Sheriff John N McCormick

Case Reference Number: B838/09

2010FAI8

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT KIRKCALDY

DETERMINATION BY SHERIFF ANDREW GRANT McCULLOCH

in the inquiry into the circumstances of the death of

BRIAN JOHN GILFILLAN

under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976

APPEARANCES:-

For the Crown: Mr Robertson, Procurator Fiscal

For the family of the deceased: Mr Clark, Solicitor

For NHS Fife: Mrs McPhail, Solicitor

KIRKCALDY 3 February 2010.

The Sheriff, having considered all the evidence adduced and the submissions made thereon, determines in terms of Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:-

Section 6(1)(a). That Brian John Gilfillan, born 3 November 1971, usually residing at 7 Brodick Road, Kirkcaldy, died some time between 0600 and 1410 hours when life was pronounced extinct, on 28 October 2008, within the grounds of Forth Park Hospital, Bennochy Road, Kirkcaldy KY2 5RA.

Section 6(1)(b). That the cause of his death was suspension by the neck from a rope ligature, otherwise hanging.

Section 6(1)(c). That there were no reasonable precautions whereby the death might have been avoided.

Section 6(1)(d). That there were no defects in any system of work which contributed to the death.

Section 6(1)(e). That there were other facts which are relevant to the circumstances of the death, as set out in more detail below, but which include the absence of proper training of managers in the correct interpretation of the management of employee conduct policy, in the failure to follow the requirements of that policy, and the absence of employee welfare considerations in that policy.

(Signed) A G McCulloch

NOTE

The following witnesses were led at the inquiry which was held on 26 and 27 January 2010:

[1] Stewart Gilfillan, father of the deceased
[2] Sean Campbell, security officer, NHS Fife
[3] Anne Starkie, medical records manager, NHS Fife
[4] Valerie Anderson, manager, NHS Fife
[5] Julie Smith, NHS Fife employee and Unison rep
[6] Audra Gibson, NHS employee
[7] Patricia Stott, former medical records supervisor
[8] Karen Laird, HR officer, NHS Fife.

Introduction

[1] At the time of his death, Brian John Gilfillan was aged 36, and had been employed for the whole of his adult life within the records department of NHS Fife, based firstly at Victoria Hospital and thereafter at Forth Park Hospital. From about 2004 he had been a supervisor within that department. He was

responsible for six others, and his line manager was Anne Starkie, who was medical records manager. Mr Gilfillan lived at home with his parents, had few hobbies, and considered his work to be extremely important to him. I heard evidence of him regularly working beyond his contracted hours, to the extent that he received a written reprimand, and of bringing work home on occasion, to correct the errors made by others.

[2] Amongst Mr Gilfillan's responsibilities was the requirement to ensure that the department had sufficient stock of stationery, and when necessary he would advise Anne Starkie, who would place the appropriate order. However, in her absence, to ensure that the department continued to have sufficient supplies, he would place stationery orders himself.

[3] It came to light that in March 2008, an order for maternity forms was queried by the appropriate department, as being an apparent duplication. On investigation Mrs Starkie realised that she had not submitted this particular order, but was informed that Mr Gilfillan had. When she asked him about this, he confirmed that he had done so, and as he believed that his signature did not carry sufficient authority for the order, he had appended Mrs Starkie's signature to the form.

[4] This was a matter of concern to Mrs Starkie. She contacted NHS Fife HR department and was advised that in terms of the disciplinary code, she ought to convene an investigatory hearing. This she did and it took place on 15 April 2008. Mr Gilfillan was not represented at that hearing, which was conducted by Anne Starkie, who had the assistance of Donna Band, an HR officer within NHS Fife. At the hearing Mr Gilfillan accepted that he had used Mrs Starkie's signature on a number of occasions to order stationery. Mrs Starkie took the view that the forging of her signature was a breach of trust and, as a result, felt some form of disciplinary outcome was necessary. Accordingly, applying the disciplinary code of conduct, she passed the matter up to her line manager, Valerie Anderson.

[5] Mrs Anderson made the necessary arrangements for there to be a disciplinary hearing in respect of "the allegations of forging your manager's signature". This hearing was originally scheduled for 5 June and then rescheduled for 1 July.

[6] At the hearing on 1 July, which was chaired by Valerie Anderson, receiving HR support from Karen Laird, an HR officer with NHS Fife, Mr Gilfillan appeared and with him was his union representative, Julie Smith. The investigating officers were Anne Starkie with Donna Band providing HR support. Mrs Starkie referred to her report, prepared after the investigation hearing. After that hearing she had made further checks of stock order forms, and found a total of 11 cases where Mr Gilfillan had signed her name. As he also had payroll responsibilities, that area was checked as well, but nothing untoward was detected. The hearing progressed, and after Anne Starkie had presented the findings of the investigation, as per her report, Mr Gilfillan accepted what was stated, and said that it was a fair account of what had happened. It is clear from the questioning of Mr Gilfillan that took place during the hearing by Mrs Anderson and Mrs Laird, that they were concerned with one particular stationery order form, upon which Mrs Starkie's signature appeared to have been copied over. Thus Mr Gilfillan was repeatedly questioned about whether he had deliberately appended Mrs Starkie's signature in a way that would make it look like Mrs Starkie's signature. It is clear to me that Mr Gilfillan was somewhat confused about this, he having always accepted that he had "forged" her signature on the form. In any event, he eventually accepted that he had written her signature in such a way as to make it look like her signature. Throughout the questioning, there had been references to fraud having been committed by Mr Gilfillan and this continued despite Mrs Smith arguing on his behalf that this could not be a fraud, because there was no element of personal gain. In any event, after an adjournment when Mrs Anderson and Mrs Laird considered the evidence before them, what had been said at the hearing, and the discipline code, Mrs Anderson gave her decision, and I quote from the contemporaneous record of the hearing, "During the probing within the investigation and apparent here today as well, it took a lot of probing to get

you to be truthful. You accepted fraud only after an adjournment. I accept that this was not for financial gain but you breached trust due to the difficulties in getting the truth from you – I consider this serious misconduct." It will be noted that the word "fraud" again appeared in the decision.

[7] Once again, the matter was referred up the chain of command. It was referred to Andrea Wilson, who was Mrs Anderson's line manager. After a hearing had been fixed for 8 August, and postponed, and another for 30 September, and postponed, a hearing was eventually scheduled for 28 October. Three letters were sent to Mr Gilfillan after the finding of serious misconduct. These related to the three further hearings, two of which were postponed. The first of these letters, dated 29 July, states *inter alia*, "Given that some form of disciplinary action is a possible outcome of the hearing, you have the right to invite a colleague ……" However, the letters of 23 September and 10 October are in a different form, as follows, "Given that some form of disciplinary action, *including your dismissal*, is a possible outcome of the hearing, you have the right to invite a colleague ……." (my emphasis). I do not consider that Mr Gilfillan had considered or been made aware of the possibility of dismissal until he received the letter dated 23 September 2008. Until then, there had been no hint of what the disciplinary outcome might be. This is despite the disciplinary code, at Appendix 3, requiring that employees who were to receive letters inviting them to disciplinary hearings, "must have identified to them the possible disciplinary actions which may be taken as a result of the hearing". All that had been said in communications up to 23 September was that "some form of disciplinary action is a possible outcome".

[8] Mr Gilfillan was said by colleagues to be upset and angry, prior to the hearing in October. Yet, at home his parents noted little change in his demeanour. He left for work as normal on 27 October, leaving his dig money as usual. A call was received at his home from Anne Starkie at 9.20 am on 27 October to say that he had not turned up for work. This was extremely unusual behaviour, and a search commenced, with the police being informed. Eventually CCTV operatives reviewing records, discovered an image of Mr

Gilfillan at about 6.00 am on 28 October exiting from a side door at Forth Park Hospital. The responsible security officer later accompanied another member of staff and two police officers in a search of the grounds, where Mr Gilfillan was found dead, hanging from a tree in a secluded wooded area within the grounds of the hospital. His life was pronounced extinct at 1410 on 28 October 2008, although it was clear that he had died some hours before then.

Submissions

[9] On behalf of the Crown, the Procurator Fiscal submitted that there were a number of areas of concern. However, so far as the formal determination under sub-paragraphs (a) and (b) were concerned, all parties were agreed. The Fiscal argued that there were two principal precautions which would have been reasonable to take whereby the death might have been avoided. The first was that Mr Gilfillan ought not be subject to disciplinary proceedings at all, and the second was not suddenly to raise the spectre of dismissal, several months after the commencement of the proceedings. With regard to sub-paragraph (d), he did not consider that there were defects in the system of working, but there had been shortcomings in the way that individuals had operated within the system of working. Finally, he felt that there were factors relevant to the death, although these would overlap in part with the reasonable precautions which might have been taken.

[10] The first Crown concern was to have a grave misgiving as to why Mr Gilfillan was even subject to disciplinary proceedings, given the terms of the discipline code, and what he accepted he had done. He accepted he should not have signed her name. However, it was conceded by Valerie Anderson, both at the hearing in July and before the inquiry, that Mr Gilfillan could have signed his own name, or placed the letters "*pp*" before Anne Starkie's name, and in those circumstances he would not have broken any rules and not been subject to any inquiries. Mr Gilfillan's problem was that he had thought, wrongly, that he had needed her to sign, or at least countersign. There was no written protocol in place for ordering stationery when Mrs Starkie was absent.

It was accepted that the categories of misconduct set out in appendix 1 were not exhaustive, but the problem seemed to be that there was a belief that he had committed fraud. Although there is no mention of fraud in Anne Starkie's report of the investigation hearing, she refers to forgery. In her evidence, she equated these two concepts. Similarly, Valerie Anderson considered that Mr Gilfillan had committed a fraud, as is apparent from her contemporaneous notes, and her written findings dated 22 July, where she refers to "his actions in fraudulently forging his line manager's signature on stores requisitions on a number of occasions". It would appear that Anne Starkie, Valerie Anderson and Karen Laird all thought that his actings had amounted to fraud. But, according to the Fiscal, on no legal view would Mr Gilfillan be guilty of any fraud or attempted fraud. There was no personal gain. The Procurator Fiscal was critical that no legal advice was sought, and that these managers were misguided. The focus of the hearing had moved from what was requested by Anne Starkie for "some sort of disciplinary outcome" and believed by Donna Band to be (in an e-mail) "a straightforward hearing" to one where serious misconduct was now established. The Procurator Fiscal was concerned that while the process had been conducted fairly, it had not been conducted properly. Had it only become serious misconduct because Valerie Anderson and Karen Laird had felt that it was fraud, and fraud featured very high up on the list of issues to be considered as gross misconduct?

[11] The Fiscal was also critical of the way in which the possibility of dismissal had suddenly appeared and was critical of the HR department for the way they handled correspondence, in that they did not follow their own code of practice, regarding the content of letters to employees invited to hearings, as set out in Appendix 3.

[12] In accepting that there was a delay between the commencement of the investigation process, and the potential outcome on 28 October, although noting that it may even have been extended beyond there if Andrea Wilson had felt her powers of discipline were insufficient, the Fiscal did not consider that the delay had any part to play in Mr Gilfillan's death. His principal concern was

that NHS Fife had acted "shoddily". They had not taken advice on legal issues. They had not followed their own practices. He considered it was unfair for Anne Starkie to investigate her own complaint, given that she went from complainer to judge to prosecutor within a short space of time; he was critical of a lack of guidance as to what serious misconduct might be and felt that if the whole matter had been dealt with rationally and proportionately, then Mr Gilfillan would never have had to face the hearing on 28 October for serious misconduct. Had he not been facing that hearing, the probability was that he would not have taken his own life.

[13] I then heard from Mr Clark on behalf of the family. He supported and adopted what had been said by the Procurator Fiscal in respect of subsections (a), (b) and (c), and associated himself with the comments in respect of subsection (e). However, he believed that there were defects in the system of working which required to be considered by the court. His reasoning was that the whole complaints system was driven by reference to the discipline code, and within that code there were defects. In particular, the code at paragraph 2.3 required there to be fairness in the process, but no timescales were set out. Mr Clark accepted that these could not be too restrictive, due to illness and availability, but if an issue was being considered, rightly or wrongly, as serious misconduct it ought to be dealt with promptly. The whole discipline process involving Mr Gilfillan had commenced in March, followed by a formal letter to him on 9 April, and had not been concluded by 28 October, when he died and, indeed, that might not have been the end of the discipline process. Further, he had not been suspended, where the discipline code would suggest that that would have been appropriate. Either the employers were not following their own policy, or the conduct was not serious enough to suspend. Thus, if it was not serious enough to suspend, should it be considered as serious misconduct at all?

[14] A further complaint was that the chairman of the discipline hearing ought to be a person with sufficient authority to impose the relevant sanction. That would avoid the further delays which occurred in this case, given that Mrs

Anderson only had the authority to impose a first warning or a second warning, but not a final warning, or a first and final warning.

[15] He was also concerned that managers who are to deal with discipline hearings ought to be familiar with policies, and the meaning of technical terms within those policies. Although some evidence was given as to what training had been undertaken by Mrs Anderson and Mrs Laird, it must have been inadequate given their failure to appreciate that, legally at least, whatever Mr Gilfillan had done, he had not committed fraud.

[16] Mr Clark also pointed out the various failings on the part of the HR department in that the letters sent to Mr Gilfillan calling him to the various hearings, did not comply with the appropriate policy. The failure to comply with the appropriate terms of the discipline code was unfortunate, particularly where Mrs Laird had then added the word "dismissal" as the only named possible sanction in the letter of 23 September. This must have added to the stress already present in facing the disciplinary process Basic errors just should not happen and this defect, of improperly operating their own code of practice, must have contributed to the decision of Mr Gilfillan to take his own life.

[17] Finally, Mrs McPhail for NHS Fife, considered the various issues that had been raised. On the question of delay, she did not consider that the evidence bore out that there was an undue delay, or that the time that had been taken to get the case from beginning to end was in any way excessive. Mrs Smith, the staff side representative, had indicated there was no real problem with delay, and whilst it was unfortunate that a number of hearings had to be cancelled, there were genuine and different reasons for the cancellation of each hearing.

[18] She addressed the decision to hold an investigatory hearing, taken by Mrs Starkie. Clearly Mrs Starkie was concerned that her signature had been used to requisition stores on at least one occasion, and having discussed the

matter with HR, she was advised to hold an investigation. That investigation then turned up the fact that Mr Gilfillan had used her signature on a number of occasions. He accepted doing this, but Mrs Starkie took the view that it was a forgery, which had left to a substantial breach of trust by Mr Gilfillan and, accordingly, had requested some form of disciplinary action be taken against Mr Gilfillan. It was quite appropriate for her to investigate the incident, and this view was supported by Karen Laird and Mrs Smith.

[19] Moving on to the disciplinary hearing, at this point it had to be noted that Mr Gilfillan was represented, and that the hearing was conducted fairly. She accepted that the decision reached by Mrs Anderson, aided by Mrs Laird, suggested that Mr Gilfillan was guilty of "fraudulently forging" his manager's signature. However, she was at pains to point out that the evidence of Mrs Anderson and Mrs Laird was that the real reason that they had decided it was serious misconduct was that there had been a number of occasions upon which Mr Gilfillan had forged the signature, and that he seemed reluctant to accept this when questioned closely at the disciplinary hearing. They said that it was his reluctance to accept what he had done as being the real cause for the finding of serious misconduct.

[20] She then dealt with the issue of why Mr Gilfillan had not been suspended, and felt that that had been adequately dealt with in the evidence, that it was not a formal requirement that there be suspension every time serious misconduct was made out, and that management had acted properly to continue Mr Gilfillan in his employment. The view that Mrs Anderson and Mrs Laird had taken regarding the likely and appropriate disciplinary sanction, was that it would be a "first and final" warning, and as it would not be dismissal, it would be inappropriate, and unfair, to suspend Mr Gilfillan.

[21] She then turned to the evidence that had been led regarding Mr Gilfillan's demeanour in the weeks and days leading up to the hearing on 28 October. Mr Gilfillan's father had not noted any particular change in his son's demeanour, Mrs Smith had spoken to him the previous week and he seemed to

be in reasonable spirits, Mrs Starkie continued to work with Mr Gilfillan and, apart from noting that he tended to work away from his usual desk, had not noted him to be under any particular stress, or giving cause for concern. This was important because is was clear that there was nothing in Mr Gilfillan's behaviour to alert anyone that he might be considering taking his own life, as in fact happened. He had not contacted his general practitioner with regard to stress in relation to the disciplinary process.

[22] Finally, Mrs McPhail accepted that the proper procedures had not been followed in the letters to Mr Gilfillan, as they had not contained all the possible sanctions that might have been imposed. There was, however, no evidence other than from Audra Gibson, that the insertion of the possibility of dismissal into the letter of 23 September, had had any effect on him.

[23] For all of these reasons, she urged that there be no findings under paragraphs (c), (d) and (e). My attention was drawn to the case of *Black v Scott Lithgow*, which confirmed that it was not the inquiry's function to establish or attribute fault or blame. Subsection (c) dealt with reasonable precautions, and a precaution should be considered as something which was designed to deal with known or foreseeable risks. It was not known to anyone that Mr Gilfillan might have taken his own life. There was no evidence of any defect in the system which contributed to his death, nor were there any facts relevant to the circumstances for the death upon which comment need to be made.

Findings

[24] I have considered all of the evidence, and at the outset of the inquiry I expressed my condolences to Mr Gilfillan's family, and I express them again here. It is always extremely sad when a person decides to take their own life, as happened here. It may never be known exactly why Mr Gilfillan chose to do so, and to a certain extent one can only speculate as to what drove him to it. What is clear, however, is that there is no evidence of any difficulties within his

life other than the disciplinary process with which he was faced, and it must be no coincidence that he took his life on the very day of the disciplinary hearing which would have imposed sanctions, which he thought included dismissal, on him.

[25] In terms of the legislation governing these inquiries, I am required to consider a number of factors. The date, time and place of death, and cause of death, are agreed by all parties, and have been set out at the commencement of the determination in sub-paragraphs (a) and (b). Turning now to sub-paragraph (c), I must consider the "reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided". It can be seen that one is not to find such reasonable precautions which "would have" avoided the death, merely how it "might have" been avoided. Under this section, I make no formal findings. I do not consider that his death was at all foreseeable, and as a precaution as something which is designed to deal with a known or foreseeable risk, I do not consider that there were any reasonable precautions which might have avoided the death. The Crown argued that Mr Gilfillan should not have been subject to disciplinary proceedings at all, effectively saying that a mountain had been made out of a molehill. The fact remains that, for whatever reason, Mr Gilfillan had forged his line manager's signature. It was certainly not for personal gain, and was most likely to ensure the continued smooth running of the department for which he was partly responsible. He accepted doing so "on a number of occasions" which subsequently turned out to number 11. I do consider that this was probably a breach of trust, and that Anne Starkie was quite correct to hold an investigatory hearing. Having held that investigation and considered matters along with Donna Band, an HR officer, Mrs Starkie was in my opinion quite entitled to refer matters onwards for, as she put it, "some form of disciplinary action". What is clear is that at this stage, neither she nor Ms Band considered that it was serious misconduct, Ms Band referring in an e-mail to the necessity of fixing "a straightforward" hearing. I do not consider that it was inappropriate for her to carry out the investigation, although to an outsider it may seem odd that she was complainer, then judge, then prosecutor, within

the system. I consider that the disciplinary system as set out in the NHS code was sufficiently robust to deal with such a situation, and that there was no inherent unfairness to Mr Gilfillan in her roles.

[26] The second matter raised by the Crown related to the sudden introduction of the prospect of dismissal, which first appeared in the letter of 23 September 2008. The argument was that if he had been aware from the outset that dismissal was a possibility, then it would not have come as a shock to him when it suddenly appeared late in the proceedings. Whilst I accept that it was unfortunate that the issue of dismissal was first raised only in the letter of 23 September, it is clear that Karen Laird, who prepared that letter, carefully considered whether the sanction of dismissal should be included in the letter and because it remained a possibility, albeit a remote one, it was felt appropriate that the possibility of dismissal should be included. The fault probably lies in the letter of 29 July, which was in identical terms save that it did not mention dismissal. Mr Gilfillan would be forgiven for wondering why, when nothing had happened within the disciplinary process, dismissal had suddenly been introduced between July and September. In any event, I am not persuaded that it can be said that it would have been a reasonable precaution to ensure that all letters sent to Mr Gilfillan included all the possible disciplinary sanctions. It clearly ought to have happened in terms of the policy, but I do not consider that removing this failing might have prevented his death.

[27] By section 6(1)(d) I am required to consider the defect, if any, in any system of work which contributed to the death. Only Mr Clark argued that there was such a defect, and this related to the operation of the discipline code itself. There were defects in the code, and the way in which it was interpreted. There were, for example, no timescales set out as to how quickly matters ought to be disposed of. Reference was made to employees suspected of serious misconduct being suspended, but that had not happened in this case. A chairman with sufficient power of disciplinary sanction had not been found to chair the meeting of 1 July, which brought delay into the system

in trying to find a more senior manager to deal with the case. There were clear training issues, such as the proper understanding of fraud. A proper period of notice was not always given for discipline hearings, as happened with the hearing scheduled for 30 September. Mr Clark argued that these basic errors should not have happened in what was already a stressful process, and that the various defects in the interpretation of their own code, and that this contributed to his death.

[28] I am unable to accept that any defects in the working of the discipline policy contributed to Mr Gilfillan's death. There are certainly deficiencies. There were inconsistencies in approach. There were failings on a number of occasions by the HR department, to follow the letter of the code. At no time did Mr Gilfillan receive a letter which contained all of the possible disciplinary sanctions as he ought. It is also clear that training is required in the proper interpretation of the more serious categories of misconduct. Three employees (Starkie, Anderson and Laird) all misdirected themselves with regard to fraud. It is quite clear that there was no fraud on the part of Mr Gilfillan.

[29] The final matter to be considered is to state whether there are any other facts which are relevant to the circumstances for the death in terms of Section 6(1)(e). In this regard I have a numbers of comments to make.

[30] In the first place, as I have already alluded to, I consider that Mrs Anderson and Mrs Laird misdirected themselves as to the gravity of Mr Gilfillan's misdemeanour. It is clear from the contemporaneous note of the meeting, and from Mrs Anderson's report thereon, that she felt that Mr Gilfillan was guilty of fraud. Although they stated in evidence, somewhat hesitatingly, that the real reason that they had thought that this was serious misconduct was that this was a course of conduct in signing her name, and his inability to admit that, I did not believe them in that part of their evidence. I am quite satisfied that they had decided that it was a fraudulent act, and that they then consulted the disciplinary code. Appendix I of that code sets out various categories under the heading "misconduct/gross misconduct". The categories get more

serious as one goes down the page and the entry "fraud or attempted fraud" comes about two-thirds the way down the list. It is thus, rightly, considered to be a serious matter. However, it is my view that Mrs Anderson, advised by Mrs Laird, misdirected herself and having decided it was fraud, she felt it had to be serious misconduct, and that therefore she could not deal with the matter of sanction, and it required to be referred on, to Mrs Anderson's line manager, Mrs Wilson. This, I believe, was the fundamental error, and hints at the lack of proper training for Mrs Anderson, and indeed for Mrs Laird, in the proper interpretation of the discipline code, and matters legal. I would not classify the actings of Mr Gilfillan as serious misconduct. He was certainly misguided in signing Mrs Starkie's signature, and it did create a breach of trust between them. A first warning ought to have sufficed, together with proper training and guidance on the correct procedures to be adopted for stationery ordering during the absence of the manager.

[31] Additionally, I considered that the failure to send out letters dealing with the disciplinary hearings, which did not contain the necessary information regarding possible sanctions, was a failing of the HR department in following their own policies, and when the sudden addition of the possibility of dismissal appeared in the letter of 23 September, the impact that this must have had on Mr Gilfillan cannot be ignored. I consider the failing of the HR department, which probably stems from an inadequate template letter, is a factor relevant to the circumstances of his death.

[32] Finally I noted that Mrs Laird had indicated that she had changed her own practices, to ensure that employees are advised to consult with occupational health services, who can provide guidance and assistance. I consider that this is good practice and it is unfortunate that it had only come about following the death of Mr Gilfillan. It is obvious that employees facing disciplinary action will be affected by that action, by the time that it takes, and the effect that it might have on their employment. I note that the discipline policy, contained in the management of employee conduct policy document produced by NHS Fife, does not deal with the issue of employee welfare during

the whole period of the disciplinary action. This is something which ought to be formally recognised, and addressed.

[33] Shortly after the death, Mr Gilfillan's father had sought closure to the matter by asking what would have been the likely outcome of the hearing on 28 October 2008. In a letter from the Chief Executive, dated 6 November, it was stated that the manager who was to chair that hearing had been asked to review the papers. She concluded that there was a case to answer, that the allegations were serious, that it was not an isolated event and that Mr Gilfillan had admitted what he had done. In those circumstances, she concluded that the appropriate sanction would have been a first and final warning, not dismissal. However, she did not give evidence to this inquiry, so how much influence the erroneous concept of fraud had in determining the appropriate sanction, is unknown.