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Public Service Labour Relations Act

Before the Public Service Labour Relations Board

BETWEEN

JOHN MAAS AND ED TURNER

Grievors

and

DEPUTY HEAD
(Correctional Service of Canada)

Respondent

Indexed as
Maas and Turner v. Deputy Head (Correctional Service of Canada)

In the matter of individual grievances referred to adjudication

REASONS FOR DECISION

Before: Steven B. Katkin, adjudicator

For the Grievors: Sylvain Beauchamp, counsel

For the Respondent: Karl Chemsi, counsel

Heard at Kingston, Ontario,
July 6 to 9, 2010.

I. Grievances referred to adjudication

[1] On May 29, 2009, John Maas and Ed Turner ("the grievors"), who were both at the relevant time Correctional Officers, classified CX-01, at the Regional Treatment Centre - Ontario Region (RTC) in Kingston, Ontario, filed grievances relating to the imposition of discipline in the form of a financial penalty equivalent to two days' pay. The remedial measures claimed by each grievor include a declaration that the discipline was void *ab initio*, the retraction of the disciplinary measure, the reimbursement of sums due and other rights under the relevant collective agreement, together with moral or exemplary damages to be applied retroactively with interest.

[2] The letters of discipline addressed to each grievor, dated May 11, 2009 and signed by Brian Trainor, Acting Deputy Warden, RTC, are identical and read in part as follows:

> *A disciplinary fact finding investigation was completed and you were provided with a copy of this report. As a result of information obtained from the fact-finding investigation a disciplinary hearing was held on April 22, 2009.*
>
> *Based on the information contained in the Disciplinary Fact-Finding Report and the Disciplinary Hearing, I have concluded that you violated the Correctional Service of Canada's Code of Discipline by committing the following infractions under the Code of Discipline:*
>
> > *5f) "fails to take action or otherwise neglects his or her duty as a peace officer";*
> >
> > *5g) "fails to conform to, or to apply, any relevant legislation, Commissioner's Directive, Standing Order, or other directive as it relates to his or her duty";*
>
> *The information obtained from the disciplinary investigation and hearing confirms that you entering the cell on December 15, 2008 and failed to initiate CPR/First Aid without delay as indicated in the Commissioner Directives. These infractions constitute a serious misconduct under the Code of Discipline.*
>
> *You acknowledged that your actions was inappropriate and would not be repeated.*
>
> *Your actions in the above situation are not consistent with the expectations of a Public Servant and Correctional Officer employed by the Correctional Service of Canada. Public servants shall act at all times in a manner that will bear the closest public scrutiny. Behaviour, both on and off duty, shall reflect positively on the Correctional Service of Canada and on the Public Service generally. All staff are expected to present themselves in a manner*

> *that promotes a professional image, both in their words and in their actions.*
>
> *However, I have taken into account your declaration, which indicated that you had learned from your mistakes. I note that you have no record of previous disciplinary infractions.*
>
> ***In order to acknowledge the seriousness of your misconduct and to encourage you to correct your behaviour I am imposing a financial penalty of three hundred and twenty dollars ($320).***
>
> . . .
>
> [*Sic* throughout] [Emphasis in the original]

[3] The grievances were referred to adjudication on September 4, 2009. In the references to adjudication, the grievors cited paragraph 209(1)(*b*) of the *Public Service Labour Relations Act,* S.C. 2003, c.22 ("the *Act*"), as the provision applicable to the subject matter of their grievances. That provision reads as follows:

> ***209.*** *(1) An employee may refer to adjudication an individual grievance that has been presented up to and including the final level in the grievance process and that has not been dealt with to the employee's satisfaction if the grievance is related to*
>
> . . .
>
> *(*b*) a disciplinary action resulting in termination, demotion, suspension or financial penalty;*

[4] Shortly after that, the bargaining agent, the Union of Canada Correctional Officers – CSN, which was of the view that the grievances did not include the disciplinary actions that had been imposed on the grievors, requested an extension of time to file further grievances. The employer refused. The grievors then filed new grievances and applied for an extension of time to file them.

[5] In *Seale et al. v. Deputy Head (Correctional Service of Canada)*, 2010 PSLRB 21, the Public Service Labour Relations Board ("the Board") ordered the original amended grievances to include "the discipline imposed" on each grievor. At paragraph 16, the adjudicator stated the following:

> *. . .I should note that the order amending the grievances is only for greater certainty. Absent an amendment, the disciplinary actions would still be properly before an adjudicator at a hearing of the original grievances.*

Accordingly, the disciplinary actions detailed in the grievances are properly before me.

II. Preliminary issues

[6] On June 30, 2010, counsel for the grievors applied to the Board for the disclosure of certain documents concerning the individuals involved in the incident in question. As some issues about the disclosure remained outstanding on the first day of the hearing, I held a pre-hearing conference with counsel.

[7] Among the documents sought by counsel for the grievors were the unredacted fact-finding reports concerning the two nurses involved in the incident, as well as the letters of discipline that had been issued to them. The basis for the disclosure request was that the different directives pertaining to the RTC set out the interaction between Health Services Staff and other staff.

[8] Counsel for the employer objected on the ground that any discipline that may have been imposed on the nurses was irrelevant to the discipline imposed on the grievors. He further stated that there was but one fact-finding report, which covered the grievors and both nurses.

[9] Under paragraph 8(2)(*c*) of the *Privacy Act,* R.S.C. 1985, c. P-21, I ordered the production of the unredacted fact-finding report, which includes the details of the involvement of the two nurses in question, subject to its admissibility as to relevance. That paragraph reads as follows:

> ***8.*** *(2) Subject to any other Act of Parliament, personal information under the control of a government institution may be disclosed*
>
> (c) *for the purpose of complying with a subpoena or warrant issued or order made by a court, person or body with jurisdiction to compel the production of information or for the purpose of complying with rules of court relating to the production of information;*

[10] With respect to the application for the disclosure of the letters of discipline issued to the nurses, I ordered the employer to disclose them to counsel for the grievors, to be reviewed by him personally, without communicating their contents in any manner whatsoever to his clients or to anyone else. Once he had done so, counsel for the grievors was to inform me whether he wished to pursue his application for disclosure, in which case I would examine the letters in the presence of counsel and rule on their admissibility. Following his review, counsel for the grievors withdrew his application for the disclosure of the disciplinary notices issued to the nurses.

III. Summary of the evidence

[11] Counsel for the employer called two witnesses, Noel Napier-Glover, Nurse Supervisor, and Mr. Trainor, Acting Deputy Warden when the discipline was imposed. Counsel for the grievors called Katherine Hinch to testify under a *subpoena duces tecum* ("subpoena for producing evidence") issued at his request, and both grievors.

A. For the employer

[12] Noel Napier-Glover has occupied the position of Nurse Supervisor at the RTC for the last three years, the first of which was in an acting position. Ms. Napier-Glover, who holds degrees in both nursing and psychology, graduated as a nurse in 1987 and joined the Correctional Service of Canada (CSC) in 1994.

[13] Ms. Napier-Glover described the RTC as a mental health facility accredited under the Ontario *Mental Health Act*, R.S.O. 1990, c. M.7, and as having approximately 143 beds. While located within the walls of Kingston Penitentiary ("the penitentiary"), it is considered a separate institution, but it shares some services with the penitentiary. The RTC treats federally incarcerated male offenders from all Ontario institutions who experience psychiatric problems. Ms. Napier-Glover explained that, save for involuntary admissions under the *Mental Health Act*, all offenders are admitted to the RTC only voluntarily. She explained that, while the penitentiary is a maximum security institution, the RTC is a multi-level institution.

[14] Ms. Napier-Glover stated that the RTC staff is multi-disciplinary. In addition to correctional officers, there are approximately 40 nurses, both registered nurses (RN) and registered practical nurses (RPN), psychologists, psychiatrists, social workers, occupational therapists, parole officers, personal support workers, chaplaincy employees, and others. Nurses and correctional officers frequently interact.

[15] Ms. Napier-Glover explained that nurses are expected to make rounds both during the day and during the night but not at set times. Should a nurse require access to a cell, a correctional officer must be contacted.

[16] Ms. Napier-Glover became involved in the matter at issue when she was directed by the then Executive Director of the RTC, Gerry Henderson, to conduct an administrative investigation into the incident. The investigation arose out of concerns

raised about the response to an inmate found lying unresponsive on the floor of his cell, particularly to the rapidity of the response and whether it conformed to the CSC's *Commissioner's Directives* (CD). She carried out the investigation with Les Jung, then a correctional manager.

[17] Before undertaking the investigation, Ms. Napier-Glover had access to the reports ("Officer's Statement/Observation Report") (Exhibit E-1, Tab 6) completed by the four employees involved in the incident, namely, the grievors and the two nurses, one a RN and the other a RPN. She also had a copy of the video recording from the inmate's cell camera.

[18] Ms. Napier-Glover stated that a camera is in every cell in the corridor containing the inmate's cell. The purpose of the cameras is for observation, as required. Observations are made when, among other things, an inmate is in crisis or may harm himself, or otherwise calls attention to himself. The cameras record continuously and the images are kept for five to seven days. She stated that the Security Control Office has two monitors, each split into nine frames, each frame representing a single cell. At the time of the incident, the cameras were not monitored on a 24-hour basis.

[19] During Ms. Napier-Glover's testimony, I viewed the video of the incident recorded by the camera located in the inmate's cell (Exhibit E-2). The recording shows the inmate on the floor of his cell, his detection by the RPN during her rounds and the interventions by the grievors and nurses until the arrival of the paramedics. The first part of the video depicts the inmate's movements for a time before and including his fall to the cell floor. That portion of the recording is of no relevance to the matter before me, as the employees involved in the incident were not and could not have been aware of the cause of the inmate being on the floor of his cell or the length of time he had been in that position.

[20] Ms. Napier-Glover and Mr. Jung viewed the video a number of times to establish a chronology of events and a baseline for their fact-finding investigation. She stated that their undated report (Exhibit E-1, Tab 9) was submitted in March 2009. The report comprised the investigators' methodology, a profile of the inmate, the profiles of the grievors and nurses interviewed, an analysis of their findings, and the documents referred to, including *Standing Orders*, *Commissioner's Directives* and employee records. The report highlighted that the grievors entered the inmate's cell, secured the area, determined that the inmate was unresponsive and did not initiate

cardiopulmonary resuscitation (CPR). Ms. Napier-Glover said that the interviews with the employees involved were conducted individually and that they were informed that they were entitled to union representation. Each employee viewed the cell camera video during his or her interview.

[21] Ms. Napier-Glover testified that, during his interview, Mr. Turner mentioned that a brief discussion had taken place among the staff as to whether an active DNR (Do Not Resuscitate) order applied to the inmate. Mr. Turner had not mentioned that discussion in his report; nor had it been mentioned in the reports of Mr. Maas and the two nurses. Ms. Napier-Glover stated that the inmate at one point had a DNR order on his medical chart but that, on the night of December 15, 2008, the employees were unaware whether it was still active. While the grievors were on their way to the cell, the nurses were reviewing the inmate's records. Mr. Turner had questioned whether legal repercussions would take place if he began CPR when a DNR order was in place.

[22] Mr. Turner said that he knew the inmate well and that he was aware that the inmate sometimes stopped breathing while asleep. He didn't want to risk waking him and being assaulted, as he knew the inmate could be very dangerous. He didn't initiate CPR, as he was awaiting information from the nurses as to the inmate's DNR status. Ms. Napier-Glover explained that correctional officers, but not nurses, are required to carry a CPR device called a Talott mask on their belts. Mr. Turner said that he did not offer it to the RPN because he thought that the emergency medical equipment was on its way. During the interview, Mr. Turner stated that, as a result of the incident, he would in future initiate CPR without delay, as he was made aware that CPR can be begun without legal repercussions concerning a DNR order.

[23] With respect to her interview with Mr. Maas, Ms. Napier-Glover stated that he told her that, since his arrival at the RTC in 2004, he was certain that the inmate was a DNR case, which meant that initiating CPR was not required. He further stated that, according to the *Commissioner's Directives*, once a Health Services employee is on the scene, that employee is in charge of the situation. As Health Services employees are always present at the RTC, he did not feel that he had to initiate CPR, and he was unaware what commencing CPR would mean when the individual concerned was under a DNR order. Mr. Maas did not check for vital signs, as the inmate might have been asleep and he was potentially dangerous. He thought that the RPN was right behind him as he went to the cell. Mr. Maas mentioned that the RPN stated that "we will have

to start CPR," which he interpreted as meaning that the nurses would be starting CPR, if required. Mr. Maas did not consider that he was a first responder, since the RPN was first at the cell, although he acknowledged that she could not enter the cell until it was unlocked by the correctional officers. Mr. Maas did not offer his Talott mask to the RPN because he thought that the emergency medical equipment was on its way, which contained better equipment than his mask.

[24] The report found that the grievors violated the policy governing responding to medical emergencies, which requires that CPR be initiated even in the absence of vital signs. The policies and specific provisions referred to by the witness were *Commissioner's Directive 800, Health Services*, clauses 26(a) and (b) (CD-800); *CD-843, Prevention, Management and Response to Suicide and Self-injuries*, clauses 28(a) and (b) (CD-843); *CD-567, Management of Security Incidents*, paragraphs (a) and (b) of clause 18 entitled "Medical Emergency Situations" (CD-567). Since the wording of each of those provisions is identical, I will reproduce as follows the relevant extract from CD-800:

> *26. In responding to a medical emergency, the primary goal is the preservation of life and each staff member has an important role to play:*
>
> *a. non-Health Services staff arriving on the scene of a possible medical emergency must immediately call for assistance, secure the area and initiate CPR/first aid without delay;*
>
> *b. responding non-Health Services staff must attempt CPR/first aid where physically feasible even in cases where signs of life are not apparent (the decision to discontinue CPR/first aid can be taken only by authorized health personnel or the ambulance service in accordance with provincial laws);*

Ms. Napier-Glover stated that the grievors are non-Health Services staff. In her view, they are first responders, as they are the first people who can physically enter a cell, since they have the key. Although the RPN was first at the inmate's cell, she was not the first responder, as she couldn't enter the cell.

[25] Ms. Napier-Glover testified that the grievors' only explanation for not checking for the inmate's vital signs was that he was dangerous and that they feared he might assault them. A correctional officer's job is to determine if an inmate is awake, asleep, dead or playing dead. With respect to Mr. Maas's statement that CPR was not initiated

because the grievors were awaiting word on the inmate's DNR status, Ms. Napier-Glover referred to the following provisions of the above-mentioned CDs: CD-800, clause 26(c); CD-843, clause 28(c); and CD-567, clause 18(c). Those provisions are identical, with the following extract drawn from CD-800, clause 26(c):

> *26 c. initiation of CPR by non-Health Services staff is not required in the following situations:*
>
> . . .
>
> - *the non-Health Services staff are aware of a DO NOT RESUSCITATE (DNR) order (responding non-Health Services staff shall verify if a DNR order exists as per the CSC Palliative Care Guidelines)*
>
> [Emphasis in the original]

[26] The relevant provisions of the CSC *Palliative Care Guidelines* referred to by Ms. Napier-Glover are found under the section entitled, "Do Not Resuscitate Procedure (DNR)," and read as follows:

> *16) Nurses shall transcribe DNR orders on the patient's Health Care Record, on the patient's Kardex, and on the Census Board in the Unit Office to ensure all appropriate personnel know the patient's wishes and the health team's decision in this regard.*
>
> . . .
>
> *22) The nurse shall transcribe the DNR order onto the patient's Health Care Record, on the patient's Kardex, and on the Census Board in the Unit Office. A copy should also be posted in the offender's cell.*
>
> . . .
>
> *28) All DNR orders shall be automatically reviewed and either stopped or re-ordered once per month.*

Ms. Napier-Glover testified that the inmate's DNR order was not posted on the unit's census board or in his cell. She stated that, whether or not an active DNR order is in effect, vital signs should be checked to determine a line of care. Based on her analysis of the investigation, the grievors should have begun CPR.

[27] Asked by counsel for the employer whether the fact-finding investigation found any violations of policy by the nurses involved in the incident, Ms. Napier-Glover replied in the affirmative. The investigation report states that both nurses violated provisions of the above-cited CDs. Ms. Napier-Glover stated that the nurses failed to provide direction to the grievors by not requesting their Talott masks and by not

directing them to begin CPR. Accordingly, the nurses were found in violation of the following provision of CD 060 - *Code of Discipline*: "5g) fails to conform to, or to apply, any relevant legislation, Commissioner's Directive, Standing Order, or other directive as it relates to his or her duty."

[28] Ms. Napier-Glover asserted that the fact that the nurses had violated policy did not detract from the fact that the grievors were the first responders to the medical emergency. While the grievors were securing the cell, the nurses were retrieving the medical equipment. As they were unaware how quickly the nurses would arrive, the grievors should have immediately commenced CPR.

[29] In cross-examination, Ms. Napier-Glover stated that, in carrying out the investigation, her role was to gather facts, analyze them and outline where errors were made, if any. She had no role in imposing the discipline.

[30] Ms. Napier-Glover stated that when, as in this case, an inmate dies while in custody, a coroner's inquest is held, and a board of investigation is created. She was unaware whether a board of investigation had been convened in this case.

[31] Asked whether she had access to video recordings of the corridor outside the inmate's cell, Ms. Napier-Glover said that she did not know whether recordings of the corridor had been made and that she had not requested the view from that camera.

[32] Although not a CPR instructor, Ms. Napier-Glover acknowledged that CPR training did not include a significant portion devoted to DNR orders. Asked whether nurses are trained for DNR orders, the witness responded that provincial legislation and CSC policies exist about them, and added that staff are to follow the policy of the institution at which they are employed. As for the inmate, Ms. Napier-Glover was unaware of the period when a valid DNR order applied to him. At the time of his death, and for some years prior, no DNR order was in his records or posted in his cell. She stated that a sticker next to an inmate's name on the unit census board indicates a valid DNR order. Although the inmate's health records could be accessed only by Health Services staff, correctional managers and staff could refer to the census board. The evidence disclosed that on the night of the incident, no such sticker was placed next to the inmate's name on the unit census board.

[33] When asked how staff are notified that a DNR order is no longer in effect, Ms. Napier-Glover replied that the sticker is removed from the census board. She acknowledged that no memo is sent to staff, as that is not required by the *Palliative Care Guidelines*. She was not involved in the DNR order not being renewed for the inmate, and the validity of a DNR order for the inmate was not part of the fact-finding investigation.

[34] Ms. Napier-Glover stated that, during their interviews, the grievors and the nurses referred to the discussion that had taken place about the inmate's DNR order, even though no reference to such a discussion was in the reports that each individual prepared on the night of the incident. She found no inconsistency in the statements of the four employees concerning the DNR order.

[35] Counsel for the grievors referred Ms. Napier-Glover to the final paragraph of the "Findings" section of the fact-finding report, which reads as follows:

> *9. There is a misconception on the* [*sic*] *behalf of many of the staff at RTC that, because nurses are on duty at all times at RTC, CPR/first aid should not be initiated unless direction is given by Health Services Staff. The board has spoken to the current institutional instructor of CPR/first aid and she confirms this misconception is present. The instructor states that she is highlighting the applicable CD's in her training to heighten awareness of the staff's roles and responsibilities in the preservation of life in medical emergency situations.*

[36] She stated that, although that paragraph was taken into consideration in arriving at the conclusions of the investigation, CD-800 was also taken into account. Although the staff had that misconception, CD-800 sets out the procedure to be followed in a medical emergency. She referred to the following three issues in the chronology of events of the incident: the grievors were first to enter the cell, they observed that the inmate was unresponsive and they did not initiate CPR.

[37] When referred in cross-examination to the finding that the nurses had failed to provide direction to the grievors, Ms. Napier-Glover stated that the CDs provide direction to the correctional officers and that they are all trained in CPR. She stated that the first responder who enters the cell is responsible for checking for vital signs.

[38] Mr. Trainor has been Assistant Warden - Operations at the Joyceville Institution since May 2009. He began his employment with the CSC in August 1997; before that, he had been employed in provincial corrections for two years. From 1997, he worked

at Kingston Penitentiary, where he occupied the positions of Correctional Officer II, Acting Parole Officer and Correctional Supervisor. He worked at the RTC from December 2007 until May 2009, where he occupied the following positions successively: Correctional Supervisor, Unit Manager, Manager-Operations and Acting Deputy Warden.

[39] Asked to comment about the interaction between correctional officers and nurses on a typical day, Mr. Trainor said that, on arriving at work, correctional officers report to a correctional manager for duty and assignment to a post. The correctional officers would discuss any health care issues concerning inmates with Health Services staff and then plan their day. Although they report through separate lines of authority on paper, correctional officers and health care staff work together. Correctional officers carry out their security functions according to the CDs and conduct security patrols at least hourly, more frequently in certain circumstances on instruction by Health Services staff. The purpose of the security patrols is to ensure that the inmates in the cells are alive and to engage the inmates in conversation about different issues.

[40] As for the procedure to follow when a problem occurs in a cell, Mr. Trainor stated that two correctional officers must be present to enter a cell. As for medical emergencies, he referred to clause 18(h) of CD-567, which reads as follows:

> *18 h. for maximum, medium and multi-level security facilities, it is expected that a minimum of two (2) staff members are present at the cell and one (1) additional staff member is observing from the control post, the head of the range or another pre-identified observation area to ensure a safer response when entering a cell during a medical emergency;*

Mr. Trainor stated that, at the RTC, nurses are considered staff members, and as such, they can be observers for the purpose of this procedure. Correctional officers are responsible for following the protocol set out in the different CDs, as cited earlier in this decision.

[41] Mr. Trainor was delegated by the Executive Director of the RTC to review the fact-finding investigation report, the cell camera video and any relevant documentation and to conduct disciplinary hearings with the grievors. He found the report factual, and he agreed with the findings, subject to his discussion with the grievors. According to Mr. Trainor, the grievors did not respond to the medical emergency in accordance with the procedures stipulated in the CDs, and the cell camera video corroborated the investigation report on that point. The grievors were the first in the cell. They left

without checking the inmate for vital signs, and they failed to initiate CPR. Referring to the grievors' training summaries (Exhibit E-1, Tab 4), Mr. Trainor indicated that both grievors had been current in their CPR and first aid training.

[42] The work description for the grievors' position, classified CX-01 (Exhibit E-1,Tab 5), particularly the key activities, include the following under the rubric of contextual knowledge:

> *Administers cardiopulmonary resuscitation (CPR) in response to medical emergencies and lends immediate support and assistance, once the area is secure, to injured parties as required*
>
> . . .

The work description also stipulates that incumbents are required to have knowledge of CSC directives, policies and protocols. Mr. Trainor stated that the grievors had signed forms acknowledging receiving the CSC *Code of Discipline* (Exhibit E-1, Tab 5) and that, during his meeting with the grievors, no dispute arose concerning their knowledge of procedures.

[43] On April 22, 2009, Mr. Trainor met separately with each grievor. The grievors were accompanied by a union representative, and a correctional manager was also present. He had issued letters addressed to each grievor, enclosing a copy of the fact-finding investigation report and informing them that they were to attend a disciplinary hearing on April 22, 2009 (Exhibit E-1, Tab 8). The letters invited the grievors to ". . . submit any comments, preferably in writing. . ." at the disciplinary hearing. Both grievors acknowledged receiving the undated letters on April 20, 2009. Mr. Trainor wasn't certain whether the grievors had been provided with an unredacted or a redacted version of the fact-finding report but thought the latter more likely. He was aware that the grievors had viewed the cell camera video during their fact-finding interviews.

[44] Mr. Trainor informed the grievors of the purpose of the meeting and asked them for their views of the report and their responses to the incident. He also ascertained their knowledge of CSC policies and directives, inquired whether the grievors thought they had done anything wrong and inquired whether they would do anything different if faced with the same situation. Mr. Trainor recorded notes during his meetings with the grievors (Exhibit E-1, Tab 10).

[45] Mr. Trainor stated that both grievors agreed that they had no concerns with the details set out in the fact-finding report and that they were aware of the directives. Both grievors said that they would commence CPR when faced with a similar situation. Both grievors said that they hesitated during the incident and didn't immediately commence CPR in part because they were confused about whether a DNR order applied to the inmate. Although the grievors explained that they were not the first responders since the RPN was first at the cell, Mr. Trainor disagreed, as it was clear from the video that the grievors had been the first to enter the cell. During the disciplinary hearing, Mr. Maas said that he didn't realize that he had been the first responder until he viewed the video.

[46] Mr. Trainor was referred to the section of the fact-finding report that details that Mr. Maas told the investigators that he thought that the RPN was right behind him as he went to the cell and her statement that "we will have to start CPR." Mr. Maas had interpreted that statement as meaning that the nurses would start CPR, if required. Mr. Trainor replied that, in his analysis, the grievors' interpretation was wrong and that the RPN's statement was a cue for the grievors to begin CPR. Mr. Trainor testified that the grievors should have entered the cell, secured the area and begun CPR. He stated that it wasn't the RPN's responsibility to start CPR, as she wasn't the first to enter the cell.

[47] When asked about the grievors' explanation that the inmate was dangerous, Mr. Trainor agreed that, although the inmate was a high risk for aggression, it was part of the job for correctional officers. Mr. Trainor referred to the cell camera video and said that the grievors made no attempt to check for vital signs during the one to two minutes that they were alone with the inmate.

[48] Mr. Trainor said that the DNR order was irrelevant to his consideration of appropriate discipline, unless the order was clearly posted or the nurses directed the grievors not to perform CPR. He stated that, had a DNR order been in effect, it would have been communicated to staff in conformity with CD-800, clause 26(c). Mr. Trainor said that correctional officers should update their awareness of DNR orders daily when they meet with the nurses. If there is any doubt, clarification could be obtained from a supervisor. He said that there is no indication of a valid DNR order for the inmate in the investigation report, and accordingly, the grievors should have begun CPR, as all applicable directives and policies indicate that life should be preserved.

[49] Addressing the disciplinary measure imposed on the grievors, Mr. Trainor stated that, based on the fact-finding report and the video, he was of the view that the grievors' conduct was serious and that it warranted discipline ranging from a financial penalty to suspension or, possibly, termination of employment. He found that the grievors had violated the *Code of Discipline*, as set out in the letters of discipline. Mr. Trainor stated that there were substantial mitigating factors arising out of the disciplinary hearings with the grievors, as follows, which he took into consideration in deciding the quantum of discipline: the grievors had no disciplinary record, they had learned a valuable lesson and they would do things differently if the situation arose again. Mr. Trainor stated that those very positive points led him to impose a penalty that, in his view, was lenient.

[50] Mr. Trainor reviewed the fact-finding report, the video, the guidelines to conducting disciplinary hearings, the applicable collective agreement and the Global Agreement between the CSC and the bargaining agent (Exhibit G-1, Tab 3) ("the Global Agreement"), as well as the relevant CDs. When questioned about cameras other than those in the cells, Mr. Trainor stated that he was aware of the cameras that provided a view of the ranges outside the cells. He said that they were useful for reviewing incidents that had taken place on the range. He did not review the range cameras for this incident and did not know whether anyone else had.

[51] Upon viewing the cell camera video, the most significant moment for Mr. Trainor was the grievors leaving the cell without performing CPR. When he asked the grievors for an explanation during the disciplinary meetings, they said that they had been confused. He asked for their version of the events, and the grievors stated that all the facts were contained in the fact-finding report.

[52] When asked in cross-examination to explain the matter of the DNR order from his perspective, Mr. Trainor replied that, in his view, it wasn't relevant, as the grievors are trained and the CDs are clear. Although he took the grievors' confusion about the DNR order into account in the decision-making process, in the absence of a clear directive not to resuscitate, life should be preserved. With respect to any potential disciplinary repercussions arising out of performing CPR when a DNR order exists, Mr. Trainor stated that, in this particular case, as staff had indicated that they were unaware whether a DNR order existed, there would not have been any repercussions.

[53] When questioned on his decision-making process concerning the selection of a disciplinary measure, Mr. Trainor stated that he first considered whether the incident constituted severe misconduct and discussed the matter with a labour relations advisor. He also discussed the matter with Mr. Henderson, the executive director, who believed that it was severe misconduct. In view of the grievors' absence of disciplinary records and their statements at their disciplinary meetings that they had learned from the incident and that they would act differently in the future, Mr. Trainor favoured a more lenient disciplinary measure. The discipline imposed was meant to be corrective, and he felt that it was appropriate in the circumstances. In selecting a two-day financial penalty, Mr. Trainor said that he considered the following provisions of the Global Agreement:

> ***III-A – DISCIPLINE***
>
> ***(REFERENCE: ARTICLE 17)***
>
> *For the purpose of these provisions, CSC will apply the following:*
>
> 1. *After CSC assesses all viable sanctions for a disciplinary offence, and decides to use a financial penalty as a disciplinary measure, the following applies:*
>
>   a) *For a first offence, an amount of one hundred sixty dollars ($160) for a Correctional Officer 1. . .*
>
> 2. *In the case of severe misconduct at any time, if CSC decides that the most appropriate sanction for a disciplinary offence is a financial penalty, the maximum that may be imposed is six hundred forty dollars ($640) for a Correctional Officer I . . . which represent[s] four (4) days of pay. In this circumstance the graduated scale of financial penalties does not apply.*

As stated in its preamble, the Global Agreement is intended to clarify certain provisions of the collective agreement governing correctional officers (Exhibit G-1, Tab 1).

B. <u>For the grievors</u>

[54] Ms. Hinch had been the deputy warden of the RTC since May 2009 and, at the time of the hearing, was Acting Executive Director. She was summonsed to appear with a copy of the video pertaining to the incident, downloaded from the range camera. Ms. Hinch stated that the video did not exist and that she had taken measures to verify

its existence both internally and with the company that maintains the RTC's recording devices.

[55] Ms. Hinch stated that, in terms of CSC policies and directives, videos are reviewed and determinations made by the executive director concerning their relevance. She said that determination has to be made within five days of the given event, after which the video is lost, and there is no backup. Circumstances for reviewing the range camera video within the five-day period include medical emergencies, incidents on the range, altercations between inmates, self-injuries or any other reportable incident. Range cameras record continuously. On the range outside the cell of the inmate in question, a camera is at each end, permitting a view of the entire range outside the cells.

[56] Ms. Hinch stated that, if an inmate died in a cell where a cell camera was recording, the video of the cell camera would be retained, as it clearly shows actions taken in response, which would not be apparent from the range camera. She conceded that the cell camera does not provide a view of what occurs on the range.

[57] John Maas began working with the CSC in 2004, classified CX-01, and has been continuously employed in that position at the RTC since then.

[58] On the night of the incident, December 15, 2008, Mr. Maas was assigned to the overnight shift, from approximately 10:30 to 06:30. Staffing on that shift consisted of three correctional officers, two of whom, namely, the grievors, were posted to the Security Control Office on the floor where the inmate's cell was located. In addition, there were two nurses, an RN and an RPN, posted on the same floor as the two correctional officers.

[59] The chronology of events as summarized in the fact-finding investigation report is as follows:

> *On December 15, 2008 at 01:50* [the inmate] *was observed on the cell floor unresponsive in cell . . . by* [the] *RPN while she was performing a nursing round. She alerted COI Maas, who was in the process of conducting his hourly range patrol, that* [the inmate] *was unresponsive. At 01:51 Maas and* [the RPN] *returned to the front of* [the inmate's] *cell and an attempt was made to initiate verbal contact with* [the inmate]*. When this proved unsuccessful, both staff exited the range to obtain assistance, cell keys and the medical equipment. A brief discussion took place regarding whether* [the inmate] *was still considered to be DNR (Do Not*

> *Resuscitate). At 01:53, Maas and Turner enter the cell to secure the area and attempt to elicit a response from* [the inmate]*. They were unable to obtain a response from* [the inmate] *and at that time did not check for vital signs. Maas and Turner exited the cell at 01:54:22 and re-enter the cell at 01:54:57 with* [the RPN]*. At 01:55* [the RPN] *attempts to physically rouse* [the inmate] *and unsuccessfully attempts to roll him on to his back. Turner then helps* [the RPN] *to roll* [the inmate] *on to his back at which time the RPN places a rolled blanket under* [the inmate's] *neck area.* [The RPN] *then checks for respirations and pulse. At 01:56:33* [the RPN]*, Maas and Turner exit the cell to look for* [the RN] *who is retrieving the medical equipment. At 01:57:16* [the RPN]*, Maas, Turner and* [the RN] *return to the cell with Medical supplies.* [The RPN] *immediately goes to* [the] *offender and commences chest compressions while* [the RN] *opens the medical equipment. At 01:59* [the RN] *assists* [the RPN] *with CPR (Cardio Pulmonary Resuscitation). They continue with CPR until the Paramedics arrive at 02:10:16 and take over care of* [the inmate]*.*

While the testimony of the grievors provided greater detail about several aspects of the events than is captured by the chronology, they agreed that the chronology represented a factual summary of the events. There were no contradictions in the testimonies of Mr. Maas and Mr. Turner with respect to the unfolding of events. Both testified in a sincere and forthright manner as to their respective roles in the incident.

[60] Mr. Maas testified that, when he and the RPN went to the unit nurse office and informed the RN of their observations, when the RN heard the inmate's name, she said, "He's DNR," and the RPN said, "Yes, I think he is." Mr. Maas said that he knew that the inmate used to have a DNR order but didn't know whether it was still in effect. The RN said that she would verify the inmate's records, and the RPN said that she would retrieve the medical bag and perform CPR. Mr. Maas told the RN that he would retrieve the keys to gain access to the cell and requested that she inform Mr. Turner, who was in the Security Control Office. He told her that he and Mr. Turner would open the cell and get it ready for the nurses. Mr. Maas believes that the conversation lasted at the most two minutes.

[61] With respect to DNR orders, Mr. Maas had been told that they were supposed to be posted in the cell and on the unit census board. He said that neither at the time of the incident nor since was a DNR order posted in either location; correctional officers do not know whether an order is in effect. He further stated that, aside from the unit census board, no procedure was in place to inform correctional officers of the existence of a DNR order; nor were they informed if a DNR order had been removed.

[62] Mr. Maas stated that the cell camera video showed him and Mr. Turner stepping out of the cell because they were looking for the RPN and that video of the range camera would have confirmed it. They didn't immediately initiate CPR because they thought that the RPN would be right behind them. She had said that she would perform CPR; she was better trained, and the medical bag had equipment better than the Talott mask carried on his belt. As the RPN had been first at the cell during her rounds, Mr. Maas' understanding was that she was the first responder to the emergency. When the RPN arrived, both grievors and the nurse entered the cell. Since until that point they had not received confirmation from the RN concerning the inmate's DNR status, he and Mr. Turner positioned the inmate so that the RPN could check for vital signs.

[63] After checking the inmate's vital signs, the RPN got up and said that she had to retrieve the medical bag, and then ran out of the cell and down the range. Mr. Maas said that he and Mr. Turner were taken aback, as they then realized that the RPN didn't have the medical bag with her as she had previously indicated. He and Mr. Turner remained in the cell and did not perform CPR on the inmate, as they were awaiting direction from the nurses. They had not yet been informed about the inmate's DNR status and didn't know what they were permitted to do.

[64] Mr. Maas testified that no training concerning DNR orders was provided before the incident occurred but that, since that time, during CPR training, a few minutes have been devoted to DNR orders. Mr. Maas stated that he had not received any training from supervisors or colleagues about DNR orders and that he had no idea about DNR orders until he saw one on a unit census board on the second floor of the RTC during the first year of his employment and asked a staff member for an explanation. He was told that, if an inmate has a DNR order, Mr. Maas was not to attempt to revive him in a medical emergency.

[65] When both nurses returned with the medical bag and began CPR on the inmate, both Mr. Maas and Mr. Turner offered to relieve the RPN with the chest compressions, but she declined. He said that the RN did not require help, as she was using a device to assist the inmate's breathing. He said that the nurses continued CPR until the paramedics took over on their arrival. Mr. Maas understood that, once he had been advised by a member of the Health Services staff that a medical emergency existed,

that member took charge of the situation. Following the events, Mr. Maas was instructed to fill out a report, which he did at approximately 03:30 (Exhibit E-1, Tab 6).

[66] Asked to explain the disciplinary process to which he had been subjected, Mr. Maas stated that it was the first disciplinary measure that he had ever received. In January 2009, before the fact-finding investigation, he was directed to meet with a board of investigation consisting of two persons whom he could not identify but whom he understood were from outside the RTC: a male with a correctional background, and a female with a nursing background. Mr. Maas stated that he met twice with the board of investigation. At the first meeting, he was questioned about the incident and was congratulated on his response to the emergency. Mr. Maas thought it unusual that the male investigator asked him if there was a camera in the inmate's cell, as he thought he would have already known. Mr. Maas stated that the second meeting occurred about two hours after the first, after the investigators viewed the video. He said that they raised the issue of the delay of 1 minute and 22 seconds, for which Mr. Maas provided the explanation described earlier in this decision.

[67] Mr. Maas was informed approximately two months later that a fact-finding investigation would be conducted by Ms. Napier-Glover and Mr. Jung. He was convened for an interview with them, which was the first occasion on which he viewed the cell camera video. Mr. Maas said that the video depicted a slightly different version of what he thought had occurred, and he was asked to explain the delay of 1 minute and 22 seconds. He was told that their findings would be submitted to the Executive Director and that he would be contacted.

[68] Mr. Maas received a redacted version of the fact-finding report (Exhibit G-2) in April 2009. He was convened to a brief meeting with Mr. Trainor, which he attended with a union representative. At the meeting, Mr. Trainor informed him that, after reviewing the video, he felt that the matter was serious enough to impose a disciplinary measure and that he would contact Mr. Maas once he made his decision. Mr. Maas stated that he wasn't given an opportunity to provide an explanation.

[69] Mr. Maas attended a second meeting with Mr. Trainor and a union representative at which he was handed the letter of discipline. Mr. Maas said that Mr. Trainor did not ask for his version of the facts and stated that he told Mr. Trainor that it was disconcerting to be penalized for being proactive.

[70] In response to his counsel's question about the effects of the disciplinary action, Mr. Maas responded that he found the entire process taxing, as about five months passed from the date of the incident to the imposition of the disciplinary measure, and 45 days passed from the date of his first meeting with Mr. Trainor to the imposition of the discipline. Mr. Maas said that he took pride in his work, no matter how mundane or menial, and that he felt that the employer had called his work ethic and integrity into question. He stated that the RPN, who had been involved in emergency responses in hospitals, had praised his and Mr. Turner's response to the incident.

[71] In cross-examination, Mr. Maas agreed that he was familiar with his work description and in particular with the contextual knowledge referred to in paragraph 42 of this decision. He further agreed that he was familiar with the CDs applicable to his position and with the following statement in the fact-finding report: "Maas confirmed that he is familiar with the CD and Post Orders pertaining to medical emergencies and that CPR is to be initiated without delay."

[72] Referred to the description of his interview with the fact finders as set out in the report, Mr. Maas agreed that it was accurate for the most part. He stated that, although the report stated that he first met the RPN in the middle of the range where the inmate's cell was located, in fact, he met her in the hallway between the Security Control Office and the unit.

[73] With respect to whether he was the first responder to the emergency, Mr. Maas stated that it was debatable, because although he was first in the cell, he was not first on the scene. He and Mr. Turner did not check the inmate for vital signs for two reasons: first, during the discussion between the four employees, the RN brought up the matter of a DNR order for the inmate, and second, the RPN said that she would perform CPR if required. While the RPN left to retrieve the medical bag, he and Mr. Turner were uncertain of what they were permitted to do. He pointed out that there had been a delay in retrieving the medical bag. Mr. Maas disagreed with the proposition of counsel for the employer that a good correctional officer should be aware of whether a DNR order exists for an inmate. Rather, it was management's responsibility to inform staff of such an order. Referred to the CSC *Palliative Care Guidelines*, Mr. Maas stated that he did not have access to and was unaware of them and that the inmate was not in palliative care. He stated that the guidelines dealing with medical

emergencies applied to all CSC institutions and that, where there were nurses on duty at all times, as at the RTC, they were in charge of such emergencies.

[74] At the meeting of April 22, 2009 with Mr. Trainor, Mr. Maas stated that he responded to questions from Mr. Trainor and that he did not know that he could comment on the fact-finding report, although he had been invited to submit comments in the undated letter from Mr. Trainor, which he received on April 20, 2009. Mr. Maas stated that, Mr. Trainor kept repeating, "Did you or did you not perform CPR?" Mr. Maas said that every time he provided an explanation, Mr. Trainor would simply repeat the same question.

[75] When counsel for the employer asked Mr. Maas to clarify how he had been proactive in the incident, he replied that he had reacted too quickly. He could have waited to ensure that the RPN had the medical bag but instead ran down the range to open the cell. He said that the situation was chaotic and that the nurses were flustered. He said that he went to the cell without waiting for the required number of staff to enter the cell as required by CD-567 (cited at paragraph 40 of this decision). He and Mr. Turner entered the cell without waiting for a third staff member. Asked to describe his actions in the cell, he stated that, after opening the door, he secured the cell and range and verbally tried to rouse the inmate.

[76] Mr. Maas stated that, to his recollection, the RPN checked for vital signs and then left to retrieve the medical bag. He stated that he left all the medical decisions to the RPN.

[77] Asked whether the report he wrote following the incident was relatively complete, Mr. Maas replied that the main details were included. He stated that he did not mention the discussion about the DNR order in his report because he didn't think that it would become an issue.

[78] In re-examination, Mr. Maas stated that, although there were many CSC CDs, some were relevant to his job, while others were not. He stated that he never received a copy of the *Palliative Care Guidelines*.

[79] Asked about his meetings with Mr. Trainor, Mr. Maas said that he might have attended three meetings: a first with Mr. Turner and a union representative; a second

with a union representative, at which he was informed that disciplinary action was pending; and a third meeting, at which the letter of discipline was issued to him.

[80] Mr. Turner has been employed by the CSC for approximately 20½ years, the last 6 at the RTC. Before his employment at the RTC, he worked at Millhaven for 12 years and at Pittsburgh for 4 years.

[81] Mr. Turner stated that, at approximately 01:55, the RPN came into the Security Control Office and informed him that the inmate was on the floor of his cell and unresponsive and that they would have to go to the cell. Mr. Turner met Mr. Maas at the front of the range and both of them ran to the cell. The remainder of Mr. Turner's testimony concerning the incident corroborated that of Mr. Maas in all relevant respects.

[82] Mr. Turner believed that a DNR order was in place for the inmate. He questioned whether he and Mr. Maas would be in trouble and would face legal consequences if they began CPR when a DNR order was in effect. During his entire career, Mr. Turner had not received any training or explanation concerning DNR orders. The first occasion on which he had heard about DNR orders was during his two-week orientation period when he began working at the RTC. On his very first walk on the range with two other correctional officers, upon arriving at the inmate's cell, one of the officers said that he had a DNR order. Mr. Turner asked what that meant and was told that it was a "Do Not Resuscitate" order and that CPR should not be performed on that inmate.

[83] Asked about the disciplinary process, Mr. Turner testified that, one evening when he arrived for the midnight shift, he was approached at about 21:00 by two individuals, one a female nurse supervisor and the other a male, neither of whom he had seen before. They were a board of investigation looking into the incident, and they wished to interview him. They told Mr. Turner that they had reviewed the matter, which "looked good," and that the interview wouldn't take long. Mr. Turner informed them that he didn't feel comfortable being interviewed at that time, and they agreed to a postponement. The interview took place approximately one to one-and-a-half weeks later. He later received a report from the board of investigation.

[84] The next part of the disciplinary process was his interview with Ms. Napier-Glover and Mr. Jung, at which he was questioned about the events of the night of December 15, 2008 and viewed the cell camera video. He specifically

mentioned to Ms. Napier-Glover that he had been unsure whether to perform CPR on the inmate in view of the DNR order, which he believed had been in effect, and that he had been concerned about the legal ramifications. Ms. Napier-Glover replied that it was an excellent question, which Mr. Turner could not answer or wouldn't know the answer to because he was not in the medical field. He told the investigators that as there were two nurses working in the unit, he thought that they were in charge of medical emergencies. He said that, before this hearing, he had seen a redacted copy of the fact-finding report pertaining only to his involvement in the incident.

[85] Mr. Turner's first meeting with Mr. Trainor was with Mr. Maas and a union representative. The meeting was very brief, with Mr. Trainor informing them that discipline would be imposed, that he had not yet decided on the penalty and that they would be contacted in the near future.

[86] Mr. Turner was called to another meeting with Mr. Trainor about two weeks later. Although informed that he could be accompanied by a union representative, he attended alone. When Mr. Trainor handed him the letter of discipline, Mr. Turner read it and said that he was shocked. When he asked Mr. Trainor how he had arrived at his conclusion, the latter asked him, "Did you or did you not perform CPR as soon as possible?" When Mr. Turner provided an explanation, Mr. Trainor repeated the question. Mr. Trainor did not invite him to go through the fact-finding report and told Mr. Turner that he was a good correctional officer who could work at his institution at any time.

[87] Mr. Turner found the process difficult, as he tried to do the best possible job he could as a correctional officer. He found it upsetting that the board of investigation had told him that he had done the right thing, only to be later contradicted by the fact-finding investigation.

[88] In cross-examination, Mr. Turner acknowledged his awareness of the policies set out in the contextual knowledge section of his work description, including the duty of intervening in medical situations, as well as of clause 26(a*)* of CD-800.

[89] Asked about his testimony that he believed that the nurses were in charge of the incident, Mr. Turner replied that, when the RPN entered the Security Control Office and informed him of the situation and that he had to get to the inmate's cell, it was clear to him that she was in charge. He said that he didn't do anything to the inmate as he was

awaiting direction from the nurse, since he believed that a DNR order was in effect. Referred to clause 28 of the *Palliative Care Guidelines*, stipulating that DNR orders shall be reviewed monthly, Mr. Turner said that he was unaware of that provision. His answer was the same about clause 22 of the same document, which provides among other things that a copy of the DNR order should be posted in the inmate's cell. Mr. Turner stated that, from the date on which he began his employment at the RTC, no DNR order was ever posted in the inmate's cell. Questioned about his responsibility to understand guidelines concerning DNR orders, Mr. Turner replied that it was an important issue and that management should provide more training than two correctional officers telling him that the inmate "was DNR" and that CPR should not be performed on him. Mr. Turner acknowledged that, if he saw an inmate lying on the floor and there was doubt about a DNR order, he should initiate CPR.

[90] In re-examination, Mr. Turner stated that, at the RTC, no procedures were in place to notify correctional officers about DNR orders. He further stated that he had never been informed by management that the inmate had a DNR order and that neither he nor any other correctional staff were informed that the inmate's DNR order had been removed.

IV. Summary of the arguments

A. For the employer

[91] Counsel for the employer referred to the letters of discipline set out in paragraph 2 of this decision and stated that in reference to clause 5(g) of the *Code of Discipline*, the CDs allegedly violated by the grievors were CD-800, CD-843 and CD-567. As each of those directives contains identical wording concerning responding to medical emergencies, he referred to clause 26 of CD-800 as a reference for all of them.

[92] Counsel for the employer stated that, in arriving at his decision concerning the disciplinary penalty, Mr. Trainor considered the following: the cell camera video, the fact-finding report, the applicable directives, his interviews with the grievors, the grievors' files and the Code of Discipline (Exhibit G-1, Tab 5). After considering those facts, Mr. Trainor selected a lenient penalty.

[93] Counsel for the employer advanced that the seriousness of the incident, namely, the death of an inmate in his cell, must also be considered from the perspective of the

inmate, the inmate's family and the employer. Counsel for the employer emphasized that the employer in no manner suggests that the inmate's death was caused by the negligence of the grievors; nor does it question the grievors' integrity.

[94] Counsel for the employer pointed out that the inmate could have died during the period in which he was lying on the floor of the cell undetected. Once the employees in question had been made aware that there might be a problem with the inmate, it was unknown how long he had been lying on the floor or if he were dead. Counsel for the employer submitted that that was the snapshot of events to be considered. He stated that the disciplinary penalty took into account the explanations of the grievors and the context of confusion surrounding the incident.

[95] Referring to clause 26 of CD-800, which deals with responding to medical emergencies, counsel for the employer stated that preserving life is at the core of that provision. He pointed out that the video shows the grievors entering the cell first, which was corroborated by their testimonies. He said that they entered at 01:53 on the night in question and that their only attempt to elicit a response from the inmate consisted of shining a light on him and yelling. They exited the cell at 01:54:22 and re-entered 35 seconds later with the RPN. Counsel for the employer argued that during the 1 minute and 22 seconds they were alone with the inmate, the grievors made no attempt to determine what had happened to him by, at a minimum, initiating first aid by checking his vital signs. Counsel for the employer referred to clause 26(b), which stipulates that "responding non-Health Services staff must attempt CPR/first aid where physically feasible even in cases where signs of life are not apparent. . ." Counsel for the employer submits that the failure of the grievors to do so constituted a violation of clause 26(a*)*, which requires non-Health Services staff to initiate CPR and first aid without delay.

[96] Counsel for the employer submitted that, after the RPN had checked the inmate's vital signs and had left the cell to retrieve the medical equipment, the grievors had another opportunity to preserve the inmate's life, using CPR but that they failed to act on that opportunity. Counsel for the employer conceded that, when the grievors exited the cell after the RPN had left, they were positioned just outside the cell, checking for the RPN's return.

[97] Counsel for the employer stated that the grievors' conviction that, once a nurse becomes involved in a medical response situation, they do not have to act unless

directed by the nurse, is an incorrect interpretation of their duties as correctional officers and an incorrect interpretation of the CDs. Counsel for the employer submitted that the grievors should have understood the CDs concerning DNR orders, as they indicate when CPR or first aid should or should not be initiated. In support of his argument, counsel for the employer cited clause 26(c) of CD-800 (reproduced at paragraph 25 of this decision), which refers to the *Palliative Care Guidelines* and contended that the grievors should have been aware of those guidelines.

[98] Counsel for the employer submitted that, although the grievors may have had doubts as to whether a DNR order applied to the inmate, the fact that no such order was posted in the inmate's cell or was indicated on the unit census board created a presumption that a DNR order did not apply to the inmate. He stated that the grievors' justification for not initiating CPR or first aid was that they were awaiting confirmation by the nurses of the inmate's DNR status. Counsel for the employer argued that that can only be considered as a mitigating factor and not as a justification for misconduct. He further argued that, when imposing discipline, the employer had taken the grievors' explanation into account.

[99] Counsel for the employer referred to the "misconception" among non-Health Services staff at the RTC that, as nurses are always on duty at the RTC, CPR or first aid should be initiated only at the direction of Health Services staff. He stated that the grievors' contention that they were not the first responders since the RPN was the first person at the inmate's cell is based on clause 26(h*)* of CD-800, which provides that, "once on the scene, Health Services or the ambulance service shall be responsible for determining the medical response to the situation." Counsel for the employer submitted that, when the RPN was outside the locked cell without access, she was not "on the scene," as she was not in a position to act. He further submitted that clause 26(h*)* cannot be interpreted as nullifying the primary purpose of clause 26, namely, preserving life.

B. <u>For the grievors</u>

[100] Counsel for the grievors submitted that the following three issues are in dispute: Did the employer demonstrate that there were sufficient and properly applied grounds to impose discipline on the grievors? If so, were the disciplinary measures appropriate? Irrespective of the first two issues, did the employer violate the rules of natural justice, which would warrant the quashing the disciplinary measures?

[101] Counsel for the grievors argued that, by imposing the disciplinary measures, the employer indicated that it did not appreciate the grievors' conduct. Rather, they were imposed to correct structural issues for which the employer is solely responsible, such as the fact-finding report's conclusion about the misconception that nurses at the RTC are always responsible for medical issues, and the confusion surrounding DNR orders.

[102] Counsel for the grievors further argued that the grievors were not provided with procedural fairness in their disciplinary hearings, thus voiding the disciplinary measures imposed.

[103] Counsel for the grievors stated that Mr. Trainor's decision that the grievors' actions constituted serious misconduct was driven by the fact that the inmate died. Mr. Trainor admitted that he was mindful of the death when deciding the discipline and that it prevented him from appreciating the entire body of facts.

[104] Counsel for the grievors argued that, in assessing the facts and the conduct of the four employees involved, the employer took a "silo" approach by ignoring the interactions between the employees during the incident and the fact that the incident was a continuum of events.

[105] Counsel for the grievors submitted that the grievors had no obligation to perform CPR or first aid in the circumstances. In addition to an argument based on his view of the facts, counsel for the grievors argued that in CD-800, clauses 26(a) to (c) inclusive must be interpreted together with clauses 26(h) and (i) in light of the purpose and object of that CD, namely, preserving life. In support of that argument, counsel for the grievors proposed what he termed the principle of "specialty," according to which the best measures to preserve life are to be provided by the most qualified individuals, namely, those having superior medical skills, knowledge and training. Counsel for the grievors submitted that that principle is embedded in CD-800 and CD-843, in that clauses 26(a) to (c) of CD-800 and the corresponding provisions in CD-843 are intended to govern situations where the only individuals able to provide a medical response are, in his terms, "non-health specialists." Counsel for the grievors argued that, in those situations, non-Health Services staff of the RTC have a minimal level of discretion for medical responses, as their training, knowledge and skill in medical matters are limited. Counsel for the grievors stated that the grievors were under the impression that the inmate was under a DNR order since at one time they had been told as much, and no one in authority had informed them otherwise. Therefore, according to clause

26(c), the grievors were not required to initiate CPR. Counsel for the grievors submitted further that they were not required to check for the inmate's vital signs, as that was part of the CPR procedure.

[106] Dealing with the issue of the moment at which the nurses arrived on the scene and assumed responsibility under clauses 26(h) and (i) of CD-800, counsel for the grievors stated that it occurred at the earliest when the RPN initially visited the inmate's cell during her rounds, and at the latest, when she and Mr. Maas were at the cell together, shining a flashlight and verbally attempting to elicit a response from the inmate. Counsel for the grievors argued that the nurses assumed responsibility from the outset, as demonstrated by the following: the RPN alerted Mr. Maas about a possible medical emergency; when she and Mr. Maas were in front of the cell together, she said, "We may have a medical emergency"; the nurses raised the question of the DNR order; the RN said that she might be required to perform CPR; and it was up to the nurses to check the inmate's medical file and retrieve the medical bag. Counsel for the grievors stated that the grievors were never consulted on the medical response and were never given directions by the nurses and that they learned only by *fait accompli* that the nurses had chosen CPR as the appropriate medical response. Counsel for the grievors submitted that the nurses acted as if the grievors were not relevant to the medical response and that the obligation of the grievors to initiate CPR or first aid under clauses 26(a) to (c) inclusive of CD-800 was overridden by the nurses' assumption of responsibility under clauses 26(h) and (i).

[107] Counsel for the grievors submitted that the grievors were not required to have knowledge of the *Palliative Care Guidelines*, as they were intended for Health Services staff. In addition, the employer did not clearly communicate the document to the grievors through training or through any other manner. He further submitted that part of the delay in the RN arriving with the medical bag was because it had been misplaced. Counsel for the grievors submitted that the grievors should not have to assume responsibility for the employer's deficiencies.

[108] With respect to the DNR order, counsel for the grievors submitted that the grievors had never been informed by the employer that the inmate's DNR order had been removed and that they had not received any training concerning DNR orders. Counsel for the grievors submitted that the fact that, since the incident, DNR orders are now briefly treated within the context of CPR training is an acknowledgement by

the employer that the lack of training on DNR orders was a deficiency not imputable to the grievors. Counsel for the grievors stated that, while clause 22 of the "Do Not Resuscitate Procedure" part of the *Palliative Care Guidelines* stipulates that a DNR order "shall" be indicated on the unit census board, it also provides that a copy of the order "should" be posted in the offender's cell. Counsel for the grievors argued that the evidence disclosed that the grievors had never seen a DNR order posted in the inmate's cell or on the census board, which diminished the probability of the grievors knowing whether the inmate's DNR order had been rescinded.

[109] Counsel for the grievors submitted that Mr. Trainor's assertion, which is that CPR must be initiated in all circumstances regardless of doubt about the validity of a DNR order, is not supported by clause 26 of CD-800 and would require the deletion or amendment of clause 26(c). Counsel for the grievors agreed with the employer's submission that Mr. Trainor took the DNR issue into account as a mitigating factor but contended that he did not properly understand that it was the grievors' justification for not initiating CPR.

[110] Counsel for the grievors submitted that, since the grievors had complied with the applicable CDs, and considering all the evidence, their actions cannot be viewed as severe misconduct, and the grievances should, accordingly, be allowed. Counsel for the grievors further submitted in the alternative that, if any discipline were warranted, it should be a verbal reprimand. Counsel for the grievors requested that damages of $1000 should be awarded to each grievor for his suffering and inconvenience.

C. <u>Reply of the employer</u>

[111] In reply, counsel for the employer pointed out the judgment of the Federal Court of Appeal in *Tipple v. Canada (Treasury Board)*, [1985] F.C.J. No. 818 (QL) (C.A.), in which the Court ruled that any procedural defects in or after the investigation process were corrected by the hearing before the Board.

[112] Counsel for the employer disagreed that the employer had conducted the fact-finding investigation with a silo approach. He stated that the fact-finding included interviews with the four employees who had intervened on the night of the incident and that the single fact-finding report applied to all four employees.

[113] Counsel for the employer stated that the grievors' principle of "specialty" was not supported by the day-to-day interaction between nurses and correctional officers at the RTC. He further stated that the applicable provisions of the CDs must be read as a whole.

[114] With respect to the grievors' argument that the nurses' assumption of responsibility and lack of direction to the grievors absolved the grievors of blameworthy conduct, counsel for the employer stated that the grievors were not directed to take no action. He submitted that, even if the nurses had been in charge, the grievors had a duty to take action.

[115] While acknowledging that the delay in locating the medical bag was not imputable to the grievors, counsel for the employer stated that the grievors failed to act during the delay while the bag was located.

[116] With respect to the damages sought by the grievors, counsel for the employer argued that no explanation was provided justifying the amount sought and that separate evidence should have been adduced of general damages.

V. Reasons

A. Ruling on the admissibility of the fact-finding report

[117] As mentioned at paragraph 9 of this decision, I ordered the employer to produce the unredacted investigation report into the incident of December 15, 2008, subject to its admissibility as to relevance. The unredacted report includes, among other things, details of the interviews conducted with the four employees who intervened in the incident, as well as the extent of the involvement of each of them. While the grievances before me were filed by the grievors, for a comprehensive understanding of the events, in my view it is necessary to consider the actions taken by the nurses as well the interaction between them and the grievors in responding to the medical emergency. The unredacted report provides that context. Furthermore, the CDs adduced into evidence set out the respective roles of Health Services and non-Health Services staff in responding to medical emergencies. In addition, Ms. Napier-Glover testified concerning the nurses' intervention in the incident, as did the grievors about their interactions with the nurses. For all of those reasons, I find the unredacted fact-finding report relevant. Accordingly, it is admitted into evidence.

B. Ruling on the alleged lack of procedural fairness

[118] Counsel for the grievors argued that the grievors were not provided with procedural fairness during their disciplinary hearings with Mr. Trainor. The evidence on this issue consisted primarily of the grievors' testimony that, during their interviews, Mr. Trainor did not allow them to provide an explanation for their failure to initiate CPR. I do not view this as procedural unfairness. The grievors provided a complete explanation to the investigators, which was set out in the investigation report, and which the grievors acknowledged was factually accurate. During the hearing, the grievors had the opportunity to cross-examine Mr. Trainor, who had made the decision to impose discipline on them. They also had the opportunity to cross-examine Ms. Napier-Glover, one of the investigators of the incident. As the Federal Court of Appeal ruled in *Tipple,* any procedural defects during or following the investigation process are cured by the hearing before the adjudicator. Furthermore, as stated as follows at paragraph 93 of *Mohan v. Canada Customs and Revenue Agency*, 2005 PSLRB 172:

> *. . .it has long-been held in the Board's jurisprudence that the adjudication hearing is a* de novo *hearing to determine whether the employer had just cause to impose discipline, and the hearing is not designed to determine whether the proper process was followed (see* Tipple *(*supra*)).…*

Thus, the grievors' argument on this point does not succeed.

C. Analysis

[119] The issues to be determined are whether the grievors' conduct contravened the CDs concerning responding to medical emergencies and, if so, whether the discipline imposed was appropriate considering the circumstances. To determine whether the grievors' actions constituted misconduct, their justifications for their actions will be examined.

1. The first responder

[120] The parties advanced contradictory positions about the employees who first responded to the medical emergency. The grievors believed that the RPN was the first responder, as she had initially observed the inmate lying unresponsive in his cell. The

employer contended that, as the grievors were the first to access the cell, they were the first responders.

[121] It is important to determine which employee was the first responder in this matter. Clauses 26(a) and (b) of CD-800 require the following duties to be carried out by non-Health Services staff arriving on the scene of a medical emergency:

> *a. non-Health Services staff arriving on the scene of a possible medical emergency must immediately call for assistance, secure the area and initiate CPR/first aid without delay;*
>
> *b. responding non-Health Services staff must attempt CPR/first aid where physically feasible even in cases where signs of life are not apparent (the decision to discontinue CPR/first aid can be taken only by authorized health personnel or the ambulance service in accordance with provincial laws);*

With respect to Health Services staff, clause 26(h) of CD-800 states that, "once on the scene, Health Services or the ambulance service shall be responsible for determining the medical response to the situation."

[122] Counsel for the grievors argued that, as the RPN had initially observed the inmate, she was first "on the scene," and therefore, she assumed responsibility for determining the medical response. He further argued that the latest moment at which Health Services were on the scene and assumed that responsibility was upon the return of the RPN and Mr. Maas to the outside of the inmate's still-locked cell, where they attempted to elicit a response from the inmate. In support for his contention, counsel for the grievors referred to the uncontradicted testimony of Mr. Maas, in which he stated that the RPN said, "There is something wrong . . . we may have a medical emergency."

[123] Based on the evidence, I cannot agree. Although the RPN was indeed the first to detect the inmate on the floor of his cell during her rounds, she could have done nothing more than observe, since she did not have access to the cell. At that point, she could not ascertain the inmate's condition. When she returned to the cell door with Mr. Maas, and their shouts and light found no response from the inmate, she was still unable to physically assess his condition.

[124] The phrase "on the scene" may be defined in several ways, depending on the context. In my opinion, within the context of clause 26 of CD-800, someone being on

the scene cannot be construed as someone being present at the scene of a medical emergency where it is physically impossible to attempt treating an inmate due to a lack of access to the cell. That cannot be the intent of that provision. As stated in the introduction to clause 26, ". . . the primary goal is the preservation of life . . ." To preserve life, it must be physically feasible to do so. In this case, only after the inmate's cell was unlocked could his condition be assessed and an appropriate response initiated. The cell camera video clearly showed that the grievors were the first to enter the inmate's cell. Therefore, I find that they were the first on the scene of the medical emergency within the context of clause 26 of CD-800.

[125] Even had I agreed with counsel for the grievors' argument that the RPN had assumed responsibility for determining the medical response, in my view that would not have discharged the grievors from their responsibilities as stipulated in clause 26(a) of CD-800. The provisions of clause 26 must be read as a whole. When Health Services staff assume responsibility under clause 26(h), it is for the purpose of determining the medical response to the situation. To determine a medical response does not necessarily mean carrying it out. Thus, when the RPN said, "we may have a medical emergency" or the RN said, "we may have to start CPR," in my opinion that did not absolve the grievors from their obligation to initiate CPR and first aid upon first arriving on the scene.

[126] This brings me to the principle of "specialty" proposed by counsel for the grievors, according to which the best measures to preserve life are to be provided by the most qualified individuals. He argued that, since non-Health Services staff have limited training in medical matters, they have a minimal level of discretion for medical responses. He submitted that clauses 26 (a), (b) and (c) of CD-800 are meant to cover situations where the only staff able to provide a medical response are what he termed "non-health specialists."

[127] In my view, the structure of clause 26 of CD-800 does not support such a principle of "specialty." The provisions of clause 26 do not create a hierarchy of response to a medical emergency based on qualifications, such that an inmate must necessarily receive emergency treatment from the most highly qualified staff member. The principle of "specialty" implies that, in an emergency at the RTC, correctional officers would not deem it necessary to respond because nurses, having more medical training, are on duty at all times. Taken to its logical extension, if a physician were

present at the RTC, nurses would then defer to that individual's medical expertise. In my opinion, that is not the intent of clause 26. Its overarching purpose, which concerns medical emergencies, is preserving life. Clauses 26(a) and (b) of CD-800 require that non-Health Services staff responding to a medical emergency initiate CPR/first aid without delay. As the grievors were fully trained and qualified in CPR/first aid and carried a CPR device, they had no reason to await the arrival of a staff member with greater medical expertise in order to check the inmate's vital signs and initiate CPR. In my opinion, the argument of "specialty" fails.

2. <u>The DNR order</u>

[128] The evidence of the grievors in respect of the DNR order may be summarized as follows. When they began working at the RTC, they were informed that a DNR order applied to the inmate, but they never saw a DNR order posted in the inmate's cell or a sticker on the unit census board indicating that a DNR order applied to the inmate. They were never advised by anyone in authority that the DNR order applicable to the inmate had been rescinded. They had never received training on DNR orders. On the night of the incident, the RN raised the issue of the DNR order applicable to the inmate. The nurses and the grievors believed that a valid DNR order applied to the inmate. The confusion concerning the DNR order was part of the reason for the grievors' hesitation in initiating CPR and first aid, in view of clause 26(c) of CD-800. That provision, which is cited earlier in this decision, is reproduced here for ease of reference:

> *26 c. initiation of CPR by non-Health Services staff is not required in the following situations:*
>
> …
>
> - *the non-Health Services staff are aware of a DO NOT RESUSCITATE (DNR) order (responding non-Health Services staff shall verify if a DNR order exists as per the <u>CSC Palliative Care Guidelines)</u>*
>
> [Emphasis in the original]

[129] Counsel for the employer relied on the parenthetic wording in clause 26(c) of CD-800 to argue that the grievors should have known when not to initiate CPR and first aid, as they should have been aware of the CSC *Palliative Care Guidelines*.

According to counsel for the employer, the following words of clause 26(c), "responding non-Health Services staff shall verify if a DNR order exists as per the CSC *Palliative Care Guidelines* [emphasis added]," creates a requirement for the grievors to be aware of the *Palliative Care Guidelines*.

[130] I disagree. First, the grievors' testimony, which was not contested, was that they had never been made aware of the *Palliative Care Guidelines* and had never been given access to that document. Second, in my opinion, the wording of clause 26(c) of CD-800 does not support counsel for the employer's argument. The words "as per" in the relevant provision of that clause do not mean that non-Health Services staff must refer to or be aware of the *Palliative Care Guidelines* to verify whether a DNR order exists. In my view, the words "as per" in that context refer to DNR orders issued in accordance with the *Palliative Care Guideline*. Such an interpretation is consistent with the words "*a été émise*" in the French version of the relevant part of clause 26(c), which provides as follows: *les intervenants non spécialistes de la santé doivent vérifier si une telle ordonnance a été émise suivant les Lignes directrices sur les soins palliatifs du SCC.*

[131] I note in passing that this is the only provision in clause 26 of CD-800 and the corresponding provisions of CD-843 and CD-567 in which the phrase "non-Health Services staff" is translated into French as "*non spécialistes de la santé*." In all other provisions of clause 26, the French version is ". . .*n'oeuvrant pas dans le domaine de la santé*." This appears to me as simply an anomaly, which does not in any manner modify the category or status of non-Health Services staff.

[132] The DNR procedure found at pages 30 to 33 of the *Palliative Care Guidelines* clearly indicates that it is intended for the physicians and nurses of the CSC. Clause 16 of the DNR procedure stipulates as follows the manner in which non-Health Services staff are made aware of DNR orders:

> *16) Nurses shall transcribe DNR orders on the patient's Health Care Record, on the patient's Kardex, and on the Census Board in the Unit Office to ensure all appropriate personnel know the patient's wishes and the health team's decision in this regard.*

Thus, clause 26(c) of CD-800 does not require responding non-Health Services staff to have knowledge of the *Palliative Care Guidelines* to be aware of a DNR order. As the evidence disclosed that only Health Services staff have access to the inmate's Health Care Record, then, according to clause 16 of the DNR procedure, non-Health Services

staff are made aware of an inmate's DNR order by the posting on the unit office census board. The testimonies of Ms. Napier-Glover and the grievors confirmed that it consisted of a sticker placed next to an inmate's name on the census board.

[133] The DNR procedure provides an additional means of making non-Health Services staff aware of a DNR order. Clause 22, under the heading "Implementation," reads as follows:

> *22) The nurse shall transcribe the DNR order onto the patient's Health Care Record on the patient's Kardex and on the Census Board in the Unit Office. A copy should also be posted in the inmate's cell.*
>
> [Emphasis added]

The use of the word "shall" in clauses 16 and 22 of the DNR procedure indicates that the transcription of the DNR order by the nurse onto the Kardex and Health Care Record is mandatory. However, in section 22, the word "should," with respect to posting the DNR order in the inmate's cell, is directory, indicating that Health Services staff are not required by the *Palliative Care Guidelines* to post a DNR order in an inmate's cell.

[134] In his argument, counsel for the employer submitted that the fact that a DNR order pertaining to the inmate was not posted on the unit census board or in his cell created a presumption that no such order applied to the inmate. I disagree. My reading of the applicable directives is that the primary source of a DNR order is the notation on the patient's Health Care Record or chart, with the posting on the unit census board serving as a secondary source for the information of non-Health Services staff. In the event that the sticker on the unit census board indicating a patient's DNR order were accidentally dislodged or disappeared, counsel for the employer's argument implies that such an order would be ignored. I cannot agree with that reasoning. As occurred in this case, nursing staff would verify the patient's Health Care Record to determine whether a valid DNR order was in effect. Therefore, I reject this argument.

3. The risk of assault by the inmate

[135] The grievors testified that one of the reasons for their hesitation in initiating CPR was that the inmate could have been dangerous. They were concerned about being assaulted if they roused the inmate, as they could not have known whether he was

feigning sleep. That the inmate was a high risk for aggression and violence is not in dispute. The investigation report states as much, and Mr. Trainor confirmed it in his testimony. However, preventing inmate assaults is part of the duties of correctional officers. In the grievors' work description (Exhibit E-1, Tab 5), the first paragraph under the heading "Job Content Knowledge" in the "Skill" section reads in part as follows:

> *It is necessary to identify risks and actively prevent or counteract inmate assaults . . .In this regard; the incumbent must employ the safest and most reasonable intervention techniques to resolve the situation in accordance with applicable policy and law. . .*

During the incident, both grievors were in the cell with the inmate. Although they may have harboured a legitimate concern of a possible assault, nevertheless, it was their duty to take the necessary measures to manage such a situation in the event of its occurrence. Consequently, in my opinion, the grievors' concern of a potential assault by the inmate is not, in the circumstances, an excuse for their failure to initiate CPR or first aid.

4. <u>Were there grounds for discipline?</u>

[136] Based on the evidence, I have found that the grievors were the first responders to the medical emergency, as they were first on the scene within the meaning of clause 26 of CD-800. As first responders, they were required by clauses 26(a) and (b) of CD-800 to initiate CPR and first aid without delay, even when signs of life were not apparent.

[137] The crucial moment of the incident occurred when the grievors first entered the inmate's cell at 01:53 on December 15, 2008 and exited at 01:54:22. During that 1 minute and 22 second span, the evidence disclosed that the grievors secured the area, beamed a light, and shouted at the inmate. They made no attempt to assess his condition by checking his vital signs. They did not initiate CPR or first aid. I find that their failure to do so constituted a clear violation of clause 26 of CD-800 and clause 5(g) of the CSC's *Code of Discipline*.

[138] The grievors raised the matter of confusion and doubt surrounding the existence of a valid DNR order pertaining to the inmate and the potential repercussions as the primary contributing factor to their hesitation in initiating CPR or first aid. Although the evidence disclosed that there was doubt about the DNR order, in

my opinion that is not sufficient to override the core requirements of clause 26 of CD-800.

[139] As stated in the introductory paragraph of clause 26 of CD-800, "In responding to a medical emergency, the primary goal is the preservation of life. . ." That is the purpose and thrust of that clause. In my opinion, that part of clause 26(c) dealing with DNR orders is an exception to the stated primary goal of preserving life, which applies when the existence of a valid DNR order is verified. Until that verification is made, non-Health Services staff responding to a medical emergency are required to immediately make every attempt to preserve life. In this case, when the grievors went to the inmate's cell, the RN was verifying the inmate's Health Care Record to determine whether a valid DNR order was in effect. Up to that point, the grievors had not received confirmation that such an order existed for the inmate. Therefore, it was incumbent upon them to initiate CPR and first aid as stipulated in clauses 26(a) and (b) of CD-800. In medical emergencies such as this incident, it is essential that the appropriate measures be initiated without delay. The evidence disclosed that the grievors failed to do so. Accordingly, I find that the employer has established that it had sufficient grounds to impose discipline on the grievors.

5. <u>Was the discipline appropriate?</u>

[140] In his argument, counsel for the employer stated, in reference to clause 5(g) of the *Code of Discipline*, that the CDs allegedly violated by the grievors were CD-800, CD-843 and CD-567.

[141] The discipline imposed on the grievors was a financial penalty equivalent to two days' pay. Mr. Trainor stated that he selected a lenient disciplinary measure based on several mitigating factors, such as the grievors' unblemished disciplinary records during their service, their acknowledgement that they did not perform CPR or first aid, their learning from the incident and acknowledgment that, faced with a similar situation, they would initiate CPR and first aid, and the finding of the investigation report that there was confusion concerning the DNR order.

[142] In imposing discipline on the grievors, the employer relied on two separate grounds of violation of the *Code of Discipline,* namely, of clauses 5(f) and (g). The employer adduced no evidence whatever with respect to the alleged violation of clause 5(f), which states, "fails to take action or otherwise neglects his or her duty as a

peace officer." No testimony or documentary evidence was introduced concerning the duties or responsibilities of a peace officer or the manner in which the grievors failed to conform to them, and no submissions were made by the employer on those issues. Since the employer failed to prove that the grievors violated clause 5(f) of the *Code of Discipline*, a reduction of the disciplinary sanction imposed on the grievors is justified. Based on the evidence, and considering all the circumstances, in my view the disciplinary penalty should be reduced by the equivalent of one day's pay. Accordingly, the grievances will be partially allowed to that extent.

[143] In his argument, counsel for the grievors submitted that the grievors were entitled to $1000 each as damages for "suffering and inconvenience." The only evidence is the grievors' testimony that they found the investigative process taxing and unnecessarily lengthy. While that may be the case, it is one of the unfortunate by-products of being involved in an incident like the one in this case. Furthermore, counsel for the grievors did not make any serious submissions about that compensation. Therefore, the claim is denied.

[144] As previously stated, a compact disc containing the video recording from the camera in the inmate's cell on the night of the incident was admitted into evidence. As mentioned earlier in this decision, the first part of the video depicts the inmate's movements for a period before and including his fall to the floor of the cell.

[145] While privacy has been acknowledged as an important personal right, I am mindful of the authorities that have stated that, nonetheless, in and of itself, the right to privacy is not sufficient to oust the public's right to information under the *Canadian Charter of Rights and Freedoms* (Part I of the *Constitution Act, 1982*, enacted as Schedule B to the *Canada Act 1982*, (U.K.) 1982, c.11. However, within the context of this matter, it is my opinion that out of consideration for the dignity of the inmate, the public's right to information should not extend to viewing the video recording. Under the circumstances, I have sealed Exhibit E-2, the compact disc of the cell camera video recording. I have also sealed Exhibit E-1, Tab 9, the unredacted investigation report.

[146] For all of the above reasons, I make the following order:

(The Order appears on the next page)

VI. Order

[147] The grievances are allowed in part. Each grievor is to be compensated for one day's pay and any related benefits.

[148] I order sealed the compact disc of the cell camera video recording of the incident (Exhibit E-2) and the unredacted fact-finding investigation report (Exhibit E-1, Tab 9).

November 22, 2010.

Steven B. Katkin,
adjudicator