the result should be that the employee does not benefit from his or her wrong. At times ... subsequently discovered conduct may be so egregious that no remedy at all should be given, notwithstanding the dismissal being technically unjustifiable. But that will not often be the outcome. After all, the employer has committed a wrong, namely an unjustified dismissal based on what he or she knew at the time. He or she did not act as a fair and reasonable employer would have acted in all the circumstances at the time.

[381] In short, the question is whether there is sufficiently egregious misconduct, either known or unknown to the employer, which should lead to a conclusion that it would be contrary to equity and good conscience to award any remedies for the dismissal grievance.

*Analysis of NDHB's assertion as to a zero award*

[382] For NDHB, it is submitted that this is a case where Dr Emmerson engaged in disgraceful and inexcusable conduct within a profession in which the highest of standards are expected, having regard not only to the misprescribing and misappropriation, but also in light of Dr Emmerson's history of personal drug use. It is argued that the assessment made by the HPDT on that topic should be considered by the Court.

[383] Mr Henderson strongly submitted that the Court should not rely on the HPDT's decision, since its assessment was one made under a different statutory regime, with the focus required of a disciplinary tribunal considering regulatory issues.

[384] Earlier in this judgment, I noted that the HPDT had considered three matters: misprescribing, personal drug use and an allegation that Dr Emmerson had lied to the PCC. It found there was professional misconduct under the Health Practitioners Competence Assurance Act 2003, and that Dr Emmerson's registration should be cancelled.

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[45] At [96]. The case was decided under the previous test of justification under s 103A of the Act, where the focus was on what a fair and reasonable employer "would" have done rather than what a fair and reasonable employer "could" have done, which is the present position.

[385] The evaluation to be undertaken by this Court must focus on the evidence which it has received so as to assess personal grievances under the Employment Relations Act. As it happens, there is an overlap with evidence on the topic of personal drug use, which was considered not only by the HPDT, but also by the Health Committee, and it must evaluate that evidence in light of the applicable employment law principles.

[386] I have already referred to the evidence which Dr Emmerson gave to the Court on this topic, but it is now necessary to analyse that evidence in more detail.[46]

[387] Starting with her use of cannabis, Dr Emmerson accepted this had occurred. She said she had occasionally had a joint with her partner. She described herself as an occasional user.

[388] Reference was made to a drug test which was taken for the purposes of the Health Committee. It was conducted on 3 and 4 June 2015 and covered the period 18 February to 19 May 2015. The report was provided to MCNZ on 11 June 2015. The analysis was based on a sample of hair. The result was negative for methamphetamine; it was positive for cannabis, recording a result for Tetrahydrocannabinol (THC) of 0.07 ng/mg, which Dr Emmerson said was consistent with use on one or two occasions in that period. She said this was a "negligible result for THC".

[389] An issue arises from an email written by Dr Emmerson to the Health Committee, relied on by the HPDT but also submitted to the Court. In it, Dr Emmerson said:

> *"I used methamphetamine on Easter Saturday prior to that it was over the Christmas break – I do not know how much a point is but it was a small amount I used. I have sat down and tried to work out my methamphetamine use this week and have probably used methamphetamine on around 6 occasions in total over my entire life and this was in the period January 2013 to April 2015".*

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[46] Above at [101](d).

[390] Ms Hornsby-Geluk submitted that in light of this concession, there must be some doubt as to the reliability of the hair test. She argued that it remained unclear as to why a Cardiff-based agency had carried out the test when the ESR in New Zealand would be an obvious choice; and further, that no evidence had been provided about the chain of custody relating to the hair sample, or even when it was collected and from whom.

[391] These may be valid criticisms, but there was no cross-examination of Dr Emmerson on the topic, and I am not prepared to rule out that the drug test is reliable. The Health Committee did not conclude otherwise. On the basis of all the information it received, which included the drug test and information submitted by Dr Emmerson, the Committee stated it was pleased to hear that she had become "abstinent from Methamphetamine and Cannabis".

[392] Dr Emmerson, when giving evidence to the Court was unsure as to the provenance of the email containing her concession as to use of cannabis and methamphetamine. Efforts were accordingly made to obtain a copy of it. When it was subsequently produced, Ms Emmerson's second counsel, Mr Martin, said that the extract cited above was part of an email which she had sent in response to observations made by a psychologist who prepared a report for the Health Committee. I consider therefore, that it is appropriate to rely on the concession made in a document which was prepared for a formal purpose.

[393] On the basis of Dr Emmerson's own evidence, I find that she used cannabis from time to time, and that this occurred between January 2013 and April 2015.

[394] In her email, Dr Emmerson also accepted she had used methamphetamine "on or around 6 occasions in total", in the same period. There appears to be an issue as to whether one of those occasions was in fact on Easter Saturday 2015, a possibility she ruled out in evidence because of the results of the drug test.

[395] Even if Dr Emmerson's point about the drug test is accepted, that merely means that the six occasions of accepted methamphetamine use occurred prior to the taking of the drug test, since she did not say otherwise in her evidence.

[396] Dr Emmerson was employed by NDHB from December 2012 until 21 May 2015. The use of those Class A and Class C drugs took place in the period of her employment.

[397] For NDHB, reliance was placed on several highly critical statements made by the HPDT as to the personal use of drugs by a doctor, whilst practicing. But as I have indicated, the Court's consideration of this issue must be through a different lens.

[398] In my view, the correct question which is raised by the personal drug use is whether Dr Emmerson's use of drugs amounted to behaviour which had the potential to bring the employer into disrepute, a matter NDHB was clearly concerned about, as express reference was made to this issue in the disciplinary process.

[399] Dr M told the Court that she considered there were some incidents of impaired performance on the part of Dr Emmerson, when she was a house officer in 2014, and more generally in early 2015. The evidence is not sufficiently precise as to allow a conclusion of impaired work performance on the basis of drug use. Dr Emmerson said observations made of her, which some thought were suggestive of drug use, were in fact due to her suffering from a post-concussion syndrome.

[400] I therefore approach this issue on the basis that Dr Emmerson's drug use was private and away from the workplace, since that is the effect of her evidence.

[401] NDHB's Disciplinary Policy contained a section regarding conduct detrimental to the best interests of the organisation, when describing grounds for disciplinary action. It stated:

> Unless the employee's off duty behaviour seriously brings the standing of his/her profession or trade or the organisation into disrepute, it is not considered to be the business of the organisation. The main consideration should be whether the offence is one that makes the individual unsuitable for his/her type of work, or disqualifies him/her from performing it. Conduct considered to be detrimental to the best interests of the organisation includes the following:
>
> (a) Behaviour, either on or off duty, which in the view of the employer could bring the organisation or the standing of the employee's profession into disrepute.

> (b) Behaviour, either on or off duty, which brings the organisation or the standing of the employee's profession into disrepute.
>
> ...
>
> (e) Conviction of an offence relating to the possession, receiving and/or supply of drugs or any other offence under the Misuse of Drugs [Act].

[402] In the examples of serious misconduct given in the appendix to the Disciplinary Policy, reference was again made to expected behaviour, which was to ensure that an individual employee's actions would not bring the organisation into disrepute. One of these was the obtaining of a conviction of an offence relating to the possession, receiving and/or supply of drugs or any other offence under the Misuse of Drugs Act 1975. The document went on to say that it was not possible for the examples given to be exhaustive; and that NDHB reserved the right to implement disciplinary procedures where there was a matter not specifically covered by the list which was given.

[403] These statements reflect many judicial expressions of opinion as to the possibility that private misconduct may legitimately be a matter of concern to an employer. Thus, in *Smith v Christchurch Press Company Ltd*, the Court of Appeal affirmed that it had long been recognised that conduct outside the work relationship, but which brings the employer or its business into disrepute, may warrant dismissal.[47] As (now) Chief Judge Inglis explained in *Hallwright v Forsyth Barr Ltd*:[48]

> It is not necessary that the conduct itself be directly linked to the employment but rather that it have the potential to impact negatively on it. That is why an employee can be held to account for what might otherwise be regarded as a private activity, carried out away from the workplace with no ostensible connection to the employment or other employees.

[404] A person using methamphetamine and cannabis runs the risk of being prosecuted and convicted for serious criminal offending under the Misuse of Drugs Act 1975. If such a person is a medical practitioner working in a mental health unit, such as Dr Emmerson was, convictions for possession and use under that Act would inevitably bring disrepute not only to that person, but to her DHB employer. This is

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47 *Smith v Christchurch Press Company Ltd* [2001] 1 NZLR 407, [2000] 1 ERNZ 624 (CA).
48 *Hallwright v Forsyth Barr Ltd* [2013] NZEmpC 202, [2013] ERNZ 553 at [49].

especially so for any conviction relating to methamphetamine, a pernicious drug, the serious effects of which are seen daily in the criminal courts.

[405] There is also a risk for a doctor using such drugs of physical impairment, and impaired judgement when at work, with the potential to cause harm to vulnerable patients, many of whom have their own complex addiction issues. These are additional factors having the potential to bring a hospital health service such as NDHB into significant disrepute.

[406] I find that a fair and reasonable employer in all the present circumstances could have concluded that this later discovered egregious misconduct was highly relevant for employment purposes. In addition, there was of course the misprescribing of drugs to Dr Emmerson's partner – on two separate occasions; as well as misappropriation of a prescription.

[407] Standing back, I am satisfied that all these circumstances constitute grave misconduct, so that notwithstanding the establishing of the dismissal grievance, it would be contrary to equity and good conscience for remedies to be awarded in respect of that grievance.

*Analysis of award for established disadvantage grievance*

[408] NDHB did not argue that a similar analysis should be undertaken for the purposes of the disadvantage grievance, and so I do not consider that possibility. Rather, the submission was that the compensatory sum which was sought, $50,000, was grossly disproportionate to the level of compensation typically made for such grievances, as well as the actual distress emanating from the events giving rise to Ms Emmerson's claim.

[409] As to typical awards, I note there are relatively few such findings in this Court.[49] Awards in the Authority are lower than in the case of compensation for unjustified dismissal grievance, but quantum depends on the type of unjustified action.

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[49] *Ramkissoon v Commissioner of Police* [2017] NZEmpC 85, (2017) 15 NZELR 203; *Spotless Facility Services NZ Ltd v Mackay* [2017] NZEmpC 15; *Lewis v Immigration Guru Ltd* [2017] NZEmpC 141.

As the authorities were not analysed by either counsel, I take this topic no further. I do however bear in mind the orthodox principles which apply when setting awards of compensation, as explained by the Court of Appeal in *Telecom New Zealand Ltd v Nutter*.[50]

[410] Just as the assessment of disadvantage had to focus on the consequences of the failure to supervise, so too must any analysis of compensation. As I found earlier, when evaluating the extent of the personal effects of that failure, it is necessary to acknowledge there were a range of other impacts which were not directly related to the failure to provide one-on-one supervision.

[411] Taking all these factors into account, in my assessment, an appropriate award under s 123(1)(c)(i) of the Act is $4,000, subject to an assessment of contributory conduct.

[412] For the purposes of s 124 of the Act, I must consider, first, whether Dr Emmerson's actions contributed towards the situation that gave rise to the failure to supervise on a one-on-one basis.

[413] The trigger for the difficulties that arose with regard to supervision involved Dr Emmerson's interactions with a particular house surgeon. Much evidence has been placed before the Court regarding that complaint, which involved communication issues between Dr Emmerson and Dr Loo. I am satisfied on the evidence that it is more likely than not there were indeed communication issues.

[414] Dr Emmerson said she interacted with Dr Loo in a manner which conformed with directions from Dr M as to how she was to engage. However, she must take some personal responsibility as to how she communicated, as a health professional.

[415] That said, Dr M had the ultimate responsibility of ensuring supervision was carried out in accordance with the requirements of the College. Relevant to that matter was the significant power imbalance which existed between her as a senior practitioner, and Dr Emmerson as a junior one.

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50 *Telecom New Zealand Ltd v Nutter* [2004] 1 ERNZ 315 (CA).

[416] In all those circumstances, I find that it is appropriate to reduce the compensatory award by 10 per cent, to reflect the matters I have just described. NDHB is accordingly liable to pay Dr Emmerson the sum of $3,600.

[417] The foregoing conclusions deal with the various remedies that were sought under s 123 of the Act.

*Penalties?*

[418] Remaining are the claims that penalties should be awarded. Having regard to the conduct issues I have reviewed, I am not persuaded that it is appropriate to award a penalty in respect of the dismissal grievance.

[419] Since the disadvantage grievance involved a relationship problem between two individuals, I am again not persuaded a penalty should be awarded in respect of that matter.

## Final matters

[420] The first cause of action has been established. The second and third have not and are dismissed. The fourth is established as to liability, but not as to quantum; it too is therefore dismissed. The challenge is accordingly allowed in part.

[421] This judgment replaces the Authority's determination.

[422] NDHB has requested that the Court's interim orders prohibiting publication of the names and any identifying details of Dr N and Dr M be made permanent. Counsel were agreed that this issue should be deferred, so that further submissions could be made in light of the findings contained in this judgment.

[423] Accordingly, NDHB is to file and serve its submissions in support of the application within 21 days; and Dr Emmerson may file and serve hers within 21 days thereafter.

[424] Costs are reserved. The Court was advised that Dr Emmerson was legally aided. If there are costs issues, these should in the first instance be discussed between

counsel. If either party chooses to advance a relevant application, that is to occur within 21 days, and any response within the same period thereafter.

[425] A final addendum to this lengthy judgment, relates to the future. The Court has necessarily focused on past events; there has been an intense look back over a very difficult period. Whilst it has been necessary to be critical of several of the participants, and particularly Dr Emmerson, consideration should now be given by all parties to looking forward.

B A Corkill
Judge

Judgment signed at 3.00 pm on 28 March 2019