

ATTENTION IS DRAWN TO THE  
ORDER APPEARING ON P. 8 & 20  
PROHIBITING PUBLICATION OF  
CERTAIN INFORMATION CONTAINED  
IN THIS DECISION.

Determination Number: WA148/04

File Number: WEA 333/04

*Under the Employment Relations Act 2000*

**BEFORE THE EMPLOYMENT RELATIONS AUTHORITY  
WELLINGTON OFFICE**

**BETWEEN**

David Hotop (applicant)

**AND**

Chief Executive of the Department of  
Corrections (respondent)

**REPRESENTATIVES**

Phillip Drummond for the applicant  
Charles Chauvel & Emma Watson for the  
respondent

**MEMBER OF THE AUTHORITY**

Denis Asher

**INVESTIGATION MEETING**

Palmerston North, 21 & 22 October 2004;  
closing argument 29 October and 1  
November 2004

**DATE OF DETERMINATION**

3 November 2004

**DETERMINATION OF AUTHORITY**

**Employment Relationship Problem**

1. By way of an urgent application for interim reinstatement the applicant, David Hotop, alleged he had been unjustifiably dismissed by the respondent (the Department) – statement of problem received on 8 September 2004. He also sought compensation

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for lost wages and benefits and compensation for humiliation, etc of \$15,000 and costs.

2. During a telephone conference call convened on the same day the parties agreed to undertake mediation on 17 September. Mediation did not resolve the employment relationship problem. Consistent with the arrangements agreed to during the 8 September conference, a two-day investigation into the substantive employment relationship problem commencing on 21 October was convened.
3. The Department filed its statement in reply on 22 September. It says Mr Hotop's employment was justifiably terminated for serious misconduct.

### **Investigation**

4. The parties usefully supplied in advance of the investigation written statements and an agreed bundle of documents as well as chronologies of key events.
5. At the conclusion of the investigation, agreement was reached on a timetabling of closing argument.
6. Efforts by the parties after the investigation to settle the problem on their on terms were, unfortunately, not successful.

### **Background**

7. The parties agree that there is little disagreement between them as to the key facts and events but that they differ markedly as to the interpretation of those matters. The key facts can be summarised as follows:

### **The respondent**

8. The Department is responsible for, amongst other things, the operation of the New Zealand public prison service.

9. The Department's Policy and Procedure Manual (the PPM – document A21) sets out a national policy in respect of the admission of inmates. It requires amongst other things that,

*Every effort is to be made to identify inmates at risk and manage them to minimise their risk of self-harm.*

(and)

**Performance Standards**

1. *On reception at the receiving office or in the most suitable location prior to the inmate being secured in cell accommodation, inmates are assessed and their at risk status identified.*
10. The assessment is primarily undertaken by way of a New Arrival Risk Assessment (NARA). The NARA is required of each new inmate within 4 hours of their reception (B.14.01, above). It is a requirement that the responses contained in the NARA are then cross-referenced with other information from the inmate's file, including any previous at risk assessments and histories of alerts.
11. The NARA provides that,
4. *Where there are two or more "yes" answers (to the NARA) or at the discretion of the assessor that the inmate is deemed at risk of self harm ... the inmate is classified as at risk and the Unit Manager/On Call Officer ... is advised immediately.*
12. At that point,
5. *The inmate is placed on observation at intervals of not more than 15 minutes.*
  6. *An at risk inmate's placement is decided immediately following at risk assessment and action taken to meet ... (their) needs.*
13. Other requirements surrounding the NARA include the following:
7. *Consultation must be undertaken by the Unit Manager/On Call Manager ... with the appropriate support person(s) skilled in assessing an inmate's at risk status, to determine whether or not the inmate continues to be managed as an "at risk" inmate.*



8. (and)

- o *If the inmate is deemed at risk, the Unit Manager/On Call Manager ... completes a management plan including an observation regime.*

(and)

***Officer Receiving Inmate***

(and)

2. *If an inmate is considered to be at risk, inform unit manager/on call officer immediately.*

***Unit Manager Delegated Officer***

1. *Decide immediate placement to ensure the inmate's safety*
2. *Address inmate's immediate needs wherever possible.*
3. *Consult with appropriately skilled personnel (Nurses ... ) to determine the degree of risk.*
4. *Note the result of the consultation on the (NARA).*

***Unit Manager***

*Decide whether the inmate is at risk*

***Sources of Further Information***

*Previous history if necessary*

14. All of the quotations set out above are taken from the PPM at B.14 and B.14.01, Procedure (document A21).
15. The application of this policy at Manawatu Prison itself is set out in an Identification and Management Procedure (the IMP – document A22). It provides amongst other things that,

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**ALL RECEPTIONS INTO MANAWATU PRISON**

*The Team Leader Unit 1 will be responsible for ensuring **all** receptions into Manawatu Prison are interviewed and the appropriate forms completed.*

*There will be no delay between the inmate arrival and processing into Unit 1.*

(and)

*The risk assessment is to be actioned immediately for those inmates even suspected of being at risk, i.e. Police, ... information.*

- a) *Immediate Needs Checklist (AO6.01.F1)*
- b) *New Arrival Risk Assessment (B14.01.F1)*

*The inmate is deemed to be at risk:*

- *If there are two or more "Yes" answers on this form.*
- *If the interviewing office for any other reason believes the inmate is at risk but has less than two "yes" answers.*

*They are deemed to be "at risk" until assessed by the appropriate support personnel (either medical staff or a Unit Manager)*

16. The IMP also includes an outline and guide to the role and responsibilities of the On Call Officer. Two examples of the outline were produced – one that applied at the time of the applicant's dismissal and another implemented some time after that date (document A 22).
17. The example applying to Mr Hotop at the time of his dismissal required, amongst other things, that:

*The CSU PCO is responsible for ensuring that the (NARA) is completed for **all** receptions.*

**Responsibility**

*Upon receiving "at risk" notification from the CSU PCO the On Call Officer is required to ... assess (the inmate) etc.*

(and)

*The CSU PCO ... is responsible for activating an 'at risk' file and developing a management plan ...*

### **The applicant**

18. Mr Hotop commenced employment as a prison or corrections officer with the Department in 1990.
19. In 2002 he was appointed to the position of Unit Manager, Manawatu Prison. His terms and conditions of employment were set out in an individual employment agreement (document A5 in the agreed bundle).
20. Part of Mr Hotop's manager duties included carrying out on call duties. Those duties encompass out of hours management of the prison and are rostered about every 6-7 weeks.

### **Events Leading to the Dismissal**

21. Mr Hotop was the rostered On Call Manager for Manawatu Prison on Saturday 12 July 2003.
22. At around 1.45 pm that day he made a routine visit to the prison as part of his normal duties. On his arrival he was informed by the 6 am – 2 pm CSU PCO (the 1<sup>st</sup> PCO) that a new reception (the inmate) was required to go to town for a medical check up. It was explained to the applicant that the inmate had been hitting his head in Police cells immediately prior to his admittance to the prison and that, consequently, the prison nurse wanted a doctor to assess the inmate's condition.
23. As it subsequently transpired, and seemingly contrary to clear PPM and IMP requirements, Mr Hotop was not advised by the 1<sup>st</sup> PCO of what the Department accepts was compelling written and oral advice he had received from the Police of their concern that the inmate was at serious risk of self-harm, i.e. of suicide.
24. Despite the accepted forcefulness of the Police advice as to the inmate's serious risk of self-harm, the 1<sup>st</sup> PCO placed the inmate on 30 minute observations rather than the 15 minute observations for inmates deemed to be at risk.

SEAL OF THE EMPLOYER

25. Apart from advising Mr Hotop that the inmate was on 30-minute medical observations and that a medical escort was required, no other information was advanced to the applicant.
26. Mr Hotop approved an escort outing for the inmate. The time of 5.00 pm that evening was decided on because of staff shortages.
27. At the same time as Mr Hotop was approving the escort, and in his presence, the 6 am – 2 pm staff carried out a shift handover with the 2 pm – 10 pm shift. This included the 1<sup>st</sup> PCO handing over to a 2<sup>nd</sup> PCO.
28. The 2<sup>nd</sup> PCO and another officer (the 3<sup>rd</sup> officer) subsequently undertook a NARA of the inmate. As it happened, he answered positively the six questions asked of him. Despite those answers and the clear requirements of the PPM and the IMP to regard the inmate as at risk and place him on 15 minute observations and advise the Call Out Manager, the officers retained the inmate on 30 minute observations and did not inform Mr Hotop of the inmate's answers or his (in terms of the PPM and IMP) at risk status.
29. After completing his approval for the escort outing of the inmate the applicant proceeded as required on a routine visit of the prison. While entering B Block Mr Hotop observed the inmate being interviewed by the 3<sup>rd</sup> officer. Mr Hotop asked the 3<sup>rd</sup> officer if there were any issues and was told that everything was fine. Mr Hotop observed the inmate and spoke briefly to him. The applicant repeated to the Authority what he had told the Department during its investigation, that neither the inmate's appearance nor his response to his inquiry gave him – Mr Hotop – any cause for alarm.
30. During the Authority's investigation it emerged that the applicant knew the inmate from previous admissions to Manawatu Prison. Because of that prior knowledge Mr Hotop took the precaution of instructing staff to ensure the inmate was always escorted by two officers. This initiative resulted from the applicant's awareness that the inmate had previously assaulted a corrections officer.

31. Mr Hotop confirmed to the Authority that the inmate had not previously been classified as at risk during his periods of prior imprisonment at Manawatu Prison.
32. Shortly afterward Mr Hotop received advice about another new reception. Another officer reported his concerns to the applicant that the other new reception had two positive answers on his NARA. Consistent with departmental policy the applicant satisfied himself that observations every 30 minutes were appropriate for the other new reception.
33. Some time later Mr Hotop received telephoned advice from the 2<sup>nd</sup> PCO that the two newly arrived inmates were on 30 minute observations; the applicant received no other information.
34. It later emerged that not only had Prison staff elected to place the inmate on 30 minute observations, notwithstanding the accepted strong advice from the Police as to their concerns about the inmate's risk of self-harm and the at risk requirements of the PPM and IMP, but the inmate was kept on 30 minute observations even after (as is made clear in par 28 above – and despite the express requirements of the PPM and IMP) – he gave 6 positive answers to the NARA when two are deemed sufficient to require an inmate to be placed on 15 minute observations.
35. Fatally, it is accepted by the Department that the inmate was also provided with non-standard clothing. Part of that clothing apparently contributed to his death. The decision to issue non standard clothing and the matters outlined above were not conveyed to Mr Hotop prior to the inmate's death despite the clear requirements of the PPM and IMP that, as the rostered On Call Manager, he be advised.
36. The Department agrees that, at the time it dismissed Mr Hotop, it was aware that – in breach of the requirements of the PPM and the IMP – the applicant had not been advised by other staff of what it accepted were powerful written and oral warnings from the Police that they believed the inmate was at serious if not extreme risk of self-harm, i.e. of attempting suicide, or that the inmate had answer positively to the 6 questions set out in the NARA form (when two positive answers are sufficient to require an inmate to be considered a serious risk of self-harm and be placed on 15 minute observations).

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37. Later that afternoon Mr Hotop received a phone call advising him that there was an incident at the prison and he was required to attend immediately. While driving back to the prison Mr Hotop was advised that one of the newly arrived inmates had been found hanging in his cell. On arrival at the prison the applicant was informed of the death of that inmate.
38. Two days after the inmate's death the Department's relevant regional manager, Peter Grant, commenced an investigation process. The process ran for one year and three days before culminating in the applicant's dismissal on 15 July 2004. The process included a number of reports (three commissioned by Mr Grant – documents A10, 12 & 19; and a separate report to the chief executive – document A17) and several meetings between the parties.
39. A number of the factual findings of the reports were contested at the time by the applicant (refer to his email of 4 May 2004 – document 13). As is made clear in par. 7 above there is now little if any dispute between the parties as to key factual events – they differ only in respect of the interpretation of those events.
40. By letter dated 9 July 2004 (document B6) Mr Grant determined the applicant had breached the second principle of the Department of Correction's Code of Conduct, i.e.:

*Employees should perform their duties honestly, faithfully and efficiently respecting the rights of the public, colleagues and offenders.*

*You should carry out your duties in an efficient and competent manner in compliance with the policies and prescribed operating standards and procedures of the Department.*

41. Specifically, Mr Grant found the applicant had committed:

*... serious misconduct "an act of negligence or unsafe practice which seriously affects security, safety or health of employees, contractors or members of the public in the workplace" by your actions in that:*

- (1) *You endorsed the management plan for (the inmate), and in doing so you accepted full responsibility for his management. In signing off and backdating the management plan you further acknowledged acceptance of the plan. In endorsing this plan which maintained (the*

*inmate) on 30 minute observations, you did not take proper account of the risk status of the inmate.*

- (2) *You did not notify the Acting Site Manager that an inmate required escorting for medical treatment for a head injury or that two at risk inmates had been received at Manawatu Prison, as is expected of the On Call Manager.*
- (3) *As On Call Manager you did not make yourself fully aware of the risks and issues relating to (the inmate), and in particular you did not query the nurse on the seriousness of the head injury to (the inmate) when completing the A09.*
- (4) *As On Call Manager you did not carry out the responsibilities of the On Call Manager to the standard expected of an after hours site visit in that:*
- *You did not visit all units.*
  - *Given the Opportunity, you did not participate to an appropriate level in the handover briefing of the two Acting Principal Corrections Officers.*
  - *Knowing that you had at least one inmate at risk, you did not take the opportunity to stay and sign off the management plan."*

(above)

42. The parties met on 14 July 2004 so that Mr Hotop could address the concerns set out in his employer's letter of 9 July.

43. By letter dated 15 July 2004 (document B9) Mr Hotop was summarily dismissed. The basis of the termination decision was based in part on the findings set out in Mr Grant's letter of 9 July. Specifically, Mr Grant found that the applicant's,

*... actions were a serious misconduct in that they were an act of negligence or unsafe practice, which seriously affects security, safety or health of employees, contractors or members of the public in the workplace.*

(and)

*The actions (taken by the applicant) in endorsing the management plan of (the inmate) which retained him on 30 minute observations contrary to the requirements, not advising the Site Manager of the medical escort, not making yourself aware of the risks and issues relating to (the inmate) and not carrying out the On-Call Manager's responsibilities to the standard expected are serious breaches of the Department of Corrections Code of Conduct. I believe the misconduct is of such a magnitude that it warrants termination of your employment.*

### Applicants' Submissions

44. Without reproducing them in full it is sufficient to record the applicant's submissions as follows:
45. Mr Hotop accepts that a single act of negligence, when sufficiently serious, can justify summary dismissal: *W & H Newspapers v Oram* [2001] EZLR 29.
46. The applicant also accepts that a single incident of carelessness, when sufficiently serious, can impair the trust and confidence of the employment relationship: *Click Clack International v James* [1994] 1 ERNZ 15.
47. There are significant factual differences between *Click Clack* and *Oram* (above) and this case: unlike those two cases Mr Hotop's actions were not contrary to expected procedures and he was not clearly negligent. In the alternative, if Mr Hotop is found to have been negligent (which is not accepted) then it is not just any negligence that is sufficient to justify dismissal and it was not sufficiently serious to impair the trust and confidence essential to the employment relationship: *Airline Stewards Union v Air New Zealand* [1991] ACJ 345, etc.
48. There has been a disparity in treatment and there is not an adequate explanation for the disparity, either in respect of the 1<sup>st</sup> & 2<sup>nd</sup> PCO or between an incident involving the Waikeria Unit Manager and the applicant, therefore the dismissal is rendered unjustifiable: *Airline Stewards and Hostesses Union v Air New Zealand* [1985] ACJ 952, etc.
49. Mr Hotop's legitimate expectations of procedural fairness have not been met.

### Respondent's Submissions

50. The respondent advances several arguments and says in particular that it is entitled to expect its managers, in complying with the departmental Code of Conduct, to demonstrate reasonable standards of professionalism and managerial responsibility. A reasonable manager in Mr Hotop's position would have known that he owed a duty to meet such standards. By his conduct on 12 July 2003 the applicant breached that

principle of the Code of Conduct and failed in his duties to the respondent. Because the breaches set out in the letter of dismissal of 15 July 2004 (document B9) were so fundamental to the applicant's duties as a manager and displayed such a failure to meet the required standard the Department was entitled to conclude Mr Hotop was guilty of serious misconduct.

51. The tests for substantive justification are well known: *Airline Stewards and Hostesses of New Zealand IUOW v Air New Zealand* [pre-1991] ERNZ Sel Cas 985 and *Oram* (above).
52. There is ample case law to illustrate that an employee's negligence may justify dismissal: *Oram* (above), etc. Mr Hotop's conduct falls within the bounds of this case law.
53. Different considerations in respect of the differing penalties applied to the 1<sup>st</sup> & 2<sup>nd</sup> PCOs and the applicant including Mr Hotop's continued denial of any wrong doing, his more senior managerial role and greater degree of culpability and the consequences of him choosing not to be represented. The Waikeria incident involved materially different facts. Other instances of disciplinary action in situations involving suicides or accidental deaths of inmates are also readily distinguishable from the present case.
54. Where a disparity of treatment is found that disparity becomes irrelevant if the employer has an adequate explanation: *Samu v Air New Zealand Ltd* [1995] 1 ERNZ 636.
55. In the event of a finding in favour of the applicant the respondent is very strongly resistant to Mr Hotop's reinstatement as he has lost the trust of his key managers. It would be impracticable for Mr Hotop to be returned.
56. Mr Hotop contributed significantly to the situation giving rise to his personal grievance and any remedies should be reduced accordingly; s. 124 of the Act.

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57. As no inquest has yet been formally conducted in respect of the inmate's death an order is sought prohibiting publication of any particulars of a death suspected to be self-inflicted consistent with the provisions of ss 29 & 43(3) of the Coroners Act 1988.

## Findings

58. Following a close scrutiny of the largely if not wholly uncontested facts and the parties' closing comments I have no difficulty in reaching a determination that Mr Hotop was unjustifiably dismissed. I make this finding for the following reasons.
59. The basis of the respondent's decision to terminate the applicant is set out in the Department's letter of 15 July 2004 (document B9). It records a finding that Mr Hotop's actions amounted to serious misconduct in that they were an act of negligence or unsafe practice which seriously affected security, safety or health of employees, contractors or members of the public in the workplace. That definition is provided in the Department's Code of Conduct (pg 29, document B1). This is a peculiar finding unless the Department is stretching the definition of a member of the public in the workplace to include the inmate – an extension that is arguably outside of the definition.
60. Leaving that concern to one side, the applicant's actions said to amount to serious misconduct were specified as:
- Endorsing the inmate's management plan which retained him on 30 minute observations contrary to the requirements,
  - Not advising the Site Manager of the medical escort,
  - Not making himself aware of the risks and issues relating to the inmate, and
  - Not carrying out the On Call Manager's responsibilities to the standard expected.
61. I am satisfied that these findings could not have been sustained on the evidence available to the Department at the time of terminating Mr Hotop, or on any other

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occasion. This is because a close scrutiny of the evidence available to the Department shows that Mr Hotop at all times met all of the specified or express requirements of the On Call Manager, as set out in the PPM and the IMP. The Department cannot demonstrate any actual breaches by the applicant of any express requirements as set out in the PPM or IMP. What became clear during the Authority's investigation – and is accepted by the Department – was the failure of other staff to meet the express requirements of the PPM and IMP, their breaches of the provisions as set out in those documents and, in particular, their failure to convey critically important information to the applicant in respect of the inmate.

62. As Mr Hotop's actions were consistent with the requirements of the position, and as they were not in express breach of either the PPM or IMP, the respondent's conclusions that they amounted to negligence or unsafe practice cannot be sustained. There was no misconduct. The applicant's conduct in no way threatened the heart of the employment relationship. His actions therefore cannot be said to amount to serious misconduct. Mr Hotop's summary dismissal was therefore unjustified: *Click Clack* (above).
63. It is clear that Mr Hotop's error, if that is what it can be called, was to rely on the managers and other staff reporting to him to undertake their defined tasks. From the Department's perspective, he 'failed' to interrogate those staff as to whether or not they had met the specifications of their positions, as expressly set out in the PPM and/or IMP. I do not accept that this amounts to serious misconduct, as defined by the Code or implied by the parties' employment relationship. Having satisfied himself as to the inmate's condition Mr Hotop had no reasonable cause to question the account of the same by staff reporting to him. In all the circumstances it was therefore an unfair and unreasonable conclusion by the respondent that the applicant's (non)actions amounted to negligence and unsafe practice to the level of constituting serious misconduct. There was no basis to conclude the Mr Hotop's (non)actions were in any way blameworthy. The outcome was such that no fair and reasonable employer could have reached it: *Oram* (above).
64. As was made clear in the Authority's investigation, the applicant's endorsement of the inmate's management plan which retained him on 30 minute observations, and which was deemed to be contrary to the requirements, amounted to Mr Hotop accepting

telephoned advice from the 2<sup>nd</sup> CSU PCO that the inmate was on 30 minute observations. Mr Hotop was not advised by that officer that the inmate had provided six yeses on his NARA (when only 2 positive answers were sufficient). Mr Grant said that *in endorsing a management plan managers have a responsibility to ask questions and to ensure that the plan has been properly formulated* (par. 52 of his statement). I am satisfied the respondent in this regard is placing the test too high. The applicant reasonably expected the CSU PCO to inform him of that information – that is an express requirement of the PPM (B.14.01., section 4, Procedure) and the IPM (pg 4 – document A22). Asking questions in a situation where Mr Hotop had no reason to be concerned is not a requirement of either of those two manuals. The requirements relied on by the Department are nowhere specified and amount to standards set by Mr Grant at a subjective level and which were any way never communicated to the applicant.

65. To say, as the Department has attempted to do, that Mr Hotop was in breach of the *no surprises* requirement of his On Call Manager's role (document A23) is once again placing too high the standard of performance reasonably and fairly expected of an employee. This is because Mr Hotop had no reason to expect any surprises. To have contacted the Site Manager on this occasion would have amounted to a requirement to advise the same person of everything that was happening at any time because of the potential for any situation to go wrong. Besides, Mr Hotop knew from considerable experience that the system at Manawatu Prison did not operate in that way.
66. The requirement to inform the Site Manager of the medical escort is set out in the IMP (Manawatu Prison On Call Officer, roles, responsibilities and requirements – document A22), but it is not – as the Department has applied it – time specific. The 'failure' to report the inmate's planned medical escort was clearly overtaken by that person's death and was any way reported in the overall context and account given by the applicant to the Site Manager and others, following the inmate's death.
67. It is also unsustainable to claim the applicant failed to make himself aware of the risks and issues relating to the inmate when vital information in respect of that inmate was not passed on to him by relevant staff in breach of the PPM and IMP. The respondent failed to properly weigh Mr Hotop's actions in observing the inmate and

talking, briefly, to him, of the applicant taking the initiative on the basis of previous encounters with the inmate of requiring two staff to accompany him and the applicant's legitimate reliance on the nurse's initiative to arrange a medical escort, in reaching this conclusion.

68. The respondent similarly failed to properly take account of Mr Hotop's evaluation of the inmate based in part as it was on the inmate not having a previous at risk history in the prison.
69. Underpinning the Department's decision to dismiss Mr Hotop is a view that an inmate who has self harmed is an inmate who is at risk and who therefore is an inmate who should be immediately placed on 15 minute observations. That is the basis of its conclusion that Mr Hotop failed to carry out the On Call Manager's responsibilities to the standard expected. However bluntly I may have paraphrased its view, that formula – or anything like it – is nowhere set out in any Departmental manual or guideline: it does not appear in the PPM. It does not appear in the Manawatu Prison IMP. It is instead a view or formula that, during the Authority's investigation, Mr Grant conceded he had applied in evaluating the applicant's conduct but had never communicated to Mr Hotop. It was unreasonable to evaluate Mr Hotop in terms of that view or formula because it is not provided for in any material defining the applicant's responsibilities and was never put to him.
70. The Department went too far. The applicant's performance was evaluated by way of unreasonable and subjective standards. They were unreasonable because they markedly exceeded the standards expressly set in place by the Department in its PPM and Code. They were also unreasonable standards because, as Mr Grant confirmed in his evidence to the Authority, they had never been communicated to the applicant as being expected of him.
71. In reaching this conclusion I wish to record my view that the Department, and Mr Grant in particular, share and are properly committed to the policy set out in the PPM at B.14 that every effort is to be made to identifying inmates at risk and to managing them so as to minimise their risk of self harm.

72. I concur with the respondent's request that, as no inquest has yet been conducted into the inmate's death, all details of the inmate's death – suspected as it is to be self-inflicted – be prohibited from publication: clause 10(2) of Schedule 2 of the Act applied.

### **Disparity**

- 73 The applicant has been treated markedly different from other corrections officer in the context of the death of the inmate. Whereas the Department accepts that other officers acted in breach of express PPM and IMP requirements, it saw fit to discipline them for serious misconduct by way of, amongst other things, final warnings and demotions. For the applicant, having found the same, it saw fit to summarily dismiss him. This amounts to a serious, but unsustainable, disparity of penalty. The Department's reasoning, and the resulting disparity, is all the more odd when the failure of those given final warnings to pass on to Mr Hotop, the On Call Manager – and as required by the manuals – information of critical value in respect of the inmate is objectively weighed.

### **Remedies**

74. I have no difficulty in accepting the remedies sought by Mr Hotop, that he be immediately reinstated to his former position as Unit Manager, Manawatu Prison and that his lost wages also be restored.
75. Reinstatement is the primary remedy: s. 125 of the Act. Reinstatement is opposed by the respondent primarily on the ground that it has lost confidence in Mr Hotop. There is no basis for that view. It arises from the same reasoning that resulted in the applicant's unjustifiable dismissal, i.e. a test or standard was required of Mr Hotop beyond those provided in his position description or the respondent's manual, etc but instead was a standard unreasonably and unfairly applied by Mr Grant without ever having been communicated to the applicant prior to his dismissal.
76. Mr Hotop is objectively a competent and well-performing officer; that was at least in part a conclusion reached by the Department when it awarded him a pay increase in March 2004.

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77. He met all of his specified requirements on the day of the inmate's death, unlike other staff. The Department had sufficient confidence to keep in employment other staff it accepts breached those same requirements: it therefore cannot properly sustain a claim of a lack of confidence in Mr Hotop meeting the requirements of his position in the context of a reinstatement.
78. I do not accept that there is *a grating state of disharmony between the parties which would render it impossible for them to co-exist*. *Chief Executive of the Ministry of Maori Development v Paul Travers-Jones*, unreported, 4 April 2003, Goddard CJ, WC 11/03, par 60.
79. In the event that problems exist or are perceived to exist then I recommend to the parties that they make use of the Mediation Service so as to explore such matters as the timing and ways and means of addressing their, no doubt, mutual concerns in respect of the applicant's return to the workplace: s. 123(a) of the Act applied.
80. Leave is reserved to the parties in the event they are unable to agree on the lost wages and benefits owed to the applicant.
81. The applicant claims \$15,000 as compensation for humiliation, etc. In all the circumstances, and in particular the uncontested evidence provided by Mr Hotop, I am satisfied that this is a fair and reasonable amount for the impact on Mr Hotop as a result of the respondent's unjustified termination of his employment.
82. This conclusion is strengthened by my finding that comments made to the applicant at the termination meeting on 15 July 2004 to the effect that he *undoubtedly contributed to the death* of the inmate and that would *need to live with that* in respect of the inmate, the applicant himself, his family and the inmate's family were gratuitous. These comments were unsubstantiated and are unsupportable: there was no evidence presented to the Authority to support the respondent's conclusion. The Department had no evidence with which to make a claim, or to infer or imply, that 15 minute observations would have prevented the death of the inmate. This conclusion is strengthened by Mr Grant acceptance, during the Authority's investigation, that had the applicant questioned the inmate's NARA assessment (and thereby become aware of the 6 yeses) but elected nonetheless – consistent with the discretionary

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authority of his position – to keep the inmate on 30 minute observations, Mr Hotop would not have been dismissed notwithstanding the death of that inmate.

83. The evidence before the Department clearly pointed instead to the possibility of staff other than Mr Hotop failing to properly and adequately carry out the inmate's 30 minute observations and that the camera surveillance of his room was inadequate.
84. Responsibility for those shortcomings, and the issuing to the inmate of a non regulation costume, cannot be sheeted home to the applicant. It was unnecessarily hurtful to suggest otherwise.

### **Contributory Behaviour**

85. I am satisfied that the applicant at all times discharged the duties specifically required of him on the day in his capacity as the On Call Manager. He has also consistently made an effort to draw the significance of his compliance with the manual requirements to the respondent's attention. Mr Hotop's actions cannot be said to be in any way responsible for the Departments unjustifiable decision to terminate his employment. There was no identifiable misdeed or course of conduct which can be said to be faulty when set against the applicant's duties . Mr Hotop cannot be said to be blameworthy: s. 124 of the Act applied.

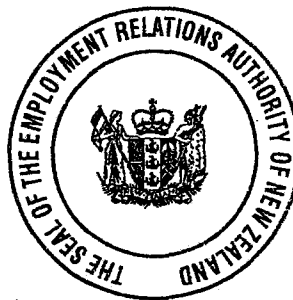
### **Determination**

86. For the reasons set out above I find in favour of the applicant, David Hotop's, claim that he was unjustifiably dismissed by the respondent, the Chief Executive of the Department of Corrections.
87. I direct that the applicant be immediately reinstated to his former position of Unit Manager, Manawatu Prison with the respondent, without loss of seniority: s. 123(a) of the Act applied.
88. I direct the respondent to pay to the applicant the wages and benefits he lost as a result of his unjustified dismissal: leave is reserved for the parties to resubmit this matter to the Authority in the event that agreement on the same is not reached between them: s. 123(b) of the Act applied.

/S/

/EN/

89. I also direct the respondent to pay to the applicant the amount of \$15,000 (fifteen thousand dollars) compensation for humiliation, etc: s. 123(c)(i) of the Act applied.
90. I also confirm my direction that no details in respect of the inmate's death are to be published: clause 10(2) of Schedule 2 of the Act applied.
91. At the parties' request costs are reserved.



A large, stylized handwritten signature in black ink, appearing to read "Denis Asher".

**Denis Asher**  
**Member of Employment Relations Authority**