IN THE MATTER OF AN ARBITRATION

BETWEEN:

ONTARIO NURSES' ASSOCIATION

- and-

LONDON HEALTH SCIENCES CENTRE

(Grievance of BS)

Hearings were held on October 11, December 5, and December 13, 2012 in London.
Final documentary material was received on December 21, 2012.

AWARD
(January 8, 2013)

Arbitrator: James Hayes

For ONA: Stephen Moreau, Counsel
Barb Conlon
Janis Murray
Jill Bishop

For the Hospital: Brian O'Byrne, Counsel
Angela Burtch
Cheryl Churcher
Robin Patterson
Cathy Monchamp
Cathy Stark
Bethany Rudd

2013 CanLII 143 (ON LA)

AWARD

Issue

1. BS was discharged on May 24, 2012. She had been relieved of her nursing duties at London Health Sciences Centre (the "Hospital") on February 15, 2011 and was subsequently placed on short term and long term disability leave which terminated on June 30, 2012.

2. The Hospital alleged that she stole narcotics and other drugs and falsified documents. It was said that her actions resulted in patients enduring avoidable pain. The Hospital was concerned that she was dishonest in the first instance and did not come forward with an apology or express any remorse or regret for her actions. Among other things the Hospital relied upon admissions made by the grievor.

3. The Hospital argues that this case presents "a pure and simple discharge for cause". In the Hospital's view, the grievor knew what she was doing and that what she was doing was wrong; therefore, her addictions described below are not relevant.

4. The union frames the facts and issue in human rights terms. It says that the grievor's actions were caused by a substance abuse disorder. The Hospital had an obligation to accommodate her disability to the point of undue hardship and failed to do so. The union requests reinstatement with compensation.

Facts

5. A Partial Agreed Statement of Facts was entered into evidence. For the most part, the facts were not in dispute. The Statement was supplemented by oral evidence from the grievor and from Cheryl Churcher for the Hospital.

6. I found the testimony of the witnesses to be entirely credible. Both testified openly, directly, and resisted any temptation to embellish or to parry questions which were unhelpful to their respective positions. Extensive documentary material from the Hospital and other sources, including the College of Nurses, was filed on agreement. The union provided expert medical reports from Dr. Martyn Judson together with evidence of a lengthy uninterrupted period of alcohol and drug testing.

7. The grievor worked in the C5 Surgical Care Unit. Among other things, this unit treats post surgical patients in the following disciplines: ear, nose and throat, urology, burns/plastics, thoracic and a small population of pediatric burn patients. The grievor worked primarily in the C5-100 unit but worked elsewhere as required. In the ear, nose and throat unit, the grievor primarily looked after patients with cancers of the head, neck and mouth. In urology, the grievor cared for patients including those who had had prostrate or bladder cancer surgery.

2013 CanLII 143 (ON LA)

8. Cheryl Churcher, before she became Director of Surgical Care, was the Manager of the C5 unit to whom the grievor was responsible. She described the requirement of C5 unit patients for pain medication. The majority of post surgery patients experience a very high degree of pain. Such pain is treated in various ways which include the continuous infusion of narcotics including but not limited to morphine and dilaudid. Patients are also provided with various sedatives including benzodiazepines. All patients in this unit experience significant pain whether or not they are post-operative.

9. Concerns regarding the grievor were first raised in January, 2011 with Unit Coordinator Robin Patterson by nurses and the daughter of a patient. One nurse expressed concern that the grievor was taking narcotics from patients. Ms. Patterson immediately looked at a random number of narcotic sheets and medication administration records but found nothing unusual. When she directly observed the grievor throughout her shift on January 26, 2011, she noticed no signs or symptoms of any impairment.

10. On February 15, 2011 urgent concerns from three nurses about the grievor's behaviour were brought to Ms. Patterson's attention. They indicated that, on the previous night shift, her speech was slurred, she appeared very tired, that she took frequent washroom breaks, and that she had signed out narcotics from the step-down unit for a patient on the ENT unit. They said that while she had charted that she had given certain injections of morphine to a patient, the patient had indicated that he had received no such injections, only tablets of percocet. In addition, these nurses reported that there were blood drops on the counter of the staff washroom and that a plastic cover for a vial of midazolam (a sedative) was found.

11. The grievor had worked overnight into the early morning of February 15, 2011. She was called in to a meeting at what would have been the beginning of her next shift in the early evening of February 15. The grievor denied everything. She stated that she had been skiing all weekend and that is why she may have appeared tired. She admitted to one instance of forgetting to document properly but had no explanation for other discrepancies. It was Ms. Patterson's observation that the grievor appeared to be under the influence of some drug or drugs. Ms. S was escorted to the Emergency Department for assessment and asked to undergo a drug test. She declined assessments and drug tests on the advice of her sister's boyfriend who was a criminal defence lawyer.

12. On February 18, 2011, 2011 the grievor attended at the Hospital's Occupational Health Department. Following this meeting, she met with her Local President at which time she admitted to a substance addiction and that she had stolen drugs from the Hospital. The Hospital was so informed by the union.

13. Following this, the Hospital did an audit of additional patient charts and medication administration records ("MARS") for the period January 7, 2011 to February 14, 2011 where the grievor had been involved. The Hospital found discrepancies in

2013 CanLII 143 (ON LA)

approximately 30 of 50 charts with respect to medications being entered in the MARS but not in the individual narcotic sheet for a patient and vice versa. The Hospital advised the union that it needed to carry out an investigation meeting when the grievor was fit to attend such a meeting.

14. The Hospital was advised on March 23, 2012 that the grievor was considered fit to return to work as of April 1, 2012. The Hospital set up a meeting on April 4, 2012 with her and union representatives to follow up on the original February 15, 2011 meeting. Detailed notes of that meeting were tendered in evidence. Internal Hospital discussions took place after that leading to the decision to discharge.

15. Ms. Churcher explained the Hospital's decision fairly and eloquently. In her estimation the grievor had admitted that she had stolen a multitude of narcotics, that she had withheld or not administered narcotics to patients, that patients and their pain control had been adversely affected, and that there were numerous fraudulent entries in the medication records. She explained the risk to patients who may not have received adequate treatment for pain as well as the dangers associated with false documentation. She was troubled by the failure of the grievor to apologize or to have expressed remorse.

16. With evident personal and professional compassion, Ms. Churcher described patients in pain in this unit, many of whom are terminal. As she put it: "At the very least, to provide pain control to them, [should be] a priority for any nurse". Referring to the grievor, she said: "For me, it's about coming to work every day and being unsure that we're not providing that. She has destroyed the relationship with the patients and I know that I couldn't trust her to care for our patients."

17. When asked in summary conclusion to respond to the possibility of the grievor's reinstatement, Ms. Churcher said: "I'm not sure I could support it based on the inappropriate behaviour demonstrated by B, and her inability and not expressing remorse. And for her to come to work every day and work on a unit where patients require ongoing administration of narcotics, I'm not sure I could endorse that. I would not endorse that. It's imperative that we provide care to patients and part of that is to provide pain medication and pain control for those patients."

18. In cross-examination Ms. Churcher acknowledged that the Hospital had an Employee Assistance Program which included treatment for addictions and that, on February 15, 2011, based on the grievor's conduct at the meeting (as well as other reports), she thought there was a distinct possibility that the grievor was using drugs herself. Indeed she agreed with counsel's suggestion that it was her belief on February 15, 2011 that the grievor had a drug addiction problem. She also agreed that there was no evidence that "Mr. A" [referred to at the meeting] had suffered additional pain other than the grievor's lie to cover her personal use of morphine. She conceded also that there was no evidence that "Mr. N", who was discussed at the April 4, 2012 meeting, was in pain or didn't get the morphine he required: "I don't have the charts. I need the records to answer."

2013 CanLII 143 (ON LA)

19. The grievor is a young nurse, 26 years of age as of the hearing dates. This was her first permanent nursing position which she commenced on May 5, 2008. I do not find it necessary to record the more intimate details about alcohol and her male family background which she touched upon. Suffice it to say that she grew up in a small town, Clinton, and that she lost her father to a motorcycle accident at the age of 12. She began drinking casually at age 12 which escalated to binge drinking in high school. The summer before she went to Queen's University she tried marijuana.

20. While at university, "any time I drank I mostly drank until I couldn't remember. It never seemed like I had control of it." By the end of university, she was smoking marijuana once a day, had used cocaine perhaps 10 times, and had tried a form of ecstasy once or twice. "I felt pretty good at first when using or smoking, I didn't need to think about much else, it took away any worries you have." She believes that she did not have control over her usage. While at university in 2006 she was prescribed percocet for pain associated with a wisdom tooth extraction. She described her reaction to percocet as "euphoric, you're floating almost".

21. The grievor commenced work at the Hospital on May 5, 2008. Her best guess is that she started using drugs at the Hospital in January, 2010. She began taking percocet and then progressed to other narcotics, including morphine, and sedatives including benzodiazepines. She is not sure why she first took percocet but she knew how it made her feel. When she took drugs, any worries were instantly gone and she felt happy and outgoing. She had a higher sense of self esteem with drugs than without them. At the time, she thought she had control but, looking back, recognizes that she had no control.

22. By the time of the February 15, 2011 interview, the grievor was injecting opioids, five or six times a day. She took drugs when she got home from work that day. All of her drugs came from the Hospital. She took narcotics from the locked narcotics drawer and benzodiazepines from ward stock which she does not recall being locked up. She used at the Hospital and at home. She took steps to conceal what she was doing from her colleagues. She administered drugs to no-one other than herself and her patients. She did not take drugs herself in the presence of anyone else. The grievor believes in her last couple of months at the Hospital that she sometimes reported to work "high". In her direct examination she accepted that her taking drugs "probably did" affect her care of patients.

23. The grievor described some of the stresses that she was experiencing while she was employed at the Hospital. She was living alone for the first time, apart from family and friends, where previously she had lived with family in Clinton and been with her older sister in Kingston. Her boyfriend lived in Burlington and the separation was difficult. She was working every other weekend. Her nursing work was enjoyable but hard work. It was "a stressful transition to being a practising nurse".

2013 CanLII 143 (ON LA)

24. The grievor lied at the February 15, 2011 meeting "because I didn't want anyone to know I was an addict. I thought I would lose my job if I admitted to that. All I thought was, how do I get drugs?" She admitted her addictions to her union representative shortly thereafter and was advised to see Dr. Jones in the Hospital's Occupational Health Department and to make an appointment with her family physician. Her family physician referred her to an addictions specialist, Dr. Judson.

25. On March 10, 2011 the grievor was referred to Westover Treatment Centre which provides in-patient treatment for addictions. She lived at Westover from April 18 until May 6, 2011 where she was treated for alcohol/drug addiction. She attended counselling, meditation groups, AA meetings, and learned the 12 Steps. Before commencing treatment at Westover, the grievor had moved back home with her mother and sister in Clinton and begun to attend AA meetings and a Health Care Professionals Group run by Dr. Judson. She found an AA "sponsor" before going to Westover. Her plan following Westover was to attend AA meetings twice a week, to keep in contact with her sponsor every other day, to attend Dr. Judson's group once a week, to see Dr. Judson privately every three months, and to attend a Westover after-care program held in Cambridge once a week for six months. The plan was drawn with the assistance of Dr. Judson and other members of the Health Care Professionals Group.

26. Since her departure from Westover the grievor has done and/or continues to do the following. She moved in with her boyfriend in Burlington in May 2011, moved back to London in January, 2012 alone, and then was joined by her boyfriend a couple of months later. She attends the Health Care Professionals Group facilitated by Dr. Judson unless she is sick or away briefly on vacation. This support group, consisting of doctors, nurses, paramedics and pharmacists who help each other in recovery, meets for two hours every Monday night. She attends three or four AA or NA meetings, usually AA meetings, every week. She is active in her home AA group and has both a sponsor and now her own 'sponsee'. On October 18, 2011 she completed the Westover six month after-care program in Cambridge. She meets with Dr. Judson as a patient every three months. In personal terms, her boyfriend is supportive. He came to the Family Program at Westover, and attends 'open' AA meetings. The grievor describes her recovery as a daily exercise which involves quiet time involving meditation, prayer and weekly church attendance. She has friends whom she sees regularly. She tries to stay in a routine with proper eating, exercising, and sleeping habits.

27. The grievor states that she has been drug and alcohol free since March 5, 2011. That statement is supported by urine test results from well back in 2011 to date. The tests have been witnessed almost invariably and continue to date. She is tested twice a week. Confirming documentation, concerning periods of time contemporaneous with the arbitration hearings, was filed post-hearing on December 21, 2012 when it became available.

2013 CanLII 143 (ON LA)

28. Since the termination of her long term disability benefits on June 30, 2012, the grievor has applied for approximately 50 different nursing positions and received about a dozen interviews. She discloses the College restrictions when the issue comes up in interviews. She received one job offer which was rescinded when a retirement home concluded that it could not accommodate the College conditions which would permit her employment. The grievor is now working full time at McDonalds at minimum wage.

29. At the conclusion of her testimony the grievor said the following:

> I love nursing. It is something I wanted to do since I was young and I miss it. Not only for financial reasons but for the emotional and spiritual rewards that aren't money. I feel terrible about the things I've done. I'm truly sorry about stealing narcotics and lying about it. I apologize for not coming out earlier with an apology. My sponsor didn't think I was ready for the Step [Step 5 of the 12 Steps]. I was going to apologize to my co-workers and to management. I can't change the past. I've learned from my recovery and I want an opportunity to show I've changed. I realize that nursing is a gift. If I got the gift back, I would treat it like a gift. I want to express how I feel about the Hospital and my managers. I can't imagine what they've had to go through.

30. The grievor's conduct was referred to the College of Nurses of Ontario and an Agreement was reached dated March 19, 2012 which incorporated a Consent Decision of the Fitness to Practise Committee. The Consent Decision found the grievor to have been incapacitated as the result of her Substance Dependence Disorder and imposed significant restrictions upon her Certificate of Registration. The Agreement with the College specifically found that: "The information available would satisfy a panel of the Fitness to Practise Committee that the Member's health would permit her to return safely to the practice of nursing provided that appropriate terms, conditions and limitations were imposed upon her Certificate of Registration."

31. Dr. Martyn Judson is a physician who specializes in addictions. His curriculum vitae is impressive. Dr. Judson has been retained as an expert witness in numerous civil, criminal, and regulatory proceedings. He is a past Chairman of the Board of Directors of Westover.

32. Dr. Judson's October 25, 2012 medical report records that during her initial assessment on March 9, 2011 the grievor told him that:

> Approximately three years later whilst at work, she accessed some Percocet tablets from her place of work with the sole intention of improving how she felt. Almost immediately her abuse of such tablets escalated and with her increased tolerance she started to use morphine and hydromorphone by intravenous injection. If these pharmaceuticals were unavailable benzodiazepines were substituted. Ms. S admitted to using opioids nearly every day at work but on the days that she was not on duty she rationed out the supplies that she had saved to use at home. In addition Ms. S has taken Tylenol with codeine tablets and even used fentanyl patches.

2013 CanLII 143 (ON LA)

33. Dr. Judson's November 15, 2012 medical report records his opinion that the grievor was definitely suffering with the condition of substance abuse in her late teens and early twenties. When he first met the grievor on March 9, 2011 she:

> answered affirmatively to all seven DSM-IV criteria of substance dependence (addiction). It is therefore possible to confirm that Ms. S's substance use disorder definitely progressed from substance abuse to substance dependence whilst she was employed at the London Health Sciences Centre. It is however not possible to exclude the possibility that she was suffering with the disease of addiction prior to working at the hospital.

34. The same report goes on to say that:

> The use of opiates, opioids, and benzodiazepines by Ms. S during the course of her employment, which she admits were for her personal use are typical behaviours or symptomatic of someone who suffers with the disease of addiction. On account of such pharmaceuticals being so readily available it made I all the more probable that Ms. S would seek those substances that she could access.

35. It also states that:

> Most individuals who suffer with active addiction exhibit a propensity to minimize if not deny their substance use. Those suffering with addiction invariably exhibit low self esteem and are fearful of the repercussions that will ensue should their behaviour be exposed. Denial in the medical sense is a psychologically protective mechanism which insulates the individual from the pain of reality. The disease of addiction or addictive thinking can influence an individual to convey the impression that they are not misusing substances in order to reduce the likelihood of intervention thereby allowing the disease to progress. The fact that Ms. S denied to her superiors that she was using addictive substances is consistent with active addiction.

36. Dr. Judson's October 25, 2012 medical report records that:

> It is the opinion of this writer that Ms. S suffers with the disease of addiction involving primarily opioids but also alcohol. She does not suffer with any concurrent disorder. There is no evidence of a personality disorder. Ms. S has now been completely abstinent from all addictive substances for over 18 months and so her condition is in full sustained remission. Ms. S nevertheless maintains a comprehensive program of recovery using community resources. When speaking with Ms. S most recently on the 17th of October, 2012 it was evident that she was demonstrating all the prognostic indicators for a favourable outcome as her attitude is honest, responsible and accountable. She has a sense of hope for her recovery and feels confident that it can be maintained. Ms. S enjoys a good support system and avoids those persons who misuse substances. She keeps herself occupied and feels good about her accomplishments to date. She is acutely aware of the harm of ingesting any amount of an addictive substance. Her prognosis is considered good.

2013 CanLII 143 (ON LA)

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> It is the considered opinion of this writer that Ms. S, being in full sustained remission from the disease of addiction and maintaining a comprehensive program of recovery corroborated by consistently negative urine test results, is well enough to return to the practice of nursing at the London Health Sciences Centre, provided the Terms and Conditions imposed by the College of Nurses are complied with. Those Conditions in essence represent a healthy program of recovery and if met are incompatible with active substance use. Ms. S first attended this office when she was employed by the London Health Sciences Centre and although she has been terminated she remains a patient of this office and that relationship will continue for as long as she considers it appropriate. During the last 18 months there has been no evidence that Ms. S has developed additional medical problems. Her condition now is stable and she does not pose a risk to the public by returning to the practice of nursing.

Employer submissions

37. Counsel for the Hospital stressed that BS was a relatively short service employee who had admitted to serious thefts, falsified records, and failed to care for patients by deliberately denying them pain medications. The thefts were premeditated, planned and steps were taken to conceal her misconduct. No timely expressions of remorse or any apology was given although there was an opportunity to do so as late as on April 4, 2012. The first time BS said she was remorseful was during an answer to a final question asked in direct examination. That apology said nothing about patients and indicates that they are "not front and centre in her conscience". This is very significant given the essential duties of her job. While the Hospital did not challenge the veracity of the urine testing, it suggested that random testing would be preferable. If workplace stress was part of the reason for her substance abuse, the employer questions why one would want to place someone back into a setting of stress. She should be commended for her efforts at recovery but she should find employment elsewhere given the massive breach of trust.

38. The Hospital submitted that an employer was entitled to expect a higher standard of conduct from a Registered Nurse than from a rank and file employee [*Oshawa General Hospital* (1976) 12 L.A.C. (2d) 182 at p. 189 (O'Shea)] and that it had a legitimate interest in "protecting itself from law suits at the hands of its patients" [*Re Religious Hopitallers of Hotel-Dieu of St. Joseph* (1974) 7 L.A.C. (2d) 280 at p. 281 (Shime)]. Ms. Churcher's evidence highlighted the risk to patients which had occurred in this case having regard to the falsification of medication records.

39. Counsel placed particular emphasis on the analysis found in *Toronto Transit Commission* (2011) 210 L.A.C. (4th) 268 (Stout) ["*TTC* (Stout)"]. In that case it was said at para. 103 that:

2013 CanLII 143 (ON LA)

> The case law is also clear that a grievor's dependence on drugs or alcohol does not automatically shield such an employee from the consequences of his or her misconduct unless there is *prima facie* discrimination or a causal connection between the disability and the misconduct.

40. The Hospital submitted that there was no evidence in the instant case that drug usage by BS was the cause of what she did and that the expert medical report did not say so. Even if there was linkage between her addiction and her self-injection, there was no causal connection with her failure to look after the patients. She deliberately chose to deny patients their medication.

41. Reference was also made to *Durham Catholic District School Board* [1998] O.L.A.A. No. 664 (Roberts) where the arbitrator emphasized at paras. 25-26 that there had been "a deliberate course of conduct perpetrated over a number of weeks" and that "at the time he committed this fraud, the grievor knew it was wrong".

42. Counsel pointed to comments from the same arbitrator in *Toronto Transit Commission (Wall grievance)* (2006) 149 L.A.C. (4th) 69 (Roberts) ["*TTC* (Roberts)"] where he said at para. 56:

> I have come to the conclusion that the proper test for causation to apply in discrimination cases challenging the automatic discharge of an alcoholic employee is as follows: Was the grievor's judgment so impaired by his or her craving for alcohol, loss of control over his or her drinking, or dependence on alcohol, that his or her alcoholism became a significant factor in motivating the commission of the industrial offence in question? If the answer to the question is no, the automatic discharge will stand because no causal connection will have been established between the alcoholism and the commission of the offence. If the answer to the question is yes, it will be concluded that the grievor's alcoholism was a significant cause of the commission of the offence for which the grievor was automatically discharged, and the discharge will become liable to be set aside as prima facie discrimination under the Human Rights Code.

43. Counsel also referred to *Livingston Distribution Centres Inc.* (1996) 58 L.A.C. (4th) 129 (MacDowell) and *Canada Safeway Ltd.* (1999) 82 L.A.C. (4th) 1 (Ish).

Union submissions

44. The union asserts that the grievor has a substance abuse addiction which was the cause of her admitted misconduct. She was improperly terminated for conduct caused by her disability. She has made considerable efforts in support of her recovery and should be accommodated by the Hospital with reinstatement and compensation from the date of her discharge. Reference was made to sections 1 and 5 of the Ontario *Human Rights Code* and equivalent discrimination language in the collective agreement. In the alternative, if the matter is framed in disciplinary terms, the union submits that discharge is too harsh a penalty in the circumstances.

2013 CanLII 143 (ON LA)

45. While the facts are largely conceded, counsel submits that there is no evidence in this arbitration that the grievor took drugs which were destined for patients or that patients' MARS had been falsified. The union asserts that Dr. Judson's reports make clear the nexus between the theft of drugs and her addiction but that it only makes common sense in any event. She took drugs only for herself, gave them to no-one else, and obtained them from no other source. Whether or not she knew what she was doing was wrong, "she's using because she's dependent". The apology issue is a red herring. Her first opportunity to do so was at the April 4, 2012 meeting but the grievor understood it to be solely a factfinding event and not an opportunity to apologize. Her contrition was manifest much earlier in her documented completion of Step 5 of the 12 Steps. Her apology at the arbitration hearing was sincere, forthright, and honest.

46. The College of Nurses treated this situation as a fitness/incapacity issue and not as misconduct. The College agrees that BS is fit to return to work subject to enumerated conditions. The grievor has been unable to obtain alternative work in nursing to date despite extensive efforts.

47. Counsel made reference to the following authorities: *Manitoba and Legal Aid Association* (Fawcett) (2009) 181 L.A.C. (4th) 296 (Graham); *Re British Columbia Telephone Company* (1978) 19 L.A.C.(2d) 98 (Gall); *Collingwood General & Marine Hospital* (Smart) (2010) 195 L.A.C.(4th) 124 (Jesin); *William Osler Health Centre* (Ward) (2006) 85 C.L.A.S. 7 (Keller); *St. Mary's General Hospital* (Harris) (2010) 199 L.A.C. (4th) 75 (Stephens); *Hydro-Quebec* [2008] 2 S.C.R. 561; *Canadian National Railway Co.* (2011) 110 C.L.A.S. 272 (M.G.Picher); *Capital Health* (O'Neill) (2008) 178 L.A.C. (4th) 350 (Lucas).

Employer reply

48. The Hospital disputes the union's argument based on 'common sense' and points out that the grievor worked without incident for eighteen months until she began stealing drugs in January 2010. She has admitted that she knew what she was doing was wrong. There is no evidence from either herself or from Dr. Judson that she was under some compulsion to steal. The mere fact that she takes and uses does not amount to causation. The absence of a timely apology is by no means a red herring. All arbitrators consider this factor. She had an obvious opportunity to apologize to the Hospital at the factfinding meeting. Whatever counsel may say about harm to patients, the grievor acknowledged this as a fact on April 4, 2012 during the meeting.

Decision

49. The employer, through Ms. Churcher supported by strong submissions from counsel, makes a powerful argument about standards to be expected of Registered Nurses and the potential exposure of the Hospital to litigation in cases of misconduct by nurses. These are not rhetorical flourishes. They are genuine real life concerns.

2013 CanLII 143 (ON LA)

50. Ms. Churcher also underlined, with appropriate passion and compassion, the fundamental ethical issue at play in the C5 unit. This unit treats patients almost all of whom are experiencing significant pain and many of whom are terminal. It is difficult to conceive of patients entitled to expect more from their nurses. They certainly have every right to expect that narcotics and sedatives intended for their care will not be misappropriated by people entrusted with their care. The Hospital's position in the BS case is quite understandable.

51. I am also not persuaded by union counsel's suggestion that there is no evidence before me that patients were affected. While this may be true in a narrow sense, the grievor herself has acknowledged the likelihood that patient care was impaired. Given the extent of her misconduct, there is probably no way of ever knowing the concomitant extent of negative impact on patients.

52. If this case were to be examined strictly from the point of view of a typical just cause for discipline analysis, I would have no hesitation in sustaining the discharge which was imposed. While she has an otherwise unblemished record of professional performance, the grievor is a short service employee. Whatever her seniority, her misconduct was extremely serious and went to the heart of what was reasonably expected of her as a nurse by the Hospital. The difficulty experienced by her in securing alternative employment I would see as the direct foreseeable consequence of that misconduct. I would not accept the grievor's genuine apology at the hearing as sufficient recompense.

53. There is an alternative narrative however. This matter also engages a human rights approach, one which has been conducted previously by other arbitrators with respect to very similar fact patterns to those presented in the instant case: *Collingwood General & Marine Hospital; William Osler Health Centre*; *St. Mary's General Hospital*. As the Hospital submitted, *TTC* (Stout) also provides a useful analysis and I am attracted to the direct approach found therein which I do not see the point of reciting. The Hospital does not dispute that its actions are subject to review having regard to the discrimination language in the collective agreement and that of the *Human Rights Code*.

54. The core facts are not in dispute here. The grievor suffers from the disease of addiction, a disability which the Hospital accepts as legitimate. When BS was first confronted on February 15, 2011, Ms. Churcher concluded, accurately, that it was likely that she had a drug addiction problem. The grievor's disability is set out in detail in Dr. Judson's medical reports quoted at length above.

55. The Hospital's primary legal position is that the union has not established that the grievor's misconduct was caused by her disability. I have reached a different conclusion.

56. In my opinion, while Dr. Judson's reports could have used more explicit language, his intention is clear and that intention is consistent with what I believe to be the only

2013 CanLII 143 (ON LA)

reasonable assessment of the facts. The grievor suffers from a drug addiction. Drugs were available at the Hospital. As her evidence made clear, she did not have control over her behaviour which is a principal feature of any addiction. With respect, I do not believe that there is any doubt that the grievor's addiction was the direct cause of her misconduct. While on some level she may well have understood her actions to be wrong, she was not capable of overcoming that understanding due to her disability. As Dr. Judson's reports make clear, denial is a common feature of addictive behaviour.

57. In *TTC* (Stout) the arbitrator found no connection between a theft of copper wire and a cocaine addiction other than that the grievor used the money received from the sale of the copper wire to purchase cocaine. The grievor in that case made a willing choice to use that money other than personal funds which were readily available. The facts are readily distinguishable in my view from those in the instant case.

58. In *TTC* (Roberts), as described in the passage set out previously in this award, the arbitrator framed the appropriate question to be whether or not a dependence on alcohol was a "significant factor in motivating the commission of the major industrial offence in question". If this be the appropriate question, I have little difficulty in concluding that BS's drug dependence was the *only* factor in motivating her thefts and related misconduct.

59. In *Collingwood General & Marine Hospital*, it was said at para.31:

> It is clear that in order to be entitled to accommodation, any disabled employee, including one suffering from a dependence on drugs or alcohol, must accept and pursue necessary treatment to alleviate the effects of the disability. Where an employee accepts and pursues such treatment, then the employer will be required to accommodate the employee's disability up to the point of undue hardship, particularly where the medical evidence establishes that the employee is fit to return to work. Even where medical evidence establishes that fitness to return to work is subject to conditions, an employer will be required to determine whether it can accommodate those conditions without suffering undue hardship. That is what the employer was required to do in *William Osler Health Centre.*

60. As counsel for the Hospital fairly acknowledged, there is nothing that BS could have done to support her recovery beyond what she has done. Steps taken by her are recorded in detail above. Once the Hospital compelled her to confront her misconduct, within days she acknowledged her addictions and took the advice of her union representative to seek medical assistance. The Hospital was promptly advised of her admission of theft. From that day forward, the grievor has done everything that anyone could ask of her concerning her recovery. While alcohol and drug addiction is a lifelong challenge, BS is now able to point to abstinence from drugs and alcohol since March, 2011. That abstinence has been verified by a sustained period of supervised testing. While recovery from addictions is a lifelong challenge, to date BS may be seen as a remarkable success story where many others have failed.

2013 CanLII 143 (ON LA)

61. The Hospital expressed concern about what it sees as a dilatory apology. While doubtless an expression of remorse could have been and arguably should have been given on April 4, 2012, I listened carefully to what BS said during her testimony. To me her apology sounded utterly genuine and uncontrived. I have little doubt that the grievor has learned all that could be learned from what has happened and that her apology was heartfelt. Based upon what I heard, I believe it highly likely that she will take every opportunity to restore her personal and professional credibility and to make a valuable contribution to the Hospital if such an opportunity is available. Her actions to date speak louder than her words at the hearing in any event.

62. The determination made by the College of Nurses is also significant. The College has treated this case as one of incapacity. The College has found that BS may now return safely to the practise of nursing subject to conditions which it has imposed. Dr. Judson's medical reports rendered several months later are equally supportive. The Hospital does not challenge the College's assessment and I certainly have no reason to do so in the case of either the College or Dr. Judson. The conditions imposed by the College are extensive.

63. While the concerns of the Hospital were and are entirely rational and understandable, in all of the circumstances I conclude that the employer did as a matter of law, *prima facie,* discriminate against the grievor because of her disability when it terminated her employment. I remit the matter back to the parties to consider whether or not she may be accommodated, short of undue hardship to the employer, having regard to the restrictions set by the College of Nurses. If she can be so accommodated, she is to be reinstated.

64. I remain seized to determine the accommodation issue if necessary, together with any other remedial issues which may remain outstanding and which the parties are unable to resolve.

James Hayes
Sole Arbitrator

Dated at Toronto
January 8, 2013

2013 CanLII 143 (ON LA)