



## AWARD

This award pertains to a five-day suspension given to Usha Pompey (the "Grievor", by the Employer on October 11, 2016. It is the Union's position that the Griever was suspended without just cause, that the suspension should be removed from her file, and that she should be made whole. The Union also contends that the suspension constituted age discrimination prohibited by the Ontario Human Rights Code, and seeks a general damages award of \$15,000 for the alleged violation of that prohibition.

During the seven days devoted to the hearing of this matter, seven persons were called as witnesses. In addition to their testimony, forty exhibits were entered into evidence during the course of the proceedings. In making the findings and reaching the conclusions set forth in this decision, I have duly considered all of that oral and documentary evidence, the submissions of counsel, and the usual factors germane to assessing evidentiary credibility and reliability, including the firmness and clarity of the witnesses' respective memories, their ability to resist the influence of self-interest when giving their version of events, the internal and external consistency of their evidence, and their demeanour while testifying. I have also assessed what is most probable in the circumstances of the case, and considered the inferences which may reasonably be drawn from the totality of the evidence. In this regard, reference may usefully be made



to the following oft-quoted passage from *Faryna v. Chorny*,,  
[1952] 2 D.L.R. 354 (B.C.C.A.), at page 357:

The credibility of [an] interested witness, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.

Since this is a discipline case, the Employer has the legal burden of proving that there was just cause for the discipline. As indicated in *F.H. v. McDougall*, [2008] 3 S.C.R. 41, in paragraphs 45, 46, and 49 (which were referred to by Union counsel during her submissions), there is only one standard of proof in civil cases and that standard is "proof on a balance of probabilities". The decision maker "must scrutinize the relevant evidence with care to determine whether it is more likely than not that an alleged event occurred", and the evidence must be "sufficiently clear, convincing and cogent to satisfy the balance of probabilities test".

Villa Forum (also referred to in this award as the "Horne") is a long term care residence in Mississauga, Ontario, that is managed by Chartwell. Since evidence adduced in these proceedings included medical and other personal information regarding some of the Home's residents, those residents and their family members will be referred to in this award through the use of initials rather than names, for purposes of



privacy.

The Grievor is a sixty-three year old married woman who commenced employment at the Home in May of 2008 as a Personal Care Provider ("PCP"). In describing how the Home provides care for its residents/ Lynn Barber/ who is one of its Co-Directors of Care/ testified that funding levels preclude the Home from using a primary care model, such as that used generally used in a hospital, where a Registered Nurse ("RN") provides care to a group of people. Consequently/ an RN looks after a floor in the *Home*, with PCP'S providing the residents with direct care such as feeding, bathing, toileting, and transferring. The Home relies very heavily on PCP's/ whom she described as "the eyes, ears, and mouth for the residents". Since they provide close and intimate care for residents, PCP's are able to observe changes in their condition, such as changes in eating, ability to transfer, and general health. Reporting such changes to a Registered Nurse ("RN") is an important function performed by PCP's, as it enables the RN to follow-up by assessing the resident and by arranging for appropriate care to be provided by a nurse practitioner, physician, or other health care professional. It also enables the RN to discuss such matters with the resident's family members in order to build and maintain the trust that is very important in long term care.

The Griever was initially hired by the Home as a part-time employee, but she became a full-time employee in her fourth year of employment. Her employment at the Home



continued until November 6, 2017, when she was terminated by the Employer. That termination has also been grieved, but the termination grievance is not part of these proceedings and is being held in abeyance by the parties, pending disposition of the two grievances that I have been appointed to hear in these proceedings.

The Home has a written policy regarding abuse prevention, education, and analysis, as well as a written policy regarding abuse allegations and follow-up. Employees receive education regarding those policies as part of the new hire orientation program, and also receive re-education about them annually through a mandatory re-education session. As a result of an incident, the Grievor was also given in-service re-education regarding those policies in October of 2015, by Loida de Vera, the Home's Assistant Director of Care.

In January of 2016, the Grievor received a three-day suspension for handling a resident in an abusive manner. That suspension was grieved and in June of 2016 was reduced to a one-day suspension by a settlement of that grievance.

During the course of her employment, the Grievor also received counselling regarding the requirement of reporting to an RN various matters concerning residents, such as when she was unable to serve residents' meals on time, when a scheduled shower was not given to a resident, and when a resident's call button was not functioning. In January of 2016, she was also given counselling by Ms. Barber regarding a number of expectations, including the requirement to "report family



member's concerns to the Nurse Manager at the time they occur" . and the requirement that "communications with family members must be done in a therapeutic manner". The counseling form that both the Griever and Ms. Barber signed at the conclusion of that counselling session listed the expectations and also contained the following information:

Failure to comply will result in discipline, which could result in the termination of your employment at Villa Forum.

As a result of your behaviour we are issuing you a counselling which will be placed in your employee file. Please note that this does not form part of the disciplinary record.

Although none of that counselling forms part of the Griever's disciplinary record, it confirms that she had been made aware of those requirements, and the possible consequences of failing to comply with them.

The reasons for the Griever's five-day suspension were described as follows in the Disciplinary Action Form dated October 11, 2016, through which the Employer imposed that suspension:

On September 27, 2016, you failed to report two incidents regarding a resident to the Nurse Manager. The manner in which you spoke with a resident's family on two separate occasions that day did not display respect, courtesy and understanding. On that day also you displayed insubordination by questioning the need for repositioning of a resident. This is a violation of the Resident's Rights, Employee Code of Conduct, and the Policy and Procedure of the home. This behavior is unacceptable and will not be tolerated at Villa Forum.

The expectation is that you will report incidents to the Nurse Manager, display Courtesy, respect, understanding to families and will follow direction give you [sic]. The expectation is also that you will follow the Employee Code of Conduct, Residents Rights, and the Policies and Procedure of the home.



Accordingly the Home has decided that a Five Day Suspension is both just and warranted....

The resident referred to in that document is V.B., a 91 year old woman whose first language is Italian. She is cognitively impaired and has physical limitations. Her medical conditions at the time of the incidents included dementia, depression, diabetes, gastro-esophageal reflux disease, urinary tract infection, and traumatic subdural hemorrhage. She required total care, including assistance with eating, cleaning, dressing, and toileting. She was easily upset, and frequently made vocalizations by yelling and calling out. This occurred not only when she was startled, receiving care, or being lifted up to be transferred or repositioned, but also at other times when there was no triggering event.

At the time of the incidents, V.B. had been living at the home for over a year. Both her room and the dining room in which she ate her meals were located on the third floor of the Home. To avoid disturbing other residents, she was generally kept in her room except at mealtimes, when she was brought to the dining room in her wheelchair and placed at a designated table ("table 2"), facing towards a window and away from other residents because seeing them would bother her. The Griever had been providing PCP services to V.B. for approximately six months at the time of the events that led to her five-day suspension.

V.B.'s daughter T.R. usually visits her at the Home



every day. She typically brings food for her mother and has it heated in a microwave oven in the Home's kitchen. She is very devoted to her mother and has high expectations regarding her mother's care.

The first incident that the Employer alleges the Grievor failed to report occurred in the dining room after the Grievor brought V.B. to her table around 12:10 p.m. on September 27, 2016. After locking V.B.'s wheelchair in place by pulling the two levers which lock its wheels so that it cannot easily be moved, the Grievor went to get another resident ("A.P.") and brought her from her room to the dining room in her "geri chair", which was a padded chair with wheels and footrests. A.P.'s geri chair was larger than a normal wheelchair, as were its footrests. When the Grievor returned to the dining room with A.P. around 12:15, T.R. was seated beside her mother at table 2, giving V.B. her lunch. Whether V.B.'s wheelchair remained locked is unclear, because T.R. testified that she sometimes unlocks her mother's wheelchair but could not remember whether or not she unlocked it that day.

In order to wheel A.P. to the table where she eats (Table 5), the Grievor had to move her geri chair between table 2 and the table behind it (which is not numbered on the sketch entered as Exhibit 32 in these proceedings, but which will be referred to in this award as "table 6", for ease of reference). While she was doing so, a resident at table 6 suddenly stood up and began to move away using her walker. In



order to avoid colliding with her/ the Griever turned A.P.'s wheelchair away from that other resident. This resulted in A.P.'s wheelchair bumping into the back of V.B.'s wheelchair, and caused V.B. to yell. T.R. then said that her mom's hand had gotten hurt. The Griever said "I'm sorry", and bent over to check V.B.'s hand/ but was unable to see it because T.R. was holding her mother's hand and rubbing it. The Griever/ who was "panicking" because she feared that she might have hurt V.B.'s hand, then said "I'm going to get a nurse".

After pushing A.P.'s chair to Table 5 and locking it in place/ the Griever went to the nearby nursing station where Joanne Sacco, a Registered Nurse ("RN") who is one of the Home's Nurse Managers, was seated having her lunch. Ms. Sacco was not the Nurse Manager assigned to the third floor that day, as she had been assigned to do the admission of a new resident who was coming into the Home. Consequently/ when the Griever attempted to advise her of the dining room incident/ Ms. Sacco told the Griever that she was not on the floor, and told her to go and get one of the two RN's who were on the floor that day. Although Ms. Sacco did not recall that brief conversation, I accept the Griever's evidence that it occurred.

There is conflicting evidence about what next occurred. It was the Griever's evidence that she went to Aarti Dhumatkar, told her about the incident in the dining room, and then went with Ms. Dhumatkar to where V.B. was seated in the dining room so that Ms. Dhumatkar could examine



V.B.'s hand. The Grievor then proceeded to serve lunch to the residents. While doing so, she again told T.R. "I'm sorry".

Ms. Dhurnatkar is an RN who was employed at the Home as a Nurse Manager for approximately six months beginning in July of 2016. She left the Horne's employ during late January or early February of 2017 to avail herself of a better opportunity elsewhere. Although she was an RN, she also sometimes performed the role of an RPN at the Horne. On September 27, 2016, she was performing that role, rather than the role of Nurse Manager, which was being performed by Eleanora Audano that day. However, the Grievor was not aware of that and since Ms. Dhurnatkar was in fact an RN, there has been no suggestion that it was inappropriate for her to have been the one who assessed whether V.B.'s hand had been injured.

Ms. Dhurnatkar was the fifth and final witness called by the Employer in these proceedings. Since she had no independent recollection of what occurred that day, her testimony about it was based solely on the contents of a statement that she wrote on September 29, 2016, the pertinent part of which reads as follows:

Statement by: AARTI DHUMATKAR (Nurse Manager)

Occurrence Date: Sept. 27th, 2016 @ 12prn in Dining Room

In the Dining Room on the above mentioned date daughter of [V.B.] approached the writer stating that Usha (PCP) pushed her mother's wheelchair from the back leading to injury of the resident's left hand fingers. She mentioned her mother's arm was resting on the arm of the wheelchair and due to the push from the back it got caught between the chair and the dining table. Upon assess writer did not find any swelling, redness,



warmth or bruising in the fingers, and upon touching the fingers the resident was smiling rather than exhibiting any signs of symptoms & pain such as facial grimacing or pulling her hand out of my hand. Her capillary refill was also good which indicated proper perfusion.

After confirming that she wrote and signed that statement on September 29, 2016, Ms. Dhumatkar gave the following evidence about it (during examination-in-chief):

Q. It accurately reflects your memory of the events?

A. [The incident took place] on September 27. I wrote it on the 29th. Whatever I could remember from that date, I wrote in my statement.

Q. Are there any errors in the statement? Is everything in the statement correct?

A. Yes. The resident 's daughter approached me and that 's what she told me.

Q. It was not Usha who brought this to your attention?

A. No, it was not Usha.

Q. Did Usha report anything to you about [V.B.] that day?

A. I really don 't remember. I don't remember what happened that day other than what is in that statement.

Union counsel then objected to the admissibility of the statement, but it was ruled to be admissible, with the weight, if any, to be given to it being reserved as a matter to be addressed in final argument.

During cross-examination, Ms. Dhumatkar stated several times that she did not think that it was possible that what she wrote in her statement about who approached her regarding the incident could have been wrong. However, under further cross-examination she conceded that "if [the Grievor]



says that she approached me, it could be possible", and reiterated: "I really don't remember what happened that day". Under further questioning, she went on to say that although she does not think that it is possible that she got it wrong, she does not remember and consequently "stands by the statement".

T.R. did not testify that she was the one who alerted Ms. Dhumatkar to the dining room incident. If she had been the one who approached Ms. Dhumatkar and told her about the incident, presumably she would have indicated that during her testimony. However, when she was specifically asked (during cross-examination) "How did Aarti get there?", her answer was "Usha went to get her". During cross-examination, T.R. initially agreed that the Grievor came back with the nurse. However, she then changed her answer by stating: "Usha said 'I'll go get the nurse', then the nurse came. I don't remember if they came back together." She also stated that she "thought it was Eleanora [Audano]", but then acknowledged that she did not remember which nurse had come to examine her mother's hand.

Ms. Dhumatkar's assertion that T.R. approached her in the dining room on September 29th and told her about the incident is also inconsistent with what T.R. is recorded as having said on October 7, 2016, when she was interviewed by Scott Ridgeway, an adviser from the Chartwell labour relations department who was involved in the investigation of the incidents. His notes indicate that when he asked her whether



she reported the dining room incident to the nurse, T.R. replied/ "Not in the dining room". His notes also indicate that when he then asked her "Did you speak to the nurse in the dining room?", she replied "No".

Ms. Audano testified (during cross-examination) that around the end of the shift on September 27th, Ms. Dhumatkar told her that the Griever had reported the dining room incident to her (i.e., to Ms. Dhumatkar). However/ when that was put to Ms. Dhumatkar in cross-examination/ she stated that she did not remember that conversation.

Having regard to all of the evidence and the submissions of counsel regarding it, I find the Griever's testimony that she told Ms. Dhumatkar about the dining room incident, and then went with her to where V.B. was seated so that Ms. Dhumatkar could examine V.B.'s hand, to be more reliable than the evidence given by Ms. Dhumatkar that the Griever did not do so. As indicated above, Ms. Dhumatkar's evidence was based solely on her written statement written two days after the incident, as she had no independent recollection of that matter when she testified in these proceedings. Ms. Dhumatkar's assertion that it was T.R. who brought the incident to her attention rather than the Griever is not supported by the evidence given by T.R., and is also inconsistent with what Ms. Dhumatkar told Ms. Audano on the day of the incident. It is also inconsistent with the statement that the Griever wrote on the day of the incident, after Ms. Audano came to her later that afternoon and told her



that Ms. Barber had directed the Grievor to write a statement and then to go home. After indicating in that statement that the front wheel of A.P.'s wheelchair had bumped into the back of V.B.'s wheelchair in the dining room, the Grievor wrote: "I said sorry to [V.B.] and her daughter and went to call the nurse Arti [sic]".

For the foregoing reasons, I find that the Grievor did report the incident to Ms. Dhumatkar shortly after it occurred, so that V.B.'s hand could be assessed to determine whether it had been injured.

It is clear from the totality of the evidence that V.B.'s hand was not injured in that incident. However, it is unclear whether her hand was actually caught between her wheelchair and the table, or whether she merely yelled because she was startled by her wheelchair being bumped, and it is unnecessary to make a determination regarding that matter for purposes of this award, because the Grievor was not disciplined for bumping V.B.'s chair, nor for any discomfort that this may have caused V.B. The bases upon which she was disciplined regarding this incident were her alleged failure to report it to an RN, and the manner in which she allegedly spoke to T.R. during the incident.

The second incident that the Employer alleges the Grievor failed to report occurred in V.B.'s room after lunch. T.R. was of the view that day that V.B. needed to be repositioned in her wheelchair so that her left thigh would not be pressing against the metal. When the Grievor heard



T.R. discussing this with Ms. Dhumatkar, she volunteered to do it because V.B. was one of the residents for whom she was responsible. Repositioning a resident such as V.B. in her wheelchair is a common procedure performed by PCP's at the Home. It involves using the lift located in the resident's room to put the resident on the bed and to then put the resident back into the wheelchair. After volunteering to do the requested repositioning, the Griever asked another PCP, Roselove Laryea, to help her because performing that procedure requires the involvement of two staff members.

There is conflicting evidence about what occurred after they arrived in V.P.'s room. It was T.R.'s evidence that her mother's foot hit the wall while the Griever was turning her wheelchair in that room. She also testified as follows during examination-in-chief:

Mom yelled because her foot was hurt. Then I asked Usha, "Why are you doing this?" Usha said, "I didn't do nothing". At that point I said, "My Mom was hurt and she's yelling and you said you didn't do it. I'm right here and I saw what you've done."

T.R. further testified that after the Griever reiterated that she did not do it, Ms. Laryea intervened and said "That's enough", after which the Griever said, "I'm going to get the nurse." Ms. Laryea was not called as a witness to refute that assertion, nor to refute any of the other testimony that T.R. gave about what occurred in her mother's room that day or corroborate the Griever's version of what occurred. Consequently, it is reasonable to infer that her testimony would not have done so if she had been called as a witness.



During cross-examination, T.R. acknowledged that she did not see her mother's foot hit the wall, but maintained that the Grievor "spinned the chair around and hit her foot". She also gave the following evidence: "I heard yelling and screaming. I was right beside her. I heard her hit the wall. I said 'why did you do it' and Usha said 'I didn't do anything'." T.R. also stated during cross-examination that her mother yelled out in Italian: "Ouch, you're hurting my feet". However, during the course of cross-examination, she also offered two other versions of what her mother said: "My foot hit the wall", and "Ouch, my foot hurts".

The Grievor testified that while she was turning V.B.'s wheelchair in her room, its footrest grazed the wall. She denied that V.B. made any vocalization when this occurred. It was also her evidence that after this occurred, T.R. turned around and said, "Be careful", and then left the room. She further testified that she did not say anything to T.R. after T.R. told her to be careful. During cross-examination, the Grievor acknowledged that T.R. also said "you nearly banged or banged my mom's foot", after Employer counsel drew her attention to the fact that notes made by Nancy Guzzo, the Union's Business Manager and Secretary-Treasurer, at an investigation meeting conducted by management on October 6, 2016, indicated that this was what the Grievor related at that meeting.

After T.R. left the room, Ms. Laryea suggested that the Grievor get a nurse for the repositioning. In explaining



why she followed that suggestion, the Griever stated that although an RN is not required to be present when PCP's reposition a resident, they sometimes seek out an RN when they feel unsafe or when they want the RN to confirm that a repositioning has occurred. Since T.R. had expressed doubt that the Griever had repositioned her mother on previous occasions, and since the Griever did not want T.R. to be further upset if her mother vocalized while she was being repositioned that day, the Griever went to get the Nurse Manager in order to protect herself and Ms. Laryea by having the Nurse Manager present during the repositioning. In doing so, she was not questioning the need for repositioning V.B. Indeed, as submitted by Union counsel and not disputed by counsel for the Employer, there is no evidence whatsoever that the Griever "displayed insubordination by questioning the need for repositioning of a resident", which was one of the grounds upon which the five-day suspension was based.

The RN whom the Griever asked to supervise V.B.'s repositioning was Ms. Audano. The Griever testified that she did not tell Ms. Audano about the footrest grazing the wall "because there was no risk of harm" and because she "had Roselove there with [her]". However, she conceded in cross-examination that whether Ms. Laryea was there or not did not have anything to do with whether she had an obligation to report the incident.

Although the Griever was of the view that the wheelchair's footrest had merely grazed the wall and that



V.B.'s foot had not hit the wall, she should have reported this incident to the Nurse Manager and advised her of the accusation that T.R. had made about it, in order to make Ms. Audano aware of what had happened, and to give her an opportunity to determine whether there was any validity to T.R.'s accusation and to assess whether the resident's foot had been injured. In the context of the dining room incident, the Griever acknowledged in cross-examination that there was a requirement to get a nurse regardless of whether there had been any injury to V.B.'s hand. She also acknowledged that when a resident's family member says that a resident is injured, that must be reported to a nurse. Moreover, as indicated above, one of the Home's expectations about which the Griever was given counselling by Ms. Barber in January of 2016 was the requirement to "report family member's concerns to the Nurse Manager at the time they occur". Although that reasonable requirement applied to the incident in the room, the Griever failed to comply with it.

Shortly after the bedroom incident, T.R. telephoned her sister ("R.G.") to tell her about the incidents. This prompted R.G, who lives in Barrie, to phone the third floor of the Home and to complain to Ms. Audano, who answered the call, about the Griever "rough handling" her mother. When Ms. Audano asked her what she meant, she did not give specifics but stated that she did not want the Griever to take care of her mother. That allegation of rough handling prompted Ms. Audana to speak with Ms. de Vera, who advised her that if it



was alleged abuse, it had to be reported. Ms. de Vera further assisted her by referring to a flow chart entitled "LICENSEE REPORTING OF PHYSICAL ABUSE" created by the Ministry of Health and Long Term Care (the "Ministry"). Ms. Audano also related that allegation to Lynn Barber, who is one of the Employer's Co-Directors of Care. She then obtained a statement from the Grievor and sent her home, as instructed by Ms. Barber. She also contacted the Ministry and V.B.'s family physician. A Critical Incident Report was also filed with the Ministry, as required by the Long-Term Care Homes Act, 2007 (the "Act").

The procedure set forth in the Home's policy regarding abuse allegations and follow-up indicates that the police must be notified of abuse if it may constitute a criminal offence, and notes that police are the only authority who can determine this. At the instruction of Ms. de Vera, Ms. Audano called the police to advise them that a complaint of rough handling had been received. This resulted in someone who identified himself as a police officer named Carl telephoning the Grievor's home three times. The first call was answered by the Grievor's husband, who advised him that she was not home. The Grievor answered the second call, but declined to speak with him because the number that he was calling from was blocked and he declined to give her his badge number. In doing so, she was following advice that she had received from Ms. Guzzo, who told her not to have any conversation with anyone about the incidents unless she knew who they were. The Grievor was not home for the third call,



in which her husband told the caller that if he wanted to speak with her, he would have to see her at home or at the workplace. After that, the Griever did not hear anything more from that individual or anyone else claiming to be a police officer. Although she was never charged, those calls left her feeling anxious and frightened. They also adversely affected her sleep and appetite, but did not result in her seeking any medical attention.

The Employer took the allegations that it received from V.B.'s daughters very seriously. During the period between September 27, 2016 (when the Griever was sent home from work) and October 11, 2016 (when the Griever was given the five-day suspension), it conducted an extensive investigation, during which the Griever continued to be paid but was not permitted to return to work. When she returned to work after her five-day disciplinary suspension, she was assigned to another floor, so that she would no longer be involved in caring for V.B.

It is unnecessary for purposes of this award to detail the investigation that was carried out by the Employer, as any deficiencies in it have been cured through the hearing of this matter, in which each party had full opportunity to adduce relevant evidence and make submissions about the incidents that occurred on September 27, 2016. (See *Re ADM Milling Co. and UFCW, Local 401 (Schoenberg)* (2017), 274 L.A.C. (4th) 333 (Chankasingh), at pp, 368-9, paragraphs 114 and 115.)



As indicated above, in addition to alleging insubordination and two failures to report, the Disciplinary Action Form also identified the following as grounds for disciplining the Grievor: "The manner in which you spoke with a resident's family on two separate occasions that day did not display respect, courtesy and understanding."

T.R. testified that during dining room incident, the Griever was very angry, and did not say "I'm going to get a nurse" politely or in a nice way. However, I accept the Griever's evidence that she was not angry, but rather was afraid because of her concern that V.B.'s hand might have been injured. I am also satisfied that if the Grievor said "I'm going to get a nurse" in an abrupt manner, it reflected her concern about V.B.'s wellbeing and her consequent desire to have a nurse examine V.B.'s hand as soon as possible, and not any intentional lack of respect, courtesy, or understanding. Moreover, I accept the Griever's evidence that she said "I'm sorry" immediately after bumping V.B.'s wheelchair, and that she later repeated that apology while serving lunch to the residents.

It was also T.R.'s evidence that the Grievor was very angry during the bedroom incident when T.R. accused her of hurting V.B.'s foot and the Griever denied doing so. As indicated above, the exchange between T.R. and the Griever became sufficiently heated that it prompted Ms. Laryea to intervene by saying, "That's enough". Although it is understandable that the Griever would have been troubled by



what she perceived to be a false accusation by T.R. that she had hurt her mother's foot, that did not excuse her from being respectful and courteous to T.R.. It is clear from her evidence that the Grievor was aware that PCP's were not permitted to argue or have disputes with residents or their families, but the evidence indicates on the balance of probabilities that she nevertheless did so on that occasion.

As indicated above, the Union also contends that the suspension of the Grievor constituted age discrimination prohibited by the Ontario Human Rights Code. The evidence indicates that the Grievor, who was sixty-two years old at the time of her suspension, was one of the oldest persons in the bargaining unit, which included about 235 employees, of whom only about five to ten were in their sixties. However, as submitted by Employer counsel, that is not enough to ground a finding of discrimination, nor is there any basis for drawing an inference that the Grievor was targeted for discipline in whole or in part because of her age, as contended by Union counsel.

The standard of care that may reasonably be expected from employees of long term care facilities such as the Home was aptly described in *Re Baptist Housing Society (Grandview Towers) and Hospital Employees' Union, Local 180* (1982), 6 L.A.C. (3d) 430 (Greyell), at page 37:

A much higher standard of conduct is expected from employees in the health care field than in other occupational fields. In this industry arbitrators are required to have regard not only to the interests of the grievor and of the employer but also must have regard to the public interest. Both employer and



employee are reposed with a public trust for which they are held accountable.

The public trust is onerous. In broad terms it is a charge of responsibility for the physical and emotional comfort of a member of our society who is unable to live independently. The institution and no less its employees, in addition to regular duties assume a role which may best be described as similar to that of a "surrogate" family. This is particularly so in a facility such as Grandview which strives to be a "home" for elderly residents. Because of the public trust reposed in him, when an employee enters the health care field he must do so with considerable ability to understand human frailty and with a gargantuan tolerance of aberrant and unpredictable behaviour that often attends the infirm or elderly.

See also *Hampton Court and British Columbia Government and Service Employees* (1998), 54 C.L.A.S. 56 (Laing).

It is common ground between the parties that, as indicated in *Re Henrickson Spring - Stratford Operations and USW, Local 8773 (Avey)* (2015), 361 L.A.C. 401 (Wilson), at page 411, in disciplinary cases it is first necessary for an arbitrator to determine whether there was just cause that warrants discipline. If there was just cause for discipline, then the arbitrator must determine whether the Employer's response was appropriate and whether there are any mitigating factors that would warrant a reduction in the disciplinary penalty.

As indicated above, although the Griever duly reported the dining room incident, she failed to report the incident that subsequently occurred in the resident's room. Failure to report an incident is of greater concern in a health care or long term care setting than it is in some other employment settings because of the consequences that can flow



from such failure: see, for example, *Hampton Court and B.C.G.E.U. (P. Arnesto Grievance)* (1998), 51 C.L.A.S. 459 (McKechnie). Consequently, the Griever's failure to report that incident constituted just cause for disciplinary action, as did her failure to display courtesy and respect in her communications with T.R. during that incident.

Since there was just cause for disciplinary action, it must be determined whether the imposition of a five-day suspension was appropriate or whether a lesser penalty should be substituted for it in the circumstances of this case.

The Employer has established that the Grievor failed to report the incident in the V.B.'s room, and has also established that the Grievor failed to display courtesy and respect in her communications with T.R. during that incident. However, it has not established that she failed to report the dining room incident, nor that the manner in which she spoke to T.R. during that incident warranted the imposition of discipline. Moreover, as indicated above, no evidence whatsoever was adduced in support of the serious allegation that the Grievor "displayed insubordination by questioning the need for repositioning of a resident", which was one of the grounds upon which the five-day suspension was based.

At the time of the dining room incident, the Griever had been employed at the Home for over eight years. If her employment record had been free of discipline throughout that period, I would have been inclined to substitute a suspension of at most two days. However, the Grievor cannot rely upon a



clear employment record as a mitigating factor in this case.

Article 10.03 of the parties' collective agreement provides:

Any letter of reprimand, suspension or other sanction will be removed from the record of an employee eighteen (18) months following the receipt of such letter, suspension or other sanction provided that the employee's record has been discipline free. Any third party interactions shall remain on the employees [sic] file, for a period of 36 months, provided there are no other incidents.

As submitted by Employer counsel, a clause of that type, which is commonly referred to as "sunset" clause, is a doubled-edged sword in that it precludes the Employer from relying on discipline imposed prior to the time periods specified but, unless it is waived, also precludes the Union from asserting that the Griever has a clear record for the length of her employment in arguing for mitigation of a disciplinary penalty: see *Rothsay and C.E.P., Local 39-X (Grievances of Bill Redpath)* (2001), 64 C.L.A.S. 225 (Tacon), at paragraph 53. That provision has not been waived in the instant case. Moreover, the Griever had a previous suspension that had not yet been removed from her record by Article 10.03 when she was given the impugned five-day suspension on October 11, 2016. As indicated above, in January of 2016, the Griever received a three-day suspension for handling a resident in an abusive manner. That suspension was grieved and in June of 2016 was reduced to a one-day suspension by a settlement of that grievance. That one-day suspension remained on her record at the time of her five-day suspension, and its presence makes the principle of progressive discipline



relevant in determining what penalty seems just and reasonable in all of the circumstances, pursuant to section 48(17) of the *Labour Relations Act, 1995*, which provides:

Where an arbitrator or arbitration board determines that an employee has been discharged or otherwise disciplined by an employer for cause and the collective agreement does not contain a specific penalty for the infraction that is the subject matter of the arbitration, the arbitrator or arbitration board may substitute such other penalty as to the arbitrator or arbitration board seems just and reasonable in all the circumstances.

The penalty that seems just and reasonable in all of the circumstances of this case is a three-day suspension. Accordingly/ the Employer is hereby directed to remove the five-day suspension dated October 11, 2016, from the Griever's employment record and to substitute a three-day suspension. The Employer is hereby further directed to compensate the Griever for all wage and benefit losses that she suffered during the two days that have been removed from her suspension. I shall remain seised for the purpose of quantifying those losses in the event that the parties are unable to agree upon the amount of those losses.

DATED at Burlington, Ontario, this 26th day of March, 2018.

  
Robert D. Howe  
Sole Arbitrator

