In the Matter of an Arbitration
Under s.48 of the *Labour Relations Act, 1995*

BETWEEN:

HUMBER RIVER HOSPITAL

(The "Hospital")

AND

ONTARIO NURSES' ASSOCIATION

(The "Association")

(Gr. of "RI")

Before: Eli A. Gedalof, Sole Arbitrator

Appearances

For the Hospital

Karen Sargeant, Counsel
Alyssa LeBlanc, Counsel
Robin Brown, Employee and Labour Relations
Mayda Timberlake, Clinical Manager, Emergency Services

For the Association

Stephen J. Moreau, Counsel
Sevda Mansour, Counsel
Mike Howell, Bargaining Unit President
Nancy Popp, Grievance Chair
Sherri Street, Labour Relations Officer
RI, Grievor

AWARD

INTRODUCTION

1. The grievor is an emergency department nurse at Humber River Hospital (the "Hospital"). This grievance arises from the termination of her employment on March 2, 2016, following the discovery that she was stealing and using narcotics in the workplace. The Association does not dispute that the grievor stole narcotics but takes the position that her conduct arose from an addiction disability, and that her termination was therefore discriminatory. The Association further argues that the Hospital failed to take any steps to meet its procedural or substantive duty to accommodate. It seeks, in addition to compensation and damages, to have the grievor reinstated to employment with appropriate accommodations.

2. The Association also takes the position that the Hospital breached the union representation provisions of the collective agreement and that the discipline must also be set aside on that basis.

3. The Hospital disputes that the grievor's termination was discriminatory and maintains that in any event this is not an appropriate case for reinstatement. The Hospital also maintains that it has complied with its obligations regarding union representation, and that even if it committed a technical breach, this is not the kind of case where it would be appropriate to void the discipline.

4. The parties have agreed to bifurcate this proceeding, addressing first the alleged discrimination and the question of whether the discharge ought to be set aside. This decision deals with these issues only, and the parties have reserved the right to address the question of the appropriateness of any particular accommodation and any other remedies, if necessary, following my determination on these first issues.

5. I note before continuing that the Association has requested that I initialize and not disclose the grievor's name in this award. This request is grounded in the nature of some of the evidence before me, which touched on highly personal details of the grievor's life and circumstances, but also the personal circumstances of third parties to this proceeding, including a child. It is also grounded in the Association's position that this is a case about a nurse with a disability who ought to be treated in a therapeutic and non-punitive manner. Given the nature of the issues in this proceeding, to identify this nurse is to attach a stigma that will follow her for her life. The Hospital opposes the request and speaks to the public interest in open proceedings and the

accountability of public institutions and the people who work within them. The Hospital specifically identifies the importance of public safety and, given the nature of the nurses' misconduct, the potential for future harm as a reason for ensuring that she can be publicly identified.

6. I am persuaded that in the particular circumstances of this case it is appropriate to exercise my discretion not to identify the grievor by name. To the extent that the Employer raises concerns of public safety, that issue is addressed by the College of Nurses, which has in fact restricted this nurse's practice. The restriction precluding the nurse from contact with narcotics in particular is publicly accessible. Further, I note that the party with carriage of this matter is the Association, which has been identified and is publicly accountable for the manner in which it applies and enforces public statutes such as the *Human Rights Code.* In this case, I find that the highly personal nature of the evidence and the potential impact on third parties, including a child, militates in favour of the Union's request to use initials.

THE EVIDENCE

7. The parties reached a partial agreed statement of facts, setting out some of the background to this grievance and describing the specific incident that gave rise to the grievor's termination from employment.

8. The grievor is a registered nurse who was at the material time employed in the Emergency Department at Humber River Hospital. She began working for the Employer as a part-time nurse in March or April of 2012 and became a full-time RN on July 1, 2013. She was terminated effective March 2, 2016 after she was discovered in possession of stolen narcotics and other medications at the end of her overnight shift, which began on February 28 and ended at 7:30 a.m. on February 29, 2016.

9. During the shift, the grievor was working in the O-Zone department with three other nurses, KV, NJ and SH. These nurses became concerned whether the grievor was actually giving patients the pain medications that had been ordered for them. In the course of the shift, the grievor approached another nurse, JJ, who was delivering morphine to a patient the other nurses believed was assigned to KV. The grievor said that she would instead give the patient the medication. The nurses then discussed who should deliver the medication, but the grievor refused to accept their decision that KV should do it and took the morphine into an empty patient room. With her back to the other nurses, the grievor drew some morphine into a syringe and then appeared to throw something into the sharps container, first two times and then a third time. On the third time, the grievor put her hand in her pocket and KV heard something

drop. KV reported what she had seen and heard to SH, who was the Team Leader in O-Zone. The agreed facts describe what happened next as follows:

- SH then approached the grievor and asked the grievor who were the patients she had given morphine to. The grievor pointed to the treatment area. SH asked the grievor where the used ampules were. The grievor responded by saying that she had thrown them in the garbage.

- SH was concerned because the grievor had syringes in her hand. So SH took the grievor to Room 35 and asked her where the ampules were. The greivor took one ampule from her pocket and gave it to SH.

- SH told the grievor that someone reported that she may have put an ampule in her pocket and SH needed to know.

- In response the greivor said "I have a lot" and pulled 6 or 7 unopened vials of morphine from her pocket. SH directed the grievor to stay in Room 35. The grievor asked for her belongings so SH allowed the grievor to leave Room 35 to retrieve the grievor's belongings.

- While the grievor was retrieving her belongings, SH called another RN in to the Emergency Room, Main Team Leader AV. SH told AV about the vials the grievor had in her pocket.

- When the grievor returned to Room 35 with her belongings, SH rejoined the grievor and asked the grievor if there was anything in her bag. The grievor pulled out plastic bag(s), with vial medications and tablets. Photos of the plastic bag(s) of narcotics and other medications are at Tab 48 of the Employer's Book of Documents.

- AV joined SH and the grievor in Room 35. When AV asked the greivor what happened, the grievor responded "I'm very sorry, I think I have brain tumour, I always have headache and I might be dying".

- AV explained that the grievor should wait for him to give a report and speak with the Manager. SH and AV then left the grievor alone and, when the Manager Mayda Timberlake arrived at work for her 7:30 am shift, informed Mayda.

- A copy of the notes entered into the Hospital's Quality Risk Manager (QRM) system by SH are at Tab 9 of the Employer's Book of Documents.

- When AV and SH informed Mayda of what had transpired, Mayda asked to meet with the grievor.

- At no time from 7:30 am onwards was the grievor uncooperative with the Hospital.

- When AV and SH went to retrieve the grievor from Room 35 to bring her to Mayda's office, Mayda called a Program Director to have her find a representative from ONA and a representative from Human Resources to attend her meeting with the grievor. When AV and SGH arrived with the grievor, Mayda took the grievor to the Human Resources Department. When they arrived in the Human Resources Department, they met with Joe Fernandes from Human Resources.

- The Hospital decided to proceed with the meeting because:

i. it was the end of the grievor's shift;

ii. the grievor wanted to go home;

iii. Mayda could not let the grievor leave with the narcotics and other medications in her pocket; and

iv. Mayda could not let the grievor leave with the narcotics and other medications in her bag.

- Mayda met with the grievor and with Joe Fernandez from Human Resources…. The following sets out the medications the grievor had in her pockets and in the plastic bags.

Medication	Dosage form	Qty
Morphine Injectable Unopened + One Broken Amp	10 mg/mL 5	5-6
Morphine Injectable Unopened	2 mg/mL	2
Metoclopramide Injectable Unopened	10 mg/mL	5
Metoclopramide Injectable Open	10 mg/mL	1
Ketotac Injectable	10 mg/mL	5
Dimenhydrinate Injectable	50 mg/mL	1
Acetaminophen Suppository	650 mg	1
Diphenhydrinate Oral	25 mg	2
Ondansetron Tab	4 mg	4
Ondansetron Tab	8 mg	1
Acetaminophen/Codeine #3 Tab		1
Furosemide (Lasix) Tab	40 mg	1

Dimenhydrinate Tab	50 mg	6
Ibuprofen Tab (Advil, Motrin)	200 mg	6
Ibuprofen Tab (Advil, Motrin)	400 mg	1
Acetaminophen Tab (Tylenol)	325 mg	24

10. Ms. Timberlake and Mr. Fernandes began the investigation meeting with just the grievor, but shortly thereafter Nancy Popp arrived on behalf of the Association and they reconvened the meeting with Ms. Popp present. The agreed statement of facts describes the continuation of the meeting as follows:

- The Hospital informed Nancy that they had proceeded with the investigation because it was the end of the grievor's shift and the grievor wanted to go home, and the challenge the Hospital had trying to find an ONA representative.

- Mayda and Joe asked the grievor what shift she worked and whether the plastic bags with drugs were the bags the grievor was carrying. After the grievor confirmed that the plastic bags with drugs were the bags she was carrying, Nancy took the grievor out of the room for a few minutes.

- When Nancy and the grievor returned, Mayda and Joe once again asked the grievor where she got the medications from. The grievor confirmed she got the medications from Humber River Hospital and said:

    i. She took the medications from the Hospital's omni cells;

    ii. The medications were taken for her patients;

    iii. She would give her patients 5 mg from a 10 mg vial and then keep 5 mg and give it later if the patient needed more. When the patient needed more, she would take a fresh 10 mg vial (which she would keep for herself) and give the patient the 5 mg remaining from the previous vial;

    iv. She did this to fight her condition; and

    v. She last took drugs before beginning her shift the night before – 10 mg at 7:30 pm the night before. She said she did so or she would not be able to work. The drugs came from the Hospital, from before, and were injectable. When it wore off, she took Tylenol, two hours before the meeting.

- Nancy expressed concern that the grievor was under the influence of drugs at the meeting and was therefore concerned about the grievor's responses.

- The Hospital ended the meeting and sent the grievor home by taxi.

11. Following the meeting, Ms. Timberlake reported the thefts to Health Canada as required. That evening, she received two emails from the grievor. The first was sent at 7:14 pm and read:

> Dear Mayda,
>
> You can not imaging how it was helpful your amazing supportive attitude in such a hard time that happened to me. I clearly understand that I could be punished in a harshest way ever.
> You let me get home safely and help my child as needed. I will never forget that.
> I will do what I have to do and seek medical assistance.
> If you ever let me back I can be taught triaging or being offload nurse-this way I will not be in contact with any meds whatsoever. I am knowledgeable and skilled enough to be successful in it. Anyway, I would never touch any controlled substances and would ask other nurses to administer it.
> Another thing. Please, spare people who trusted me and were signing with me. I don't want any damage done to them. I am ready to take all responsibility on my self.
> I am only provider for my family. I am scared for my child. I pray to God to get through all this turmoil and give me strength and health to raise and provide for my child. I am blessed You are my manager.
> Thank you!
> [RI]

12. The second email was sent approximately two hours later at 9:20 and read:

> Dear Mayda,
> I need your advise. Don't feel talking with anybody else about it, just you. Trust you and love you greatly.
> What really can I expect. Should I pack up and leave to another country to be able keep working and providing for my child?
> I wish I never leave you. I feel like strangling my self for such trouble I caused you and also for my child.
> Reality is I have to keep working to keep my child afloat. There is no financial support around for us. And I want to be clean doesn't matter

what, and I want to continue being a nurse because its what I know to do the best.
I just pray, I'll be given one more chance. Sorry and Thank you.
[RI].

13. Following these events, the Hospital conducted its investigation which confirmed the facts set out above. The Hospital terminated the grievor's employment on March 2, 2016. At the termination meeting, the Hospital verbally offered the Employee Assistance Program (EAP) to the grievor.

14. In addition to setting out the incident giving rise to the termination, the agreed facts also describe several prior incidents documented by the Hospital. The Association does not dispute that the documents exist but does not agree that they are relevant. The documents describe a series of performance issues between January 10, 2013 and January 6, 2015 ranging from improper administration of an IV to documentation and confidentiality issues to complaints of an interpersonal nature. The Hospital agrees that none of these incidents constituted discipline and they were not in the grievor's HR file.

15. The grievor did, however, have a 3-day suspension on her file for falsely documenting vital signs, not following a medication order from an emergency department physician for pain management, and multiple medication errors. Included in this discipline was a significant incident in which the grievor did not administer a dose of morphine to a patient as directed by the physician. The grievor addressed this incident in her evidence, and I will discuss it further below.

16. In addition to receiving the agreed statement of facts and the documentary record, I heard from five witnesses. The Hospital called its Manager of Emergency Services, Mayda Timberlake. The Association called Nancy Popp (a representative with many roles, including acting bargaining unit president) Bonnie Boyce (a site representative at the Wilson site) Mike Howell (bargaining unit president), the grievor, and Dr. Jake Bobrowski (a specialist in addiction medicine who has been treating the grievor).

17. Much of the evidence is not in dispute, and with the exception of Ms. Timberlake and the grievor, cross examination was directed at clarifying and expanding on the evidence in chief. With respect to Ms. Timberlake's evidence, the issue in dispute is whether the Hospital knew or ought to have known that the grievor had a drug problem. With respect to the grievor's evidence, there are significant factual disputes and it is necessary for me to make findings of credibility. In so doing, I have considered the entire evidentiary record and have assessed the internal consistency of the grievor's testimony in addition to considering how that evidence fits with the evidence as a whole, including

the uncontested testimony and documents. The following is a summary of only that evidence that is most pertinent to the parties' arguments and my decision.

Mayda Timberlake

18. Ms. Timberlake is the Manager of Emergency Services at the Hospital. She was able to confirm and expand upon many of the agreed facts. Her evidence was focussed on the union representation issue and the question of whether the Hospital was aware of the grievor's addiction disability at the time she was discharged from employment.

19. Timberlake met with the grievor and Joe Fernandes from human resources on February 29, 2016 after she learned that the grievor had been found with the narcotics. The meeting began without a union representative. The grievor was asked about the medications, and according to Ms. Timberlake, the grievor explained that she needed them because of serious pain she was suffering and she would pass out if she did not have them. The grievor explained how she had taken the medication from the Omnicell and that they were signed out for patients but she would keep them for herself.

20. Shortly after the meeting began, Nancy Popp arrived on behalf of the Association, and they went through the questions a second time, before the grievor and Ms. Popp stepped out of the room to caucus. Thereafter, the grievor described in more detail how she had stolen the drugs and explained that she had a "serious problem" she had kept from her family and friends and was passing out at home. Ms. Timberlake testified that she understood this to be a reference to passing out from pain, as the grievor had mentioned earlier that she was experiencing pain.

21. According to Ms. Timberlake, she did not really know why the grievor was taking the morphine, whether for self-administration or for some other purpose outside of the hospital, although she again noted that the grievor had said she was having pain and had mentioned some history of brain tumour in her family. Generally, she understood the grievor to be saying that she would not have pain if she took the morphine and could still function. She described the grievor as "smiling with tears" while admitting that she was taking morphine from the hospital. She recalled Ms. Popp expressing the concern that the grievor appeared to be under the influence of narcotics at the time. Ms. Timberlake advised the grievor to seek medical care for the pain she was in. However, Ms. Timberlake stated that at no time did the grievor say anything about having a drug addiction.

22. Ms. Timberlake was questioned about the emails she received, described in the agreed statement of facts above, and specifically what she understood the grievor was referring to when she said, "And I want to be clean…". Ms. Timberlake responded that she was not quite sure what this was referring to. She was also asked why the Hospital offered the grievor access to the EAP at the termination meeting and responded that they always offer EAP to staff for any kind of stressful event. She confirmed that neither the grievor nor the union representative mentioned anything about having a problem with drugs at the termination meeting.

23. The bulk of Ms. Timberlake's cross examination was directed toward her claim that she did not know or have any indication that the grievor had a drug problem. She maintained that none of the physical signs, including passing out, the volume of injectable drugs, the grievor's references to using the drugs herself, including at work, the Association's expressed concerns that the grievor was under the influence during the interview, Ms. Timberlake's own concerns about the safety of the grievor and her family following the email exchange, the grievor's reference to keeping a secret from her family and friends, or the reference to wanting to be "clean", could allow her to draw any conclusions about the grievor's drug use. She maintained that her concern was that the drugs were stolen and that is all that she focussed on.

24. While Ms. Timberlake stated repeatedly in her cross examination that she did not know how much drugs the grievor was taking or the extent to which she was taking them herself or if she could have been selling them to others, there is no evidence that anybody on behalf of the Hospital made any inquiries in this regard. She did acknowledge, however, that in her report to the College of Nurses prepared on March 3, 2018, she indicated that the investigation concluded:

- Theft of narcotic and other medications
- Self-Injection of narcotics removed from the Omnicell
- Removal of medications for the Omnicell not given to the patient.
- Self-medicating with a large amount of medications removed from the HRH Omnicell and administered to herself.
- Working under the influence of a narcotic during her shift
- Falsified medication administration documentation
- Drug diversion

<u>Nancy Popp</u>

25. On February 29, 2018 Ms. Popp was carrying out her role as ONA's designated site representative when she was contacted by human resources and asked to attend a meeting. Before going to the meeting, she spoke with

Mike Howell, who told her that it was about a nurse in the emergency department who had stolen narcotics. Ms. Popp confirmed the details of the meeting described above, including the concern she expressed that the grievor appeared to be under the influence. She had met the grievor before and now she appeared to be a "different person"; her eyes were dull and closing, she appeared "spaced out", he speech was slurred and her responses were not always coherent. The grievor seemed to be nodding off, and Ms. Popp was concerned about her answering questions in that condition. Ms. Popp therefore arranged to get the grievor home in a taxi. It was obvious to Ms. Popp that the grievor had a dependency issue and while the grievor kept talking about her childcare responsibilities, Ms. Popp urged her to "get help" for herself. According to Ms. Popp, this conversation happened in front of Mr. Fernandes, who did not testify in this proceeding.

Bonnie Boyce

26. Bonnie Boyce is the ONA site representative who attended the termination meeting with the grievor on March 2, 2016. She was working on her unit when she received a message or a call to contact Joe Fernandes or HR. She did not remember specifically what she was told about the meeting but did recall that at some point before she entered the meeting Mr. Fernandes told her it was "not good", which she described as "Joe's way of saying somebody is going to be let go". She did not know anything else until Ms. Timberlake read the grievor's termination letter. Ms. Boyce testified that she had attended termination meetings before and that typically she would speak with either Mike Howell or Nancy Popp beforehand. They would let her know ahead of time the nature of the meeting, so she would not be caught off guard. She said that she was upset by this meeting because although she understood there had been a serious theft, to her that was not the underlying cause. She saw what she described as "something different" in the grievor's demeanor and how she was sitting, and that she seemed to be under the influence of something.

Mike Howell

27. Mike Howell is the bargaining unit president for ONA at the Hospital. On the morning of February 29, 2016, Mr. Howell received a phone call from somebody at the Hospital advising him that they needed an ONA representative for an urgent meeting and that the matter was serious. Mr. Howell was not at the Hospital that day but advised that he would call Ms. Popp and have her attend human resources. He could not recall receiving any further information regarding the underlying issue. He contacted Ms. Popp and told her about the meeting and that it was serious. Ms. Popp advised that she was aware of the meeting and was on her way.

28. With respect to the termination meeting, Mr. Howell testified that he received notice of the meeting by email from Mr. Fernandes, and might also have had a phone conversation, but that he did not recall receiving the "heads up" about what was going to happen that he would have expected in cases of termination. However, when presented with the Hospital's step 2 response, which indicates that the Hospital did in fact advise Mr. Howell that there would be a serious outcome and that it was not yet certain that the nurse would be terminated, Mr. Howell agreed that the conversation sounded familiar.

29. Mr. Howell also testified that based on his experience with cases of narcotics theft, if the investigation found the employee had some form of illness, he would be given an opportunity to speak to the grievor. He could then have the grievor self-admit the illness to the Hospital so that they could deal with the illness through the benefits process. This did not happen in this case.

The Grievor

30. The grievor initially testified on April 13, 2017 and June 23, 2017. This timing is significant because new information came to light after the grievor had testified and both before and after Dr. Bobrowski testified on August 4, 2017. As discussed below, the grievor was re-called to give additional evidence. At this point, however, I am addressing only the grievor's initial testimony.

31. The grievor described her background, family and personal circumstances in some detail. It is not necessary to report these details beyond what is necessary to address the parties' arguments. Suffice to say the grievor has experienced significant difficulties in her personal life and carries substantial caregiving responsibilities in addition to carrying out her role as the primary source of income for her family.

32. The grievor described her first interaction with narcotics as arising from a running accident. She was an avid runner and in the fall of 2015 she was on a long-distance run of around three hours when she fell badly. She believed she had broken her rib, could not breath properly and was in serious pain. She attended at the Hospital's emergency department to seek help. X-rays did not show a broken rib, but it felt broken to her and still hurt. She was prescribed 40 tablets of Percocet, to take 1-2 tablets every 4 hours as per need. According to the grievor, she had never taken opioids before. She had been previously prescribed opioids once for her teeth but said that she did not even pick up the prescription from the pharmacy. She had similarly never taken Tylenol 3s when they had been prescribed.

33. According to the grievor, she resisted taking the Percocet until the evening, but when she could not move or look after her family obligations and needed to sleep, she took two of the pills. She described the results as "euphoric". She woke up feeling great, stress free, happy and without pain. She felt that the Percocet was like "gold" and decided to make them last as long as she could. It took 3 weeks to finish the pills, and by the end she said she was already planning how to get another prescription.

34. Her plan, which she said she carried out, was to approach a different emergency room doctor and say that she needed Percocet for terrible headaches. According to the grievor, she had suffered from migraines for her entire life, though she had always been able to deal with them without opioids. She said she was prescribed another 40 tablets. As her tolerance increased, she required more of the drug to achieve the same effect, and this second prescription lasted only two weeks. By this time, she no longer needed the drugs for chest pain, but took them because they were like "magic" and seemed to solve all of the difficulties of her daily life.

35. When the second prescription ran out, the grievor was convinced that she would not be prescribed more. She testified that by this point she was already hooked. She knew that patients in the Emergency room wanted morphine, so she decided to move to that. Some time around December 2015, the grievor said that she took 5 mg of morphine which she injected inter-muscularly. She described the feeling as "very very good, full of energy, light, very happy, euphoric, amazing. Much better than Percocet." According to the grievor, she had a chemical dependency, and "needed to be on something" to deal with the difficulties in her life.

36. According to the grievor, she stole narcotics from the Hospital from some time in December 2015 until February 2016 when she was fired. At the beginning, her use was not consistent. She initially took it inter-muscularly, but it left "ugly bruises" and in January she began to take it intravenously. At this point her tolerance was growing quickly, and she went from 5mg to, by the time of her termination, 60mg daily if she could get it. By the end, she said she had to use every 5 hours or she would not be able to function.

37. When asked whether she had ever taken prescription medication from a patient such that the patient was deprived, the grievor answered "never, practically never, never got complaints from patients about the way I took care of them, never ever." In cross-examination she maintained that all narcotics prescribed to patients were given to the patients.

38. The grievor also described the events of February 28/29, 2016 set out in the agreed facts. According to her, she planned to get caught that night. She felt that based on her pattern of use, she was going to be dead in two weeks. She was "like a train without brakes" and needed to be seen by somebody and somebody needed to stop her. She found it too hard to go to her manager, who she respected deeply, and tell her "look at me. I'm a junkie, why don't you see it?" Over the night, she accumulated several ampules in the manner described above, having her colleagues sign for the waste on the basis of the trust she had earned over her time working with them. She then intentionally pocketed the morphine while being watched by a nurse that she knew was not her friend. According to the grievor, she "put it on show" because she had to be seen, so that "like a ball, you can't stop it now it's coming." In other words, she wanted to be caught and made sure that she was. That was why she cooperated with the investigation and was relieved that she had finally been stopped.

39. The grievor's recollection of the meeting with Ms. Timberlake and Mr. Fernandes was limited as she was both under the influence of the morphine and exhausted at the end of her shift. She could not remember the details of what she was asked and could not dispute Ms. Timberlake's account. She answered the questions, and then explained that she needed to go home and look after her child. Although she said that was basically true, in reality she was embarrassed, ashamed and just wanted to disappear.

40. The grievor confirmed in cross-examination that she did not at this meeting or in her discussions with the other nurses prior to the meeting say that she had an addiction. At this point, she maintained, she was unaware and had not yet put the label "addiction" to her condition. Instead, she gave "100 reasons" why she took morphine but did not say "I'm an addict". She maintained, however, that notwithstanding her own denial it should have been obvious to anyone in the emergency medicine field observing her that she had a drug addiction. One of her colleagues who had seen her that day followed up with her after to encourage her in getting through withdrawal.

41. When the grievor got home and before she sent the emails to Ms. Timberlake, she took more morphine. She had a supply at home to last a couple of more days and explained that she was under the influence until March 2, 2016. She was dependent on the drug in order to function. When she told Ms. Timberlake she wanted to be "clean", she understood that to mean clean of the addiction, although she also claimed to be in denial at this time. According to the grievor, emergency room staff see a great many people suffering from addiction, and when they say "clean" they mean out of dependency.

42. On March 1, 2016 she went to her family doctor, Dr. Gelman. They discussed treatment options, including methadone and suboxone, but decided that total abstinence was the better course. Dr. Gelman told the grievor to call the Centre for Addiction and Mental Health ("CAMH"), which she did, but she determined that they did not have a program suitable for her.

43. On March 2, 2016, Ms. Timberlake contacted the grievor and told her that she had to come to a meeting. She was not told the reason for the meeting. At the meeting, which lasted approximately 15 minutes, she was read the termination letter and given a taxi chit to get home.

44. By this point, the grievor testified that she was out of morphine. She described the next days as she went through withdrawal in graphic detail and as the ugliest of her life. After around 7 days she was able to get out of bed, and after 10 she could leave the house.

45. Around 10-12 days after she stopped using morphine, the grievor contacted ONA's Legal Expense and Assistance Plan for advice and began to seek out treatment programs.

46. She first saw Dr. Madonik, an addictions specialist at North York General Hospital. The grievor described Dr. Madonik as unhelpful and unsupportive and the grievor was not receptive to the treatment options Dr. Madonik proposed. She then found Dr. Bobrowski, the addictions specialist who continues to treat her to this day. Her first appointment with him was on April 5, 2016. The grievor wanted to be admitted to a caduceus group—a peer support group for health care professions suffering from addiction—co-facilitated by Dr. Bobrowski's. The challenge was that before entering such a program, the grievor needed to complete a residential treatment program and pass regular supervised urine drug screen tests. The grievor has a disabled child who is highly dependent on her for support. Although the grievor identified a limited number of family members who could help on a short-term basis, her extended absence would be highly disruptive to the child's routine and cause significant hardship. She also had no income or access to her benefits, and viewed the expense of a residential treatment program as prohibitive. She did not, therefore believe that a residential program was feasible.

47. Dr. Bobrowski also referred the grievor to a psychiatrist to determine whether she might have other conditions that would impact on her treatment. According to the grievor, hers was a case of addiction without further complicating mental health issues.

48. Instead of attending a residential treatment program, on May 18, 2016 the grievor began attending an outpatient program at Edgewood Health that included regular drug screens. She paid for the program out of her savings. In July, 2016, however, she relapsed and was discharged from the program. She explained that the combination of her migraine headaches, continued withdrawal and the fact that she was not working and felt she could "do whatever she wanted" lead her to use again. Although she did not disclose this to Dr. Bobrowski, she had sourced the morphine from the street.

49. In her examination in chief, the grievor gave the impression that the relapse was a relatively isolated incident. In cross-examination, however, it became clear that the grievor had missed almost half of the Edgewood sessions, and had missed and sought to manipulate the testing at various times. She was, in her own words, "trying to cheat" and was not yet ready for treatment. When offered readmission to the program in August, she turned it down for financial reasons and because she did not think it was a good program. She referred specifically to an incident where she believed that a doctor had said something "horrible" about her child and accused her of having urine that was not within the temperature range, notwithstanding that he did not actually do a temperature check and just touched the bag. She maintained that that particular sample was legitimately her own urine and that the comment, which she did not describe, was so bad that she simply left. The grievor also confirmed that she continued to work intermittently as a nurse while she continued to use opiates.

50. According to the grievor she was extremely upset with herself for the relapse. In her examination in chief, she claimed that she had stopped using by some point in September 2016. In cross-examination, when referred to various medical records, she allowed that her use might have continued into October or November.

51. In November 2016 she began an outpatient rehabilitation program at St. Mike's and commenced regular supervised drug screenings, first through Dr. Bobrowski and then through the program at St. Mike's. She explained that Dr. Bobrowksi did not consider the program adequate to her needs, but that she found the daily meetings helpful. Notwithstanding Dr. Bobrowski's concerns, the grievor said that because her tests were coming back clean,[1] Dr. Bobrowski was prepared to admit her to the caduceus group, subject to continued regular testing and her participation in the Bridgeway Chemical Dependency Treatment Program. The grievor described the Bridgeway program as very thorough, rigorous and effective. The grievor completed pre-

[1] The grievor did have one positive test for Percocet in January 2017. The drug had been prescribed, however, as a result of dental surgery, and was disclosed and approved.

treatment and then entered the program in March 2017, completing it in April 2017. From that date until the date she gave evidence the grievor continued with supervised testing three times a week.

52. The grievor was cross-examined on her motivation for treatment, and in particular a number of references throughout the record suggesting that her primary motivation in treatment was to satisfy the criteria necessary to return to work as suggested by the Association and in anticipation of hearing dates in this proceeding. The grievor agreed that returning to work was crucial to her and meant "everything". She was also taken to several references in the medical records where she had not been forthright about the extent of her dependence, including why she took the morphine, the amounts she was taking, and the fact that after the supply she had from work was exhausted she sourced it from the street. The grievor acknowledged that she had been in denial and that it took her almost a year to understand the extent of her problem, and to be able to acknowledge fully that she is an addict.

53. The grievor was also challenged on her reasons for resisting a residential treatment program. It was clear from her evidence that while part of her resistance may have come from a refusal to accept the extent of her addiction, entering a residential program would also have interfered with her caregiving responsibilities in a way that could have had a significant impact on her family. I am satisfied that even had the grievor been highly motivated to enter a residential program, it would have been a very difficult decision to do so.

Dr. Bobrowski

54. Dr. Bobrowski is an addiction medicine specialist with extensive credentials and experience in the field. He has provided expert advice and been consulted with respect to addiction in a wide range of areas, including by the College of Physicians and Surgeons with respect to assessing and determining the disposition of cases involving doctors ill with addiction. He has been the grievor's addiction medicine physician since April 5, 2016, and as discussed above she attends his caduceus group. The Association initially sought to qualify Dr. Bobrowski as an expert witness, and to introduce his expert report. The Hospital did not object to Dr. Bobrowski testifying but did oppose his qualification as an expert on the grounds that he is the grievor's treating physician and therefore lacked the requisite impartiality. At the time Dr. Bobrowski prepared his report on March 24, 2017, he had met with the grievor 8 times, and he continued to meet with and treat the grievor thereafter. The Association maintained that Dr. Bobrowski could nonetheless be appropriately qualified as an expert.

55. The parties ultimately agreed that as the bulk of Dr. Bobrowski's anticipated evidence would be admissible in any event, they would argue the admissibility of any contested expert opinion evidence in closing. This proved unnecessary. Dr. Bobrowski was a highly informative and compelling witness. While clearly supportive of the grievor's treatment and recovery, Dr. Bobrowski was at all times careful to articulate the basis for his conclusions with respect to the grievor's addiction, treatment and prognosis. Where there was a degree of uncertainty in his conclusions, he was careful to qualify those conclusions and to explain those qualifications. In the end, both parties accepted Dr. Bobrowski's evidence for what I also accept it to be; a fair and balanced account of the grievor's addiction, treatment and prognosis provided by an informed specialist in the area of addiction medicine and made on the basis of the best evidence available to him at the time. This last point, however, is significant, as it became clear that at least some of the information provided to Dr. Bobrowski by the grievor was either mistaken or deliberately false.

56. Dr. Bobrowski explained his methodology in assessing the grievor and the basis for his conclusion that she satisfied the DSM-V criteria for severe opioid disorder, i.e. exhibiting 6 or more of the 11 diagnostic criteria. The Hospital does not now dispute that the grievor suffers from an addiction disorder and that she did at the time of her termination.

57. The two aspects of Dr. Bobrowski's evidence most critical to the parties' arguments are his testimony concerning the link between the grievor's addiction and her theft of narcotics and other medications from the hospital, and his evidence concerning the onset of the grievor's use of narcotics and the progress of her treatment.

58. With respect to the first issue, Dr. Bobrowski identified drug access as an identified risk factor for addiction in health professionals, with availability defining the drug of abuse. He advised that evidence of diversion of drugs for personal use is a "hallmark of addiction in health professionals". He concluded that "[RI's] theft of drugs could reasonably have been driven by her addictive illness." Dr. Bobrowski was cross examined on this conclusion, particularly in light of the fact that the grievor had stolen not only narcotics, but non-narcotic drugs including drugs that are available over the counter. In addition to morphine, the grievor's drug of abuse, she was found to have taken various forms of Metoclopramide, Ketotac, Dimenhydrinate, Acetaminophen, Diphenhydrinate, Ondansetron, Lasix, Acetaminophen/Codeine #3 and Ibuprofen. Many of these drugs treat nausea and headaches or pain, and Dr. Bobrowski explained that their theft could be explained as part of the grievor's "self-medication" for the effects of opioid addiction, which he described as "what addicts do". He could not think of any good reason that an addict would

take Lasix (a diuretic) but noted that even when there is no discernable value to the addict in taking the drug, it may still fall within the lines of self-medicating behaviour arising from the addiction.

59. With respect to the second issue, Dr. Bobrowski summarized the grievor's history of use/addition and treatment as follows, with reference to the DSM-V criteria:

> [RI], a 47-year-old nurse employed in the emergency room of Humber River Hospital fractured a right rib while running a marathon in September of 2015. She received Percocet for analgesia, reported that she liked the psychoactive effect of this drug, and consequently began to self-medicate parenterally with morphine sourced in the workplace. This drug diversion was discovered on March 1, 2016, and [RI] has subsequently been off work since March 2, 2016.
>
> [RI] relapsed on April 8, 2016, and once again in July 2016 while attending the Edgewood program, with subsequent sobriety.
>
> [RI] has satisfied the DSM-V criteria for an opioid use disorder that is severe and that is now in early remission. To be specific, this nurse has demonstrated tolerance or a need for a markedly increased amount of opioids in order to achieve a desired effect, along with a markedly diminished effect with continued use of the same amount of opioids. She initially started with a prescription for Percocet in September of 2015 in order to manage pain subsequent to a fall and fracture of a right rib. By history, the dose, route of administration, and opioid potency of drugs she was using for analgesia increased, and she also began to use opioids in order to "feel good", or obtain "energy" as well as a psychoactive effect. [RI] reported that she self-administered morphine parenterally, first by intramuscular route in December of 2015, and then by intravenous route by January of 2016, at a progressive frequency that depended on availability rather than therapeutic efficacy (Criterion 10). There is additional history that indicates that [RI] used opioids in larger amounts and over a longer period than initially intended, and that she had difficulty and cutting down or controlling opioid use (Criteria 1 and 2). That is to say, although this nurse endorsed only a short period of withdrawal, she did experience chronic relapsing behaviour on April 8, 2016 and in July of 2016. This data speaks to the fact that opioids were taken to relieve or avoid withdrawal symptoms, as well as to abate craving, or strong desire or urge to use opioids (Criteria 11 and 4). Moreover, [RI] acknowledged that she had proceeded to source opioids in the workplace, and that she used this class of drugs in spite of the fact that her actions in this regard threatened her occupational standing and impacted her professional capacity as a nurse (Criterion 7). She spent a great deal of time in surreptitious activities necessary to obtain opioids, use opioids, and recover from their effect. Despite a denial system which refused to

> acknowledge the severity of her addictive disease, she has now invested a good deal of time in a recovery process intent on regaining her employment (Criterion 3). There is certainly no doubt that [RI] opioid use manifested as a potential hazard and risk to patients given the fact that her job as an emergency department nurse has been classified as safety critical (Criterion 8).

60. Dr. Bobrowski then summarized the interaction between the grievor's use of opioids and difficult relationships and stressors in her personal life in support of his diagnosis under the DSM-V. I do not find it necessary to set out these personal details here, but suffice it to say that Dr. Bobrowksi found that the interaction between the grievor's use of opioids and her difficult personal circumstances exacerbated her condition, leading to both increased dependence and her denial of that dependence, and supported his diagnosis under the DSM-V.

61. Just prior to giving his evidence, Dr. Bobrowski learned several new facts that caused him to qualify some of the findings in his report.

62. First, he learned that the grievor had once again tested positive for opioids on July 5, 2017. The grievor explained to him that the positive test was the result of eating a cake containing poppy seeds. Dr. Bobrowski explained that it was not possible to distinguish between a positive test from poppy seeds from a positive test from opioid use. Consequently, his general practice is to tell patients not to eat poppy seeds and to treat a positive test as a relapse. This, he acknowledged, would alter the conclusion in his report that the grievor was in early remission. Dr. Bobrowski would require a further extended period of negative tests before concluding definitively that she had achieved that status. Nonetheless, Dr. Bobrowski also pointed out that all of the grievor's adjacent tests had been negative, which did suggest that she was stable, and lend some credibility to her explanation for the positive test. In the end, he concluded that it was one more factor in assessing the grievor's progress in treatment that had to be watched. He found that the grievor had made significant progress in accepting the severity of her disability and her ability to confront it in a forthright manner, but that the intermittent positive tests continued to concern him and he was not yet certain how best to deal with them.

63. Also just prior to giving his evidence, Dr. Bobrowski learned, from both the reports of other medical professionals and for the first time from the grievor, that at the time the grievor was terminated her volume of use was actually significantly higher than she had previously reported to him. He also learned that the grievor had been significantly underreporting her symptoms of withdrawal, and that she had sourced drugs from the street. In cross

examination, Dr. Bobrowski was taken through his report and conclusions, and questioned about those aspects of the report that were based on information reported by the grievor. Dr. Bobrowski acknowledged that much of this self-reported information was unreliable, but explained how denial and underreporting were common defence mechanisms adopted by addicts, and were symptoms of the disorder itself.

64. Of particular significance, Dr. Bobrowski testified that having learned of the significantly higher amounts of opioids that the grievor now acknowledged she was using, in addition to what he had learned from the other medical reports he reviewed, Dr. Bobrowski had serious doubts about the accuracy of the timeline that the grievor had provided him of her opioid use. He explained how tolerance to the drug increases over time, and expressed doubt that the grievor could have built up the kind of tolerance she would need to have built up over the relatively short period of use she had described. In light of the evidence that emerged following Dr. Bobrowski's evidence, I find that this observation was entirely prescient.

Additional Evidence Concerning Time of First Use

65. In light of Dr. Bobrowski's testimony, the Hospital conducted a further investigation of the grievor's claim that she first used opioids in September 2015 and did not begin stealing morphine until December 2015. In particular, the hospital obtained the emergency room records related to the grievor's fall and her initial prescription for Percocet. These records revealed that this incident in fact took place on June 13, 2014, more than a year earlier than the grievor had reported. As a result of this information, the hospital also obtained records from OHIP and other medical service providers which revealed other opioid seeking behaviour. The hospital took the position that the records were *prima facie* evidence that the grievor had repeatedly and consciously lied about when she began using narcotics, and that the reasonable inference was that she had been stealing narcotics from the Hospital for far longer than she admitted, and had likely been diverting narcotics at the time of her prior discipline for failure to administer opioids to a patient under a doctor's direction. The Association sought to recall the grievor to address the apparent discrepancy, and the Hospital opposed this request. By decision dated December 12, 2017 and for the reasons set out in that decision I held that it was fairest to permit the Association to recall the grievor for the limited purpose of addressing the new evidence, and to grant the Hospital a full right of cross-examination.

The Grievor Recalled

66. On February 7, 2018, the grievor gave evidence for the second time. She was taken to each time she had reported that her first use of opioids was in September 2015 and repeatedly affirmed that she was at all times trying to be truthful. She was then taken to the record indicating that the fall and initial Percocet prescription actually took place in on June 13, 2014, well over a year prior to the date the grievor had previously reported. The subsequent prescription for reported "sinus headaches" appears to have taken place on June 2, 2015.

67. The grievor was asked how she could explain these discrepancies and provided two reasons. The first was that working night shifts in emergency can affect your memory and cause you to lose your sense of time. The second was that her addiction and drug use clouded her mind. The two factors combined, explained the grievor, to prevent her from thinking clearly and to be wrong about the dates. She accepted that the truth was that she started with Percocet in the summer of 2014. She maintained, however, that she did not intend to mislead anybody, and had no reason to mislead. Beyond underreporting her usage to Dr. Bobrowski out of shame, she said she had never intended to be dishonest with any of her treatment providers or in her evidence in this proceeding. Asked why she did not come forward to correct the record herself once she had received the medical records from Bridgeway or the ER, she explained that she did not think she had the right to speak directly with the Hospital or the arbitrator beyond saying "hello".

68. The grievor was pressed on how definitive she appeared to be with respect to dates during her initial testimony, and on the numerous occasions that she reported the dates and events leading to her addiction to various health care professionals. When asked if had ever used opiates before the fall of 2015 she had responded "no no no no no". She maintained that while she was confused about the date of the fall and the initial prescription, she knew that she did not start taking morphine until December 2015, or November 2015 at the earliest. She claimed that she knew that it was cold and snowing out, and that her use of morphine did not start until after a September 2, 2015 incident when she passed out a work. When reminded of Dr. Bobrowski's evidence that her reported use escalated more quickly than he would have thought possible, the grievor responded that her athleticism explained her ability to develop tolerance more quickly. According to the grievor, she remembered all events well and it was only her timeline with respect to the initial Percocet prescription that was confused.

69. However, when presented with records from the Nymark Medical Centre from May 6 and 15 of 2015, the grievor agreed that the symptoms she

exhibited at that time might have been symptoms of withdrawal and that the medications she was seeking on the 15th were opiates and medication to help with her withdrawal symptoms. The doctor at the Nymark Medical Centre declined to give her opioids, concerned that she would simply go home and self-medicate, and advised that she should attend at the ER. Instead, the grievor went to work.

70. Notwithstanding this evidence of significant opiate use and withdrawal at the time, the grievor denied that she was using morphine, explaining that had she been she would not have been seeking Percocet. There was no hint of an extended period of Percocet abuse or withdrawal in the grievor's initial evidence. She also denied that her use of opiates or the fact that she was seeking opiates from Nymark had anything to do with the incident in April 2015 for which she was disciplined, where she failed to administer morphine to a patient as directed by the physician. Her position was that the refusal to administer the drug to the patient in that case was correct and she was happy she did it and would do it again because he would not have been able to handle it. She denied that her drug use had anything to do with the other performance issued identified in the agreed statement of facts. She did not agree that she had lied about the time she began using Percocet because she was afraid that her drug use would be linked to the prior incidents.

71. When challenged on the implausibility of confusing a few short months from initial use to termination with closer to two years of use, the grievor maintained that while it sounds ridiculous to a clean person and even to her now that she is clean, her brain was not in control when she was using and even now timing is confusing for her.

72. The grievor was also again cross examined on her relapses and previous efforts to cheat the drug tests and to obtain documentation for the purpose of supporting ONA's position in this arbitration or before the college. She did not deny that she had relapsed and cheated, or that she was motivated at times by the desire to get back to work, but maintained that she was at all times trying to get clean and was seeking help to do it. Neither did she deny that she had lied to her doctors about the volume of her use, explaining that all addicts lie. The grievor maintained, however, that she had been clean and sober since November 2016.

ARGUMENT

The Association's Argument

73. The Association seeks to have the grievor reinstated to employment on two grounds. First, the Association argues that under human rights law, the

grievor's termination was *prima facie* discriminatory. Second, the Association argues that the Hospital violated the union representation clause under 7.02 of the Collective Agreement. This second ground, argues the Association, is relevant to the assessment of the first, since the failure to allow for the grievor to have proper union representation likely deprived the Hospital of material information that might have impacted its consideration of the discriminatory effect of terminating the grievor at the time. The Association further argues, however, that if I accept the Hospital's position that this case should be assessed on a just cause and not a human rights basis, the breach of the union representation provision ought to render the discipline void in any event.

Human Rights

74. The Association acknowledges that the grievor's conduct—theft and use of morphine on the job—raises very serious concerns, about which the Hospital and the public are rightfully troubled. But where that conduct arises from an addiction disability, the Association argues that human rights law demands that we address these concerns from a human rights perspective. There is no dispute that the grievor suffers from an addiction disability. The Association argues that the evidence establishes a nexus between that addiction and the grievor's actions leading to her termination. In these circumstances, terminating the grievor without first inquiring into whether the Employer could have accommodated her to the point of undue hardship is *prima facie* discriminatory.

75. The Association relies on s.5 of the *Human Rights Code*, RSO 1990 c H.19 (the "*Code*") which guarantees "equal treatment with respect to employment without discrimination because of…disability". It argues that the real essence of this case, however, lies with s.17(2) of the *Code* which codifies the duty to accommodate. The focus, argues the Association, should be on whether the grievor is capable of working as an RN with appropriate accommodations. In support of this position, the Association relies on article 3.05 of the Central Hospital Collective Agreement, where the parties recognize their joint duty to accommodate disabled employees in accordance with the provisions of the *Code.* The Association also relies on the Human Rights Commission Policy on preventing discrimination based on Mental health disabilities and addictions, in support of the proposition that the imposition of generally acceptable rules can be applied improperly to undermine the duty to accommodate, particularly in cases of addiction where societal prejudice is brought to bear.

76. The Association relies on the three-part test for *prima facie* discrimination set out by the Supreme Court of Canada in *Moore v British Columbia (Ministry of Education)*, 2012 SCC 61 ("*Moore*") as affirmed in the

more recent addiction case of *Stewart v Elk Valley Coal Corp,* 2017 SCC 30 ("*Elk Valley*"). It argues that: i) the grievor has a characteristic protected from discrimination (an addiction disability); ii) the grievor has experienced adverse impact (she was terminated); and, iii) the protected characteristic (her addiction disability) was a factor in the adverse impact (her termination). In applying this test, the Association emphasizes that the failure to take appropriate procedural steps to assess the disability and potential accommodation is a component of the discrimination. In this regard, the Association relies on *British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights)* [1999] 3 SCR 868, *British Columbia (Public Service Employee Relations Comm) v. BCGSEU,* [1999] 3 SCR 3 ("*Meiorin"*) and *ADGA Group Consultants,* 2008 CanLII 39605 (Ont Div Ct).

77. The bulk of the Association's argument is directed toward the third part of the test. The Association argues that where there is sufficient evidence to establish a link between the addiction and the misconduct, the employee is entitled to be accommodated. In this regard, the Association relies on *Sunnybrook Health Sciences Centre v Ontario Nurses' Association,* 2016 OLAA No 361 (Jesin), *ONA v Collingwood General and Marine Hospital,* [2010] OLAA No 196 (Jesin) and *Direct Energy and Communications, Energy and Paperworkers Union of Canada, Local 975,* 184 LAC (4th) 7 (Burkett). The Association submits that the evidence of Dr. Bobrowski in particular establishes the requisite nexus, and that this case is similar in this regard to *Sunnybrook, Collingwood General*, *William Osler Health Centre v ONA,* [2006] OLAA No. 115 (Keller), *London Health Sciences Centre and ONA,* [2013] OLAA No 24 (Hayes) ("*London Health Sciences*"), *St. Mary's General Hospital v ONA,* [2010] OLAA No 465 (Stephens) and *Thunder Bay Health Sciences Centre and ONA, Re,* 104 CLAS 263 (Sheehan) ("*Thunder Bay Health Sciences*"), where the grievors were reinstated to employment.[2] The Association argues that these cases, which include decisions arising under the Association's central hospital agreement, establish a substantial arbitral consensus that I ought to follow (see *Irving Pulp & Paper Ltd v. CEP, Local* 30, 2013 SCC 34).

78. The Association argues that once it has established a nexus between the grievor's disability and her misconduct, and in the absence of any dispute with respect to the other two factors, it has met its onus to establish *prima facie* discrimination. The next step is therefore to assess whether the grievor can be accommodated. The Association acknowledges, however, that the

[2] The Union also relies on the following cases outside of the healthcare sector: *Canadian National Railway and teamsters Canada Rail Conference, Re,* 2011 CarswellNat 6231, *Direct Energy v CEP, Local 975,* [2009] OLAA No 216, *Manitoba v Legal Aid Lawyers' Assn,* (2009) 181 LAC (4th) 296, *UNA Local 33 v Capital Health (Royal Alexandra Hospital),* 2008 CarswellAlta 2236, *Hydro One Inc v LIUNA, Ontario Provincial District Council,* 2014 CarswellOnt 15867.

authorities require that before the Hospital's duty to accommodate is engaged, the employee must accept and pursue treatment to alleviate the effects of the disability, and that the duty is subject to the limits of undue hardship (see *Collingwood General* at para. 44 and *Sunnybrook Health* Sciences at para. 43). The Association maintains that the grievor has pursued treatment, and that to the extent that she has not been a "poster child" for recovery, denial and relapse are features of the disease, and in the end she has persevered.

79. While the Association maintains that there is essentially an arbitral consensus in Ontario, it also identifies and addresses a divergent line of cases arising from *British Columbia (Public Service Agency) v. British Columbia Government and Service Employees' Union,* 2008 BCCA 357 ("*Gooding*"). The Association argues that *Gooding* and the cases that have followed it (see, e.g., Wright *v College of Assn of Registered Nurses of Alberta (Appeals Committee)*, 2012 ABCA 267 adopt a long-discredited and rejected "formal" view of equality, based on the mistaken premise that treating people the same (i.e. imposing the same consequences for the same action) cannot be discriminatory. This formalistic view of equality, argues the Association, has been rejected since the earliest *Charter* cases and in seminal decisions such as the USSC's *Brown v. Board of Education*. A proper human rights analysis does not require that the complainant establish that the Hospital's "decision" was based on arbitrary or discriminatory beliefs or attitudes. Most recently, the *Gooding* approach was not adopted by the Supreme Court of Canada in *Elk Valley,* and the Association argues that the improper focus on attitude as opposed to adverse effect in *Gooding* is inconsistent with the human rights analysis endorsed by the Court in *Elk Valley*.[3]

80. The Association requests therefore that I find that the Hospital has *prima facie* discriminated against the grievor, and that this matter continue to determine whether the grievor can be accommodated.

Union Representation

81. The Association also argues that the Hospital breached Article 7.02 of the Collective Agreement by failing to give proper notice to both the grievor and the Association in advance of the termination meeting. For this reason, it argues that even if the Hospital otherwise had just cause to discipline the grievor, the discipline should be void.

82. Article 7.02 of the collective agreement reads:

[3] The Union also notes that the language of the s.13 of the British Columbia *Human Rights Code*, which provides that an employer may not refuse to employ and a person "because of…the mental disability…of that person" is in any event different from the Ontario *Code*.

> At the time formal discipline is imposed or at any stage of the grievance procedure, including the complaint stage, a nurse is entitled to be represented by her or his union representative. In the case of suspension or discharge, the Hospital shall notify the nurse of this right in advance. The Hospital also agrees, as a good labour relations practice, in most circumstances it will also notify the local Union.
>
> The Hospital agrees that where a nurse is required to attend a meeting with the Hospital that may lead to disciplinary action, as a good labour relations practice, it will inform the nurse of the purpose of the meeting and her or his right to union representation.
>
> All investigations related to a nurse's employment will be completed in a timely manner.

83. The Association argues that the notice provided to both the Association and the grievor in this case was deficient. With respect to the grievor, she was not told of the purpose of the meeting or of her right to union representation; only that she was required to attend. Neither, argues the Association, were its representatives given any substantial information about the purpose of the meeting. In all the circumstances the Association reasonably understood that the meeting was a continuation of the investigation meeting, and not a termination meeting in which the Hospital had already reached the decision that the grievor would be terminated and had written the termination letter.

84. The Association argues that the failure to provide the requisite notice of the meeting was not merely a technical breach, but rather deprived the Association of the ability to provide, and the grievor the opportunity to receive, meaningful representation that might have changed the disciplinary outcome in this case.

85. In support of its argument, the Association relies on the principles summarized in *Brown & Beatty Canadian Labour Arbitration,* 7:2130, particularly with respect to the substantive nature of union representation rights, and the recognition by arbitrators that union representation will generally improve the discipline process. The Association relies principally upon the decisions in *Oshawa Genera Hospital and O.N.A., Re,* 1988 CarswellOnt 5428 (Thorne), *Montfort Hospital. V. O.N.A.,* 1988 CarswellOnt 3817 (Adell), *Joseph Brant Memorial Hospital v. O.N.A.,* 2011 CarswellOnt 9503 (Newman), *St. Joseph's Hospital (Brantford) v. O.N.A.,* (1987) 28 L.A.C. (3d) 408 (Picher), *St. Joseph's Health Centre (London) v. O.N.A.,* 1990 CarswellOnt 5793 (Briggs), each of which deal with Article 7.02 of the Collective Agreement in a similar or identical form. The Association also relies on *Toronto Western Hospital v. C.U.P.E., Local 1744*, (1985) 19 L.A.C. (3d)

191 (M.G. Picher) and *Albert v. Alberta Union of Provincial Employees (R Grievance),* (2011) 213 L.A.C. (4th) 299 (Ponak).

The Hospital's Argument

Human Rights

86. The Hospital's primary position is that it had just cause to discharge the grievor from employment, because she:

- stole a substantial amount of Hospital property, including narcotic medication, and over-the-counter medication easily purchasable at any drug store;
- failed to follow the rules for wasting narcotics;
- risked patient safety by working under the influence of drugs; and
- was repeatedly dishonest with the Hospital when employed and following her discharge with respect to her misconduct, both when using drugs and after she stopped doing so.

87. The Hospital, like the Association, relies on the 3-part test for establishing a *prima facie* case of discrimination. It does not now dispute that the grievor was addicted to narcotics at the time of her termination, and that she therefore meets the first part of the test. Neither does it dispute that the grievor has experienced an adverse impact in being terminated from employment, and therefore meets the second part of the test. What it does dispute is that her addiction disability was a factor in her termination. Instead, the Hospital maintains that it neither knew nor ought to have known that the grievor was an addict at the time it terminated her employment. The grievor herself gave explanations such as thinking she might have a brain tumor and might be dying or that she took the medication for pain or to "fight her condition", and was not clear even in her evidence about what she meant by wanting to be "clean". The Hospital argues that its decision to terminate her employment was made with just cause, based entirely on the seriousness of her misconduct.

88. The Hospital's primary argument is that *Gooding* provides the correct approach to cases such as this, and in particular the appropriate way of applying the third part of the three-part test for establishing *prima facie* discrimination. Under this approach, argues the Hospital, the court found that there must be a causal link between a disability and the *decision* to terminate.

The fact that the employee's misconduct may have been influenced by their disability does not lead to a conclusion that the Hospital's "decision" to terminate for that conduct was motivated by the existence of the disability. The mere existence of a disability ought not, argues the Hospital, to insulate an employee for the consequences of serious and even criminal misconduct, and ought not to preclude an employer from taking legitimate action on the basis of that misconduct (see also *Wright v. College Assn. of Registered Nurses of Alberta*, 2012 ABCA 267, leave to appeal refused 2013 CarswellAlta 341 (SCC) and *Menard v. Royal Bank of Canada,* 2013 FCA 273 (CanLII)). As the court stated in *Gooding* the "Code [is] not designed to prevent employers from dismissing an employee who has committed a crime related to his or her employment" (at para. 8).

89. The Hospital also relies on the decision of the Ontario Court of Appeal in *Bellehumeur v. Windsor Factory Supply Ltd.*, 2015 ONCA 473, which cites *Gooding* and finds that an employer did not discriminate in terminating an employee for making workplace threats of violence, because it was unaware of the employee's mental disability.

90. In the instant case, the Hospital argues that it did not even know of the grievor's disability at the time of the discharge, and that disability played no part in the Hospital's decision to terminate her employment. She suffered no impact greater than any other employee would receive for the same misconduct.

91. The Hospital also argues that the line of cases relied upon by the Association, which have been followed by a number of Ontario arbitrators and which it describes as the "addicted nurses who steal" cases, have mistakenly applied this third part of the test conflating the issues of *prima facie* discrimination with the duty to accommodate, effectively assuming a nexus between the disability and the termination, and skipping over the need to find that the employer discriminated in the first place.

92. In this regard, in addition to *Elk Valley,* the Hospital relies on *Ontario Human Rights Commission and O'Malley v. Simpsons-Sears Ltd.,* [1985] 2 SCR 536 ("*O'Malley*"), *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal,* 2007 SCC 4, *Quebec (Commission des droits de la personne et des doits de la Jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center),* 2015 SCC 39, *Moore v. British Columbia (Education),* 2012 SCC 61, emphasising the Association's obligation to first establish a case of *prima facie* discrimination before engaging the employer's duty to accommodate. Conflating the two parts of the test in this manner is, argues the Hospital, an error in law (see *Health Employers Assn. of British Columbia v. BCNU,* 2006 BCCA 57).

93. The Hospital also relies on two Ontario arbitral awards in support of the *Gooding* approach.

94. In *Royal Victoria Regional Health Centre v. Ontario Nurses' Association,* [2016] OLAAS No. 373, arbitrator Raymond considered both the *Gooding* approach and the "addicted nurses who steal" approach, noting that Ontario arbitrators had not substantively addressed the *Gooding* test or provided any analysis for why it is wrong. Arbitrator Raymond did not make any definitive pronouncement on which approach was correct, however, as he found that on either approach it would not be appropriate to overturn the discharge.

95. In the alternative, the Hospital argues that I ought to adopt the approach of arbitrator Randall in *Cambridge Memorial Hospital and Ontario Nurses' Association,* [2017] OLAA No 22. In that case, the arbitrator was guided by but did not adopt the *Gooding* analysis "full bore" (para. 79). What the arbitrator did take from *Gooding* was the principal that establishing a nexus between the addiction and the misconduct is not *prima facie* evidence of discrimination. He found that the grievor's misconduct—stealing drugs from the hospital over a period of 11 years—was serious criminal misconduct that was an "absolute breach" of the employment relationship and the nurse's duty toward her patients. Given that he found that the grievor's use was not compulsive, she did not use at work, she went on vacation without using, she suffered little or no withdrawal, she failed to provide a comprehensive narrative of her addiction that dovetailed with the evidence of the addiction specialist and failed to own up to the full extent of her misconduct, he upheld the discharge. To do so, he noted, would fail to send a message of deterrence in times when opioid addiction is a major issue for healthcare professionals: "sending a message that pleading addiction, only after being caught stealing one's drug of choice, should be strongly deterred" (at para. 84).

96. In the further alternative, the Hospital argues that even applying the approach adopted in the "addicted nurses who steal" cases I ought to dismiss the grievance for reasons similar to those in the *Royal Victoria* case. The Hospital lists ten such reasons, noting that the grievor:

- stole more than just the drug to which she was addicted;
- was not "compelled" to use-she did not take drugs when they were not available;
- did not take drugs every day;
- did not immediately proceed to detox;
- did not follow repeated recommendations that she attend in-patient treatment;
- was not a "poster child" for recovering medical professionals;

- relapsed;
- has had subsequent positive drug tests;
- has never fully admitted the extent of her addiction; and
- has repeatedly failed to be honest and forthright.

97. The Hospital maintains that the evidence simply does not establish that the grievor's theft of drugs was caused by her addiction. Neither, argues the Hospital, are the grievor's reasons for refusing to follow the recommended treatment plan compelling. Most significantly, however, the Hospital maintains that the grievor not only has an established history of serial dishonesty, but continues to be dishonest about her drug use to this day, including in her testimony under oath. The Hospital argues that what is most likely on the evidence as a whole is that the grievor began stealing and using morphine far earlier than she has ever acknowledged, including during the period of her earlier discipline for refusing to administer opioids to a patient as directed by a physician. The grievor's evidence in which she purports to come clean and take responsibility for her actions is in fact, argues the Hospital, an elaborate and ongoing lie. Even if one accepts that the grievor's actions were caused by her disability and that the Association had satisfied its onus, the Hospital argues that it would be improper and constitute an undue hardship to require it to reinstate the grievor given all of these distinguishing features.

Union Representation

98. The Hospital denies that it breached Article 7.02, and argues that even if I find that it failed to give the requisite notice, any breach would be technical in nature and ought not to result in voiding the discipline. The grievor was in fact represented at the termination meeting by an experienced ONA representative, who did not raise any objections at the time. The Hospital had contacted and involved the Association during the investigative meeting, and contacted the bargaining unit president in advance of the termination meeting and effectively communicated the seriousness of the circumstances. To the extent that the Hospital did not explicitly advise the grievor of her right to union representation, the Hospital maintains that this failure is of no significance, since the grievor in fact had union representation from the outset of the termination meeting. In this regard, the Hospital distinguishes the cases relied upon by the Association and relies on *Timmins and District Hospital and ONA (Meranger), Re,* 2010 CarswellOnt 11672 (McNamee), *Toronto Hospital (General Division) v. O.N.A.,* 1996 CarswellOnt 6096 (Brown) and *Royal Ottawa Health Care Group v. O.N.A.,* 2001 CarswellOnt 1671 (Bastien). The Hospital also relies on *Revera Retirement v. U.S.W., Local 8300*, 2012 CarswellOnt 5523, which does not deal with the ONA union representation language, but in which Arbitrator Bendel rejects the conclusion that a breach of a union representation clause will necessarily warrant voiding the discipline.

ANALYSIS

Human Rights

99. In order to assess the merits of the human rights aspect of the grievance it is necessary to determine first the correct analytical approach. Of particular significance to each parties' argument is the question whether I ought to apply the reasoning set out in the *Gooding* decision of the British Columbia Court of Appeal. I will therefore address squarely this question at the outset: for the reasons that follow I find that the analysis in *Gooding* is inconsistent with the Supreme Court of Canada's established human rights analysis, affirmed most recently in *Elk Valley*. I therefore reject the *Gooding* approach put forward by the Hospital.

100. *Elk Valley* originated as a complaint before the Alberta Human Rights tribunal. The complainant was a loader operator at a mine, who was fired when he tested positive for cocaine use in a post-incident test following an accident involving his loader. The employer's Alcohol, Illegal Drugs and Medications Policy contained a "no free accidents" rule, which the Court described as follows: (at para 1):

> Employees were expected to disclose any dependence or addiction issues before any drug-related incident occurred. If they did, they would be offered treatment. However, if they failed to disclose and were involved in an incident and tested positive for drugs, they would be terminated—a policy succinctly dubbed the "no free accident" rule. The aim of the Policy was to ensure safety by encouraging employees with substance abuse problems to come forward and to obtain treatment before their problems compromised safety. Employees, including Mr. Stewart, attended a training session at which the Policy was reviewed and explained. Mr. Stewart signed a form acknowledging receipt and understanding of the Policy.

101. Following the incident, but not before, the complainant disclosed that he was addicted to cocaine. Because he had not disclosed his cocaine use and addiction prior to the incident, he was fired for breach of the rule. The tribunal found that the employee was not fired because of his disability, but rather for breach of the rule. The majority of the Supreme Court of Canada upheld this conclusion on the narrow ground that it was a reasonable finding of fact, open to the tribunal on the record before it. The Court summarized its conclusion as follows (at para. 5):

> Like the majority of the Court of Appeal, I find no basis for interfering with the decision of the Tribunal. The main issue is whether the employer terminated Mr. Stewart because of his addiction (raising a *prima facie* case of discrimination), or whether the employer terminated him for breach of

> the Policy prohibiting drug use unrelated to his addiction because he had the capacity to comply with those terms (not raising a *prima facie* case of discrimination). This is essentially a question of fact, for the Tribunal to determine. After a thorough review of all the evidence, the Tribunal concluded that the employer had terminated Mr. Stewart's employment for breach of its Policy. The Tribunal's conclusion was reasonable.

102. Before conducting its analysis, the Court reiterated that it was maintaining the settled legal principles applicable in cases of alleged discrimination due to disability—including addiction—and the fact-based nature of the issue before it as follows (at para. 22):

> In sum, this case involves the application of settled principles on workplace disability discrimination to a particular fact situation. The nature of the particular disability at issue — in this case addiction — does not change the legal principles to be applied. The debates here are not about the law, but about the facts and the inferences to be drawn from the facts. These issues were within the purview of the Tribunal, and attract deference. The only question is whether the Tribunal's decision was reasonable.

In identifying those settled principles, the Court reviews its general approach to determining whether there is a *prima facie* case of discrimination and identifies several features of the analysis that are important in assessing cases of addiction disability. It is these principles and the features of these principles identified by the Court that lead me to conclude that I cannot follow the *Gooding* approach urged upon me by the Hospital.

103. The Court summarizes its general approach at para. 24:

> To make a case of *prima facie* discrimination, "complainants are required to show that they have a characteristic protected from discrimination under the [*Human Rights Code*, R.S.B.C. 1996, c. 210]; that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact": *Moore*, at para. 33. Discrimination can take many forms, including "'indirect' discrimination", where otherwise neutral policies may have an adverse effect on certain groups: *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Center)*, 2015 SCC 39 (CanLII), [2015] 2 S.C.R. 789, at para. 32. Discriminatory intent on behalf of an employer is not required to demonstrate *prima facie* discrimination: *Bombardier*, at para. 40.

104. There are, then, three elements in the analysis. In *Elk Valley*, there was no dispute that the first two elements were met: i) the complainant had a characteristic protected from discrimination, i.e., an addiction disability and ii)

the complainant experienced an adverse impact, i.e., discharge from employment. The only question was whether the third element was satisfied, or whether the addiction disability was "a factor in the adverse impact".

105. As summarized above, the Court concluded that on the factual record before the tribunal, it was reasonable for the tribunal to find that the complainant's addiction was not a factor. The Court found that the evidence, including the expert evidence, "demonstrated that Mr. Stewart's addiction did not diminish his capacity to comply with the terms of the Policy" (para. 34) (emphasis added). Accordingly, the Policy did not adversely impact Mr. Stewart.

106. In reaching its conclusion the Court emphasized the fact-specific nature of the assessment. In some cases, an addiction may have no effect on an employee's ability to comply with workplace rules, while in others it may deprive the employee of the capacity to comply at all. But the Court notes that "[m]any cases may fall somewhere between these two extremes." (para. 39). What is clear from the Court's reasoning, and highly significant to my assessment of the *Gooding* approach, is that where it is established that an employee's addiction disability is a factor in their inability to comply with a workplace rule (even where the employer's decision-making process focussed on the conduct in isolation, irrespective of the disability that contributed to the conduct), the employee will have established a *prima facie* case of discrimination.

107. The following passages from the Court's reasons make clear that in cases of indirect discrimination the focus of the analysis must be on the effect of the disability on the employee's ability to comply with the rule, and not on the extent to which the employee's disability was a factor in the employer's decision to take disciplinary action for breach of the rule (paras 39-46):

> [39] It cannot be assumed that Mr. Stewart's addiction diminished his ability to comply with the terms of the Policy. In some cases, a person with an addiction may be fully capable of complying with workplace rules. In others, the addiction may effectively deprive a person of the capacity to comply, and the breach of the rule will be inextricably connected with the addiction. Many cases may exist somewhere between these two extremes. Whether a protected characteristic is a factor in the adverse impact will depend on the facts and must be assessed on a case-by-case basis. The connection between an addiction and adverse treatment cannot be assumed and must be based on evidence: *Health Employers Assn. of British Columbia v. B.C.N.U.*, 2006 BCCA 57 (CanLII), 54 B.C.L.R. (4th) 113, at para. 41.

…

[42] Where, as here, a tribunal concludes that the cause of the termination was the breach of a workplace policy or some other conduct attracting discipline, the mere existence of addiction does not establish *prima facie* discrimination. If an employee fails to comply with a workplace policy for a reason related to addiction, the employer would be unable to sanction him in any way, without potentially violating human rights legislation. Again, to take an example given by the majority of the Court of Appeal, if a nicotine-addicted employee violates a workplace policy forbidding smoking in the workplace, no sanction would be possible without discrimination regardless of whether or not that employee had the capacity to comply with the policy.

[43] It is, of course, open to a tribunal to find that an addiction was a factor in an adverse distinction, where the evidence supports such a finding. The question, at base, is whether at least one of the reasons for the adverse treatment was the employee's addiction. If the Tribunal in this case had found, on the evidence, that the employer terminated Mr. Stewart's employment, or that the Policy adversely affected him, because, either alone or among other reasons, he was addicted to drugs, *prima facie* discrimination would have been made out. However, in the Tribunal's view, the evidence did not support that conclusion. As a result, Mr. Bish did not establish a *prima facie* case of discrimination.

[44] Two other points raised by the parties, while not essential to the decision in this case, merit comment.

[45] First, I see no basis to alter the test for *prima facie* discrimination by adding a fourth requirement of a finding of stereotypical or arbitrary decision making. The goal of protecting people from arbitrary or stereotypical treatment or treatment that creates disadvantage by perpetuating prejudice is accomplished by ensuring that there is a link or connection between the protected ground and adverse treatment. The existence of arbitrariness or stereotyping is not a stand-alone requirement for proving *prima facie* discrimination. Requiring otherwise would improperly focus on "whether a discriminatory *attitude* exists, not a discriminatory impact", the focus of the discrimination inquiry: *Quebec (Attorney General) v. A*, 2013 SCC 5 (CanLII), [2013] 1 S.C.R. 61, at para. 327 (emphasis in original). The Tribunal expressly noted that proof of arbitrariness and stereotyping was not required, at para. 117.

[46] Second, I see no need to alter the settled view that the protected ground or characteristic need only be "a factor" in the decision. It was

> suggested in argument that adjectives should be added: the ground should be a "significant" factor, or a "material" factor. Little is gained by adding adjectives to the requirement that the impugned ground be "a factor" in the adverse treatment. In each case, the tribunal must decide on the factor or factors that played a role in the adverse treatment. This is a matter of fact. If a protected ground contributed to the adverse treatment, then it must be material.

108. With these principles in mind, I turn to consider the reasoning in *Gooding. Gooding* arose from the discharge for theft of a liquor store supervisory employee who was caught stealing substantial amounts of liquor from his employer. When confronted with the thefts, the employee disclosed for the first time that he was an alcoholic, began rehabilitation, and thereafter abstained from alcohol. The discharge was grieved and the arbitrator found that because the grievor's alcohol dependency was a factor in the theft, the discharge for theft was *prima facie* discriminatory. In setting aside the arbitration award, the Court of Appeal did not focus on the grievor's disability and whether or not that disability was a factor in the misconduct and therefore the sanction for that misconduct, but rather on the employer's "decision" to terminate the employee for theft. At para 11 the Court concludes:

> [11] I can find no suggestion that Mr. Gooding's alcohol dependency played any role in the employer's decision to terminate him or in its refusal to accede to his subsequent request for the imposition of a lesser penalty. He was terminated, like any other employee would have been on the same facts, for theft. The fact that alcohol dependent persons may demonstrate "deterioration in ethical or moral behaviour", and may have a greater temptation to steal alcohol from their workplace if exposed to it, does not permit an inference that the employer's conduct in terminating the employee was based on or influenced by his alcohol dependency.

109. In arriving at this conclusion, the court reviews several authorities in which decision makers refer to the employer's impugned "decision", a word that the court repeatedly emphasizes (paras 4-7). There will of course be cases where, on the particular facts before a tribunal, the basis for the employer's "decision" is precisely what is in issue. Indeed, it is axiomatic that in any case of direct discrimination, the decision itself will constitute *prima facie* discrimination, as for example when a person refuses to employ an individual *because* they have a disability, or *because* they are of a particular race. Conduct based on prejudice and preconceptions of individuals based on prohibited grounds of discrimination will of course constitute discrimination. But the Supreme Court of Canada has repeatedly and explicitly mandated a much broader and robust understanding of discrimination and equality, and

specifically one that accounts for the discriminatory effects of applying standards that may have been adopted with no discriminatory intent whatsoever.

110. In *Meiorin*, for example, the basis for the employer's decision to terminate Ms. Meiorin's employment as a forest firefighter was that she failed an aerobic capacity test. The employer terminated her employment just as they would have any employee who did not pass the test, irrespective of whether they were male or female. Yet the Court found that the imposition of the high aerobic standard adversely affected most women because of their generally lower aerobic capacity as compared to men (at para 69). The finding of *prima facie* discrimination is not predicated on any finding of bad faith or explicitly prejudicial thinking. It is based on the differential effect that the application of the rule has on individuals on the basis of a prohibited ground of discrimination.

111. In *Elk Valley*, as set out above, the Supreme Court of Canada again cautioned that the focus of the analysis is not on whether there is a discriminatory "attitude" but rather a discriminatory "impact". The court specifically rejects any notion of requiring complainants to prove that a decision was arbitrary or based on stereotypes precisely because to do so would improperly restrict the analysis from addressing the discriminatory impact of seemingly neutral policies and rules (at para 45).

112. Yet in *Gooding,* at para 15, the court concludes as follows:

> [15] I can find no suggestion in the evidence that Mr. Gooding's termination was arbitrary and based on preconceived ideas concerning his alcohol dependency. It was based on misconduct that rose to the level of crime. That his conduct may have been influenced by his alcohol dependency is irrelevant if that admitted dependency played no part in the employer's decision to terminate his employment and he suffered no impact for his misconduct greater than that another employee would have suffered for the same misconduct.

113. The court in *Gooding* here effectively concludes that even though the employee's addiction may have affected his ability to comply with the workplace rule (i.e. no theft), it is "irrelevant" because the employer's decision was not based on its attitude toward the employee as an addict, but rather its attitude toward the employee as a thief. This distinction, which goes so far as to deem "irrelevant" the effect of the employee's ability to comply with a rule by virtue of having a characteristic protected from discrimination, is precisely what the Supreme of Canada rejects in cases such as *Meiorin,* as reinforced in *Elk Valley*. To adopt the *Gooding* approach would be to read adverse effect discrimination out of our human rights analysis and to embrace a superficial

understanding of discrimination that the Supreme Court of Canada has rejected.

114. I note that the Court in *Meiorin* adopted a unified approach to assessing discrimination in employment, irrespective of whether it was termed "direct" or "adverse effect" discrimination. It did so because having now recognized and advanced our understanding of adverse effect discrimination, it found it was no longer useful to maintain two separate tests based on a distinction that is in practice difficult to maintain. Further, the Court found that "not only is the distinction between direct and indirect discrimination malleable, it is also unrealistic: a modern employer with a discriminatory intention would rarely frame the rule in directly discriminatory terms when the same effect—or an even broader effect—could be easily realized by couching it in neutral language." (at para. 29) Far from diminishing the significance of adverse effect discrimination, the Court in *Meiorin* made the significance of the discriminatory effect of workplace rules and standards, as opposed to intent, the paramount concern. In my view, the *Gooding* approach would move in the opposite direction, ignoring the discriminatory effects of workplace rules, and substituting a test of attitude-based direct discrimination.

115. Before leaving *Gooding*, I note that the Hospital relies on the endorsement of the Ontario Court of Appeal in *Bellehumeur v. Windsor Factory Supply Ltd.,* 2015 ONCA 473, upholding the trial decision at 2013 ONSC 4373 (CanLII), as supporting the *Gooding* approach. It is true, as the Hospital notes, that the court quotes the passage from *Gooding* finding that the employer based its decision to terminate the employee on his conduct and not any preconceived ideas concerning his addiction. But the court does not engage in any substantive analysis of the issue and is not required in that case to assess the broader meaning of discrimination the Supreme Court of Canada addresses in cases such as *Elk Valley*. The basis for the Court of Appeal's decision is both that the employer had no knowledge of the employee's disability at the time it terminated his employment, and that it accepted the trial judge's decision that in the particular circumstances of that case, the "the employment relationship could no longer exist." I note in this regard that the court below does not reject the possibility that an employer may be required to reconsider a decision to terminate once it becomes aware of a disability. The court below also specifically notes that some individuals may be unable to communicate their disability in which case employers may be required to take proactive steps to offer accommodation (at para 117). In *Bellehumeur*, which was not a case involving addiction and involved workplace threats, the court found that the employee had not communicated his need for accommodation and that the employer was entitled to take the threats seriously and take steps to protect its employees. I do not read *Bellehumeur* as a general endorsement of *Gooding*, particularly in light of *Elk Valley.*

116. In considering the arbitral jurisprudence relied upon by the parties, it is important to bear in mind that each of those decisions arises from their own particular set of facts. I accept, as the Association has argued, that where an arbitral consensus has emerged it forms compelling, although not binding, authority. But in light of the fact-specific nature of the exercise one must be cautious of making overly broad statements of principle and it is important to read such statements in the context of the facts from which they arise and the manner in which the case was argued. Ultimately, I must apply the test set down by the Supreme Court of Canada to the particular fact situation before me. Where prior arbitral awards are consistent with the Court's approach and shed light on how I ought to apply it, they are of course of assistance.

117. To the extent that the decisions in *Royal Victoria Regional Health Centre* and *Cambridge Memorial Hospital* adopt or endorse the approach in *Gooding*, I must respectfully disagree. Neither do I find that either decision assists me in applying the two-part test mandated by the Court to the facts before me.

118. In *Royal Victoria Regional Health Centre*, after considering *Gooding*, the arbitrator finds that in any event because the grievor was guilty of the criminal offence of theft, and therefore had the requisite "*mens rea*", her thefts were voluntary. It could not therefore be, he found, that she had "no control" over her actions. Further, the arbitrator found that in light of the medical evidence before him it would not be beneficial to the grievor's recovery to return her to the "scene of the crimes". The arbitrator also found that unlike the nurses in the "addicted nurses who steal" cases, the nurse before him had rehabilitated herself and was gainfully employed as a nurse elsewhere, and did not therefore need to be reinstated in order to maintain a career as a nurse.

119. To the extent that the reasons in *Royal Victoria Regional Health Centre* suggest that it is necessary to find that the compulsion to steal due to the addiction is so absolute as to obviate any notion of choice or intention, I must again respectfully disagree. The Court in *Elk Valley* is clear that the disability must be a factor in the adverse consequence, and the Court explicitly rejects the notion of applying a higher standard. The evidence before me supports the conclusion that the grievor stole and used the medications she stole because she is a drug addict. I need not find that the effects of her addiction were such as would negate *mens rea* for the offence of theft in order to conclude that her disability was a factor in the adverse impact of her termination. The further points the arbitrator raises in *Royal Victoria Health Centre* may be relevant to whether the grievor can be accommodated in the workplace or to remedy, but those are not issues I am dealing with at the *prima facie* discrimination stage.

120. In *Cambridge Memorial Hospital*, the arbitrator does not adopt *Gooding* "full bore", but rather is "guided" by its approach. In this regard, he rejects the notion that "establishing a nexus between the addiction and the misconduct, is, in itself, a defence to termination…it is not *prima facie* evidence of discrimination". I agree that where such a nexus exists it is not alone a defence to termination. Whether or not an arbitrator ultimately determines to overturn a termination may depend on any number of factors, including whether or not the employer ought to be required to accommodate the grievor's disability. A finding of *prima facie* discrimination is not synonymous with a determination to overturn a termination. To the extent that *Cambridge Memorial Hospital* appears to suggest that it is necessary to establish some factor beyond the three set out in the test for *prima facie* discrimination affirmed in *Elk Valley,* I respectfully disagree. Further, while the arbitrator does not require the grievor to meet what he describes as the "criminal defence of being 'unable to appreciate or understand the nature of their actions'", he finds that the standard is "relevant to cases of this kind" (at para 84). It is not entirely clear to me what this statement means, but to the extent that it suggests that the Association must establish something more than that the addiction was a factor in the adverse impact, I again respectfully disagree. Instead, I agree with arbitrator Hayes in *London Health Sciences* that the fact that the addict may be capable of understanding that her actions are wrong does not alter the fact that her disability drives the behaviour (at para. 56).

121. The Hospital takes issue with the "addicted nurses who steal" cases as conflating the first and second stages of the discrimination/accommodation analysis. I agree that conflating these stages would be in error. As has been clear since the Supreme Court of Canada's decision in *O'Malley*, the onus to establish a *prima facie* case of discrimination rests squarely on the complainant, and it would be an error to shift the onus to the employer to establish that they have accommodated to the point of undue hardship before first determining whether the complainant has met that onus (para. 28). However, I do not agree that this error is a common feature in the line of cases relied upon by the Association. At most, I would say that arbitrators have not always been explicit about moving from the first to the second stage of the analysis, but this is not the same as conflating the two stages. In my view, the awards reflect the manner in which the cases were argued and focus on what was material to those arguments. In most (though not all) cases, as in this one, the existence of an addiction and an adverse consequence is not in dispute. The first and second elements of the *prima facie* discrimination stage of the analysis have been satisfied. The real dispute between the parties lies in whether the disability was a factor in the adverse impact. In this context to say that where the union has established the nexus between the disability and the termination it is necessary to consider accommodation is really just

to say that the union has met its onus and made out a case of *prima facie* discrimination.

122. For example, in *Sunnybrook Health Sciences,* it was conceded that the grievor at all material times suffered from a drug addiction and there was no dispute that she had been terminated for theft of narcotics. It is in this context that arbitrator Jesin followed the line of cases finding that "because in each case the evidence showed that there was a link between the addiction and the theft of drugs to sustain the addiction, then once the employee accepted treatment and is rehabilitated, that employee is entitled to accommodation from the employer, subject as always to the point of undue hardship" (at para. 43). In concluding that the union had established the requisite link between the grievor's disability and the theft of narcotics, arbitrator Jesin accepted what he found was the majority view of the experts in addiction disability that: (at paras. 45-45)

> The disease of addiction is coincident with chemical changes within the brain that make resistance to the urge to continue drug use extremely difficult. Furthermore, destructive behaviours such as theft, lying and dishonesty are often coincident with the disease as the addict seeks to continue the drug use. At the same time, the addict feels a heightened sense of shame which makes the addict resistant to disclosure and treatment.
>
> …I am compelled to accept the majority view that addiction is indeed a disease and further, the urge to continue the addiction is linked to the employee taking the easy path and diverting drugs for her own use. Thus in my view, the evidence does support a linkage between the addiction and the theft.

123. The employer in *Sunnybrook Health Sciences* also argued that the grievor's termination was not discriminatory because it was based on her conduct—theft—and not a distinction based on a prejudice or stereotype. Arbitrator Jesin rejected this argument, finding that where the theft is compelled by the grievor's disease, the failure to assess whether or not that disease can be accommodated does in fact perpetuate a prejudice, i.e., that employees with other diseases that prevent them from doing their jobs must be accommodated to the point of undue hardship, while employees with the particular disease of addiction do not (at para 52). Such discrimination and perpetuation of stereotype may not be the intention of the employer who terminates an employee on the grounds that "theft is theft", but that is the effect of such an application of the rule.

124. Again, I emphasise that the focus of the inquiry ought not to be on whether the employer exhibited a prejudicial attitude. The evidence before me, particularly in the testimony of Ms. Timberlake, is that the Hospital was motivated to terminate the grievor because she had committed repeated and serious acts of theft of narcotics. I accept that the Hospital did not terminate the grievor because she was an addict *per se*, or because of a prejudicial attitude toward addicts. As emphasised in *Sunnybrook Health Sciences, London Health Sciences* and *Thunder Bay Health Sciences,* the theft and use of narcotics in a hospital setting is extremely serious. Theft in general undermines the essential trust relationship between employer and employee. The repeated theft and use of narcotics by a nurse in a hospital layers on top of this basic concern further serious and legitimate concerns for the safety and care of patients as well as the safety of the nurse and her or his co-workers. The Hospital's desire to protect itself and others from the harm and potential harm inherent in the grievor's behaviour is exceedingly well-grounded.

125. The question is not, therefore, whether an employer is entitled to take action to ensure the behaviour does not continue; clearly, it is. And the need to address effectively the problem behaviour is no less pressing simply because there is a nexus between the conduct and a disability. The question is rather whether the employer can take action that both addresses its legitimate interests and accommodates the employee's disability. And in this regard, arbitrators have been careful to emphasise that a finding of *prima facie* discrimination does not automatically entitle an employee to accommodated employment. Arbitrator Jesin addresses the limits to the duty to accommodate in *Sunnybrook Health Sciences* as follows (at para 53):

> That does [not] mean that every employee who suffers from an addiction to drugs will have to be accommodated. Clearly, it would be an undue hardship to require an employer to accommodate a disabled employee who refuses treatment or who refuses all reasonable treatment recommendations. Similarly it may be an undue hardship for an [employee] who refuses to acknowledge the full extent of her addiction, even when the addiction may be in remission. That is because without such acknowledgment, the employee could not be able to rebuild the trust necessary to further the employer employee relationship. Indeed, in circumstances in which the employee does not accept treatment, or in which the employee refuses to acknowledge the extent of addiction, an employer cannot be assured with any degree of confidence that the behaviours which are incompatible with the employment relationship would not reappear or continue. However, where the addicted employee is in remission, is fully cooperative in accepting recommended treatment and acknowledges the extent of addiction and the improper behaviours that have occurred as a result, efforts can then be made to determine whether accommodation of the employee's disability can be accommodated.

(See also *Collingwood General & Marine Hospital* at para.31, cited in *London Health Sciences Centre* at para. 59).

126. With these principles in mind, I now turn to the facts of the case before me.

127. At the first stage of the test, having found that the grievor suffers from a disability and has experienced an adverse impact, the onus remains on the Association to establish that the grievor's addiction was a "factor" in her termination from employment. In order to meet this onus, the Association must establish the nexus between the grievor's addiction disability and the theft of drugs for which she was terminated.

128. The Hospital argues that the evidence does not support the conclusion that the grievor's disability compelled her to steal. It relies on the evidence that she used only when available, experienced limited withdrawal and did not only steal drugs upon which she was dependant. It also argues that Dr. Bobrowski's evidence of the link between the grievor's addiction and at least some of the drugs she stole was equivocal.

129. It is true that at various times the grievor reported limited use of opiates and limited withdrawal. But the evidentiary record before me as a whole belies these statements, which the grievor acknowledged were false. The grievor's actual evidence of her symptoms of withdrawal was graphic and compelling. That the grievor had underreported her use was apparent to Dr. Bobrowski from the evidence of her volume of consumption at the time of her termination alone. The evidence before me of both the volume and frequency of the grievor's consumption, and the evidence that the grievor was seeking both opiates and medication to manage the symptoms of withdrawal for a time that predates even her initial reported date of first use, all support the grievor's evidence that she felt she needed the drugs to get through her shift and stole the drugs to manage her addiction. Dr. Bobrowski's evidence of the link between the grievor's addiction and the diversion of most of the drugs the grievor stole was unequivocal. Diversion of drugs is a feature of addiction, especially for healthcare professionals. It is true that his evidence was less definitive with respect to the small number of drugs that would not have been effective in assisting the grievor in managing her addiction, but he maintained that even the use of drugs that are objectively useless could fall within the self-medicating behaviour of the addict. On balance, I am satisfied that the theft of medications was caused by the grievor's addiction disability. It is simply the only explanation before me that makes sense.

130. For these reasons, I am satisfied that the Association has met its onus and established that the grievor's termination from employment was *prima*

facie discriminatory. As discussed above, however, it does not follow from this finding alone that the Hospital was required to accommodate the grievor.

131. In this case, the Hospital argues that at the time it terminated the grievor, it did not know that she suffered from an addiction. Before turning to the evidence on this issue, I note that even were I to find that the Hospital did not know that the grievor was addicted to drugs at the time it terminated her employment, this would not be a complete answer. The evidence before me is clear, as it was before the several arbitrators that have dealt with this issue: denial and the willingness to risk loss of employment in service of the addiction are common feature of an addiction disability. As is apparent in the authorities put forward by the parties, it is not uncommon for an employee to confront their addiction only after they have been forced to do so as a result of their loss of employment. It cannot be that an employer is absolved of any duty to accommodate simply because it acts to terminate before the addict has an opportunity to come to terms with the real nature of their disability. The question of what the employer knew and when is relevant to the question of if, and when, the employer will be required to assess its duty to accommodate. This in turn has implications for what if any remedy will be available even where the Association has made out a *prima facie* case of discrimination. But the failure to disclose explicitly the disability in advance of termination cannot alone preclude the duty to accommodate, when the inability to disclose may be a feature of the disease itself.

132. In the present case, the Association filed a grievance alleging a breach of the *Human Rights Code* and s. 3 of the Collective Agreement, which explicitly references the duty to accommodate disabled employees—dated March 2, 2018, the same day the grievor was terminated from employment. While the grievance is drafted in a generic manner, as is common, in the context of a termination for theft of narcotics I find that this is a relatively clear indication to the Hospital of the issues in this grievance. But in any event, I also find that the Hospital had ample information prior to the grievor's termination to identify the disability issue, and that it chose to ignore the issue and proceed with the termination in light of its views concerning the seriousness of the theft.

133. The evidence establishes that the grievor was in possession of a large volume of opioids and was clearly under the influence of the drugs at work and behaving strangely. The hospital knew, as it reported to the College of Nurses, that the grievor was stealing/diverting drugs from the hospital in order to self-inject and self-medicate "a large amount" of opioids and was working under the influence of drugs. Although the grievor did not at that time say that she was taking the drugs because she was an addict, she did make clear that she was taking the drugs herself, and her explanation for why she needed

them was neither clear nor coherent. In this context, her references to having a serious problem she kept from her family, wanting to be "clean", needing help and wishing to work away from controlled substances all point to the link between the grievor's theft of drugs and an addiction disability. I accept the Association's argument that faced with this overwhelming evidence, the hospital either knew or ought to have known that the grievor's conduct could be related to a drug addiction.

134. The evidence further establishes that the Hospital made no effort to inquire into the grievor's disability or to determine whether it could be accommodated, either before or after the grievance was filed. Rather, it moved swiftly to terminate the grievor's employment for theft, without regard to the duty to accommodate, and maintained the position that "theft is theft" throughout. In this way, the Hospital breached its procedural duty to accommodate, and violated s.5 of the *Human Rights Code.* It also violated s.3.05 of the Collective Agreement, in which the Hospital and the Association "recognize their joint duty to accommodate disabled employees in accordance with the provisions of the *Ontario Human Rights Code*".

135. In other circumstances, having decided that the union had met its onus and established that the termination was *prima facie* discriminatory and that the employer had not met its procedural duty to accommodate, I would remit the matter back to the parties to determine whether the grievor could in fact be accommodated in employment, and to determine whether any other remedial relief was appropriate. That was the approach taken in *Collingwood General & Marine Hospital, London Health Sciences* and *Thunder Bay Health Sciences*. In this case, however, the Hospital has made a compelling argument that even if I find that it breached the *Code* and the collective agreement in terminating the grievor, the facts here militate against reinstating her to employment.

136. As set out above, the Hospital relies on a list of factors that distinguish this case to varying degrees from those relied upon by the Association. These reasons include the grievor's failure to follow recommended treatment programs, relapses and positive drug tests. She was not, in short, a "poster child" for recovery. Most significantly, however, the Hospital points to what it terms the grievor's continuing dishonesty concerning her theft and use of substances, including in her sworn testimony before me. This ongoing dishonesty, it argues, so fundamentally undermines the trust relationship between employer and employee as to make reinstatement to employment unfeasible.

137. The Association does not dispute that the grievor has experienced significant difficulties on the road to recovery. As Dr. Bobrowski affirmed,

addiction and its treatment are frequently characterized by denial and relapse as the individual works toward sobriety. I agree with the Association that features of the disability itself should not displace the duty to accommodate, although they may inform whether the grievor is in fact fit to return to work and be accommodated. But I do not accept that this is an answer to the Hospital's concerns arising from the grievor's testimony in this proceeding. On the evidence before me, I cannot account for the inconsistencies in the grievor's testimony as the product of an imperfect memory clouded by drug use, fatigue, the passage of time, or mistaken but honest beliefs.

138. In her initial examination, the grievor provided a narrative of her use and theft of narcotics that was very specific and tracked the timeline that she has given to numerous health care providers over time, including in the period immediately following her termination. She described a single precipitating event: a fall while running in September 2015 for which she received a prescription for Percocet. She sought a second prescription several weeks later, allegedly for headaches, when the first one ran out. She consumed the second prescription more quickly, and by that time she believed she was hooked. According the grievor's initial evidence, she did not begin stealing opioids from the hospital until December 2015, and she continued to do so, at first intermittently and using intramuscularly and then regularly every five hours and using intravenously, until she deliberately arranged to be caught in February 2016. The grievor, who at the time of her initial testimony in April and June 2017, purported to be in remission, to have achieved a full understanding of her addiction, and to be telling the truth, swore that she had never before touched an opioid. As set out in my review of the evidence above, this narrative was both false and highly incomplete.

139. While it is true that the grievor experienced a fall for which she was prescribed Percocet, this in fact took place in June 2014, well over a year earlier than the grievor had reported. By May of 2015, before the grievor obtained the prescription for headaches in June of 2015, the evidence supports the conclusion that the grievor's use had already escalated to the point that she was experiencing withdrawal symptoms, and she was seeking both opioids and drugs to manage symptoms of withdrawal. The grievor has provided no explanation for how she got to that point. Her only explanation for these wildly divergent narratives, is that she remembered the events but was confused about the timeline. That is simply not true. One cannot take the events the grievor reported in her initial testimony and adjust them to the new timeline. To do so leaves massive holes and contradictions in the narrative.

140. I accept that it is necessary to make considerable allowance for not only the fading of memory over time, but also for the fact that the grievor's illness would have impaired her ability to recall accurately and recount her

experiences. As Dr. Bobrowski's evidence made clear, addicts are likely to be inherently unreliable narrators. The grievor's evidence is replete with small contradictions that, on their own, would not cause me to conclude that she is being dishonest. The problem is that what emerged following the grievor's initial testimony can only be described as an entirely *different* narrative. Further, it is one thing to mix up the date for a single event by a year when you are testifying about it some two years later still. It is quite another to do so when the events are fresh, and to confuse a few short months of use with what appears to have been over a year and half of use, with several other intervening events, including what appears to be an entirely different stream of use. The Hospital argues that the most likely inference to draw is that the grievor in fact began stealing narcotics much earlier, was likely already diverting drugs by the time of her prior discipline, which included withholding opioids from a patient, and continues to lie, mislead and minimize her conduct to this day. In this light, the Hospital argues that the most recent positive drug test, which the grievor says resulted from eating poppy seeds, is highly concerning.

141. The grievor unequivocally denies any suggestion that she has not been forthcoming about when she began stealing morphine, and only slightly qualified her earlier testimony to allow that she might have begun stealing morphine by November 2015 at the earliest. The grievor also maintains that her conduct in refusing to administer the drugs to the patient as directed was entirely correct and that she would do the same thing again. She holds that she has been clean since November 2016.

142. On the basis of the evidence before me, I can only conclude that the grievor has still not been forthcoming about her addiction and the events leading up to her theft of narcotics from her employer. I am less troubled by the lies that the grievor told to her various doctors in the course of obtaining treatment for her addiction, particularly in the early stages when she was in denial and experiencing withdrawal and relapse. But the grievor claims that she has not used since November 2016 at the latest. She claims to be in remission with full insight into her disability, and is asking her employer to trust her by reinstating her employment. Yet in light of the grievor's evidence, I find that the Hospital's ongoing lack of trust is warranted. This is true whether the grievor was in fact stealing morphine or other drugs from a much earlier date, risking patient care over a far more extended period of time, or depriving patients of medication in order to feed her addiction, as the Hospital infers, or whether there is some other story of the grievor's addiction as yet untold.

143. As arbitrator Jesin explains in *Sunnybrook Health Sciences*, where an employee has not been forthcoming about their addiction, "an employer

cannot be assured with any degree of confidence that the behaviours which are incompatible with the employment relationship would not reappear or continue." I agree with this statement. To be clear, my conclusion here is not about whether or not sufficient safeguards could be put in place to ensure that the grievor does not have access to drugs in the course of her employment. That is a question that, had it needed to be answered, would have been addressed in the second stage of this bifurcated proceeding. Rather, I find that the grievor's ongoing lack of candour even while purporting to be clean and in remission has undermined the trust that is essential to the employment relationship.

144. For these reasons, I find that this is not an appropriate case in which to require the Hospital to reinstate the grievor to employment. The duty to accommodate to the point of undue hardship places a substantial responsibility on employers, but it does not require them to employ individuals where the necessary trust relationship between employer and employee has not been rehabilitated.

145. My finding that the grievor should not be reinstated to employment does not preclude the Union from seeking other remedies arising from the Hospital's breach of the *Code* and the Collective Agreement, and I address this issue further below.

Union Representation

146. The Association also argues that the discipline in this case ought to be void *ab initio* because the Hospital breached Article 7.02 of the Collective Agreement. However, as I have already found that the Hospital breached the collective agreement when it terminated the grievor's employment on disciplinary grounds without regard to the duty to accommodate, I need not determine whether this is the kind of breach that would void the discipline *ab initio*. The fact that subsequent events have led me to conclude that this is not an appropriate case in which to reinstate the grievor does not cure the initial defect in terminating the grievor's employment. However, the Association has argued that other remedies may arise from a finding of a breach of the union representation clause, and it is therefore necessary to address this issue.

147. For ease of reference, I repeat Article 7.02 of the collective agreement here:

> At the time formal discipline is imposed or at any stage of the grievance procedure, including the complaint stage, a nurse is entitled to be represented by her or his union representative. In the case of suspension

> or discharge, the Hospital shall notify the nurse of this right in advance. The Hospital also agrees, as a good labour relations practice, in most circumstances it will also notify the local Union.
>
> The Hospital agrees that where a nurse is required to attend a meeting with the Hospital that may lead to disciplinary action, as a good labour relations practice, it will inform the nurse of the purpose of the meeting and her or his right to union representation.
>
> All investigations related to a nurse's employment will be completed in a timely manner.

148. Under this provision, the grievor had an unequivocal right to be represented by her union representative at the meeting and, because this was a meeting where formal discipline was imposed in the form of a discharge, to be notified of the right to union representation "in advance". The evidence is that the Hospital arranged for the grievor to have union representation at the meeting, and the grievor was in fact represented by an experienced union representative at the meeting. The Hospital did not, however, explicitly advise the grievor of her right to that representation in advance of either the meeting or the imposition of the termination during that meeting and provided no advance notice of the purpose of the meeting. The grievor was simply told she was required to attend.

149. I have reviewed the authorities provided to me by the parties. The cases split between those where the breach of Article 7 resulted in setting aside the discipline, and those where the breach was found to be procedural or technical, but not warranting setting aside the discipline entirely. For the reasons set out above, I need not determine that particular remedial issue in this case. The weight of the authority affirms that Article 7.02 confers substantive representation rights. There is some support for the Association's argument that the grievor's right to notice of the meeting includes notice of the reason for the meeting, i.e., that the grievor may be subject to suspension or discharge, and that this is a substantive right (see, e.g., *Oshawa General Hospital* at paras 31-32). There is broad support for the proposition that "advance" notice means advising the grievor of the right to representation before actually imposing that discipline (See, e.g., *Oshawa General Hospital* at paras. 31-32, *St. Joseph's Health Centre* (London) at p. 7, *Timmins and District Hospital* at paras. 27-31, *Toronto Hospital (General Division*) at para 19 and *Royal Ottawa Health Care Group* at paras. 42 and 47)). I note again, however, that there is no consensus on whether a breach of this clause is substantial or merely "procedural" in circumstances where the grievor is in fact represented, or whether or not a voiding remedy would be appropriate in the event of a breach.

150. In this case, the Hospital argues that the need to provide the grievor with advance notice was either satisfied or unnecessary simply because the grievor was in fact represented at the meeting. I do not agree. Article 7.02 distinguishes between suspension and discharge, on the one hand, and other kinds formal discipline on the other, by specifically requiring "advance" notice for the former. I accept the Association's argument that this language is intended to permit the employee to consult with her representative before the discipline meeting. The fact that the representative happens to be at the meeting where the discipline is imposed does not satisfy this requirement. In this case, the Hospital said nothing at all to the grievor about either her right to union representation or the nature of the meeting, and instead simply directed her to attend and, with a union representative present, terminated her employment. This is a clear breach of the obligation to provide advance notice of the right to union representation. The failure to advise her of her right to union representation at all in advance of imposing her termination from employment is a breach of Article 7.02.

151. The Association has also claimed a breach of its right to notice under Article 7.02, as distinct from that of the nurse. The Association's rights under this provision are more qualified. The Hospital has agreed that "in most circumstances it will also notify the local Union". Beyond stating that the Hospital is doing so as a "good labour relations practice", the clause does not expand on the nature of the "circumstances" that will fall in or outside the scope of this obligation. However, I need not determine the nuances of this aspect of the provision, because I find that on the facts before me the Association in fact received advance notice of the nature of the termination meeting.

152. Specifically, there is no doubt that the Hospital notified the Association about the meeting in advance, contacting both Ms. Boyce and Mr. Howell. It is true that the Hospital did not explicitly state that the meeting was a "discharge" meeting. The Hospital's communication was needlessly coy. But the evidence also establishes that the Association knew what Mr. Fernandes meant when he said it was "not good". This was, "Joe's way of saying somebody is going to be let go". There also evidence that the employer had at least specifically told the Association that termination was a possibility, although no final decision had been made. Further, while neither Ms. Boyce nor Mr. Howell had participated in the earlier investigation meeting, the local Union had been represented at that meeting and was aware of all the same information that the Hospital was aware of concerning the grievor and her theft and use of narcotics. In this way, I find that the Association had effective and advance notice of discharge meeting on any reading of the clause.

153. I therefore find that the Hospital breached Article 7.02 by failing to provide the grievor with notice of her right to union representation in advance of imposing the termination. The Hospital has argued that in the event I find a breach of this provision, declaratory relief ought to be sufficient. The Association has argued that if reinstatement is not appropriate, damages may be warranted. I remit this issue back to the parties to be addressed together with the remedial issues arising from the human rights breaches found above.

Conclusion

154. For all of these reasons I find that the Hospital breached section 5 of the *Human Rights Code* and Article 3 of the Collective Agreement when it terminated the grievor from employment without satisfying its procedural duty to accommodate. I also find that the Hospital breached Article 7.02 of the Collective Agreement by failing to provide the grievor with advance notice of her right to union representation before imposing her termination from employment. Notwithstanding these breaches, I find that this is not an appropriate case in which to reinstate the grievor to employment. The Association has argued for other remedies, including but not limited to remedies arising from the fact that as a result of her termination, the greivor was not able to access her sick leave and long-term disability benefits during the period she was unable to work. I remit the issue of remedies arising from the breaches of the *Code* and the collective agreement to the parties and remain seized in the event the parties are not able to resolve these issues themselves.

Dated at Toronto, Ontario, this 4th day of December 2018.

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Eli A. Gedalof
Sole Arbitrator