**Date:** 20210331

**File:** 566-02-14365

**Citation: 2021 FPSLREB 33**

*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

**ALEKSANDRA BESIROVIC**

Grievor

and

**DEPUTY HEAD**
**(Correctional Service of Canada)**

Respondent

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

In the matter of an individual grievance referred to adjudication

**Before:** Ian R. Mackenzie, a panel of the Federal Public Sector Labour Relations and Employment Board

**For the Grievor:** Adam Cembrowski, counsel

**For the Respondent:** Richard Fader, counsel

Heard by videoconference,
November 17, 18, and 20, 2020.

**REASONS FOR DECISION**

## I. Individual grievance referred to adjudication

[1] Aleksandra Besirovic ("the grievor") was a correctional officer (CX-1) at Edmonton Institution, a maximum-security facility ("the Institution"). Her employment was terminated on April 18, 2017. The alleged misconduct was negligence in the performance of her duties on February 24 and 27, 2017, while she was on high suicide/self-injury watch. The Deputy Head ("the employer") alleged that the grievor slept while on duty on February 24 and that she did schoolwork while on duty on February 27. It alleged that on both shifts, she failed to maintain direct and constant supervision of an inmate and failed to document his activities, as required by its policy.

[2] The grievor has conceded that discipline was warranted but that the termination of her employment was excessive, in the circumstances.

[3] For the following reasons, I find that the discipline was indeed excessive and should be substituted with a lengthy suspension.

## II. Confidentiality and sealing order

[4] This grievance involved the grievor's monitoring of an inmate. Video evidence of the events at issue contained images of him and one other inmate. In addition, documents mention his name. The employer asked for an order that the video evidence be sealed, along with some documents reporting the incident at issue. The grievor did not object.

[5] The principle of the public nature of evidence and hearings before the Federal Public Sector Labour Relations and Employment Board ("the Board") is well established. The test for restricting the open court principle is whether the restriction is necessary to prevent a serious risk to an important interest, because reasonable alternative measures will not prevent the risk, and whether the salutary effects of the order outweigh its deleterious effects, including the public interest in open and accessible court proceedings; see *N.J. v. Deputy Head (Correctional Service of Canada)*, 2012 PSLRB 129 at para. 48.

[6] In the present circumstances, I find it appropriate to seal the exhibits. It is in the public interest to respect the privacy of inmates. Sealing the videos and documents

does not in any way affect the transparency of this decision or this quasi-judicial process. Therefore, the following exhibits are ordered sealed: Exhibits E-3 and E-4 (videos) and the employer's book of exhibits, volume 2. Additional exhibits have been redacted by the employer to protect the identity of the inmate who was being monitored.

[7] At several points during the hearing, when the videos were shown to witnesses, the hearing was closed to the public.

## III. Summary of the evidence

### A. The grievor's work history

[8] The grievor was hired as a correctional officer in October 2009. She worked at the Institution until her termination of employment. Before that, she had no discipline on her record.

[9] The grievor had been on leave for two years before her return to work in the fall of 2016. She testified that she had received good performance reviews and a superior performance review before going on leave in 2014.

[10] The two correctional officers who testified at the hearing — Alastair Sanderson and James Cochrane — testified about their separate relationships with the grievor. Mr. Sanderson testified that his was "cordial", and Mr. Cochrane testified that his had been "indifferent". Carmen Ings was the supervising correctional manager on night shifts. She testified that she had a good working relationship with the grievor and that there were no issues. Clovis Lapointe, the warden, testified that he had no issues with the grievor before the events that led to her discipline.

[11] The grievor is married with two young children. In 2017, the children were 5 and 2 years old. She and her husband could not afford childcare, so they had to work opposite shifts. Due to these family obligations, she was being accommodated by the employer with 8-hour shifts (instead of the normal 12-hour shifts) and worked exclusively on night shifts, from 23:00 to 07:00. She was entitled to two 15-minute breaks and one half-hour meal break.

[12] The grievor testified that at the beginning of each shift, she would go to the correctional manager's office and would be assigned duties at that time. She did not know what post she would be assigned to until she arrived at work.

[13] The grievor attended school part-time in 2017.

## B. Training and policies on suicide watch

[14] Correctional officers receive instruction on suicide prevention and on responding to suicide and self-injury situations in their initial training. They also receive refresher training in these areas approximately every two years. The grievor received refresher training in 2014.

[15] Commissioner's Directive 843, "Management of Inmate Self-Injurious and Suicidal Behaviour", sets out the process for identifying suicide or self-harm risks and the monitoring requirements. A healthcare professional first assesses and assigns an inmate to an observation level. The professional then completes an observation form. The form is provided to the duty correctional manager, who is required to ensure that it is accessible to all staff who interact regularly with the inmate. There are two levels of observation specified in the directive: "High Suicide/Self-Injury Watch" and "Modified Suicide/Self-Injury Watch". For both levels of watch, the correctional officer is required to document the inmate's activities on a "Seclusion and Restraint Observation Report" as required, "but at least every 15 minutes". Ms. Ings confirmed that correctional officers are required to record their observations every 15 minutes.

[16] An inmate is put on high suicide/self-injury watch if he or she is in imminent risk of suicidal or self-injurious behaviour. The directive requires that inmates on such a watch be under "constant, direct observation" by a correctional officer. Under the directive, monitoring by camera does not fulfil this requirement.

[17] Ms. Ings testified that no training is required for the direct observation of an inmate on high suicide/self-injury watch. The training and refresher training relate to suicide prevention and recognition, not observation, she testified.

[18] Mr. Lapointe testified that the Seclusion and Restraint Observation Report is handed in by the outgoing correctional officer on watch and is then placed in a binder.

## C. High suicide/self-injury watch at the Institution

[19] The high suicide/self-injury watch is done in what was called the segregation unit. Ms. Ings testified that there were 48 single-occupant cells in this unit and that it was always less than full.

[20] There is also a secure sub-control post or "bubble". The officer there has access to cameras that show different areas of that part of the Institution, including a camera inside each segregation cell. The sub-control officer controls the lights and doors on the segregation unit. Ms. Ings testified that that officer can see the correctional officer on high suicide/self-injury watch from the post. Mr. Cochrane testified that to see the officer on watch, the officer in sub-control would have to crouch down.

[21] There is also a multifunction correctional officer on duty, who performs range walks and relieves other correctional officers for breaks.

[22] When there is an inmate on high suicide/self-injury watch, a correctional officer is assigned to what is called an "extra-duty" post. A chair is provided for the officer. Mr. Sanderson testified that the officer should be able to see into the cell while sitting in the chair. He also testified that most high suicide/self-injury watches are conducted from a seated position. He also testified that the doors were poorly designed for watching inmates.

[23] Ms. Ings testified that when the lights were on in the hallway, there was a glare on the cell window, and officers would have to get up and look into the cells they were watching. Mr. Lapointe also testified that it was not possible for a correctional officer on watch to observe an inmate from a seated position. He stated that if an officer was seated, he or she "would not be able to see what he [the inmate] is doing". He testified that using a flashlight to look into the cell was the proper method for observing an inmate on watch.

[24] Mr. Sanderson testified that if an officer on suicide watch needed a short break, another officer on the floor would provide it. If a longer break was needed, the officer requesting the break would have to contact the correctional manager on duty. Ms. Ings confirmed that this was the practice at the Institution.

[25] Ms. Ings testified that the rules on the length of time for high suicide/self-injury watch changed approximately two weeks after the grievor's termination of employment. The change was announced on May 3, 2017, in this memo to wardens in the CSC's Prairie Region from the ACCO:

> *As you are aware, UCCO SAC* [sic] *CSN engaged with the Deputy Commissioner and myself during the most recent RLMC about the rotation of correctional officers assigned to high suicide watch*

> *duties under the authority of CD 843. Specifically, the request was whether we would be willing to restrict or limit the number of hours in which an officer could be assigned to the duties at one time. At the RLMC, there was agreement I would consult with each of the Wardens on this as we believed there was indeed merit to limiting the numbers of hours one could be assigned to these duties.*
>
> *After consultation with all sites in the region and the union, it has been agreed that such assignments to these duties* ***shall not normally exceed two (2) hours at a time****. It is felt limiting the number of hours an officer might be assigned to these specific duties would enhance the diligence required to ensure the well being of the inmate on high suicide watch.*
>
> *Please ensure this regional direction is shared with your Correctional Managers and ensure to the greatest extent possible we are limiting such assignments to the two hours. I understand there will be circumstances when it won't be possible to rotate officers but those situations are likely to be far and few between. In these situations I would expect the Correctional Manager* [sic] *facilitate the post exchange as soon as possible after the two hours.*
>
> …
>
> [Emphasis in the original]

[26] Mr. Lapointe testified that he was involved in the consultations on this change. He did not recall when the consultations were done but stated that he did recall that the initiative had been "in the works for some time". He testified that he was aware of concerns about the length of high suicide/self-injury watches before the grievor's termination of employment.

## D. Alleged misconduct

[27] The employer relied on two incidents to support the discipline imposed on the grievor. The warden testified that he first examined the video of the incident of February 27, 2017. He then reviewed video of the grievor's previous shift on high suicide/self-injury watch of February 24, 2017, on which he observed further conduct that in his view justified discipline. He testified that he viewed the February 24 video to give the grievor "the benefit of the doubt". I have summarized the evidence relating to both incidents in chronological order.

### 1. The February 24, 2017, incident

[28] The grievor arrived at work on February 23, 2017 and went to Ms. Ings' office to receive her assignment. She was assigned to high suicide/self-injury watch.

[29] Ms. Ings testified that the inmate on high suicide/self-injury watch was a prolific self-harmer and well known in the Institution. She stated that the correctional officers talked about the inmate regularly. In cross-examination, she agreed that the grievor might not have been as familiar with this inmate. She could not recall if she briefed the grievor on the inmate at the beginning of her shift. Mr. Cochrane testified that the inmate was devious and that he had already slashed himself two times that week. He also testified that he did not believe that the inmate was suicidal.

[30] The grievor testified that the correctional officer on watch before her told her that the inmate had been "on great behaviour all day, and no worries". She testified that other than that, she knew nothing about the inmate's history or reputation.

[31] The video that the warden relied on to impose discipline began recording at 4:02 a.m. on February 24, 2017. The lights were off in the segregation hallway that evening. As a result, the video is gray and grainy. Ms. Ings testified that the officer on watch would advise whether he or she wanted the lights on. In cross-examination, she agreed that she did not know if the grievor asked for the lights to be off. The grievor was not examined on this question.

[32] The grievor testified that she placed the chair so that she could see the inmate. She testified that she could see him. She was wearing a parka. She testified that it was often cold in the hallway of the segregation unit and that it was "really cold" that night. Mr. Sanderson testified that it could be cold on the segregation unit. During his rounds that evening, he can be seen on the video wearing a toque. Mr. Lapointe testified that he had never received complaints about the segregation unit being cold.

[33] The grievor then used a second chair to put her legs on. She also had a neck pillow on. She testified that she regularly brought the pillow to work, to support her neck. She stated that she had some neck issues due to a car accident.

[34] During her shift, she got up and left her post for about a minute to fetch a blanket. She testified that she went to the office down the hall to retrieve it because she was cold. She also testified that had she known about the inmate's reputation; she would not have left the post.

[35] On the video, at approximately 4 a.m., the grievor remains motionless until approximately 4:20 a.m., when Mr. Sanderson comes by on his rounds. After he

finishes examining the cells, the grievor repositions herself with her feet up on the chair and slumps down on it. She once again moves her feet at about 5:18 a.m., when Mr. Sanderson comes by on his rounds.

[36] The grievor testified that she did not intentionally go to sleep. She stated that she was "99% sure" that she had not slept but that she then started to doubt herself when the warden said that he had video of her falling asleep. At the hearing, she testified that she did not think that she fell asleep. In cross-examination, she did not deny that she might have dozed off.

[37] Mr. Sanderson testified that he had viewed the video before the hearing. He testified that before seeing it, he had very little recall of that night. He testified that at that time, he did not regard the grievor's behaviour as putting the inmate at risk. He also testified that he did not think that he paid attention to her, as his sole objective was to look in on the inmate.

[38] Ms. Ings testified that if Mr. Sanderson had had concerns about the grievor sleeping, it was his duty to bring it to her attention.

[39] Ms. Ings did not observe the grievor on this shift. The first time she saw the video of this incident was in preparation for this hearing. She testified that a correctional officer should never leave his or her post unless he or she had arranged for relief.

[40] Ms. Ings testified that if a correctional officer is unable to do his or her duties, he or she must inform the correctional manager. She testified that she is located outside the segregation area and that she would not know if someone is not able to carry out his or her duties. She also testified that correctional officers swap and trade posts all the time, which is acceptable as long as each post is covered.

[41] Ms. Ings was not involved in the disciplinary process relating to this incident. At the hearing, she was asked for her reaction to the video. She testified that she could not say if the grievor was asleep or not but that it was a reasonable assumption that the grievor was asleep or close to being asleep. She also testified that she was shocked by the video and that the grievor had been neglectful of her duty.

**2. The February 27, 2017, incident**

[42] The grievor went to Ms. Ings' office before the start of her shift and was again assigned to high suicide/self-injury watch. She told Ms. Ings that she had received a reminder about suicide prevention refresher training and that her certification had expired. The grievor testified that Ms. Ings stated that she did not have anyone else available for the watch. Ms. Ings did not recall this conversation.

[43] The grievor also testified that she told Ms. Ings that some correctional officers did not appreciate her late shift start time and had been upset with her. Ms. Ings testified that the grievor did mention to her some concerns about the start time of her shift and that some correctional officers "weren't polite about it".

[44] At the beginning of her watch, on the video, the grievor can be seen talking to the correctional officer she is replacing. She testified that he told her that the inmate had been on good behaviour.

[45] In the video, visible beside the chair is a magazine or newspaper, put there by the outgoing correctional officer. The warden stated that it was inappropriate for the officer to have reading materials with him, but he did not read, and it did not interfere with his duties.

[46] The grievor testified that she understood that reading while on suicide watch was "okay" and that she had seen others do it. In the video, she is seen taking out books and a notebook and starting to read.

[47] Ms. Ings testified that sometimes, officers bring books to their posts, but that high suicide/self-injury watch is a different kind of post. She stated that she was not aware of any correctional officers reading while on suicide watch. Mr. Cochrane testified that he would have seen the grievor reading when he did his rounds. He testified that he did not report her. He stated that some correctional officers read while on suicide watch and that some do not. He said it was "not unheard of" for reading to be done while on suicide watch. He also testified that a correctional officer would not have a book visible if the warden was coming down to the unit.

[48] The grievor testified that she was able to see the full mattress and the inmate's body shape under his blanket. There are times during the video where the grievor can be seen talking (there is no audio). She testified that she was talking to both the inmate

and the one beside him. In cross-examination, the grievor went through parts of the video and identified when she looked into the cell. She testified that these glances were two or three seconds each.

[49] Ms. Ings testified that she did not see the radio on the grievor's duty belt. She testified that correctional officers are required to wear a radio at all times, for immediate access. The grievor agreed that for part of the shift, she did not have her duty belt on.

[50] Mr. Sanderson was working in the sub-control unit on the evening of February 27, 2017. He was able to observe the inside of the segregation cell through a video monitor. He prepared an observation report on February 27, 2017. He reported that he noticed the inmate "acting strangely". He was fidgeting under his blanket. When the inmate moved the blanket, Mr. Sanderson noticed a dark spot on the mattress that he thought resembled blood. He advised his partner, Mr. Cochrane, who then went to the cell.

[51] Ms. Ings also arrived outside the cell. She testified that before entering the cell, she and Mr. Cochrane tried to get the inmate to apply pressure to his wounds. They waited to enter the cell until they had the appropriate personal protective equipment — in this case, disposable gloves.

[52] Mr. Cochrane completed an observation report on February 27, 2017. He wrote that Mr. Sanderson had asked him to take a closer look at the inmate, as he reported that the inmate was "behaving strangely underneath his security blanket" and that he believed he had spotted blood on the mattress. In his report, Mr. Cochrane stated that after the inmate removed the security blanket, he observed an "active bleed" in both arms with a "… substantial amount of coagulated blood on his mattress/clothing". When he administered first aid to the inmate, he noticed that the cuts on the left arm were "actively bleeding and appeared deep/substantial". He testified that he applied a tourniquet to the inmate's arm. He also testified that he had never seen that much blood. He testified that he believed that the inmate had been bleeding for 10 to 15 minutes before he was discovered.

[53] Ms. Ings prepared an observation report on February 27, 2017. She reported that the inmate had stated that he had cut his biceps with pieces of a sprinkler head he had broken on the previous evening. Mr. Cochrane was also aware that the inmate had

broken a sprinkler head and referred to an observation report he had prepared the previous day in relation to that incident. Ms. Ings was asked if it was an oversight not to remove a potential weapon from an inmate on suicide watch. She stated that she did not know the inmate's status on the night that he had broken the sprinkler head. She also noted that inmates hide things inside their bodies. She did not know if concerns had been raised with her about the presence of pieces of the sprinkler head before the incident.

[54] Ms. Ings also stated in her report that when the inmate removed the security blanket, there was what appeared to be a "significant amount of blood". The inmate told her that he did not want to die. She noted that although he was pale and light-headed, he was talking and responsive and was able to clearly articulate what he had done. She testified that the injuries looked "pretty serious" and that bandages would not have been sufficient to stop the bleeding.

[55] After the Emergency Medical Services personnel arrived at the segregation unit, the inmate was transported to a hospital for treatment. The grievor and another correctional officer escorted the inmate to and from the hospital. Ms. Ings testified that it made sense to send the grievor, since she was no longer required for high suicide/self-injury watch.

[56] The employer did not provide an observation report from the grievor. She testified that although she was not sure, she thought she had handed a report to Ms. Ings before taking the inmate to the hospital.

[57] A report prepared by the Security Intelligence Officer indicated that the severity of the inmate's injury was "non-serious bodily injury". The Officer did not testify at the hearing.

[58] The inmate was returned to high suicide/self-injury watch on his return to the Institution.

[59] Ms. Ings was asked if the grievor expressed any remorse. She testified that she had no conversations with the grievor after the inmate was sent to the hospital.

[60] Ms. Ings viewed the video of this incident for the first time in preparation for this hearing. She testified that from her review of the video, she did not believe it was possible that the grievor could have been observing the inmate.

**E. Disciplinary hearing and termination of employment**

[61] The warden, Mr. Lapointe, was the decision maker in the discipline of the grievor. Ms. Ings had no involvement in the disciplinary process.

[62] Mr. Lapointe testified that after being advised of the February 27, 2017, incident, he decided to review the grievor's previous shift (February 24) to give her "the benefit of the doubt". He did not look at any other shifts, as he testified that she might have been at another post.

[63] Mr. Lapointe testified that on viewing the video of February 24, 2017, he observed the grievor preparing to make herself comfortable and leaving her post to retrieve the blanket. He also noted that she had brought a pillow into the facility. He testified that he concluded that she was putting herself into a comfortable position, with the intention of falling asleep.

[64] Mr. Lapointe testified that based on observing the video of February 27, 2017, the grievor showed no intent to carry out her duties of observing and monitoring the inmate. He testified that no other correctional officers were disciplined as a result of this incident.

[65] The grievor provided a typed document to the warden on March 13, 2017. The employer has referred to this document as a "rebuttal", but it was provided before the grievor's disciplinary hearing. It reads as follows:

> *Firstly, I would like to ask that we immediately proceed to an expedited hearing; a disciplinary investigation will not be necessary due to the fact that I will admit that my actions were not acceptable and I sincerely regret that you had to see me in this negative light: I am mortified and feel rather embarrassed.*
>
> *I feel like I owe you as well as myself an explanation for my behavior.*
>
> *Two month ago, I lost two members of my family within the same week: one of those two people was my grandfather who was very dear to me: I was devastated and I felt an immense amount of pain because I was not able to travel to Europe in order to go to his funeral and say goodbye; to grief* [sic] *my grandfather's loss. I contacted work and requested to take compassionate leave but I was questioned and told that I do not qualify for bereavement leave because I am not attending my grandfather's funeral and that I will have to use my own leave instead. Feeling already low, I was in disbelief that I had to explain how I was going to spend my*

*days grieving and was shocked at the lack of compassion my manager showed and guilt for taking time off to grieve.*

*I felt pressure to return back to work before appropriately mourning and healing. Instead of dealing with my emotions I was consumed by them. I started to experience constant fatigue and trouble sleeping which directly impacted every aspect of my life and instead of acknowledging and sharing my emotions I kept them bottled up. Once I realized the true extent of my loss, grief took over my life. I felt lonely, isolated, anxious, helpless and sad. I got addicted to caffeine as a means of staying awake. I was feeling particularly down over the last few weeks and my body was exhausted physically and mentally, we had been very short staffed for the last little while and I knew that complaining to the manager about being put on suicide watch would have caused everyone extra grief: the state that I was in mentally impacted my decisions to report to post, on the night in question as opposed to going home and taking a mental health day.*

*I have two young boys and I often feel like a single mother because my spouse works long hours in order to support our family. I fear that the fact that my relationship is unbalanced in regards to the children and household responsibilities often causes me further distress. I am also furthering my education by working towards my Master's degree in Psychology in order to attain a better position in Corrections. My career in the service is very important to me. I strongly believe in the rehabilitation and reintegration of offenders and I know the importance that CSC plays in that role; I have recently applied for the parole officer competition which would allow me to take on a caseload and do something more stimulating, work reasonable hours and get enough rest and improve the strain on my mental health.*

*I will admit that being a CO, mother, wife and student puts a lot of pressure on performing adequately and that my personal loss on top of all that pressure overwhelmed me. My unresolved feelings have had an immense impact on my career and as a new R2MR facilitator and an empathetic person I am used to people turning to me for mental health and support; I must admit that it is hard for me to switch roles and be the individual that is asking for help. I was not prepared for the intensity and duration that my emotions have had on my life and my mental health.*

*Witnessing that offender mutilate his body during my most recent shift while on suicide watch brought on worse feelings of anxiety, total lack of sleep or nightmares, flashbacks and avoidance of places and people. I think that I would have benefited from being offered CISM after the incident happened; I have reached my breaking point and I would like to improve my mental health and go back to living my regular life, before the mental state I am currently in becomes normal. I am tired of pretending and decided to get help, I have had an appointment with my doctor and he has prescribed me some medication that will help me regulate my sleep, deal with my anxiety and he strongly recommended seeing a*

> *psychologist in order to process what I have been trying to suppress in the past few months; which I will gladly do.*
>
> *I take full responsibility for my actions and I am ready to accept my discipline; I sincerely ask of you to take into consideration my current situation and spare my job.*
>
> [Emphasis throughout]

[66] The grievor testified that it was a difficult time for her due to losing family members and managing her school studies. She also testified that she was not receiving pay at the time due to the issues with the Phoenix system and therefore had financial issues.

[67] The disciplinary hearing was held on March 16, 2017. Its purpose was stated to be to provide the grievor with an opportunity to present her comments and any additional information that she felt was relevant for the warden to consider before he made a decision on whether disciplinary action was warranted. Mr. Lapointe conducted the hearing, and a labour relations officer attended by phone, who prepared detailed notes of the hearing. The grievor did not dispute the accuracy of the notes.

[68] The grievor was accompanied by a colleague at the disciplinary hearing. Mr. Lapointe noted that the colleague was not there as a union representative and stated, “so he can’t support you from a union standpoint”.

[69] Mr. Lapointe told the grievor that no disciplinary investigation was needed “as we felt with the evidence, we had that we could go straight to a hearing”. He told the grievor that he would show her the videos from the two shifts. She responded that she did not want to see them and that she would be “mortified”.

[70] The grievor told Mr. Lapointe that she could not remember if she was given the observation report by the previous officer on the post.

[71] Mr. Lapointe told the grievor that from viewing the video of February 27, 2017, “at no time” did he see her looking into the cell. The notes of the labour relations officer continue:

> *Aleksandra: Where I was sitting I could see into the cell. He was in the bed under a blanket. Throughout the night we were talking. I could see him moving under the blanket.*
>
> *Clovis: I think it is very important you watch the video. It is in high definition. It’s very clear that you didn’t look in the cell even one*

*time. So based on that as there were significant issues with your performance I wanted to see if this was just a bad night for you. You were doing homework, so was this just a one off. I pulled the video from your previous shift on February 24th. On that one he [you] actually go off and get a blanket, you had a pillow with you and then it appears that you sleep for about a little more than an hour.*

*Aleksandra: Yes, when you are sitting on that post it can be for 10-12 hours. The chair is hard. It's freezing back there. I wear double clothes. You don't get relief your whole shift.*

…

*Clovis: Have you ever asked for relief on that post?*

*Aleksandra: When you are on suicide watch usually no one wants anything to do with it. The first night I asked for a break. Alastair gave me a tiny break. They are reluctant to help out. The keeper should make sure that someone comes to relieve me.*

…

*Clovis: In the end, if you are asking a CM for a break and they aren't giving you one, we can deal with that.*

…

*Clovis: You left the post for a blanket. Where did you get that from?*

*Aleksandra: I got it from the office. Sleeping, I don't do that on post.*

*Clovis: Have you ever slept on post before?*

*Aleksandra: No, especially not on high suicide watch.*

*Clovis: You were aware he slashed twice that week already. Anything else you want to say?*

*Aleksandra: I'm mortified.*

*Clovis: What have you learned?*

*Aleksandra: I've learned if I'm not fit for duty I shouldn't report to work. I don't have a post. I' m accommodated for my personal life. I don't want to complain. The night I came in I didn't get a break. I didn't feel it was worth complaining to the CM.*

*Clovis: Do you understand your role? He is a mental health inmate on High Suicide Watch. That is why he is under constant watch. He will try to hide what he is doing. Often hides under the blanket.*

*Aleksandra: I understand the importance.*

*Clovis: When someone is on high suicide watch there is no time for complacency. You were just reading or doing your homework. There is no evidence on the videos that you were doing any of your duties.*

[72] The grievor's colleague told Mr. Lapointe that when he made his decision on discipline, he should take into account the grievor's exemplary career. He continued:

> *…She has been going through a rough personal time. She is doing her masters. She accepts when* [sic] *she did and is admitting in* [sic] *was unacceptable. She asked for relief but didn't get it. She will accept any discipline. She has been to her doctor. She shouldn't have come in that night, she should have called in sick. She feels she has been railroaded into this post that no one wants. They are all part of what happened here.*

[73] Mr. Lapointe asked the grievor if she had anything else to say. She concluded:

> *I know that it looks bad. The two occasions don't capture what I usually do. I often do walks for others. I'm mortified by this. I've been going through personal issues. I had 2 people pass in the same week. Just everything I'm finding hard to manage between my kids, school and work.*

[74] Her colleague stated that she did not want to view the videos, that she accepted responsibility, and that she would accept discipline for the misconduct.

[75] The grievor testified that at the disciplinary hearing, she was in shock and confused. She testified that she felt horrible and ashamed that the inmate self-harmed while she was on watch. She testified that if she had had the knowledge about the inmate that she has now, she wished that she would have done things differently.

[76] Mr. Lapointe was asked if the grievor took the position that she had not slept. He stated that "she owned up to her actions". He did not recall her denying that she had slept. She testified that at the disciplinary hearing, she did not acknowledge falling asleep.

[77] In cross-examination, Mr. Lapointe was shown several parts of the video of February 24, 2017. He agreed that he could not know for certain if she had fallen asleep but stated that it was "beyond probability" that she had slept. Mr. Lapointe did not accept that the grievor fetched the blanket because she was cold. After reviewing the toque worn by Mr. Sanderson, the parka that the grievor was wearing, and her comments at the disciplinary hearing that that area had been freezing, he admitted that possibly, it had been cold, but stated that it had still been not appropriate for the grievor to use a blanket.

[78] In cross-examination, Mr. Lapointe was taken to several parts of the video of February 27, 2017. He admitted that at times, the grievor looked into the cell, and at one point, she appeared to be talking to the inmate. He then testified that the proper method was to use a flashlight to look into the cell, as the officer on rounds had done.

[79] Mr. Lapointe testified that he had the authority to conduct a disciplinary investigation if the perpetrator contested or denied the facts. He stated that an investigation is not necessary when the facts are not contested and if there is enough evidence to proceed directly to a disciplinary hearing. He noted that the grievor took "accountability" for her actions and did not contest her mistakes.

[80] The grievor attended a disciplinary meeting on April 18, 2017, at which she was provided with a letter from Mr. Lapointe terminating her employment. The letter set out the following findings of misconduct:

> *The Correctional Service of Canada (CSC) expects all employees to conduct themselves in a manner consistent with CSC's Standards of Professional Conduct and Commissioner's Directives. After a thorough review of the evidence including video footage from February 24 and 27, 2017 and the information provided by you during the disciplinary process; I find that your actions were not in accordance with the behavior expected of a CSC employee. Your actions were willful and deliberate when you slept on duty and did your school work while on high suicide watch of an inmate. On both shifts you failed to maintain direct and constant supervision on the inmate and you also failed to document the inmates* [sic] *activities as required. Your behaviour shows clear disregard for the Standards of Professional Conduct.*

[81] These were the provisions of the employer's code of discipline that the grievor was found to have breached:

- Paragraph 6(f), "fails to take action or otherwise neglects his/her duty as a peace officer".
- Paragraph 6(g), "fails to conform to, or to apply, any relevant legislation, Commissioner's Directive, Standing Order or other directives as it relates to his or her duty". Specifically, under Commissioners Directive 843, documenting the inmate's activities on a Seclusion and Restraint Observation Report at least every 15 minutes and constant, direct observation of the inmate.
- Paragraph 6(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".
- Paragraph 8(i), "sleeps on duty".

[82] The letter then stated:

> *After careful consideration, I have determined that you do not demonstrate the values and ethics required of a CSC employee as outlined in CSC's Mission Statement. By your actions you have irreparably broken and compromised the employment relationship. Your misconduct is of such a serious nature that you breached the fundamental principles of fairness, professionalism and accountability within the employment relationship which must exist between you and CSC. I am therefore unable to maintain confidence or trust in your ability to perform your duties as an employee of CSC and peace officer.*
>
> *Accordingly, given the seriousness of your misconduct a decision has been made to terminate your employment for disciplinary reasons.…*

[83] Mr. Lapointe testified that the trust relationship had been broken based on his determination that the grievor had come to work prepared to sleep and to do homework. He stated that had the inmate died, this would have reflected badly on the Institution's reputation. He testified that in his view, the grievor had engaged in intentional culpable misconduct.

[84] Mr. Lapointe testified that he did not consider the grievor's clean disciplinary record or her overall job performance when assessing discipline. He testified that he did not consider her years of service but stated that in any event, it would not have mitigated the penalty, in his view.

[85] In the final-level reply to the grievance, Acting Assistant Commissioner Nick Fabiano stated that management had considered the grievor's years of service, her discipline record, and the comments she made during the disciplinary hearing of March 16, 2017.

### F. Post-termination

[86] The grievor received Employment Insurance benefits after her termination of employment. She remained unemployed until June 2019. She is currently working as a trauma counsellor.

## IV. Reasons

[87] The employer submitted that the grievor's behaviour on the nights of February 24 and 27, 2017, was both abhorrent and ridiculous. In its view, the termination of employment was warranted. The grievor admitted her misconduct but

submitted that in all the circumstances, the termination of employment was excessive and that a lesser disciplinary penalty should be substituted.

[88] In discipline cases, the test to be used by an adjudicator is set out in *William Scott & Company Ltd. v. Canadian Food and Allied Workers Union, Local P-162*, [1977] 1 Can. LRBR 1, [1976] B.C.L.R.B.D. No. 98 (QL) ("*Wm. Scott*"), and *Basra v. Canada (Attorney General)*, 2010 FCA 24, and states as follows:

- Has the employee given reasonable cause for some sort of discipline by the employer (i.e., was there misconduct by the employee)?
- If so, was the discipline the employer imposed an excessive penalty in the circumstances?
- If it was excessive, what alternate measure should be substituted that is just and equitable in the circumstances?

**A. Was there misconduct?**

[89] The employer relied on these three allegations of misconduct to justify the termination of the grievor's employment:

- falling asleep while on duty, thus not paying attention and not performing her required duties;
- doing homework while on duty, thus not paying attention and not performing her required duties; and
- not preparing observation reports as required while on high suicide/self-injury watch.

[90] The grievor has admitted that there was misconduct. She disputed the employer's conclusion that she slept on the job on February 24, 2017.

[91] The employer argued that at her disciplinary hearing, the grievor admitted to having fallen asleep. That conclusion was based on a misreading of the summary of the hearing. The warden referred to her fetching a blanket and having a pillow with her and then stated that "it appears that you sleep for about a little more than an hour". The grievor is reported as replying "Yes," and then noting that the area had been freezing and that the chair had been hard. This response suggests that the grievor was only agreeing that she had fetched a blanket and had a pillow. The warden did not accuse her of sleeping — he said that it appeared that she had slept. At best, it could be said that the grievor agreed that it might have looked like she had slept. However, later in the disciplinary hearing, she stated unequivocally that she did not sleep on that post and that she never slept during suicide watch. The employer suggested that she was referring to other instances of being on suicide watch. I find

that on reading the summary of the disciplinary hearing in its entirety, the grievor did not admit that she had fallen asleep.

[92] No witness directly observed the grievor sleeping. However, the video shows her with her legs on a chair, slumped down and motionless for a lengthy period. I find that is more likely than not that she did fall asleep for a portion of her shift of February 24, 2017. If I am wrong, the video does show that she was not attentive to her duties and that she did not directly observe the inmate for extended periods, both of which constitute misconduct.

[93] The warden's view that the grievor came to work with the intention of sleeping was not proven on a balance of probabilities. She testified that she used a neck pillow regularly, due to a neck injury. The warden was also of the view that retrieving the blanket showed an intention to sleep. However, the grievor and Mr. Cochrane testified that it was cold on the unit, which is supported by the toque worn by Mr. Cochrane as well as the grievor wearing her parka. I find that the employer did not demonstrate that the grievor's sleeping was intentional.

[94] The grievor admitted to the other allegations of misconduct, although she disputes the seriousness of that misconduct. I address its seriousness in the discussion of whether it warranted the termination of employment.

[95] In its submissions, the employer referred to the grievor's failure to wear her duty belt at all times. She objected to what she perceived was an expansion of the grounds for termination. In its reply submissions, the employer clarified that the reference to the failure to wear the duty belt was an example of her inattentiveness to duty while on high suicide/self-injury watch.

[96] I have not considered this evidence for two reasons. Firstly, the failure to wear the duty belt was raised for the first time at the hearing. It was not fair to the grievor to raise new misconduct allegations at that stage of the grievance process. Secondly, although the employer stated that it was not expanding the reasons for the termination of employment, it attempted to use that failure to buttress its argument that the grievor was inattentive to her duties. The inattentiveness that the employer relied on to support the termination, as set out in the letter of termination, was the grievor's failure to consistently watch the inmate. Wearing a duty belt was not related

to watching the inmate. It was not open to the employer to include new misbehaviour allegations at adjudication, to buttress its termination decision.

**B. Did the misconduct warrant the termination of employment?**

[97] The employer submitted that there was a clear case for the termination of employment on the basis that the grievor's conduct was extreme and fundamentally at odds with her status as a peace officer, the consequences of her misconduct were significant, and she showed no true remorse or understanding. She admitted to misconduct but submitted that there are mitigating factors that the employer should have considered that would justify discipline short of the termination of employment.

[98] As noted in *Lagacé v. Treasury Board (Solicitor General Canada - Correctional Service)*, PSSRB File No. 166-02-16037 (19881007), [1988] C.P.S.S.R.B. No. 275 (QL), the consequence of a grievor's actions or inactions is not the only relevant consideration when assessing an appropriate disciplinary sanction. Other factors may also be relevant and should be taken into account when determining the appropriate penalty.

[99] The factors to be considered are well established in the jurisprudence and non-exhaustive lists of them were first comprehensively set out in cases such as *United Steelworkers of America, Local 3257 v. Steel Equipment Co.* (1964), 14 L.A.C. 356, [1964] O.L.A.A. No. 5 (QL) and *Wm. Scott*. The relevance and weight of a particular factor varies according to the facts of each case. When determining whether a termination of employment is justified, both aggravating and mitigating factors should be considered when evaluating the appropriateness of the discipline imposed by the employer. (See, for example, *Yayé v. Deputy Head (Correctional Service of Canada)*, 2017 PSLREB 51 at para. 119.)

**1. The seriousness of the offence**

[100] The employer submitted that the suicide of an inmate while on suicide watch is a significant public issue and a priority for the CSC; see *Bridgen v. Deputy Head (Correctional Service of Canada)*, 2012 PSLRB 92 (upheld in 2013 FC 956 and 2014 FCA 237). The CSC provides training for correctional officers on suicide prevention and has clear policies on the management of self-injurious and suicidal behaviours. The employer submitted that these policies are effective only if they are taken seriously. It also stated that taking a "quick peek" into a cell is not sufficient when an inmate is on

high suicide/self-injury watch. It also submitted that the grievor was aware that the inmate had already self-harmed twice that week and that the inmate's self-harming behaviour was well known in the Institution.

[101] Although the grievor admitted her misconduct, she submitted that it was not serious. I have already addressed her contention that there is no proof that she was asleep on February 24, 2017. She also submitted that although she was not as diligent as she should have been, she was able to see into the cell on February 27, 2017. She also noted that the inmate's suspicious activity might not have been visible from her viewing point. She submitted that she had not been made aware of the level of risk associated with this inmate. In addition, she disputed the seriousness of his injuries.

[102] The grievor also referred me to *King v. Deputy Head (Correctional Service of Canada)*, 2014 PSLRB 84, in which the Board Member concluded that video surveillance footage was unreliable because it lacked audio. This grievance was related to a use of force, and the audio of the inmate was a critical part of determining if the use of force had been appropriate. In the case before me, the audio of the inmate is not relevant to assessing the seriousness of the misconduct. The grievor can be observed talking to the inmate, but there is no suggestion that the content of that conversation is relevant to the misconduct.

[103] Correctional officers are held to a higher standard of conduct than those in other occupations, as set out as follows in *Dekort v. Deputy Head (Correctional Service of Canada)*, 2019 FPSLREB 75 at para. 142:

> *[142] … As peace officers, correctional officers are charged with upholding the law. Their designation under the* Criminal Code *and the fact that they are armed and authorized to use force to protect the safety and security of inmates, other staff, and the public, places upon them a very high standard of behaviour. Thus, a deliberate effort to abandon one's position or to significantly reduce one's capacity to respond to a sudden emergency is far more serious in a correctional environment than it would be in most federal public service positions.*

[104] In *Yayé*, the Board Member noted the importance of monitoring inmates, highlighting the seriousness of failing to monitor them. At paragraph 130, she stated, "When it comes to the safety of the inmates and the institution, there is no margin of error."

[105] The grievor also referred me to *Calgary (City) v. CUPE, Local 38*, 2018 CanLII 67047 (AB GAA), 2018 CarswellAlta 1418, which notes the higher standard that applies to peace officers.

[106] Under the employer's directive, a correctional officer on high suicide/self-injury watch is required to keep the inmate under constant, direct observation. Observation solely by camera is not considered sufficient under the directive. The grievor significantly reduced her capacity to respond to a sudden emergency and did not have the inmate under constant, direct observation. The video of both high suicide/self-injury watches demonstrate that her glances into the cell were intermittent and not lengthy. I agree that this inattentiveness of the inmate constituted serious misconduct.

[107] The inattentiveness to the duty to observe was not made less serious by the extent of the injuries sustained by the inmate. Although he was identified as a high self-injury risk and not as being at risk of suicide, there was the potential for serious injury. In the end, after receiving medical attention offsite, it was determined that his injuries were not serious. However, I accept the testimony of those observing the injuries that they looked serious. In any event, they could not be treated at the Institution.

[108] The seriousness of the misconduct was reduced slightly by the lack of a proper briefing for the grievor on the extremely high likelihood that the inmate would self-harm. Ms. Ings and Mr. Cochrane both testified that the inmate had broken a sprinkler head the night before. At the disciplinary hearing, Mr. Lapointe told the grievor that the inmate had already self-harmed twice that week. Mr. Cochrane testified that the inmate was well known in the Institution as a self-harmer. Although the employer submitted that the grievor knew of the inmate's reputation, there is no evidence to support this contention. At the disciplinary hearing, Mr. Lapointe stated that she was aware of it, but the hearing notes do not confirm that she acknowledged it. Because of her reduced shift hours, the grievor did not attend the regular briefing at the beginning of the shift for all correctional officers. Also, she had been back at work for only several months after a lengthy period of leave. Apart from assigning her to high suicide/self-injury watch, Ms. Ings did not provide any information to the grievor about the inmate. The directive requires that the correctional manager on duty ensure that the form prepared by the healthcare professional is accessible to all staff having

regular interaction with the inmate. Ms. Ings did not testify about her efforts to make the form accessible to the grievor, who testified that she was told by the correctional officer on watch before her that the inmate was on good behaviour. The correctional officer was not called as a witness, and I find the grievor credible on this point. In addition, she was not cross-examined on her knowledge of the inmate's reputation or history.

[109] This lack of information provided to the grievor is troubling and was contrary to the directive. The employer could not rely on the inmate's reputation to support its decision to terminate employment without evidence to support that the grievor either knew of his reputation or had been advised of it. As noted in *Matthews v. Deputy Head (Correctional Service of Canada)*, 2016 PSLREB 38, the grievor's negligence must be evaluated in light of the failures of others, which compound the severity of the events. In *Matthews*, the Board Member noted that it was the duty correctional manager's responsibility to provide the escort officer with a proper briefing and to explain the levels and conditions of supervision and contact requirements. As in this case, she found that it was not done.

[110] However, this failure to inform the grievor did not detract from her obligation to keep the inmate under constant and direct observation. Her misconduct remains serious.

[111] The employer provided little evidence about the practice at the Institution of completing Seclusion and Restraint Observation Reports every 15 minutes. At the disciplinary hearing, the grievor stated that it was normal for the officer on watch to hand the observation form to the officer coming on to the watch. That officer did not testify, and it is not clear from the grievor's evidence that the form was ever provided to her. The observation report that the previous officer on watch should have prepared was not entered as an exhibit at the hearing.

[112] The grievor admitted that she did not complete the observation report, as required under the directive. Therefore, there was misconduct, but I am not able to conclude that it was serious. I heard no evidence on these reports and no testimony from other correctional officers as to whether they filled them out routinely. The employer had an opportunity to question Mr. Cochrane on this point when he was

asked about the duties of a correctional officer on high suicide/self-injury watch, but it did not.

[113] In conclusion, I find that the failure to constantly observe the inmate on both February 24 and 27, 2017, was serious misconduct. The failure to complete observation reports, in the absence of any evidence about the consistent practice at the Institution, was not serious misconduct.

**2. Premeditated or repetitive conduct**

[114] The employer submitted that the grievor intended to sleep on duty, as demonstrated by her use of a blanket and a pillow. It also submitted that the grievor set herself up to do her schoolwork as soon as her shift started on February 27, 2017. In addition, it submitted that the conduct was repetitive, as it occurred over two shifts. The grievor submitted that there is no evidence to indicate that she had an intention to sleep while on duty. She also disagreed that her conduct was premeditated.

[115] As I have already concluded, the employer did not prove that on a balance of probabilities, the grievor intended to fall asleep.

[116] In this case, the inattention to the inmate on suicide watch was repetitive and occurred twice. Even though the act of falling asleep might not have been premeditated, it is clear from the video that the grievor did not place herself in a position to watch the inmate on a consistent basis. On February 27, 2017, she set herself up to do her schoolwork, which was premeditated conduct. In addition, she was not attentive to her duties on two shifts in the same week, which was repetitive behaviour.

**3. The consistent application of organizational policy**

[117] Although each discipline case depends on its own facts and circumstances, it is important to consider whether an employee has been singled out for harsh treatment and whether the employer has applied its policies or directives consistently.

[118] The grievor submitted that reading was common practice while on high suicide/self-injury watch duty. She also noted that other correctional officers saw her reading and that her conduct was not reported to management. The employer submitted that this alleged common practice was not supported by the evidence of either the warden or Mr. Cochrane. It also noted that the failure of other correctional

officers to report her behaviour was not relevant, due to the existence of a "rat code" in the correctional system (see, e.g., *Mackie v. Treasury Board (Solicitor General Canada - Correctional Service)*, 2004 PSSRB 3).

[119] There would be better evidence of a consistent application of the directive on high suicide/self-injury watch had a full investigation been conducted. In this case, the warden observed only video from the grievor's shifts on suicide watch. The only reason that the shift of February 24, 2017, was viewed was the events on the February 27, 2017 shift. It is likely that had the inmate not self-harmed on February 27, 2017, the grievor would not have been disciplined for her behaviour of February 24, 2017.

[120] The employer also relied on a standard for watching an inmate on high suicide/self-injury watch that was not supported by the evidence. The employer does not routinely check video of officers on that watch duty. Both Ms. Ings and Mr. Lapointe testified that it was not possible to conduct such a watch from a seated position. From the testimony of Mr. Cochrane, as well as the grievor, the standard practice at the Institution was to conduct the watch from a seated position. Both Ms. Ings and Mr. Lapointe would have observed this, had they looked at videos of other correctional officers on that watch, or had other correctional officers been interviewed.

[121] In addition, it cannot be said with any degree of certainty whether the directive has been consistently applied at the Institution. The only time management checked on the behaviour of a correctional officer while on this watch was due to the self-injury incident at issue.

[122] I do not accept the grievor's argument that there was a duty placed on other correctional officers to report her inattentiveness while she was on suicide watch duty. However, their lack of concern about the behaviour at the time provides some support to her argument that the high suicide/self-injury watch directive was not consistently followed at the Institution and that officers read while on that watch. In addition, on the night of February 27, 2017, the officer on watch before the grievor had a magazine or newspaper on hand, which was visible on the floor. The warden did not view the video of the shift of that officer to determine if he had been reading during his watch.

[123] I am unable to conclude that the directive on high suicide/self-injury watch was consistently followed and enforced at the Institution. I have earlier noted that the

requirement of a correctional manager to ensure that all correctional officers were provided with the healthcare professional's report was not followed.

[124] The employer also changed its practice for high suicide/self-injury watches in the months after this incident and only two weeks after the grievor's employment was terminated. She submitted that the policy change was relevant to assessing her misconduct. The change was significant in that it now required breaks for correctional officers on watch every two hours. The employer downplayed this change in its submissions, suggesting that it was a union initiative. The employer also submitted that the change simply formalized how correctional officers on high suicide/self-injury watch handled their breaks.

[125] The memo establishing the new two-hour limit on watches does not reflect the employer's submissions. Although the issue was raised at labour-management consultations, the ACCO noted that "there was indeed merit to limiting the numbers of hours one could be assigned to these duties". He also stated that limiting the number of hours "would enhance the diligence required to ensure the well-being of the inmate on high suicide watch". The seriousness with which management took this policy change is highlighted by the statement that it might not be possible to rotate officers but that those situations were to be few and far between, and it was expected that the correctional manager would facilitate a post exchange as soon as possible after the two hours.

[126] There was no consistent evidence that regular breaks were arranged by correctional officers before the policy change. There was testimony that an officer could call on another officer for a short break, but there was no evidence that it was done consistently at the Institution, let alone every two hours.

[127] I find that the policy change, so soon after the grievor's termination of employment is significant. The self-harming by the inmate happened more than two hours into the grievor's shift. In addition, the warden was aware of concerns about the length of the high suicide/self-injury watch shifts before the termination but did not take it into account as a mitigating factor in the discipline of the grievor.

**4. Remorse and recognition of wrongdoing**

[128] The employer submitted that the grievor showed no meaningful remorse or understanding of her misconduct. It stated that she attempted to minimize every aspect of her conduct and that she admitted only what was incontrovertible. She disagreed and submitted that she had expressed remorse and an understanding of her conduct.

[129] I find that the grievor did acknowledge wrongdoing and that she expressed regret when she was informed of the upcoming disciplinary hearing. Before the disciplinary hearing, she provided a detailed letter setting out her position. She stated that an investigation was not necessary as she admitted that her actions were not acceptable. She also stated that she was mortified and was embarrassed. She ended her letter with the following: "I take full responsibility for my actions and I am ready to accept my discipline; I sincerely ask of you to take into consideration my current situation and spare my job."

[130] At the disciplinary hearing, she stated that she had learned not to report for work if she was not fit for duty. She also stated that she understood the importance of the high suicide/self-injury watch role. At the hearing, she acknowledged that she had engaged in misconduct and expressed regret for her lack of vigilance.

[131] I find that the grievor did express remorse and a recognition of her wrongdoing both before and after discipline was imposed.

**5. Personal circumstances, work relationships, and economic hardship**

[132] The grievor provided some context or explanation of her behaviour in her letter to the warden. At the disciplinary hearing, she also mentioned some of her personal circumstances, including that she was finding it hard to manage her family obligations, school, and work. The warden asked no questions about her personal circumstances, which were not addressed in the letter of termination. Although the final-level grievance response stated that her comments at the disciplinary hearing were considered, the warden testified that he did not consider her personal circumstances.

[133] In her letter to the warden, she recounted a period of grief that had led to constant fatigue and sleep difficulties. The grievor provided no testimony on the impact of the grief on her work performance, and she provided no medical evidence of

sleep issues. In the letter, she mentioned that she had been prescribed medication for her sleep issues but provided no evidence at the hearing of a prescription or a diagnosis from her doctor.

[134] Therefore, the evidence is weak on any underlying medical issue that might have explained the grievor's inattentiveness on both shifts. However, the employer should have addressed her overall personal circumstances, including her grief, in its determination of the appropriate penalty.

[135] The grievor provided some evidence about her difficult relationships with some correctional officers that might have had an impact on her willingness to call for relief. She mentioned this at the disciplinary hearing, but the warden did not follow up on it. Ms. Ings testified that she was aware of concerns raised by the grievor. Ms. Ings had no involvement in the disciplinary investigation or process and did not share the grievor's concerns with the warden. This was a mitigating factor that should have been considered by the employer.

[136] However, I give this mitigating factor little weight. The grievor testified about her challenges with other correctional officers, but these interactions did not involve any correctional officers on duty during her shifts. In particular, she did not identify any issues with Mr. Cochrane, who was on duty that night and so was the most likely person to provide relief.

[137] As noted in *Matthews*, when considering termination, its long-standing impact on the grievor must be considered. Given her age (35 at the time of the hearing), it had a great impact. This was also a mitigating factor that should have been considered by the employer.

**6. Disciplinary record and years of service**

[138] The grievor had no previous discipline and had been employed for eight years at the time of her termination. She submitted that the employer should have considered her years of service and discipline-free record as mitigating factors. The employer submitted that her years of service should be considered an aggravating factor, as an experienced correctional officer should be expected to know better.

[139] The warden made no comments on her performance. Ms. Ings testified that she had had no issues with the grievor before her misconduct. The correctional officers

who testified stated that each had either a cordial or an indifferent working relationship with her. The grievor testified that her performance appraisals had been good and that before her period of leave, she had received a very good evaluation.

[140] The warden testified that he did not consider the grievor's years of service or her lack of a disciplinary record when coming to his disciplinary decision. The final-level grievance reply states that her years of service and lack of a disciplinary record were considered. I prefer the testimony of the warden on this point, as he was the decision maker, and there was no mention of these factors in the letter of termination.

[141] The employer suggested that the grievor's years of service were an aggravating factor. However, it is not open to the employer to add factors at adjudication that it did not consider in its disciplinary decision.

[142] I find that the employer should have considered the grievor's work history, lack of discipline, and years of service when determining if the termination of employment was appropriate.

**7. Failure to conduct a disciplinary investigation**

[143] The grievor submitted that because the warden did not conduct a meaningful investigation of the incidents, there was a procedural irregularity that affected the discipline. The employer submitted that she was being represented by her union when she stated that no investigation was required and that therefore, the warden should not be criticized for not conducting one. It also submitted that any procedural defects in the investigation process were "cured" by this hearing; see *Tipple v. Canada (Treasury Board)*, [1985] F.C.J. No. 818 (QL)(C.A.).

[144] In her letter to the warden, the grievor stated that a disciplinary investigation was not necessary. She wrote this without union representation and before her disciplinary hearing. In addition, the warden acknowledged at the beginning of the disciplinary hearing that she was not being supported by her union at that hearing. I find that the grievor's statement was not made while being represented by her union. The warden also stated at that hearing that no investigation was needed because of the video evidence he had reviewed. On the evidence, I find that the grievor's statement that no investigation was necessary was not a factor in the warden's decision not to conduct a full investigation.

[145] I agree that any procedural defects in a disciplinary process are cured by a hearing before the Board. However, an employer that fails to properly investigate runs the risk of having flaws exposed at adjudication, and its conclusions may be overturned; see *King*, at para. 106. That is so in this case, as the employer's failure to adequately investigate resulted in a failure to assess the mitigating factors when it imposed discipline.

[146] A full investigation by the employer would have addressed some of the mitigating factors in imposing discipline that I have already addressed in this decision, including the practices of other correctional officers while on high suicide/self-injury watch and the grievor's personal circumstances.

**8. Progressive discipline, deterrence, and the bond of trust**

[147] The employer submitted that it had to send a clear message to all employees that the grievor's behaviour was fundamentally incongruent with the requirements of a correctional officer on high suicide/self-injury watch. It also submitted that the bond of trust between the employer and the employee had been irreparably broken by the grievor's misconduct, which justified the disciplinary sanction without progressive discipline. The grievor submitted that she was redeemable, and that progressive discipline was appropriate in the circumstances.

[148] General deterrence is an appropriate consideration when assessing discipline, especially for serious misconduct relating to inmates' safety and security; see *Ranu v. Deputy Head (Correctional Service of Canada)*, 2014 PSLRB 89. In that case, a 30-day suspension for sleeping and missing rounds on a segregation unit was upheld by the Board Member.

[149] Balanced against the employer's interest in general deterrence is the grievor's (and the union's) interest in progressive discipline.

[150] Progressive discipline is the norm in unionized settings. This is based on the premise that employees deserve an opportunity to demonstrate that they can correct their behaviour if the employment relationship is not damaged beyond repair. The employer argued that the employment relationship was damaged beyond repair by the grievor's misconduct. I do not find that the evidence supports a conclusion that the relationship was damaged to that extent.

[151] The employer provided many decisions involving sleeping at work in a correctional setting and in other safety-sensitive positions. Few cases have involved terminations of employment. In *Tousignant v. Treasury Board (Solicitor-General of Canada)*, [1979] C.P.S.S.R.B. No. 26 (QL), a decision from 1979, the grievor had previously received verbal reprimands. The other cases provided by the employer did not involve terminations of employment, but all had elements of corrective discipline being imposed before the discipline that was grieved; see *Ranu* (a 30-day suspension after a previous 3-day suspension); *Bélisle v. Treasury Board (Solicitor General of Canada)*, PSSRB File No. 166-02-15175 (19860505), [1986] C.P.S.S.R.B. No. 116 (QL) (a 20-day suspension after a previous suspension); and *MacLean v. Treasury Board (Department of the Solicitor General)*, PSSRB File No. 166-02-757 (19730608) (a 9-month suspension after a previous suspension for sleeping on the job).

[152] In *Yayé*, the most similar case to this one, the correctional officer's employment was terminated for a failure to monitor inmates. In that case, the officer lied about his conduct, did not admit to any wrongdoing, and showed no appreciation or understanding of the potential consequences of his actions. In this case, the grievor recognized that there had been wrongdoing, although she did try to downplay some of that misconduct when she stated that she had monitored the inmate. She has also expressed remorse as well as an understanding of the consequences of her actions.

[153] I question the relevance of a disciplinary decision from over 40 years ago (*Tousignant*) to a determination of the appropriate disciplinary sanctions today. However, I note that in that case, the grievor had received previous disciplinary warnings. In addition, he had tried to obtain special leave fraudulently.

[154] The employer also referred me to an Ontario case involving the termination of employment of two correctional officers for falling asleep on duty. In *Management and Training Corp. of Canada (c.o.b. Central North Correctional Centre) v. Ontario Public Service Employees Union*, [2006] O.L.A.A. No. 146 (QL), two correctional officers were terminated for falling asleep while escorting an inmate to a hospital. Of significance to the arbitrator was the public setting in which there was a potential danger to the public from the officers' negligence. In addition, the officers did not appreciate the seriousness of their misconduct and were short-term employees. The arbitrator also found no evidence of mitigating factors.

[155] In *Dekort*, the correctional managers and the warden testified that they would have difficulty placing the grievor in that case in a situation of trust in which other staff would have to depend on the wisdom of his decisions and actions for their safety. The Board Member noted that these were simply their personal opinions.

[156] In this case, the only witness who testified about the bond of trust was the warden. Ms. Ings stated that she was "shocked" at what she saw in the video. I note that she viewed the video for the first time in preparation for the hearing and that she was not interviewed before the imposition of discipline. However, she was not asked if she would have any difficulties supervising the grievor or putting her in a position of trust. Similarly, Mr. Sanderson and Mr. Cochrane were not asked if they would have had concerns with continuing to work with the grievor after a disciplinary suspension.

[157] As noted in *Dekort* (at paragraph 197), the bond-of-trust principle is closely tied to the assessment of the grievor's honesty and accountability. I have already addressed those issues. The Board Member in *Dekort* goes on to state that further evidence would have to be adduced to support a finding of an irreparable breach of the bond of trust. In that case, the limited nature of the fact-finding process and the lack of a full investigation made that impossible. In this case, as I have noted, there was no investigation of the attentiveness of other correctional officers on high suicide/self-injury watch. In light of the ongoing discussions about the challenges of the high suicide watch with the union, it is clear that the warden knew that there were concerns about staying alert while on that watch.

[158] I am satisfied from her testimony as well as the letter she provided to the warden shortly after the events in question that the grievor has learned from her misconduct and that it is highly unlikely that she will repeat it.

[159] In my view, a sanction less severe than the discharge would have been enough to correct the grievor's behaviour while still sending a strong and clear message to all employees.

## 9. Conclusion

[160] I therefore find, on a balance of probabilities, that termination of employment was an excessive penalty for the grievor's misconduct.

**C. What penalty would be just and equitable instead of the termination?**

[161] Although I agree with the employer that other cases involving the discipline of correctional officers have not shown the same constellation of facts, there are some important common elements to be considered when assessing the just and equitable disciplinary penalty.

[162] In *Dekort*, a case involving sleeping at a post, the termination of employment was substituted with a lengthy suspension up to the date of the decision (just over two years). The misconduct in that case was described as follows (at paragraph 222):

> *On the morning of February 24, 2017, Correctional Officer William Dekort deliberately removed his boots and vest, reclined in his seat in the vehicle, and closed his eyes. He at least drifted off for a time. His attentiveness and good judgement were severely diminished. He effectively abandoned his armed mobile post and therefore failed to carry out his peace officer duties, and he did not follow the mobile post order.*

[163] The Board determined that the grievor did not abandon his post to the extent that the employer concluded he did. There was also a finding that discipline that was no longer on his record might have influenced the Warden's discipline decision. The Board also considered the fact that the disciplinary process consisted of a 10-minute fact-finding meeting and no investigation. A significant mitigating factor was that "from the first moment he could" the grievor acknowledged his wrongdoing and expressed a desire to improve. The grievor had nine years of service.

[164] The employer also referred me to a case involving the termination of employment of a personal support worker at a group home who fell asleep at work: *Canadian Union of Public Employees, Local 3207 v. Cheshire Homes of Regina Society*, 2016 CanLII 152568 (SK LA). The arbitration board found that the conduct was serious but that there were mitigating factors, including expressions of remorse and recognition of the seriousness of the misconduct; a vow not to repeat such misconduct, if given another chance; the otherwise good work record; and the hardship resulting from the termination, which left that grievor unemployed for the following 5 months. A lengthy suspension of 1.5 years (from the termination until 15 days after the issuing of the decision) was substituted.

[165] The employer also referred me to *Brink's Canada Ltd. v. I.W.A., Loc. 1-217*, (1990) 13 L.A.C. (4th) 427, [1990] B.C.C.A.A.A. No. 113 (QL), a British Columbia case involving the termination of a security guard for sleeping on duty. The arbitrator substituted a six-week suspension based on the grievor's good work record, the lack of progressive discipline, and other surrounding circumstances. In the case before me, the circumstances are clearly different, but the commonality is the grievor's good work record and the lack of progressive discipline.

[166] The employer also provided older decisions involving suspensions of correctional officers for sleeping. In *McLean*, in addition to sleeping on the job, the correctional officer left open both a barrier and a gun porthole. In addition, he had received previous discipline for sleeping on the job. A 9-month suspension was substituted for the termination of employment. In *Belisle*, the correctional officer received a 20-day suspension for sleeping on the job. It was his second such suspension in a three-month period. The suspension was upheld. In the case before me, the grievor has a clean disciplinary record and no other incidents of sleeping on the job.

[167] More recent cases involving correctional officers sleeping on the job have resulted in lengthy suspensions of 20 to 30 days. In *Ranu*, the correctional officer was responsible for the rounds on a segregation unit. He fell asleep and missed two rounds, although he recorded in the log that he had conducted them. The employer imposed a 30-day suspension. The Board Member found that a slightly less-severe penalty might have been sufficient but maintained the discipline because she did not consider it unreasonable.

[168] The employer provided me with other termination decisions of correctional officers engaged in different kinds of conduct than in this case. I find that these cases are of limited value; however, in all the cases, I note that there were aggravating factors that were not present in the case at issue.

[169] *Kikilidis v. Treasury Board (Ministry of Solicitor General)*, PSSRB File Nos. 166-02-3180 to 3182 (19771011), involved a termination of employment after a culminating incident of the dereliction of duty by a correctional officer. In that case, the officer had had four incidents of dereliction of duty. The clear application of progressive or

corrective discipline was evident in that case. The adjudicator also found no mitigating circumstances and noted the grievor's short service.

[170] In *McKenzie v. Deputy Head (Correctional Service of Canada)*, 2010 PSLRB 26, a correctional officer was terminated for forging her physician's signature on nine different medical certificates. The termination was upheld at adjudication and was supported by her sustained denial of the forgery, her short employment history (4.5 years), and a disciplinary record of a 5-day financial penalty involving a relationship with an inmate.

[171] In *Baptiste v. Deputy Head (Correctional Service of Canada)*, 2011 PSLRB 127, a nurse's employment at a correctional institution was terminated for administering incorrect medication to several inmates and falsifying drug records. In that case, the Board Member determined that the grievor's lack of forthrightness and of cooperation in the disciplinary process were determining factors in her ability to be rehabilitated. The Board Member also had evidence from the grievor's former colleagues that they would move or retire were she to be reinstated. In the grievance before me, the grievor was forthright and cooperative. In addition, there is no evidence before me that her co-workers would refuse to work with her.

[172] In *Richer v. Deputy Head (Correctional Service of Canada)*, 2012 PSLRB 10, a correctional officer was dismissed for the off-duty conduct of a drug overdose and an indictment for the possession of drugs for the purposes of trafficking. In addition, the correctional officer had three years of service. The circumstances in the grievance before me do not involve criminal conduct, and the grievor has more than three years of service.

[173] The employer also provided me with cases involving suspensions of correctional officers for failing to monitor inmates, along with related misconduct.

[174] In *Buchanan v. Treasury Board (Solicitor General Canada - Correctional Service)*, 2002 PSSRB 91, a correctional supervisor received a 20-day suspension for having provided little or no supervision on one of the ranges (he was watching television) and for not intervening when a correctional officer covered a surveillance camera with tape. In that case, the supervisor had received previous discipline, had not cooperated in the investigation, had poor work performance, and had expressed no remorse.

[175] In *Stead v. Deputy Head (Correctional Service of Canada)*, 2012 PSLRB 87, two correctional officers had not properly accounted for inmates, resulting in one inmate sustaining injuries. Each correctional officer received a four-day financial penalty. The Board Member noted that the misconduct was very serious and that while it was not the primary cause of the inmate's injuries, it contributed to a situation in which the risk of injury among inmates increased. The seriousness of the misconduct was increased by the false statements that counts had been done. The adjudicator noted that a four-day financial penalty was on the low end of sanctions imposed in other cases. He also noted that it was of "considerable significance" that the grievors took immediate responsibility for their misconduct. He also noted this:

…

> *I take the evidence of Ms. Knopf* [the warden] *to be that a major factor in the respondent's decision was the grievors' initiative in meeting with her and taking responsibility for what happened or part of what happened. In fact she was urged by her superiors to terminate the grievors' employment. However, as Ms. Knopf put it, the grievors demonstrated their capacity to change and learn from their mistakes and a four-day financial penalty reflects that fact. I agree that the grievors' actions after January 9, 2009 reflect well on them and should be given weight in determining the penalty in these grievances. Put another way, without the grievors' immediate acceptance of responsibility the appropriate penalty would have been more severe. This is consistent with a progressive approach to discipline for a serious offence.*
>
> …
>
> [Emphasis added]

[176] In the case before me, the grievor wrote a letter to the warden before any disciplinary hearing was held accepting responsibility for all or part of what happened. This acceptance of responsibility is an important mitigating factor that was considered by the warden in *Stead* but not by the warden in this case in his decision to terminate the grievor's employment.

[177] In *Desjarlais v. Deputy Head (Correctional Service of Canada)*, 2014 PSLRB 88, a correctional officer had left a door propped open, for which she received a one-day financial penalty. In that case, the financial penalty was reduced to a written reprimand. Although the seriousness of the misconduct in that case does not approach the level of seriousness of misconduct in the grievance before me, it is important to

note that among other things, the adjudicator considered the grievor's appreciation of the seriousness of her error and her years of service.

[178] The employer also referred me to cases from other jurisdictions involving suspensions of employees responsible for security. In *Canadian Union of Public Employees Local 38 v. Wood's Homes*, [1998] A.G.A.A. No. 17 (QL), the grievor was suspended for sleeping while supervising at a group home. The length of the suspension is not provided in the arbitration decision. In that case, it was not the first time she had fallen asleep. She also denied any wrongdoing.

[179] The grievor referred me to *Canada Malting Co. v. UFCW, Local 1118*, 2015 CanLII 34244 (AB GAA), 2015 CarswellAlta 1382, a case involving safety violations. While the facts of that decision are not relevant to the facts before me, the arbitrator noted that aside from the deterrence factor, there was no reason to believe that progressive discipline would not have served its purpose. He also noted that the grievors had demonstrated a positive attitude toward the employer and had expressed genuine remorse and a willingness to learn from what they admitted was a serious mistake.

[180] I find that in the circumstances of this case, a lengthy suspension should be substituted for the termination of employment. The grievor's misconduct of failing to consistently and attentively watch an inmate on high suicide/self-injury watch was serious, and it warranted significant discipline. The deterrence of such behaviour is a significant factor in my determination that a lengthy suspension is warranted. However, the mitigating factors of the grievor's remorse, her acceptance of most of her misconduct, her personal circumstances, the lack of evidence of a consistent application of the policy on high suicide/self-injury watches, as well as the significant change to that policy shortly after the grievor's misconduct have persuaded me that the termination of employment was an excessive disciplinary response by the employer.

[181] I did not receive submissions from the grievor on the appropriate length of a suspension.

[182] In cases of serious misconduct, this Board and other arbitrators have substituted terminations with suspensions until the date of hearing or date of the decision – sometimes referred to as "time served": see, for example, *Matthews*, *Dekort*,

and *Andrews v. Deputy Head (Department of Citizenship and Immigration),* 2011 PSLRB 100 from this Board. The reasoning for imposing a suspension tied to the start of the hearing or the issuing of a decision is not always articulated.

[183] In *Hughes v. Parks Canada Agency*, 2015 PSLREB 75, cited in *Dekort*, the adjudicator stated:

> *In this case, while the grievors also had lengthy years of service without discipline, and contrary to the* Andrews *decision, they acted on the spur of the moment, I am not convinced that they expressed genuine remorse for what they did. In the circumstances, just like in* Andrews*, I am reluctant to impose a disciplinary penalty that would result in them being paid for time not worked. Therefore, I order the grievors reinstated effective the date of this decision but with no retroactive pay.*

[184] As I understand the reasoning in *Hughes*, the lack of genuine remorse led to the adjudicator's reluctance to allow a shorter suspension that would result in the grievors receiving back pay. I do not have such concerns in this case, as the grievor has expressed genuine remorse.

[185] In *Dekort*, the Board determined that a suspension without pay to the date of the decision was the appropriate penalty:

> *Similar to the reasoning of the adjudicators in those cases* [Andrews and Hughes]*, I think that Mr. Dekort must be sent a strong message consistent with the magnitude of his misconduct in the hope that it serves as a very strong reminder of his obligations as a CSC peace officer. For that reason, I make an award that does not result in retroactive pay.*
>
> [Emphasis added]

[186] In this case, I believe a strong message consistent with the magnitude of her misconduct can still be sent to the grievor that might result in retroactive pay.

[187] In my view, determining a just and equitable penalty for misconduct should not be dependent on the scheduling of a hearing, where the grievor has no control over that scheduling. I agree that if a grievor is responsible for a delay in the scheduling of a hearing that there may be consequences for the grievor in terms of the remedy. However, that is not the case here. The grievance was referred to adjudication in April 2017 and the hearing was not scheduled until November 2020. Part of that delay was

due to systemic issues and part was due to the lockdown following the declaration of the COVID-19 pandemic. In determining a just and equitable penalty for misconduct, the decision-maker should look at the nature of the misconduct as well as the aggravating and mitigating factors. Although each grievance should be decided on its own merits, it can also be instructive to look at similar cases to determine the just and equitable penalty. The two cases most similar to the misconduct in this case are *Matthews* and *Dekort*.

[188] In *Matthews*, a lengthy suspension up to the date of the decision (approximately two years) and a demotion were substituted for a termination of employment. The grievor was escorting an inmate and allowed an unauthorized stop at a pub. He then collaborated with the inmate and a parole officer to hide the unauthorized stop from his superiors, admitting to it only later, during an investigation of the inmate's conduct. The Board Member concluded that the termination of employment had been too harsh a penalty, considering the grievor's remorse and ability to be redeemed. In *Dekort*, the termination of employment was substituted with a lengthy suspension up to the date of the decision (just over two years). As discussed earlier in this decision, a significant mitigating factor was the acknowledgment by the grievor of his wrongdoing.

[189] What distinguishes the grievance before me from both *Matthews* and *Dekort* is the immediate expression of remorse on the part of the grievor. In both *Matthews* and *Dekort*, the grievors eventually expressed remorse, but not as quickly and as comprehensively as the grievor in this case. In *Matthews*, the grievor actively tried to hide his misconduct from the employer before eventually expressing remorse for his actions. In *Dekort*, the Board noted (at paragraph 157) that:

> *…the extent and degree of his remorse might not have come across to the employer before the decision was made to terminate him; his clearest and strongest statements accepting responsibility for his actions were made only during the disciplinary action meeting on May 4, 2017, and at the hearing before the Board.*

[190] In the case before me, the grievor made a clear and strong statement accepting responsibility for her actions prior to the disciplinary hearing of March 16, 2017. She took the initiative in preparing a fulsome letter which is set out earlier in this decision (at paragraph 65) and unlike Mr. Dekort did not wait until the disciplinary action meeting. In fact, Mr. Dekort only provided a clear and strong statement

accepting responsibility **after** he received his letter of termination. The grievor in the case before me accepted full responsibility for her actions before she knew what the penalty was going to be. It is worth quoting again the last paragraph of her letter to the warden: “I take full responsibility for my actions and I am ready to accept my discipline; I sincerely ask of you to take into consideration my current situation and spare my job”. In addition, the grievor has been consistent in her expression of remorse from the disciplinary hearing through to the hearing of this grievance.

[191] In light of the seriousness of the misconduct and considering all of the mitigating factors set out in this decision, especially the grievor’s early expression of remorse, I have determined that a just and equitable penalty for the grievor’s misconduct is a suspension of 18 months (from April 18, 2017 to October 17, 2019). I am satisfied that this lengthy suspension will send a message both to the grievor and to other correctional officers that misconduct while watching inmates on high suicide/self-injury watch is very serious. I also believe that the grievor has learned a lesson and will be a more vigilant correctional officer as a result.

**D. Remedy**

[192] At the end of the hearing, I advised the parties that I would retain jurisdiction on the remedy portion. The parties are directed to discuss the remedy, in light of my order that a lengthy suspension of 18 months is to be substituted for the grievor’s termination of employment.

[193] If the parties are unable to reach a mutually acceptable resolution within 120 days of the date of this decision, further hearing dates will be scheduled.

[194] I remain seized of this grievance.

**V. Conclusion**

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

*(The Order appears on the next page)*

## VI. Order

[196] The grievance is allowed in part. The grievor's termination of employment is substituted by a suspension from April 18, 2017, until October 17, 2018.

[197] Exhibits E-3 and E-4 (videos) and the employer's book of exhibits, volume 2, are ordered sealed.

March 31, 2021.

**Ian R. Mackenzie,**
**a panel of the Federal Public Sector**
**Labour Relations and Employment Board**