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Federal Public Sector Labour Relations and Employment Board Act and *Federal Public Sector Labour Relations Act*

Before a panel of the Federal Public Sector Labour Relations and Employment Board

BETWEEN

SAGHAR (SARA) MOHAJER-BAYANI, TENEILLE LEDDING, AND KARLA HERMAN

Grievors

and

DEPUTY HEAD
(Correctional Service of Canada)

Respondent

Indexed as
Bayani v. Deputy Head (Correctional Service of Canada)

In the matter of individual grievances referred to adjudication

Before: John G. Jaworski, a panel of the Federal Public Sector Labour Relations and Employment Board

For the Grievors: Kris Hawkins, Professional Institute of the Public Service of Canada

For the Respondent: Christine Langill, counsel

Heard at Saskatoon, Saskatchewan,
September 27 to 30, 2016, and March 28 to 31, 2017.

I. Individual grievances referred to adjudication

[1] At the relevant time, Saghar (Sara) Mohajer-Bayani, Teneille Ledding, and Karla Herman ("the grievors") were all employed by the Treasury Board ("the employer") at the Correctional Service of Canada ("CSC") as registered nurses ("RNs") and were all working at the Regional Psychiatric Centre ("RPC") for the CSC's Prairie Region in Saskatoon, Saskatchewan.

[2] On January 15, 2014, Ms. Ledding was given a two-day suspension (totalling 15 hours) without pay after an investigation by the CSC determined that she had provided a false statement in relation to the performance of her duties on January 17, 2013. She filed a grievance against the discipline the same day.

[3] On February 7, 2014, Ms. Bayani was given a two-day suspension (totalling 15 hours) without pay after an investigation by the CSC determined that on January 19, 2013, without the appropriate authorization, she administered a dosage of insulin to a patient at the RPC. She filed a grievance against this discipline the same day.

[4] On February 6, 2014, Ms. Herman was given a one-day suspension (totalling 7.5 hours) without pay after an investigation by the CSC determined that on January 17, 2013, without the appropriate authorization, she administered a dosage of insulin to a patient at the RPC. She filed a grievance against the discipline the same day.

[5] Each grievor stated the following in her individual grievance:

- the discipline was unwarranted, unjust, excessive, and without cause;
- the investigation report was flawed and denied her natural justice;
- the investigators reached conclusions that had no basis in fact; and
- at no point during the investigation was she advised that her actions were being investigated or that she would be subject to discipline as a result of the information she provided to the investigators.

[6] Each grievor requested the same relief, which was that her suspension be rescinded, the investigation report be destroyed, all references to the discipline be removed from all her personnel files, and she be made whole in every way.

[7] On November 1, 2014, the *Public Service Labour Relations and Employment*

Board Act (S.C. 2013, c. 40, s. 365: *PSLREBA*) was proclaimed into force (SI/2014-84), creating the Public Service Labour Relations and Employment Board ("the PSLREB") to replace the former Public Service Labour Relations Board ("the PSLRB") as well as the former Public Service Staffing Tribunal. On the same day, the consequential and transitional amendments contained in ss. 366 to 466 of the *Economic Action Plan 2013 Act, No. 2* (S.C. 2013, c. 40) also came into force (SI/2014-84). Pursuant to s. 393 of the *Economic Action Plan 2013 Act, No. 2*, a proceeding commenced under the *Public Service Labour Relations Act* (S.C. 2003, c. 22, s. 2: *PSLRA*) before November 1, 2014, is to be taken up and continue under and in conformity with the *PSLRA* as it is amended by ss. 365 to 470 of the *Economic Action Plan 2013 Act, No. 2*.

[8] The grievances were referred to adjudication on February 20, 2015.

[9] On June 19, 2017, *An Act to amend the Public Service Labour Relations Act, the Public Service Labour Relations and Employment Board Act and other Acts and to provide for certain other measures* (S.C. 2017, c. 9) received Royal Assent, changing the name of the PSLREB and the titles of the *PSLREBA* and the *PSLRA* to, respectively, the Federal Public Sector Labour Relations and Employment Board ("the Board"), the *Federal Public Sector Labour Relations and Employment Board Act*, and the *Federal Public Sector Labour Relations Act* ("the *Act*").

II. Summary of the evidence

[10] The events that led to the grievors' discipline arose between Monday, January 14, 2013, and Saturday, January 19, 2013, in the Churchill Unit ("the Churchill") at the RPC and involved prescribing and administering medication to a female inmate (whose name is anonymized as "IM A" in this decision), specifically Humulin R, an insulin, and documenting those activities.

[11] All times are identified using a 24-hour clock.

A. The Churchill

[12] The RPC is a federal correctional institution with male and female inmates under minimum, medium, and maximum security. The inmates were described as having elevated needs and as suffering from a variety of and high degree of mental illnesses and many different medical conditions. Female inmates are all housed on the Churchill, which consists of 12 cells. During the week of January 14, 2013, the evidence disclosed that all 12 cells were occupied, one by IM A.

[13] The Churchill is laid out as a square, with three sides each containing four cells and the fourth side (the most northerly) housing the entrance to the unit as well as the control post, nursing station, and medication room.

[14] Access to the Churchill is via a corridor (Hallway E-02) that runs north-south from the main corridor (Hallway E-01), which is at the north end of Hallway E-02; the Churchill is at the south end. Just inside Hallway E-02 after entering it from Hallway E-01 and immediately to the west are a series of cells with cameras, which are also part of the Churchill.

[15] The control post, nursing station, and medication room are all part of one series of rooms accessed by a single door that exits into Hallway E-02 from the east just before the entrance from Hallway E-02 into the Churchill. The nursing station is accessed through the control post and is separated from it by a door. The path to the medication room goes through the control post and nursing station. The control post was also referred to as the "nursing bubble". At the south end of the nursing station is a small area with a window that opens south, into the common area of the Churchill. This is where the inmates go to speak to a nurse and to have their medication dispensed or administered to them.

[16] Behind and to the east of that dispensing area and still within the nursing station is the locked medication room. Its keys are secured in a cabinet in the nursing station by a combination lock. All nurses who work on the Churchill know the combination. While both RNs and correctional officers (CXs) would generally access and work within the control post, the medication room can be accessed only by the RNs working in the unit.

[17] On exiting Hallway E-02 and turning left (or west) into Hallway E-01, the adjacent wing of the RPC is the CSC's Regional Hospital. Clinics take place there. Patients are brought for meetings with or examinations by physicians, psychiatrists, and psychologists.

[18] Nurses' shifts were standardized throughout the RPC. The "A" shift was from 06:45 to 19:45, the "B" shift was from 09:15 to 22:15, and the "C" shift was from 19:00 to 07:00. In simple terms, this meant that largely during the day, between 09:15 and 19:45, two nurses were on the Churchill, and that overnight, between 22:15 and 06:45, there was only one.

[19] Telephone calls to or from the RPC were channelled through a switchboard system. Cell phones were not allowed into the RPC; those entering the institution, including physicians, had to leave them behind.

B. The individuals involved

[20] IM A suffered from a variety of medical conditions, including type 2 diabetes, which was first identified in December of 2012 while she was on the Churchill. She died in the early hours of January 20, 2013.

[21] All the grievors obtained their bachelor of science (BSc) degrees in nursing from the University of Saskatchewan, Ms. Herman in 2007, Ms. Bayani in April of 2010, and Ms. Ledding in 2011. All became RNs by enrolling as members in the Saskatchewan Registered Nurses' Association ("SRNA").

[22] All the grievors began working at the RPC on the Churchill after joining the CSC, Ms. Herman in January of 2008, Ms. Bayani in April of 2010, and Ms. Ledding in June of 2011. Ms. Ledding left the CSC in June of 2016; Ms. Herman did so in January of 2017. As of the hearing, Ms. Bayani was still employed at the CSC.

[23] Carson Gaudet (at the material times, she was known Carson Shaw, and will be referred to as "Ms. Shaw" in this decision) is currently employed by the CSC at the RPC as the senior clinical manager classified at the AS-07 group and level. She obtained her BSc in nursing from the University Of Saskatchewan in 2010. She is an RN and a member of the SRNA. At the material times (January of 2013), she worked on the Churchill.

[24] Lisa Madrega is currently employed by the CSC as the acting clinical team lead for the female unit at the RPC. In January of 2013, she was the nursing supervisor on the Churchill and had been one since 2009. She is a registered psychiatric nurse.

[25] Dr. Jonathan Witt received his medical degree from the University of Saskatchewan's College of Medicine in 1998 and since then has practised both family and emergency medicine in Saskatchewan. As of the hearing, he was an emergency physician in the Saskatchewan Health Region, a transport physician for STARS (Shock Trauma Air Rescue Service), and a medical director with the Saskatchewan International Physician Practice Assessment. Since 2002, he has practised primarily in the emergency medicine area and has taught at the University of Saskatchewan's medical school. He testified that starting in or about the summer of 2010 and for a

term of four years, he and other physicians in a group of emergency and family physicians (the Saskatchewan Regional Group or "SRG") provided medical services to the CSC at the RPC, under contract; they were not CSC employees.

[26] Benjamin Spicer obtained BScs in kinesiology and nursing from the University Of Saskatchewan in April of 2009 and became an RN by becoming a member of the SRNA in June of 2009. He joined the CSC at the RPC in March of 2010. He stated that in 2007-2008, he did his nursing practicum at the Saskatchewan Penitentiary. He remains employed as an RN at the RPC. In January of 2013, his main work area was the Bow Unit, but he said that he often worked on the Churchill and that he worked with all the grievors.

[27] As of the hearing, Shawn Bird had been with the CSC for 28 years and at the RPC for 5½ years. Before the RPC, he had been at the Saskatchewan Penitentiary as a CX, a correctional manager, an assistant warden, and a deputy warden. He moved to the RPC in 2011 as the executive director and was made the warden in 2014.

[28] As of the hearing, Calvin Clements had been with the CSC since 2009. He obtained his BSc in pharmacy in 2001 from the University of Saskatchewan. He was licensed from 2001 to 2003 in Alberta and in 2003 in Saskatchewan. Between 2001 and 2009, he worked as a pharmacist in the community. In 2009, he joined the CSC as a staff pharmacist; in 2012, he became the regional pharmacist. The CSC's Regional Pharmacy in Saskatchewan is located at its regional headquarters ("RHQ").

[29] After IM A died on the Churchill, an investigation was convened into her death.

[30] On May 3, 2013, based on information gathered during the course of that investigation, Mr. Bird convened an investigation into Ms. Bayani's actions. The relevant portion of the order convening that investigation stated that "it is alleged that on January 19, 2013, Saghar (Sara) Mohajer-Bayani, Staff Nurse, allegedly failed to have obtained proper authorization prior to the administration of insulin to patient [IM A] (FPS#. . .)." Mr. Bird appointed Michelle Beyko and Matthew Gee ("the investigators") to conduct it ("the Beyko investigation").

[31] During the Beyko investigation, they uncovered information that they believed implicated two of the grievors, Mses. Ledding and Herman, along with Ms. Shaw, in misconduct related to administering medication to IM A. As such, Mr. Bird expanded the investigation to include them.

[32] The investigators issued their final report on their investigation on August 23, 2013 ("the investigation report"), which the RPC's acting executive director received on August 26, 2013.

[33] As of the hearing, Ms. Beyko had been with the CSC for 21 years and at the RPC for 13 years. She is an RN and holds that designation in Saskatchewan, Alberta, and Manitoba. She worked as an RN, program co-ordinator, and program director. After her time at the RPC, she became a manager of public health and is currently the regional manager of clinical services. In January of 2013, she was the regional manager of public health at RHQ in Saskatoon.

[34] In August of 2013, Mr. Gee was an acting manager of programs at Stony Mountain Institution in Manitoba. He did not testify.

[35] "FPS No. (#)" is a CSC acronym for a fingerprint system number assigned to every federal inmate. It is used as an identifier. It is referred to as "FPS number" in this decision.

C. Policies, standards, documentation, and process with respect to medications prescribed and administered to patients

[36] The CSC has a number of rules and regulations on administering medication to inmates in its custody. They are set out in a number of documents. They require that the CSC's healthcare professionals authorize and maintain certain forms and documentation.

[37] All the grievors, as well as Ms. Shaw and Mr. Spicer, were known as staff nurses at the RPC and were governed by a work description, the key duties and responsibilities of which stated as follows:

> . . .
> *Provides health care services to implement therapeutic, preventative, diagnostic, rehabilitative interventions with mentally ill forensic patients using the nursing process.*
>
> *Administer medication to patients in accordance with the Law, provincial standards, institutional procedure and Doctor's orders.*
>
> *Provides for the safe and legal management, storage, recording and administration of pharmaceutical and medical supplies.*
>
> . . .
> *Observes and reports changes in patients mental and physical condition.*

. . .

[38] Ms. Madrega stated that in January 2013, her nursing supervisor duties and responsibilities for the Churchill included the following:

- developing clinical plans for patients in conjunction with healthcare teams, including medical treatment and psychiatric teams for females with complex cases (which included a number of self-harming women) and developing behaviour modifications to achieve mental health stability;
- being the clinical lead of the Churchill;
- supervising the nurses on the staff;
- handling staffing;
- carrying out performance evaluations of her staff;
- ensuring that mental health and physical care were being carried out, and appropriately; and
- providing input into admissions and discharges to and from the Churchill.

[39] The CSC has a series of policies and commissioner's directives ("CDs") that govern health services and administering and documenting medications in its facilities. CD 800 is entitled "Health Services" and states as follows at section 17:

> *17. Medication for inmates shall be prescribed by an institutional Clinician only when clinically indicated. The administration of medication to inmates for restraint or for other security purposes is not permitted.*

[40] CD 805 is entitled "Administration of Medication" and states the following:

> ***POLICY OBJECTIVE***
>
> *1. To ensure the safe and legal management, storage, recording, dispensing and administration of medication in order to meet the Service's obligation to provide health care in accordance with the* **Corrections and Conditional Release Act.**
>
> . . .

DEFINITIONS

. . .

9. Institutional Clinicians – Includes physicians, dentists, and psychiatrists who have the authority to order medications due to their contractual scope of work.

. . .

INSTITUTIONAL RESPONSIBILITIES

19. After a nursing assessment, a registered nurse may administer appropriate medication as per the clinical order for medication.

20. When on site, the institutional nurse shall be responsible for the administration of medication as prescribed by the clinician.

. . .

23. Registered nurses shall be responsible for initiating the ordering, recording, receipt, safekeeping and issue of all narcotics, controlled, prescription and over-the-counter drugs excluding those over-the-counter drugs available through the inmate canteen.

. . .

PROCEDURES

. . .

26. The management, control, storage and dispensing of drugs and medical supplies shall be in accordance with generally accepted management and pharmacy practices.

. . .

37. The nurse or clinician who administered the medication shall record the following information in the inmate's health care record:

a. all medication dispensed and administered to an inmate by the Health Services Centre;

b. medication incidents and adverse drug reactions;

c. telephone and verbal orders from a clinician and signed by the nurse receiving the order (the clinician shall sign the order on the next visit to the institution).

[41] CD 835 is entitled "Health Care Records" and states as follows:

POLICY OBJECTIVE

1. To facilitate the provision of effective medical and health services to inmates by keeping consistent health care records.

. . .

> ***ORGANIZATION AND CONTENTS***
>
> . . .
>
> *8. Every significant interaction between an inmate and any member of the health services team shall be noted on the offender's health care record, including a summary of the nature of the interaction, the time of the interaction and a description of the action taken by health services staff.*
>
> . . .

[42] The CSC's guidelines entitled, "Medication Distribution and Administration" ("the MDA guidelines"), in effect in January of 2013, provided the following:

> ***3.1. Medication Distribution and Administration — General Guidelines for Health Care Professionals***
>
> . . .
>
> *7. High-alert/high-risk medications*
>
> - *Independent double check (as evidenced by double signatures on the High Risk/High Alert Medication Double Check Log) by a second nurse is recommended for administration of some high-alert/high-risk medications (see Appendix B).*
> - *In situations where only one nurse is available, that nurse will double check the medication prior to administration and ensure that standards of practice are followed at all times as evidenced by signature on the High Risk/High Alert Medication Double Check Log and indication on the log that the nurse was alone.*
> - *The completed High Risk/High Alert Medication Double Check Log will be filed on the same section as the Medication Administration Record on the Health Care Record.*
> - *Other measures are utilized by CSC to alert health care staff to the high risk nature of these medications including special labelling and auxillary (sic) stickers*
>
> *8. Documentation*
>
> - *Document the distribution / administration of each medication on the Medication Administration Record (CSC **946**).*
> - *Where relevant (offender refuses or misses medication, has side effects, etc.), document further details on the Doctor's Orders and Progress Notes (CSC **471**) on the offender's Health Care File for the physician/psychiatrist's review, as per the **Documentation for Health Services Professionals.***

[Emphasis in the original]

[43] Appendix B sets out high risk/high alert medications. The CSC also has a guideline entitled "High Risk/High Alert Medications" ("High Risk/High Alert guidelines") that was in effect in January of 2013. It identifies that high risk/high alert medications are drugs that bear a heightened risk of causing significant patient harm when used incorrectly and that all nurses should be aware of them. That document is available to all CSC staff via its "Info Net".

[44] The CSC policy entitled, "Documentation for Health Services Professionals" ("the documentation policy"), in effect in January of 2013, provided the following:

> ***1.1 Purpose of these Guidelines***
>
> *The purpose of these guidelines is to present norms for documentation of health care on the Health Care File for nurses and other health care professionals working for CSC.*
>
> . . .
>
> ***3.1 Purposes of the Health Care File (HCF)***
>
> . . .
>
> **3.1.1 Accurate Record of Care**
>
> - *In accordance with professionally accepted standards of practice and CD **835**: "Every significant interaction between an offender and any member of the health services team shall be noted on the offender's health care record, including a summary of the nature of the interaction, the time of the interaction and a description of the action taken by health services staff."*
>
> - *Thus, documentation includes but is not limited to the following: progress notes of significant encounters by members of the health services team; intake assessments; interventions; Medication Administration Records; prescriptions; consultation reports; X-ray reports; ongoing blood work/treatments; and health-promotion and illness-prevention activities relating to the offender in question.*
>
> ***3.1.2 Planning and Continuity of Care***
>
> *Good documentation is the basis for ensuring continuity of care, ensuring the following components:*
>
> - ***Communication among health professionals** – good documentation allows all health professionals to make decisions regarding care taking into account the input of all other care providers and results of all*

investigations.

- ***Coordination of care*** *– good documentation helps providers to better coordinate and plan the provision of care.*

3.1.3 Legal Accountability and Protection

The Health Care Record also serves as a tool to protect the legal interests of the offender, CSC and the Health Services staff.

All ***regulated health professionals*** *must document the care they provide. (See Section 3.2.1.a. Role of Designated Recorder During Emergencies below.)*

- *Documentation is a legislative requirement; it is proof that the care was provided. Legally, the provision of health care is not considered completed or done unless it is documented.*

- *The health record is a legal document and can be used as evidence during a Board of Investigations, a coroner's inquest, a court of law, etc.*

- *The best legal protection for the health care professional is to ensure their documentation adheres to the professional standards of practice and follows CSC policies, procedures and guidelines.*

- *The provision of health care will be measured according to the standards of a reasonable and prudent practitioner with similar education, experience, and knowledge in similar situation* [*sic*].

. . .

3.2 Basic Documentation Requirements

To ensure legal accountability and to facilitate continuity of care, all ***regulated health professionals must document the care they provide,*** *as per the following basic requirements:*

3.2.1.a) General Requirements

. . .

- ***Order*** *– Enter all information in chronological order, leaving no gaps or blank lines.*

- ***Gaps*** *– If it is necessary to leave a space between entries, draw a single line through the empty space.*

. . .

4.3 Telephone Calls to Physicians Regarding Care

If the nurse must phone the institutional physician to advise

> *of an event or a significant change in a [sic] offender's condition, it is very important to* ***document this accurately and completely*** *in their health care file. Do not simply write "Doctor informed of offender's condition and orders received". Note the following information on the Progress Notes:*
>
> - *details of the nursing assessment that led to the call to the institutional physician*
> - *date and time the call was made to the physician;*
> - *name of the physician who responded to the call;*
> - *time the physician responded to the call;*
> - *information that was provided to the physician*
> - *all the instructions given by the physician*
> - *any subsequent assessments and interventions carried out as a result of the call*
>
> . . .
>
> ***5. MANAGING THE HEALTH CARE FILE***
>
> *The maintenance of the Health Care File is a continuous process and is largely the responsibility of nursing staff.. . .*
>
> . . .
>
> [Emphasis in the original]

[45] Each inmate on the Churchill had a medical record containing materials relevant to her treatment and care that was kept in a large three-ring binder. The individual inmate records were separated by tabs. Included in each inmate's record was a living document identified as "Progress Notes". Each inmate had a medication record that was also kept in a large three-ring binder. The evidence was not clear if there were one or two binders or some combination of them.

[46] At the time of IM A's death, all her records were seized by a person or persons not identified to me. I was provided with no clear chain of control over her medical and medication records.

[47] Ms. Madrega identified Progress Notes as the record of care referred to in the documentation policy at section 3.1.1, entitled, *Accurate Record of Care*. The Progress Notes are lined but otherwise blank pages divided into two sides. The left one-third of one side is used to identify who makes the observation and the date and time. The right two-thirds of the page is used to set out the observation being made. The

observations are handwritten and are initialled by the person making them. Ms. Madrega said that all healthcare professionals, including physicians, RNs, and social workers, write in the Progress Notes.

[48] Institutional clinicians are defined in CD 805 as including physicians, dentists, and psychiatrists who have the authority to order medications due to their contractual scope of work. Orders to administer medication to a patient are set out on a document called a "Doctors Order Sheet".

[49] The Doctors Order Sheet is a printed form that at the top sets out the institution name and patient details. It is otherwise blank but contains lines and columns for the date of the order, the time of the order, the specific medication order, the notation that someone verified it, and the expiry date of the order. However, with respect to orders for insulin, the physicians use a second document entitled, simply, "Physician's Orders".

[50] The Physician's Orders is also a printed form that at the top sets out patient details. The balance of it sets out specific potential options for the type of insulin, the time of the dosage, and the dosage amount on a sliding scale based on blood-sugar readings. At the bottom is a space for the ordering physician to sign and date it.

[51] For diabetic patients who receive insulin, another document must be completed that is entitled, "Diabetic Chart". It is a printed form that sets out the patient's name and that is divided into 22 separate lines to record the following information:

- the date;
- the time;
- the blood-sugar reading;
- the urine test results (if one was done);
- the patient's weight;
- any comments (the action that was taken and the amount and type of medication administered); and
- the initials of the person administering the medication.

[52] Each patient also has a document called the "Medication Administration Record" ("MAR"). It is a printed form that at the top has blank boxes to be filled out for the patient's name, the institution name, the assigned physician's name, the patient's problems, the patient's FPS number, the patient's hypersensitivities (if any), the date on which the order was made and the stop or end date, and any comments.

[53] Information on the MAR is colour coded. The end date is written in red ink, and if the order is stopped or superseded by another order, the entire box is highlighted in yellow. Below this information and on the right one-third of the balance of the form are seven blank boxes in which medications are listed along with the prescribing physician's name. To the right of each box is a box for the time and date covering four timeslots daily for each day of a month. The time slots are blank and are to be filled in depending on the time and frequency of each medication dosage.

[54] Dr. Witt described a standing order ("SO") as one for an intervention or medication that is to be administered or performed in a given clinical situation, the duration of which varied. He stated that a "stat-order" is a one-time, isolated intervention. The evidence disclosed that both SOs and stat-orders were written on the Doctors Order Sheet.

[55] According to Ms. Madrega, a nurse on her staff would have been authorized to administer medication per a clinical order once she or he had assessed the patient who would receive it.

[56] Dr. Witt described his duties and responsibilities as a contract physician as including the following:

- providing medical services to the inmates at the RPC that would ordinarily be provided by a family physician;
- providing services at clinics for methadone treatment ("MTD") and chronic disease management ("CDM"), which consisted largely of diabetic issues; and
- being the on-call physician.

[57] Dr. Witt testified that the physicians would be on call to address urgent or emergency situations. He stated that the SRG used an answering service to direct incoming calls. The RPC would contact the answering service, which would in turn text

the physician on call, who would then call into the RPC and be directed to the area of the institution that needed his or her assistance.

[58] The evidence disclosed that physicians may make medication orders in person, by filling out forms and signing them, or by telephone. If a telephone order is made, the order is to be transcribed on the appropriate form such that it is recorded and documented. The ordering physician is supposed to sign the form the next time he or she is at the RPC.

[59] The evidence disclosed that with respect to a telephone order from a physician for medication, the Director General of Health Services issued a memo on February 20, 2012, the relevant portions of which read as follows:

> . . .
>
> *According to Accreditation Canada, pharmacy and other service providers accept telephone orders for medication only in emergencies.*
>
> *Recognizing, that CSC faces unique challenges in terms of restricting telephone orders to only emergency situations, staff are expected to respect the following guidelines, as outlined in the Regional Pharmacy Operations and Standards Manual:*
>
> ***Telephone Medication Orders Note:***
>
> *In order to minimize transcription errors, telephone orders must be kept to a minimum. They should only be accepted in emergency situations and/or those situations where interruptions in treatment may occur.*
>
> - *They may be given to a nurse or pharmacist by a physician and should always be re-read to the caller to ensure accuracy.*
>
> - *Telephone orders taken by nurses must be transcribed in the health care file and faxed to the pharmacy.*
>
> - *Telephone orders must be signed by the physician at the earliest opportunity.*
>
> . . .

[60] The evidence also disclosed that for telephone orders, the nurse speaking with the physician about the request is to provide information to the physician that is critical for the physician to consider when determining the medication order. At the time of the events at issue, the RNs at the RPC were using a document called the "9 Liner", which was a list of nine points of information they were to have on hand when they contacted the physician. The 9 Liner stated as follows:

1. *Nurse ID*
2. *Unit ID*
3. *Patient ID (name, age)*
4. *Chief Complaint/Concern*
5. *Vital Signs – BP, TPR, SpO2, BSL, GCS (include any allergies)*
6. *Assessment – e.g.) s/s, pale, diaphoretic, SOB, lung sounds, pain, anxiety etc…*
7. *Current Meds*
8. *Nurses Impression*
9. *What do you want for the patient/what do you think the patient needs?*

[61] Blood sugar (also referred to as blood glucose) is measured in millimoles per litre (mmol/l) of blood. For ease of reference in this decision, when I refer to blood-sugar readings, they are in those units, but I include only the number value.

[62] Insulin in several forms and brand names, including Humulin R, is found on the list of high risk/high alert medications on page 4 of the High Risk/High Alert guidelines and in the MDA guidelines.

[63] Dr. Witt testified that Humulin R is fast-acting and takes effect within 15 to 30 minutes of administration. He described that the phrase "high intensity" is based on the individual patient's needs. He described a "sliding scale" as a different pre-set dosage of the drug to be administered based on the patient's blood-sugar reading. The nurses on the unit took those readings via a "Chemstrip", which tests blood glucose via a finger stick needle.

D. The Regional Pharmacy

[64] Mr. Clements testified that the regional pharmacist's duties are to oversee all pharmacy services, including ensuring that federal and provincial legislation is adhered to and that CSC standards and polices are followed.

[65] Mr. Clements testified that in January of 2013, when a physician prescribed a drug, his or her written order was faxed to the Regional Pharmacy, which had two fax machines, one designated for orders from the RPC. He said that when an order came in

by fax, a pharmacist input the information into the computerized record system to ensure that there were no contraindications with respect to the prescription and any other medications an inmate might be taking. That information included the patient's name, FPS number, and date of birth and the specifics of the order.

[66] Mr. Clements stated that the regional pharmacy keeps an up-to-date record of all medications that inmates receive; it also provides printed MARs to institutions. The system also contains a database of inmate allergies and performs a drug interaction assessment.

[67] Introduced into evidence were two reports from the regional pharmacy. The first was a patient profile record of all drug orders received for IM A from January 12 to January 19, 2013, and the second was a record of all drug orders for Humulin R received from the RPC for January 12 to January 19, 2013. The records indicate that three orders for Humulin R were sent to the Regional Pharmacy in the week of January 12 to 19, 2013. Two were not for IM A; only one was for her. That order was made on January 15, 2013, and Dr. Witt was the prescribing doctor.

[68] The records specific to IM A show that eight orders for medications were faxed to the Regional Pharmacy between January 12 and 19, 2013. Of them, only one was for Humulin R, and the prescriber was Dr. Witt. Four drugs were prescribed after the Humulin R, all by Dr. Witt. While two did not have a date on the list, the final two did, which were shown as having been prescribed on January 18, 2013.

[69] With respect to the MAR, Mr. Clements stated that all sites in the CSC's Prairie Region are serviced through the Regional Pharmacy, and they all use the same MAR form.

[70] In cross-examination, Mr. Clement agreed that he had received some complaints from RNs that faxes had not transmitted properly, although he stated that it was not a common occurrence. He did state that telephone orders that had been transcribed but that had not been signed by the prescribing doctors had been faxed. However, before the pharmacy would dispense medication pursuant to such an order, the prescribing doctor would have to contact it or co-sign the order.

[71] Mr. Clements stated that if an order came in after 14:00, Monday through Friday, it would be logged in the next business day. Orders faxed on a weekend would be logged into the system on the following Monday morning.

E. Relevant SRNA guidelines

[72] Entered into evidence were the following two documents from the SRNA:

- "Documentation: Guidelines for Registered Nurses", effective December 1, 2011 ("the SRNA Documentation Guidelines"); and
- "Medication Administration: Guidelines for Registered Nurses", effective February 2007 ("the SRNA Med. Admin. Guidelines").

[73] The following sections of the SRNA Documentation Guidelines were highlighted in the evidence and reviewed with each grievor in cross-examination:

> *Introduction*
>
> . . .
>
> ***Documentation is not separate from care and it is not optional. It is an integral part of nursing practice.***
>
> . . .
>
> *. . . There is also substantial evidence to indicate that when documentation concerning client care is poor (incomplete, inaccurate or even inappropriate) and the care team is unsure as to the care required (or provided), potential negative consequences for clients may occur from:*
>
> - *inability to provide continuity and consistency of care;*
> - *the omission or duplication of treatment;*
> - *inappropriate care decisions;*
> - *inability to evaluate the effectiveness of care/treatment; and*
> - *responding ineffectively to deterioration in a client's health status (Marsh, 2007, p.4).*
>
> . . .
>
> ***. . . RNs are expected to adhere to all relevant legislation, standards and competencies, and agency policies and procedures related to privacy, documentation and information management (e.g., verbal, written or electronic).***
>
> *Although different documentation formats and technology may be used throughout the province, quality nursing documentation is an expected RN practice in every area of care, service delivery and setting. This includes RNs who are self employed and/or working in an independent practice.. . .*
>
> . . .

1. Why Should RNs Document?

. . .

1.3 Mechanism for Professional Accountability

Accountability means being answerable for one's own actions. The health record demonstrates RNs' accountability and gives credit to RNs for the care they give or the service they provide. In Saskatchewan, all RNs are required to document evidence of safe, competent and ethical care in accordance with the current Standards and Foundation Competencies for the Practice of Registered Nurses; Registered Nurse (Nurse Practitioner) RN(NP) Standards & Core Competencies; Code of Ethics for Registered Nurses; *and applicable agency policy. Documentation must reflect the RN's professional judgment, assessment, coordination of care, decisions, actions, and evaluation. Additionally, documentation must honour the ethical concepts of good practice such as promoting respect, confidentiality, and informed decision making.*

1.4 Protection Against Liability

The client's record is a legal document and, as such, can be used as documentary evidence in a court of law. Documentation should provide a chronological record of the events involving client care and services and may be used to refresh one's memory, if required to give evidence in court. Courts will use clinical documents to reconstruct events, establish times and dates, and to substantiate and/or resolve conflict in testimony.

Documentation provides specific information (who, what, how and why) about the planning for, provision of, and client's response to care or services. It provides evidence that safe and competent care was delivered, that the care/service met acceptable standards of care, was reasonable and prudent, was provided in a timely manner and, was consistent with agency policies and procedures. Altering or failure to keep records as required could result in legal and professional ramifications. The perception of alteration and/or falsification reduces the credibility of documentation, and can undermine the ability for defence in an inquiry, investigation, or proceeding (Brous, 2009). One example would be using whiteout or correction tape on the medical record and writing over top. Quality documentation is a RN's best defence in legal proceedings (Canadian Nurses Protective Society [CNPS], 2007b).

. . .

2. Who Should Document?

. . .

2.1 Firsthand Knowledge

Legal and professional principles dictate that the provider with personal or firsthand knowledge (you did it or you saw it) should document the information. *Firsthand knowledge in this context means that the professional who is doing the recording is the one who provided the care. For example, completion of an incident report by the RN who witnessed a client fall.*

In situations when two or more people provide care or services, the RN who has the primary assignment is expected to document the assessment, intervention and client response, noting as necessary the role of other care providers. However, the second nurse is expected to review the documentation, making an additional entry if necessary and, in accordance with agency policy cosign the record (see Section 2.3). In some cases it may be more appropriate for both people to document his/her role in the care, for example to reflect different assessments or roles, or to meet agency policies that require more than one care provider (e.g., two nurse assist for high risk delivery).

. . .

1.3 Cosigning and Countersigning Entries

. . .

There are some examples where cosigning is prudent practice, such as, recording a critical incident witnessed by a second care provider, verbal consent or telephone orders, verification of a medication dosage, discarding of a narcotic, or client identification for a blood transfusion. Cosigning implies shared accountability. ***It is imperative that the person cosigning actually witnessed or participated in the event.***

. . .

3. How Should RNs Document?

. . .

3.2 Blank (White) Space

There should be no blank or 'white' space in documents as this space presents an opportunity for others to add information unbeknownst to the original author. To avoid this risk, ensure that documentation is charted in a consecutive manner and draw a single line completely through the blank space, ending with your signature/designation.. . .

. . .

3.4 Mistaken Entry/Errors

Inaccuracies in documentation can result in inappropriate care decisions. ***Errors must be corrected according to agency policy in an open and honest manner.. . .***

. . .

Do not make entries between lines, remove items (e.g.,

monitor strips, lab reports, requisitions, and checklists), erase or use correction products, hide or obliterate an error. . .

. . .

4. What Should RNs Document?

4.1 Clear, Concise, Unbiased and Accurate

Precision in documentation is imperative. . .

. . .

4.2 Date, Time, Signature and Designation

Notations in a health care record generally begin with the date and time of an entry and conclude with the recorder's signature and designation. Policies for documenting date, time and signature will vary from agency to agency . . . The record is a chronology of events and must be accurate, it is therefore critical to use the appropriate form of time as outlined by the agency (a.m./p.m. vs military time) and that a consistent timepiece or devise (e.g., watch, clock, monitor, computer) is used to record entries to accurately reflect sequencing of events.

. . .

4.5 Communications Among Health Care Providers

. . .

Faxing is a method for communicating information between health care providers in different locations. Although this is a commonly-accepted practice in most settings, RNs need to ensure that information is transmitted to the correct source and verify that the facsimile was completed as intended. . .

. . .

5. When should RNs document?

5.1 Timely, Frequently and Chronologically

Completion of the health care record notes should be done as close to the time of care as possible (also known as contemporaneous documentation) to enhance the credibility and accuracy of health care records (CARNA, 2006). *Documentation should* **never** *be completed before the care/service is provided. Frequent documentation supports accuracy, particularly when precise assessment is required as a result of changing client conditions or to limit reliance on memory when caring for multiple clients. Charting should be comprehensive, in-depth and frequent as a client's condition progresses towards greater complexity, is very ill or high risk (CNPS, 2007b). The frequency and amount of detail required is generally dictated by a number of factors, including:*

- *agency policies and procedures;*

- *complexity of a client's health problems;*
- *degree to which a client's condition puts him/her at risk;*
- *degree of risk involved in a treatment or component of care;*
- *changes in care plan; and*
- *client transition, e.g., admission/discharge, transfer or transport.*

Documenting events in the chronological order in which they took place is important, particularly in terms of revealing changing patterns in a client's health status. Documenting chronologically also enhances the clarity of communications; enabling health care providers to understand what care was provided, based on assessment data, and any outcomes or evaluations of that care, including client responses.

5.2 Late or Lost Entries

Record information as soon as possible after the event occurs. When it is not possible to document at the time of or within a reasonable period following an event, a late entry is required. Late entries should be defined in agency policy. Late entries in a health record should be made on a voluntary basis and only when a RN can accurately recall the care provided or the event. Late entries for paper-based health records must be clearly identified and dated with reference to the actual time of documentation as well as the time when the care/event occurred.

In the event of a lost entry (mislaid paper or a computer glitch), the RN may be asked to reconstruct the entry. The Registered Nurses Act, 1988 *states that professional misconduct occurs when a RN has falsified a record with respect to the observation, rehabilitation or treatment of a client [26(2)(i)]. Therefore, the new note must clearly indicate the information recorded is a replacement for a lost entry. If the care/event cannot be recalled, the new entry should state that the information for the specific time of the event has been lost (CRNNS, 2005).*

. . .

[Emphasis in the original]

[74] The following sections of the SRNA Med. Admin. Guidelines were highlighted in the evidence and reviewed with each grievor in cross-examination:

Introduction

. . .

Registered nurses receive significant educational preparation in medication administration over the course of their nursing education program. Preparation includes pharmacology, pathophysiology and nursing courses as well as other support courses and case studies. Registered nurses gain clinical knowledge of medications and integrate learning into practice through care planning, experience and continued education opportunities.

. . .

GUIDELINES FOR MEDICATION ADMINISTRATION

PRESCRIBING

. . .

Verbal, telephone and faxed orders

Verbal orders are those given by the prescriber face-to-face. Registered nurses should avoid accepting verbal orders when the prescriber is present and can document his or her own orders. Verbal orders are acceptable in emergent or urgent situations such as a code or trauma situation when it is difficult for the prescriber to document.

Telephone orders (verbal orders received via the telephone) can be more error-prone than written orders due to a number of variables such as misinterpretation of spoken language, background noise, disruptions and the potential for error with drug names that sound alike. Telephone orders should be limited to those situations in which direction for client care is required and the prescriber is not present. The prescriber is accountable for documenting and signing his or her telephone and verbal orders in a timely manner. Registered nurses are not responsible for ensuring such orders are signed.

. . .

Registered nurses:

- *Require knowledge of the client and the medication before accepting telephone orders*

- *Are accountable for recording information received verbally or by telephone accurately, repeating the order to the prescriber for verification, and for assessing the appropriateness of the medication for the client*

- *Document verbal or telephone orders and include faxed orders on the client record*

- *Follow agency policies related to verbal, telephone, and faxed orders*

. . .

TRANSCRIBING

> *Transcribing medication orders is a basic competency of registered nurses. It is a process of transferring the prescriber's order to a medication administration record for the purpose of directing administration of the medication. In some practice settings individuals other than registered nurses may be designated to complete the paper work involved in transcribing orders.*
>
> . . .
>
> [Emphasis in the original]

[75] In their cross-examinations, all the grievors were asked questions about both guidelines, and they agreed with the statements in them when those statements were put to them.

F. January 15 through 19, 2013

[76] Ms. Madrega stated that in January of 2013, approximately 40 nurses worked in 5 different units at the RPC (including the Churchill) and that she had 5 or 6 nurses reporting to her in each unit. She said that her normal working hours were from Monday to Friday, 08:00 to 16:00, and that her office was adjacent to the Churchill. In addition to her as a supervisor, 2 nursing shift supervisors were always in the RPC every day, 7 days a week, from 05:30 to 22:00.

[77] The schedules for the nurses at the RPC from Tuesday, January 15, through Saturday, January 19, 2013, were entered into evidence. Sometimes, they did not work full shifts in the same unit. The schedules together with the oral testimony disclosed that the grievors and Ms. Shaw worked as follows between January 15 and 19, 2013:

Date	Nurse	Unit	Shift	Start and end times
Jan. 15	Ms. Bayani	Churchill	A	06:45-19:45
	Ms. Shaw	Churchill	B	09:45-22:15
Jan. 16	Ms. Ledding	Churchill	A	09:45-19:45
	Ms. Bayani	Churchill	B	09:15-22:15
	Ms. Shaw	Churchill	B	09:15-18:15
Jan. 17	Ms. Ledding	Churchill	A	09:45-19:45

	Ms. Herman	Churchill		16:45-19:45
Jan. 18	Ms. Ledding	Churchill	A	09:45-19:45
	Ms. Shaw	Churchill	A	17:45-19:45
	Ms. Herman	Reg. Hospital		09:15-19:45
Jan. 19	Ms. Shaw	Churchill	A	06:45-19:45
	Ms. Bayani	Churchill	B	09:15-22:15

[78] The evidence disclosed that the physicians' schedule for the week of Monday, January 14, through Saturday, January 19, 2013, was as follows:

Date	**On call**	**Clinic**	**Rounds**	**MTD**	**CDM**
	(8:00-8:00)	**(8:00-12:00)**	**(13:00-14:00)**	**(8:00-12:00)**	**(13:00-17:00)**
Jan.14	O'Neill (8h-22h)	O'Neill	O'Neill	-----	-----
	Witt (22h-8h)				
Jan. 15	Witt	Witt	-----	-----	-----
Jan. 16	Witt	Witt	-----	-----	Witt
Jan. 17	Witt	-----	-----	Witt	-----
Jan. 18	Witt	Witt	-----	-----	-----
Jan. 19	Froh	-----	-----	-----	-----

[79] The patient records for IM A for January 15 to 19, 2013, were entered into evidence. Some contained information that predated January 15, 2013. The following were entered:

- the Doctors Order Sheets starting with an entry for January 7, 2013, and ending with an entry on January 19, 2013, at 21:00;
- the Progress Notes starting with an entry for January 12, 2013, at 13:00, and ending with an entry on January 19, 2013, at 21:10;

- the Diabetic Chart starting with an entry for November 30, 2012, and ending with an entry on January 19, 2013, at 23:55;
- the MARs for January of 2013; and
- Physician's Orders dated January 13, 2013, by Dr. O'Neill, and January 15, 2013, at 10:45, by Dr. Witt ("the January 15 Witt SO").

[80] Recorded on the Doctors Order Sheet for January 12, 2013, at 12:20, was an entry for eight units of Humulin R to be given immediately (a stat-order). The entry appears to have been a telephone order as also appearing on it was, "p/o [phone order] Dr Witt/BH RPN". Under that was written, "(pls send Hum R as ward stock)". In the columns for it being checked and noted are again the initials BH. Next to them is written, "faxed Jan 12/13". Those were the initials of an RN who worked at the RPC at the time.

[81] Also on that Doctors Order Sheet is another entry for Humulin R on January 12, 2013, at 22:45, to be administered immediately. This stat-order indicated that it was also a telephone order as per Dr. O'Neill and that it was taken by RN "LP", who initialed the entry. The entry also contained the following referenced comment: "Use intermediate sliding scale for the weekend and refer to the Clinic Monday."

[82] On the Doctors Order Sheet for January 13, 2013, at 00:55, is a stat-order for 10 units of Humulin R to be administered immediately. Again, it was noted as a phone order as per Dr. O'Neill. It was recorded by RN LP, who also initialed the entry.

[83] There is a handwritten order for Humulin R on a Physician's Orders document dated January 13, 2013, which appears to be under Dr. O'Neill's name. It is an intermediate-intensity sliding-scale order, that stated the following:

- the patient's name, date of birth, and FPS number;
- the date the order was made;
- the insulin was to be administered based on a sliding scale at an intermediate dosage depending on the blood-glucose (sugar) reading taken;
- the blood-glucose readings and insulin administration were to take

place 4 times per day ("QID"), 30 minutes before each meal (breakfast, lunch, and dinner) and at bedtime;

- insulin was to be given as follows:

Blood-glucose reading (mmol/L)	Units of insulin
4.1 to 7	0
7.1 to 10	2
10.1 to 14	4
14.1 to 17	6
17.1 to 20	8
20.1 to 22	10
above 22.1	call physician

- a blood glucose reading of over 22.1 required calling to consult the physician before any insulin was administered; and

- Dr. O'Neill's name, which was printed on the order; however, there was no signature.

[84] Neither Dr. O'Neill nor the nurse identified as LP testified. However from the documentation in evidence it appears that the telephone order recorded on the Doctors Order Sheet for January 12, 2013 at 22:45 and the order for insulin on the Physicians Orders under Dr. O'Neill's name, dated January 13, 2013 appear to be the same. That order appears to be recorded on the MAR for IM A, and showing as being authorized on January 12, 2013, for the weekend. It indicates four time slots, 08:00, 12:30, 17:30, and 20:30. There are initials in the boxes indicating that RNs would have administered the Humulin R on January 13 and 14, allegedly pursuant to the order, at all those time slots; on January 15 at 08:00 the dose was marked as being "held", that is, not administered.

[85] The January 12, 2013 Humulin R MAR entry is highlighted in yellow, which, as testimony indicated, meant that it was stopped. The evidence further indicated that the stop date is written in red, and on the MAR this date was January 14, 2013. A

notation of "held" is written on this MAR for January 15, 2013 at 08:00 which would coincide with that instructions that this was an order only valid for the weekend.

[86] The Progress Notes for IM A for January 12 and 13, 2013, indicate as follows:

> [For January 12, 2013, at 23:00:]
>
> *Pt. Hyperglycemic. Pt requested blood sugar be checked @ 2215. HI result. Stated she had eaten bananas & jam & toffee before bed. Dr. O'Neil contacted and ordered 12 units of Humulin R. & blood drawn for labs. Hyperglycemic. Continue to monitor and assess.*
>
> [For January 13, 2013, at 04:00:]
>
> *Pt. Hyperglycemic. Blood drawn for labs @ 0010. Blood sugar remains HI. Dr. O'Neil ordered 10 units of Humulin R. To check blood sugar if pt. awake. Lab called @ 0345 and blood sugar was 30. Hyperglycemic. Referral to Clinic & will monitor bld. sugar QID*
>
> . . .

[87] On the Doctors Order Sheet for January 14, 2013, at 22:40, is a stat-order for eight units of Humulin R to be given immediately. RN Kemp noted the physician as Dr. Witt and initialed that the insulin was administered.

[88] The diabetic chart is supposed to be a continuous document, meaning that as one page finishes a new page starts and the entries are chronological. During the course of reviewing the documents in the investigation report, I noticed that this was not in fact the case for the period covering January 12- 16, 2013. Instead, there were four distinct pages covering some of the same time frames; the same dates sometimes had the same information and sometimes different information. It highlights that there were clearly issues with respect to the charting of information which is confusing and makes it difficult to assess what the true state of affairs was at that time. In addition, the January 12, 2013 Humulin R MAR contains some but not all of the information contained on these diabetic charts.

[89] The next day, Dr. Witt issued the January 15 Witt SO, which was an SO for Humulin R. He wrote it by hand on a Physician's Order. It was a high-intensity sliding-scale order. He stated the following on it:

- the patient's name, date of birth, and FPS number;

- the date and time the order was made;
- the insulin was to be administered based on a sliding scale at a high dosage depending on the blood-glucose (sugar) reading;
- the blood-glucose readings and insulin administration were to take place 4 times per day, 30 minutes before each meal (breakfast, lunch, and dinner) and at bedtime;
- insulin was to be given as follows:

Blood-glucose reading (mmol/L)	**Units of insulin**
4.1 to 7	0
7.1 to 10	4
10.1 to 14	6
14.1 to 17	8
17.1 to 20	10
20.1 to 22	12
above 22.1	call physician

- a blood glucose reading of over 22.1 required calling to consult the physician before any insulin was administered;
- the order was in effect for one year; and
- Dr. Witt's signature and the date on which he signed it.

[90] Dr. Witt explained the reference on the Physician's Orders about calling the physician before administering insulin when the blood-sugar reading was over 22.1. He said that for such a reading, the January 15 Witt SO did not allow for the administration of any amount of insulin but required a call to a physician. The physician would be provided with information based on the 9 Liner and then decide what to do.

[91] Ms. Bayani wrote on the face of the January 15 Witt SO the following: "T.O Dr.

Froh/S. Bayani Rn 22.1 and higher 12 u 24 and higher 16 u and [illegible]". She testified that she spoke to Dr. Froh on January 19, 2013, at 21:10, which represented a new order from him. He did not testify; nor was he interviewed as part of the Beyko investigation. This was also written onto the Doctors Order sheet by Ms. Bayani, on January 19, 2013, at 21:00, which she states was given by Dr. Froh (however it was not signed off by Dr. Froh) and which states as follows:

- when IM A had a blood-sugar reading of 22.1 and higher, she was to be given 12 units of Humulin R;
- IM A was to be checked in half an hour; and
- for blood-sugar readings of 24 and higher, IM A was to be given 16 units of Humulin R, and the physician was to be called.

[92] Between Tuesday, January 15, and Saturday, January 19, 2013, the following information was set out on IM A's Diabetic Chart with respect to blood-sugar readings of above 22.1:

Date	**Time**	**Blood-sugar reading**	**Insulin given**	**RN's initials**
Jan. 16	12:30	22.9	12 units	C. Shaw
Jan. 17	17:30	29.6	12 units	K. Herman
Jan. 17	18:30	30.2	12 units	K. Herman
Jan. 19	17:30	25.1	12 units	S. Bayani
Jan. 19	18:30	30.8	12 units	S. Bayani
Jan. 19	19:00	22.2	12 units	S. Bayani

[93] Entered on the Doctors Order Sheet after the stat-order that Dr. Witt issued on January 14 are two further medication orders from him, one on January 15, 2013, at 10:40, and one on January 18, 2013, at 11:22; neither was for insulin. An unidentified physician made another medication order for IM A on January 18, 2013 (no time was recorded), which was not for insulin; it was identified as being for chlorpromazine.

[94] IM A's Progress Notes have notations on January 15, 2013, at 08:30 and 10:10; January 16, 2013, at 10:15; January 17, 2013, at 06:00 and 08:30; January 18, 2013, at

15:00; and January 19, 2013 at 21:10. None of the entries for January 15 to January 18 refer to anything about IM A's blood-sugar levels, the administration of insulin of any type, or any medication orders made by any physicians. The last entry, on January 19, 2013, by Ms. Bayani, stated that IM A had a high blood-sugar reading, the on-call physician had been notified, there was a new order for high blood sugar, and IM A had settled and would be monitored.

[95] The MAR for January of 2013 disclosed the recording of the January 15 Witt SO as follows:

- Ms. Shaw wrote it into the MAR by hand;
- it had four timeslots in descending order, 08:00, 12:30, 17:30, and 20:30, which roughly represented when blood sugar would have been tested and insulin would have been administered;
- adjacent to each time slot were 31 boxes for every day of the month, starting at 1 and ending at 31; and
- whenever a dose of insulin was administered, the nurse administering it was to initial the box corresponding to the number representing the date and the time closest to when it was administered.

[96] Ms. Shaw recorded on the MAR the first entry for the administration of the Humulin R under the January 15 Witt SO. That is disclosed by her initials in the box that coincides with the 15th day and the 12:30 time slot. The balance of the entries on the MAR disclose as follows:

Date	**Time**	**Nurse's initials**
January 15	17:30	S. Bayani
	20:30	S. Bayani
January 16	08:00	illegible
	12:30	C. Shaw
	17:30	C. Shaw

	20:30	C. Shaw
January 17	08:00	T. Ledding
	12:30	T. Ledding
	17:30	K. Herman
	20:30	illegible
January 18	08:00	T. Ledding
	12:30	T. Ledding
	17:30	illegible
	20:30	illegible
January 19	08:00	C. Shaw
	12:30	C. Shaw
	17:30	S. Bayani
	20:30	S. Bayani

G. Ms. Shaw's evidence

[97] The investigators interviewed Ms. Shaw on July 31, 2013. Their handwritten investigation notes were entered into evidence. Ms. Shaw signed the bottom of Ms. Beyko's notes that same day, signifying her agreement as to their accuracy. They reflect Ms. Shaw stating the following:

- the Churchill was her main work location at the RPC;
- the January 15 Witt SO stated that for blood-sugar readings above 22.1, the nurses were required to call the on-call physician, unless another SO was in place;
- she had no recollection of calling a physician on January 16, 2013;
- had she called a physician, she would have charted it in the patient's Progress Notes;

- she would have recorded an SO or a stat-order on the MAR if she had received either; and

- often, only one RN was on duty on a unit, and therefore, it was not possible to obtain a second signature.

[98] In her evidence before me, Ms. Shaw confirmed the following:

- that the schedule showed that she worked on January 16, 2013;

- that she made the entries on IM A's Diabetic Chart and MAR on January 16 at 12:30; and

- that the IM A's blood-sugar reading on January 16, 2013, at 12:30, was 22.9 and that she administered 12 units of Humulin R at that time.

[99] When Ms. Shaw was asked on what authority she administered those 12 units of Humulin R, she said that it was on the basis of an SO given by Dr. Witt that was an expansion of the January 15 Witt SO.

[100] On August 2, 2013, following her interview with the investigators, Ms. Shaw emailed Mr. Gee (and copied Ms. Beyko), stating as follows:

> *I have had a chance to review the written notes you have provided me following our interview on July 31st 2013. I agree with all of your notes with the exception of point number 8 where you have written "Shaw has no recollection of a standing order". This statement is completely incorrect.*
>
> *I can not recall what date specifically the standing order was written. I was not the RN who took the standing order or wrote the standing order. However, I can say and recall that with 100 percent certainty, having seen a standing order which had been provided by a GP for* [IM A] *for insulin when her blood glucose levels were above 22.1.. . . Typically, if I had contacted a GP to obtain a stat order for insulin, I would indicate having done so on the diabetic record. I stated that following having seen my administration notes from January 16th, I did not record or document that I had contacted a GP. Therefore, a standing order may have already been in place. I also stated that* [IM A] *was the first and only patient that I have ever worked with in my practice, who had a standing order for insulin when blood glucose levels were above 22.1. This stands out very clearly in my mind, as I stated I do not believe that provided a standing order of typical practice as I have only ever seen stat orders provided prior to this patient.*

. . .

[101] Between January 15, 2013, at 10:45, and Ms. Shaw's recording of IM A's blood-sugar reading of 22.9 and the administration of 12 units of Humulin R on January 16, 2013, at 12:30 (a little under 26 hours), IM A's blood-sugar readings were all below 22.1. The 07:30 reading on January 16, 2013 was 18.6.

H. Evidence specific to Ms. Herman

[102] On January 17, 2013, at 17:30 and 18:30, IM A's Diabetic Chart disclosed that her blood-sugar readings were 29.6 and 30.2, respectively, and that at those times, Ms. Herman administered 12 units of Humulin R to her.

[103] The investigation report indicates that the interviewers interviewed Ms. Herman on May 17, 2013, and that she told them the following:

- she normally worked at the hospital, but on January 17, 2013, she was "floated" to the Churchill;
- January 17, 2013, was the first time she met IM A;
- she could only vaguely recall her interactions with IM A on January 17, 2013;
- she did recall seeing a high blood-sugar reading and administering one dose of insulin;
- she did not call a doctor;
- another nurse told her that IM A's blood-sugar readings were constantly high and that there was a Doctor's Order for managing blood sugar levels over 22.1;
- she seemed to recall seeing an order written on a Physician's Orders sliding-scale insulin sheet; and
- she would not have administered the insulin based on another RN's verbal information but would have checked the order before preparing the medication.

[104] In her examination-in-chief, Ms. Herman reviewed Ms. Beyko and Mr. Gee's notes

and stated that they appeared accurate. The notes reflect that she said the following:

- this was the first time she met IM A;
- she did not recall calling a doctor for IM A's high blood-sugar reading;
- had the blood-sugar reading been over 22.1, she would have called a doctor;
- she would have written a telephone order on a Doctor's Order and in the MAR, but she would not have charted it in the Progress Notes;
- she would have seen the order before administering the insulin; and
- she recalled administering only one injection on January 17, 2013.

[105] In her evidence before me, Ms. Herman stated as follows:

- she did not work on January 15 or 16, 2013;
- on January 17, 2013, she had been originally supposed to work on the MacKenzie Unit but started on the Bow Unit, where she worked from 06:45 to 09:15 before moving to the Assiniboine Unit from 14:00 to 16:45 and finally to the Churchill from 16:45 to 19:45;
- she could not confirm where she had been between 09:00 and 14:00;
- she worked on many different units, but the MacKenzie Unit was her primary unit;
- she was familiar with the Churchill;
- the Churchill was a high-intensity unit, with many daily incidents and self-harming patients;
- she did not like getting floated to the Churchill;
- physicians sometimes used "custom standing orders";
- she could think of one inmate who had a blood-sugar reading of 22.1, so for the physician to not field calls, a SO was made to address the

over-22.1 blood-sugar reading that was a custom standing order;

- the RNs would often call physicians because the inmates' needs would often change;
- the initials were hers on IM A's Diabetic Chart for January 17, 2013, at 17:30 and 18:30, showing blood-sugar readings of 29.6 and 30.2 respectively and the administration of 12 units of Humulin R both times; and
- she followed a custom standing order to administer the 12 units for readings over 22.1.

[106] With respect to the administration of insulin, Ms. Herman said that in January of 2013, the documentation included the Diabetic Chart, and if the insulin was regularly scheduled, it would have been on the MAR. If a new order were prescribed, it would have been handwritten by the RN and handwritten onto the MAR. She said that medication orders and the MAR were kept in a binder, in the same unit as the inmate.

[107] When I asked Ms. Herman why, on January 17, 2013, she made a second reading at 18:30 after she had taken a reading and administered the Humulin R at 17:30, she answered because the order would have stated so. This is consistent with a faded notation on the Diabetic Chart which says: "to be checked in one hour."

I. Evidence specific to Ms. Ledding

[108] Ms. Beyko and Mr. Gee interviewed Ms. Ledding on May 22, 2013. The interview notes produced at the hearing, the summary of the interview in the investigation report, and Ms. Ledding's evidence were largely the same, disclosing the following:

- on January 16, 2013, from 06:45 to 09:15, she worked in the hospital wing and moved to the Churchill from 09:45 to 19:45;
- on January 16, 2013, Ms. Bayani and Ms. Shaw also worked on the Churchill;
- on a date she does not recall, she said that she remembered that IM A's blood-sugar reading was over 22.1 and that she spoke to the doctor on call, Dr. Witt, who gave her an SO to address such situations that was in conjunction with the January 15 Witt SO;

- she spoke to Dr. Witt from the nursing station at the Churchill;
- she recalled writing the telephone order on a "green" physician's sheet, which she identified as a Doctors Order Sheet;
- she should have written it down on the MAR but did not; and
- orders for medication are always faxed to the regional pharmacy, whether or not they are telephone orders and whether or not the doctor has signed it.

J. Evidence specific to Ms. Bayani

[109] The interviewers interviewed Ms. Bayani twice, on May 16 and May 29, 2013. She was accompanied by a representative of the Professional Institute of the Public Service of Canada both times. The interviewers each made handwritten notes, and Ms. Bayani signed that she reviewed them on May 29, 2013. Their notes contain in essence the same information about the events on January 19, 2013, which reflect Ms. Bayani stating as follows:

- she took a blood-sugar reading of IM A at 17:30 or 17:45 and it was 26 or high, and she administered insulin at around 18:00;
- she took a blood-sugar reading a half-hour or an hour after the 17:30-17:45 reading and it was again high, so she administered another dose of insulin;
- she administered 2 or 3 doses before calling the doctor;
- she called the doctor at around 19:30, and Dr. Froh returned her call at 21:00;
- Dr. Froh made a new SO;
- the new order followed the one that Ms. Ledding took from Dr. Witt on January 17, 2013; and
- she initialled that the 20:30 insulin dosage had been administered, but no insulin was administered then as it had been done at 19:00.

[110] The investigation report indicates that on May 16, 2013, Ms. Bayani told the

investigators that she worked on the Churchill on January 19, 2013, from 09:15 to 22:15. With respect to that day, she stated as follows:

- IM A's blood-sugar reading was 22.6 at 17:30, and she administered insulin according to a telephone order she said Ms. Ledding had received on January 17, 2013, from Dr. Witt, which applied to blood-sugar readings over 22.1;
- she tested IM A's blood sugar again 30 to 60 minutes later, found it was still high, and administered more insulin, again stating that it was pursuant to the same doctor's order taken by Ms. Ledding;
- she tested IM A's blood-sugar reading 30 minutes after the second reading, found it was still high, and administered a third dosage of insulin, again stating that it was pursuant to the doctor's order taken by Ms. Ledding;
- after the third dose, she called the on-call doctor and left a message, and Dr. Froh returned her call about an hour-and-a-half later, at 21:00;
- at 21:00, Dr. Froh made a telephone order for insulin, which she recorded onto the Doctors Order Sheet; and
- she did not administer any insulin pursuant to that order as IM A's blood-sugar level had decreased below 22.1.

[111] The investigation report indicates that Ms. Bayani was interviewed a second time because of alleged discrepancies between what she indicated in her May 16, 2013, interview and the information she provided to the investigators in the Beyko investigation. The investigation report indicates that on May 29, 2013, Ms. Bayani told the investigators the following:

- She thought that she had contacted Dr. Froh at 17:30 on January 19, 2013, before administering insulin to IM A. However, when Dr. Froh stated that he had been contacted only once, at 21:00, she stated that she must have administered insulin only pursuant to the order Ms. Ledding took on January 17, 2013.
- When she was asked why she contacted Dr. Froh if there was already

an order from Dr. Witt for blood-sugar readings over 22.1, she stated that she had previously had a bad experience with a diabetic patient who had had a seizure and that she did not feel comfortable with not consulting the doctor.

- When she was asked about the difference in time intervals in her administration of insulin at 17:30, 18:30, and 19:00, she stated that the telephone order must have given direction to administer at different frequencies.

- She would administer medication only according to an order.

[112] In a written response to the investigation report, dated November 18, 2013, Ms. Bayani stated the following:

- She did not tell the investigators that on January 17, 2013, she heard another nurse take the telephone order for IM A for blood-sugar readings over 22.1. She said that given how the question had been phrased, she answered that it had been a couple of days before IM A's death. She stated that the investigators suggested January 17, 2013, and that her answer had been, "Maybe". She said that only when she saw the investigation report did she check the days that she had worked and verified that she had not worked on January 17, 2013.

- She said that the discrepancy between what she said to the investigators and what is recorded in their report and in the medication record about the times she administered the insulin arose because she signed the MAR indicating that the 20:30 dose was administered, but it was done at 19:00 and not at 20:10.

[113] In her evidence before me, Ms. Bayani stated that on January 19, 2013, she worked a B shift (from 09:15 to 22:15) on the Churchill and that it had been a busy day as many inmates had self-harmed, and one was being restrained and held in the camera cell off Hallway E-02. She did not recall IM A's blood-sugar level before dinner, but she did recall that it was high. When she was shown the Diabetic Chart for January 19, 2013, she identified her initials next to the readings and the insulin administrations at 17:30, 18:30, and 19:00. She said that she marked the MAR for the January 19, 2013, dosage at 17:30, but not the extra doses. She then stated that when a

dose is not administered, "H" is put on the MAR so that the other nurses will know that it was held or not administered.

[114] Ms. Bayani stated that she called the on-call doctor at around 19:00 or 19:30 and that "he gave me another standing order but I didn't need to use it when he called back because the blood sugar was coming down." She identified her handwriting on the Progress Notes for January 19, 2013, at 21:10, and on the January 15 Witt SO. When Ms. Bayani's representative asked her why she wrote on the January 15 Witt SO, she said that a routine was followed in that if a sliding-scale order was made, a copy of it would be put up in the medication room, and that if a second order was made, for blood sugar over 22.1, it would be put up as well. She said that she had intended to photocopy the January 15 Witt SO and put it on a wall because she "wanted the other nurses to know there was a new order from Dr. Froh". When her representative asked her why she called Dr. Froh, she said that she had wanted the on-call physician to know what was going on.

[115] In cross-examination, Ms. Bayani confirmed that the following occurred on January 19, 2013:

- she was responsible for the blood-sugar testing of IM A at 17:30, 18:00, and 19:00;
- at those times, the readings were above 22.1;
- she administered 12 units of Humulin R at those times;
- she recorded those doses on the MAR for 17:30 and 20:30 but not for 18:30 or 19:00; and
- she should have written "held" in the 20:30 box in the MAR.

[116] Responding to my question on the whereabouts of the other nurse on duty on the Churchill for the evening of January 19, 2013, Ms. Bayani stated that she was monitoring the inmate being restrained in a camera cell off Hallway E-02. She said that the other nurse sat in the hallway with the cell door open and watched the inmate. The only other CSC staff member on duty on the Churchill was a CX in the control post.

[117] The investigation report disclosed that a review of Ms. Bayani's personnel file identified an event that occurred in January of 2012, in which she and a supervisor

discussed an issue of inadequate documentation. In her evidence before me, Ms. Beyko stated that a "Quality Improvement Review" had disclosed that it had had to do with the grievor failing to administer insulin properly.

[118] Ms. Bayani testified about the event in January of 2012. She stated that a diabetic inmate with a very high blood-sugar reading (which she could not recall) receiving insulin based on a sliding-scale order had a seizure. She stated that she called 911 and that after that, the inmate began to foam at the mouth. She stated that she knew that the paramedics were about 7 to 10 minutes away. She felt that the inmate would not survive, so she gave her a dosage of insulin. Ms. Bayani said that she called her supervisor and told her what had happened. She said that she also told the on-call doctor at the time and that he told her that she had done the right thing and that the inmate would have died had she not administered the insulin. She said that no one ever spoke to her about the event after it happened; it was an emergency.

K. Mr. Spicer's evidence

[119] Mr. Spicer testified that on January 16, 2013, he worked an A shift on the Bow Unit and that he had been responsible for a practicum student, which required him to visit all the units, for orientation purposes. He said that they went to the Churchill and to the nursing bubble, and he recalled a nurse (whom he could not identify) being flustered due to an inmate's high blood-sugar reading. He recalled that the inmate was IM A. He said that he recalled seeing an order for IM A posted on a window. He said that it was not a typical insulin order because it was above the normal sliding scale and had dosage amounts for readings over 22.1 and because the policy was to call a physician for such readings.

L. Dr. Witt's evidence

[120] Dr. Witt testified that he had no recollection as to whether or not he made an order for insulin for IM A after the January 15 Witt SO.

[121] In cross-examination, he said that during the week of January 15, 2013, he switched cell phones, meaning that while the search of his cell phone records would show incoming and outgoing calls, it would not show incoming texts, which is how he would have been alerted to a call from the RPC from the answering service.

[122] In response to my questions, Dr. Witt stated that access to the RPC was regulated, that he was required to sign in and out, and that at some point, he was

issued an access card that was digitally read when it was swiped.

[123] I was not provided with any records of Dr. Witt's ingress to or egress from the RPC for the week of January 15, 2013.

[124] In cross-examination, he conceded that he had no recollection of going to the Churchill on January 15 or 16, 2013, and that it is possible that Ms. Ledding could have called him when he was somewhere in the RPC.

[125] When he was asked if he has ever provided a sliding-scale order for insulin when the blood-sugar reading was over 22.1, he said that he could not recall. He said that the purpose of the 9 liner was to determine the cause of the problem, that it was typical for nurses to call when blood-sugar readings were over 22.1, and that a nurse would use a new blank Doctors Order Sheet when taking a verbal order. Responding to my question, he stated that insulin can be administered when the blood-sugar reading is over 22.1, which is unlikely to cause an adverse reaction.

[126] When it was put to Ms. Beyko in cross-examination that RNs had a practice of putting telephone orders on a new sheet, she confirmed that she knew that it would happen and that it was not supposed to be done.

[127] There was no evidence as to Dr. Witt's practice with respect to diabetic patients and sliding-scale orders for insulin. In cross-examination, Ms. Beyko confirmed that she and Mr. Gee did not review Dr. Witt's practice with respect to other cases involving sliding-scale orders for insulin and blood-sugar readings over 22.1.

[128] Dr. Witt stated that he had a good working relationship with all the grievors.

[129] Entered into evidence were Dr. Witt's telephone records for his home and cell phones. The records do not disclose any calls to the RPC on either January 16 or 17, 2013.

M. Discipline of Ms. Ledding

[130] In a memo incorrectly dated January 15, 2013 (it was meant to be dated that day in 2014), Mr. Bird disciplined Ms. Ledding with the two-day suspension without pay, as follows:

. . .

Further to the disciplinary hearing held on November 27, 2013 I have concluded, based on all the available evidence

> *submitted prior to and during the disciplinary hearing, that there is sufficient proof that you provided a false statement in relation to the performance of your duty on January 17, 2013 and that your actions violated CD 060 – Code of Discipline as follows:*
>
> *Standard One: Responsible Discharge of Duties 6(j), "willfully or through negligence, makes or signs a false statement in relation to the performance of duty."*
>
> . . .

[131] In his evidence, Mr. Bird stated that the Beyko investigation disclosed to him that Ms. Ledding had provided false information with respect to a telephone order that was supposedly made by a physician to administer medication (Humulin R). He said that during the disciplinary hearing, Ms. Ledding said very little, did not admit any wrongdoing, and showed no remorse. As a mitigating factor, he said that she had no previous discipline.

N. Discipline of Ms. Bayani

[132] In a memo incorrectly dated January 16, 2013 (it was meant to have been dated on that day in 2014), and received by Ms. Bayani on February 7, 2014, Mr. Bird disciplined her with the two-day suspension without pay. He wrote as follows:

> . . .
>
> *Further to the disciplinary hearing held on November 26, 2013 I have concluded, based on all the available evidence submitted prior to and during the disciplinary hearing, that there is sufficient proof that you failed to obtain authorization for the doses of insulin provided to patient* [IM A] *on January 19, 2013 and that your actions violated CD 060 – Code of Discipline as follows:*
>
> *Standard One: Responsible Discharge of Duties:*
>
> *f. fails to take action or otherwise neglects his/her duty as a peace officer;*
>
> *g. fails to conform to, or to apply, any relevant legislation, Commissioner's Directive, Standing Order, or other directive as it relates to his/her duty;*
>
> *j. willfully or through negligence, makes or signs a false statement in relation to the performance of duty;*
>
> *m. performs his/her duty in a careless fashion so as to risk or cause bodily harm or death to any other employee of the Service, or any other person(s), either directly or indirectly;*
>
> . . .

[133] In his evidence, Mr. Bird stated that the Beyko investigation disclosed to him that Ms. Bayani had administered medication (Humulin R) to IM A on three occasions without proper authorization. He said that during the disciplinary hearing with Ms. Bayani, she said very little, did not admit any wrongdoing, and displayed no empathy. As a mitigating factor, he said that she had no previous discipline.

O. Discipline of Ms. Herman

[134] In a memo incorrectly dated January 17, 2013 (it was meant to have been on that day, but in 2014), which Ms. Herman received on February 6, 2014, Mr. Bird disciplined her with the one-day suspension without pay, stating as follows:

> . . .
>
> *Further to the disciplinary hearing held on November 27, 2013 I have concluded, based on all the available evidence submitted prior to and during the disciplinary hearing, that there is sufficient proof that you failed to obtain authorization for the doses of insulin provided to patient* [IM A] *on January 17, 2013 and that your actions violated CD 060 – Code of Discipline as follows:*
>
> *Standard One: Responsible Discharge of Duties:*
>
> *f. fails to take action or otherwise neglects his/her duty as a peace officer;*
>
> *g. fails to conform to, or to apply, any relevant legislation, Commissioner's Directive, Standing Order, or other directive as it relates to his/her duty;*
>
> *j. willfully or through negligence, makes or signs a false statement in relation to the performance of duty;*
>
> *m. performs his/her duty in a careless fashion so as to risk or cause bodily harm or death to any other employee of the Service, or any other person(s), either directly or indirectly;*
>
> . . .

[135] In his evidence, Mr. Bird stated that the Beyko investigation disclosed to him that Ms. Herman had administered medication (Humulin R) to IM A on one occasion without proper authorization. He said that during the disciplinary hearing with her, she spoke and displayed compassion; she understood the gravity of the situation and the impact it had on the CSC. While she also did not admit any wrongdoing, it was clear that the incident had affected her.

III. Summary of the arguments

[136] Both parties, on consent, indicated at the outset of the hearing that they wished

sealed the documents containing the personal information of Dr. Witt and IM A.

A. For the employer

1. Investigation issues

[137] All the grievors had representation in their investigation interviews, despite it not being a requirement under the relevant collective agreement. Clause 37.03 of that agreement uses the word "may". The grievors also had representation at the disciplinary hearing and had the opportunity to respond to the allegations in writing.

[138] A hearing before an adjudicator is a hearing *de novo*. In this respect, the employer referred me to *Patanguli v. Canada (Citizenship and Immigration)*, 2014 FC 1206 (upheld in 2015 FCA 291), *Tipple v. Canada (Treasury Board)*, [1985] F.C.J. No. 818 (QL), *Turner v. Treasury Board (Canada Border Services Agency)*, 2006 PSLRB 58, and *Varin v. Canada (Public Works and Government Services Canada)*, 2016 FC 213.

2. Merits of the grievances

[139] There is clearly a gap in the evidence with respect to the circumstances that the grievors state occurred and the standard operating procedure or practice set out and used at the RPC. In assessing the credibility of the evidence, the employer referred me to *Albano v. Deputy Head (Correctional Service of Canada)*, 2015 PSLREB 79, and *Pinch (Guardian ad litem of) v. Morwood*, 2016 BCSC 938.

[140] All the grievors acknowledged their provincial professional standards and the content of their work description and that they are to administer medication on a physician's orders. They all confirmed the vital integral action of documenting actions taken; they all were aware that documentation forms a legal record and confirmed that it is an important tool to keep all healthcare team members informed for the continuity of a patient's care.

[141] The employer trusted and relied on its staff to conduct itself with basic nursing skills. The grievors' documentation was very problematic. If an order was made, it was not recorded. It was not mentioned in the different places it was supposed to be recorded, which were the Progress Notes, the MAR, and the chart. All the grievors displayed a lack of basic nursing skills required with respect to recording important information about the order, if it existed, and with respect to administering it. This is assuming that Dr. Witt actually made the order, of which there is no actual copy.

[142] The employer submitted that the discipline imposed was reasonable and that it should not be disturbed. It referred me to *Ranu v. Deputy Head (Correctional Service of Canada)*, 2014 PSLRB 89, *Mercer v. Deputy Head (Department of Human Resources and Skills Development)*, 2016 PSLREB 11, *Turner, Baptiste v. Deputy Head (Correctional Service of Canada)*, 2011 PSLRB 127, and *Bridgen v. Deputy Head (Correctional Service of Canada)*, 2012 PSLRB 92.

[143] The employer also referred me to *Gemoto v. Calgary Regional Health Authority*, 2006 ABQB 740, *Langley Memorial Hospital v. British Columbia Nurses' Union*, [2005] B.C.C.A.A.A. No. 116 (QL), *Telus Communications Inc. v. Telecommunications Workers Union*, 2014 ABCA 199, and *Lapostolle v. Deputy Head (Correctional Service of Canada)*, 2011 PSLRB 138.

B. For the grievors

[144] The disciplinary process was unjust and heavy-handed. It was politically motivated. It was to take pressure off Mr. Bird. The suggestion that the employer might contact the SRNA was an act of intimidation.

[145] All the grievors were aware of the CSC's rules and the SRNA's professional standards. In practice at the RPC and the Churchill, the CSC's rules were not always followed. No witnesses were brought forward to show that national standards were being followed at the RPC. Ms. Madrega did not know if the second-signature standard was being followed there. If she did not know, how could the CSC hold the grievors and the other RNs to that standard?

[146] The work that the RNs do at the RPC and on the Churchill is dangerous and challenging. The grievors felt that the disciplinary process questioned their integrity.

[147] The discipline was unwarranted, unjust, and without cause. The Beyko investigation was flawed. Mr. Bird had been under pressure, and the investigator, Ms. Beyko, was inexperienced.

[148] The original investigation was into Ms. Bayani's conduct, and the investigator determined on her own to expand it to include other matters.

[149] The grievors maintained continuously that the time that has passed between the events and the investigation has put them at a disadvantage. The entire investigation process from start to finish took too long.

[150] Mr. Bird's evidence was contradictory. For the employer's case to be legitimate, one would have to accept that four nurses colluded to ignore IM A's high blood-sugar levels over a number of shifts and over a number of days and then to administer an inappropriate amount of insulin. One would also have to accept that all these relatively new nurses would do that to a patient out of the blue.

[151] The evidence disclosed that while the three grievors knew each other, they were not friends socially. Ms. Bayani waited until she saw that IM A was okay before she left after her shift. Why would the three grievors administer insulin without authorization? Why would they jeopardize a person's life and their careers?

[152] If they did all those things, which were incorrect, then why would they document their wrongdoing on IM A's diabetic chart? That would make no sense. Accepting the employer's reasoning would mean having to accept that the grievors, Mr. Spicer, and Ms. Shaw have all lied throughout the investigation, grievance and adjudication process.

[153] Dr. Witt said that he had no recollection of making the order, but he could have made it. He said that insulin was required at the level it was given. Ms. Ledding said that she took the order from Dr. Witt; Ms. Bayani said that she heard the order being taken.

[154] The employer misled both Mses. Ledding and Herman as to the context of the Beyko investigation, which impacted their ability to respond. The investigators did not follow any documentation. The grievors were not disciplined for a documentation error.

[155] The order could have gone to the hospital, been lost, or gone missing during the investigation into IM A's death. It was not the grievors' responsibility to secure the documentation when an inmate died.

[156] The documentation errors were all admitted to. The grievors had been new, young RNs. The RPC's practices did not align with the national practice standards. The Churchill experienced a number of competing issues at one time. Other nurses (eight, in addition to the grievors and Ms. Shaw) worked on the Churchill during the week of January 16 to 19, 2013; none was interviewed. It is far too late to do that four years later.

[157] Mr. Bird stated that the grievors said little during his disciplinary hearings with

them. This should not be held as a negative against them. They denied that they had done what they are accused of doing. The employer could have disciplined them for poor documentation; it did not.

[158] The grievors referred me to *Wm. Scott & Company Ltd. v. Canadian Food and Allied Workers Union, Local P-162,* [1977] 1 CLRBR 1, *Faryna v. Chorny*, [1952] 2 D.L.R. 354, *Samra v. Treasury Board (Indian and Northern Affairs Canada)*, PSSRB File No. 166-02-26543 (19960911), [1996] C.P.S.S.R.B. File No. 70 (QL), and Brown and Beatty, *Canadian Labour Arbitration* (4th ed.) at paragraph 7:2300, entitled "Burden of Proof".

IV. Reasons

A. Request to seal documents

[159] The parties submitted as evidence copies of documents that dealt with IM A's health and medical treatment. Her death is the subject of an inquest that at the time of the hearing, was still pending. IM A was not a party to this proceeding; nor is her personal information relevant except that her treatment forms part of the record because of the actions taken by the employer and the grievors in dealing with their employment relationship.

[160] While the parties requested that the documents with respect to IM A be sealed, in effect, doing so would require me to seal almost all the exhibits entered into evidence. That would not be conducive to the operation of law and the dispensing of justice in our legal system or to what is set out in *Basic v. Canadian Association of Professional Employees*, 2012 PSLRB 120:

> *[10] However, occasions arise where freedom of expression and the principle of open and public access to judicial and quasi-judicial hearings must be balanced against other important rights, including the right to a fair hearing. While courts and administrative tribunals have the discretion to grant requests for confidentiality orders, publication bans and the sealing of exhibits, it is circumscribed by the requirement to balance these competing rights and interests. The Supreme Court of Canada articulated the sum of the considerations that should come into play when considering requests to limit accessibility to judicial proceedings or to the documents filed in such proceedings, in decisions such as* Dagenais *and* Mentuck. *These decisions gave rise to what is now known as the* Dagenais/Mentuck *test.*
>
> *[11] The* Dagenais/Mentuck *test was developed in the context of requests for publication bans in criminal proceedings. In* Sierra Club of Canada, *the Supreme Court of Canada*

> *refined the test in response to a request for a confidentiality order in the context of a civil proceeding. As adapted, the test is as follows:*
>
> . . .
>
> 1. such an order is necessary in order to prevent a serious risk to an important interest, including a commercial interest, in the context of litigation because reasonably alternative measures will not prevent the risk; and
>
> 2. the salutary effects of the confidentiality order, including the effects on the right of civil litigants to a fair trial, outweigh its deleterious effects, including the effects on the right to free expression, which in this context includes the public interest in open and accessible court proceedings.
>
> . . .

[161] I am not satisfied that the test in *Basic* has been met. I find that the privacy of IM A and her family, can be protected by the alternative of redacting IM A's identity and as such I order that all documents that set out the particulars of her identity, including but not limited to her name, date of birth, address, and FPS number, be sealed for a period of 45 days from the date of this decision, to allow the parties to provide to the Board, within that same 45-day period, duplicate copies of those exhibits with that information redacted. Each party shall be responsible for the documents it submitted into evidence.

[162] Entered into evidence were certain records that disclosed personal information related to Dr. Witt, namely, his home address and telephone numbers. To protect his privacy and that of his family, I order sealed all documents that set out the particulars of his address and phone number, namely, Exhibits E-2 and E-3 also for a period of 45 days from the date of this decision to allow the employer to provide to the Board, within that same 45-day period, duplicate copies of those exhibits with that information redacted.

[163] Entered into evidence were certain records with respect to another inmate ("IM B"), exhibit E-9, which contained that inmates identity and FPS number. IM B had nothing to do with the facts surrounding this hearing and as such Exhibit E-9 shall be sealed for a period of 45 days from the date of this decision to allow the employer to provide the Board, within that same 45-day period with a duplicate copy of that exhibit with that information redacted.

B. Merits of the grievances

[164] Adjudication hearings with respect to discipline under s. 209(1)(b) of the *Act* are hearings *de novo*, and the burden of proof is on the employer. As far as issues might have arisen in the investigation of the facts that led to disciplining the grievors, they were remedied by the hearing before me.

[165] The usual basis for adjudicating discipline issues involves considering the following three questions (see *Wm. Scott & Company Ltd.*): Was there misconduct by the grievors? If so, was the discipline the employer imposed an excessive penalty in the circumstances? If not, what alternate penalty is just and equitable in the circumstances?

[166] For the reasons that follow, the grievances are allowed, and the discipline is set aside.

[167] The first question to be asked is whether misconduct occurred. The misconduct alleged with respect to Mses. Bayani and Herman was that they administered insulin to IM A without proper authorization. For Ms. Ledding, it was that she misled the Beyko investigation into Ms. Bayani's alleged misconduct by stating that she had received an order when in fact she had not. To be clear, the grievors were not disciplined because of their poor recording, charting, or documenting of the prescription or administration of insulin to IM A, which is required, as set out in the employer's policies and directives.

[168] In essence, this case stands or falls on whether Dr. Witt issued an order sometime after the January 15 Witt SO and before Ms. Bayani spoke with Dr. Froh during the evening of January 19, 2013. The evidence, both whether an order was made, as the grievors maintained, or not, as the employer maintained, was at times vague, inconsistent, and contrasting.

[169] Issues of credibility are dealt with by the test articulated in *Faryna*, in which the British Columbia Court of Appeal stated as follows:

. . .

> ***10*** *If a trial Judge's finding of credibility is to depend solely on which person he thinks made the better appearance of sincerity in the witness box, we are left with a purely arbitrary finding and justice would then depend upon the best actors in the witness box. On reflection it becomes almost axiomatic that the appearance of telling the truth is but one of the elements that enter into the credibility of the evidence of a witness. Opportunities for knowledge, powers of observation, judgment and memory, ability to describe*

> *clearly what he has seen and heard, as well as other factors, combine to produce what is called credibility . . . A witness by his manner may create a very unfavourable impression of his truthfulness upon the trial Judge, and yet the surrounding circumstances in the case may point decisively to the conclusion that he is actually telling the truth. I am not referring to the comparatively infrequent cases in which a witness is caught in a clumsy lie.*
>
> ***11*** *The credibility of interested witness, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.. . .*
>
> . . .

[170] The most appropriate place to start when addressing the evidence in this respect is to go back to the statement in the SRNA Documentation Guidelines identified as "Protection Against Liability". After hearing the witnesses and the arguments and reviewing the documentation relating to the three grievors, this statement has a resounding ring to it, where it states as follows:

> *The client's record is a legal document and, as such, can be used as documentary evidence in a court of law. Documentation should provide a chronological record of the events involving client care and services and may be used to refresh one's memory, if required to give evidence in court. Courts will use clinical documents to reconstruct events, establish times and dates, and to substantiate and/or resolve conflict in testimony.*
>
> *Documentation provides specific information (who, what, how and why) about the planning for, provision of, and client's response to care or services. It provides evidence that safe and competent care was delivered, that the care/service met acceptable standards of care, was reasonable and prudent, was provided in a timely manner and, was consistent with agency policies and procedures.. . .*

[171] As set out earlier in this decision, the CSC has a number of different policies, guidelines, standards, and documents in place to ensure the accurate record keeping of medical treatment, including the prescribing and administering of medication. In many ways, these are more detailed than what the SRNA has set out.

[172] As of January 2013, when the events related to these grievances took place, all the grievors were relatively recent graduates of the University of Saskatchewan's nursing program, having graduated between 2007 and 2011. They all had available the relevant CSC policies, guidelines, and standards relating to patient care and documentation of medication, and they all agreed that the SRNA Documentation Guidelines and the SRNA Med. Admin. Guidelines not only bound them but also made sense. That said, if I accept their evidence, there is no question that they failed to follow the policies, directives, standards, and guidelines of both the CSC and the SRNA.

[173] The employer submitted that Dr. Witt did not make an order for IM A prescribing insulin on a sliding scale when her blood-sugar reading was over 22.1 at any point after the January 15 Witt SO. In support of its position, it pointed to the fact that there is no record whatsoever of an order being made after that SO. According to all the grievors and two other nurses, Mr. Spicer and Ms. Shaw, this allegedly non-existent order did in fact exist. Ms. Ledding stated that she took the order, and the others said that they saw it. Some suggested that it was taped up in the nursing bubble.

[174] The employer's position is supported by the fact that the CSC's policies, guidelines, and standards (set out earlier in this decision) provide a fail-safe procedure in the event an order for medication is lost. It requires that every order for medication be faxed to the regional pharmacy. Ms. Ledding knew of that procedure; in her evidence before me, she admitted to it. The difficulty is that she also said that she did not follow it.

[175] According to Ms. Madrega, the nursing supervisor, a telephone order for medication should also have been recorded in IM A's Progress Notes. The evidence was incongruent on this point. A review of the notes that were produced at the hearing showed that they did not disclose that all the medication orders for her were written in them. This indicates that not all the healthcare professionals followed that practice.

[176] The employer also pointed to the inconsistencies in the evidence of two of the grievors, Mses. Ledding and Bayani, along with Ms. Shaw, with respect to the order. The January 15 Witt SO provided for administering Humulin R for blood-sugar readings taken at four times during the day (at the three scheduled meal times and at bedtime), depending on the blood-sugar readings, up to and including 22.1. Any readings higher than 22.1 required a discussion with a physician.

[177] IM A's Diabetic Chart disclosed that Ms. Shaw administered Humulin R to her on January 16, 2013, at or about 12:30, when her blood-sugar reading was 22.9. According to Ms. Shaw, in both the Beyko investigation and before me, she administered the Humulin R pursuant to an SO she said existed from Dr. Witt for blood-sugar readings over 22.1. However, this fact is somewhat problematic for the simple reason that the blood-sugar reading that she took at 12:30 on that day was the first time since the January 15 Witt SO was issued that IM A's blood-sugar reading reached over 22.1. Assuming that IM A's Diabetic Chart is correct, there would have been no reason for anyone to have called Dr. Witt or any other physician about IM A's blood sugar and Humulin R dosage before then because it had not been over the 22.1 threshold, which required making the call.

[178] Given those facts, the call to Dr. Witt, or any other physician, if it was going to be made, would have been made with the first blood-sugar reading over 22.1, after the January 15 Witt SO. That was by Ms. Shaw, at or about 12:30, on January 16, 2013. All things being equal, given that Ms. Shaw tested IM A's blood sugar and eventually administered the Humulin R, it would make logical sense that she would have made the call. However, that was not in her evidence or in the evidence of Mses. Ledding and Bayani.

[179] Ms. Ledding stated that she spoke with Dr. Witt and obtained a new SO for IM A for blood-sugar readings over 22.1. Ms. Bayani stated that she witnessed Ms. Ledding receive the callback from Dr. Witt.

[180] The Beyko investigation suggested that Ms. Ledding made the call to Dr. Witt on January 17, 2013. She later stated that she had not said that but that the investigators had asked if it was possible, to which she had replied in the affirmative. She later said that she made those comments in her interview with the investigators without the benefit of her schedule. In her examination-in-chief, she said that she could not recall the exact date on which she made the call. She also said the following:

- she took Dr. Witt's return call and wrote the order down on a green physician's sheet;
- she was supposed to also document the new order on the MAR, but said that she did not do it;
- with respect to faxing the order to the regional pharmacy, she said that

even if the doctor had not signed it, it had to be faxed there, even though the pharmacy would not process it without a signature; and

- the order is also supposed to go in what she called the "clinic book" (binder).

[181] The nursing schedule entered into evidence for January 15 to 19, 2013, is extremely difficult to decipher. It has one page per day for all shifts on all units. It is an amalgam of typewritten and handwritten names and times with highlighting, whiteout, and names and times scratched out, along with check marks.

[182] On January 17, 2013, Ms. Ledding worked the A shift (from 06:45 to 19:45) on the Churchill, but Ms. Bayani, who said that she witnessed the call to the doctor, did not work that shift. Ms. Herman did work on January 17, 2013; however, at no time did she state that she saw Ms. Ledding take the call from Dr. Witt. That said, according to IM A's Diabetic Chart, Ms. Herman did administer Humulin R twice on January 17, 2013, for blood-sugar readings over 22.1. She said that she did so on the basis of a written order.

[183] Ms. Ledding said that medication orders are to go in the clinic book. Did it go into that book? According to the employer, the order does not exist; therefore, it could not be in the clinic book. That said, IM A died sometime between the time Ms. Bayani left the institution late in the evening of January 19, 2013, and before dawn on the morning of January 20, 2013. At some point shortly after her death, a person or persons unknown to this Board went to the RPC and collected the documentation relating to IM A. That documentation was not provided to this hearing; nor was any chain of evidence as to what was seized, by whom or when. Nor was any information provided as to where it was maintained and who had access to it. Is it possible that the material has been misplaced or lost? It is.

[184] If Ms. Ledding faxed the order to the regional pharmacy, its records certainly do not disclose that it received the fax. Is it possible that she faxed it but that it did not arrive? Yes, but at no point in either the Beyko investigation or at the hearing did she say that she faxed it. If she did, it was her responsibility to ensure that the regional pharmacy received it.

[185] Dr. Witt had no recollection of issuing a new SO for Humulin R for IM A for blood-sugar readings over 22.1 after the January 15 Witt SO was issued. While some

phone records were introduced into evidence, they were not helpful, because there is a possibility that Dr. Witt was in the RPC when the order was given (if it was given). The records disclose that on January 16, 2013, Dr. Witt was both the on-call physician that day and that he was in the RPC between 08:00 and 17:00. If Ms. Ledding did call him on January 16, 2013, and he was in the institution, his cell phone and office phone records would not disclose it because it was an internal call. No internal phone records were produced.

[186] CSC institutions are highly regulated. People who enter and exit them are recorded. No evidence was produced of Dr. Witt's entrance to and egress from the RPC. That was under the employer's control. If he was not in the institution on January 16, 2013, it certainly could have been established.

[187] However, if Dr. Witt was in the RPC and issued a new SO on January 16, 2013, why did he not sign it? If he was in the RPC and did make the order by telephone, he would have done so before the 12:30 administering of the Humulin R to IM A, because that was the first time her blood sugar went above the 22.1 threshold. According to the RPC's records, he was supposed to be in the institution doing clinic work until 17:00. It would be logical that at some point, he would have gone to the Churchill and signed the order. That said, perhaps he did. The difficulty lies in the fact that he has absolutely no recollection of whether he gave an order, and if he did and he did sign it, perhaps it never was processed as it should have been, and it was lost. Is that possible? Yes. Is it probable? It is difficult to say and certainly is not definitive.

[188] If I am to accept the employer's position that no new SO was made for administering Humulin R for IM A when her blood-sugar reading was over 22.1, which would have been made sometime after January 15, 2013, it would mean that somehow, the grievors and Ms. Shaw all conspired and concocted a story that an SO was made that never existed. There is absolutely no evidence of that.

[189] All three grievors admitted that they took the actions that the employer characterized as misconduct. It is interesting to note that when the grievors and Ms. Shaw were interviewed, the only one under suspicion of wrongdoing was Ms. Bayani, as she was the only one into whose actions an investigation had been launched.

[190] I took particular note of Ms. Shaw's evidence. She is no longer in a nursing position but is a senior clinical manager classified at the AS-07 group and level. Why would she lie? Would her giving misinformation to an investigation and at a hearing

into misconduct not place her in a precarious position as a manager working at the CSC? If that were not foolhardy enough, consider that as of the time she testified, two of the three grievors were no longer employed by the CSC. This does not make any sense.

[191] Also of particular note is that accepting the employer's position would mean that three relatively junior nurses, Mses. Bayani, Herman, and Shaw, all recent university graduates (as of January 2013), jeopardized not only their jobs but also their professional careers as nurses by doing something as egregious as administering prescription medication to a patient, without authority. It is not lost on me that at the time these three nurses administered the Humulin R to IM A, Ms. Shaw and Ms. Bayani had been nursing graduates for only between two and three years and Ms. Herman for between one and two years.

[192] I also have Mr. Spicer's evidence. He is also an RN. At the time of the events at issue, he was also a recent graduate of the University of Saskatchewan nursing program. As of January of 2013, he had a bit more than three years' experience as a nurse and had been employed with the CSC for just over two years. Was he mistaken about seeing an SO, as described by the three grievors and Ms. Shaw? Did he lie? There is nothing to suggest that he was mistaken or that he lied.

[193] The employer emphasized the difference in the facts set out by Ms. Bayani and Ledding when they were interviewed as part of the Beyko investigation. I am not prepared to give any weight to these inconsistencies.

[194] The grievors and Ms. Shaw worked in a challenging environment in which they often worked up to 12 hours per shift; they were responsible for the healthcare needs of patients who were described as having high needs. An integral part of their job was dispensing and administering medication to those inmates, whether they worked on the Churchill with the female inmates, on another unit, or in the hospital wing.

[195] While I was not privy to the medical records of any other inmates, the very nature of the workplace and the work itself disclosed that as a part of their daily work routine, the RNs working at the RPC would administer medications to different inmates at different times. Based on the limited information I received with respect to IM A (she was on several different medications, including Humulin R, which she received often four or more times per day), it would not surprise me if during the course of a workweek, however that workweek was calculated, any one of the grievors

would have been responsible for dispensing and administering medication up to 100 times per week. It also appeared that being required to call doctors about inmates' health and medications was a regular routine for the RNs.

[196] I am not surprised that at interviews that took place four months after the death of IM A, the grievors might have been mistaken about exactly what they might have done on a shift in a particular unit and the details of a telephone call or specific drug administration. Those particular tasks were done over and over again, day in and day out, as part of their regular duties. At the same time, it highlights the importance of the timely and accurate charting and documenting of the tasks carried out with respect to patient care as set out in both the SRNA Documentation Guidelines and SRNA Med. Admin. Guidelines, along with the CSC's policies, guidelines, and standards.

[197] The employer also pointed out that two of the grievors, Mses. Bayani and Herman, as well as Ms. Shaw, all inappropriately documented the administration of the Humulin R on the MAR for the January 15 Witt SO. That is accurate. Also accurate is that there was no MAR for the order they stated existed. That said, none of them made any attempt to hide the fact that they administered the Humulin R when they did and at the amounts they did. They wrote them all down on IM A's Diabetic Chart. I find it strange that on one hand, they would administer a drug with no authorization, and for both Mses. Herman and Bayani, multiple times in a short period, including when it was not to be administered, and yet, on the other hand, admit this alleged wrongdoing by writing it down and dating and initialling that they did so.

[198] The facts with respect to the administration of the Humulin R to IM A on the evening of January 19, 2013, and Ms. Bayani's call to Dr. Froh could also be seen as somewhat peculiar.

[199] According to IM A's Diabetic Chart, Ms. Bayani tested IM A's blood sugar at 17:30, 18:30, and 19:00, at which times it read 26.1, 30.8, and 22.2, respectively. At all those times, she administered 12 units of Humulin R. According to the Doctors Order Sheet, Ms. Bayani wrote that at 21:00, she received a telephone order from Dr. Froh for administering Humulin R at 12 units for blood-sugar readings of 22.1 to 24 and at 16 units for readings of over 24, and to call a physician. In IM A's Progress Notes, Ms. Bayani wrote about this and noted the time as 21:10. If there was already a new SO from Dr. Witt that Ms. Ledding had taken sometime earlier in the week, which Ms. Bayani said she followed, what reason did she have to call Dr. Froh that evening?

[200] Ms. Bayani said that she called the on-call physician in the evening of January 19, 2013, due to concerns about IM A's high blood-sugar readings because of her previous experience with an inmate in a similar high blood-sugar situation who eventually had a seizure. This was certainly reasonable and logical, despite the fact that a new SO was in place (since no copy of it was ever found, and no one recalled its exact details) and that not least of all, IM A's blood sugar did not drop despite not one but two administrations of 12 units of Humulin R. The evidence disclosed that after the first administration, her blood sugar actually rose, from 26.1 to 30.8.

[201] Based on all the evidence and on a balance of probabilities, I am not convinced that Dr. Witt did not make a new SO on or about January 16, 2013, which was in conjunction with the January 15 Witt SO. Given that finding and on a balance of probabilities, the employer failed to establish that Mses. Bayani and Herman committed misconduct by administering medication to IM A without proper authority and that Ms. Ledding did so by giving false information to the Beyko investigation.

[202] In all of the grievances the grievors asked, as part of the relief requested, that the investigation report be destroyed. I heard no reference to this request in the grievor's opening statement nor did I hear any argument on this. I assume the request is for me to order the destruction of the copies of the investigation report within the employer's control. The investigation report, flawed as it may be, was created in the course of the employer's business and forms part of the employer's record. I am not prepared to order that it be destroyed. I am however prepared to order that if the investigation report is maintained in any of the grievors' personnel files or any file with respect to the grievors, a copy of this decision shall be appended to it.

[203] For all of the above reasons, the Board makes the following order:

(The Order appears on the next page)

V. Order

[204] The grievance against the two-day suspension in file 566-02-10798 is allowed. Ms. Bayani is to be reimbursed all lost salary and benefits that she would otherwise have earned had she not been disciplined. I also award interest on the net lost salary as set out in ss. 36 and 37 of the *Federal Courts Act* (R.S.C., 1985, c. F-7), to be calculated from the date of the first pay period after January 16, 2014. The interest is to be compounded annually up to and including the day on which the payment is made.

[205] The grievance against the two-day suspension in file 566-02-10799 is allowed. Ms. Ledding is to be reimbursed all lost salary and benefits that she would otherwise have earned had she not been disciplined. I also award interest on the net lost salary as set out in ss. 36 and 37 of the *Federal Courts Act*, to be calculated from the date of the first pay period after January 15, 2014. The interest is to be compounded annually up to and including the day on which the payment is made.

[206] The grievance against the one-day suspension in file 566-02-10800 is allowed. Ms. Herman is to be reimbursed all lost salary and benefits that she would otherwise have earned had she not been disciplined. I also award interest on the net lost salary as set out in ss. 36 and 37 of the *Federal Courts Act*, to be calculated from the date of the first pay period after January 17, 2014. The interest is to be compounded annually up to and including the day on which the payment is made.

[207] All exhibits that set out the particulars of IM A's identity including her name, date of birth and FPS number be sealed for a period of 45 days from the date of this decision to allow the parties to provide the Board with copies of those exhibits with that information redacted for the record, after which the unredacted exhibits shall be returned to the parties.

[208] Exhibits E-2 and E-3 shall be sealed for a period of 45 days from the date of this decision to allow the employer to provide the Board with copies of those exhibits with Dr. Witt's telephone numbers and address redacted for the record, after which the unredacted exhibits shall be returned to the employer.

[209] Exhibit E-9 shall be sealed for a period of 45 days from the date of this decision to allow the employer to provide the Board with a copy of that exhibit with IM B's name and FPS number redacted for the record, after which the unredacted exhibit shall be returned to the employer.

[210] If the investigation report dated August 23, 2013 ("the investigation report") remains in any of the grievors' personnel files or any file with respect to the grievor, the employer shall append to it a copy of this decision.

April 17, 2019.

John G. Jaworski,
a panel of the Federal Public Sector
Labour Relations and Employment Board