IN THE MATTER OF AN ARBITRATION

BETWEEN:

THE REGIONAL MUNICIPALITY OF WATERLOO (SUNNYSIDE HOME)
(the "Employer")

and

ONTARIO NURSES' ASSOCIATION
(the "Union")

RE: Grievance of DS

Before:

Larry Steinberg, Arbitrator

Appearances:

For the Employer:
Brian P. Smeenk, Counsel
Megan Rolland, Counsel
Heather Larmour, Manager Labour Relations, Region of Waterloo
Connie Lacy, Director., Senior Services
Helen Eby, Administrator, Long-Term Care
Diana Ulett, Manager, Resident Care
Stacy Charron, Labour Relations Advisor

For the Union:
Robert Dobrucki, Counsel (April 11, 2017 only)
Kate Hughes, Counsel
Tyler Boggs, Counsel
Diane Peckham, Labour Relations Officer, ONA
D.S., Grievor

Hearings held in Kitchener Ontario on April, 11, 2017, January 29, May 22, June 22, June 28, September 19 and October 19, 2018

2019 CanLII 433 (ON LA)

Overview

[1] The grievor, DS, was terminated by the employer on September 29, 2016 because, during the two-year period up to and including August 22, 2016, the grievor was misappropriating narcotics for her own use and falsifying medical records to cover up her actions. The grounds for termination were theft of drugs and gross misconduct relating to protocols.

[2] The grievor is a Registered Nurse ("RN") and the employer operates a long-term care home. The grievor's actions were at the highest level of misconduct for someone in her position and amount to just cause for termination. Both the union and the grievor acknowledge as much.

[3] But the parties accept that, at all relevant times, the grievor was struggling with an addiction. She was diagnosed with severe opioid use disorder and mild to moderate sedative-hypnotic use disorder.

[4] The grievor wishes to return to work with the employer. The union and the grievor argue that, on the facts of the case, *prima facie* discrimination has been established and that the employer has not demonstrated that the grievor cannot be accommodated without causing the employer undue hardship.

[5] The employer argues that the grievor has not demonstrated *prima facie* discrimination. In the alternative, the employer argues that the grievor does not fulfill the *bona fide* occupational requirements of the job. In the further alternative, the employer argues that it cannot accommodate the grievor without undue hardship.

[6] Having considered the evidence and argument of the parties, I am of the opinion that the union has established *prima facie* discrimination and that the employer has violated the procedural duty to accommodate and has not demonstrated that it cannot accommodate the grievor without suffering undue hardship. The employer is ordered to reinstate the grievor forthwith and to accommodate her to the point of undue hardship. I

2019 CanLII 433 (ON LA)

remit that matter and the union's request for compensation to the parties and remain seized.

Facts

[7] The parties proceeded by way of a Statement of Agreed Facts (Partial) ("SAF") supplemented by the evidence of a number of witnesses.

[8] The employer called Helen Eby ("Eby"), the retired Administrator of Long-Term Care and Diana Ulett ("Ulett"), Manager, Resident Care. The union called the grievor to testify.

[9] In addition, the parties called expert medical evidence. The employer called Dr. Lawrie Reznek ("Reznek"), a psychiatrist and Associate Professor in the Department of Psychiatry, University of Toronto and Dr. David Wolkoff ("Wolkoff), a psychiatrist and an expert in addiction treatment. The union called Dr. Gerrit (Gary) Veenman ("Veenman"), the grievor's addiction physician, who is a physician and an expert in the treatment of addiction with particular emphasis on health professionals. All of these witnesses filed written medical opinions and testified at the hearing.

[10] In addition, the parties entered, on consent, the discharge summary of Dr. Stephen Clarke ("Clarke") dated November 9, 2016 who treated the grievor at the Homewood Health Centre ("Homewood") and a letter from Dr. Rodney Bruce ("Bruce"), the grievor's family physician.

[11] The SAF is as follows:

> DS (the "Grievor") was terminated on September 29, 2016 for theft of narcotics and gross misconduct relating to protocols. The letter of termination is attached at Tab 79 of Sunnyside's Book of Documents. The following facts are agreed between Sunnyside and ONA, and admitted by the Grievor.

2019 CanLII 433 (ON LA)

Background

1. The Grievor was at all material times a Registered Nurse (“RN”) and Team leader at the Region of Waterloo’s Sunnyside Home Long Term Care Facility. She worked for Sunnyside on a full-time basis since December of 2002. As such she was covered by the collective agreement between Sunnyside and ONA.

2. The Grievor worked in the Franklin Building at Sunnyside, home to a total of 263 residents. Sunnyside employs approximately 28 RNs and approximately 47 Registered Practical Nurses (“RPN”) . The Grievor was responsible for the Castle Kilbride and Shantz Hill wings. The unit contains a total of 54 beds. The Grievor was trained to care for any of the patients on this unit.

3. Narcotic and controlled drugs that are considered in use, for example narcotics that are administered to the residents on a daily basis or on an as needed basis, as well as narcotics that belong to the Emergency Starter Box are kept under triple lock in the medication room on each unit. Emergency supplies are stored in a locked cabinet with a double lock on it (the “Emergency Cabinet”). The Emergency Cabinet is accessed by use of keys that were in the control of the RPNs up until May 10, 2016. Since May 10, 2016 the keys have been in the control of RNs.

4. The Medication Cart (the “Medication Cart”) for regularly prescribed drugs (which has a two lock system) is also stored in the medication room, behind a locked door, which provides a triple lock level of security. The Medication Cart for regularly prescribed drugs is access by use of keys that are in control of the RPNs.

5. Narcotics and controlled drugs that are no longer being given to residents and are marked for destruction are kept under double lock in the medication room in a wooden box. The medication room door and the locked wooden box are the double locks for those drugs. The medication room also houses a sealed sharps container where nurses place used cartridges/syringes as well as used or partially used ampoules of drugs and wasted drug tablets.

6. Narcotics waiting for destruction and narcotics waiting to be used are not kept together.

2019 CanLII 433 (ON LA)

7. Pain management is an essential part of resident care and nurses are expected to routinely assess pain levels and use this information to determine the need for pain medications. The nurse should perform a pain assessment at the time the resident requests the medication in order to determine the correct dose to be provided.

8. Residents at Sunnyside may receive regularly scheduled doses of medication, and/or “as needed” medication. “As needed” medication is generally not provided to the resident on a strict schedule, but on a true as needed basis.

9. The practice is that if a resident needs an injectable narcotic, the RN asks the RPN to get the medication. The RPN then goes into the medication room, opens the Medication Cart, or the Emergency Cabinet if required, counts the number of medications for the resident and matches it against the narcotic count sheet (the “Narcotic Record”). There is a separate Narcotic Record for each medication room and within the Narcotic Record there is a separate record for each patient. The RPN is to confirm that the amount in the cabinet is correctly recorded on the Narcotic Record, is to document the date, time, and dose being removed, as well as completing a balance for the amount of medication left in the Medication Cart or the Emergency Cabinet as the case may be. Finally, both the RN and RPN initial the Narcotic Record to record what has been taken out and the balance left.

10. If a resident needs a pill form of narcotic the RPN then goes into the medication room, opens the Medication Cart, counts the number of medications for the resident and matches it against the Narcotic Record.

11. The RN or RPN who administers the medication and is required to transcribe onto the resident’s Medication Administration Record (“MAR”) the time, the amount of medication provided and initial the entry. Documentation on a resident’s MAR should be done immediately after the resident takes the medication, in accordance with Sunnyside’s Pharmacy Policy & Procedure Manual for Long Term Care Homes (found at Tab 85 of Sunnyside’s Book of Documents). As a practical matter these entries are sometimes delayed.

12. Should only a portion of a narcotic or other controlled drug removed from the Medication Cart be used, the RN is required to “waste” the remaining medication in the presence of another registered health professional after preparing the dose to the resident. Both registered health professionals are required to sign the Narcotic Record to record and to confirm that wastage has

2019 CanLII 433 (ON LA)

occurred. Wasted half tablet doses, ampoules and cartridges/syringes must be disposed of in a sharps container in the medication room.

13. The Grievor was fully trained in all of the above nursing protocols.

2019 CanLII 433 (ON LA)

Overview of Infractions

14. From approximately the summer of 2014 until August 2016 the Grievor engaged in the repeated misappropriation of narcotics and controlled medications for her own use, including Hydromorphone (brand name Dilaudid) and Morphine.

15. The Grievor also on many occasions falsified medical records including the Narcotic Record and Patient Charts, including MARs, to conceal the misappropriations. She documented giving a narcotic to a resident at their false request. She then falsified the charts to show that they had received the narcotics and she instead took the narcotics for herself.

16. The Grievor's actions violated Sunnyside's Resident Abuse and Neglect Policy (found at Tab 83 of Sunnyside's Book of Documents), Sunnyside's Pharmacy Policy & Procedure Manual for Long Term Care Homes (found at Tab 85 of Sunnyside's Book of Documents), as well as the Ontario Long Term Care Homes Act, 2007 and the Ontario Ministry of Health and Long-Term Care Standards.

July 25, 2015 Incident

17. In the early morning of July 25, 2015 the RN working the night shift, Kasia Znaniecki, found an empty ampoule of Hydromorphone 2 mg/ml on the sink in the staff bathroom on CK/SH around 6:15 a.m. Ms. Znaniecki had been in the same staff bathroom earlier in the night and the empty ampoule was not present. She was very concerned. Hydromorphone is a fast-acting, potent opioid medication that is used to treat moderate to severe pain. . Ms. Znaniecki contacted RPN Pamela Folkes to witness what she had found. Ms. Znaniecki then placed the empty ampoule in a Dixie Cup and wrapped it in paper to ensure that the empty ampoule remained in the Dixie Cup.

18. That same morning the Grievor had arrived at Sunnyside earlier than her scheduled start time of 7 a.m. Ms. Znaniecki noted that the Grievor had arrived at approximately 6 a.m., which was unusually early. During report time the Grievor took the Dixie Cup and said she would pass it on to the Manager of Food Services

when she came on shift. When the Grievor passed the empty ampoule onto the Manager, Ms. Barb Collins, it was in a Styrofoam cup, not a Dixie Cup.

19. Sunnyside reviewed the medication room. All narcotics appeared to be accounted for. Sunnyside conducted investigative interviews and checked the card readers to trace who was at the facility at the time the empty ampoule was located. It was determined that the Grievor was at Sunnyside and further she had regularly been coming in earlier than needed. When asked about this on October 7, 2015 the Grievor admitted that she often came in early and stated that it was unfortunate that things always happened when she came in to work . The Grievor maintained that her presence at the time the ampoule was located was a coincidence.
20. The Grievor denied that the ampoule was hers and did not admit to changing the cup which Ms. Znaniecki had provided to her.

August 2016 Incident

21. In the first eight (8) month of 2016, other RPNs and RNs noticed that the Grievor would repeatedly prepare medications in one unit and then take them over to the other unit to administer. The Grievor sometimes took the tray of medication, after it had been prepared in the medication room, to her office before administering to residents.

22. On Monday, August 22, 2016 a multidisciplinary staff meeting was held. Following the meeting RPN Pamela Folkes left a voicemail for Sunnyside's Manager of Resident Care, Diana Ulett and noted that she was disturbed about something and needed to speak to Ms. Ulett.

23. On the morning of August 24, 2016 Ms. Ulett telephoned Ms. Folkes to inquire about what had disturbed her. Ms. Folkes told to Ms. Ulett that she had worked the night shift on August 21-22, 2016. At approximately 6:20 a.m. she went to use the washroom in the staff service corridor on her floor. Through the crack under the door Ms. Folkes saw that the light in the washroom was on, so she assumed that someone was in the washroom. After waiting a few minutes, Ms. Folkes knocked on the washroom door to determine if anyone was inside. No one answered. She waited a few minutes, then she knocked for a second time and there was still no answer. She pulled the door handle down and pushed the unlocked door open. As she opened the door she saw the Grievor sitting on the toilet with an ampoule of Hydromorphone sideways in her mouth. The Grievor shoved the door shut as Ms. Folkes backed away and apologized.

2019 CanLII 433 (ON LA)

24. Ms. Folkes also informed Ms. Ulett of another incident that had happened approximately two (2) weeks prior to August 22, 2016. The Grievor had insisted that a resident rang signaling that he needed to be given a Hydromorphone injection. Ms. Folkes had not heard the resident ringing nor had it registered on her phone, as it normally would. Ms. Folkes was suspicious and followed the Grievor to the resident's room. The resident was asleep. The Grievor did not administer the injection. Rather she discreetly placed the syringe of Hydromorphone into her own pocket. Contrary to the indication in the Narcotic Record and the patient's MAR, the Hydromorphone had not been dispensed to the resident by the Grievor when Ms. Folkes was present.

25. After speaking with Ms. Folkes, Sunnyside determined that an investigation would be conducted and the Grievor would be put on paid stand down leave while the investigation was being carried out. Ms. Ulett spotted the Grievor at the elevator and approached her to inform her that she was being sent home. Ms. Ulett called out to the Grievor and asked how she was doing. Ms. Ulett notes that the Grievor's eyes were glossed over yet she replied that she was fine. Ms. Ulett, aware of the Grievor's past difficulties with kidney stones, next inquired about how her kidney stones were. The Grievor again insisted that she was fine and that she was drinking a Coke beverage which was helping her.

26. Ms. Ulett informed the Grievor that she was not fine and she was being sent home. The Grievor was not happy and immediately contacted her ONA representative. A telephone conference occurred on August 24, 2016 at Sunnyside with the Grievor, Ms. Ulett and the Grievor's ONA representative. The Grievor inquired about why she was being sent home. Ms. Ulett informed the Grievor that Sunnyside was concerned for her well-being and it appeared she was not safe to practice. The Grievor was instructed to go home and not come back to work until contacted. Later that evening the Grievor returned to Sunnyside and presented Ms. Ulett with a medical note that stated that she should be off work for "medically substantiated reasons" until Saturday, August 27, 2016.

27. On Monday, August 29, 2016 Ms. Ulett received a telephone call from the Grievor. The Grievor informed Ms. Ulett that she had had surgery to remove thirteen (13) stones from her ureters and had had a stent put in. The Grievor further informed Ms. Ulett that she was medically prescribed to be off work for a two (2) week period. Ms. Ulett told the Grievor that she was to contact her when she was recovered because Sunnyside had to interview her as part of the investigation process.

2019 CanLII 433 (ON LA)

28. At no point up to August 30, 2016 did the Grievor acknowledge that she had an addiction to narcotics. Nor did she acknowledge that she had engaged in acts of misappropriation and falsifying resident records in conjunction with the theft.

The Grievor Admits to Thefts of Narcotics and Falsifying Records

2019 CanLII 433 (ON LA)

29. On Wednesday, August 31, 2016 the Grievor again called Ms. Ulett. The Grievor informed Ms. Ulett that she was being admitted to the hospital as she was going through severe withdrawal from the use of narcotics. The Grievor, for the first time, informed Ms. Ulett that she was abusing, amongst other controlled substances, Tylenol 3s (containing codeine), Percocet, Hydromorphone (brand name Dilaudid) and Morphine. She also said that she had been misappropriating injectable narcotics from Sunnyside over the past two years for her own use.

30. Hydromorphone (brand name Dilaudid) is five (5) times stronger than Morphine, and stronger than Percocet.

31. The Grievor reported that she repeatedly failed to give residents the correct dosages of injections as documented. She had withheld from residents some of their documented medication so that she could instead inject herself. The Grievor repeatedly falsely recorded on the Narcotic Record and the resident's MAR that she had provided more pain medication to the resident, than was actually received by the resident during the shift.

32. The Grievor also admitted that she had not always been wasting the unused remainder of liquid narcotics when preparing the injections for residents. Rather, she repeatedly kept the remainder for herself. In order to disguise her theft she often took the ampoule from the RPN, retreated privately to the medication room to prepare the medication, then put water in the open ampoule to show the second nurse the water and say she was wasting the remainder. The Grievor informed Ms. Ulett that she had to be smart when doing this in order to hide her actions from the RPN who was required to witness the waste.

August 2016 Spot Audit

33. In the course of Sunnyside's various investigations, concerns regarding improper drug administration arose. A spot check was done for the period of August 1, 2016 - August 24, 2016 (the report is found at Tab 62 of Sunnyside's Book of Documents).

34. A review of the Narcotic Record and the charts of three residents under the Grievor's care showed that she falsified the medical records and stole Hydromorphone. Sunnyside identified six (6) incidents between August 1, 2016 and August 24, 2016 where the Grievor recorded removing Hydromorphone or morphine from the medication room for residents but did not record on the relevant resident MAR that she administered the relevant dose to the resident.

Conclusion

35. The Grievor attended four fact-finding investigation interviews to discuss many of the discrepancies outlined above. Representatives from Sunnyside and ONA were present at these meetings. Sunnyside's notes from the fact-finding investigation interviews with the Grievor are found at Tabs 15, 16, 26, 45, 46, 71 and 72.

36. In summary, the investigations showed that for two years leading up to and including August 22, 2016, the Grievor was misappropriating narcotics for her own, improper purposes, while at the same time falsifying medical records in conjunction with each theft.

Prior to Addiction

[12] The grievor is currently 50 years old. She is married with three children.

[13] She worked part-time as an RN with the employer from 2002 to 2004 and full-time as an RN from 2004 to 2012. In 2012, she was successful in obtaining the position of Team Leader and was in that position when she was terminated in September 2016.

[14] The Team Leader coordinates resident care through an interdisciplinary team, including RNs, RPNs, PSWs, food services assistants, resident home assistants and unit clerks. The Team Leader prepares individualized plans of care for each resident and assesses their status on an ongoing basis. In addition, the Team Leader is responsible for coordinating the multidisciplinary care for the residents and communicating information about resident care needs to, among others, families and designated decision-makers. The Team Leader also administers medications as necessary and

2019 CanLII 433 (ON LA)

approves the use of “as needed” medications. The Team Leader is responsible to ensure that correct procedures for the handling and control of medications are followed by all registered staff.

2019 CanLII 433 (ON LA)

[15] Prior to the events giving rise to this case, the grievor received excellent performance reviews. For example, in 2006 it was noted that she was “professional and is always groomed well”. Another review in 2009 noted that the grievor “is a great RN with excellent assessment skills”. Both Eby and Ulett echoed these comments.

The Grievor’s Kidney Condition

[16] The grievor suffers from a kidney condition which causes her to produce an excess of kidney stones. She has had approximately 6 to 8 surgeries as a result of this condition to remove kidney stones. Her physician prescribed Percocet, an opioid, to control pain.

[17] Prior to 2014, the grievor testified that she used Percocet strictly to control her pain in connection with kidney stones. This changed in the fall of 2014.

Use of Narcotics for Other Than Pain Control

[18] At that time, as a result of a stressful personal situation, the grievor took Percocet as a means of relieving stress and not pain. Unfortunately, she continued to use Percocet for more than just pain control. She testified that the Percocet she took were either prescribed by her doctor, stockpiled from previous kidney stone attacks, or taken from her friends and family.

[19] The grievor testified that she first diverted drugs from the employer in late October 2014 to control pain. By this time, she testified that she was using non-prescribed narcotics on a daily basis. She testified that she needed the narcotics to get through each day at work and, notwithstanding her promises to herself to stop, she testified that she could not.

[20] Grievor testified that when she was absent from the workplace she would stockpile narcotics in advance which would be supplemented by over-the-counter medications from the pharmacy.

[21] Grievor also testified that when she did not have a sufficient supply of narcotics, she would experience signs of withdrawal which included chills, piloerection, feeling of her skin crawling and diarrhea.

[22] The grievor’s use of narcotics impacted her family life and her work life.

[23] With respect to her personal life, the grievor testified that she was frequently in conflict with her husband regarding family responsibilities. Since she could no longer carry out her family responsibilities, the grievor testified that she began transferring responsibility for her children to her husband, parents or in-laws. She testified that she was isolating herself in her bedroom. Moreover, as a result of her physical appearance, her family and colleagues became concerned. As a result, she stopped attending social and family functions.

[24] Similarly, at work, concerns about the grievor were raised by her co-workers. These concerns were documented in the evidence as having occurred in 2015 and 2016. The comments were in respect of her appearance (weight loss, wearing same uniform for 5 days), her interactions with her coworkers (she received a written warning on August 10, 2016 for using profanity to staff), odd behaviour whereby she would draw up medications and sit in her office with them for several minutes, commission of medication errors during which she seemed confused and not focused, a change in character from what she used to be, an apparent awkwardness when she was around narcotics, and not going for breaks or sitting through breaks with her eyes closed or head on the table.

[25] By mid August 2016, both Ulett and Eby were concerned that the grievor looked ill and withdrawn.

2019 CanLII 433 (ON LA)

July 25, 2015 Incident (SAF paras. 17-20)

[26] In relation to the empty ampoule of hydromorphone found on the sink in the staff bathroom on July 25, 2015, the grievor testified that she was responsible for it. The grievor testified she took the ampoule, which was intended to be wasted, from the wastage container in the medication room.

2019 CanLII 433 (ON LA)

[27] Grievor testified that when she was interviewed about this incident, she denied any involvement because of the shame she felt. She testified that she did not seek help at that time, or at any time prior to the events at the end of August 2016, because she believed that she should have been able to stop without help.

[28] The grievor testified that she was remorseful and embarrassed by her actions.

August 25, 2016 Incident (SAF paras. 21-27)

[29] The grievor testified, supported by other evidence, that she did not recall this incident but she does not deny it.

[30] The grievor testified that she only became aware of the details of the incident when she was visited by a police officer at her home in September 2016. The police officer was investigating the grievor's misconduct. She was not charged by the police.

Events Leading up to Admission of Theft of Narcotics and Falsifying Records (SAF paras. 29-32)

[31] The grievor testified that following her surgery to remove kidney stones (para. 27 SAF), she exhausted her prescribed medications. She testified that she then went into extreme withdrawal. As a result, she was prompted to contact a family member for help.

[32] The grievor testified that she was taken to the hospital and was admitted in order to obtain treatment for her severe withdrawal. Thereafter, on August 31, 2016, she contacted Ulett by telephone as outlined in the SAF. During that conversation she admitted to theft of narcotics and falsifying records as outlined in the SAF[1].

2019 CanLII 433 (ON LA)

[33] The grievor testified that she has not used narcotics since September 1, 2106.

The Grievor is Terminated

[34] Following an investigation, the employer terminated the grievor's employment by letter dated September 29, 2016. The employer was aware of the grievor's addiction at the time of termination. The grounds for termination were stated to be patient abuse (falsification of records indicating that residents received narcotics when they had not), an irreparable breach of trust and gross misconduct.

[35] Both Eby and Ulett testified that the fact of the grievor's addiction was not a factor in the decision to terminate.

[36] Ulett testified that she supported the termination because of the grievor's patient abuse (not administering drugs that were ordered and needed and falsifying medical records), the irreparable breach of trust, and the failure of the grievor to confess to her wrongdoing at an earlier point in time. She felt there was a high-risk to the residents of exposing them to similar conduct if the grievor continued to be employed.

[37] Eby testified that the addiction played no role in her decision and that the key factors supporting termination were the theft and record falsification, abuse of residents and breach of trust.

---

[1] An issue arose at the hearing that some the evidence was inconsistent with the contents of para. 31 of the SAF regarding whether the grievor "shorted" residents, that is, whether she did not give medication at all or the required dosage to residents which she kept for herself. As I indicated at the hearing, it was not necessary to resolve the inconsistency since it would not be relevant to the issues I have to decide.

Post Termination Evidence

Admission to Homewood

[38] On October 5, 2016, the grievor entered into a 35-day inpatient program at the Homewood.

[39] On admission, the grievor was diagnosed as having a severe opiate use disorder and a mild-to-moderate sedative-hypnotic use disorder. This diagnosis was accepted by all the medical witnesses.

[40] The grievor successfully completed the inpatient program and was discharged on November 9, 2016.

[41] The Homewood program is held in high esteem by all of the witnesses, and in fact, both Veenman and Wolkoff worked there. The discharge summary from Homewood, prepared by Dr. Clarke, the grievor's treating physician at Homewood, stated in part as follows:

> [DS] connected well with peers and engaged well in the process of [sic] program. She participated actively in all groups and phases of program, including, as a nurse, the inpatient Health Professionals' Group and the out-patient Caduceus[2] support group. In due course she was discharged with solid recovery plans. By discharge she had demonstrated a good understanding of the steps necessary to maintain sobriety, and had established good connections with 12-step recovery supports in the community. She made excellent progress with issues of shame, had made solid plans around recurrence of renal colic, and in general was viewed as a role model by her peers.

[42] Following her discharge from the Homewood residential program, she received treatment from Veenman and enrolled in the Homewood aftercare program.

---

[2] A group for health professionals with addictions from various sectors who come together to discuss their recovery and treatment plans.

2019 CanLII 433 (ON LA)

[43] In March 2017, Veenman outlined his treatment plan for the grievor. In addition to complete abstinence, the plan included monthly visits with him, weekly attendance at Caduceus at Homewood, weekly attendance at Phase III Aftercare at Homewood, attendance at 4-5 Twelve Step meetings per week and random urine drug testing 36 times per year (three times a month). Veenman testified that the grievor strictly complied with the treatment plan.

2019 CanLII 433 (ON LA)

[44] In addition, the grievor communicates by email with Veenman when suffering from pain for kidney stones. She advises him of the medication she is taking and seeks his advice about how to control her pain without the use of opioids.

Agreement with the College of Nurses of Ontario ("the CNO")

[45] On September 2, 2016, the employer reported the events which led to the grievor's discharge to the CNO as it was required to do. The CNO is responsible for protecting the public interest by ensuring, among other things, that its members are fit to practice nursing safely and that the public is not at risk.

[46] The CNO prohibited the grievor from the practice of nursing until June 6, 2017. At that time, the grievor entered into an Undertaking and Agreement ("Undertaking") with the CNO, regarding the conditions under which she could return to the practice of nursing.

[47] The Undertaking is a comprehensive document consisting of 45 paragraphs and 36 pages inclusive of Appendices. Among the terms of the Undertaking which are most significant in this case, the grievor:

- undertakes to follow Veenman's treatment and monitoring recommendations which are included as an appendix to the Undertaking (para. 10);

- agrees that she will not administer or have access to Controlled Substances in her nursing practice (para. 19);

- agrees to only work in a setting where her practice performance, and/or behaviour can be directly observed at any given time (para. 18);

- agrees to limit her nursing practices to “those places and those limitations as determined appropriate by Dr. Veenman, which limitations may include, but are not limited to, the specific environment, maximum number of hours, days or the specific times during which I should engage in nursing” (para. 20);

- agrees to have a Workplace Monitor (RN or another regulated healthcare practitioner if approved by the CNO) and Workplace Supervisor (para. 24 (a) to (e)); and

- agrees that, in the event of a breach of the Undertaking or relapse “in a manner which would affect [her] ability to practise nursing safely, puts the public at risk…” the CNO can impose significant sanctions, up to and including revocation of her certificate of registration (paras. 37 and 38).

[48] Appendix A1 to the Undertaking is the Healthcare Professional Treatment Participation Agreement (“Participation Agreement”) by which Veenman agrees to treat and monitor the grievor for substance use disorders. Paragraph three of the Participation Agreement sets out in great detail the nature of the treatment and monitoring including detailed requirements regarding attendance at various types of counselling, a requirement to provide urine samples “at such frequency as I determine appropriate”, provisions regarding how the samples are to be obtained and tested, and making recommendations in respect of the grievor’s working environment. Other provisions require Veenman to provide positive results of tests to the CNO and to report to the CNO regarding a number of other matters, including if the grievor’s substance use disorder is interfering with her ability to practice nursing safely.[3]

[3] A similar Participation Agreement with the grievor's family physician, Dr. Rodney Bruce, containing somewhat different provisions is Appendix “A2”.

2019 CanLII 433 (ON LA)

[49] Appendix “B” to the Undertaking is the Workplace Supervisor Agreement (“WSA”) which is a required element of the Undertaking. This agreement specifically recognizes that “… there is always some possibility that the Member’s health condition(s) may relapse. The Member recognizes that unusual behaviour may serve as an early warning sign of potential concern”.

[50] The WSA provides that the Workplace Supervisor is the point of contact with the CNO to ensure that the CNO is advised quickly if it appears that the Member cannot practice safely. The WSA provides that Workplace Monitors are colleagues who can assist the Member to manage her health condition(s) by observing changes in mood or behaviour of the Member. Workplace Monitors must be healthcare professionals (an RN or other approved registered staff) who have regular contact with the Member. The WSA provides that the Workplace Supervisor is responsible to ensure that at least one Workplace Monitor is on each of the Member’s shifts and specifically notes that such monitors “need not be in the immediate vicinity of the Member while on shift, but will need to have contact with the Member to be able to observe the Member’s behaviour and mood at least once per shift”.

[51] The WSA provides that the Workplace Supervisor is required to remove the Member from practice if there are concerns that might indicate a relapse and/or a risk to public safety and to report the same to the CNO. In addition, the Workplace Supervisor is to request a urine sample from the Member. Finally, the Workplace Supervisor is to be aware of the restrictions on the Member’s practice “and to take reasonable steps within [the] organization to ensure the Member’s practice is restricted accordingly”.

[52] Appendix “C” of the Undertaking consists of an information sheet for Workplace Monitors. It specifically states “there is always some possibility that the Member’s health condition may relapse” and “The College recognizes that it is possible that the Member could relapse without demonstrating warning signs to a Workplace Monitor, despite the diligent efforts of the Workplace Monitor”.

2019 CanLII 433 (ON LA)

Compliance with CNO Restrictions on Grievor's Practice

[53] Eby and Ulett testified that the employer could not comply with many of the restrictions imposed by the CNO on the grievor's practice.

Restriction on Access to Narcotics

[54] They testified that because of the prevalence of controlled substances in the workplace, all healthcare professionals would have access to controlled substances as part of their duties. In their view, it is not possible to work as a Team Leader or RN without some access to them.

[55] Examples referred to in the evidence included narcotics in pill form left unattended at the resident at the bedside, injectables prepared for administration to a resident left unsupervised in the Medication Room, and during the admission process when new residents will often bring their medications with them, which could include narcotics.

[56] Particular concern was expressed with respect to fentanyl patches. A very high percentage of the residents of the home have such patches and dementia. They testified that, in their view, residents would not be aware if an RN inappropriately took the fentanyl patch which can easily be taken off a resident and reapplied. Moreover, they testified, it is not uncommon for fentanyl patches to fall off a patient in their bed, in their clothing or on the floor.

[57] In re-examination, Ulett testified that the patches do not go missing very often.

Restriction on Administering Narcotics

[58] The witnesses gave detailed evidence regarding the current staffing arrangements at the workplace. They testified that there can be situations where only one RN is responsible for all of the residents (263 residents in two buildings) because the other RNs

2019 CanLII 433 (ON LA)

are absent due to illness or other reasons. The evidence was that this occurs most frequently on weekends, evenings or nights.

[59] The witnesses expressed concern regarding the administration of injectable narcotics. While at one time only RNs were permitted to administer these drugs, RPNs are being trained to do so. At the time of the hearing approximately 30% of the RPNs were trained but that number was increasing.

[60] The witnesses expressed concern about the impact of having another employee (either RN or RPN) administer injectable narcotics to the residents under the grievor's care. They testified that given the frequency of injections, the time involved, waiting time and interruption to the work needed to be done by others, it was simply not feasible to have other nurses complete narcotic injections for the grievor. The problem would be exacerbated on weekend shifts due to the reduced staffing levels.

[61] Related to the above, they expressed concern that requiring residents to wait for narcotic pain relief because the grievor could not administer narcotics to her own residents would result in inferior care.

Need to Work Independently

[62] Eby and Ulett testified that much of the work of the Team Leader is done independently. In their view, therefore, the employer could not provide a setting where the grievor's practice, performance and/or behaviour can be directly observed at any given time as required by the CNO. Examples included being alone in a resident's room when assessing the resident.

[63] Particular emphasis was placed on the admissions process where the admitting RN is required to reconcile the drugs (which may include narcotics) that the resident brings with them. In their view, since it is a core part of her job to create a Care Plan and coordinate the resident's care, it would not be feasible to have another RN do this work.

2019 CanLII 433 (ON LA)

Trust

[64] The witnesses testified that trust is an essential and critical aspect of a Team Leader's role. They testified that the residents, their families, other healthcare workers and management must trust a Team Leader.

[65] The witnesses testified that by her actions the grievor violated the trust of the residents and their families, coworkers and management. In cross-examination, grievor admitted that it would be reasonable to expect that the residents and their families would have issues trusting her and would worry about possible relapse on her part. She acknowledged that such concerns would not be healthy for the residents.

[66] Eby testified that the loss of trust is impossible to mend and that the employer could not expect the residents and their families to trust the grievor again.

[67] In cross-examination, the witnesses agreed that neither the residents nor those responsible for them were advised of the grievor's misconduct in diverting drugs intended for the residents and falsifying the medical records, notwithstanding the requirement to do so pursuant to the Resident Abuse & Neglect Zero Tolerance policy.

[68] Ulett testified that she has lost all trust in the grievor and felt that she could not expose the residents to the attendant risks.

Workplace Monitors and Workplace Supervisor

[69] Ulett testified that committing to the WSA would be professionally irresponsible because the grievor's practice could not be restricted as required and there are not enough RNs to fulfil the role of Workplace Monitor. She testified that she would not risk her professional license by entering into a WSA.

2019 CanLII 433 (ON LA)

[70] She also testified that in her opinion it was not feasible to have RPNs act in the role of a monitor because they are in a subordinate role to the RN and they are busy.

[71] In cross-examination, the grievor acknowledged that she had not found healthcare professionals willing to act as Workplace Monitors.

2019 CanLII 433 (ON LA)

Medical Evidence

[72] The medical evidence can be summarized as follows:

Reznek

[73] Reznek is a psychiatrist and Associate Professor in the Department of Psychiatry, University of Toronto and Honorary Staff Psychiatrist at Sunnybrook Health Sciences Centre. He was retained by the employer to provide evidence.

[74] He described himself as a generalist and does not specialize in the treatment of addictions. While he has treated patients with substance use disorders since 1991, at the time of the hearing a small minority of his patients are suffering from the sole issue of addiction.

[75] He testified that he was of the opinion that addiction should not be classified as a mental disorder. In his view, it was more in the nature of a bad habit. In cross-examination, he acknowledged that this was a minority view in the psychiatric profession and that it was contrary, for example, to the DSM-5.

[76] Following from this view, he also testified that in his opinion the grievor had the capacity to disclose her addiction at an earlier stage and comply with policies prohibiting the theft of drugs and falsification of records. In cross-examination, he testified that in his view people with substance use disorder have the capacity to make choices and should be held accountable for the choices they make, in this case, to divert drugs and falsify

medical records. The grievor was aware that what she was doing was wrong and had totally free will not to act in this way.

[77] He referred to a number of studies regarding relapse rates and concluded that in his opinion, while relapse rates decrease over time, even after 15 years approximately 25% of addicts will relapse.

[78] In cross-examination, he agreed that many of the study subjects had very different characteristics than the grievor. However, he did cite one study (McLellan (2008)) concerning health professionals (physicians) which found that the relapse rate after five years was approximately 25%. That same study noted, and Reznek agreed, that "identification, intervention, formal treatment, professional support, and monitoring by physician health programs is effective in rehabilitating most of these addicted physicians". He also acknowledged that the program referred to in the study was similar to the CNO program undertaken by DS.

[79] He testified that the factors that increase the likelihood that DS would relapse would be if the grievor has unsupervised access to opiates and if she returns to the environment where drugs were diverted.

[80] He also testified that there were factors which indicate that DS has a less than average risk of relapsing. These included the fact that she completed an in-patient treatment program, attends an after-care program, she is female, has a relatively short history of abusing narcotics and has a supportive family. He testified that, as a result, she falls into a relatively good prognostic group.

Wolkoff

[81] Wolkoff is a psychiatrist and is certified by the American Board of Addiction Medicine. He practised psychiatry at Homewood where he ran the addiction program from 2010 to 2012. He is a Clinical Assistant Professor at McMaster University where he

2019 CanLII 433 (ON LA)

teaches about psychiatry and addiction. He is also a Practice Assessor for psychiatry and addiction medicine for the College of Physicians and Surgeons of Ontario.

[82] He disagreed with Reznek that substance use disorders are in the nature of a bad habit. It was his opinion that the predominant view among psychiatrists is that such conditions are health conditions and that to view them as bad habits stigmatizes these conditions and makes it harder for people to get help.

[83] He also disagreed with Reznek that the choices made by people with addictions is entirely a matter of free will. He was of the view that such people have an impaired or diminished capacity to control certain urges that involve their addiction and agreed that a lack of insight is a common condition for addiction. It was also his evidence that other factors beyond the control of the individual (i.e., genetics) influence the likelihood of someone developing an addiction.

[84] Based on his review of the grievor's medical records and after discussion with her treating physician at Homewood and Veenman, he testified that the grievor had a significantly diminished capacity to resist the urges to engage in behaviours that supported her addiction. He agreed that he did not believe the grievor had total free will with respect to her behaviours.

[85] His evidence was that 80% of healthcare professionals (i.e., doctors) who return to work and who have completed treatment programs similar to that completed by the grievor, attend appropriate after-care programs, are subject to random testing, attend 12-step meetings and attend Caduceus meetings, will remain abstinent for at least five years. It was his evidence that nurses do not do as well as doctors because of the OMA's program is a superior program to that available for RNs.

[86] He testified that DS would be at a greater risk of relapse if she was exposed and/or had access to opioids at work, returned to the environment where she previously used

2019 CanLII 433 (ON LA)

opioids, and had poorly controlled pain. He shared Reznek's opinion that return to the environment where drug use occurred is a significant risk factor for relapse.

[87] In cross-examination, he agreed that the CNO Undertaking contemplates the possibility of relapse and that the process outlined in the Undertaking secures the safety of the residents subject only to the question of how closely she would be monitored.

2019 CanLII 433 (ON LA)

Veenman

[88] Veenman is a physician and a certified addiction specialist. He is also a co-facilitator for the Homewood Caduceus Group. Approximately 80% of his practice are healthcare professionals, of which 70% are nurses.

[89] The grievor became Veenman's patient on her discharge from Homewood in November 2016. He continues to be her addiction specialist and is a party to the Undertaking with the CNO in that capacity. He acknowledged in cross-examination that he was testifying as an advocate for his patient, only had a duty to her, that it would be difficult for him to take a position that was against her interest and that he is a strong advocate for recovering healthcare professionals. He also testified that he remained objective and that if he had concerns about her ability to practise, he would express them.

[90] He testified that the grievor is in excellent sustained recovery. She is compliant with all aspects of the aftercare program which includes attendance at 3 to 4 12-step meetings per week, completion of phase 3 aftercare at Homewood, regular contact with her sponsor, attendance at Caduceus meetings on a regular basis and random urine drug screens conducted at least 36 times per year.

[91] He testified that the pain from her kidney condition is well-controlled by the use of non-narcotic painkillers. The grievor advises Veenman of issues related to her kidney condition, including any pain, via email. He provides advice on how such pain is to be controlled.

[92] It was Veenman's opinion that the grievor is fit to return to work under the conditions imposed by the CNO. This view is also shared by Bruce.

[93] Like Wolkoff, Veenman testified that he disagrees with Reznek's view that addiction is not a mental illness and that those who suffer from it have the capacity and free will to make rational decisions. In his view, the grievor had no capacity to make choices about whether or not she could prevent herself from diverting medications or disclosing her addiction. He took issue with Wolkoff's opinion that she had diminished capacity because of the imprecise nature of the word "diminished" in this context.

[94] With respect to the risk of relapse, Veenman testified that he did not think the risk of relapse was that great so long as the grievor continued to strictly follow her recovery program. He was of the opinion that a nurse returning to the environment where they diverted drugs did not pose a serious risk of relapse so long as they were not administering narcotics.

[95] In cross-examination, he testified that he would not disagree with Wolkoff's evidence that the risk of relapse remains at 20% for those who have undergone a quality residential treatment program and who remain abstinent on a long-term basis. He agreed there is no data to support the belief that the risk is lower for healthcare professionals who have undergone a similar treatment program.

[96] Also, in cross-examination, he agreed that if all the conditions of the CNO Undertaking were complied with, he believed the risk of relapse would be 10% or less.

[97] In cross-examination, he agreed that the strength of her addiction and chronic or recurring pain could increase the risk of relapse by the grievor. He could not say whether returning the grievor to work with the employer would increase the likelihood of relapse because he did not know the workplace.

2019 CanLII 433 (ON LA)

[98] With respect to the question of access to narcotics, with specific reference to fentanyl patches, Veenman testified that so long as the grievor was in good healthy recovery, he did not believe the fact that fentanyl patches were ubiquitous in the workplace would increase the risk of relapse. He also referred to the fact that, by law, fentanyl patches are now strictly monitored.[4]

[99] Finally, both Clarke, the Homewood physician, and Bruce, the grievor's family physician, support the grievor's return to work.

STATUTORY PROVISIONS

Human Rights Code, RSO, 1990, c. H.19 as amended

> **5** (1) Every person has a right to equal treatment with respect to employment without discrimination because of… disability.
>
> **11** (1) A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,
>
> (a) the requirement, qualification or factor is reasonable and *bona fide* in the circumstances
>
> **17** (1) A right of a person under this Act is not infringed for the reason only that the person is incapable of performing or fulfilling the essential duties or requirements attending the exercise of the right because of disability.
>
> (2) No tribunal or court shall find a person incapable unless it is satisfied that the needs of the person cannot be accommodated without undue hardship on the person responsible for accommodating those needs, considering the cost, outside sources of funding, if any, and health and safety requirements, if any.

Submissions

[4] *Safeguarding Our Communities Act (Patch for Patch Return Policy), 2015* and Regulation 305/16.

2019 CanLII 433 (ON LA)

[100] The parties made extensive submissions which are summarized below.

Employer

[101] The employer argues that three issues must be determined. First, whether the grievor's termination of employment was *prima facie* discriminatory. Second, if the answer to the first question is in the affirmative, does the grievor fulfil the *bona fide* occupational requirements ("BFOR") of the job of Team Leader. Third, if the answers to the previous questions are in the affirmative, can the employer provide reasonable accommodation to the grievor without undue hardship.

2019 CanLII 433 (ON LA)

No *Prima Facie* Discrimination

[102] The employer agrees that the first two steps which must be established to show a *prima facie* case of discrimination (existence of a disability which is protected under the *Code* and adverse treatment with regard to employment) are met in this case.[5] However, the employer argues that the third step (that the disability was a factor in the adverse treatment) has not been met.

[103] The employer argues that the third step has not been established because the grievor did not disclose her addiction until after her conduct was discovered, her disability played no part in the employer's decision to terminate her (relying on the evidence of Ulett an Eby) and she suffered no impact for her misconduct greater than would any other employee for the same behaviour.

[104] In making this argument, the employer relies primarily on *Elk Valley*; *British Columbia v. British Columbia Government and Service Employees' Union*, 2008 BCCA 357 ("*Gooding*"); *Bellehumeur v. Windsor Factory Supply Ltd.,* 2015 ONCA 473

---

[5] *Stewart V. Elk Valley Coal Corp.*, 2017 SCC 30 ("*Elk Valley*") at para. 24 and *Moore v. British Columbia (Education)*, 2012 SCC 61 ("*Moore*") at para.33.

2019 CanLII 433 (ON LA)

("*Bellehumeur*") and *Wright v. College and Association of Registered Nurses of* Alberta, 2012 ABCA ("*Wright*), leave to appeal denied, 2013 CanLII 15573 and the arbitration awards in *Cambridge Memorial Hospital v. Ontario Nurses' Association*, 2017 CanLII 5289 (ON LA) (Randall)("*Cambridge Memorial"*) and *Royal Victoria Regional Health Centre v. Ontario Nurses' Assn. (P. S. Grievance)*, [2016] O.L.A.A. No.373 (Raymond)("*Royal Victoria* ").

Grievor Cannot Fulfill BFOR of Team Leader

[105] The employer relies on the standard set out in the decision of the Supreme Court of Canada in *Meiorin*[6] for a BFOR. These are that the standard was adopted for a purpose rationally connected to the performance of the job, the standard was adopted in an honest and good faith belief that it was necessary to the fulfilment of the work-related purpose and that the standard is reasonably necessary to the accomplishment of that work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate the employee without imposing undue hardship on the employer.

[106] The employer argues that the grievor cannot fulfil the following BFORs of a Team Leader: having the trust of residents, their families, other healthcare professionals and her employer that she would not steal drugs, falsify patient records and be reliable in the delivery of patient care; having a positive therapeutic relationship with the residents and their families; having access to controlled drugs; and the need to work independently.

[107] The employer argues that these are all reasonably necessary in the healthcare environment and are essential for the employer who has a legitimate interest in protecting residents and providing the best possible care.

[6] *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, 1999 CanLII 652 (SCC) at para. 54.

[108] The employer argues that in view of the grievor's misconduct and the risk of relapse if she returns to work with the employer, she cannot fulfil the BFORs. The employer places heavy reliance on the evidence of the grievor and employer witnesses regarding trust issues, and the evidence of Reznek and Wolkoff regarding relapse rates.

2019 CanLII 433 (ON LA)

[109] In addition, the employer argues that it cannot fulfil some of the conditions imposed by the CNO, and specifically, the requirement that she work in an environment where she can be directly observed at any given time, the prohibition on the administration of controlled substances and the requirement to have a Workplace Supervisor Agreement.

Accommodation without Undue Hardship

[110] The employer argues that it would cause undue hardship on the employer to accommodate the CNO restriction requiring that the grievor not administer controlled substances and be monitored on every shift.

[111] The employer argues that the administration of narcotics is a core duty of the Team Leader that can occupy anywhere from 1.5 to 4.33 hours per shift and that it would be disruptive and detrimental to patient care to have other nursing staff administer drugs to the grievor's patients. The employer argues that the same considerations apply in the case of the admission of new residents.

[112] The employer also relies on what it asserts is extreme difficulty in arranging for a Workplace Monitor on every shift. This is particularly the case on weekend shifts. The employer emphasizes that, in the view of its witnesses, having RPNs fulfil the role as a monitor is problematic because of the subordinate position they hold relative to the grievor who is an RN.

Union

[113] The union notes that addiction is classified as a mental health disease which has been recognized by courts[7] and arbitrators as a disability under s.5 of the Code. The union agrees with the employer that the initial question is whether the claimant can establish a *prima facie* case of discrimination and focuses its discussion on the third factor necessary to establish *prima facie* discrimination since the employer has conceded that the first two factors are satisfied.

[114] The union argues that the third factor required to demonstrate a *prima facie* case of discrimination, establishing that the disability was a factor in the adverse treatment, is satisfied by showing that the protected characteristic is at least one of the factors leading to adverse impact. It asserts that “The question, at base, is whether at least one of the reasons for the adverse treatment was the employee’s addiction”.[8]

[115] The union argues that intent is not relevant to the discrimination analysis and that it cannot be a factor if the legislation is to protect against indirect discrimination. The union asserts that discriminatory impact, not attitudes or intent, is the correct analytical framework that must be applied.

[116] The union refers to the medical evidence that, as a result of her addiction, the grievor either had no capacity to make choices about whether or not she could prevent herself from diverting medications or disclosing her addiction (Veenman) or she had diminished capacity to control urges that involve her addiction (Wolkoff), to argue that the grievor’s addiction was causally related to her misconduct.

[117] The union argues that the overwhelming weight of arbitral authority is that the presence of an addiction and its impact on a nurse’s ability to control or prevent diversion

---

[7] *Canada (Atty. Gen.) v. PHS Community Services Society*, 2011 SCC 44 at para. 101 (“*PHS*”); *Entrop v. Imperial Oil Limited*, [2000] OJ NO 2689 (CA) at para. 89.

[8] *Elk Lake* at para. 43 and *Peel Law Association v.Pieters*, 2013 ONCA 396 at para. 59. ("All that is required is that there be a "connection" between the adverse treatment and the ground of discrimination”.)

2019 CanLII 433 (ON LA)

of medications satisfies the requirement that the addiction is a factor in the adverse treatment of the employee.[9]

[118] The union argues that *Gooding* is premised on a flawed understanding of the law of discrimination because it imports notions of the employer's intention into the analysis. The union points out that, while intention may be important in cases of direct discrimination, it can play no role in cases of indirect discrimination where, as here, neutral policies have an adverse effect on a person suffering from an addiction disability. The union primarily relies on the decision of the Supreme Court of Canada in *Elk Valley* to support its argument.

Duty to Accommodate

[119] The union argues that the employer breached the procedural and substantive aspects of the duty to accommodate.

[120] The union asserts that the procedural aspect of the duty to accommodate was breached by the failure of the employer to give any thought or consideration to the issue of accommodation which includes the duty to inquire where there are reasonable concerns that the employee may be suffering from a disability.

[121] The union relies on the failure of the employer to make the necessary inquiries in the weeks and months prior to her termination because of the observations of her colleagues and management regarding her appearance and the failure of the employer

[9] *London Health Services Centre and ONA (SB)*, [2013] OLAA No. 24 (Hayes) ("*London Health Sciences Centre*"); *William Osler Health Centre v. ONA* [2006] OLAA No. 115 (Keller) ("*William Osler*"); *Collingwood General & Marine Hospital v. ONA (Smart)*, [2010] OLAA No. 196 (Jesin) ("*Collingwood Genera Hospital*"); *Thunder Bay Health Sciences Centre and ONA (Gabriele)*, [2010] CLAS 263 (Sheehan) ("*Thunder Bay Health Sciences*"); *St. Mary's General Hospital v. ONA* [2010] OLAA No. 465 (Stephens) ("*St. Mary's General Hospital*"); *Hamilton Health Sciences Corporation v. ONA (Pisonneault)*, [2013] 117 CLAS 6 ("Herman") ("*Hamilton Health Sciences*"); *Windsor Regional Hospital v. ONA (Mee)*, 2015 CanLII 100162 (Harris) ("*Windsor Regional Hospital*"); *Sunnybrook Health Sciences Centre and ONA (SB13-04)* [2016] OLAA No. 361 (Jesin) ("*Sunnybrook Health Sciences Centre*").

2019 CanLII 433 (ON LA)

to consider or give any thought to what steps could be taken to accommodate the grievor once she acknowledged she was suffering from a substance use disorder.

[122] With respect to the substantive aspects of the duty to accommodate, the union asserts that the employer has failed to prove that it could not accommodate the grievor's restrictions, including those imposed by the CNO, without undue hardship. The union points to the evidence that the employer took no steps to even consider what changes could be made in the organization of work to meet her limitations. As further evidence of the employer's utter lack of effort in this regard, the union points to the failure of the employer to consult with the Region's Coordinator for Accommodations in Returns to Work regarding how the grievor might be accommodated.

[123] The union notes that both Eby and Ulett conceded in cross-examination that some of the CNO restrictions that they initially testified would be impossible to comply with (for example monitoring) could be carried out once they properly understood what those requirements entailed. In addition, the union points to the fact that a number of changes have been made at the workplace since the grievor's termination as evidence of the ease with which changes in the workplace can be accomplished that would accommodate her restrictions. These changes include RPNs being trained to give injectable narcotics, narcotic counts been completed by RPNs, a camera in the medication room and a new wastage box which is more secure than existed at the time of the grievor's misconduct.

[124] The union requests that the grievance be allowed, that the grievor be reinstated to her previous position as Team Leader on days or, alternatively, reinstated as an RN, that she be assigned to work straight days until such time as Veenman indicates otherwise and compensation from June 6, 2017, the date of the grievor's Undertaking with the CNO, or alternatively, from the first day of the hearing. In addition, the union requests damages for injury to dignity, feelings and self-respect.

Employer Reply

2019 CanLII 433 (ON LA)

[125] The employer criticizes the arbitration decisions relied on by the union. The employer asserts that the arbitrators in those decisions conflated the *prima facie* discrimination and accommodation analysis. As a result, the employer argues that these decisions should not be followed.

2019 CanLII 433 (ON LA)

[126] The employer also argues that the union glosses over the fact that there is no evidence that the Workplace Supervisor Agreement could be fulfilled. In fact, argues the employer, Ulett specifically said that she would not sign it because she did not believe that she could fulfil its requirements.

[127] The employer also argues that, with respect to access to narcotics, the evidence of Veenman was inconsistent with the evidence of Reznek and Wolkoff and internally inconsistent that access to narcotics increases the risk of relapse. The employer criticizes his evidence more generally as Pollyannaish because he is testifying as an advocate.

[128] With respect to the significance of the CNO Undertaking, the employer notes that, while it supports the grievor's return to nursing in some capacity, it does not indicate that she should return to work in the same workplace.

Decision

The Nature of Addiction

[129] Based on the evidence in this case, I have no hesitation in concluding that opiod use disorder is a disease and that persons suffering from that disease have little or no control over their addiction.

[130] According to DSM-5, opioids are a class of drugs which are part of substance-related disorders (at p.481). The essential feature of these disorders "[is] a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems". (at p.483)

2019 CanLII 433 (ON LA)

[131] Impaired control, social impairment and risky use are among the diagnostic criteria of substance use disorder (DSM-5 at p.483).

[132] For example, DSM-5 (at p. 542) includes among the diagnostic features of opioid use disorder “[s]igns and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose... Individuals with opioid use disorder tend to develop such regular patterns of compulsive drug use that daily activities are planned around obtaining and administering opioids.” Indeed, the Supreme Court of Canada has accepted “that addiction is a disease in which the central feature is impaired control over the use of the addicted substance”.[10]

[133] The weight of the medical evidence in this case also supports this view. Veenman was of the opinion that the grievor’s addiction had control of her and her urges to the extent that she had no capacity to make choices about diverting drugs.

[134] Wolkoff, while not going as far as Veenman, testified that the grievor had diminished capacity to make a choice about her drug use and falsification of medical records. He also testified that she had significantly diminished capacity to resist the urge to engage in the behaviour supporting her addiction. He did not believe that the grievor had total free will in connection with matters associated with her addiction. He also testified that he spoke to Clarke who used the term “coercion” as an analogy to the reduced capacity caused by the impulse to use the addictive substances and he agreed that was an apt description of the grievor’s inability to prevent herself from diverting medications and/or disclosing her addiction.

[135] These opinions are in direct contradiction to those of Reznek. His view is that addiction is akin to a bad habit and not a disease. As a result, he is of the view that the grievor had the capacity/ability to control her behaviour and to both disclose her addiction at an earlier stage and comply with the policies prohibiting theft of drugs and falsification of records

[10] *PHS* at para. 101.

[136] Not only is Reznek's opinion rejected by both Veenman and Wolkoff, Reznek himself acknowledges that it is a minority view among psychiatrists and is contrary to DSM-5. His opinion on this issue was also rejected by Arbitrator Jesin in *Sunnybrook Health Sciences Centre* (at para. 45).

2019 CanLII 433 (ON LA)

[137] As a result, I reject Reznek's opinion on this point. Indeed, Reznek's rejection of the prevailing views of the psychiatric profession on the nature of addiction causes me great concern about the extent to which many aspects of his opinion can be relied on.

[138] All the medical witnesses agree that the grievor was suffering from severe opioid use disorder and mild to moderate sedative-hypnotic use disorder. I find that these substance use disorders are a mental disorder characterized by, among other things, compulsive behaviour and either a complete inability or a diminished capacity to resist the urge is to engage in behaviour supporting her addiction.

The Grievor's Misconduct

[139] The grievor's misconduct is described in detail in the SAF. During a two-year period, the grievor misappropriated narcotics for her own improper purposes, while at the same time falsifying medical records in conjunction with each theft. (SAF at para. 36)

[140] The improper purposes referred to above were to satisfy her addiction. The SAF makes clear that the misappropriation was "for her own use" (at para. 14), that "she… took the narcotics for herself" (at para. 15), that medication was diverted "so that she could instead inject herself" (at para. 31) and, rather than wasting the unused remainder of liquid narcotics, "she repeatedly kept the remainder for herself." (at para. 32). There is no allegation or evidence that she diverted the narcotics for any other purpose.

[141] There is no evidence that the grievor engaged in any of the misconduct that resulted in her termination from employment before the substance use disorder manifested itself in the fall of 2014. She only engaged in the misconduct when, as

described by Veenman, her addiction had control of her and her urges and her choices were motivated by obtaining narcotics to satisfy her addiction.

[142] I find that the evidence clearly establishes that the grievor’s behaviour was entirely consistent with the behaviour demonstrated by persons suffering from substance use disorder.

2019 CanLII 433 (ON LA)

***Prima Facie* Discrimination**

[143] The parties agree that the first step in the human rights analysis requires the union to prove a case of *prima facie* discrimination. The parties also agree that the first two factors (that the grievor has a characteristic protected under the *Code* and that she suffered adverse treatment with regard to employment or a term of that employment) are satisfied. The only dispute is whether the grievor’s disability was a factor in her adverse treatment.

[144] The employer argues that the third factor has not been satisfied because the grievor did not disclose her addiction until after her conduct was brought to the attention of the employer, the grievor’s disability played no part in the employer’s decision to terminate her employment and the grievor suffered no impact for her misconduct greater than would any other employee for the same behaviour. The employer relies primarily on the reasons in *Elk* Valley, *Gooding*, *Wright, Bellehumeur, Cambridge Memorial Hospital and Royal Victoria*.

[145] The union argues that *prima facie* discrimination has been established because there is a nexus between her disability and the reasons for her termination and therefore her disability was a factor in her adverse treatment.

[146] As this award was being prepared, the award in *Humber River Hospital and Ontario Nurses’* Association, 2018 CanLII 115718 (ON LA) (Gedalof) (“*Humber River Hospital*”) was released. It has an extensive analysis and discussion about the

applicability of the *Gooding* approach and the cases on which the employer relies (at paras. 99 to 125). The same arguments were made to Arbitrator Gedalof as were made in this case. The parties were given the opportunity to make submissions on *Humber River Hospital* which I have read and considered.

2019 CanLII 433 (ON LA)

[147] Arbitrator Gedalof rejected the *Gooding* approach because “the analysis in *Gooding* is inconsistent with the Supreme Court of Canada’s established human rights analysis, affirmed most recently in *Elk Valley*”. (at para. 99)

[148] Arbitrator Gedalof began his analysis with the decision of the Supreme Court of Canada in *Elk Valley.* In *Elk Valley*, an employee, who was addicted to cocaine, was involved in an accident at work. He was terminated because he failed to disclose his addiction prior to the accident, contrary to employer policy. He filed a complaint with the Alberta Human Rights Tribunal alleging that he had been discriminated against on the basis of addiction disability. The Tribunal dismissed the complaint and held that he was not dismissed because of his addiction but for breaching the employer policy. The Tribunal concluded that, notwithstanding his addiction, the evidence before it demonstrated that he had the capacity to comply with the policy. The dismissal of the complaint was upheld by the Alberta Court of Queens Bench and by a majority in the Alberta Court of Appeal.

[149] On appeal to the Supreme Court of Canada, the issue was whether the Tribunal’s conclusion that the employee was terminated for breach of the policy and not because of his addiction was reasonable. The majority of the court held that the issue was “essentially a question of fact for the Tribunal to determine” and held that its conclusion was reasonable (at paras. 5 and 28). In the course of its decision, the Court made it clear that in such cases considerable deference is owed to the decision of the Tribunal. (at para. 20 and 22)

[150] After observing that the Court in *Elk Valley* based its decision on "settled legal principles in cases of alleged discrimination due to disability", Arbitrator Gedalof noted that two of these principles are particularly important in analyzing *Gooding.*

2019 CanLII 433 (ON LA)

[151] The first is what is required to satisfy the third element of the *prima facie* discrimination test. Arbitrator Gedalof stated (at para. 106):

> 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.

[152] The second relates to the proper focus in cases of indirect discrimination. Arbitrator Gedalof stated (at para. 107):

> The following passages [paras. 39 and 42-46] 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 <u>decision</u> to take disciplinary action for breach of the rule. (emphasis in the original)

[153] Arbitrator Gedalof then analysed the decision of the court in *Gooding* as measured against the settled discrimination principles articulated by the Court in *Elk Lake*.

[154] Gooding was the store manager of a liquor store who was dismissed for stealing alcohol. At the time of his dismissal he disclosed that he was an alcoholic. A grievance was filed and the arbitrator concluded that the termination for theft was *prima facie* discriminatory because his disability was a factor in that theft.

[155] A majority of the British Columbia Court of Appeal held that Gooding's alcohol dependency played no role in the employer's decision to terminate him. The court stated that, in its view, he was terminated for theft just like any other employee (at para. 11). The

court also stated that there was no evidence that Gooding's termination was arbitrary and based on preconceived ideas concerning his alcohol dependency[11] and concluded "[t]hat 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." (at para. 15). (emphasis added)

[156] Arbitrator Gedalof was of the opinion that the court's reasoning was focussed on the employer's decision to terminate and not on the effect or impact of the workplace rule on the employee. He also noted that the court did not focus on whether the employee's alcohol-related disability was a factor in the misconduct. In reference to the above quote from *Gooding*, he clearly and succinctly articulated why *Gooding* was inconsistent with the settled jurisprudence from the Supreme Court of Canada on the law of discrimination (at paras. 113-114):

> 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 the rule by virtue of having a characteristic protected from discrimination, is precisely what the Supreme [*sic*] of Canada rejects in cases such as *Meiron*, 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 *Meiron* 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

[11] The Court in *Elk Valley* (at para. 45) explicitly rejected adding a requirement of a finding of stereotypical or arbitrary decision-making to the test for *prima facie* discrimination. The Court held that to do so would improperly focus the inquiry on "whether a discriminatory attitude exists, not a discriminatory impact…" (emphasis in the original)

2019 CanLII 433 (ON LA)

> 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 the discriminatory intention would rarely frame the rule in directly discriminatory terms when the same effect—or an even broader effect—could easily be realized by couching it in neutral language." (at para. 29) Far from diminishing the significance of adverse effect discrimination, the Court in *Meiron* 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.

2019 CanLII 433 (ON LA)

[157] I would only add the following additional comment regarding *Gooding.* By its comments in para. 15 of its decision quoted above, it is obvious that the court was influenced by a concept of formal equality to the exclusion of the principles underlying indirect discrimination where otherwise neutral policies have an adverse effect on certain groups (*Elk Valley*, at para. 24).[12]

[158] In its submissions regarding *Humber River Hospital*, the employer asserts that the arbitrator's reasoning is flawed. The employer argues that Arbitrator Gedalof's reasoning contradicts or misapprehends the reasoning in *Elk Valley*. The employer asserts that he removes from the analysis any examination of the employer's decision-making or reasons and points to the statement at para. 107, in reference to cases of indirect discrimination, that "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 <u>decision</u> to take disciplinary action for breach of the rule".

[159] The employer relies on the following sentences from *Elk Valley* to make its point: "It is, of course, open to the Tribunal to find that an addiction was a factor in an adverse

---

[12] In her speech delivered on October 23, 2018 at the President of Israel's Symposium on the occasion of the 70th anniversary of the Supreme Court of Israel, Justice Rosalie Abella referred to one of the Supreme Court of Canada's developed "justice consensus" features in the following terms: "Where for others treating everyone the same is the dominant governing principle, for us it takes place alongside the principle that treating everyone the same can result in ignoring the differences that need to be respected if we are to be a truly inclusive society."(as reported in the Globe & Mail, October 26, 2018)

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."** (para. 43) (emphasis added by employer) and "Second, I see no need to alter the settled view that the protected ground or characteristic **need only be " *a factor* " *in the decision.*"** (para. 46) (emphasis added by employer)

2019 CanLII 433 (ON LA)

[160] I disagree with the employer. *Elk Valley* (as have many previous decisions of the Court) makes clear that in cases of indirect discrimination, discriminatory intent by an employer is not required to demonstrate *prima facie* discrimination (at para. 24 and quoted by Arbitrator Gedalof at para. 103 of his award) and that the focus in these cases is on "discriminatory impact" (at para. 45 and cited by Arbitrator Gedalof at para. 107).

[161] Arbitrator Gedalof's award reflects these basic principles. The sentences relied on by the employer must be understood in this context. The reference to "reasons" in para. 43 must be understood as a reference to a "factor" in the adverse impact. This is clear from the immediately preceding sentence and the fact that discriminatory intent is irrelevant. For the same reason, the reference to "decision" in para. 46 relates to the employer's response (termination) to the misconduct (stealing drugs) which is the adverse impact in the case of an addict where that addiction is a factor in the misconduct. This does not require an analysis of whether the fact that the employee was an addict played any role in the thought process leading the employer to terminate the employee.

[162] The employer also criticizes the award in *Humber River Hospital* because, it asserts, the arbitrator fails to explain how rules such as "no theft of drugs" and "no falsification of patient records" can have a discriminatory effect. The employer asserts that there was no evidence in that case (or in this case) about the disproportionate impact of such rules on people suffering from substance use disorders. The employer says that it cannot be discriminatory to insist that such rules be followed and to respond in the normal manner, for the protection of residents, when they are not.

2019 CanLII 433 (ON LA)

[163] Arbitrator Gedalof was quite clear that theft generally and theft of drugs in particular is "extremely serious" and accepted that "[t]he Hospital's desire to protect itself and others from the harm and potential harm inherent grievor's behaviour is exceedingly well grounded" (at para.124). But far from failing to explain how valid workplace rules such as "no theft of drugs" can be discriminatory, he carefully analyzes how the law of indirect discrimination applies in the case of an addict whose illness is a factor in causing the breach of the valid workplace rule.

[164] Arbitrator Gedalof also addresses the decision of the Ontario Court of Appeal in *Bellehumeur* and noted that the court does not engage in any substantive analysis (indeed the decision is styled as an Endorsement and was delivered orally) of whether *Gooding* is consistent with *Elk Valley* or the myriad of other Supreme Court of Canada discrimination jurisprudence. Moreover, it does not appear from the decision that the arguments before Arbitrator Gedalof and me about whether *Gooding* is consistent with that jurisprudence were addressed. Finally, and contrary to the facts in this case, the court was strongly influenced by the fact that the employer did not have knowledge of the employee's disability at the time of termination. Arbitrator Gedalof concluded (at para. 115) that *Bellehumeur* was not a general endorsement of *Gooding*. I agree with his conclusion.

[165] The employer asserts that Arbitrator Gedalof committed a fundamental error by refusing to follow the decision of the Ontario Court of Appeal in *Bellehumeur*. I do not agree for the reasons noted above.

[166] In my opinion, the award in *Humber River Hospital* is a carefully reasoned analysis of how *Gooding* departs from the settled principles of the Supreme Court of Canada in cases of this sort. In my view, the analysis is correct and the employer has not persuaded me to the contrary. I adopt its reasoning and conclusion.

[167] Arbitrator Gedalof also considered the arbitration awards in *Royal Victoria* and *Cambridge Memorial Hospital* which were relied on by the employer in this case. He

disagreed with them, as do I, to the extent that they can be read to endorse the *Gooding* approach (at para. 117).

[168] He also disagreed, and so do I, with *Royal Victoria* to the extent that it suggests that it is necessary to find that the compulsion to steal due to addiction must be so powerful as to eliminate any notion of choice or intention[13] (at para. 119) and with *Cambridge Memorial Hospital* to the extent that it suggests that something more is required than that the addiction was a factor in the adverse impact (at para. 120).

[169] The employer in this case also relied on W*right*. This case involved professional misconduct charges filed by the professional regulatory body against two nurses who stole narcotics from the hospitals where they worked. The nurses were addicts and defended the charges against them on that basis. Notwithstanding medical evidence that there was a plausible connection between the opioid dependence and the behaviour, the Tribunal hearing the charges concluded that there was not a sufficiently close nexus between the addiction and the conduct and that the issue, in each case, was not disability but rather theft and fraud. Appeals to the Alberta Court of Appeal were dismissed.

[170] The court relied on *Gooding* to conclude, with respect to adverse effect discrimination, that since the case involved theft of narcotics "[D]iscipline for criminal conduct is based on objectively justifiable social criteria, not stereotypical thinking or arbitrary judgement of personal characteristics. While the law recognizes that an addict cannot always control her addiction, the law does require that the addict control her conduct sufficiently to comply with the criminal law" (at para. 64).

[171] Having followed *Gooding*, it is not surprising that the decision of the court in *Wright* is also contrary to the fundamental principles of discrimination law outlined in *Elk Valley*. While paying lip service to the concepts underlying indirect discrimination, it imported the

---

[13] See also the joint dissenting reasons in *Elk Valley* of Justices Moldaver and Wagner (at para. 50) and the dissenting reasons of Justice Gascon (at para. 118) where the fact that an employee maintains some control over their addiction does not eliminate the addiction as a factor in a *prima facie* discrimination analysis. Nothing in the majority decision is inconsistent with this.

2019 CanLII 433 (ON LA)

requirement for stereotypical or arbitrary characteristics into the test for *prima facie* discrimination which *Elk Valley* specifically rejected (at para. 45). As a result, the court did not address whether the addictions were a factor in the adverse findings against the nurses.

2019 CanLII 433 (ON LA)

[172] The employer criticizes the arbitration cases relied on by the union which are referred to at footnote 9 above for conflating the *prima facie* and accommodation analyses. The same argument was made in *Humber River Hospital*. Arbitrator Gedalof rejected that criticism (at para. 121). It was his view that arbitrators have not always been explicit about moving through the discrimination/accommodation analysis but observed that in most of the cases the only real dispute was whether the disability was a factor in the adverse impact and, where it is, to move to issues of accommodation simply means that the union has established *prima facie* discrimination. A fair reading of those cases indicates that his view is well-founded (see for example *Thunder Bay Health Sciences Centre* at para.; 55; *St. Mary's* General *Hospital* at para. 19; *London Health Centre* at para. 56; *Sunnybrook Health Sciences Centre* at paras. 43 and 54; *Collingwood General & Marine Hospital* at para. 24).

[173] Applying the above analysis, the union has clearly discharged its onus of showing *prima facie* discrimination.

[174] The parties agree that, at the relevant time, the grievor suffered from a substance use disorder which was a disability under the Code. The evidence shows beyond any doubt that there is a connection or nexus between the grievor's substance use disorder and the adverse effect of termination of employment for violation of admittedly valid workplace rules. Compulsive behaviour and impaired judgment are symptoms of the mental illness of substance use disorder. They were manifested in this case, according to the weight of medical evidence, by either no capacity or diminished capacity on the part of the grievor to comply with workplace rules prohibiting diversion of narcotics and falsification of medical records. Moreover, the grievor testified that she needed opioids "to get through this shift…get through the evening…get through the next day and I won't

anymore; I am going to stop. But I couldn't stop". There was no evidence that the grievor diverted the drugs for any reason other than to satisfy her substance use disorder.

[175] The employer's witnesses testified that the grievor's addiction was not a factor in the decision to terminate and the employer relies on this to support its argument that the grievor's addiction was not a factor in her termination. Respectfully, that is not the issue in a case such as this. The focus at this stage is whether the application of valid workplace norms has a discriminatory effect on the grievor because her disability interferes with her ability to comply with those norms.

2019 CanLII 433 (ON LA)

[176] I therefore reject the employer's argument that the union has not demonstrated that the grievor's disability was a factor in her adverse treatment.

CNO Undertaking

[177] I think it is important to make some general comments regarding the CNO Undertaking in view of some of the arguments made by the employer in this case.

[178] The CNO is the governing professional body for RNs in Ontario. It is created by statute (*Nursing Act, 1991*, S.O. 1991, c. 32, s.6). Section 2.1 of the *Health Professions Procedural Code*[14] provides that "It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals."

[179] The CNO fulfils its role by establishing requirements for entry to practice, articulating and promoting practice standards, administering its Quality Assurance

---

[14] Schedule 2 to the *Regulated Health Professions Act, 1991*. It is deemed by section 4 of that *Act* to be a part of the *Nursing Act, 1991.*

Program and enforcing standards of practice and conduct.[15] The mission statement of the CNO is "Regulating nursing in the public interest".[16]

[180] When the grievor's substance use disorder was revealed, the CNO, exercising its authority and acting in the public interest, prohibited the grievor from engaging in the practice of nursing. Subsequently, after the grievor received treatment for her substance use disorder and after being assessed by a medical expert which it retained, the CNO, once again exercising its authority and acting in the public interest, determined that she was fit to return to the practice of nursing subject to the terms and conditions of the Undertaking.

[181] The CNO has been granted the statutory authority and responsibility to determine whether RNs, like the grievor, who suffer from substance use disorder and who are in remission, can return to the practice of nursing and under what conditions. It is explicitly required to exercise its authority with the public interest as its main focus.

[182] Given its statutory role and its expertise in these matters, it can safely be assumed, as confirmed by the terms of the Undertaking, that the CNO is acutely aware of the significance and risks associated with issues such as relapse rates, trust issues and the like in returning nurses in remission to nursing practice and has designed the Undertaking accordingly.

[183] As a result, it is my view, that the opinion of the CNO, as expressed in the Undertaking, must be given significant weight in addressing some of the issues raised by the employer.

Accommodation and Undue Hardship

[15] http://www.cno.org/en/what-is-cno/

[16] http://www.cno.org/en/what-is-cno/mission-vision/

2019 CanLII 433 (ON LA)

[184] The union has discharged its onus of establishing *prima facie* discrimination. The onus now shifts to the employer to establish that the grievor cannot be accommodated without imposing undue hardship on the employer.

[185] The employer argues that the grievor cannot fulfill the *bona fide* occupational requirements of the job of Team Leader. The Supreme Court of Canada set out the following analytical approach to these questions.

> 54. Having considered the various alternatives, I propose the following three-step test for determining whether a *prima facie* discriminatory standard is a BFOR. An employer may justify the impugned standard by establishing on the balance of probabilities:
>
> (1) that the employer adopted the standard for a purpose rationally connected to the performance of the job;
>
> (2) that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
>
> (3) that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible[17] to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.[18]

[186] The employer identified a number of BFORs of the job of Team Leader that it asserts the grievor cannot fulfil: have the trust of the residents, their families, other health care professionals and her employer that she would not repeat her misconduct; have a positive therapeutic relationship with residents and their families; have access to

---

[17] In *Hydro-Québec v. Syndicat des employées de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43 (CanLII) at para. 12 the Supreme Court clarified that "impossible" meant undue hardship.

[18] *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, 1999 CanLII 652 ("*Meiorin*").

2019 CanLII 433 (ON LA)

controlled drugs, including narcotics; and work independently. In addition, the employer identified aspects of the Undertaking, some of which overlap the above, which it asserts cannot be satisfied at all or without undue hardship: the requirement to have a Workplace Supervisor Agreement in place; the requirement to work in a setting where her practice performance, and/or behaviour can be directly observed at any time; the requirement that she not administer or have access to controlled substances;and the requirement to have a Workplace Monitor on every shift.

[187] The position of the employer must be evaluated in context. The employer has consistently approached this as a case of just cause for termination. At no time, even after the grievor entered into the Undertaking with the CNO, did the employer consider this as a case raising human rights issues and never considered how the grievor might be accommodated. The employer did not, for example, avail itself of the resources at its disposal, such as the Region's Coordinator for Accommodations and Returns to Work, to review and consider possible accommodation for the grievor.

[188] The employer's lack of appreciation of its *Code* obligations is thrown into sharp relief in the evidence of Ulett. She testified that her compliance with the *Code* might depend on whether such compliance was in conflict with her conscience and convictions that she held. She also testified that she was only beginning to understand that addiction is a disability covered by the *Code*.

[189] Two consequences flow from this. First, I agree with the union that the employer has violated its procedural duty to accommodate because it failed to give any thought or consideration to accommodation issues. [19] The procedural duty to accommodate was also violated when the employer failed to take any steps or make any inquiries of the grievor, in the face of some obviously troubling observations of and reports about the

[19] *Meiorin* at paras, 64,65 and 68; *ADGA Group Consultants Inc.* v. *Lane*, 2008 CanLII 39605 (Div. Ct.) at para. 106; *Humber River Hospital* at para. 134.

2019 CanLII 433 (ON LA)

appearance and behaviour of the grievor, which should have caused the employer to perceive that a disability of some kind might be present.[20]

[190] Second, the evidence of the employer's witnesses about whether the grievor could be accommodated is based on how the work is currently organized and implemented. Those opinions were formed and expressed without any analysis or thought about what changes in work organization or implementation might be required and might be possible to accommodate the grievor. Any assertion that it would be impossible to accommodate the grievor, or that doing so would cause undue hardship to the employer must be evaluated in that context.

2019 CanLII 433 (ON LA)

Trust and Positive Therapeutic Relationship with Residents

[191] The employer strenuously argues that trust between the Team Leader and residents, their families, their colleagues and management, is an essential and critical aspect of the job of Team Leader. The union did not dispute this as a general matter.

[192] The employer asserts that the grievor's breach of trust is irreparable. It relies on the grievor's evidence in cross-examination that it would "be reasonable" to expect that residents and their families would no longer trust her, would worry about her relapsing and engaging in misconduct and that these concerns would not be healthy for them and not in their best interests. The employer also relies on the evidence of Eby (trust is "impossible to mend") and Ulett (she has lost all trust in the grievor).

[193] I do not accept that the evidence supports the conclusion that the grievor's breach of trust is irreparable. The cases and the evidence of Veenman support the conclusion that the breach of trust that inevitably flows from the diversion of narcotics by health care professionals can be repaired. Similarly, the CNO, which must be assumed to be aware

[20] OHRC Policy on Preventing Discrimination Based on Mental Health Disabilities and Addictions (January 31, 2014) at p.49; *Sears* v. *Honda of Canada Mfg.*, 2014 HRTO 45 at para. 114; *Hamilton Health Sciences* at paras. 30-31; *Direct Energy v. CEP, Local 975* (2009) OLAA No.216 (Burkett) at para. 24.

of the critical importance of trust issues, did not include in the Undertaking a term that the grievor not return to work with the employer. The evidence of Ulett and Eby was conditioned by their view that this was a termination for just cause and not in the context where the misconduct was directly related to a mental illness which is now in remission. It is to be hoped that Ulett, as an experienced and caring health care professional, who is now aware that the grievor's misconduct was directly related to her illness, can re-evaluate her feelings regarding the possibility of re-establishing the required trust.

2019 CanLII 433 (ON LA)

[194] In evaluating the impact of trust issues on the residents and their families, the evidence is that the employer did not advise the residents and/or their families of the grievor's misconduct at the time it was revealed, or thereafter. In the absence of such knowledge, it is not clear to me how, as a practical matter, such trust issues could arise.

[195] Moreover, these breach of trust issues, or viewed another way, re-establishment of trust issues, must be evaluated in the context of the terms and conditions of the Undertaking and Veenman's evidence about the grievor's compliance with the terms of his treatment plan. Any concerns must be assuaged by the conditions of the grievor's return to work.

[196] This also applies to the risk of relapse. Even if I accept the evidence of Wolkoff and Reznek that the risk of relapse is significant—in the order of 20% to 30%--the CNO is alert to this possibility and has imposed conditions that are specifically designed to detect relapse at the earliest possible time. Veenman, although somewhat inconsistent in his view of the risk of relapse, also clearly acknowledges that the risk is always there and has developed his treatment plan accordingly.

[197] Both Wolkoff and Reznek were of the opinion that returning to the environment where drugs were abused increases the risk of relapse, a fact which the CNO would be aware of. But there was no restriction in the Undertaking prohibiting the grievor from returning to work with the employer and no evidence that there were any facts unique to the employer that increases the risk in this case.

[198] The CNO is obviously satisfied that, notwithstanding the risk of relapse, the Undertaking sufficiently protects the public interest. Even Reznek acknowledged that with the exception of the degree of monitoring of the grievor, he was satisfied, as a general matter, that the Undertaking secures the safety of the patients.

Work Independently

[199] Both Eby and Ulett testified that the employer is not "a setting when [a Team Leader or RN] practice, and/or behaviour can be directly observed at any given time" as required by para. 18 of the Undertaking. Several examples were given where the Team Leader must work independently (alone with residents in their rooms or her office; when admitting residents; when assessing residents after admission; on evenings and weekends due to a limited number of staff).

[200] In the absence of any effort on the part of the employer to consider what accommodation might be possible, I do not believe that the employer's concerns are well-founded.

[201] Schedule B of the Undertaking is quite clear that such observations are only required once per shift. It is not obvious to me why the grievor could not be observed in any of the settings referred to by the employer.

[202] Moreover, this is an example of the employer declaring some aspect of the Undertaking impossible to comply with when it has not even considered how it might accommodate the grievor. For example, the concerns about weekend and evenings can be easily solved with scheduling changes that do not require the grievor to work those shifts (in fact, Veenman recommends that initially, the grievor only be assigned to work the day shift). In addition, Ulett agreed in cross-examination that there is a mandatory reporting session at the beginning of every shift. It is not clear why this would not be in compliance with the Undertaking.

2019 CanLII 433 (ON LA)

[203] Similarly, the concern about the admissions process (which also includes access to drugs since a drug reconciliation occurs at this time) has also never been the subject of consideration by the employer regarding how changes to its existing processes might be made in order to accommodate the grievor. Examples might include assigning another nurse to drug reconciliation duties and assignment and scheduling changes.

No Administration of or Access to Controlled Drugs Including Narcotics

[204] The employer asserts that it is both impossible and would amount to undue hardship to comply with a “no administration no access” restriction.

[205] This is yet another example where the employer’s evidence and argument are lacking because of its failure to turn its mind to how it might accommodate the grievor’s restrictions.

[206] There is no doubt that the administration of narcotics is a core duty of a Team Leader. Insofar as injectables are concerned, the evidence is that the employer is in the process of training all the RPNs to perform this work. At the time of the hearing approximately 30% of the RPNs were trained and that number is no doubt higher now and will continue to increase.

[207] Although the employer asserts that it would be impractical and result in unacceptable delays to have others administer narcotics to the grievor’s residents, once again this is based on how the work is currently performed without any analysis of how it might be performed in order to accommodate the grievor.

[208] The restriction of access to narcotics is a more difficult issue because of the ambiguity of the term “access” in a health care setting. It could mean that the grievor cannot be in the same physical space where narcotics are located. Or it could mean that the grievor cannot be in a position where, as part of her nursing practice, she is in a position to access such narcotics.

2019 CanLII 433 (ON LA)

[209] On October 2, 2018, in-house counsel at the union responsible for the grievor's file wrote to the CNO's Monitoring Administrator on the Monitoring Team seeking clarification of the meaning of "no access" in the Undertaking. By email dated October 10, 2018, the Monitoring Administrator advised that "no access" includes a) not counting or administering controlled substances, b) not witnessing wastage, signing pharmacy receipts for controlled substances, or having the ability to access storage areas for controlled substances, and c) not calling, faxing, or otherwise electronically authorizing prescriptions for controlled substances". This was entered as an exhibit on consent subject to the employer's argument regarding the weight to be given to it.

2019 CanLII 433 (ON LA)

[210] The employer argued that it should not be given much weight. The employer noted that the list is not intended to be an exhaustive list and that there are other matters that might also be included if the request had specified them, such as fentanyl patches.

[211] The employer is correct that the list is not exhaustive and that other situations might also be encompassed in the definition. On the other hand, the mere presence of narcotics and controlled substances in the area where the grievor is assigned is not included on the list. Indeed, the fact that specific actions in respect of such substances is prohibited (i.e. not counting or administering) seems to imply that the presence of such substances is assumed and not part of the prohibition.

[212] In addition, Veenman testified that many of his patients returned to work under the same restriction of no access and the mere fact of the presence of narcotics or controlled substances did not create an insurmountable obstacle to compliance with that term or condition.

[213] The employer emphasized that the grievor will always have access to fentanyl patches (both on the patient and in other areas where they have fallen off), narcotic medications left on the bedside (contrary to policy) and injectables waiting to be administered or wasted and therefore the grievor cannot be accommodated

[214] I do not accept this. If narcotics are left on the bedside contrary to policy, then it is a simple matter for the policy to be enforced. Fentanyl patches are no different than other narcotics except that it seems that they sometimes fall off and can be found in various locations. But as the union pointed out these patches are regulated by statute and each patch must be accounted for. Moreover, the terms and conditions of the Undertaking and the grievor's treatment plan would quickly detect any diversion. Finally, Ulett testified that the patches do not go missing very often.

Workplace Supervisor and Workplace Monitor

[215] The employer relies on Ulett's testimony that she would not agree to be the Workplace Supervisor since she did not feel she could comply and that she felt she would risk her license by doing so since there not enough RNs to fulfill the Workplace Monitor role and she felt the grievor's practice could not be restricted as required by the CNO.

[216] Ulett's evidence demonstrated that she did not fully comprehend the various roles of the Supervisor or the Monitor or the employer's obligations under the *Code*. Moreover, her opinion about what was possible was premised on the workplace as it is and not as it could be. With a comprehensive understanding of the various roles and having considered possible modifications in the organization of work, it is possible that she might alter her opinion.

[217] However, even if she does not, the evidence is that there are three Resident Care Coordinators who could also fill the role Workplace Supervisor. There is no evidence that they were approached about it.

[218] The same holds true for the argument that there are not enough RNs to fill the role of Workplace Monitor. Moreover, I reject the employer's assertion that it is not appropriate for RPNs to fill the role because it would require them to observe and possibly report on someone to whom they report. The RPNs at this workplace reported their observations of the grievor's behaviour before she was terminated and there is no reason to doubt that

2019 CanLII 433 (ON LA)

they would do the same in the role of Workplace Monitor. Indeed, Veenman's evidence was that this is not an unusual occurrence in his practice for RPNs to assume that role and it has not been an issue. Finally, RPNs are regulated by the CNO. There is no reason to believe that they would not carry out their duties and responsibilities in a professional manner.

2019 CanLII 433 (ON LA)

Remedy

[219] I have found that the union has satisfied its onus to demonstrate *prima facie* discrimination. I have also found that the employer has violated both its procedural duty to accommodate and has not satisfied its onus of demonstrating that it cannot accommodate the grievor without suffering undue hardship.

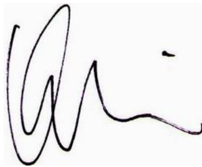
[220] The union requests that the grievor be reinstated to employment, that the employer be ordered to accommodate her and that she be compensated for any losses including general damages for injury to dignity, feelings and self-respect.

[221] I agree. I order the grievor to be reinstated forthwith and order the employer to accommodate her to the point of undue hardship. The grievor is entitled to be compensated for the breach of the procedural duty to accommodate which normally gives rise to a general damages award. Compensation for monetary losses should await the outcome of the accommodation process.

[222] I encourage the employer to avail itself of all the available resources such as the Coordinator for Accommodations and Returns to Work to assist in understanding its obligations and to provide whatever other assistance it can. If there is a dispute about whether a proposed accommodation complies with the Undertaking or if clarification of the Undertaking is required (this list is not meant to be exhaustive), the parties, or either of them, are free to contact the CNO Monitoring Team, as the union did regarding the general question of access, to seek its input on the matter. It appears that the CNO is prepared to respond to such questions.

[223] The issues of accommodation and compensation are remitted to the parties and I remain seized in the event that they encounter any difficulty in implementing any aspect of this award.

Dated at Toronto Ontario this 10th day of January 2019.



Larry Steinberg

2019 CanLII 433 (ON LA)