IN THE EMPLOYMENT COURT OF NEW ZEALAND
WELLINGTON

I TE KŌTI TAKE MAHI O AOTEAROA
TE WHANGANUI-A-TARA

[2020] NZEmpC 225
EMPC 425/2019

IN THE MATTER OF	a challenge to a determination of the Employment Relations Authority
BETWEEN	LEANNE GAYE DAVIS Plaintiff
AND	IDEA SERVICES LIMITED Defendant

Hearing: 13 and 16 July 2020 (and on further submissions received on 31 July and 17 and 31 August 2020)

Appearances: S Meikle until 16 July 2020; thereafter P Cranney, counsel for plaintiff
G Ballara and S Radcliffe, counsel for defendant

Judgment: 11 December 2020

JUDGMENT OF JUDGE B A CORKILL

Introduction

[1] Ms Leanne Davis claims her employer, IDEA Services Ltd (ISL) failed to comply with its health and safety obligations, as owed to her with regard to a particular service user.

[2] The key question is whether the service user's behaviour escalated, resulting in an incident on 5 December 2016 when he assaulted Ms Davis after chasing her from his residence to a neighbouring residence; and whether this possibility was foreseeable so that relevant safety steps should have been implemented.

[3] After this incident, Ms Davis brought a disadvantage grievance, which was investigated by the Employment Relations Authority. On 23 October 2019, it dismissed her claim.[1]

[4] Ms Davis has now brought a challenge to the Authority's determination. She says she was disadvantaged in her employment, and/or that the terms and conditions of the applicable collective employment agreement (CEA) were breached. The relevant provisions of the CEA provide:[2]

> 16.7.1 The parties to this agreement recognise their obligations under the Health and Safety in Employment Act 1992 and the Health and Safety in Employment Act 2002. The parties acknowledge that the Act places responsibilities on both the employer and the employee. Accordingly the parties acknowledge their joint commitment to carrying out the Act's provisions and the need for the employer's management and employees to actively familiarise themselves with their respective responsibilities. The parties acknowledge that the undertaking of sleepovers by employees in accordance with the terms of the Agreement does not by itself give rise to any health and safety issues or compromise the obligations of the employer parties to this Agreement, or their employees, under the Health and Safety in Employment Act 1992.
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> 16.7.2 To give effect to this intention the employer will ensure that no employee shall be required to undertake any work without proper instruction as to the hazards likely to arise in connection with that work, and for the employee to have access to appropriate training and all known relevant information as to the precautions to be taken to avoid such hazards.
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> For the avoidance of doubt, within the employer's operations the hazards in the workplace may include challenging behaviour of service users.

[5] It is pleaded for Ms Davis that ISL acted unjustifiably and/or breached these terms by:

a) failing to have the service user's disability treatment and care reassessed prior to November 2016, as requested by Ms Davis;

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1 *Davis v Idea Services Ltd* [2019] NZERA 610 (Member Loftus).

2 The term of the IEA placed before the Court was from 21 October 2014 to 20 October 2016. Both parties proceeded on the basis that this was the operative CEA at the time.

b) failing to have his disability treatment and care reassessed after an incident in early November 2016;

c) failing to fix a lock on the office of the service user's residence;

d) failing to provide Ms Davis with a safe place of work so that the assault which occurred on 5 December 2016 would have been prevented;

e) failing to have a safe place for Ms Davis to retreat, such that the service user would have been unable to assault her on 5 December 2016;

f) continuing to care for the service user when it was ill-equipped to do so; and

g) failing to inform WorkSafe New Zealand of the 5 December 2016 incident.

[6] In relation to these allegations, ISL pleads:

a) Ms Davis did not request a reassessment and, in any event, the service user's care was managed appropriately.

b) The lock of the office was not broken;

c) ISL was not required to provide a workplace where the 5 December 2016 incident "would have been prevented"; that is not the law.

d) Ms Davis breached protocols in a number of respects during her 4/5 December 2016 shift.

e) The protocol described safe places to which Ms Davis should have followed. She did not do so, despite being aware of the protocol.

f) The allegation of continuing to care for the service user when it was ill-equipped to do so was denied.

g) In the circumstances which developed, notification to WorkSafe was not required.

[7] ISL also raises several procedural matters. First, it says the grievance was not raised within the 90-day period which followed the incident that caused injury to Ms Davis on 5 December 2016.

[8] ISL's second point relates to an aspect of Ms Davis' grievance which took place on 14 February 2017. She alleges she was in a shop, which was visited by the service user with a support worker. Ms Davis says the service user ranted and acted aggressively towards her, and that the service worker who was caring for him was unable to restrain him. This caused further distress.

[9] ISL says this allegation was never pleaded as a distinct disadvantage claim before the Authority, and so cannot be properly raised before the Court now. Alternatively, the claim has no merit because the incident was an unfortunate coincidence or bad luck. Moreover, this was not a problem which occurred when Ms Davis was "on the job".

[10] As regards Ms Davis' claim alleging a breach of the CEA, ISL says this cause of action was not pleaded in the statement of problem; thus it cannot be considered now.

Resolution of preliminary points

[11] The first preliminary point requiring consideration is whether Ms Davis' personal grievance, asserting that she had been unjustifiably disadvantaged in her employment, was raised within a period of 90 days of the circumstances giving rise to the grievance.

[12] In their submissions, counsel discussed this point in light of a letter sent by E tū Union (the Union), of which Ms Davis was a member; it was dated 7 March 2017 and received by ISL on 8 March 2017. The letter referred to a range of issues arising from the incident which took place on 5 December 2016.

[13] Whilst the letter appears to have been the first occasion when express reference was made to the raising of a personal grievance, this was not the first time that the Union had raised on Ms Davis' behalf acute concerns about the assault.

[14] The question for the Court, then, is whether the previous interactions amounted to the raising of a disadvantage grievance.

[15] In *Chief Executive of Manukau Institute of Technology v Zivaljevic*, Judge Holden summarised the principles which apply as to the raising of a grievance.[3] She emphasised that the grievance process is designed to be informal and accessible; that a grievance may be raised orally or in writing; that there is no particular form of words that must be used; and that where there has been a series of communications, not only would each be examined as to whether it might constitute the raising of a grievance, but the totality of those communications might also amount to the raising of a grievance.[4]

[16] The essence of the statutory requirement to raise a grievance within the 90-day timeframe is that the employer must know what it is responding to. The employer must be given sufficient information which will allow it to address the grievance on its merits with a view to resolving the grievance promptly and informally, at least in the first instance.[5]

[17] In light of these principles, I consider the events which followed the incident on 5 December 2016.

[18] On 23 December 2016, Ms Adrienne Transom, Area Manager of the region for which Ms Davis worked, wrote to Ms Davis and to Ms Laurel Reid, a Union organiser who was representing her interests, following a conversation which had occurred earlier that week. Ms Davis was still an employee, expected to return to work when able to do so. It is plain that there had been a detailed discussion at that meeting about steps for a better exit plan for staff working with the service user, Mr A, and to increase

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3 *Chief Executive of Manukau Institute of Technology v Zivaljevic* [2019] NZEmpC 132.
4 At [36].
5 At [38].

security for other staff and service users at his residence. Particular proposals for achieving this were advanced.

[19] On 6 January 2017, Ms Reid responded. She took strong exception to a number of aspects of the proposed plan. In essence, she suggested Mr A needed to be moved to a high-needs care facility, or that his care should be delivered by two employees, not one. She addressed other perceived inadequacies of his residence from a safety perspective.

[20] Ms Transom responded that day. She said the Union had a responsibility to support staff on employment matters, but this did not mean it could advise ISL on how to run its business in relation to a placement of a service user, or to judge the suitability of the service.

[21] On 11 January 2017, Mr Alastair Duncan of the Union responded in Ms Reid's absence. He emphasised, amongst other things, that safety at work was a fundamental right; and that employers had significant responsibilities under the health and safety legislation.

[22] I find on the basis of these exchanges that significant health and safety issues were raised as a result of the assault suffered by Ms Davis on 5 December 2016. In effect, it was being asserted, on behalf of Ms Davis, that the conditions of her employment had been affected to her disadvantage because health and safety standards had not been maintained; and that there were ongoing concerns.

[23] ISL was plainly given clear information as to what should be done to address her concerns. In substance, a personal grievance was thereby raised. On that basis, there is no issue as to time limitation.

[24] However, even if I am wrong in that conclusion, the same result is reached with reference to the letter which expressly referred to the raising of a personal grievance, dated 7 March 2017. The letter was two days beyond the 90-day period which ran from 5 December 2016. That letter was responded to in substance by Ms Transom. In her subsequent letter of 17 March 2017, she referred in detail to the assertion that

ISL had not taken all practicable steps to identify, manage and reduce health and safety risks. She answered all the concerns raised, from ISL's perspective.

[25] She concluded her letter by saying ISL wished to work towards Ms Davis returning to work when ready, and that the organisation would discuss this with her when appropriate.

[26] She also said ISL agreed to attend mediation regarding the issue, and would wait to hear from the Ministry of Business, Innovation and Employment in that regard. Subsequently, mediation was arranged for 19 June 2017.

[27] On 16 June 2017, Mr Ballara, counsel for ISL, emailed Ms Reid stating that attendance by his client at mediation would be without prejudice to its belief that there was a 90-day issue regarding Ms Davis' "purported personal grievance".

[28] If it were to be considered that a personal grievance was not in fact raised until 8 March 2017, when the letter of the previous day was received, I consider that in its 17 March response ISL consented impliedly to, or acquiesced in, the raising of Ms Davis' grievance out of time.

[29] As is noted in the authorities, the question of whether a consent to the late raising of a grievance can be implied is a matter of fact and degree.[6] In this case, that assessment may be made not only with regard to the exchange of correspondence, but with regard to the earlier comprehensive discussions between the parties. The letter of 7 March 2017 could not have been regarded as a bolt out of the blue. In her response, Ms Transom expressly referred to the previous discussions, and the issues which had been raised. ISL did not raise a concern as to time limits, and indeed, adopted a positive and forward-looking approach to the issues, which included its agreement to attend mediation.

[30] Even when counsel was briefed, the date for mediation was maintained. In those circumstances, the without prejudice caveat could not override the previous

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6 These are summarised in *Turner v Talley's Group Ltd* [2013] NZEmpC 31 at [80].

comprehensive interactions of the parties. Accordingly, I would have concluded that there was an implied consent to the late raising of a personal grievance.

[31] The next procedural issue relates to the alternative cause of action brought in contract.

[32] The facts relied on for that cause of action are identical to the facts relied on for the purposes of the disadvantage grievance. At the heart of both claims is an allegation that a safe workplace was not maintained.

[33] An issue was raised as to whether the Court could hear and decide the second cause of action in contract, since that was not pleaded at the Authority stage.

[34] However, the alleged breach of contract relates to a "matter" which was determined by the Authority when it considered Ms Davis' employment relationship problem.[7] The Authority considered precisely the same issues: were health and safety obligations met?

[35] It is well established that an overly technical approach is not to be taken which would enable form to trump substance.[8] This is a case where it is important that the real controversary is considered, so that there is a just determination of the proceeding.[9]

[36] That being the case, I am satisfied that the second cause of action is properly before the Court. It squarely raises the issues on which Ms Davis focused on in the Authority and wishes to raise again in the Court by way of a challenge.

[37] The breach of contract cause of action is plainly within the timeframe applicable to such claims.

[38] In short, I find the Court has jurisdiction to consider both causes of action.

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7 Employment Relations Act 2000, s 179(1).

8 *Udovenko v Offshore Marine Services (NZ) Ltd* [2013] NZEmpC 174 at [11]; *Hatcher v Burgess Crowley Civil Ltd* [2019] NZEmpC 5 at [7]–[12].

9 *Thornton Hall Manufacturing Ltd v Shanton Apparel Ltd* [1989] 3 NZLR 304 at 309.

[39] Finally, I refer to the question of whether it was permissible to refer in the statement of claim to the incident which occurred on 14 February 2017. It was pleaded as being a circumstance which exacerbated the stress Ms Davis suffered as a result of the assault. It should be regarded as part and parcel of the matter which was before the Authority.

Health and safety obligations

[40] The provisions of the CEA cited earlier, referred to the health and safety legislation which applied when the CEA terms were agreed, that is, on 9 April 2015. On 4 April 2016, the Health and Safety at Work Act 2015 (the HSAW Act) came into force.[10] It repealed the Health and Safety in Employment Act 2002. By necessary implication, the new Act became the applicable statute for the purposes of the CEA. It is common ground that by the time of the subject events, ISL had an obligation to take all reasonable and practicable steps to maintain a safe workplace under that statute.

[41] The scope of those obligations was succinctly summarised by the Court of Appeal in *Attorney-General v Gilbert*, when the Court observed:[11]

> [83] ... The standard of protection provided to employees by the Health and Safety and Employment Act is ... 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.[12] These are formidable obstacles which a potential plaintiff must overcome in establishing breach of the contractual obligations. 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 ... 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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10 Health and Safety at Work Act 2015, s 2.
11 *Attorney-General v Gilbert* [2002] 2 NZLR 342, [2002] ERNZ 31 (CA).
12 In the current Health and Safety at Work Act 2015, see ss 45-46.

...

> [88] The legislation requires the employer to do what is practicable to contain known and unacceptable risks. The statute seeks to prevent harm to employees by promoting health and safety management. The reasonableness of the employer's conduct must therefore be measured against knowledge reasonably attained by employers mindful of their responsibilities.

[42] Although this dicta involved a consideration of the "practicable steps" provisions of the Health and Safety in Employment Act 1992, the HSAW Act adopts the same test, as Mr Ballara properly accepted.[13] In my view, the *Gilbert* dicta continues to apply.[14]

Key facts

Background information

[43] ISL operates three particular residences which are in close proximity to each other; for the purposes of this judgment, I will refer to them as Residences 1, 2 and 3. The service user whose circumstances must be considered, Mr A, lives in Residence 2.

[44] Mr A suffers an intellectual disability. His behaviours can be very challenging; these may include shouting, swearing, verbal abuse, banging walls and throwing objects around, or physical aggression. He has a history of nocturnal issues. At a height of 195 cm, he can be very imposing.

[45] On the other hand, he enjoys chatting, laughing and joking, helping at the residence, and engaging in other activities which appeal to him.

[46] ISL developed and maintained support information relating to Mr A, which it is common ground needed to be followed. This included:

a) A behavioural support plan, which included high level information as to what to do in the event of adverse behaviour escalating; it referred to the possibility that Mr A may attempt to hit a staff member.

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13 Health and Safety at Work Act, s 22.

14 *Attorney-General v Gilbert*, above n 9. See also for example *Emmerson v Northland District Health Board* [2019] NZEmpC 34, (2019) 16 NZELR 590.

b) Personal support information, which included details of Mr A's bedtime routine and the need for consistency, and a general description as to how to provide support for reducing anxiety. This particular information was updated in May 2016.

c) An Alerts and Crisis Response document, which described particular forms of behaviour and how to deal with it, including responses required for disturbed sleep/wakeful nights, verbal aggression, or physical aggression. The responses to the last of these were:

> Say as you are walking away "I want to talk to you but not while you are yelling so I am leaving". Do not raise your voice. Talk even lower if necessary. Give [Mr A] time to calm down. Keep your personal space. Don't stand too close to him and *if he attempts to hit you*, use the approved Breakaway techniques taught by Behaviour Support. Remove yourself from the area. If necessary get in your car and leave the area. This is often only for 5 minutes. It is essential that you contact your [service manager] or the on call [service manager] at this time. Keep clear records for crossover staff.
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> (Emphasis added)

This document had been updated by Mr Brigham Anderson, the then service manager for Mr A, on 17 August 2016.

[47] Mr A required one-on-one care from support workers. Ms Davis was one of those, and she was experienced in the role. She first started working for ISL in 2013. By 2016 she was a Level 4 Support Worker, which denotes some seniority. Ms Davis also worked at one of the neighbouring residences for two years, prior to working at Residence 2. Thus, she knew Mr A before working in that residence in about mid-2016.

[48] Ms Davis had also received training on a range of relevant topics when she became an employee. In early 2015, she received "CPI" training, which relates to the identification of escalating behaviour, and physical breakaway techniques for self-defence purposes; these could be relevant if a service user becomes aggressive. Ms Davis undertook a refresher, for a further 12-month period, in February 2016.

[49] Ms Davis was site oriented by Mr Anderson with regard to Residence 2 in March 2016. An update of that training was given to her by Mr Anderson on 12 October 2016.

[50] Support workers were engaged for both day shifts and night shifts. The support worker was required to stay with Mr A for the duration of their shift, looking after his personal care (toileting and bathing), and taking him on visits. Daily tasks included cleaning, cooking, and ensuring any prescribed medications were taken.

[51] Staff were required to fill out a daily diary for their shift, which was kept at the residence; incoming staff were required to refer to the diary before their shift commenced. This was so they would know what had occurred during the previous shift and could take that into account.

[52] When an untoward event occurred, staff were required to write incident reports. These covered a wide range of issues. There are some 47 incident reports relating to Mr A for the period early January to early December 2016.

[53] Incident reports were reviewed twice weekly by service managers for all homes and services. Ms Kim Hildred, a service manager, explained that as many as 60 to 70 incident reports could be considered in a particular week, over a period of one to two hours. Any decisions made by service managers with regard to a particular service user were to be filtered back to support workers at the subject residence.

[54] It is evident from the particular incident reports which are before the Court that these documents were annotated over time, usually by Mr Anderson as the relevant service manager. His comments were often repeated on several incident reports, in brief form. This means that the piecing together of the chronology is not at times straight forward for any reader. Mr Anderson was not called to expand on the opinions he expressed in his brief notes.

[55] Some incident reports were not completely signed off until, often, weeks after the subject event. It appears that copies of those incident reports, showing the conclusions of service managers, were made available at the relevant residence for the

benefit of staff on the frontline, but it appears this occurred in some instances many weeks or even months after the relevant incident.

[56] Fortnightly team meetings were held at each residence at which a wide range of issues were discussed, including individual reviews/planning issues, service practices, and safety/risk management issues. Staff members who had not attended a meeting for a particular reason, were required to read and sign the minutes of those meetings, so that they were kept up-to-date with any developments.

[57] From time to time the area manager would attend those meetings. Ms Transom was appointed as the relevant area manager on 7 November 2016. Her previous experience involved working on health promotion and public health issues for a District Health Board. She had not previously been involved in the provision of services for the intellectually disabled. There was, however, an overlap with an acting area manager and Ms Transom of about a month, presumably to assist in her orientation.

[58] I turn to consider the evidence placed before the Court as to Mr A's behaviour over the course of 2016.

January to August 2016

[59] As already noted, there are many incident reports before the Court, which potentially contain a great deal of information which must be carefully analysed to assess the context of Ms Davis' allegations.

[60] I do not propose to record each and every adverse event with regard to the first half of 2016, other than to refer to a sequence of incident reports filed by or concerning Mr M, a support worker who cared for Mr A from time to time.[15]

[61] Mr M prepared five incident reports for the period 13 to 30 April 2016, in which he recorded Mr A as having been unusually aggressive, and where on one occasion he pushed another service worker. He was noted, on another occasion, as

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[15] Mr M did not give evidence, and as the evidence that was given about him was critical of some aspects of the care he administered, I have anonymised his name.

having been angry, aggressive, confrontational and abusive towards Mr M. At the time, Mr Anderson recorded on the incident reports that staff scheduling had not been consistent, and this had led to Mr A's aggressive behaviour.

[62] In late June, Mr M filed an incident report in which he said Mr A had refused to go to bed, had turned off heating in the residence, opened ranch-sliders, and was sitting in the lounge when it was cold. When Mr M went to close the doors, Mr A verbally abused him in an aggressive way; Mr M said this was dangerous for staff and the service users' health.

[63] Mr Anderson recorded he had discussed issues arising with the staff member, including the need to use non-verbal prompts, not to give Mr A coffee or tea at night, and to take Mr A for an evening drive.

[64] On 8 July 2016, Mr M made an abusive remark to Mr A, who subsequently threatened to hit him. Mr M was given a formal warning in respect of this incident.

[65] At the time, this sequence of events was regarded as involving particular interactions between Mr A and Mr M, rather than a more fundamental underlying problem.

[66] In August 2016, Mr Anderson filed a series of incident reports which related to wakefulness and difficulties in encouraging Mr A to go to bed. The conclusion was reached in respect of one of these incidents that Mr A had not expected Mr Anderson to be on shift, and this had caused anxiety.

[67] On 14 August 2016, Mr Anderson reported Mr A becoming angry and hitting a wall, whilst a nose hair trimmer was being used. This issue was discussed at a subsequent team meeting.

[68] At that point, the Alerts and Crisis Response document was updated, as summarised earlier, although what changes were made was not explained.[16]

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[16] See above at [46(c)].

[69] On 21 August 2016, Ms Davis reported an incident when Mr A has pushed Mr M, and yelled abuse at him. Subsequently, he punched Mr M on the shoulder. She was able to redirect Mr A away from any further confrontation with Mr M. She recorded that Mr A's behaviour had been very aggressive towards Mr M for quite some time, a matter she had referred to in previous incident reports. Ms Transom suggested in evidence this incident also arose in the context of Mr M not getting on with Mr A.

[70] Two incident reports were filed in relation to a further instance of physical aggression on 23 August 2016. This was described as Mr A being verbally aggressive and hitting staff on a changeover.

[71] Mr Anderson discussed the matter with those involved, and at a subsequent review meeting noted that Mr A was always upset at a changeover time.

[72] In mid-September 2016, a series of incident reports were filed as a result of unsettled behaviour after a relocation of the staffroom within the residence.

[73] An example relates to an incident which occurred on 27 September 2016. Ms Davis filed an incident report which recorded that Mr A had become highly agitated and threw items outside, when he was supposed to be going to bed. She did not consider any aggression had been directed at her. At a subsequent team meeting on 29 September 2016, it appears the incident was thought to be related to the relocation of the office.

[74] At the team meeting on 13 October 2016, attended by Mr Anderson, Ms Davis and other staff, as well as Mr A's father, there was a discussion that most staff were having trouble in getting Mr A to sleep at night. It was recorded that the words "tired", "sleep", "bed", and so on should not be used; and that staff should sleep on the staff bed, and not position themselves elsewhere in the residence with Mr A.

[75] On 14 October 2016, a bedtime incident occurred. Ms Davis was on duty. As she prepared to go to bed, Mr A objected. She then sat down in a chair and said she was going to watch TV. He grabbed her left arm very tightly. She asked him to remove his hand, but he would not. She then stood up and removed his hand. He started

yelling. When he would not lower his voice, she went to the office and locked herself in. He banged on the door for a while, then settled down. It was her assessment that Mr A seemed to be struggling for the right words to say; and that he was confused and frustrated with himself.

[76] A related incident occurred on 15 October 2016. Mr A was able to unlock the door of the office where Ms Davis was situated. He then moved away. Ms Davis said she believed the fact Mr A was not having sufficient sleep was having a huge effect on his mood. Mr Anderson also recorded that the staffroom door being closed at night was a trigger.

[77] Mr Anderson was on duty overnight from 15 to 17 October 2016 and filed several incident reports which again included reference to sleeping issues.

[78] On or about 18 October 2016, Mr Anderson recorded he had discussed these issues with Ms Davis, and Mr A's father, including the possibility of a referral to Explore, a third-party agency specialising in behavioural support. He also recorded that staff should leave the door of the staffroom open, since a closed door was a trigger for Mr A. Staff should pretend to be asleep in the room; Mr A would check the staff member, then go away.

[79] An incident involving Ms Davis occurred on 28 October 2016. She wrote a long account as to what had occurred. Again, there were sleeping difficulties, and an objection to Ms Davis sleeping in the staffroom. She attempted to divert Mr A in the living area. He remained agitated and threw books at her. She rang on-call, who asked her if she was safe and told her to get out of Mr A's range. She attempted to move back into the office, and Mr A became aggressive. She recorded that she tried to lock the office door "but it wouldn't lock". Mr A then burst through the door. He damaged items within the room. Ms Davis felt she had become trapped. He continued to direct abuse at her. A short time after Mr A left the room, he grabbed a fax machine and microwave to throw at her. She recorded that she exited the residence via the backdoor and went to Residence 3. By this time, the Police had been contacted. Ms Davis spoke to them, advising them not to attend as this would not provide any benefit. Mr Anderson attended, taking Mr A for a drive to settle him.

[80] Mr Anderson discussed the incident with Ms Davis, on-call staff, and Mr A's father, over succeeding days. It was agreed Mr A should attend a general practitioner (GP) for "sleeping and PRN options".

[81] Mr Anderson recorded on the incident report that the safety protocol in such circumstances was for staff to leave premises and go to another facility, and to call the Police/on-call staff member. He did not refer to other responses described in the Alerts and Crisis Response document, such as getting in a car and leaving the area.

[82] Mr Anderson also recorded that Ms Davis had asked to come off sleepovers for a little while. She said she then worked at a different facility for two to three weeks.

[83] On 29 October 2016 Mr Anderson was on duty, working with Mr A delivering pamphlets. There was an incident of verbal abuse, after Mr Anderson told Mr A his father would be on duty next. Commenting on this reaction, Mr Anderson noted that Mr A had not had much sleep over the past three to four weeks, and this was due to him refusing to sleep at night.

[84] Mr A attended his GP on 1 November 2016. An entry was made in the daily diary for that date that PRN 0.5mg Clonazepam was to be taken twice daily, although staff would need to ring on-call until a policy was available. Although it had been agreed Mr A would attend his GP for PRN options,[17] and sleeping options, no medication for the latter was prescribed. There is no evidence before the Court as to what information about Mr A's issues was provided to his GP; nor were relevant medical records as maintained by the GP made available.

[85] The Court was also advised that no drug administration chart was available. Details of the administration of Clonazepam must therefore be obtained from such references as are contained in the daily diary, incident reports, and in one instance a weekly meeting minute.

[86] On 3 November 2016, a support worker recorded Mr A being unsettled and agitated, perhaps because of roster issues. It was noted he had sworn and gesticulated

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17 PRN: pro re nata, as circumstances require.

at people at a public venue. In the incident report, it was recorded PRN 0.5mg Clonazepam had been administered at 2.00 pm. From this time onwards, Clonazepam was often given around the time of the afternoon changeover, apparently to calm Mr A at the time of that event.

[87] On the same day, a request was made for an assessment by the DHB Mental Health Team. The DHB declined to do so any earlier than the following February, when he was already scheduled for an assessment.

[88] On 10 November 2016, staff discussed "PRN medication", presumably a reference to the Clonazepam which had been prescribed. It was noted this was effective, taking about 20 minutes to operate with a calming effect.

[89] On 17 November 2016, a support worker noted that he was verbally abused by Mr A, on arrival, with "mass shouting as I approached the front door", which carried on for another 10 minutes. At the time it was not known what caused the incident. The incident was reviewed several months later; at some stage there was a discussion between the support worker and the area manager, when it was decided he would not return to work with Mr A.

Incidents from late November 2016

[90] The frequency of incident reports increased from 25 November 2016. On that day whilst on an outdoor activity, Mr A lost focus and had a near miss with traffic . Although the date of review may not have been until sometime later, Mr Anderson subsequently noted that sleeping was a concern, and this affected Mr A's behaviour.

[91] On 26 November 2016, at 2.45 pm, PRN medication, presumably Clonazepam, was given by Ms Davis. I infer that this was in anticipation of an upcoming handover.

[92] On the same day, there were three incident reports, all lodged by the same support worker who worked the sleepover shift following Ms Davis' morning shift. The issues were attributed to the fact a new staff member had assumed sleepover duties.

[93] In the first, Mr A was recorded as throwing items around, so that the staff member had to attend the neighbouring facility to enable Mr A to calm down. The problem was recorded on the incident report as involving Mr A being unhappy to see a new staff member taking over.

[94] The second incident report is timed for an event that occurred at 9.45 pm. Mr A was recorded as refusing to take his bedtime medications for seizure and nerve pain. Healthline was consulted, who advised that Mr A could not be forced to take these medications, but he should be observed for any consequences.

[95] At 10.20 pm the same support worker completed a third incident report in which he noted Mr A was upset and did not want staff to be around. The support worker consulted on-call staff, who advised he should go to the next-door residence until Mr A calmed down. Later, it was noted he had fallen asleep. On-call staff then authorised the support worker to return to the residence.

[96] On 28 November 2016, Ms Davis recorded that Mr A had a scalp rash, and that he would need to see a doctor. Mr A's father confirmed the appointment could take place that day. The daily diary records a new medication for these issues being prescribed. Again, there is no evidence as to whether the possibility of medication for nocturnal issues was raised.

[97] In the daily diary it is recorded Mr A started to elevate that night and "PRN", presumably Clonazepam, was given at 11.00 pm.

[98] The next day, 29 November 2016, Ms Davis reported an incident that occurred at 3.50 pm. She wrote that Mr A had become agitated throwing things around, slamming doors and swearing. A colleague had recommended by phone that Mr A's PRN, Clonazepam, be given. This occurred. Ms Davis noted on the incident report that this behaviour was "becoming a pattern".

[99] On 30 November 2016, a team meeting was held. The meeting was facilitated by Mr Brian Sami, a service manager, along with several support workers including Ms Davis; Mr Anderson was not present. Ms Transom said she also attended, although

this was not recorded. It was agreed that start times for overnight shifts would in weekends be changed from 3.00 pm to 4.00 pm. Protocols for the administration of PRN Clonazepam were discussed, since Mr A was becoming agitated before shifts and at bedtime. The protocol stated Clonazepam would be administered at 3.00 pm, an hour before the commencement of the sleepover shift. It was also noted that a referral had been made for Mr A to see a psychiatrist.

[100] At 3.00 pm on 1 December 2016, 0.5 mg Clonazepam was given. This was presumably under the protocol just discussed.

[101] No incident reports were completed for Friday, 2 December 2016. Mr A's behaviour on that day was, according to the daily diary, positive, apart from the fact that in the evening he did not wish to sleep in his bed despite staff attempting to encourage him to do so; he wished to stay in his chair. It was also recorded that he started to get uptight when staff themselves wished to retire to bed.

Saturday, 3 December 2016

[102] At 4.00 pm on Saturday, 3 December 2016, Mr Phillip Murray, a support worker, was assaulted by Mr A. An incident report was prepared later that day; this was noted as having been received by management on 6 December 2016.

[103] In the report, Mr Murray recorded that when he arrived at Residence 3 Mr A came outside and started swearing at him. When Mr Murray walked past him, Mr A punched him in the shoulder from behind. Whilst reading relevant entries as part of the handover, Mr A seized the diaries he was reading, and hit Mr Murray on the head with them. Mr Murray then accompanied the staff member he was replacing to her vehicle, at which point Mr A came from behind and punched him in the lower back, and then again inside the facility with such force as to cause him to hit a wall outside the office.

[104] After more similar behaviour, Mr Murray telephoned on-call staff; he was told to leave the residence and go to the neighbouring facility because Mr A was not going to stop attacking him. He did so and observed Mr A from that position. He was

contacted by on-call staff twice who advised they were attempting to obtain relief staff; otherwise Mr A's father would be asked to come and pick him up. This happened.

[105] In the subsequent review, which was undertaken on the following Tuesday, it was noted Mr Murray had attempted to defuse the situation, but Mr A's aggression had switched from verbal to physical quickly. In the debriefing, Mr Murray said he would work at the residence again, but safety issues needed addressing. An investigation of this incident was carried out by a Senior Service Manager, Ms Linda Hudson, on Thursday 8 December 2016.

[106] Above Mr Murray's signature on the incident report is recorded his opinion that behavioural issues had occurred due to a continual change in staff being rostered to work with Mr A at his residence.

[107] In the daily diary for that day, a very brief summary of these events was recorded. It stated Mr A had been given PRN at 2.00 pm, that Mr Murray had been assaulted by Mr A, that on-call staff had been rung, and that Mr A's father had been called in.

4-5 December 2016

[108] Ms Davis was rostered to work a sleepover shift on Sunday, 4 December to Monday 5 December 2016. It appears this was the first sleepover shift she had undertaken since the incident which occurred on 28 November 2016.

[109] She commenced her shift at 3.00 pm, but Mr A was away from his residence. She therefore waited at the next-door residence until 3.45 pm. Then she went to Residence 2 and commenced preparing Mr A's evening meal. At about 4.00 pm, he returned with the service worker who had worked the previous shift. Ms Davis was given a handover. She asked about Mr A's PRN administration. She discussed with her colleague whether it should be given to Mr A then. Ms Davis said Mr A appeared to be a little grumpy. Her approach was that if PRN Clonazepam was needed, she would administer it.

[110] At about 5.30 pm, Mr A was noted as being grumpy. After he had taken a shower, Ms Davis administered Clonazepam at about 6.30 pm.

[111] At about 10.00 pm, when preparing to go to bed, Mr A became uptight saying "You can't sleep in that bed". He began opening doors of the residence, turning on lights and "ranting". Ms Davis therefore decided to remain seated in the lounge, which appeared to calm the situation. However, a second administration of Clonazepam was given at 12.40 am because, as reported to on-call staff, Mr A was "starting to wind up".

[112] Mr A slept for 20 minutes; then he awoke and became angry instantly. He began throwing items out of the residence. Ms Davis left, going to Residence 1.

[113] From there, she spoke by phone to Ms R, a service manager, who was available on-call.[18] Over the next half hour, there were three calls, the contents of which were duly recorded.

[114] The first was at 2.34 am for three minutes, when Ms Davis described the events which had occurred.

[115] The second was at 2.42 am, when Ms Davis spoke to Ms R for some 16 minutes. In the course of that call it was noted Ms Davis could still hear Mr A, who had now come over and was standing at the end of the residence at which Ms Davis was positioned. Ms R told her to observe Mr A from her location.

[116] The third took place at 3.09 am which continued for four minutes. Ms R recorded that Mr A had returned to Residence 2. She told Ms Davis she would come out to assist her. She did so. Then Ms R and Ms Davis returned to Residence 2, at which point Mr A came out of the residence. He was aggressive at first. However, he settled and assisted in the picking up of furniture and photos which had been thrown outside, as it was by this time raining.

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[18] Ms R was not called as a witness; I have accordingly anonymised her identity on the same basis as for Mr M.

[117] Just before 4.30 am, Ms R asked Ms Davis if it was okay for her to leave, as Mr A had settled. Ms Davis agreed to this.

[118] Soon after, at 4.36 am, Ms Davis phoned Ms R in response to a text, stating that Mr A seemed to have settled. There is no evidence that he was sleeping.

[119] About 30 minutes later, the situation deteriorated. Mr A's conduct escalated again with him ranting and throwing items out of the residence. Ms Davis was hit in the head by some footwear. She decided she should proceed to the next-door facility. Mr A saw her and began chasing her. She ran towards Residence 3. On arrival she banged on the door asking to be let in. Because Mr A was nearby, she attempted to evade him by running around the residence, but he followed her. He picked up items to throw at her. She again attempted to attract attention by banging on the wall of Residence 3.

[120] On the second lap, Mr A caught up with Ms Davis and tackled her to the ground. She was winded. Mr A fell when assaulting her. He then stood up and began hitting her around the head, shoulder and arm. Ms Davis lost consciousness briefly.

[121] During this incident, the support worker in Residence 3, Mr Nicolas Corrigan, woke to hear Ms Davis screaming and banging on the residence wall. He attempted to locate her; he saw Mr A chasing Ms Davis, then pushing her to the ground. He immediately ran towards Mr A and engaged him in conversation to direct him away from Ms Davis; he then led Mr A to a different area.

[122] Then Mr Corrigan returned to Ms Davis' location to find her lying motionless and not making any noise. Ms Davis responded verbally, and he assisted her by guiding her inside Residence 3. He locked the residence and closed its curtains to mitigate the possibility of a further assault.

[123] Ms Davis then stated she needed an ambulance, so Mr Corrigan telephoned for one. Police were called as well. Mr A continued to bang at the windows and yell. By this time, the two service users in Residence 3 had been woken. Mr Corrigan and Ms Davis took steps, as they could, to calm them.

[124] Ambulance staff then arrived, taking Ms Davis to the Emergency Department at a local hospital. It was there recorded that she had been assaulted by a client who had caused concussion, and soft-tissue injury to her right shoulder and right hip. She was, however, certified able to resume full duties, and discharged.

[125] Although no evidence was presented on the point, in the absence of any evidence to the contrary, I infer Mr A was managed appropriately upon returning to his residence.

Subsequent events

[126] Mr A's circumstances then became the subject of significant review. On 7 December 2016, a team meeting was held at which a new safety plan for Mr A was discussed and recorded. It was noted that if angry, he was more likely to throw objects at staff. If staff needed to move away quickly, they should not run in a straight line. If Mr A was angry or upset, it would be necessary to tell him the staff member would be going out of the home until he was calm. A staff member would need to exit through the sliding doors and proceed to Residence 3. If Mr A had chased the staff member, or had thrown objects, Police and on-call staff should be called from a safe location. A work cell phone should be charged and kept by the staff member at all times.

[127] It was recorded in the same minutes that a new medication, Zopiclone, to assist Mr A to sleep, had been given on the evening of 6 December 2016. This was positive, in that Mr A went to bed about 10.30 pm and woke at 7.30 am the next morning. It was recorded that arrangements had been made for Mr A to see a psychiatrist. Annotations were made on numerous recent incident reports to the same effect.

[128] Ms Hudson then conducted an investigation into the assault of Ms Davis. In her notes of 8 December 2016, she briefly outlined the incident. She said that interviews with relevant staff confirmed there were "huge concerns about risk to other staff". A key finding was that Mr A's behaviour had now escalated to physical assaults of staff. He had not been sleeping well, but night mediation from a doctor had now been obtained.

[129] She recorded that leaving the residence had worked well for the incident. Other steps needed to be taken, including updating support information, providing a safety plan, and involving external agencies such as meeting with Explore and the Mental Health Disability Team. Consultations had been arranged for 15 and 20 December 2016 respectively.

[130] As mentioned earlier, between late December 2016 and mid-January 2017, there were exchanges between Ms Reid and Ms Transom as to steps that needed to be taken by way of follow-up to the incident. Consideration was given to double-staffing, moving Mr A to another location, and/or modifications to his home. As well as the steps referred to above, more staff training was ultimately undertaken; further psychiatric and other assessments of Mr A were performed, and significant physical modifications were made to Mr A's residence.

The subsequent incident in February 2017

[131] On 14 February 2017, Ms Davis by chance and while not at work, met Mr A and his support worker Ms Joe Ward at a Hospice Shop. This was an aspect of his community/vocational programme, which provided for supervised activities in the community.

[132] Ms Davis had understandably been traumatised by the incident which occurred on 5 December 2016; this further incident was also stressful. In a consultation with a Specialist Occupational Physician Prepared for Ideas Insurer, Work AON, on 26 July 2017 Ms Davis reported that she was cornered in this shop, and that Mr A had "shoved her against the wall". She said she had been doing quite well up to that point, but this had made her shaky and fearful. She felt her concerns about staff safety were not being listened to, and that they were being placed at risk with the individual. She said the Police would not charge him because of his particular condition.

Consequences for Ms Davis

[133] Ms Davis described the ongoing consequences she suffered. She sustained physical injuries. She said her confidence had been hugely affected, which had impacted on her trust of others.

[134] After a long period off work, Ms Davis began working part-time for ISL, for about two hours a week. This was increased to four hours a week subsequently. From May to September 2018, she was not allocated regular shifts, but worked at a variety of locations. She ceased working for ISL in November 2019, as she was no longer physically able to conduct the work required of her, due to injuries inflicted by Mr A. She has been on the unemployment benefit since.

[135] Medical records were produced including from an orthopaedic surgeon, a specialist occupational physician, and a psychiatrist. It suffices to say that Ms Davis was diagnosed with a possible post-traumatic stress disorder with associated fear and anxiety, major depression which had been catalysed by the assault, a right-shoulder sprain which triggered an underlying degeneration, concussion which had been resolved, and possible spinal injuries/pathology, which required further consideration.

Analysis

[136] It is common ground that the essence of the problem before the Court is whether ISL's health and safety obligations, as owed to Ms Davis, were adequately discharged.

[137] In summary, Mr Meikle, counsel for Ms Davis, argued that Mr A demonstrated an escalating pattern of aggressive behaviour which placed staff at risk, including Ms Davis, and that she had suffered significant disadvantage.

[138] For ISL, Mr Ballara submitted in summary that although there were discrete examples of aggressive behaviour, there was no escalating pattern. Moreover, there were no red flags suggesting the systems and processes which had been developed over time were inadequate. In essence, Ms Davis as an experienced support worker, also held health and safety responsibilities; she unfortunately placed herself at risk.

[139] The starting point is the Alerts and Crisis Response document, which was updated on 17 August 2016. One of the alerts it identified was "physical aggression". It was expressly noted that Mr A may attempt to hit a staff member.[19] In such a case,

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[19] See above at para [46].

the staff member was advised to either use approved breakaway techniques; or remove themselves from the area, if necessary by car, and to contact on-call staff. From this document, I conclude it was clearly known Mr A could be physically aggressive to staff. However, as from that date, the level of aggression was described only as an "attempt to hit a staff member". The safety plan was framed on that basis.

[140] Turning to the circumstances leading up to 5 December 2016, I focus on the question as to whether there was a discernible escalating pattern of aggressive behaviour.

[141] I begin with the events which occurred from mid-October onwards, although these must be considered against the background of aggression directed at staff earlier in the year, particularly Mr M.

[142] At the team meeting held on 13 October 2016, which was attended by Mr Anderson and support workers and also Mr A's father, reference was made to the fact that most staff were having trouble getting Mr A to sleep at night. Ms Davis said in evidence that the situation had become sufficiently serious that the staff were maintaining sleep charts. At the time, it was thought the relocation of the staff room had led to bedtime issues.

[143] There is some evidence to suggest that Mr A had suffered previously from sleep apnoea, and that he had previously attended a sleep clinic. This was referred to in the later letter from Ms Reid to Ms Transom of 7 March 2017, and not challenged at the time or at the hearing. No further details were provided, and this evidence can only be considered as general background.

[144] At team meetings up to this time, the importance of consistency in the approach to Mr A's bedtime protocol to prevent night-time behavioural escalations was emphasised.

[145] However, problems continued. There was an incident on 14 October 2016 at Mr A's bedtime. Ms Davis recorded that Mr A grabbed her left arm very tightly.

Because of his reaction, it was necessary for her to lock herself in the office of the residence.

[146] On succeeding nights, from 15 to 17 October 2016, Mr Anderson was on duty and was able to observe the issues for himself. He then discussed the sleeping problems with Ms Davis, and also Mr A's father, raising the possibility of a referral to the third-party agency specialising in behavioural support, Explore. This was not able to take place immediately.

[147] A yet further night-time incident occurred on 28 October 2016 when Mr A became aggressive by throwing books at her. After discussing this incident with Ms Davis, on-call staff and Mr A's father, it was agreed Mr A should attend his GP for sleeping and PRN options. As indicated earlier, Clonazepam was prescribed on a PRN basis, but not night medication.

[148] Staff continued to be concerned. Following a further incident on 3 November 2016 when Mr A was unsettled and agitated, perhaps because of the rostering of multiple staff, a referral was made to the DHB Mental Health Disability Team. Again, a prompt appointment was not able to be arranged.

[149] Mr A attended his GP on 28 November 2016, but the focus of that consultation appears to have been on skin and rash issues.

[150] By the end of November, Clonazepam was being used to help settle Mr A, especially at a handover. There is no evidence that this medication was intended to address the problem of sleeplessness.

[151] No explanation was provided to the Court as to why the issue of sleep medication was not addressed. The events to that point strongly suggest a pattern of sleep deprivation, which staff recorded affected Mr A's mood and impacted on his behaviour. There was an obvious need to address this issue.

[152] In that context, the concerns were such that two external referrals were made, but as noted these could not take place immediately. It had been suggested that the

possibility of night-time medication be raised with the GP, but there is no evidence before the Court that this happened at the first GP consultation on 1 November 2016, or at the second which took place on 28 November 2016. It has not been explained why this did not occur.

[153] I conclude that by late November 2016, a fair and reasonable employer could be expected to have followed up on the issue of night-time medication, especially where appointments with external agencies could not be obtained in the meantime.

[154] I refer to Ms Transom's evidence that particular incidents to which I have referred were explicable because there had not been sufficient adherence to the relevant protocols by individual support workers. That may have been a factor in respect of the incidents involving Mr M. However, the same cannot be said concerning subsequent events. By November, circumstances had obviously changed.

[155] Given her relatively recent appointment, Ms Transom's view that particular incidents demonstrated a failure to follow protocols is perhaps understandable; however, I do not consider her opinion acknowledges sufficiently the clear picture which is evident from a careful analysis of the incident reports. They obviously suggest deteriorating behaviour arising from significant and ongoing sleep deprivation.

[156] Coming forward to the events of late November and early December 2016, problematic behaviour continued. In the incident report which Ms Davis completed on 29 November 2016, she recorded that a pattern was emerging of Mr A becoming agitated, throwing things around, slamming doors and swearing.

[157] The same theme is evident from notes of a team meeting which took place on 30 November 2016, when it was recorded Mr A was becoming agitated before shifts and at bedtime.

[158] It was thus determined that Clonazepam should be administered at 3.00 pm, an hour before a change of shift to staff who would care for Mr A overnight. It must be recognised, however, this was not a complete answer, because the assessments sought

from Explore, and the DHB Mental Health Disability Team, were still some way off. Moreover, it could not have been expected to be a substitute for night-time medication.

[159] The circumstances which pertained at that time were confirmed by an entry made on the incident report relating to the 29 November incident; Mr Anderson recorded that "non-sleeping" was a concern and that the lack of it was affecting Mr A's behaviour. This was an observation he had made previously. I have no doubt Ms Davis was also concerned about what she described in the incident report as a "pattern" of concerning behaviour.

[160] I turn next to the incident of Saturday, 3 December 2016 involving Mr Murray. This event was a significant red flag. As described, he was assaulted. This was put down to change of staff issues – it appears Mr Murray had not worked previously with Mr A, at least in the later part of 2016. The matter was sufficiently serious for Mr Murray to lay a complaint with Police.

[161] He had felt it necessary to remove himself from Residence 2, which was obviously a significant step. This was the second time within a relatively short period where a staff member had to do so. As noted earlier, Mr Murray recorded on the incident report that there were staff safety issues which needed addressing.

[162] Despite the seriousness of the incident, there is no evidence that senior staff became involved in the matter over the weekend. The incident report is annotated as not having been received until Tuesday, 6 December 2016. However, on-call staff were contacted at the time, and Mr A's father was called in. No information was provided to the Court as to the steps taken at that time. Despite the severity of the circumstances, these contacts did not lead to management obtaining the incident report quickly, or to an immediate review of Mr A's care arrangements.

[163] In my view, a fair and reasonable employer could be expected to regard these events as sufficiently serious as to warrant an immediate consideration of Mr A's care arrangements. It was apparent his level of aggression had increased from that described in the Alerts and Crisis Response document.

[164] Although a one-line reference was placed in the daily diary confirming Mr Murray had been assaulted, and that on-call staff and Mr A's father had become involved, it is unclear if any further information was available to Ms Davis at the time of the handover to her on 4 December 2016. Certainly, there is no evidence that she was warned that Mr A's behaviour had escalated to the point where safety issues needed to be addressed.

[165] I also note that Mr Corrigan, who was on the 4/5 December overnight shift at Residence 3, recorded in his notes that he had been unaware of the incident concerning Mr Murray which occurred on the previous day. This reinforces the conclusion that handover arrangements after the incident involving Mr Murray were limited.

[166] The events which unfolded on the overnight shift at Residence 2 were very challenging. Mr A was noted as being "very tired". The only medication available was Clonazepam. Ms Davis was criticised for the fact that this medication was not administered prior to the changeover. It was, however, administered at several subsequent stages of her shift. There is no evidence that the timing of the Clonazepam administration contributed to the aggressive behaviour which occurred; or that an earlier administration would have mitigated the later aggression. It was given on a PRN basis, as apparently prescribed.

[167] Rather, the evidence suggests that Mr A's behaviour was due to his well-established sleep issues, and perhaps as a reaction to Ms Davis returning as an overnight support worker.

[168] I am not persuaded that Ms Davis' reaction to these circumstances were due to failures of judgement on her part. Indeed, in the subsequent review, a senior service manager concluded: "the whole incident was handled well by this staff member". There was no suggestion, in that review, that Ms Davis should have taken all the steps referred to at the hearing, such as using her car to get away. These were points made in hindsight at the hearing, without sufficient regard to the contemporaneous evidence. Nor is it contended Ms Davis failed to follow her training, which in respect of relevant modules was up to date.

[169] It was also recorded on the incident report that the Mental Health Team had recommended to Mr A's GP that Zopiclone – a well-known night-time medication – be administered and that on 6 December 2016 this had an "immediate positive effect". This outcome was foreseeable.

[170] The parties debated the question of whether it was appropriate for Ms Davis to return to Mr A's residence, when this possibility was raised by Ms R. She was not called as a witness by ISL. The Court has been presented with little evidence as to the extent of Ms R's awareness of all the circumstances, including the incident concerning Mr Murray. It can certainly be said that a fair and reasonable employer through a senior support worker, properly appraised of all of the circumstances including the background events, could not have presented Ms Davis with the option of returning to Residence 2. I note that when Mr Murray had departed Residence 2 the night before, he had not been asked to resume his duties; Mr A's father had been called in to manage him. However, I put those issues to one side, since there is no evidence as to the extent of Ms R's knowledge.

[171] I deal briefly with several remaining matters. The first relates to whether there had been a failure to fix a lock on the staff room door. I am not satisfied that this was a live issue on 5 December 2016. Retreat to the staff room was not a prescribed step in the Alerts and Crisis Response document. Nor is there any contemporaneous evidence to confirm there was an outstanding issue as to the lock, after the incident on 28 October 2016 when Ms Davis had trouble locking the staff room door.

[172] Next, I consider whether ISL should have reported the matter to WorkSafe, having regard to the obligations of notification under the Health and Safety at Work Act 2015. As Mr Ballara submitted, Ms Davis was not admitted to hospital, but was seen at the Accident and Emergency Department, and then discharged. Arguably, in those circumstances there was not a notifiable injury, and such an obligation did not arise.

[173] The final issue relates to the interaction that occurred on 14 February 2017, at a Hospice shop. At the time of the incident, Ms Davis was not "at work".[20] The

[20] A disadvantage grievance generally relates to an "on the job" situation: *Henderson v Nelson*

meeting occurred entirely by chance. I accept, however, that it understandably aggravated Ms Davis' distress. But I am not satisfied that this unfortunate event could be put down to a breach of health and safety obligations, when it was not in any way foreseeable.

[174] On the evidence I have reviewed, I conclude that ISL's health and safety obligations were not adequately discharged, and that the steps either taken or not taken before 4/5 December 2016, were not those of a fair and reasonable employer.

[175] I record that ISL did take appropriate steps thereafter, but by then the assault had occurred.

[176] I am satisfied that having regard to the injuries sustained by Ms Davis she suffered significant disadvantage.

[177] This finding deals in substance with most of the pleaded breaches referred to in the statement of claim with regard to the disadvantage grievance. Those findings also establish the elements of the contract cause of action.[21]

Result

[178] The disadvantage grievance is established. I declare that the steps which ISL took were not those of a fair and reasonable employer. They were insufficient. Disadvantage was suffered which included injuries and significant stress.

[179] Alternatively, the health and safety obligations set out in the CEA were breached.

[180] I set aside the Authority's determination.

[181] Ms Davis is entitled to costs, which are reserved. My provisional view is that the appropriate costs classifications are 2B. The issue of costs should, if possible, be

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Marlborough District Health Board [2016] NZEmpC 123 at [75]–[77].

21 At [34](a), (b), (d), (e) and (f)].

resolved directly between the parties. If an application is necessary, it should be filed and served by 29 January 2021, with a response filed by 12 February 2021.

B A Corkill
Judge

Judgment signed at 3.45 pm on 11 December 2020