File: 166-2-27620

Public Service Staff Relations Act

Before the Public Service Staff Relations Board

BETWEEN

ARTHUR O'HAGAN

Grievor

and

TREASURY BOARD
(Solicitor General - Correctional Service Canada)

Employer

Before: Joseph W. Potter, Board Member

For the Grievor: Evan M. Heidinger, Professional Institute of the Public Service of Canada

For the Employer: Richard Fader, Counsel

Heard at Saskatoon, Saskatchewan,
March 24 and 25, 1998.

Mr. Arthur O'Hagan is a nurse, level 1, in the Regional Psychiatric Centre (Prairies), Correctional Service Canada, in Saskatoon (the Centre). He is grieving a four-day suspension. The reason for the suspension is outlined in the "Disciplinary Action Report" filed as Exhibit E-2. The summary of facts reads as follows:

> *On Feb. 3/96 at about 7:30 a.m., you as the Charge nurse on Bow Unit contacted the psychiatrist to seek a medical order to place a patient in IPC* [Intensive Psychiatric Care, i.e. stripped cell]. *The information you provided Dr. Gopi was misleading in that you omitted to inform him that the patient was asleep in bed and not presenting any problems at that time. Based on the information you provided, Dr. Gopi made a decision that he would not have made had he been given all the appropriate information. Your action caused the patient to be wakened from his sleep and placed unnecessarily in IPC. I consider this to be a very serious matter.*

I heard from six witnesses and received 16 exhibits. A request was made and granted for the exclusion of witnesses.

The facts of the case can be summarized fairly succinctly.

Facts

Mr. Marcel Chiasson, the Executive Director of the Centre, testified that the Centre is a medical health facility designed to serve inmates with mental health problems. It is a fully accredited hospital.

February 3, 1996 was a Saturday and for the grievor was the first day back to work following two days of rest (Exhibit E-8). Scheduled to work with the grievor on the day shift, which commenced at 6:45 a.m., were two staff nurses, namely, Denis Penner and Sheldon Feschuk. Mr. O'Hagan was the charge nurse on that shift, and his job description was identified as Exhibit E-7. It indicates the charge nurse acts as the head nurse on weekends. The shift began with a scheduled briefing provided by the Patient Care Manager from the midnight shift, Mr. Ralph Denny. Mr. Denny testified that he typically briefed the incoming shift on the events that had occurred at the Centre in the last 24 hours and answered a few questions. On February 3, included in his briefing were comments about the general behaviour of one of the patients in the Centre (hereinafter referred to as Patient "X").

Mr. Denny told the three nurses that the previous day, Patient "X" was locked in his room for having displayed negative behaviour. Patient "X" had been pressing other patients for sexual favours and one patient had vigorously complained to staff about this. In addition, during the evening of February 2, staff had discovered some derogatory comments written on a blackboard in the patients' kitchen, comments directed at a female staff member. The words were "Susan is a bitch", and Mr. Denny stated it was believed that Patient "X" had written the message, and he stated as much in his briefing to the three nurses.

There was no disagreement from the parties that Patient "X" had caused problems in the past.

The three nurses discussed the actions of Patient "X" with Mr. Denny and Mr. Denny instructed them to decide what action, if any, they felt should be taken and report back. With the pre-shift briefing over at about 6:55 a.m., Mr. O'Hagan testified the three nurses discussed the events further, looked at written reports to see if, in fact, there had been something written on the blackboard, and to confirm that a patient had complained about Patient "X" pressuring him for sex. Nurse Penner testified that all three nurses felt there was an increasing number of occurrences where Patient "X" was either making threats, or displaying negative behaviour, and all three nurses decided the best course of action would be to lock Patient "X" up in what is known as a strip cell. This term simply means a cell that is stripped of furniture, or anything else, that patients could use to harm themselves or others. In addition, their liberty is restricted in that they are observed every 15 or 30 minutes. Witness Penner stated it was probably himself who initially suggested that Patient "X" be put in a strip cell, but ultimately the three nursing-team members decided on this course of action. Nurse Feschuk testified that Patient "X" had exhibited behaviour which was disrespectful to staff, and he had agreed with the team decision to place Patient "X" in a strip cell.

Nurse Penner stated, in cross-examination, that the action taken was necessary because of possible harm to other patients that may have occurred later that day. Messrs. Penner, Feschuk and O'Hagan stated, in cross-examination, that the action was preventive in nature.

Mr. O'Hagan telephoned Mr. Denny to explain their proposed course of action and Mr. Denny instructed Mr. O'Hagan to make sure the duty psychiatrist knew of this.

In order to place a patient in a strip cell, authorization must be obtained from the unit psychiatrist or, on weekends, from the duty psychiatrist, who is not located in the facility. This is specified in the "Standing Order - Intensive Psychiatric Care" (Exhibit E-9, paragraph 4) and in the "Policy and Procedure - Use of Seclusion" (Exhibit E-10). On February 3, 1996, the duty psychiatrist was Dr. Gopi Radhakrishnan. Dr. Radhakrishnan testified he is commonly referred to as Dr. Gopi and as most exhibits refer to him in that light, I will as well.

Nurse O'Hagan called Dr. Gopi shortly after 7:00 a.m. and, according to Dr. Gopi's memorandum (Exhibit E-4), asked if Dr. Gopi knew Patient "X". Dr. Gopi replied that he did and was aware of various incidents concerning this patient over the past week. Nurse O'Hagan then indicated that Patient "X"'s difficult behaviour had been escalating and he was seeking permission to move Patient "X" to a strip cell before the unit was unlocked. The grievor testified Dr. Gopi gave the necessary authorization. Nurse O'Hagan omitted to inform Dr. Gopi that, at that moment, Patient "X" was asleep in his cell and was therefore obviously not causing an immediate problem. Nurse Feschuk testified, in cross-examination, that if he had made the call he would have informed Dr. Gopi that Patient "X" was asleep at the time. Witness Denny stated, in cross-examination, he was not aware Patient "X" was asleep at the time of his telephone conversation with Nurse O'Hagan and felt the duty psychiatrist should have been informed Patient "X" was sleeping.

In any event, Mr. O'Hagan informed the other two nurses that the necessary authorization was granted and security was called to remove Patient "X" from his cell. There was no dispute Patient "X" was asleep at the time, and was then awakened and moved to a strip cell.

Dr. Gopi testified that, in order for him to authorize a patient be placed in a strip cell, there must be a demonstration of the escalation of a problem and potential for harm must exist. The witness said he was under the impression the situation was immediate and his rationale for providing the needed authorization was based on good faith and his knowledge of the previous history of Patient "X". Dr. Gopi testified he

thought Patient "X" was in an escalating mode. No authorization would have been provided, Dr. Gopi said, if he had been made aware Patient "X" was asleep. The ramifications of making this authorization were, according to Dr. Gopi, to remove the patient's freedom and due process to remove this freedom was not followed.

The "Nursing Progress Notes" for Patient "X" were introduced as Exhibit E-11 and Dr. Gopi was asked to review them and comment on the days leading up to the incident of February 3. He did so and said that, in his view, there was no emergency in the days immediately prior to February 3, 1996.

In cross-examination, Dr. Gopi was asked if it was necessary that there be an emergency at the time the request for movement to a strip cell is made. He replied that there had to be a demonstration of something occurring, unless a patient himself asks to be put in a strip cell. He indicated there should have been evidence a patient was acting out minutes or hours before the call was made to him, not days before.

Dr. Gopi confirmed, in cross-examination, that he did not inquire as to whether Patient "X" was asleep or not and, in fact, did not think he asked Nurse O'Hagan any questions at all. Nurse O'Hagan testified he did not tell Dr. Gopi that Patient "X" was asleep because it never occurred to him.

When Executive Director Chiasson learned of the incident, he asked Dr. Gopi to submit a report, and this report was referred to earlier as Exhibit E-4. The grievor was asked for a report and this report is contained in his letter of April 12, 1996 (Exhibit E-5). (Note: This exhibit contains information related to a separate issue as well.) This exhibit states, at page 3, that the decision to request that Patient "X" be placed in a strip cell was made following a number of incidents in the previous two to three weeks. At page 4 of Mr. O'Hagan's letter of explanation, he writes:

> *... It was the nurses' opinion that an emergency situation existed.*

Further on, again at page 4, Nurse O'Hagan wrote:

> *... In their professional opinion, each of the three nurses on duty considered there to exist a harmful situation. They decided to exercise the preventative measure permitted by ... Standing Order 590.*

This "Standing Order" (Exhibit E-9) deals with placing a patient in Intensive Psychiatric Care and states, at paragraph 3:

> *I.P.C. may be used as a therapeutic measure to control a disturbed patient to prevent the patient from harming himself or another person....*

It is clear, both from the testimony of the three nurses and from Mr. O'Hagan's letter of April 12, that they felt collectively Patient "X" should be placed in a strip cell as a preventive measure. At page 5 of the April 12 letter of explanation, Mr. O'Hagan writes:

> *... We, the day shift nurses, considered a harmful situation to exist and attempted to deal with it in a preventative fashion, in accordance with Standing Order 590, prior to the inmate awakening.*

Mr. O'Hagan readily admits he did not inform Dr. Gopi that Patient "X" was asleep at the time but writes, again at page 5 of the April 12 letter:

> *... I did not intend to mislead Dr. Gopi. In fact the events which I described were clearly in the context of occurring over the previous days.*

Mr. Chiasson stated that, in deciding on the penalty, he took into account the grievor's long history with Correctional Service Canada and his very positive performance reviews (Exhibits G-2 and G-5). This was balanced with Mr. Chiasson's perception of the seriousness of the incident itself and the fact the grievor did not acknowledge his mistake, as seen in Exhibit E-5.

Arguments

Mr. Fader argued that the grievor now claims the action of placing Patient "X" in a strip cell was preventive in nature. However, Mr. Fader said this was not the grievor's claim in his April 12, 1996 letter, which outlined the reasons for his action (see Exhibit E-5, page 4, point number 6). The grievor's letter stated: "It was the nurses opinion that an emergency situation existed." In fact, the evidence shows no emergency situation existed as it is not in dispute that the patient was asleep at the time the decision was made to move him to a strip cell.

The grievor said it was common for inmates to be asleep at 7:00 a.m. on a weekend and Dr. Gopi should have known this. Counsel argued if Dr. Gopi should have known this, so too should the grievor.

Counsel stated the facts indicate that within 15 minutes of arriving at work on February 3, 1996, and after being off the previous two days, the grievor decided to put Patient "X" in a strip cell and he knew an emergency had to currently exist to justify such action. He called Dr. Gopi and led him to believe the patient's behaviour was escalating. Dr. Gopi testified that, had he known the patient was asleep, he would not have authorized the placement in a strip cell.

Counsel said the grievor's current testimony about the events leading up to the decision is different from those outlined in Exhibit E-5. Now we are hearing about the blackboard incident and the sexual advances made to another patient. Even if they are true, counsel suggested they do not justify the action taken by the grievor.

The facts show the patient was asleep and not causing a disturbance. The grievor failed to state this to Dr. Gopi. Executive Director Chiasson took all mitigating factors into account, including positive performance reports and long service, when deciding on an appropriate penalty.

In this light, I was asked to uphold the suspension. Counsel referred to *Wilson* (Board file 166-2-25841).

Mr. Heidinger argued that much of the evidence is not in dispute. The parties agree that Patient "X" had been a problem in the past and had a history of being locked up. The attitude Patient "X" had recently displayed was stated by Nurse Denny in the briefing and the three nurses on duty were asked to review the situation and decide what to do with Patient "X". The three nurses did discuss the issue and collectively decided that Patient "X" should be placed in a strip cell. Nurse O'Hagan called Dr. Gopi and received authorization to place Patient "X" in a strip cell. Only Nurse O'Hagan was disciplined.

What was not in agreement was the issue of whether or not Dr. Gopi was misled. Mr. O'Hagan said he simply never thought about whether Patient "X" was asleep or not. He did not mislead Dr. Gopi; he just never thought of it.

Mr. Heidinger stated Messrs. Brown and Beatty, in *Canadian Labour Arbitration*, Third Edition, discuss what adjudicators must consider when deciding the propriety of a disciplinary action. At paragraph 7:0000 it states:

> *First, it must determine whether the employee actually engaged in some form of misconduct. Then, if it answers that question in the affirmative, it must decide whether such misconduct warrants the particular discipline imposed....*

In applying this to the case of Mr. O'Hagan, Mr. Heidinger stated the employer alleges misconduct in that Nurse O'Hagan did not provide Dr. Gopi with appropriate information. Mr. Heidinger suggested Dr. Gopi had some responsibility to raise certain questions if he felt he needed more information before exercising his authority. While Mr. O'Hagan recognizes he committed an error, he did not misconduct himself. So, in this case, while there might have been an error, there was no misconduct. Without that element, there can be no discipline.

In the alternative, Mr. Heidinger said if I were to find there was some misconduct, I had to look at whether the discipline was appropriate or not. Four days is a very significant penalty for what is, at most, an error in judgement. The grievor had a lengthy and excellent record. No one else was disciplined even though it was a team decision to put Patient "X" in a strip cell. What this amounts to, Mr. Heidinger stated, was a "discipline the messenger" situation.

In reply, Mr. Fader stated the discipline was based on the phone call and as Mr. O'Hagan made it, there was no need to discipline others. While Dr. Gopi may have had some responsibility to raise issues, the discipline was based on what was misrepresented to Dr. Gopi.

Decision

Mr. Heidinger stated that he believed there was no misconduct at the outset and, absent a finding of misconduct, there can be no discipline attached. I will deal with that issue firstly.

The responsibility to make the telephone call seeking authorization fell to the grievor in his capacity as charge nurse, so he contacted Dr. Gopi. The imposition of a four-day suspension was based on the fact the grievor did not provide Dr. Gopi with all

relevant information. The "Disciplinary Action Report", Exhibit E-2, states that the suspension was taken "[b]ecause of the seriousness and the consequences of your not providing the psychiatrist with appropriate information, and because the patient was asleep in bed and no emergency existed...."

While there is no question that the patient was asleep and not causing any problem at that time, in order to find misconduct I believe I must look at the information imparted by Nurse O'Hagan to Dr. Gopi and determine if it was untrue or if there was a deliberate attempt to mislead. Nothing in the evidence suggests that such was the case.

I was not made aware of anything that was said to Dr. Gopi that was untrue. It has also not been shown, I believe, that Mr. O'Hagan deliberately omitted what Dr. Gopi felt was relevant information. There was no evidence that Mr. O'Hagan intended to mislead Dr. Gopi and there was no evidence that the omission of the fact Patient "X" was asleep at the time was anything other than an innocent omission.

Dr. Gopi stated that, in order for him to authorize placement in a strip cell, there had to be a demonstration of the escalation of the problem and potential for harm must be prevalent. Dr. Gopi stated these factors were absent with respect to Patient "X" and he would not have authorized the placement in a strip cell had he known Patient "X" was asleep. Exhibits E-9, the "Standing Order - Intensive Psychiatric Care", and E-10, the "Policy and Procedure - Use of Seclusion", specify that seclusion may be used to prevent a patient from harming himself or other patients. No such need prevailed at that moment, according to Dr. Gopi.

In this case, Dr. Gopi said he acted in good faith based on what Mr. O'Hagan told him. However, what Mr. O'Hagan told him was not incorrect, nor does the evidence show he purposely omitted details.

While there is no question it would have been better to provide Dr. Gopi with as complete a picture as possible about the situation, I have not been persuaded there was any attempt to mislead. I believe that Nurse O'Hagan was of the honest belief that the appropriate course of action to follow was to put Patient "X" in a strip cell. However, the authorization to do so was Dr. Gopi's and his permission was sought.

The fact there was information omitted from the briefing Mr. O'Hagan gave to Dr. Gopi is not, I believe, reason, in and of itself, for discipline. It has not been proven to me that there was a deliberate attempt to mislead and, accordingly, I cannot find that misconduct exists.

For these reasons, the grievance is sustained. Mr. O'Hagan is to be reimbursed for four-days pay which has been deducted from him for this event.

Joseph W. Potter,
Board Member

OTAWA, May 4, 1998.