DECISION

Fair Work Act 2009
s.394—Unfair dismissal

Samantha-Jane Jacobs

v

Moonta Health Aged Care Services T/A Parkview Aged Care
(U2022/9272)

DEPUTY PRESIDENT HAMPTON ADELAIDE, 30 MARCH 2023

Application for unfair dismissal remedy – valid reason for dismissal related to the employee's conduct (including its effect on health and safety) – dismissal was not harsh, unjust or unreasonable – application dismissed – observations made about responsibility for some of the circumstances.

1. Background

[1] On 15 September 2022, Ms Samantha-Jane Jacobs (**Applicant**) made an application to the Fair Work Commission (**Commission**), pursuant to s.394 of the *Fair Work Act 2009* (Cth) (FW Act), alleging that she had been unfairly dismissed from her employment with Moonta Health Aged Care Services T/A Parkview Aged Care (**Moonta Health** or **Respondent**). The Applicant seeks a remedy of compensation.

[2] Moonta Health is a privately run not for profit charitable facility providing aged care accommodation and respite care in Moonta, a town on the Yorke Peninsula of South Australia. The Applicant commenced employment with the Respondent as a Personal Care Assistant in January 2021 and remained in that role until her dismissal.[1]

[3] Ms Jacobs was notified of her dismissal on 25 August 2022, with the dismissal taking effect on the same day. The reason for dismissal given by the Moonta Health at that time was alleged to be serious and wilful misconduct, compromising of:

- Professional misconduct – documenting safety checks without attendance.
- Neglect resulting from failure to provide duty of care to residents. Namely pressure care and safety checks.
- Breach of infection control. Namely not wearing Personal Protective Equipment (**PPE**) (a gown) during a Covid-19 outbreak.

[4] The stated misconduct is alleged to have essentially occurred during a night shift undertaken by Ms Jacobs on 3 and 4 August 2022. Ms Jacobs largely denies the misconduct

and contends that the related events occurred in a context where she was not at fault and was being held responsible for events beyond her control.

[5] The context for the events is that during the shift in question, part of the facility (the High Care section) was subject to a Covid-19 outbreak and this led to enhanced PPE requirements, some staffing constraints, and other consequences. During the early hours of 4 August 2022 a resident in the high care section had a medical episode and fell from her bed, and was left unattended for some time prior to being discovered by a Registered Nurse (RN) who attended the resident's room for something other than a standard safety check. The Resident was taken to hospital and passed away some days later following what I understand was a subsequent medical episode. The enquiries that immediately followed these events led to the various allegations being made by the Respondent against Ms Jacobs. I emphasise that it is not the role of the Commission to make any findings about whether the events relevant to this application played any role in that outcome. Further, as will become clear, the findings that are made in the decision that follows, demonstrate that the conduct which occurred has been considered in the employment context, without attribution of responsibility for outcomes. I also observe that it is less than clear that Ms Jacobs was solely responsible for the care of the Resident at the critical times.

[6] There were no jurisdictional barriers to the application being heard and determined on its merits.

[7] There being contested facts involved, the Commission was obliged by s.397 of the FW Act to conduct a conference or hold a hearing. After considering the views of the Applicant and the Respondent, I considered it appropriate to hold a hearing for the matter.[2] The Commission conducted an MS Teams Video Hearing to enable the matter to be determined.

[8] Ms Jacobs appeared for herself while Ms Truong, of counsel, appeared with permission[3] for the Respondent.

[9] As Ms Jacobs was not represented, I assisted with the conduct of the hearing, gave considerable latitude as to the form of her evidence and submissions, facilitated submissions on the relevant statutory considerations, and enabled the presentation of the cases in a strictly non-partisan manner consistent with the statutory charter of the Commission.[4]

[10] For reasons that follow, I have determined that elements of the alleged misconduct took place and that, having regard to the statutory considerations and the entire relevant circumstances of the matter, the dismissal of Ms Jacobs was not unfair. The basis of those findings is set out in the decision which follows.

2. The cases presented by the parties

2.1 Ms Jacobs' case

[11] Ms Jacobs contends that the dismissal was unfair on various grounds including that the alleged misconduct did not occur as alleged, the procedure adopted by the Respondent was not

fair and breached its own policies, and that the dismissal was, in effect, harsh given the circumstances at the time and the impact upon her.

[12] In connection with the resident safety and pressure checks, I understand that Ms Jacobs, in effect, contends that:

- The first step of a shift is to receive a handover. There was no handover meeting on the evening in question and the whiteboard in the Nurses station did not advise of a resident that required additional safety checks. As a result, she was unaware of the increased care requirements for the resident concerned – that they required pressure area care and hourly visual safety checks;

- The only error in the documentation recording the safety checks was that she should have recorded as "did not disturb" but otherwise her approach was consistent with what she had been trained to do;

- At the (likely) time of the incident with the Resident, Ms Jacobs was looking after residents in the low care part of the facility, not in high care where the resident was located;

- Ms Jacobs was not solely responsible for the 70 residents that night and worked under the direction of 2 RNs. Further, there were other staff working that evening and Ms Jacobs was the only one questioned and held responsible without reason. This included that Ms Jacobs worked in the low care unit for 2 consecutive hours at one stage and assumed that during this period, other staff were attending to the Resident in question. Indeed, the RN and the buddy shift employee should have found the resident after the incident;

- The requirements for safety checks in connection with the resident concerned was changed from hourly to half-hourly after the incident occurred;

- Safety checks were performed by Ms Jacobs during the shift, and this was done by checking for signs of disturbance outside the resident's door (about 2 or 3 times during the whole shift), and other times by merely being aware of the resident's location in the facility (in their room). This was all that was required – in the absence of specific instructions to do more; and due to being understaffed and overworked – all that was possible. Furthermore, the Resident in question also did not have a pressure mat, further reason for Ms Jacobs not to suspect that they were on hourly visual checks;

- The checks were entered into the system in batches, due to not having time to enter them in as they were being done, but instead during breaks – but they were still conducted;

- Ms Jacobs logged the safety checks for 23:00 hours based on checks that RN had made and informed her about. Ms Jacobs also logged all the safety checks performed by another employee, the buddy shift worker, as that employee did not yet have a login and password to do so themselves; and

- Given what Ms Jacobs described as the understaffing on the night in question, management should be held responsible for any consequences associated with the absence of care.

[13] As to the alleged breach on infection control, I understand that Ms Jacobs contends, in effect, that:

- On entry, the PPE station had everything except the gowns. As it was night shift, Ms Jacobs put on all PPE that was available and checked the PPE stations on the way to the Nurses Station. She passed three stations before finding one that was stocked with gowns. Having to put on PPE gear was also the reason she clocked on at the time she did;

- In relation to CCTV screenshots showing Ms Jacobs not wearing her full PPE gear, Ms Jacobs contends that those are instances where she is either changing gowns because she has been exiting residents' rooms and moving between low and high care or she is in certain areas where it was acceptable practice not to be wearing a PPE gown such as in the staff kitchen area. Ms Jacobs also contends[5] that she was advised by management that she did not need to wear the full PPE;

- There was a policy that employees were not to work in both High Care and Low Care given the Covid-19 outbreak. This did occur on the night in question and Ms Jacobs contends, in effect, that this breach of policy means that the strict application of the policy to her was not reasonable; and

- The only other reason Ms Jacobs removed her PPE gear was in an effort to lower a resident's distress who was having trouble recognizing who she was.

[14] In relation to the procedure leading to the dismissal, Ms Jacobs contends that the Respondent twisted her words during the discussions and the General Manager lost control of the final meeting and slammed her hands on the desk and terminated the employment immediately.

[15] As to the alleged unfairness and harshness of the dismissal, Ms Jacobs also contends that:

- She was being blamed (thrown under the bus) as a scapegoat for the staff shortages and "incompetence of management" and this had a major impact upon her standing in a county town. She speculated that she was being singled out and blamed due to being gay.

- The Respondent was being investigated for other falls and this dismissal was, in effect, a deflection where Ms Jacobs was being held responsible for something that was not her fault.

- The Respondent's (discipline) policies were not followed in that an employee may have up to 3 serious and wilful misconduct matters in 12 months without being

dismissed and the person investigating the matter was not impartial, had already decided to terminate, and was also responsible for making the dismissal decision.

[16] Ms Jacobs gave evidence[6] and relied upon the witness statement[7] of Ms Seoyoung Kang, Registered Nurse, who was on duty at the facility on the night in question.

2.2 Moonta Health's case

[17] The Respondent submitted that there was a valid reason related to the Ms Jacobs' conduct. In particular, Moonta Health principally relied upon the issues associated with the requirements that safety checks were to be conducted on the residents during the shift in question and the alleged breach of the PPE requirements (infection control) in place at the time. The Respondent further relies upon an alleged failure to meet a duty of care to the residents on the shift in question, by not actually conducting the safety checks and pressure area care as required.

[18] In particular, Moonta Health contended that Ms Jacobs documented having performed safety checks on 30 residents between 23:00 hours on 3 August 2022 and 05:00 hours on 4 August 22, when these safety checks were not actually performed. Further, it was contended that:

- Safety checks for 30 residents were documented by Ms Jacobs as having been conducted in Rose Court, Jubilee and Wattle units of the facility.

- There were 30 safety checks recorded at 23:00 hours on 3 August 2022. CCTV footage supports that Ms Jacobs was in Jubilee until 23:24 at which time attended a bell in Wattle. Evidence shows that Ms Jacobs was still in the Jubilee kitchenette area until after 24:00. There were another 30 safety checks recorded at 24:00. Evidence does not support that these were completed.

- The evidence demonstrates that around 00:19 hours on 4 August 2022, Ms Jacobs was returning a trolley to the kitchen. Ms Jacobs then returned to the High Care Nurses station around 00:45 hours. Evidence further supports the contention that various call bells were answered by Ms Jacobs in Rose Court and Jubilee, during which time Ms Jacobs also disposed of waste.

- During the phone interview conducted between the General Manager and the Applicant on 4 August 2022, Ms Jacobs confirmed she did not do the safety checks.

- Visual safety checks were required on all residents as part of normal care on night shifts, except where a do not disturb sign was displayed for the resident, which followed a detailed assessment. This did not apply to the Resident in question and was not common in the high care area. A safety check involves opening the resident's door and sighting them to ensure that they were in bed and comfortable/safe.

- The requirement for 2 hourly pressure care checks on the resident in question would have been known to Ms Jacobs by checking Individual Carer Handover Sheet for that Resident.

[19] In terms of the alleged breach of infection control (PPE) requirements, the Respondent relies upon CCTV footage screenshots[8] which show Ms Jacobs was not wearing a gown or mask in the High Care Area (Red Zone). It further contends that:

- There is always enough PPE, and all staff are required to be in full PPE gear during a Covid-19 outbreak and that there would have been enough PPE gear available throughout the facility.

- The relevant policy was that full PPE gear is to be worn in all areas of the High Care Unit, changes of PPE gear were to be made immediately after exiting resident's rooms and old gowns discarded in the bins located rights outside residents' rooms.

- The correct procedures were confirmed by various emails and PPE training and all other employees on the shift in question were wearing the correct PPE at all times.

[20] The alleged absence of due care is associated with the failure to perform the safety checks and the absence of the required pressure area care, in effect, repositioning the resident on a stated schedule. Moonta Care contends that the Daily Repositioning Schedule for the Resident concerns shows the last entry for repositioning was at 21:00 by another carer on 3 August 2022. Further, there was no documentation supporting 2 hourly repositioning for the Resident in question by Ms Jacobs, despite this being a requirement stated in the relevant care notes.

[21] During the hearing, Moonta Health also relied upon allegations associated with certain actions that were not undertaken by Ms Jacobs in connection with a buddy shift staff member who was working on the night in question. In particular, that duty lists, handover sheets, checklists, the requirements for safety checks were not explained by Ms Jacobs despite having that employee assigned to her at the time.

[22] Moonta Health also relied upon earlier incidents in July 2022 concerning the Applicant's late attendance and her alleged inappropriate departure from the workplace during a shift.

[23] Moonta Health contends that the actions in August 2022 represented serious misconduct. Further, it submits that during the investigation Ms Jacobs accepted that she was "guilty as charged" and this meant that the Applicant conceded that these actions had occurred. Further, Ms Jacobs failed to understand the seriousness of the conduct and this also supported the dismissal.

[24] The following witnesses gave evidence on behalf of the Respondent:

- Ms Alison Clare, General Manager of Moonta Health[9]; and
- Ms Sonya Lee-Anne Tiver, Care Manager of Moonta Health[10]

3. Observations on the evidence

[25] In giving evidence, Ms Jacobs was often unable to respond to allegations against her without being offended and tended to be argumentative and defensive. Of more significance, Ms Jacob's also changed the factual basis of her case at times, particularly in response to allegations and factual propositions put to her on behalf of the Respondent. In assessing that evidence, I have taken into account that the events of the shift in question, and the subsequent investigation and dismissal of Ms Jacobs, have impacted upon her and she feels the weight of the circumstances. I have made allowances for this in assessing her evidence. However, the tendency to change the evidence itself and not to directly respond to clear allegations, leads me to treat her evidence with considerable caution.

[26] Ms Kang was overseas at the time of the hearing and her statement was admitted by consent without being required for cross-examination. I accept that evidence. I observe that Ms Kang's evidence was limited to the staffing context during the shift in question and did not directly engage with the substantive allegations.

[27] I found the evidence of Ms Clare reliable and of assistance in determining this matter. Where there is a dispute about facts that Ms Clare directly observed or was involved in, I prefer her evidence to that of Ms Jacobs.

[28] I also found the evidence of Ms Tiver to be of assistance. Ms Tiver was not however clear on some aspects that arose during the hearing, largely as a result of the understanding of Ms Jacob's position as it emerged. Given that circumstance, I do not draw any adverse inference about that aspect but must ultimately determine this matter based upon the evidence that is before the Commission. This approach is also informed by the fact that the (represented) Respondent did seek leave to subsequently supply some of the documentation that became relevant as the case unfolded.[11] Where there is a dispute about facts that Ms Tiver directly observed or was involved in, I prefer her evidence to that of Ms Jacobs.

[29] The Respondent did not call any evidence from those who were working on the shift in question. There were also documents, including the emails said to confirm the Covid-19 related PPE requirements, that were not put into evidence. This has impacted upon certain findings. The Respondent did rely upon some screen shots taken from CCTV footage recorded at the time. Ms Jacobs accepted that these screen shots were genuine. However, the actual CCTV footage was not available, and I have had regard to this absence of context in assessing the weight to be afforded to some elements of this evidence.

[30] There are elements in most of the witness statements that rely upon information provided by others, and I have taken this into account in assessing the weight to be given to such. Given the above, I have placed most weight upon the facts evident from direct sources.

[31] There are also elements of opinion in some of the witness evidence regarding matters that are to be determined by the Commission. Accordingly, I have treated these aspects as submissions.

[32] In my consideration of the disputed evidence and making my findings of fact in this matter, I have had regard to the approach of Dixon J in *Briginshaw v Briginshaw*[12] as follows:

> "The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. It cannot be found as a result of a mere mechanical comparison of probabilities independently of any belief in its reality. No doubt an opinion that a state of facts exists may be held according to indefinite gradations of certainty; and this has led to attempts to define exactly the certainty required by the law for various purposes. Fortunately, however, at common law no third standard of persuasion was definitely developed. Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences."

[33] Further, I note that in *Budd v Dampier Salt Ltd*[13] a Full Bench of the Australian Industrial Relations Commission said the following in relation to *Briginshaw v Briginshaw*:

> "[14] The second ground of appeal is that the Commissioner erred in the application of the principle in Briginshaw. So far as relevant, that case decided two things. The first is that where allegations are made in civil proceedings which, if proven, might found criminal liability, the standard of proof remains the civil standard. It follows that it is necessary that the court only be satisfied on the balance of probabilities. The second thing is that in such a case a proper degree of satisfaction is required having regard to the seriousness of the allegations. In the words of Dixon J., as he was: "The nature of the issue necessarily affects the process by which reasonable satisfaction is obtained."
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> [15] In *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* the High Court pointed out that care needs to be taken in applying what was said in Briginshaw. Furthermore, it would be wrong, for example, to apply a standard of proof higher than the balance of probabilities. Counsel for the appellant contended that the Commissioner failed to have regard to the seriousness of the situation for the appellant in making findings of fact as to what had occurred and in deciding that there were no extenuating circumstances for the appellant's behaviour.
>
> [16] In relation to fact finding, the Commissioner analyzed the evidence with care. In making findings he indicated how the findings were reached, in particular why he rejected some evidence and accepted other evidence. There was no error in the fact-finding process. To the extent that this ground involves a contention that the Commissioner did not exercise the statutory discretion properly it should also be rejected. Briginshaw was a case concerned with the nature of findings about conduct. It is potentially misleading and unnecessarily complicated to attempt to apply Briginshaw to the exercise of judgement required once the findings about conduct have been made. Section 652(3) specifies the way in which the discretion is to be exercised and the matters to be taken into account. Loss of employment is a serious matter and applications for a remedy are to be dealt with seriously. That the Commissioner so

> regarded it in this case is clear from his decision. There is no basis on which to conclude that the Commissioner's approach to the fact-finding process or to the exercise of the discretion was erroneous because of anything said by the Court in Briginshaw. The second ground of appeal must be rejected."

[34] I have applied this approach with particular regard to the more serious of the allegations made against Ms Jacobs.

4. The Facts of the Matter

4.1 The General Chronology of Events

[35] The Applicant commenced employment with the Respondent in January 2021 as a part-time Personal Care Attendant.[14]

[36] The Applicant's employment contract states that "Moonta Health and Aged Care Services Inc, has in place policies and procedures and you are required to comply with these policies. A failure to comply with these policies may result in disciplinary action. These policies are found in each workstation."[15] The contract also outlines the requirement for the Applicant to annually complete a number of mandatory competencies at KPI of 100%. These include aged care standards, infection control and COVID-19 training competencies.[16]

[37] Moonta Health is a privately run not for profit facility providing aged care accommodation and respite care. During the time of the alleged misconduct in August 2022 the facility was dealing with a Covid-19 outbreak and had in place certain Covid-19 policies.

[38] There are various resident wings of the facility including most relevantly – High Care units – Jubilee, Wattle Court, Rose Court. These are all connected (by corridors) both to each other and the entrance, main kitchen and laundry areas. There is also an adjacent facility, Parkview. Each of the resident wings and units have their own staff rooms, dining facility and kitchens and most of have a separate external entry point.[17]

[39] There is no indication in the evidence that Ms Jacobs was subject to disciplinary action other than as set out below or that management of the Respondent held any particular concerns about the Applicant's work before these events.

[40] On 26 July 2022, the Respondent emailed Ms Jacobs requesting that she attend a meeting at 2:30pm on 27 July 2022. The meeting was set to discuss two allegations against the Applicant concerning leaving her shift early and arriving late. This meeting did eventually take place on 27 July 2022 and these matters were discussed but did not resolve the issues. In effect, the events of early August 2022 overtook that process.

[41] Indeed, during a disciplinary meeting concerning the alleged misconduct on 25 August 2022, Ms Jacobs received a first Written Warning[18] concerning allegations that she:

- Left her shift at around 21:00 on Friday 22 July 2022 without reporting to the Nurse; and

- Was late to her shift on Sunday 24 July 2022, arriving at around 20:15.

[42] This discussion during the 25 August 2022 meeting arose at the initiative of the Respondent. However, the prospect that a "first warning" would be issued was in response to Ms Jacobs expressly raising that issue during what became the termination meeting.

[43] I observe that at least in respect of the 22 July matter, Ms Jacobs advised Ms Tiver by text message at 8.34 pm that she was going to leave work at 9.30 pm due to (poor) working conditions. Ms Tiver was not on duty and not at the facility at the time. There is a dispute about the conditions and whether Ms Jacobs had advised the RN on the night in question, which I need not resolve for present purposes. It is sufficient to indicate that the advice to Ms Tiver mitigates the conduct; however, if Ms Jacobs did leave the workplace at that time without advising the Nurse in charge at the facility, this would have warranted some sanction given the implications of her absence for the facility and the other staff. I observe that even if the RN was advised, leaving the shift in effect as a protest about tidiness of the facility was a disproportionate response and not appropriate. The late attendance on 24 July 2022 followed Ms Jacobs advising the Respondent that she would be late due to the absence of a ride to work. Given her location, in another town some distance away without access to public transport, this was not unreasonable. It is also apparent that Ms Jacobs was keen to spend some time with her child (children) and I make no adverse finding about this aspect.

[44] The misconduct leading to the dismissal is alleged to have occurred during a night shift on 3-4 August 2022. I will return to the detail of these matters shortly. Ms Jacobs was rostered to work in the High Care Unit between 10.45 pm on 3 August and 7.00 am on 4 August 2022. Ms Jacobs clocked on at 10.50 pm.

[45] On the night in question, there were 31 residents in High Care, 9 in the Memory Support Unit and 32 in Low Care. The Memory Support unit is part of the High Care facility and one carer is nominated to be responsible for that unit. Ms Jacobs claims that this is the unit she was originally allocated to, however due to another staff member not wanting to work in the main High Care Unit along with Low Care and the level of staffing at that time, Ms Jacobs instead worked in both High Care and Low Care during the shift. I accept that evidence. The staffing for the facility that night was 2 RNs, and 3 Carers (inclusive of the buddy shift carer). Ms Clare and Ms Tiver both stated that the buddy shift worker was rostered on as a full resource and was to be utilised as such because of short staffing. The buddy shift worker was new to the Respondent's facility but not new to aged care.

[46] The evidence does not permit me to make any definitive findings as to the impact of the staffing levels on the shift in question. However, I am prepared to accept that the staffing in the context of the Covid-19 outbreak in the High Care unit(s) would have had some impact upon the work requirements of each of the staff involved and meant that some additional tasks were involved that would have added to the time to undertake certain functions. As will become clear, I have made allowance for this factor and it is relevant to the assessment of the alleged misconduct; however, this does not provide a complete answer by any means.

[47] During the shift in question, the Resident in the high care unit was found injured (likely to be associated with a fall from bed some hours earlier leading to hypothermia) by an RN around 6.00 am on 4 August 2022. The Resident was taken to hospital.

[48] The General Manager, Ms Clare, was advised of the incident. A review of the safety records indicated that Ms Jacobs had reported undertaking an hourly check on the resident concerned from 11.00 pm on 3 August 2022 and Ms Clare formed the view that this appeared to be contradictory to the circumstances of the injury sustained by the Resident. Ms Jacobs was also advised/became aware of CTV footage that appeared to indicate that Ms Jacobs was not wearing part of the required PPE during her shift and that her location at certain times was not consistent with the safety check records or the conduct of the necessary checks recorded in the High Care Night Shift List.[19]

[49] On 4 August 2022, there was a telephone conversation between Ms Jacobs and the General Manager, after the Applicant had finished her shift. I find that the notes of the conversation prepared by Ms Clare are broadly representative of the substance of the conversation, as follows:

> "… …
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> Sam (Ms Jacobs) called at approximately 16:00 on 4/8/22.
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> GM Alison Clare explained to Sam that the resident had been sent to hospital and was critical. Alison asked Sam, when was the last time she saw the resident during the shift. Sam stated that she didn't actually see the resident. Alison stated that there is documentation by Sam showing hourly checks from 23:00 on 3/8/22 through to 05:00 on 4/8/22. Sam said Yes but I actually don't go in the room, I just stand outside the room and listen to see if I can hear anything. The GM asked Sam how she would know if the person had fallen and was unconscious. Sam stated that she just listens for noises. The GM again stated that safety checks are to visually observe the resident each check and that means opening the door and checking the resident is safe and sleeping. The GM proceeded to caution Sam that if the resident doesn't make it the case would go to the coroners court and that Sam will need to defend her documentation. The GM stated that fraudulent documentation is very serious and this will need to be investigated further.
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> The phone call ended."[20]

[50] On 5 August 2022, Ms Jacobs was stood down on full pay pending an investigation.[21]

[51] The Respondent investigated the response times report which confirmed that the Resident had actioned an alarm at 6.10 am, leading to the Registered Nurse finding the injured resident. The Respondent also subsequently interviewed the employee undertaking the buddy shift on the night in question.

[52] On 16 August 2022, the Respondent requested a meeting with the Applicant to be conducted on 17 August 2022 to discuss an alleged complaint regarding her "performance and conduct". The email notified Ms Jacobs of the allegations and that she would have an opportunity to respond and attend with a support person. The Applicant was also notified that the meeting may result in disciplinary action, including termination of employment.[22] The allegations were stated to be:

> "… …

1. **Allegation**

- Safety checks being documented for 30 residents between 23:00 3/8/22 and 05:00 4/8/22. Allegations that Safety checks not actually being performed.

Evidence

- Safety checks for 30 residents documented in Rose court, Jubilee and Wattle
- There were 30 safety checks recorded at 23:00 on 3/8/22. Camera footage supports that Sam (Ms Jacobs) was in Jubilee until 23:24 at which time attended a bell in Wattle. Evidence shows that Sam was still in Jubilee kitchenette area until after 24:00. There were another 30 safety checks recorded at 24:00. Evidence does not support that these were completed.
- Around 00:19 returning a trolley to the kitchen. Evidence then supports returning to the High Care Nurses station around 00:45. Evidence then supports various call bells being answered in Rose Court and Jubilee, during which time evidence also supports the disposal of waste.
- Phone Interview record between the GM & Sam Jacobs on 4/8/22, where Sam confirmed she did not do the safety checks.

2. **Allegation**

- Allegation not wearing PPE during shift (whilst in outbreak management)

Evidence

- Observation from cameras approximately 24:00 PPE was not worn correctly with gown removed.

3. **Allegation**

- Allegation by buddy shift staff member stated that duty lists, handover sheets and or checklists were not explained.
- Allegation by buddy shift staff member stated that Safety Checks were not explained.

Evidence

- Interview record with buddy shift staff member stated that she was told to follow her buddy and the following duties were performed

  i. Emptying the bins in the corridors, attend buzzers
  ii. Empty skips, clean the kitchenette
  iii. Toilet residents who need assistance
  iv. Changed incontinence aids for double assists.

- Buddy shift staff member stated that safety shifts were not discussed or explained.

4. **Allegation**

- Allegation Pressure Area Care not being attended to as per the Repositioning Schedule of 2 hourly during toileting overnight.

Evidence

- Daily Repositioning Schedule shows the last entry for repositioning was at 21:00 by another carer on 3/8/22. No documentation supporting 2 hourly repositioning for this resident."[23]

[53] This meeting did not take place, as Ms Jacobs could not attend; 22 August 2022 was instead agreed by the parties.[24] Ms Jacobs did not attend the meeting on 22 August 2022, but emailed the Respondent and advised that she required more time in the following terms:

> "Due to the seriousness of the allegations that have been made regarding myself as Carer on the shift of the 3rd of August, I am not ready to defend myself today as I need a little more time to prepare emotionally and I will need to have someone present for me in the meeting and Im still under-sided (sic) on what type of support I will need to have with me.
>
> Emotionally this has nearly destroyed me, expecially (sic) as I have not received any support from Management regarding if I am ok.
>
> … …"[25]

[54] A further meeting request was sent on 22 August 2022 for a meeting to take place on 25 August 2022, largely in the same terms as the earlier request.[26] Despite a further suggestion[27] from Ms Jacobs that an additional delay occur, the meeting was held on 25 August 2022. This was not unreasonable given the circumstances. Ms Jacobs was also advised, in advance, that Ms Tiver would be in attendance.

[55] During the abovementioned meeting, the Respondent provided Ms Jacobs with the *First Warning Letter* regarding her alleged conduct on 22 and 24 July 2022 as outlined earlier.[28]

[56] The 25 August 2022 meeting then discussed the alleged misconduct. I am satisfied that the notes[29] of the meeting produced by Ms Clare are broadly representative of the meeting. Having regard to those notes and the evidence of those in attendance, the following more significant events took place:

- Ms Jacobs attended the meeting, which was scheduled for 09:00am, at approximately 09:20 am.
- Ms Jacobs did not have a support person with her, having decided that this was not required.
- Ms Tiver was present.
- Ms Clare advised that they would discuss the outcome of the July 2022 disciplinary meeting as this was not yet completed. Ms Clare read out the allegations and summarised her view of the responses and the conclusions.
- Ms Jacobs questioned some of the discussions and conclusions and asked why the General Manager hadn't asked (the RN) if she (Ms Jacobs) had told the RN that she was leaving her shift on 22 July 22. Ms Clare advised, in effect, that it hadn't been confirmed one way or the other. However, Ms Clare explained that the issue was about leaving a shift without a sound reason, due to the implications of leaving a

shift which puts residents at risk in terms of care and well being. Ms Jacobs indicated that the reason she left her shift on 22 July was that she found a mess in Wattle court and didn't want to stay at work and, in effect, condone those working conditions.

- Ms Clare then discussed the other incident where Ms Jacobs had arrived to her shift late on 24/7/22 for the stated reason of having no transport. Ms Clare advised that this was also putting staff and residents at risk given they were working short staffed.
- Ms Jacobs wanted to know if she was getting a written warning.
- In response, Ms Clare advised that based on the responses and the "breaches of the Policy Performance Management and Misconduct" there would be a first written warning.
- Ms Jacobs acknowledged a first written warning was being given. Given the context, it would not have been reasonable for the Respondent to presume that this meant that Ms Jacobs had accepted the basis of that warning.
- Ms Clare then commenced to discuss the more recent letter detailing the incidents on the night shift commencing on 3 August 2022.
- Ms Jacobs stated words to the effect of "I'm guilty as charged."
- Despite this indication, Ms Clare proceeded to go through the list of allegations and made observations and findings gleaned from the investigation that she had conducted. This included her view that Ms Jacobs did not do Safety checks or any pressure area care on this Resident in question and that there were no safety checks completed for any residents.
- Ms Clare advised that there was (or would be) a Coroners Court enquiry into the death of the Resident. Ms Clare also advised that in any event a "priority 1" report had been made to the Aged Care Quality Agency and this would lead to a full investigation. Further, she advised that under the Aged Care standards it was the Respondent's duty to investigate and take action if it held any areas of concern. This was acknowledged by Ms Jacobs.
- Ms Jacobs stated words to effect of "I'm guilty, what are you going to do, take me off night shift or give me a second warning?" Ms Jacobs also raised the question as to whether she would be terminated. In context and given the tone of the discussion, this would not reasonably have been understood that Ms Jacobs considered this to be appropriate. Rather, given her (incorrect) understanding of the disciplinary policy (I will return to this aspect) this would reasonably have been understood as an indication that the conduct was not serious and that dismissal should, in any event, not take place.
- Ms Clare confirmed that the meeting was to consider Ms Jacobs' responses to determine if this was wilful misconduct. Further, given Ms Jacobs responses, management did consider that the events of the shift in question represented wilful misconduct by reference to the alleged neglect, resulting in a failure to provide a duty of care to residents, as well as professional misconduct with falsifying documentation.
- Ms Clare advised that Ms Jacobs would be terminated effective immediately.

- Ms Jacobs requested that the written warning be sent to her by email, which was confirmed by Ms Clare.
- Ms Clare also stated that usually there is no notice in lieu for wilful misconduct, however Moonta Care would provide 2 weeks payment and that the termination pay would be completed on the next day by payroll.

[57] I am not persuaded that Ms Clare lost her composure and slammed the table. However, it is likely that she did find Ms Jacobs' response distressing given the significance of the issues being raised and this is also likely to have been perceived by Ms Jacobs as strong frustration and disappointment. It is also likely that Ms Jacobs was emotional during the meeting given the context and her response to the events more generally.

[58] The dismissal was confirmed via email on the same day, with the dismissal taking effect on 25 August 2022. Ms Jacobs was also advised that a report would be made to the Aged Care Quality Agency as required and that there would be an investigation – the outcome of this is still pending.

[59] The written reasons given for dismissal by the Respondent were as follows:

> "I refer to our Phone Conversation on 4th August following a serious allegation regarding provision of care and safety checks where a resident was injured. An investigation has been conducted including interviews, documentation, and CCTV footage.
>
> You have been stood down on full pay pending the investigations.
>
> We have met on 25th August 2022 to seek your response to the allegations. You were advised to bring a support person and decided that you would not have a support person present.
>
> Allegations are as follows:
>
> 1. Allegations of Professional Misconduct by documenting Safety checks but not attending.
> 2. Allegations of Neglect resulting in failure to provide duty of care to residents.
>   a. Namely Pressure Area Care
>   b. Safety checks.
> 3. Allegations of breach of Infection Control
>   a. Namely not wearing PPE during Outbreak.
>
> Policies discussed were:
>
> - Code of Conduct
> - Performance Management and Misconduct
> - Dismissal for Misconduct Procedures
>
> After careful consideration of your response to the allegations we do not find that your response explains, justifies or excuses your Performance or Conduct. Your responses were decisive and to the point where you stated "I'm guilty of everything".

> Accordingly, MHAACS has decided to terminate your employment for professional misconduct and negligence and deem to be serious and willful (sic) misconduct.
>
> Under our policy termination for serious and wilful misconduct means the right of notice of termination is waived.
>
> However to assist you financially whilst you seek alternative employment we will pay you 2 weeks notice in lieu of termination and any other entitlements owing in accordance with fair work.
>
> Your employment will be terminated effectively immediately."[30]

[60] As the handover requirements and the events on the night in question have some significance, I deal with those general requirements and events now.

[61] Ms Jacobs maintained that on the night in question a handover did not occur, and neither was there any handover information provided on the whiteboard, where it "usually is".

[62] The Respondent contended that it was Ms Jacobs' responsibility to seek a handover form from the RN and that the CCTV screenshots of the night in question, confirm that Ms Jacobs was part of a handover.

[63] Ms Tiver outlined that there was to be a handover from the nurse on the morning shift to all afternoon care staff and nurses. She also stated that handovers occur between carers: a carer finishing a shift is to report on every resident they were responsible for in the area, to the carer commencing the next shift. It is the responsibility of the two carers to ensure handover takes place.[31] Ms Tiver also states that when handover between carers is not possible due to, for example, a carer being late to a shift, that carer is to seek handover from the nurse in charge of the area.[32] I accept that evidence.

[64] Ms Tiver stated that handover sheets were, in any event, available to Ms Jacobs. I accept that evidence. Further, the High Care Night Shift List[33] outlines the activities to be completed by staff during the night shift in the High Care Unit. The list requires staff to perform safety checks on all residents every hour. Along with requiring the repositioning of residents that are on pressure area care every two hours. The first activity on the list is to "report on duty to RN/EN and receive handover."

[65] The absence of evidence from any other employee[34] working on the night in question has led to limited evidence about the degree of handover. There is some indication from the CCTV screen shot that Ms Jacobs was involved in a discussion that may have been a handover. Ms Jacobs did accept[35] that she was given a handover sheet as some point. However, I cannot be satisfied that a full handover occurred on the night in question.

[66] However, for reasons outlined above and further examined below, I am satisfied that the requirement for an hourly safety check to be undertaken on all residents (except those where a do not disturb sign was displayed) was a standard requirement and this applied to the Resident in question. No change to this requirement was made in relation to this shift and no notice of this was required. Further, I accept that Ms Jacobs had an obligation to obtain an understanding of any changed care needs. The fact that this may not have occurred, beyond the provision of the handover sheet, would only be relevant to the repositioning requirements (which do change

more regularly) and this should be assessed in the context of the reality of the work on the night in question, including the staffing levels and the additional requirements flowing from the Covid-19 outbreak.

4.2 The alleged misconduct

[67] Against that background, I turn now to findings regarding the alleged misconduct relied upon by the Respondent.

Breach of Infection Control – Not Wearing full PPE during Covid-19 Outbreak

[68] The relevant policy required, in effect:

> "**2. Care Staff**
>
> … …
>
> **PPE**
>
> Personal Protective Equipment refers to the use of gloves, gowns, masks, and eye protection.
>
> a. Care Staff are to ensure that Infection Control procedures are undertaken during all aspects of care.
> b. Care Staff are to use PPE where indicated and request further supplies if running low.
> c. Care Staff are to ensure adequate PPE is available for the oncoming shift at the Residents room when indicated.
> d. See MHAACS Infection Control Manual - Policy 3.1.7 Personal protective equipment (PPE), donning and removing PPE. or **Appendix 7**"[36]

[69] The comprehensive Covid-19 procedures document provided as follows with respect to waste management:

> "… …
>
> **Waste Management**
>
> All waste generated during the care of a resident suspected or confirmed to have COVID 19 should be managed as clinical infectious waste.
>
> a. Staff should use contact and droplet precautions when transporting and disposing of this waste in the yellow infectious waste bin.
> b. Once waste has placed in the appropriate yellow infectious waste bin the staff member should remove their PPE and dispose of it into the yellow infectious waste bin.
> c. The staff member should then proceed to attend to good hand hygiene and apply a hand sanitizer before returning to area of work.
>
> Transporting Infectious waste or clothing/linen to caged area follow **Appendix 10**."[37]

[70] Further, I find that the Covid-19 outbreak requirements indicated that clinical care employees must remain within their work area allocated on the roster and anticipated that staff

would not work during the same shift in those units where an outbreak was underway and in the non-outbreak areas of the facility: Specifically high care and low care.[38] However, I observe that some exceptions are noted in the policy including in relation to clinical treatment, Doctors Rounds and maintenance. This practice was discouraged and involved strict PPE and infection protocols.

[71] I find that during the shift in question, Ms Jacobs was required to work in both the high and low care units of the facility. This was not consistent with the thrust of the Covid-19 policy. This is relevant but does not wholly excuse non-compliance more generally. Indeed, it is conceivable that attention to the PPE requirements would become more important. However, I add that there is no indication that Ms Jacobs wore the same PPE from the high care units when working in the low care units.

[72] During Covid-19 outbreaks, additional requirements were also implemented, and these were advised to the employees via emails provided by Ms Tiver. I accept that the emails were sent to the employees, and it is likely that this included Ms Jacobs. However, the detail of those emails is not before the Commission.

[73] During night shifts, the Residents were generally in their rooms and during the Covid-19 outbreak, were generally expected to remain so at all time, with some limited exceptions.

[74] The allegation that the Applicant did not comply with the PPE requirements for Covid-19, creating serious risk to health and safety, is based on the contention that Ms Jacobs was not wearing a gown. Moonta Health principally relies upon CCTV footage which shows that at various times Ms Jacobs was not wearing a gown whilst on duty in high care.

[75] Ms Jacobs states the reason she may have been seen not wearing a gown is because many of the workstations were out of stock and that she had to walk through the facility until she found the required gowns. Further, Ms Jacobs contends that this, along with having to put on the PPE, is also the reason she clocked in at 10:50pm, not 10:45pm. The Applicant also claims in later evidence that by midnight she would have definitely been wearing a gown, and if there are moments where she is not wearing one it would have been because she was in between removing and old gown and replacing it with a fresh one after leaving residents' rooms. Later in oral evidence under cross-examination when confronted with the CCTV stills showing various times when she was not wearing the full PPE in the high care units, Ms Jacobs indicated that she was not required to wear the full PPE in or around the Nurses stations and when leaving the unit to dispose of rubbish (including disposed PPE).

[76] Despite Ms Tiver's evidence that there would have been enough PPE gear available throughout the facility, it is conceivable that not all stations had been restocked on the night in question. Ms Jacobs explanation about her actions at the commencement of the shift is plausible. There is no suggestion that the full PPE was not otherwise available to Ms Jacobs and the other employees on the night in question.

[77] The question remains is whether Ms Jacobs was required to wear the full PPE, including the gown, at all times during her shift in the High Care units on the night in question. It would be reasonably evident that this would not include, as a matter of practical reality, the very short time taken to remove and replace the relevant PPE between the rooms of the residents where

Ms Jacobs had entered. However, there are other times when Ms Jacobs was not wearing the full PPE including at the Nurses Station and when taking out clothing and rubbish from the high care unit to the laundry area.

[78] I observe that all other staff shown in the CCVTV footage were wearing full PPE at all time in the High Care units. I also infer that at times, the RN on shift must have seen Ms Jacobs at the Nurses Station (3 employees are evident in the still shot). There is no indication that the RN took any action at that time, or subsequently, to report the incident or otherwise require Ms Jacobs to comply with the PPE requirements at the time.

[79] Ms Jacob's explanation, which initially only referred to the time when not wearing her full PPE due to needing to find the stocks on initial entry to the facility, does lead to doubts about her evidence on the PPE matter more generally. However, for reasons that I will come to, the Respondent must demonstrate the alleged misconduct to the necessary standard.

[80] I find that as a general statement, the requirement for the full PPE to be worn whenever involved in attending to residents and when dealing with laundry and rubbish removal from the high care area, was in place at the relevant time. This is supported by the documentary material and the evidence of Ms Tiver. I do not accept that Ms Jacobs was informed by management or the RN that she was not required to wear the PPE at all times in the high care units during the Covid-19 outbreak. However, as the detailed requirements set out in the emails, including whether there was any dispensation when in or around the Nurses stations, are not before the Commission, I cannot be satisfied that there was a deliberate and substantial breach of the PPE requirements by Ms Jacobs in that regard.

Safety checks on Residents

[81] Ms Jacobs recorded having performed safety checks on the Resident in question (and others) for each hour of her shift. I note here that the Resident in question was entered as "resting" not "asleep" on the Safety Daily Check Form.

[82] It was Ms Jacobs' contention that she performed safety checks as she had been trained. That is, only sighting those residents for whom visual checks had been expressly stated and for the others it was merely having an awareness of their location. Further, given the level of staffing and the work requirements, it would have been impossible to complete a visual safety check hourly for all residents.

[83] Ms Jacobs contended that she entered the first round of safety checks (11.00 pm) for all the residents in the high care unit (except for 2 residents that she was aware of needing hourly checks) on the basis of information given to her by the RN that the resident were "In Bedroom and Asleep".[39] The actual safety check requirements are in dispute. The Applicant has stated that the only communication she had with the carer before her was in the form of a note requesting that she see a particular resident who needed attention when she begin her shift.[40] I accept the latter part of this evidence.

[84] The Respondent maintains that all residents in the facility require hourly visual checks, unless a risk assessment has been performed and a "do not disturb" sign is present on their door. I accept that this was the requirement. It is the Respondent's position that Ms Jacobs ought to

have known this, as it is a common sense understanding of a safety check and it would have been explained to her during training and induction.

[85] I accept Ms Tiver's evidence about this issue was sound, as far as it went. This includes that the requirements as described above were the subject of training and would have been generally understood and applied in the workplace. Although, there was no direct evidence about the induction or other training that was supplied to Ms Jacobs, it should have been self-evident that the form of safety check explained by Ms Jacobs would be completely inadequate for the purpose. This includes the notion that merely being aware that the Residents were in their room was sufficient. I do not accept that Ms Jacobs was trained or informed that this cursory approach to the safety checks was the required practice. I also prefer Ms Tiver's evidence about the practice that was in place within the facility.

[86] The balance of the evidence is that during the shift in question, Ms Jacobs did not perform the safety checks as required and for long periods did not undertake any form of check on most of the Residents. I will return to the impact of the staffing and other potentially mitigating circumstances as part of my consideration of the fairness of the Applicant's dismissal.

[87] In terms of the suggestion made by Ms Jacobs at some points that she was unaware that the safety check in relation to the Resident (and others) needed to be performed hourly, this cannot be easily reconciled with the fact that she made records of the hourly safety checks having been performed. I find that Ms Jacobs was aware of the requirement and that this involved actually checking upon the Residents by entering the room (unless a do not disturb sign was present).

[88] I also accept that the employees at Moonta Health are required to record the safety checks for their own work reasonably proximate to when they were undertaken. I also find that this record keeping is vitally important for the administration of care to the residents and that the need for accuracy of the record is well understood, including by Ms Jacobs.

[89] In evidence, Ms Jacobs contended that the safety checks were subsequently changed for the Resident in question to half-hourly. No direct evidence was provided for that proposition. In any event, the Respondent did not rely upon anything other than the standard hourly checks, a change to the check regimen for the Resident after the events of 3 and 4 August 2022 may be expected, and is not relevant to the assessment being made here.

[90] Ms Jacobs stated that she had to enter the safety checks for the buddy shift employee as they did not yet have log-in details. This is disputed by Moonta Health. The evidence before the Commission does not enable a finding to be made as to whether the fact the Ms Jacobs may have recorded some work for that employee was a significant issue. However, it is clear to me that Ms Jacobs would need to have been sure that the work had actually been undertaken before recording the resident safety checks. I find that Ms Jacobs did not ensure that that the safety checks had been undertaken by the buddy shift employee or the RN(s) prior to recording their completion. I will return to this aspect.

[91] I will also return shortly to the fact that no (other) employee performed an hourly safety check on, or a repositioning of the Resident in question, and that the medical episode and fall incident with that Resident may have occurred whilst Ms Jacobs was in the Low Care units.

Repositioning of Residents (pressure care)

[92] The requirement that certain residents be repositioned in bed as part of pressure care was subject to change, and this varied both between residents and potentially from time to time for a resident.

[93] The evidence reveals that on the relevant night, there was a requirement that the Resident in question be repositioned every 2 hours. This was confirmed on the individual handover sheet for that Resident.[41]

[94] The evidence[42] is that the Resident was not repositioned each 2 hours as required during the night shift in question. Further, the Resident was last repositioned at 9.00 pm on 3 August 2022, by another carer on a previous shift. The Applicant's response to this allegation includes that as there was no handover, she was not informed that they were needed for that resident and that it was not routine to check the individual vital information sheets for each of the residents as there is simply no time for this.

[95] I find that Ms Jacobs was required to check the available care information that reveals the changed care requirements for the residents. That check would have revealed that the Resident in question required the 2 hourly repositioning on the shift in question. However, I also find that there were times, when Ms Jacobs was on the low care units, that she could not have performed that duty. Further, the staffing levels in the context of the Covid-19 outbreak and the overall responsibility of the RNs are relevant factors that provide potential mitigation factors and I will return to this aspect in assessing the fairness of the dismissal.

The alleged falsification of the safety checks

[96] I have found that Ms Jacobs did not perform the safety checks as required and for long periods did not undertake any form of check on most of the Residents despite having recorded these as being performed. Further, some of the recorded safety checks were undertaken on the basis that the buddy shift employee or the RN must have (or did) undertake those checks. This was not verified prior to making the record.

[97] Even allowing for the different view about what constitutes a safety check, aspects of the safety check records produced by Ms Jacobs were false on any account.

The alleged neglect

[98] This is an emotive term and suggests that Ms Jacobs was solely responsible for the care of the residents. The actual conduct of Ms Jacobs is the relevant aspect for present purposes. I do accept that the conduct may have contributed to a serious risk to the health and safety of residents.

[99] I observe however, that it is less than clear that Ms Jacobs was solely responsible for the care of the Resident at the critical times. Although the evidence is incomplete, it is certainly possible, if not likely, that when the Resident had the fall and was not checked until found by the RN, Ms Jacobs was undertaking care at least for some time in the low care part of the facility. This does not excuse the actual misconduct, but may be important more generally for both Ms Jacobs and the Respondent.

The buddy training

[100] During proceedings, the Respondent also relied upon allegations that Ms Jacobs did not fulfil her duties to explain tasks to her buddy shift training staff member. The responsibilities for these tasks and the events on the night in question are in dispute. There was little or no direct evidence about this element provided by Moonta Health and it will not be explored further here.

5. Was Ms Jacobs' dismissal unfair within the meaning of the Act?

[101] Section 385 of the Act provides as follows:

> "**385 What is an unfair dismissal**
>
> (1) A person has been ***unfairly dismissed*** if the FWC is satisfied that:
>
> (a) the person has been dismissed; and
>
> (b) the dismissal was harsh, unjust or unreasonable; and
>
> (c) the dismissal was not consistent with the Small Business Fair Dismissal Code; and
>
> (d) the dismissal was not a case of genuine redundancy."

[102] There is no dispute that the Application was made within the time required by s.394(2) of the Act, or that Ms Jacobs was a person protected from unfair dismissal. Further, it is common ground that there was a dismissal and that the Small Business Fair Dismissal Code and the genuine redundancy provisions of the Act (as a jurisdictional objection) are not relevant.

[103] Accordingly, the Commission must determine whether the dismissal was harsh, unjust, or unreasonable within the meaning of the Act. If so, the dismissal of Ms Jacobs will be unfair and the relevant remedy provisions must be applied to consider whether a remedy is to be awarded.

[104] Section 387 of the FW Act provides that, in considering whether it is satisfied that a dismissal was harsh, unjust or unreasonable, the Commission must take into account:

> (a) whether there was a valid reason for the dismissal related to the person's capacity or conduct (including its effect on the safety and welfare of other employees); and
>
> (b) whether the person was notified of that reason; and

(c) whether the person was given an opportunity to respond to any reason related to the capacity or conduct of the person; and

(d) any unreasonable refusal by the employer to allow the person to have a support person present to assist at any discussions relating to dismissal; and

(e) if the dismissal is related to unsatisfactory performance by the person—whether the person had been warned about that unsatisfactory performance before the dismissal; and

(f) the degree to which the size of the employer's enterprise would be likely to impact on the procedures followed in effecting the dismissal; and

(g) the degree to which the absence of dedicated human resource management specialists or expertise in the enterprise would be likely to impact on the procedures followed in effecting the dismissal; and

(h) any other matters that the FWC considers relevant."

[105] I am required to consider each of these criteria, to the extent they are relevant to the factual circumstances before me.[43]

[106] I set out my consideration of each below.

Section 387(a) – whether there was a valid reason for the dismissal related to Ms Jacobs' capacity or conduct (including its effect on the safety and welfare of other employees)

[107] Valid in this context is generally considered to be whether there was a sound, defensible or well-founded reason for the dismissal, and the reason should not be "capricious, fanciful, spiteful or prejudiced".[44] Further, in considering whether a reason is valid, the requirement should be applied in the practical sphere of the relationship between an employer and an employee where each has rights, privileges, duties and obligations conferred and imposed on them. That is, the provisions must be applied in a practical, common-sense way to ensure that the employer and employee are each treated fairly.[45]

[108] The Commission will not stand in the shoes of the employer and determine what the Commission would do if it was in the position of the employer. The question the Commission must address is whether there was a valid reason for the dismissal related to the employee's capacity or conduct (including its effect on the safety and welfare of other employees).[46]

[109] It is also clear from the authorities that the reason for termination must be defensible or justifiable on an objective analysis of the relevant facts before the Commission. That is, it is not enough for an employer to rely upon its reasonable belief that the termination was for a valid reason.[47] The employer bears the evidentiary onus of proving that the conduct or incapacity on which it relies took place.[48] For there to be a valid reason related to the Applicant's conduct, I must find that the conduct occurred and justified termination.[49] "The question of whether the alleged conduct took place and what it involved is to be determined by the Commission on the basis of the evidence in the proceedings before it. The test is not whether the employer believed, on reasonable grounds after sufficient enquiry, that the employee was guilty of the conduct which resulted in termination."[50]

[110] For reasons set out earlier, some of the alleged grounds of dismissal are serious, with serious consequences, and the approach set out in *Briginshaw* is relevant to those aspects.

[111] I have made detailed findings about these matters earlier in this Decision. Without repeating this here, the following summarises the basis for my findings as to a valid reason for dismissal.

[112] I am not persuaded that the alleged misconduct concerning the buddy employee or the knowing breach of the Pressure Care requirements concerning the Resident in question have been demonstrated by the Respondent. I do accept that Ms Jacobs should have taken steps that would have alerted her to the additional requirements for repositioning of the Resident in question and this aspect remains significant.

[113] Further, it is less than clear that Ms Jacobs was solely responsible for the care of the residents in the High Care area at the critical times relevant to the Resident in question.

[114] I am satisfied that Ms Jacobs did not at times wear the required PPE on the shift in question. In particular, the gown was not worn as required at times in the High Care area of the facility. However, as the detailed requirements set out in the emails, including whether there was any dispensation when in or around the Nurses stations, are not before the Commission, I cannot be satisfied that there was a deliberate and substantial breach of the PPE requirements by Ms Jacobs.

[115] However, I am satisfied and find that the hourly safety checks were required for all residents (except where a Do Not Disturb sign was displayed) and that this requirement was known by Ms Jacobs. A safety-check involves the need to physically sight a resident and not merely relying on a lack of cues indicating disturbance coming from behind a closed door. I also find this to be a common-sense understanding of what a safety check would involve and this was the understanding in operation at the facility. Subject to the exception above, the Applicant was required to perform hourly safety checks for all the residents she was responsible for in the high care unit, at least when she was in that unit. Further, the fact that these safety checks were recorded by Ms Jacobs as being done reinforces this expectation and that Ms Jacobs was aware of the hourly requirement. The absence of a proper handover is not a basis to contend otherwise in this case, given that the requirement applied generally, and no change was made concerning the Resident on the night in question. In any event, the handover sheet, which Ms Jacobs accepted she had been provided, confirmed the standard requirement. I also find that most of the required safety checks were not performed as required and the entries were made by Ms Jacobs without her, or probably to her direct knowledge, anyone undertaking the required checks on some or all of the residents.

[116] Although I am willing to accept that Ms Jacobs may have been under pressure due to the facility being short staffed (at least in the context of the Covid-19 outbreak), I consider that taking the time to review the Vital Information Carers Handover Sheet for each of the residents, was vital and realistic. Additionally, irrespective of whether the individual vital information sheets were accessed, or not, Ms Jacobs should have known that all residents in the high care unit required hourly safety checks per the High Care Night Shift List.[51] I am also satisfied that, at least whilst in the high care units, the performance of the visual safety check on the relevant

residents was reasonably required. The failure to perform the relevant safety checks was misconduct.

[117] I have also found that even allowing for the different view about what constitutes a safety check, aspects of the safety check records produced by Ms Jacobs were false on any account. Given the context and circumstances of the workplace, this was also misconduct.

[118] There was no reliable basis advanced for Ms Jacob's contention that the actual reason for the dismissal was due to, or influenced by, any discriminatory ground.

[119] Having regard to the matters I have referred to above, I find that there was a valid reason for the dismissal related to Ms Jacob's conduct.

Section 387(b) – Was Ms Jacobs notified of the reasons for dismissal?

[120] Notification of a valid reason for termination must be given to an Applicant before the decision is made to terminate their employment,[52] and in explicit[53] and plain and clear terms.[54]

[121] The Respondent submitted that the Applicant was notified of the valid reason on the basis that the Applicant was notified of the serious misconduct as early as 4 August 2022, again in writing on 16 August 2022 and during the meeting on 25 August 2022.

[122] I find that the meeting request of 16 August adequately notified Ms Jacobs of the valid reasons. The meeting request set out the date and shift when the alleged conduct took place, the allegations, and the evidence against the Applicant. The request also noted the purpose of the meeting was to give Ms Jacobs an opportunity to respond to the allegations and that it may result in disciplinary action and/or termination depending on the outcome. Further, Ms Jacobs was again notified of the valid reasons during the meeting of 25 August 2022, prior to the dismissal.

[123] Having regard to the matters referred to above, I find that the Applicant was notified of the reason for her dismissal prior to the decision to dismiss being made, and this was done in explicit and plain and clear terms.

Section 387(c) – whether Ms Jacobs was given an opportunity to respond to any reason related to her capacity or conduct.

[124] An employee protected from unfair dismissal should be provided with an opportunity to respond to any reason for their dismissal relating to their conduct or capacity. An opportunity to respond is to be provided before a decision is taken to terminate the employee's employment.[55]

[125] The opportunity to respond does not require formality and this factor is to be applied in a common-sense way to ensure the employee is treated fairly.[56] Where the employee is aware of the precise nature of the employer's concern about his or her conduct or performance and has a full opportunity to respond to this concern, this will generally satisfy the requirements.[57]

[126] Further, in order to be given an opportunity to respond, the employee must be made aware of allegations concerning their conduct so as to be able to respond and defend themselves before the point is reached where a firm decision has been made irrespective of anything the employee might say in his or her defence.[58]

[127] Ms Jacobs contended, in effect, that she did not have an opportunity to respond to any valid reason, based, in part, on the fact that the meeting was conducted by the General Manager, Ms Clare along with Ms Tiver, both of whom the Applicant claims could not be impartial concerning the matter. Ms Jacobs also contends that during the first section of the meeting, which was used to discuss and issue a first written warning associated with the events of 26 and 27 July 2022, Ms Clare said to her that "she did not need to (speak to the RNs on shift to investigate the complaints) and she did not believe a word I had said."[59] I cannot be satisfied that this was said, although I have little doubt that Ms Clare's frustration and concerns at the attitude taken by Ms Jacobs would have been evident.

[128] Moonta Health submitted that the Ms Jacobs did have an opportunity to respond to any valid reason related to her conduct because Ms Jacobs was provided with an opportunity to respond to the allegations of serious misconduct in a meeting on 25 August 2022 prior to any decision being made.

[129] I am satisfied that Moonta Health provided Ms Jacobs with an opportunity to respond to the valid reason related to her conduct as required. I will further consider the issue of impartiality and compliance with policy and procedure in conjunction with sections 387(f), (g) and (h) below.

Section 387(d) – any unreasonable refusal by the respondent to allow Ms Jacobs a support person.

[130] Where an employee protected from unfair dismissal has requested a support person be present to assist in discussions relating to the dismissal, an employer should not unreasonably refuse that person being present.

[131] As noted by a Full Bench of this Commission, "[t]he subsection is not concerned with whether or not the employee was informed that he or she could have a support person present".[60]

[132] I find that Ms Jacobs had the opportunity to bring a support person to the meeting of 25 August 2023, but chose not to. This opportunity was outlined to the Applicant in the meeting request letters of 16 August 2022 and 22 August 2022. I find that the Moonta Health did not unreasonably refuse to allow Ms Jacobs to have a support person present at discussions relating to the dismissal.

Section 387(e) – if the dismissal is related to unsatisfactory performance by Ms Jacobs – whether she has been warned about that unsatisfactory performance before the dismissal.

[133] The dismissal did not directly relate to unsatisfactory performance. There are aspects of the allegations that do touch upon how Ms Jacobs carried out her duties. However, these are more in the nature of conduct rather than performance as contemplated by this consideration.

[134] Further, although the events of July 2022 were raised in these proceedings, this was a matter of context. I observe the issuing of a first warning at that point was unusual and somewhat problematic, and I have taken this into account. However, this aspect and any absence of warnings does not in my view lead to any unfairness in the dismissal given the other findings set out in this decision.

Section 387(f) – the degree to which the size of the respondent's enterprise would be likely to impact on the procedures followed in effecting the dismissal.
Section 387(g) – the degree to which the absence of dedicated human resource management specialists or expertise in the enterprise would be likely to impact on the procedures followed in effecting the dismissal.

[135] I will deal with these matters together.

[136] The Respondent submitted that the size of its enterprise was likely to impact on the procedures followed in effecting the dismissal as follows:[61]

- Moonta Health is a not-for-profit aged care services provider. It thus has a corresponding limit on managerial and administrative resources. It employed around 123 employees at the time of the Applicant's dismissal and although not a small business is of limited size; and

- Moonta Health does not employ a dedicated industrial relations specialist.

- Moonta Health's General Manager, Ms Alison Clare, was responsible for the investigation and decision making regarding the warning and termination of the Applicant's employment.

[137] Ms Jacobs submitted that the size of the Respondent's enterprise did not mean that it was open to the Respondent to apply procedures that were devoid of fairness and contrary to the Dismissal for Misconduct Procedures Policy. I will return to the substance of this contention in the consideration below.

[138] I find that Moonta Health is not a small organisation and operates in a highly regulated environment. Although it is a not-for-profit business, I do not consider that its size would reasonably impact upon the procedures it followed in making and implementing the dismissal decision.

[139] I find that Moonta Health did not have a dedicated human resource management specialist or expertise in the enterprise. I accept that this would have been likely to impact on the procedures followed in effecting the dismissal. This informs the consideration of certain elements of its own policies that I will return to below. I would however add that, as Ms Jacobs submitted, this would not mean that it was open to the Respondent to apply procedures that were devoid of fairness.

Section 387(h) –Other relevant matters

[140] Section 387(h) requires the Commission to take into account any other matters that the Commission considers relevant.

[141] Ms Jacobs, in effect, submitted that the following additional matters are relevant to the Commission's consideration of whether the dismissal was harsh, unjust or unreasonable:

- She is being made to bear all the responsibility for what happened during the shift in question because management needs someone to blame due to the problems arising out of the facility being short-staffed. She claims that staff are doing the job of three staff members and there is no duty of care provided towards the employees.

- In all probability she was in low care when the resident suffered the medical episode and should have been found by the RN or buddy shift employee on their safety checks that morning, not when the RN was doing the medication round early that morning. She was the only staff member that shift that was held accountable for that evening and Moonta Health should not have found that she was solely responsibility when there were 2 RNs on that night.

- The Respondent breached its own disciplinary policy in 2 respects. Firstly, the policy contemplated that there would be 3 strikes (incidents of serious misconduct) prior to dismissal being applied. Secondly, that the investigation should not have been conducted by Ms Clare as she was also the decision maker and was partly responsible for the events.

[142] The Respondent submitted that the following other matters are relevant to the Commission's consideration of whether the dismissal was harsh, unjust or unreasonable:

- That Ms Jacobs was provided with a discretionary two weeks' payment to assist in finding alternative employment. In the circumstances of the Ms Jacob's serious misconduct, that was beyond what was due to her and that was made clear to Ms Jacobs during the meeting of 25 August 2022.

- Moonta Health is subject to Aged Care Quality Standards and the oversight of the Aged Care Quality and Safety Commission. All residents of the respondent need a higher level of care, hence the requirement for hourly safety checks which is part of the Moonta Health's Risk Management. Where there is a higher risk of health concerns, more frequent checks may be implemented.

- The Respondent had to report a serious incident regarding the events of 3 and 4 August 2022 to the Aged Care Quality and Safety Commission.

- There is understandably significant community concern regarding the health and safety and treatment of residents in aged care. Those residents are vulnerable including due to Covid-19.

- Moonta Health must be permitted to take serious action including termination of employment in the event of falsification of safety checks on elderly residents and also for failures to adhere to PPE requirements during a Covid-19 outbreak in its facility.

[143] I observe that the consideration established by s.387(h) is limited only by reference to matters considered to be relevant. In this case there are some additional, and somewhat competing, considerations.

[144] For reasons set out earlier, the impact of the Covid-19 outbreak, staff shortages and additional requirements of staff, is relevant. I have made appropriate allowances for such including in relation to absence of steps taken, or not taken, to follow up the care requirements in the absence of a full handover and in terms of accepting that Ms Jacobs spent some time in both High and Low Care units on the shift in question. These are mitigating circumstances particularly in relation to those aspects.

[145] The fact that the conduct took place in the context of an aged care facility and the associated need for compliance with care requirements and record keeping are factors compounding the seriousness of the conduct in this case.

[146] Moonta Heath have a number of intersecting policies bearing upon this matter. The MHAACS Dismissal for Misconduct Procedures Policy states:

> "an investigation must be conducted by an impartial and competent person. If possible, this person should not be the same one who makes the final decision whether to terminate the employee. You should consider appointing an external party to lead the investigation where the matter is particularly serious, or where impartiality or expertise (for example in matters of fraud) of internal staff may be questioned"[62]

[147] The Dismissal for Misconduct Procedure for MHAACS states:

> "Where the misconduct is sufficiently serious an employer may dismiss an employee without having given the employee a formal warning addressed specifically to that employee. In those cases, the employer must believe on reasonable grounds that the behaviour is sufficiently serious that an earlier warning was not required to alert the employee that a dismissal could result should they engage in that behaviour. In very rare cases, a summary dismissal may be justified."[63]

[148] The Performance Management and Misconduct Policy for MHAACS states:

> "In the case of Employees that are subject to termination for serious and wilful misconduct the Procedures outlined in the policy "Serious and Wilful Misconduct Policy" will be followed. The definition of Serious and wilful misconduct is outlined in the "Serious and Wilful Misconduct Policy" and includes but is not limited to the following:… professional misconduct…negligence resulting in failure to provide a duty of care to residents…"[64]

[149] The Performance Management and Misconduct Policy also states that:

> "summary (instant) dismissal for serious and willful misconduct" is available, and that if "an employee is found guilty of serious and willful misconduct, their right of notice of termination is waived."[65] Further, the same policy also mentions that in circumstances where an employee is being dismissed due to conduct, "senior management will ensure

> a thorough investigations of the allegations and suspend the employee on full pay whist the investigation is taking place. It is advisable that MHAACS consult with their industrial relations consultant prior to taking this action."[66]

[150] The relevant policy, reasonably applied, did not require that multiple warnings be provided in the case of serious misconduct. The policy did however suggest that, in effect, some external advice be sought and that any investigation be undertaken by an impartial and competent person other than the final decision- maker. This is not however stated in absolute terms.

[151] A more detailed investigation was warranted and in other circumstances this would have been more significant. However, given that Ms Jacob's approach in both the telephone conversation on 4 August and the meeting of 25 August 2022 – including to, in effect, indicate that she was guilty of the alleged misconduct which by that time had been specified on several occasions, the Respondent would reasonably have understood that the substance of the allegations was not in dispute.

[152] The impact of the dismissal upon Ms Jacobs is also relevant. Ms Jacobs has lost her employment with Moonta Health, which she had held for approximately 18 months, with the consequences that flow from that outcome including the income and personal impact. This also occurred in the context of employment in a regional location where it might reasonably be suggested that employment options are more limited than in a larger community.

[153] Ms Jacobs was paid 2 weeks in lieu of notice.

[154] I have taken all these matters into account in assessing the dismissal.

Was the dismissal of Ms Jacobs harsh, unjust or unreasonable?

[155] I have made findings in relation to each matter specified in section 387 as relevant.

[156] I must consider and give due weight to each as a fundamental element in determining whether the termination was harsh, unjust or unreasonable.[67]

[157] Having considered each of the matters specified in section 387 of the FW Act, I am not satisfied that the dismissal of Ms Jacobs was harsh, unjust or unreasonable. Without duplicating all of the findings and considerations set out above, I consider on balance that the misconduct which has been demonstrated was significantly serious such that when all of the relevant factors are weighed against one another and taken into account, the dismissal was warranted and not harsh, unjust or unreasonable within the meaning of the FW Act.

6. Conclusion and Order

[158] Not being satisfied that the dismissal was harsh, unjust or unreasonable, I am not persuaded that Ms Jacobs was unfairly dismissed within the meaning of section 385 of the FW Act. The application must therefore be dismissed. An Order[68] is being issued in conjunction with this decision.

[159] I would however repeat my earlier observations for the benefit of the parties and others with an interest in this matter. It has not been the role of the Commission to make any findings about whether the events relevant to this application played any role in the ultimate outcome for the Resident concerned. As a result, the findings that are made in the decision regarding the conduct of Ms Jacobs have been considered in the employment context, without attribution of responsibility for outcomes. Further, whilst not detracting from the misconduct that I have found to have occurred, it is less than clear that Ms Jacobs was solely responsible for the care of the Resident at the critical times relating to that resident.

DEPUTY PRESIDENT

Appearances

S Jacobs, the Applicant on her own behalf.
L Troung (of counsel), with *A Ly* appeared with permission for the Respondent.

Hearing Details

2023
February 13, 14
Video Hearing.

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[1] Applicant Outline of Argument Digital Court Book (DCB) page 37.

[2] S.399 of the FW Act.

[3] Permission was granted for reasons provided separately to the parties in advance of the hearing.

[4] See also the discussion of some of the relevant considerations for a similar Tribunal in *Minogue v HREOC* [1999] FCA 85.

[5] Transcript PN122.

[6] Including confirming her statement - Exhibit A1 and Form F2, Exhibit A2.

[7] Exhibit A3.

[8] Exhibit R3.

[9] Exhibit R1 - Witness Statement of Ms Alison Clare.

[10] Exhibit R2 - Witness Statement of Ms Sonya Tiver.

[11] In particular, the emails providing the additional details and instructions concerning revised requirements during a Covid-19 outbreak identified in the oral evidence of Ms Tiver.

[12] (1938) 60 CLR 336.

[13] (2007) 166 IR 407 at [14] - [16].

[14] Applicant's Outline of Argument, exhibit A2 DCB page 37.

[15] Witness Statement of Ms Clare, Annexure AC-2 DCB page 236.

[16] Witness Statement of Ms Clare, Annexure AC-2 DCB page 236.

[17] Witness Statement of Ms Clare, Annexure AC-1 DCB pages 183 and 184.

[18] Witness Statement of Ms Clare, Annexure AC-17 DCB page 346..

[19] Witness Statement of Ms Clare, Annexure AC-4 DCB page 240.

[20] Witness Statement of Ms Clare, Annexure AC-6 DCB page 274.

[21] Form F3 – Employer Response, Annexure ER-8 DCB page 129.

[22] Form F3 – Employer Response, Annexure ER-9 DCB page 130.

[23] Witness Statement of Ms Clare, Annexure AC-9, DCB page 327.

[24] Witness Statement of Ms Clare, Annexure AC-11, DCB page 333.

[25] Witness Statement of Ms Clare, Annexure AC-12, DCB page 338.

[26] Witness Statement of Ms Clare, Annexure AC-13, DCB page 339.

[27] Witness Statement of Ms Clare, Annexure AC-15, DCB page 343.

[28] Form F3 – Employer Response, Annexure ER-12, DCB page 133.

[29] Witness Statement of Ms Clare, Annexure AC-18, DCB page 347.

[30] Witness Statement of Ms Clare, Annexure AC-19, DCB page 349.

[31] Witness Statement of Ms Tiver, DCB page 355.

[32] Witness Statement of Ms Tiver, DCB page 355.

[33] Form F3 – Employer Response, Annexure ER-5, DCB page 94.

[34] Ms Kang was not available for cross-examination and her statement did not directly address most of the significant matters to be determined here.

[35] Transcript PN108.

[36] Witness Statement of Ms Clare, Annexure AC-1 DCB page 160.

[37] Witness Statement of Ms Clare, Annexure AC-1 DCB pages 160-161.

[38] Witness Statement of Ms Clare, Annexure AC-1 DCB page 173.

[39] Form F2, Attachment, DCB page 25.

[40] Form F2, Attachment, DCB page. 25.

[41] Witness Statement of Ms Sonya Tiver, Annexure ST5, DCB page 396.

[42] Witness Statement of Ms Sonya Tiver, Annexure ST3, DCB page 363.

[43] *Sayer v Melsteel Pty Ltd* [2011] FWAFB 7498, [14]; *Smith v Moore Paragon Australia Ltd* PR915674 (AIRCFB, Ross VP, Lacy SDP, Simmonds C, 21 March 2002), [69].

[44] *Selvachandran v Peteron Plastics Pty Ltd* (1995) 62 IR 371, 373.

[45] *Selvachandran v Peteron Plastics Pty Ltd* (1995) 62 IR 371 as cited in *Potter v WorkCover Corporation*, (2004) 133 IR 458 per Ross VP, Williams SDP, Foggo C and endorsed by the Full Bench *in Industrial Automation Group Pty Ltd T/A Industrial Automation* [2010] FWAFB 8868, 2 December 2010 per Kaufman SDP, Richards SDP and Hampton C at par [36]

[46] *Walton v Mermaid Dry Cleaners Pty Ltd* (1996) IRCA 267 per Moore J at [685].

[47] See *Australia Meat Holdings Pty Ltd v McLauchlan* (1998) 84 IR 1; *King v Freshmore (Vic) Pty Ltd* AIRCFB Print S4213 per Ross VP, Williams SDP, Hingley C, 17 March 2000; *Edwards v Giudice* (1999) 94 FCR 561; *Crozier v Palazzo*

Corporation Pty Limited t/as Noble Park Storage and Transport AIRCFB Print S5897 per Ross VP, Acton SDP and Cribb C, 11 May 2000 and *Rode v Burwood Mitsubishi* AIRCFB Print R4471 per Ross VP, Polites SDP, Foggo C, 11 May 1999

[48] *King v Freshmore (Vic) Pty Ltd* (unreported, AIRCFB, Ross VP, Williams SDP, Hingley C, 17 March 2000) Print S4213 at [24].

[49] *Edwards v Justice Giudice* [1999] FCA 1836, [7].

[50] *King v Freshmore (Vic) Pty Ltd* Print S4213 (AIRCFB, Ross VP, Williams SDP, Hingley C, 17 March 2000), [23]-[24].

[51] Respondent's Form F3, Annexure 5, DCB p. 94.

[52] *Crozier v Palazzo Corporation Pty Ltd* (2000) 98 IR 137, 151.

[53] *Previsic v Australian Quarantine Inspection Services* Print Q3730 (AIRC, Holmes C, 6 October 1998).

[54] Ibid.

[55] *Crozier v Palazzo Corporation Pty Ltd t/a Noble Park Storage and Transport* Print S5897 (AIRCFB, Ross VP, Acton SDP, Cribb C, 11 May 2000), [75].

[56] *RMIT v Asher* (2010) 194 IR 1, 14-15.

[57] *Gibson v Bosmac Pty Ltd* (1995) 60 IR 1, 7.

[58] *Wadey v YMCA Canberra* [1996] IRCA 568.

[59] Form F2, Attachment 1, DCB p. 17.

[60] *Jurisic v ABB Australia Pty Ltd* [2014] FWCFB 5835, at [84]

[61] Respondent Submissions, Digital Court Book p.144

[62] Witness Statement of Ms Clare, Annexure AC-1 DCB page 216.

[63] Witness Statement of Ms Clare, Annexure AC-1 DCB page 215.

[64] Form F3 – Employer Response, Annexure ER-4, DCB page 92.

[65] Form F3 – Employer Response, Annexure ER-4, DCB page 93.

[66] Form F3 – Employer Response, Annexure ER-4, DCB page 93.

[67] *ALH Group Pty Ltd t/a The Royal Exchange Hotel v Mulhall* (2002) 117 IR 357, [51]. See also *Smith v Moore Paragon Australia Ltd* PR915674 (AIRCFB, Ross VP, Lacy SDP, Simmonds C, 21 March 2002), [92]; *Edwards v Justice Giudice* [1999] FCA 1836, [6]–[7].

[68] PR760706