Occupational Health and Safety Council
Appeal Hearing

Nov 14-17 & Dec 13, 2012

United Nurses Association – Appellant

and

Alberta Health Services – Respondent

Panel Members

Peter Schaefer (Chair), Peter Bowal, Hal Griffith

Appearances:

For the appellant: Kristan McLeod, Counsel - United Nurses Association (UNA)
Mark Cowan, Dewey Funk, Lisa Hein

For the respondent: Lynn Michelle Angotti, Counsel - Alberta Health Services (AHS)
Wayne Mayell, Douglas Worton

Observer

Mike Rappell - Alberta OH&S Officer

Alberta Human Services

Occupational Health and Safety Council

Panel Decision

The Appeal Panel (the Panel) issues this decision to allow the appeal by a majority (Schaefer and Griffith; Bowal dissenting). The three Panel members' independent reasons for their decision appear below.

Reasons for Decision of Peter Schaefer (Chair)

The Panel convened on Nov 14-17 2012 in Grande Prairie Alberta and Dec 13, 2012 in Nisku Alberta to hear an appeal pursuant to Section 37 of the *Alberta Occupational Health and Safety (OH&S) Act*. (*Act*)

Section 37 of the *Act* reads:

> *37(1) A worker who has reasonable cause to believe that that the worker has been dismissed or subjected to disciplinary action in contravention of section 31(5) or 36 may file a complaint with an officer.*
> *(2) An officer who receives a complaint under subsection (1) shall prepare a written record of the worker's complaint, the investigation and the action taken and shall give the worker and the employer a copy of the record.*
> *(3) A worker or an employer who receives a record under subsection (2) may request a review of the matter by the Council by serving a notice of appeal on a Director of Inspection within 30 days from the receipt of the record.*
> *(4) After considering the matter, the Council may by order*
> *(a) dismiss the request for a review, or*
> *(b) require one or more of the following:*
> (i) *reinstatement of the worker to the worker's former employment under the same terms and conditions under which the worker was formerly employed;*
> (ii) *cessation of disciplinary action;*
> (iii) *payment to the worker of money not more than the equivalent of wages that the worker would have earned if the worker had not been dismissed or had not received disciplinary action;*
> (iv) *removal of any reprimand or other reference to the matter from the worker's employment records.*
> *(5) If the worker has worked elsewhere while the dismissal or disciplinary action has been in effect, those wages earned elsewhere shall be deducted from the amount payable to the worker under subsection I4)(b)(iii).*
> *(6) An appeal lies to the Court of Queen's Bench from an order of the Council on a question of law or a question of jurisdiction and on hearing the matter the Court may make any order, including the awarding of costs, that the Council considers proper.*
> *(7) An appeal under subsection (6) shall be made by way of originating notice within 30 days from the date that the order of the Council is served on the person appealing the order of the Council.*

(8) The commencement of an appeal under subsection (6) does not operate as a stay of the order of the Council being appealed from except insofar as a judge of the Court of Queen's Bench so directs.

The Appellants contend that:

- It is the position of the Appellants that they had reasonable grounds to believe that they faced an imminent danger in their workplace on Jan 17, 2011;
- This belief provided reasonable grounds to refuse unsafe work on the basis of the imminent danger;
- The employer failed to adhere to its responsibilities under the Occupational Health and Safety Act;
- The investigating officer made error in his conclusion on Aug 10, 2011.

The Issue(s) to be Resolved:

Does the action taken against the Appellants by the Employer constitute a violation of s.36 of the *Alberta Occupational Health and Safety Act*?

Submissions Considered by the Appeal Panel

From the Appellant, Kristan McLeod- UNA

- OHSC Appeal Questionnaire – completed by Brenda Jack & Kristan McLeod - Legal Counsel - United Nurses Association (UNA)
    - Evidence by Witnesses
      Jennifer Ward – RN
      Brenda Jack- RN
      Diana Van Eerden- RN
      Michelle Marie Lambert- RN
      Sharon Parsons- RN
      Roxann Dreger- RN
- Evidence presented by Kristan McLeod- UNA
    - Exhibit A- Floor Plans of 5 South
    - Exhibit B- Occupational Health & Safety and Staff Abuse Report form dated Nov 21, 2010.
    - Exhibit C- Professional Responsibility Report form dated Nov 21, 2010.
    - Exhibit D- Meeting Minutes Dec 01, 2010.
    - Exhibit E- Professional Responsibility Committee (PRC) dated Jan 11, 2010.

- Exhibit F- Professional Responsibility Report form dated Jan 15, 2011.
- Exhibit G- Email dated Jan 16, 2011.
- Exhibit H- Email dated Jan 17, 2011. Titled- Seclusion room kicked open again.
- Exhibit I- Professional Responsibility Committee (PRC) dated Jan 28, 2011.
- Exhibit J- Timeline dated Jan 17, 2011.
- Exhibit K- Photo of 5 South seclusion room door(outside of room)
- Exhibit L- Photo of 5 South seclusion room door (inside room)
- Exhibit M- Exhibit N - Photo of 5 South mattress
- Exhibit N- Photo of room 523
- Exhibit O- View down the hall towards RN station
- Exhibit P - View down the hall towards doors
- Exhibit Q – OH&S Committee Meeting Minutes Queen Elizabeth Hospital dated Dec 09, 2010.
- Exhibit R – Email dated Jan 18, 2011. Roxann Dreger
- Exhibit S- Meeting minutes dated Jan 18, 2011.
- Exhibit T- OH&S Committee Meeting Minutes dated April 14, 2011.

- The panel considered and provided strong weighting to the testimony from the witnesses in regards to timing of the additional security personnel being added to 5 South on the night of Jan 17, 2011 and to when the staff were notified of the magnet strengths.
- Exhibits "D" titled Dec 01. 2010 5 South Staff Meeting Minutes, exhibit "E" titled Professional Responsibility Committee (PRC), exhibit "G" Email dated Jan 16th 2011, and exhibit "H" email dated Jan 17, 2011 at 12:03 were strongly considered and weighted accordingly as they demonstrated that the concerns were raised by the Appellants to their management prior to the events on the evening of Jan 17, 2011 and that the Appellants believed these concerns presented a hazard beyond what is "normal" for their work environment.

From the Respondent, Lynn Michelle Angotti: Legal Counsel - Alberta Health Services

- Evidence by Witnesses

  Wayne Mayell- AHS OH&S Consultant

  Don Hunt - Director of Patient Care

Dr. David Henry Block

Laurel Reynolds- RN

Regina (Jeanie) Dawe- RN

Julie Lorrie Gear- LPN

Sian Lewis- Area Manager

Sandra Guzzell- Transition Coordinator

Bonnie Kennedy- RN, Unit Manager of Medicine

Dr. Kertar Lal

Dr. Robert (Bob) Lyons

- Evidence presented by Lynn Michelle Angotti- Legal Counsel - AHS
  - Exhibit U- Notes dated Jan 18, 2011.
  - Exhibit V- Emerging Issue Update Meeting re: 5 South minutes dated Jan 18, 2011.
  - Exhibit W- Sian Lewis Summary dated Jan 17, 2011.
- The panel considered and provided weighting to the testimony from the witnesses in regards to the events of Jan17th, 2011. Testimony provided particular details to establish the expected "normal" work environment and controls available to the staff on the unit.

Position of the Parties and Remedy Requested:

Appellant,

United Nurses of Alberta (UNA) requests Council issue an order for the following remedies in accordance of the Act:

a) A declaration that the disciplinary action against the Appellants cease;
b) An order to pay to the Appellants (Brenda Jack, Diana Van Eerden, Joanne Nixon and Sharon Parsons) the wages they would have earned but for the disciplinary action;
c) An order requiring the Employer to remove any reprimand, record of discipline, or other reference to the matter from the worker's employment records, and to confirm to confirm to UNA that the removal of any discipline has been accomplished.

Respondent,

Alberta Health Services (AHS) position is that based upon the safety measures put in place by the Employer, the Employer's appropriate reactions to the Nursing Staff's refusal to

work, and the normal hazards that exist on a psychiatric unit, the Office's decision that this was not a refusal of unsafe work must be upheld.

Test Applied

- The Legal Test to determine a Contravention of s.36 of the *Act* includes:
    - Disciplinary action must have been taken against the complainant;
    - The disciplinary action must have been taken as a result of the complainant acting in compliance with the *OHS Act*, Regulation, or Code; and
    - There must be a causal and demonstrable relationship between the disciplinary action taken against the complainant and the complainant's act of compliance with the OHS Act, Regulation, or Code.

After considering the evidence and reviewing the legislation, we find that it was reasonable for the Appellants to believe a danger existed to their health and safety.

We found that the evidence, witnesses' testimony and arguments provided by the Appellants (UNA) to be more persuasive than the information provided by Alberta Health Services.

Specifically, more weighting was given to the testimony and exhibits that indicated the following;

- the strengths of the door magnets were not known by the staff or by area management at the time of the refusal;
- the repairs had not been completed; the additional security personnel were not present at the time of the initial refusal
- the additional security coverage inconsistent throughout the event.

This is contrary to the Officer's justification provided in his decision letter. Specifically, the Officer supported his decision not to proceed with a Disciplinary Action Compliant with statements, "As a precaution, and prior to the re-admission of the patient, the Employer brought in extra security guards to ensure worker safety." and "Further evidence showed when the patient was re-admitted he was taken to a different seclusion room that had a known higher strength rating." The evidence supported that the additional security guards were not brought in until after the refusal and that coverage was inconsistent throughout the shift as well as the strengths of the door magnets were not known by the staff until after the refusal occurred.

We found that these circumstances presented a danger that is not "normal" for these workers. The evidence supported a causal link between the discipline and the workers acting in compliance with the Act.

After considering evidence given by both United Nurses of Alberta (UNA) and Alberta health Services it is our determination to order the Employer to:

a) cessation of disciplinary action against the Appellants
b) payment to the workers of money not more than the equivalent of the wages the workers would have earned if the workers had not received disciplinary action;
c) removal of any reprimand or other reference to the matter from the workers employment records.

Peter Schaefer, Appeal Panel Chair

Reasons for Decision of Hal Griffith

I agree with the Chair that this appeal must be allowed. I am submitting my decision process in this somewhat lengthy document to clarify my findings on the matter.

I reviewed the matter and determined there was evidence that Workers were disciplined. I considered if the discipline was a result of Workers complying with the Act. I found that Workers had been disciplined for refusing to work. I looked at evidence and considered arguments and determined that the work refusal was in compliance with Sections 2 and 35 of the Act. I concluded that the appeal should be allowed.

Remedy Provided:

After considering the matter and finding for the Appellant I looked to the remedy. I decided the appropriate order would be to have the Employer to make payment to the workers of money not more that what the worker had not received, cessation of disciplinary action and removal of any reprimand or other reference to the matter from the worker's employment records.

These remedies are consistent with the Act at Section 37(4)

Deliberations:

In regards to the part of the test, "There must be evidence that the Worker(s) was disciplined", I found that Workers were disciplined.

The Officer found that there was discipline.

The parties agree that there was discipline.

The disciplinary letters were provided under tab 4 of the Evidence binder.

For the purposes of the three-part test Workers were disciplined.

In regards to the part of the test, "There must be evidence that the Worker(s) was disciplined because of his/her act of compliance", I found that Workers were disciplined for the work refusal central to this matter.

The Appellant has the position that the work refusal was an act of compliance.

The question of whether or not the work refusal was an act of compliance remains.

In a Client Contact Report (Tab 3 of the Evidence Binder) the Officer noted that found that there was no procedure in place for worker refusal. He ordered that the Employer outline a method to ensure staff members affected by the policy / procedure would be trained accordingly.

The Act specifies that a worker will inform the employer of an imminent danger.

> 35 (3) A worker who
>
> (a) refuses to carry out work, or
>
> (b) refuses to operate a tool, appliance or equipment pursuant to subsection (1)
>
> shall, as soon as practicable, notify the worker's employer at the work site of the worker's refusal and the reason for the worker's refusal.

The Act specifies that an Employer will prepare a written record of the worker's notification, the investigation and action taken and give the worker who gave the notification a copy of that record.

> 35 (4) On being notified under subsection (3), the employer shall
>
> (a) investigate and take action to eliminate the imminent danger,
>
> (b) ensure that no worker is assigned to use or operate the tool, appliance or equipment or to perform the work for which a worker has made a notification under subsection (3), unless
>
> (i) the worker to be so assigned is not exposed to imminent danger, or
>
> (ii) the imminent danger has been eliminated,
>
> (c) prepare a written record of the worker's notification, the investigation and action taken, and
>
> (d) give the worker who gave the notification a copy of the record described in clause (c).

It is not contested that the Employer did not prepare a written record of the worker's notification, the investigation and action taken, or give any refusing worker a copy of that

record. The investigating Officer observed that deficiency in a client contact report that became part of the evidence in this matter and neither party has contested.

The Officer also found that there was no procedure in place for worker refusal.

Discussion on Employer Response to Section 35(4)

> The Respondent maintains that, "The Employer played its part Effectively" in the approach that legislation contemplates in solving concerns around "imminent danger".
>
> The Appellant submits that the Employer's violation of the Act at Section 35(4) caused the Employer to vacate the ability to claim the refusal was not reasonable. The Appellant holds that the Employers violations effectively obstructed the workers access to Section 35(7) "If a Worker who receives a record is under subsection (4)(d) is of the opinion that an imminent record still exists, the worker may file a complaint with an officer." The Appellant suggests that the Act at Section 35(8-10) allows imminent dangers concerns to continue until either resolved to the Worker(s) satisfaction or by the Council. They refer to Ferussi v. Canada as well as Lequesne v. Canada.

The OHS Act directs specific actions from the Employer for work refusals concerning imminent danger.

The Officer issued an Order to Remedy Unhealthy or Unsafe Conditions with the requirement that the Employer develop a policy/procedure for ensuring compliance with Section 35 of the Act in it's entirety when work refusal based on the perception of existence of imminent danger are brought forward to the Employer.

The Respondent, does not contest that Workers notified the Employer reasonably quickly about the work refusal and that the reasons were for fear for safety. Testimony supports that the Employer knew about and was reacting to a work refusal based on safety concerns.

Evidence was presented that the employer did have the workers remain at the worksite engaged in care of the other Unit 5 patients.

> 35 (5) The employer may require a worker who has given notification under subsection (3) to remain at the work site and may assign the worker temporarily to other work assignments that the worker is reasonably capable of performing.

Nursing staff that refused to care for the Patient were kept on site performing related duties. The evidence suggests that their work was, except for the Patient, harder in that they helped plan and execute the movement and care of other patients in another section of the hospital.

Two of the three nurses that originally refused to work with Patient were asked to remain longer than scheduled to provide extra workers. They did stay later as directed. The third

nurse was not directed to stay as she was under an accommodation arrangement. Their shift was missing the fourth nurse that would have made up the normal complement.

A Manager gave evidence that refusing workers had stated belief to her that Patient was too aggressive to safely house on the unit and cited the kicked out seclusion room door as one reason. She advised the panel that safety of patients and staff was paramount and she took the concern seriously. She participated in planning the move of other patients to another area of the hospital so the Workers could continue to work with those patients away from the claimed imminent danger of Patient's return to Unit 5 South.

The Appellant requests a presumption that the Workers were reasonable in the refusal.

The Appellant submitted that if the Employer failed to prepare a written record of the worker's notification, the investigation and action taken, and give the refusing worker a copy of that record, then the refusal must be presumed reasonable and the Employer vacates the right to impose discipline.

Additionally, the Appellant asserts that the initial refusal continues by default until the worker receives the record and may form an opinion in reference to Section 35(7).

The Appellant contends that the failure of the Employer to follow the legislated investigation process may result in the Panel presuming the Workers had reasonable cause to refuse work.

> As in Lequesne v. Canada National Railway the Employers failure to follow the mandated investigation process closed the door on the Employer's ability to conduct it's own investigation and discipline employees in subversion of the Act.
>
> The Appellant notes that in Ferussi v. Canada, "the Board found that the employer's failure to investigate and follow the subsequent procedure under the Code deprived he employees the right to exercise the appeal procedure under the Code, and the employer was not allowed to circumvent the investigation process. The discipline was vacated and the employees were ordered to be reimbursed"

The Respondent asserts that the Panel must either give deference and respect to the Officers decision that the workers did not act in compliance or else decide from the evidence if there were reasonable and probable grounds for the workers to believe that there was "imminent danger".

The Respondent directs that the Panel must consider the validity of the continued belief over a span of 24 hours. Consideration of that 24 hour period is to include the Employer's response to workers expressed concerns. Consideration must be given to the kind of danger that was at issue. Consideration must be limited to the Nursing Staff that were at the site at the time of work refusals.

The Appellant contends that if Employers could justify discipline the moment a danger was eliminated, then the intent of the Act, to protect workers, would be subverted.

The Respondent suggested that regard should be had to the attached decisions of other Panels confirming the three-part legal test and other considerations.

The Respondent asserts that at all times the nursing staff, that was later disciplined, refused to provide care to the patient despite the safety measures put in place.

The Appellant argues that there was one basic refusal and that the Employer's failure to follow legislated requirements, for response to the refusal, impaired progression of the concern. As in *Ferrusi* the Workers were entitled to refrain during a complete cycle of investigation process that could include participation of an OHS Officer after the Employer provided Workers with written notice of its investigation.

Workers did not receive a written record from the Employer of the worker's notification, the investigation and action taken. Workers did not then progress to filing an optional complaint with an Officer that an ongoing imminent danger situation existed.

> (7) If a worker who receives a record under subsection (4)(d) is of the opinion that an imminent danger still exists, the worker may file a complaint with an officer.

I considered if the question about the continuing refusal may relate to the Employer's failure to satisfy Section 35(4) requirements. Section 35(4) does not have a modifier such as, "if reasonably practicable." The legislation directs that the Employer shall prepare a written record of the worker's notification, the investigation and action taken, and give the worker who gave the notification a copy of the record.

The Appellant contends that proper investigation reporting by the Employer is required. Proper reporting signals that a worker is to either accept that it is safe to return to the task in question or else to move on to next step in resolving imminent dangers. The Appellent submits that the Employer is sophisticated with a dedicated OHS practitioner assigned to the QEII Hospital. There is no cause for this Employer to violate Section 35(4) of the Act and then to blame Workers for not acting on information that the Employer did not properly provide them.

I considered that question of the continuing refusal may also relate to uncertainty in who knew about what safety enhancements and when. This goes back to adequate communication with workers. There may have been some vicariousness in communications about what safety controls were introduced and when the controls were introduced. Testimony supported a conclusion that affected workers did not have consistent awareness of alleviation of the imminent danger.

The Appellant asserts that the Employer had somewhat flipped the responsibility of the investigation and reporting. It seems to the Appellant that the Employer requires the Workers to continually monitor alleviation of unsafe working conditions in an investigatory fashion. The Appellant points to Section 35(4) requirements that the

employer investigate, report back to the worker and provide the worker the follow-up opportunity of calling in an OHS Officer to investigate the concern of continuing imminent danger. UNA contends that until the investigation process and report back is clearly completed the worker is "entitled to refrain from working" as was discussed in Ferrusi v. Canada.

In the absence of a clear written report to the refusing workers it is not clear where decision points were for workers. If the workers were subjectively and objectively reasonable in the initial refusal is there a threshold, later on in the refusal period, at which it should have been seen to be objectively unreasonable for workers to continue to refuse? The Employer submits that over the course of the matter they increased security officer numbers and competency, put the Patient into a more secure room with monitors, added chemical restraint, and changed protocols to better protect nurses entering seclusion. At the end they transferred Patient out of the facility.

Evidence suggests that the workers would not have been aware of the stronger room. Testimony was provided that the room Patient was put into had blind spots that were not monitored by camera. It is not very clear from the evidence if any refusing workers had a clear understanding of the changes in protocol for nurses entering seclusion.

On the night of the 17th, Nursing Staff returned the other patients to the Unit but did not resume care of the Patient. Don Hunt testified that before the Nursing Staff had returned to the unit he had explained to Lisa that there was extra security and chemical restraints on Patient and asked her to report that to the Nursing Staff.

Brenda Jack testified that at about 2200 or 2230 management said there were to be 5 security guards at the secure room and the corridor would be locked at both doors, but the nurses did not trust they would be safe. We do not have direct testimony on that from the nurses.

Diana Van eerden testified, that when the Patient was returning, she understood that there was an agreement that there would be 3 security guards watching Patient and a nurse monitoring him via camera.

Evidence suggests that all Nursing Staff knew that Doctors were working on getting Patient transferred out and that Patient was receiving care from alternate providers.

Evidence shows that there was an unannounced reduction in security staff numbers at some point for an hour or two that Don Hunt was required to fix.

Shortly before Patient was transferred out, the Employer briefed Sharon Parsons on many of the safety enhancements and tasked her to inform the refusing workers that it was deemed safe for them to return. She was on her way to share that information when word of the Patient transfer came and she instead arranged for his transfer by air ambulance.

The Respondent suggested that the union could have been keeping workers aware of the actions being taken to alleviate the danger.

The Act does not contain provisions for the Employer to rely on union representatives for the notifications required under Section 35(4) of the Act. The Supreme Court of Canada's decision in Parry Sound (District) Social Services Administration Board v. O.P.S.E.U., Local 324, [2003] 2 S.C.R. 157 suggests that the Employer and the Union are not able to negotiate away legislated rights or duties. Whether or not the Union accepted the role of messenger, the Employer was still required to adhere to Section 35(4) and cannot hold the Worker responsible for the Employer's failure to communicate in accordance with the Act.

The generic "questionnaire" that the OHS Officer sends out to the parties does anticipate that a worker may be represented by a union is in a separate context and does not imply the union holds duties at Section 35.

The Act does not discuss the union. The Act does not relieve the Employer of any burden to communicate directly to the Worker. An argument might be able to assert the Employer could use the Union if there was phrasing like, "caused to be known" or "though a representative". The phrasing used in the Act describes a need to investigate and report in writing to the Employee. This panel does not possess the jurisdiction to interpret the Act to mean verbal is acceptable. Even if there was margin to interpret verbal reporting as adequate, it would be too far a stretch to take it even further to presume that the verbal report could be provided through a union representative.

The Panel may consider the arguments and evidence around the Employers lack of adherence to Section 35(4) as part of the overall matter. The Panel may be in a position to determine if Worker concerns of Imminent Danger were reasonable and honestly held in the absence of the required written Record.

The Appellant suggests that the mere absence of the Record may cause the presumption that the Workers were reasonable in the refusal.

I am not comfortable that a decision made on that item alone, without further review, would be maintained. I am comfortable that the onus is on the Employer to demonstrate that the Worker(s) refusal was unreasonable and that there was no imminent danger to them. The panel can consider the Worker(s) refusal was reasonable unless the Respondent demonstrates clearly, that it was not.

An additional consideration is the absence of evidence that the Employer ensured, as far as reasonably practicable, that workers were aware of their responsibilities and duties under the Act. Those duties include the duty to refuse imminently dangerous work. The education mandated for the duty of work refusal was the Employer's responsibility under Section 2(1)(b) of the Act.

The merits of the matter will rest largely on the merits of the refusal put forward when Patient returned to Unit 5-South. The facts of that refusal will be put to the test.

Discussion on the Refusal:

The Patient was "Certified" and required placement in a designated facility such as the Queen Elizabeth Hospital in Grande Prairie (QEII) possessing a closed mental health unit, Unit 5 South (5S)

Patients who leave the unit to smoke cigarettes or for weekend passes must have approval to leave the unit.

The Patient was certified as a formal patient under the Mental Health Act meaning he was suffering from a mental disorder, likely to cause harm to himself or others (or to suffer substantial mental or physical deterioration or physical impairment) and is unsuitable to be admitted on any other status but formal patient.

During the admission the Patient was mostly kept in a seclusion room on the unit.

Almost from the moment of hearing that the Patient would be returning, the Employer began working on his transfer to another facility.

Throughout January 17 and 18, 2011, management and psychiatrists attempted to transfer the Patient to another facility.

The Respondent submits that on January 17 and 18, 2011 eight nursing staff refused to provide care to the Patient upon his return from RCMP lockup up to an including his transfer to another facility in Alberta.

The Appellant agrees that Workers refused to provide care to the Patient upon his return to Unit-5 South, January 17, 2011, and that the work refusal lasted until the Patient was transferred out, January 18, 2011

The Respondent asserts that it is normal for Unit 5S to have patients with unpredictable and changing levels of aggression.

Evidence supports that a correctly functioning psychiatric unit, such as Unit 5 South is meant to be, is still considered normal if a patient on it has unpredictable and changing levels of aggression.

The Respondent states that it is normal for Unit 5S to have safety measures including protocols and polices, staff training, environmental restrains, chemical restraints, physical restraints, and security, in place to deal with patients who are exhibiting or might exhibit aggressive or violent behaviour.

The Appellant contests this. The Appellant states that that Unit 5S did not have consistent staff training and re-certification in mandatory Non-Violent Crisis Intervention.

> Evidence showed that it was a known issue that the environmental restraint of the seclusion room magnetically locked doors had been breached on several occasions.

I consider that normally a psychiatric unit would be able to depend on its secure doors to remain secure.

> The Evidence showed that there was a known issue that the emergency button that was not well located to summon staff assistance in the event of an emergency.

I consider that normally a psychiatric unit with an emergency button would have a well-located button.

> Evidence showed that physical restraints were not normally used or available for the seclusion room.
>
> Evidence indicated that no staff knew of physical restraints being used in the seclusion room.

Evidence showed the seclusion rooms had no attachment points for commonly used restraints.

Evidence indicated that Straight-jackets were not normally used or available on the Unit.

The Appellant asserted that that security was not consistently competent to handle powerful, aggressive patients.

Evidence did not show that Security had ever lost control of a powerful aggressive patient to the point that the Patient escaped custody.

Evidence did show that there were a variety of physical competencies and skills in in the Security personnel ranging from very little physical aspect to able-bodied.

Some security personnel were able bodied and trained for control tactics while others were not.

On January 12 able-bodied security staff had to take physical control of the Patient and some security staff suffered injuries.

Evidence showed that one security guard was placed on modified duties by the Worker's Compensation Board.

Two nights before returning to the Unit, on January 15, 2011, the Patient became violent and damaged the seclusion room door. RCMP attended and removed the Patient on charges of uttering threats and destruction of property. The staff did not report any physical injuries from the incident.

Management was advised a Judge dismissed the charges as the Patient was Certified and so not criminally responsible his actions.

The Respondent has said that upon learning that the Patient would return the nursing staff refused care for him and that upon his return they acted upon and continued in their refusal to provide care. Elsewhere in their submission the Respondent identifies that the Nursing Staff refused to provide care to the Patient upon his return. "The expressed reason for the Nursing Staff's actions was concern for their safety in relation to the Patient. At no time did the Nursing Staff provide care to the Patient."

The Respondent also argues that other patients missed care until discussions with management restored care.

The Appellant argues that no other patients missed care although their routine would have been altered.

Enhanced safety measures noted in evidence include: Additional security for much of the time the Patient was on the unit, New protocols for nurses entering and leaving seclusion rooms, Ordering chemical restraints for the Patient.

The appellant maintains that the security was uncertain, and the protocols and chemical restraint Order not secured until after the point of refusal.

The Patient was transferred to another facility at approximately 1600-hours on January 18, 2011. He had remained cooperative and complaint from his return January 17, 2011 until he left.

That the Patient remained calm is not contested although the Appellant argues that the Patient behaviour after his return is not relative to the matter.

The Respondent refers the Panel to the Act at Sections 35 and 36. The OHS Officer applied a three part legal test and found that the disciplined workers did not comply with Section 35 regarding the refusal of unsafe work. The main issue for the Panel is determining if the Nursing Staff were permitted under the OHS Act to refuse to work in accordance with Section 35 in the circumstances.

1. There must be evidence that the Worker(s) acted in compliance with *the Act, Regulation or Code.*

Normally a worker must work. Even if they do not agree with the direction, a general rule of thumb is do the work now and grieve later. An exception exists in Section 35 of the Occupational Health and Safety Act of Alberta. Under the Act when a worker believes, on reasonable and probable grounds that there exists an imminent danger to the health and safety of that worker or another worker present at the work site then that worker shall not carry out that work. Both parties described it as a 'Right to Refuse'. Section 35 reads as a "duty" to refuse work that is imminently dangerous to self other workers at the work site. It does not describe the worker "may" refuse but rather that the worker "shall" refuse.

The Act imposes a legal duty on workers to refuse work they believe on reasonable and probable grounds is imminently dangerous to themselves or others.

> 35(1) No worker **shall**
>
> (a) carry out any work if, on **reasonable and probable grounds**, the worker **believes** that there exists an **imminent danger** to the health or safety of that worker,
>
> (b) carry out any work if, on reasonable and probable grounds, the worker believes that it will cause to exist an imminent danger to the health or safety of **that worker or another worker present at the work site,** (emphasis added)

Evidence was not presented on whether or not workers were influenced by the punishment for and Offence under *the Act.* Under the Act, punishment could be applied to a worker that failed to refuse to perform imminently dangerous work.

> *Offences*
>
> *41(1) A person who contravenes this Act, the regulations or an adopted code or fails to comply with an order made under this Act, the regulation or an adopted code or with an acceptance issued under this Act is guilty of an offence and liable*
>
> *(a) for a first offence,*
>
> *(i) to a fine of not more than $500 000 and in the case of a continuing offence, to a further fine of not more than $30 000 for each day during which the offence continues after the first day or part of a day, or*
>
> *(ii) to imprisonment for a term not exceeding 6 months, or to both fines and imprisonment,*

I found it a fact that the workers engaged in the work of the employer had not been made aware of their responsibilities and duties under the Act, the regulations and the adopted code.

> Obligations of employers, workers, etc.
>
> 2(1) Every employer shall ensure, as far as it is reasonably practicable for the employer to do so,
>
> > (b) that the workers engaged in the work of that employer are aware of their responsibilities and duties under this Act, the regulations and the adopted code.
>
> (2) Every worker shall, while engaged in an occupation,
>
> > (a) take reasonable care to protect the health and safety of the worker and of other workers present while the worker is working,

The question considers if workers honestly and reasonably believed that such danger was imminent that they should refuse to perform that work. Another way to describe that question is if the workers subjectively and objectively believed an imminent danger existed.

The evidence is clear that Workers were honestly fearful of the Patient.

Sian Lewis, Manager testified that the nurses would not provide care to Patient as he was aggressive, the unit was unsafe with him, and he had kicked out the seclusion room door days prior. Sian related taking the safety of patients and staff as paramount and taking the concern seriously and beginning solution seeking.

Brenda Jack, Nurse Testified that she felt unsafe having the Patient on the unit after having breached seclusion. She was also afraid for the safety of other patients.

> Brenda Dianne and Joanne were concerned for their safety and the safety of other patients.
>
> Brenda phone the Administrator Sandra for advice but Sandra did not have advice and did not know what to do. Sandra said that is Brenda refused she would report Brenda to her professional Association.
>
> Brenda considered that given that The RCMP had to be called in on Patient and that three security staff had been assaulted by him and that he had breach the seclusion doors, the only containment available, there was no way for her to keep herself safe in the circumstances.
>
> Normally there would be 4 nurses but they were short one.
>
> Brenda Dianne and Joanne were looking for options. They did not feel they were safe or that the other patients would be safe.
>
> Was not aware of current meds.
>
> The nurses did not trust they would be safe.
>
> She returned to work at 0700 Jan 18.
>
> At about 1500, Patient was transferred to a dedicated mental health facility.

Diana Van Eerden, Nurse Testified to being nervous about the Patient's return because of previous experience with him.

She was considering how they could restrain the Patient if he acted up again

Diane knew the Patient had broken out of doors

Diane believed chemical restraints were no longer an option for the Patient

Sharon Parsons testified that although she never knew the Patient as a patient that she was aware that throughout his previous stay he was disruptive, impulsive, and unpredictable.

The Patient disrupted other patients and unsettled the unit.

Was difficult to medicate the Patient, as he was sensitive.

At one point the Patient developed side effects and had to go to ICU

Wayne Mayell, Employer OHS Practitioner Testified that management reported to his that Staff was refusing based on threats from the Patient and that that the seclusion room door had started to come apart.

Don Hunt, Manager testified that he did not tell nurses that the Patient was in a stronger room.

Don speculate that nurses would have been concerned when the Patient arrived at 3:30.

Robert Lyons Director testified that he took phone call about 4-430pm January 15, 2011 informing him that an aggressive violent patient had knocked security door ajar. 2 staff and one security held the door. RCMP responded and took to cells.

Charges had not been maintained at court and he was coming back and nurses were threatening to withhold service to Patient.

Emailed the Chief Psychiatrist that an aggressive violent patient had compromised doors. Worry and fear amongst staff) returning from cells

There was a huge fear-factor for this fellow despite enhanced security. He had broken a door. They were fearful of him like a monster.

He was violent and showed unpredictability

At a staff meeting later on after the Patient was gone the fear factor was acknowledged as being very real and efforts were made to not have it repeated.

In the evening staff meeting one nurse was considering leaving the psych unit altogether.

Now that they knew there were two stronger rooms they would not use the two compromised rooms for any patient with potential for violence or aggression until fixed.

Patient caused a great deal of fear on the unit

Admin on Call Event Log dated January 16, 2011 from Unit 5S Supervisor

The supervisor reported she had received a phone call January 15 that a psychiatric patient had become homicidal and uttered threats to staff.

The panel heard how two nights earlier the Patient had kicked open the door and if not but for the actions of two nurses who braced the door with their bodies, would have escaped from the seclusion room. He threatened to kill them.

The Patient was described as a 250 pound, powerful man.

The Respondent has acknowledged that the Nurses may have been experiencing real fear and may have subjectively believed they were in danger.

The Respondent reminds the Panel that Imminent Danger is defined in the Act as danger that is not normal for that occupation or a danger under which a person engaged in that occupation would not normally carry out the person's work.

The Respondent states it is normal for RNs and RPNs in psychiatric units to deal with patients that may or do become unpredictably violent or aggressive and that It is normal for the staff to be trained to work with patients that may or do become unpredictably violent. Because of those two normalcies, the threshold for imminent danger under the Act was not met.

> The Respondent referred to an 1981 decision discussing "normalcy" in relation to "Imminent danger", *Labarge v. Bell Canada*. The right to refuse, "… has been tempered however by the mandatory considerations of normalcy." "Normal or standard work processes are a consideration when assessing whether or not danger is so imminent that it prevents an employee from continuing to perform his duties. A finding that imminent danger does not exist does not necessarily mean that danger does not actually exist or that remedial action or further inquiry is not required."

The Respondent suggests that the above interpretations be applied to the Alberta's OHS Act to conclude the nurses were not in imminent danger. It is normal for a RN or RPN who are trained for and routinely work on a psychiatric unit to face patients with violent and unpredictable behaviors.

The Respondent contends that the work hazard level was objectively normal. The Patient was of a type normally expected to be encountered from time to time on the unit. Nursing staff would normally be expected to care for a patient like this Patient. The danger was ordinary.

The Appellant argues that as in *Eric V. Canada,* "danger cannot be assessed in a vacuum" and refers the Panel to *P&O v. ILU* for an explanation of what an employer must satisfy before saying a danger is a normal condition of work.

The Appellant contends that the training was not kept to mandated standards and also that the normal environment of a psychiatric unit for handling unpredictably violent or aggressive patients was not in place at Unit 5 South.

The Appellant maintains that normal includes other factors found lacking in Unit 5 South. Normal includes polices and procedures for refusing unsafe work, consistently competent security, properly located emergency call buttons or staff being equipped with personal

emergency calls, staff involvement in and awareness of hazard assessments and control implementation documentation, well maintained locks that hold to an engineered standard, swipe cards that consistently work, functional mechanical restraints, and dependable use of chemical restraints.

The Appellant maintains that these normal controls for a psychiatric unit were not in evidence when the Nursing Staff made the work refusal.

Robert Lyons, Director testified that the post-work refusal follow up included:

- Reviewed training for de-escalation
- Seclusion room doors fixed with magnets and reinforcement
- Enhanced security glass recommended at nurse station to reduce eye contact to reduce antagonism
- Glass around the open side of nursing station recommended
- Protocol for security to enter room first and nurse second
- Security card issues for unlocking doors
- Changing that some security doors had been wedged open
- Recommendation to do mock drills including mock takedowns
- Recommendation that nurses be allowed to carry a personal alarm
- Recommendation that nurses carry a mask and latex glove pack.
- Alarm button outsider of the station recommended to be moved inside.
- Something to allow patient to go to bathroom in the room
- Not sure if he had seen any orders from OHS

Mr. Lyons was not sure if there was any training planned about OHS Act obligation of employers to investigate imminent danger refusals and provide a report and allow for employee response.

The Respondent discusses that it is normal for the employer to always have multiple safety measures in place, so that health and safety can be ensured without strict reliance upon one type of safety measure. The Respondent asserts that upon being advised of the Nursing Staff safety concerns, the employer instituted appropriate additional safety measures to counter act the loss of one of its normal safety measures and the potential violence of the Patient. The Respondent considers that the safety of the unit was at or higher than normal and the threshold for imminent danger under the Act was not met.

The Appellant contends that the delivery and the communication of the additional safety measures was inconsistent and vicarious. The security staff came and went. The employer did not investigate and communicate as required in legislation. “The Act’s provisions protecting employees are meaningless if employers, as this one did, fail to follow the Act’s requirements and none the less imposes discipline on nurses because in retrospect it deems its own actions to be sufficient.” (Appellant Submission)

The Respondent discusses how other patient care was affected by Nursing Staff actions. Management permitted temporary removal of the other psych patients from the unit. The

Patient was calm at the moment he returned to the unit which is when the workers refused. Nursing staff refused RCMP assistance to administer medication to the Patient. The Patient may have been neglected during that period of his stay at QEII Hospital. The Patient was cared for by staff without normal level of psychiatric experience or training. Staffing on other areas of the hospital was impacted. Resources were reallocated to Unit 5S. The nurses refused to assist in preparing the Patient for safe transport.

The Appellant notes that Workers accepted re-assignment and other related duties and refused no work other that that they reasonably believed to be unsafe to the point of imminent danger. They ensured that the patients under their care did not miss "even so much as a vitamin". The Appellant notes that Workers never had an opportunity to assist, or to refuse to assist, in preparing for the Patient's safe transport. The person that the Employer had assigned to go ask the Workers to resume care prior to the Patient transfer was instead re-directed into coordinating the Patients transfer.

The Appellant brings forward the 2011 *Aleksandrov v. g. Zavitz Ltd* decision the board found that even though the complainant's views were ultimately unfounded, they were nevertheless honestly held and the employee had reasonable grounds to believe.

The Respondent asserts the hazard was normal to the occupation. The danger was one under which similar staff on a similar unit would carry out their work. The actions created hardship for the Employer. The hardships could have impacted the health and safety of others.

The Appellant maintains that an improperly controlled hazard cannot be considered as normal. The requisite controls were not in place and/or not maintained. Another psychiatric unit would have properly functioning controls of adequate effectiveness. The Appellant submits that such was not the case. The Appellant submits that Workers were acting in compliance with the Act. The Workers had no ulterior motive for refusing to treat the Patient. They had never refused to treat this Patient or any other patient before. The Workers continued to care for all the other patients and their refusal to work was limited to the extent of their assessment of their danger. The Workers lacked training for handling patients who cannot be chemically sedated. After learning the Patient could breach the doors they refused to care for him. Prior to the Patients violence on January 15, 2011 the Workers had asked the Employer to repair the seclusion room doors.

The Respondent refers the panel to *Timpauer v. Air Canada*. This was a Canada Labour Code matter. The imminent danger provision of the *Code* (as it was then) (was) designed to provide protection to workers who perceive that in the here and now that the roof is going to fall in on them and they must immediately get out of the way to save themselves.

> (Panel Note *Timpauer* was a case about a work refusal concerning exposure to second hand tobacco smoke. It was a 1985 decision, later quashed on a procedural fairness)

The Appellant holds that the Employer recognized that the unit was not an appropriate facility for the Patient and were looking for a more secure and appropriate facility to which to transfer the Patient. The Nursing staff was concerned that they would not be able to defend themselves or other patients if the Patient repeated his breach of the seclusion room and then enacted his threat to kill nurses.

A psychiatrist testified that prior to January 17, 2011 he had seen Patient on a previous admission with delirium, substance abuse, and psychosis. The historical diagnosis was schizophrenia. While they had not ruled it our completely that was not his current diagnosis.

> The Patient was admitted again in the second week of January 17, 2011 with the diagnosis of substance abuse delirium and anti-social personality. The Psychiatrist said the Patient had a high propensity for violence and that he exhibited unprovoked goal oriented aggression. He had along term pattern of hurting people with no remorse.

The Respondent notes the *Bonnet* decision discusses that while the employee may have had a subjective belief that his health and safety were in jeopardy, he was not open to an objective assessment of that belief. The Respondent asserts that the circumstances with the Patient did not present an unacceptable degree of hazard such as to be distinctly unsafe within the context of the working environment.

> (Panel Note: *Bonnet* at page 274 discusses the employer applying the 4-part test. "The employer says there is no evidence that anything changed or was unusual or different after the Apr 5 assault and therefore no new or different circumstances to justify concluding there was a basis for the grievor's belief." *Bonnet* at 275 says the employer pointed out that there was no evidence that any other worker refused as a reason why the worker was not justified in his refusal.)

The Appellant holds that the Worker's concern for their safety was objectively reasonable. The seclusion rooms had been breached on a number of occasions and not properly repaired. The Patient had breached a seclusion room door two days earlier and then was taken away by RCMP. The Patient was unpredictably violent and was a poor candidate for chemical restraint. He had attacked security staff and threatened to kill the nurses caring for him.

The Appellant directs the panel to *Eric V. Canada* where the Canadian OHS Tribunal found the normal exception was to be interpreted narrowly and that danger could not be assessed in a vacuum. It was not sufficient in a correctional setting that transfers were a normal part of a correctional officer's work.

The Respondent maintained that the Patient acted calm when returned to the hospital on January 17th in mechanical restraints in the custody of RCMP. There was not "immediate danger" of "immediate harm" in the "here and now" which was when the nursing staff initially refused to provide service to the Patient.

The Respondent submitted Patient was placed into an environmental restraint, chemical restraint, constant observation, under an increase security watch. Safety was enhanced.

The Evidence is clear that the Patient had a recent history of being unpredictably violent and that he could breach seclusion room doors.

The Evidence is clear that at the point of refusal the Nursing Staff would not have known about the improved protocol for Security to be first in and last out when a Nurse was required in the Patient Seclusion room.

Don Hunt testified to introducing the protocol after the refusal began.

The Respondent submits that obligations of the employer to ensure as far as reasonably practicable the health and safety of nursing staff were fulfilled.

The Appellant holds that the employer failed to fulfill obligations in Section 35. The Employer requirements are legislated to help ensure Worker Health and Safety. Also the employer had not met the requirements for hazard assessment or for maintaining or altering equipment.

The Respondent states they have the objective view that, as a result of the safety measures put in place, and the ability of the staff treating the Patient to keep him calm, imminent danger did not exist. The Respondent states the Nursing Staff failed to objectively evaluate the Employer's actions in creating a safe work environment.

The Appellant maintains that the Nurses evaluation of the danger at the time of refusal was objectively reasonable.

The Respondent holds that Legislation contemplates a team approach to solving concerns around imminent danger, as it requires participation by both the worker and the Employer to solve a shared problem. The Respondent maintains that the Employer played its part effectively. The Respondent contends that the Nursing staff failed to participate in the spirit of the legislation when they failed to assess the Patient's state upon his return and up until his transfer. The Respondent states the Nurses failed to respond to the Employer's requests to commence treating the Patient in light of the steps taken. The nurses failed to deal with the Patient at all.

The Appellant asserts that the Employer, in failing to satisfy the letter of Section 35 of the Act vacated the ability to impose discipline for the work refusal.

The Respondent states that the Employer had in place, policies and protocols for restraints to control aggressive behavior by way of the "Intervention for Control Policy" and "Use of RCMP for Assistance"

> RCMP had been placed on alert
>
> Two of the Nursing Staff were RPN's RPN's receive additional educational training in regards to the treatment of psychiatric patients compared to an RN. All of the refusing nursing staff had training related to medicating mentally ill patients.
>
> NVCI training had been imposed by the Employer for several years. Some nursing staff had received an advanced level of NVCI. NVCI includes verbal methods to help prevent or reduce a patients aggression, along with methods of self-defense and physical containment of a patient.
>
> The appellant takes the view that objectively, Nursing Staff would nave little reason to have believed that their level of training would have allowed them to control or otherwise evaded the Patient.

The evidence was not clear that the NVCI training had been kept up to the mandated standard. The training program had been in place for several years. In that time the Patient continued to display unpredictable violence and aggression. No nursing staff physical injuries were in evidence from the Patients outbursts. Security staff had been injured. One injured security staff was placed on modified duties through the WCB.

The evidence was not clear as to the regard Nurses had for the ability of the RCMP to consistently be summoned and available to intervene in time to prevent them from coming to harm.

The Respondent discussed that Environmental Restraints included locked unit doors that required swipe cards to be unlocked.

The evidence noted some problems with swipe card locks as well as an internal door being breached allowing a patient to get into the lounge.

The information provided by the Respondent that there was an Emergency Call Button located "in" the nursing station was not supported by the evidence.

> Respondent written submission at paragraph 37 submitted that, prior to the Patient return, safety measures in place included an emergency button.
>
> Respondent written submission at paragraph 46 submitted, "In the Nursing Station was an emergency call button staff members could push to get assistance of other staff within the QEII"

Jennifer Ward testified that the 'panic button' was in the wrong place and too far to be useful in an emergency.

A Professional Responsibility report Form was prepared by Jennifer Ward and dated November 21, 2010. In the form Jennifer Ward states, "Need a safe place for staff if confronted by aggressive pt that allows us to signal for assistance. The Emergency button is out in the main area and not the nursing office.

Robert Lyons, Director testified that a post incident recommendation was that the alarm button located outside of the station be moved inside.

The Respondent has noted that the Patient was placed into a seclusion room that had a stronger door and had never been breached.

The evidence is clear that objectively, the Nursing Staff would not have known that there was any difference in strength in any of the Seclusion Room doors.

The assertion by the Respondent that the Nurses knew that the Patient was under a Chemical Restraint at the point of refusal is not supported by evidence.

Chemical Restraints were used on the Patient after his return to the Unit.

Evidence is clear that the Patient was known to have previous medical complications with Chemical Restraints.

Nurses testified to their objective belief that there would not be Orders for Chemical Restraints.

The Nursing Staff refused to care for the patient when he arrived back at the unit late in the afternoon January 17, 2011.

Manager Don Hunt testified that when he arrived on the unit in the later afternoon of January 17, 2011 the Patient was already secured in a Seclusion Room.

Don Hunt was aware that was a medical concern with the Patient's potential reaction to chemical restraints.

Don Hunt asked Dr. Block to write an Order for Chemical Restraint as a preventive measure against aggression from the Patient.

The assertion by the Respondent that mechanical restraints were available is not supported by the evidence.

The Policy for Intervention and Control lists Room Restriction, Seclusion, Chemical and Mechanical Restraint. Robert Lyons, Director guessed that physical restraints included straight jackets or handcuffs but that nothing used in recent history. Pictures of the seclusion rooms showed no attachment points for restraints.

Manager Sian Lewis stated that the 3-point-to-bed physical restraints mentioned in Restraint Policies were not available in seclusion rooms. Seclusion rooms have no beds.

The Respondent submitted that, prior to the Patient return, safety measures were in place including a seclusion room equipped with a camera. The room was one of two rooms that were seldom used and that had not been breached.

> The evidence shows that the two rooms that had not been breached did not have as good of camera coverage as the seclusion rooms normally used.
>
> Exhibit W Report re: January 17, 2011 Incident on 5 South Page two paragraph 5 states; "The nurses have traditionally used the 2 doors with the 3000 lb strength as they are located in closer proximity to the nursing station, have no blind spots when looking at the monitor and are better situated for patient's bathroom use."

Manager Sian Lewis Testified that there were black out areas on the other cameras.

The Respondent advised that Security had previously controlled aggressive patients including the Patient. Upon the Patient's return to Unit 5S, the Employer took immediate steps to increase the security presence for the duration of the patient's stay by placing 4 security guards outside the seclusion room. There was one brief lapse. Respondent holds that the security staff assigned January 17 and 18, 2011 was competent for the task. Other security staff was available in the building. Management changed the practice of a nurse entering the Patient's room first. Security entered first and exited last.

The Respondent submitted that Nursing Staff advised the Employer of their intended refusal to work prior to the patient being re-admitted on January 17, 2011. They expressed their refusal repeatedly throughout the patient's stay. AHS sincerely asserts that the nurses were in violation of the Legislation whether or not the Employer did "direct' the Nursing Staff to return to work.

There is a discussion point available about workers planning to refuse work they believed would be imminent danger. My opinion is that forethought does not indicate malice. Rather, forethought is considered an essential element of health and safety. It is a component of hazard assessment and safe work procedure. Workers may be trained to not do something that would be imminently dangerous. Workers may discuss safety concerns, 'what-to-dos' and 'what-not-to-dos'. "Do stop and look both ways and assess traffic before crossing to the flag person post" "Do not work within 7 meters of that power-line until the City has issues the safe work permit and other safety measures are satisfied" "I heard the weather report calls for blowing snow and unless it changes I am not driving to Calgary tonight on summer tires"

If Workers (some or all) did contemplate some theoretical safe actions to take if faced with an event of future danger then that is more in line with reasonable thinking than evil intent. If workers hear that they may be coming across an imminent danger they would be less than reasonably cautious if they would not discuss it until they were directly exposed to the danger. That Workers had discussions about working with Patient under potentially imminently dangerous conditions before his return may be considered prudent. Workers may reasonably consider the 'what-ifs' of safety.

The Appellant brings forward *Sidbec Dosco Inc* (1988) where the Ontario Labour Board stated that, "at no stage of the proceedings must an employee be proved correct regarding the safety of his work and his consequent work refusal. Generally the Board only looks to the reasonableness of the employee's views in light of the information available to him at the time"

> Sian Lewis, Manager, testified that Joanne Nixon gave a refusal in the late afternoon of January 17, 2011. Joanne told Sian that they, the nurses, would not provide care to the Patient as he was aggressive, the unit was unsafe with him, and he had kicked out the seclusion room door days prior. Sian related taking the safety of patients and staff as paramount and taking the concern seriously and beginning solution seeking.
>
> Brenda Jack, Nurse, testified that given that the RCMP had to be called in on the Patient and that three security staff had been assaulted by him and that he had breached the seclusion doors, the only containment available, there was no way for her to keep herself safe in the circumstances. She informed the Transition Coordinator of her refusal to provide care for the Patient.
>
> Diana Van eerden, Nurse, testified that she was never asked to provide care to the Patient. She participated in the planning and movement of other patients to a different area of the hospital because of fears oft. Diane was nervous about the Patient's return because of previous experience with him. She was wondering how they could restrain the Patient if he acted up again. Diane knew the Patient had broken out of doors. Diane believed chemical restraints were no longer an option for the Patient.
>
> Michelle Marie Lambert testified that the Patient was not assigned to her.
>
> Sharon Parsons testified that she was never asked to provide care for the Patient or put him on patient assignment list or assign him to one of the nurses. At about 1400-hour or 1430 hour on January 18, two managers and the AHS OHS Officer met with her to discuss safety measures in place and asked her if it was safe to provide care. Sharon was asked to go back to tell staff about the measures in place but when she went back to the unit a bed had been found for Patient and so she had to phone dispatch to arrange for air ambulance to fly him out.
>
> Roxann Dreger testified having a conversation with management planning for the relocation of other patients based on staff concerns they could not work safely with the Patient on the unit.
>
> Wayne Mayell AHS OHS testified that management reported to him that staff was refusing to work with The Patient based on threats and that that the seclusion room door had started to come apart.
>
> He stated that he had a meeting with management in the afternoon of January 18, 2011 about the matter. Sharon Parsons was brought into the room as charge nurse and told that reasonable precautions had been put in place and that they should resume patient care. Sharon agreed to take it back to staff.
>
> Don Hunt, Manager testified that Joanne Nixon discussed plans with him to move other patients on the unit away from The Patient. He gave directions about the

planning and provided his personal keys to a secure space. He arranged for alternate care for the Patient and had the Security Chief increase security staff, and enhanced the protocol for entering the seclusion room and asked a Dr. to order a chemical restraint on the Patient.

Bonnie Kennedy, Manager, testified that a staff spoke to her about the work refusal.

Robert Lyons, Director testified that he received a phone call around 1600 or 1630 January 17, 2011 and was informed that on the night of January 15, 2011 an aggressive violent patient had knocked a security door ajar. Two Nurses and one security held the door until RCMP responded and took patient to cells. He was advised that the Charges had not been maintained at court and the patient was coming back and nurses were threatening to withhold service to Patient.

He emailed the chief psychiatrist that an Aggressive violent patient had compromised doors, and that there was worry and fear amongst staff about him returning from cells.

An Urgent Notification to an Emerging Issue Report dated January 17, 2011 describes that nurses were refusing work based on immense concerns for their safety. The report states that Don Hunt, Sian Lewis, Senior Administration Allan Bradley, and Director Bob Lyons were advised.

> In bold letters at the bottom of page one, the report states,
>
> "The urgent need is for this patient to be transferred to a safe location, with appropriate physical facilities to house him. At present, the seclusion room door at the QEII is compromised and is deemed unusable."

The 4 Part Test Re: *Steel Co. of Canaday v. U.S.W. Loc.1005* (1973) edited from *Bonnett* (referenced in *Brown and Beatty*, Canadian Labour Arbitration, 2nd ed.(1984)

Did the Worker honestly believe his/her health or well-being was endangered?

Did the Worker communicate that belief to the supervisor in a reasonable and adequate manner?

Was the belief reasonable in the circumstances?

Was the danger sufficiently serious to justify the particular action taken?

I will feed my findings into the test as a quality check.

Did the Worker honestly believe his/her health or well-being was endangered?

Yes. The strong fear of the Workers was acknowledged as real.

Did the Worker communicate that belief to the supervisor in a reasonable and adequate manner?

Yes, given lack of policy/procedure or training at that time, the Employer was made aware of the belief in a reasonable and adequate manner.

Was the belief reasonable in the circumstances?

Yes, When the Patient arrived the Nurses had no confidence that the Patient would not return to his behavior of two nights previous where he breached the seclusion room door and nurses held the door closed from the other side. The Patient had threatened to kill nursing staff. The nurses objectively believed he would not be placed in chemical restraint and the mechanical restraints mandated in policy were not available for use on the Patient in the seclusion room. As far as Nursing Staff knew all seclusion rooms were could be breached as well as at least one internal locking door. The swipe cards did not always work and the Panic button was poorly located. Security guards were of mixed competency and protocols were such that nurses entered seclusion rooms before security staff. The nurses were not confident that their training was up to standard and any ways were not confident that the standard was up to controlling the Patient given that he had not been successfully controlled two night previously. The training was not known to be effective for Patient, in part because he gave no warning of elevating aggression. His demeanor had previously gone from calm too violent too quickly to intervene.

Was the danger sufficiently serious to justify the particular action taken? Yes.

The Patient was a 250lb certified mental patient with a history of unprovoked violence and remorseless, goal oriented aggression. He had injured security guards, one to the point of requiring medical aid and modified duties. Two nights previously he had threatened to kill the nurses.

The Unit had deficiencies in engineering controls and administrative controls.

The Unit did not have the safeguards of a normal psychiatric unit to consistently control hazards such as the Patient.

The danger was not normal for the circumstance that existed when the refusal was made.

The test is satisfied

The workers engaged in the work of the employer had not been made aware of their responsibilities and duties under the Act, the Regulations and the adopted Code however they did know enough to refuse to perform work that they reasonably believed was imminently dangerous to themselves or other workers.

Workers honestly believed that caring for the Patient would pose a serious danger that could fall upon them at any moment, with little or no warning or opportunity for intervention before coming to harm.

Objectively, controls expected to be in place in a normal psychiatric unit were not known to be in place on Unit 5 South as the point of refusal. Incidents with serious potential of harm had been occurring in the days prior.

Nurses saw themselves in harms way and advised the Employer of their refusal and concerns.

The Employer did take actions to mitigate the risk however has disciplined the workers for refusing.

I find that the discipline was imposed upon workers by reason that they were acting in compliance with the Act.

The discipline is contrary to Section 36 of the Act.

Hal Griffith

Reasons for Decision of Peter Bowal (dissenting):

I have read the reasons for decision of my panel colleagues and respectfully disagree with their disposition of this appeal. The hearing of this appeal took place over four days in Grande Prairie and legal arguments were presented for a further half day. The appeal raises serious questions around safety-related work refusals.

The Respondent hospital takes the position that 8 nurses unreasonably refused to provide care to one patient throughout his stay at the hospital lasting about 22 hours and less than continuous care to 12 other patients on January 17 and 18, 2011. Four nurses were suspended for 2 days without pay; the other four were issued letters of warning.

The Appellant nurses union maintains that these nurses acted reasonably and lawfully under section 35 of the *Occupational Health and Safety Act*, R.S.A. 2000, Ch. O-2 and that the employer wrongfully disciplined them, contrary to section 36. The nurses seek a remedy pursuant to section 37, which sets out the jurisdiction of this Council to hear and decide this matter. The OHS officer dismissed the Appellant's first level of appeal and this is an appeal from his decision.

It is my view that the OHS officer properly investigated this complaint and made a decision that is supported by the evidence. The officer's conclusion in this case was reasonable. I would dismiss the appeal.

Facts

The facts are nuanced and especially critical in these disciplinary action complaints. The OHS officer who investigated the case set out some of the principal facts from which he drew legal conclusions in his decision (p. 3). Most of the main facts of the case are not in dispute and should be stated.

Some of the most serious mentally ill individuals spend much of their lives moving between Alberta hospitals, as patients in either specialized mental health facilities or in community-based acute care facilities, and courtrooms and jails as offenders under the

control of the criminal justice system. This encompasses a variety of individuals who present significant risk to themselves and to others, often accompanied by alcohol and substance abuse with other severe psychiatric conditions. If their behaviour can be characterized as criminal, they are usually in the custody of the police or corrections under some form of remand warrant.

If the criminal justice (forensic) system lacks the authority to hold them, but they remain in an acute, crisis condition, they may be admitted (medical) to an Alberta health care facility, with or without their consent, under the *Mental Health Act*, RSA 2000, ch. M-13. Usually admissions are intended for short periods of time to obtain release to community supports as soon as possible. Formal or "certified" patients are admitted without their consent and can present extreme challenges episodically for the nursing staff at the approximately 20 community, general medical hospitals in Alberta designated to admit and care for them.

The Queen Elizabeth II hospital in Grande Prairie is one of the few designated facilities for certified mental health patients in northern Alberta. Other designated facilities in the North Zone are in Fort McMurray and St. Paul. They are equipped to admit and care for severe patients. For example, at the QEII in Grande Prairie, there are 4 secure seclusion rooms, regular staff training in Non-Violent Crisis Intervention (de-escalation), access to medical and some physical restraints, physical safety set ups like key / card pass doors, alarms and perimeter security of lockable doors, nursing stations and corridors. There are mock drills, Hazard Assessments and protocols in place, updates among staff about patients, assignment of "constants" to work in singular dedication with patients, access to security as required, ability to call the RCMP in appropriate circumstances, and the possibility of transferring forensic-type patients. The facilities and staff are better equipped and prepared for the most serious mental health patients at dedicated facilities such as the institution in Ponoka. Medical staff at the community designated facilities will invariably seek the transfer of a problem patient to another facility.

Nurses working on the 5 South psychiatric unit at the Queen Elizabeth II hospital in Grande Prairie are trained to expect and care for the occasional physically threatening and potentially violent patient. The nurses on this unit say it is even common in psychiatric wards to have patients who verbally abuse and attempt to physically violate staff. Nurse Michelle Lambert testified that "violent patients on 5 South are common, an everyday occurrence almost." Psychiatrist Dr. Block said, "many psychiatric patients are violent and that is what we do as physicians in the health care system. It is something I expect could happen from any patient I see." His colleague, Dr. Lal, agreed: "aggression is not uncommon in psychiatry. It is part of psychiatry. Patients are often deluded and psychotic so it is common to see aggression." Licensed Practical Nurse (LPN) Julia Gear attested that she "has been hit, kicked, punched and spat upon on medical, surgical and psych units." She added, "the psych nurses and RNs usually take the more aggressive patients."

For example, on November 21, 2010 the nurses called hospital security and police to restrain a patient in a seclusion room who had breached the door. As a result of this incident, meetings were held with hospital administration to strengthen the seclusion room doors and security on the unit overall. The hospital was looking into it to see what it could do in that respect and, by mid January 2011, was having door parts made.

Two months later, patient TG, described as a short-heavy set man, was admitted to 5 South for was 6 days. On the last day, January 15, 2011, TG, a diagnosed schizophrenic on medication, was an impulsive and dangerous patient. In one of the seclusion rooms he ripped a sheet, spilled his urine on the floor, kicked and managed to pop open the door. The nurses held the door shut and called security. The three security guards who responded were strong, young men who took over. The RCMP came and transported TG to jail. On his way out, TG verbally taunted and uttered threats to kill the nurses. Mischief and threat charges were laid and later dismissed.

This was a particularly horrifying incident for the nurses on that shift. They assumed the doors of all four seclusion rooms were the same strength. Two rooms were now out of use. As it turned out, the doors of the other two seclusion rooms had newer, much stronger magnets that could not be breached but no one at the hospital told the nurses about this before TG made a return visit two days later.

This case is about TG's admission to 5 South on the afternoon of January 17, 2011. None of the nurses on duty that afternoon and evening were working on the unit two days earlier when he caused that disturbance, but they had heard about his last stay and it was still fresh in their minds. The nurses immediately protested his return, saying TG should not be admitted to 5 South because he was volatile and dangerous. They were not confident that adequate security backups were in place at the hospital or in their training. Moreover, he had recently threatened other nurses and they feared him. A few nurses spoke of a rumour that TG had been on his snowmobile with a loaded gun threatening to kill people. Overall, they saw his return as an unacceptable risk of injury to themselves or others on the unit.

TG had also been in the hospital at other times freely circulating without incident. One other time, he had an adverse reaction to a certain dose of the sedative which may have left the nurses doubting whether he could tolerate the regularly-used chemical restraint. Diana said she had her previous interactions with TG before "made her nervous and (she) didn't look forward to him coming back." However, only the previous month TG was admitted and discharged without any aggressive incidents.

Two psychiatrists assessed TG. Dr. Lal diagnosed TG with delirium, substance-induced psychosis, anti-social personality, historical schizophrenia, high propensity for violence and abuse of drugs and alcohol. Dr. Block described TG as beset by an abusive background with severe conditions, including fetal alcohol spectrum disorder. His coping skills caused problems because he was unable to control his impulses. When he last met with him, TG was pleasant, co-operative, spontaneous and even remorseful in the

sense that he was aware he had done something wrong but he was not able to do anything about it at the time. His behaviour was rooted in various damages to his brain over the years which were unlikely to be reversed.

On January 17, 2011, the RCMP could no longer legally hold TG in their cells. Ordered released, he had to be returned to the Queen Elizabeth II hospital, the designated mental health care facility to which he was already committed. The word went out in the early afternoon that TG was on his way back to the hospital.

Medical staff and hospital management immediately began calling other secure facilities in the province to see if they would accept TG by transfer. Nothing would come available until the next day. The psychiatrists considered whether the certification could be lifted and TG released into the community, but they decided he might harm himself or others if released. That left the hospital with no legal alternative but to admit him when the police returned him.

By 3:00 p.m., the nurses on shift heard that TG would be returning within a few hours to 5 South. They felt unsafe to be with this patient. They knew the two seclusion room doors had not been repaired yet and assumed that the remaining two seclusion rooms could be similarly breached. They phoned the Administrator-on-Call with their concerns. They called the transition co-ordinator and told her they "felt unsafe and would not be able to care for this patient" (evidence of Brenda Jack), describing his violent history. They said "they would need to go to a safe location and would not provide care for this patient." It appeared at this point in time, between 1:00 p.m. and 4:00 p.m., that the nurses had decided as a group to refuse to care for TG. Dr. Lal said the nurses told him "between 1 to 4 p.m." that if TG comes back they will not be staying on the unit.

This refusal arose out of concerns for their personal safety, primarily because of TG's aggressive behaviour that they had heard about two days earlier. They believed there was inadequate security in place. In addition to the broken seclusion room doors, in the past, elderly Commissionaires had served as security guards and were not completely sufficient to the task, although the young, strong guards two days earlier were. It should be noted that none of the 8 nurses who would refuse to care for TG over the 22 hours he was at the hospital on January 17 and 18, 2011 were actually working on the unit on January 15th when TG was last belligerent and had threatened nurses working that shift. There was no evidence that any of these 8 nurses had been personally threatened by TG.

The Co-ordinator replied that the nurses should provide care for this patient, that there was no choice about whether they could take him back at the hospital. The nurses reiterated their refusal. They scrummed to discuss their options in a separate room to determine the safest location to relocate the other 5 South patients. For about 30 minutes those patients may not have had direct nursing care. The nurses decided the staff lounge would provide easy access to washrooms and containment. Those 12 patients were moved there. Everyone agreed that these 12 other psychiatric patients needed to be carefully monitored at that time.

Communications and negotiations with hospital administration were tense and sporadic, as one might imagine in this suddenly strained and urgent situation. 5 South is a locked unit which means that all corridors, rooms, elevators, nursing stations and doors can be locked. Administrators promised to post up to 5 security guards at TG's seclusion room door, to lock the corridors at both ends of the nursing area, and nurses could remain at their nursing station and other safe areas. When they had to attend to TG, the security guards would enter the room first and restrain him for nursing care and they would exit the room after the nurses. In the incident with TG on January 15th, 3 security guards controlled TG but this time there would be 4 or 5 security guards posted outside his seclusion room.

These nurses' notified administrators that they would refuse to care for TG if he was admitted. The hospital was the only designated facility in northwestern Alberta to care for certified psychiatric patients. Turning TG away was not an option.

Administrators gathered on 5 South and scrambled to manage this refusal of care. They continued to seek a transfer of TG to another facility as soon as possible. The Transition Co-ordinator, Laura Reynolds, arrived on the unit. She advised the nurses that the hospital was making arrangements for more security and that the RCMP had agreed to respond quickly if called. When TG arrived, Reynolds said the nurses were near the nursing station, in the alcove, discussing among themselves for about 15 minutes. The other 12 patients were in a dining room. TG was quiet and did he not say anything when he arrived. Reynolds said that Roxann Dreger, the union representative, advised her that the nurses had done a fan-out to 5 South nurses to tell those reporting for their shift not go to the unit but to report to the staff lounge. Regular night staff for 5 South were not coming up to the unit because of this fan-out.

The nurses were present when TG arrived in handcuffs with the RCMP escort and other security around 5 pm. He arrived calm on the stretcher, although another nurse said TG walked into the unit. He was taken directly to one of the two seclusion rooms that remained in service. The nurses did not ask management what protective security measures were in effect at that time. The OHS officer, during his interviews with the nurses, was told that "Joanne (Nixon, one of the nurses on the unit) had dismissed the RCMP" after they brought TG to the unit, and that they were "unaware of security that was around" (p. 36 of OHS officer's notes).

Sian Lewis, Acting Supervisor of 5 South at the time, testified that she received a call around 4:00 p.m. to 4:30 p.m. from Dr. Lal that "the nurses were going to walk off." When Lewis got to the unit, she said Joanne Nixon (who did not give evidence at the appeal hearing) was speaking for the nurses. When Joanne said they would not be providing care to TG, "the other nurses were standing there as in agreement – they were not saying otherwise." Don Hunt, the Director of Patient Care, arrived on the unit at about 5:30 p.m. TG was secure in his room by that time. Three security guards were outside TG's room when Hunt arrived. Hunt said, "a fourth came shortly after and a 5th

guard came within another hour." The OHS officer concluded, after his investigation, that the refusal occurred at approximately 5:45 p.m. which is when additional security guards would have been on site.

The nurses informed Reynolds and Hunt they would be providing only "custodial care" (basic needs but no medications) to the 12 other patients. Hunt said it was unacceptable for these patients to miss their medications. He arranged for the narcotics to be taken down to a room next to where the other patients were and locked, but accessible when necessary. He asked a psychiatrist on duty to authorize chemical restraint to TG, which apparently was done. Other non-UNA staff were sought out to come to work to cover this situation.

Lewis said Hunt had "two rounds of conversations with Lisa and Roxann" asking the nurses to come back to 5 South. Hunt reiterated that TG was calm and quiet, extra security guards were in place and the hospital had done everything within its ability. The nurses declined again.

Reynolds administered the anti-psychotic chemical restraint to TG at 19:10 p.m. The security guards went in the room first. TG was co-operative. He lied down as requested and Reynolds injected him in the hip. She asked a few LPNs, one of whom was Julia Gear, to monitor TG on the screen outside his room. A camera into his room was constantly recording him. The two LPNs were watching for any reactions TG might from the injection. Another worker relating to mental health was also there.

Management asked the nurses to return the other patients to their rooms on 5 South and explained the security guard arrangements and advised them that TG was sedated and calm. In the words of Reynolds, "we were discussing what it would take to bring the patients back up." The nurses replied that they were still not comfortable returning to the unit. Later, between 9:30 p.m. and 10:00 p.m., they did return to 5 South with these other patients but continued to refuse all care for TG. They say they were not asked to care for TG any more. No one else on the unit expressed their concerns for their physical safety that night.

Regina (Jeannie) Dawe relieved Hunt to care for TG. TG asked to go to the bathroom around 10 p.m. which the guards helped him do. When he asked for something to eat, Dawe prepared that and gave it to him and he thanked her for that. The security guards opened the door, told TG to remain on the bed, Dawe put the tray on the floor, then they left and shut the door. TG listened to the guards. Dawe released the two LPNs because she did not think it was necessary for all 3 of them to be looking at the monitor together.

Through that evening, there were 3 to 5 security guards (in Julia Gear's words, "all big boys") outside TG's door. Around 11:30 p.m. two security guards returned to emergency but the increase to 4 guards was restored within 30 to 45 minutes. The nurses, having returned to the unit, were sitting in the nearby nursing station. Later, Dawe gave TG

another injection, following the same security protocol. He was given more food and at all times was polite and co-operative. As Dr. Block said, "TG was settled that evening."

The morning of January 18, 2011, Lewis said she asked the nurses, namely Acting Unit Manager, Sharon Parsons, and Brenda Jack to care for TG. They did not. Lewis asked Bonnie Kennedy to work with the 3 security guards and psychiatrists to care for TG until he was transferred out about 3:00 p.m. January 18th. He was calm and well behaved all that day, indeed throughout his 22 hour stay. He was cared for by "out of scope" nursing managers, psychiatrists, LPNs and security guards, none of whom expressed any out of the ordinary fear for their safety.

The nurses suggested, though they did not press forcefully, that they were not sufficiently trained for disruptive, volatile mental health patients like TG. The hospital affirmed that they were mandated to take non-violent crisis intervention training (certification over 2 years) emphasizing de-escalation techniques such as tone of voice, body language, reading cues of others and positive engagement with the patients, as well as self-defence. Nurses were told they did not require permission to call the RCMP to remove any patient if they felt their safety was in jeopardy.

At the appeal hearing, I found some of the nurses' evidence on cross-examination to be vague about details in those critical 4 hours around TG's arrival on the unit. They could not consistently remember, for example, whether they told hospital administrators that they "would not help TG regardless of security that night", whether they discussed solutions with administrators, how the fan-out happened, when they caucused, what they knew when, and when they made the decision not to care for him (before or after he arrived). They did not remember Lewis asking for help with nursing care for TG or several conversations where they allegedly told managers that nursing care would not be provided during that shift to TG. The nurses' union representative had arrived on the unit and a collective plan of action for was being developed at that critical time, which may explain the lack of clarity as to what was said to management in the few hours before and after TG arrived on the unit.

Applicable Law

The *Alberta Occupational Health and Safety Act* mandates workers to refrain from what they reasonably believe to be imminently dangerous work. If they do so, and are then disciplined in any way for that, they have access to the OHS officer and, by appeal, to this Council for a remedy. This duty to refrain from the dangerous work is set out in section 35 of the Act:

> Existence of imminent danger
>
> 35(1) No worker shall . . .
>
> (b) carry out any work if, on reasonable and probable grounds, the worker believes that it will cause to exist an

> imminent danger to the health or safety of that worker or another worker present at the work site . . .
>
> (2) In this section, "imminent danger" means in relation to any occupation
> (a) a danger that is not normal for that occupation, or
> (b) a danger under which a person engaged in that occupation would not normally carry out the person's work.
>
> (3) A worker who
> (a) refuses to carry out work . . . pursuant to subsection (1) shall, as soon as practicable, notify the worker's employer at the work site of the worker's refusal and the reason for the worker's refusal.

To my knowledge, no Alberta court has considered the merits of these provisions.

Analysis

It was suggested by the Appellant union that the nurses did not refuse to work because each one of them was not specifically and individually asked to care for TG, especially after they returned to the unit around 9:30 p.m. on January 17, 2011 and throughout January 18, 2011 until TG was transferred. I am satisfied from the evidence that they did refuse to care for TG while he was on the unit during that time. They clearly and expressly withdrew around the time he was being returned to the unit. Others were specifically requested on January 18 to care for TG and they did not do so.

At the appeal, the Respondent hospital took the position that the nurses "abandoned" the other 12 patients of 5 South who may have been out of eyeshot for 15 minutes or up to a half hour in the dining room while the nurses were deciding what to do. There may be a suggestion that the initial plan for only "custodial care" of these patients was also a refusal to work, since they were limiting the scope of their work. There is no merit in this position of the hospital. When a worker is contemplating a dangerous work situation and a course of action, and conferring about it with fellow workers momentarily, there is no refusal in that short interlude. On the contrary, the nurses were conscientious in their care toward these 12 other patients. Moreover, all the letters of discipline refer only to a refusal "to provide care to a certain patient." The hospital cannot now attempt to expand the refusal in order to justify the discipline. This case is only about refusal of care to TG on January 17 and 18, 2011.

One notes that, while the nurses said they acted as they did in part to protect their other patients (and that would be consistent with their professional obligations), section 35(1) only envisions the protection of a "worker". They would not be able to defend their refusal on the basis of protecting patients under narrow scope of this legislation. In any event, they do assert they were protecting themselves by their refusal.

We can also dispense with section 35(3). The nurses quickly and fully notified their employer of their refusal to care for TG and their reasons for that refusal.

Was the impending return of TG an "imminent danger"? I have no doubt that the nurses were in fear of him. Their actions immediately upon learning that he might be returned to the unit support their fear. They conferred among themselves for what was likely a few hours overall about what they perceived was a serious situation. They went to great lengths to evacuate themselves and the other patients to another floor of the hospital. This was not done lightly.

But was TG an "imminent danger" as defined by section 35(2)? Was he an abnormal danger for nurses on 5 South? According to the evidence, I do not think he was. He was at the serious end of the normal range of mentally ill patients that designated facilities for certified patients admit and care for. He had been in this hospital several times before, sometimes in unsecured units and often without incident. One bad event two days earlier with other nurses would not itself raise him to the status of an abnormal danger. Psychiatric patients can be verbally abusive and physically violent. The employer's Hazard Assessments identify this as regular occupational risk. The judge in criminal court did not convict TG of any criminal threats and the police believed he could be released to the hospital. That the RCMP did leave TG on 5 South meant he was under control and safe at that time. In short, TG was the *type* of patient the nurses on 5 South were trained to care for.

Under the second prong of the definition, was TG a danger under which a 5 South nurse would not normally care for? By this, one might envision a mentally ill man with a weapon or under the influence of some hallucinogen. The nurses say TG was different, more mean and purposive, than other psychiatric patients. I do not see how TG, in particular, was an abnormal risk for nurses on a psychiatric unit of a designated hospital.

Counsel for the union points out that "imminence" is not emphasized in the section 35(2) definition. Rather, the risk and more specifically the scope of danger of the work beyond what is normal is the issue. She referred us to the federal Occupational Health and Safety Tribunal decision of *Eric V. and Canada* (2009 LNOHSTC 9) where corrections officers refused to escort a dangerous prisoner outside of prison without being equipped with protective firearms when it was known that prisoner was a target for others. The Appeals Officer in that case found that this extra risk went beyond what the normal risk of a corrections officer and they were justified in their refusal to conduct the escort. While *Eric V.* distinguishes abnormal danger within regularly dangerous workplace situations, I do not see how the same distinction can be made in the current case. TG presented the same risk every time he was admitted to the unit, albeit at the upper end of what could be expected to be normal at this designated facility.

Therefore, as this was not an "imminent risk" as defined by the legislation, the nurses could not have believed in its existence in this case. While this alone would dispose of

the appeal, I will consider whether the nurses believed that caring for TG on January 17 and 18, 2011 would cause an imminent abnormal danger to their safety on objective "reasonable and probable grounds."

The precise moment that the nurses made the refusal decision is not known to Council. The evidence shows that it was made very quickly after learning of the *possibility* that TG might return. To have reasonable and probable grounds to believe an abnormal risk was imminent calls for one to be as objective and informed as the circumstances permit. That was not what happened in this case.

The nurses decided to refuse to care for TG before they fully understood what security measures could and would be implemented by the hospital. They decided early as a group that they were not going to provide care to TG if he was admitted that afternoon regardless of the entreaties and security precautions put in place by hospital management. This was evident in how quickly they decided to move, and did move, the other 12 patients. They expressed their refusal to care for TG before he had arrived, was seen or was assessed. They said they did not have to assess TG this time because they already knew he was too dangerous, although that was not consistent with their previous experience with him and their near-unanimous description of TG as "unpredictable". The nurses chose to consider him as predictably violent on January 17 and 18, 2011. It would be difficult to envision a nurse, for OHS purposes, reasonably categorizing a patient as inhospitably dangerous merely the basis of what one heard the patient said or did in his last hospital stay.

Reasonable grounds for believing an imminent abnormal risk exists would have called for the nurses to express their concerns and then objectively and rationally investigate them. This would include considering the totality of the numerous measures the employer planned to secure the facility for TG's stay. They waited almost 5 hours after TG arrived to return the other patients to the unit and even then did not seem to actively engage administrators about the measures that were in place even while working on the unit.

Appellant's counsel pointed out that nurses must be able to rely on informal, secondary reports about patients. Yet, the nurses unreasonably based their fears on what they heard from others about what transpired on January 15, 2011, despite themselves having no, or uneventful, hospital interactions with TG in the past. If they were primarily concerned about safety at the time TG arrived on the unit, they would not have waived the RCMP off. They would have seen at least three strong, fit security guards at TG's door, similar to the three guards used to effectively control TG just two days earlier. The nurses would have known that TG was calm when he arrived. They might have provided care to TG the next day, knowing that TG had not been aggressive, chemical restraints were working, and security remained strong.

After they refused and the danger could easily be reassessed over the 22 hours he was on the unit, the nurses refused to engage hospital administration in security matters, even though they had returned to the unit and were working nearby. Assessment of the danger

at 4:00 p.m. on January 17th could not reasonably be the same assessment justifying refusal right through to the time TG was transferred on the afternoon of Jan 18th. There were no reasonable and probable grounds for the same imminent danger during all that time. While the nurses may have genuinely held this belief of imminent danger, it was not based upon reasonable and probable grounds as it was not open to an objective assessment at the moment TG arrived on the unit and after he had been there for some time. See *Re Bonnet* (19 L.A.C. 4th) 266, at p. 284 in a labour arbitration context.

Appellant's counsel argued that the danger does not have to real, to actually materialize. The right of refusal operates to protect workers who merely perceive and honestly believe that imminent abnormal danger exists: *Elgaard v. Sidbec Dosco Inc.* [1988] O.L.R.B. Rep. 1334 at para 40; and *Aleksandrov v. G. Zavitz Ltd.* [2011 CIRB 602]. I agree with that proposition, but the belief still must be based on objective reasonable and probable grounds which in this case entailed, *inter alia*, informing oneself at the time TG arrived on 5 South about the actual security measures already in place and planned.

The fact that TG was not violent during this stay on 5 South and that other caregivers attended to him without incident are irrelevant. The nurses' refusal is evaluated on the basis of whether their belief about imminent danger was reasonable at the time of the refusal. I draw no inference adverse to the nurses' position that ultimately TG turned out to be a quiet and co-operative patient on this occasion, other than to say that objective assessments on their part at the critical time he arrived might have shown that to be a reasonable possibility.

Section 35(4) of the *OHS Act* requires employers, once faced with a safety-related refusal, to "(c) prepare a written record of the worker's notification, the investigation and action taken, and (d) give the worker who gave the notification a copy of the record." The nurses point out that these written requirements were not met until some four months after the event, suggesting that they did not have to re-assess the danger situation because, having refused, they were entitled to await the paperwork. The hospital says it was working very hard to get the nurses back under their direction after the refusal and fan-out, as well as ensuring care was being administered to all patients. They were operating a regional hospital. Management said it could not provide the written response to the refusal notification at that time, but was attempting to update the nurses on an ongoing basis of the enhanced security precautions being taken.

Once their section 35 refusal occurred, the nurses take the position that they could await the written process in section 35(4)(c), subject to temporary re-assignment to modified duties. In other words, they did not need to check on what hospital management was doing about their safety concerns. They say they did not need to continue to re-assess the danger, even though they were physically working nearby. In support, they rely upon *Ferrusi v. Canada* [2007 PSLRB 1], at paragraph 54, for the proposition that workers, once having refused, do not have to return to work during the ensuing negotiations:

> 54. It seems clear that the procedure governing work refusals set out in the *(Canada Labour) Code* is intended to provide protection for an employee whose assessment of his or her working circumstances is that they pose a risk of injury or illness. That employee is entitled to refuse to work – and is protected from the disciplinary consequences that would ordinarily attend such a withdrawal of services – *until there is an opportunity for the alleged threat to health and safety to be investigated. In some cases, the employer may agree that the risk described by the employee is present and may make a commitment to ameliorate the risk. In other cases, the employer and the employee may disagree concerning the existence of a risk, and an external party – a health and safety officer employed by HRSDC – may be asked to conduct an assessment of the risk.* During all of this investigation process, the employee is entitled to refrain from returning to work. *[my emphasis]*

The conclusions of this labour arbitration decision pursuant to federal legislation do not bind this Council but, even if they did, the case at bar is different from *Ferrusi*. That case involved four distinct refusals between August and November "on a broader set of concerns about workplace safety that had been the subject of discussion . . . over a number of years" (para 3), relating to additional safety equipment and protocols. This case is about one isolated individual during one hospital admission about which the employer had no legal choice in the matter about whether to accommodate. It was a safety risk that was focused on a few hours. The employer frantically struggled to mediate the concerns of the nurses along with the immediate health care needs of the patient and all other interests in the hospital, including other staff members. Hospital management did agree with the safety risk and committed to reducing it but the nurses had already decided that they were not receptive to discussing those measures. They had decided if TG was coming back to the unit they were not going to care for him.

We must interpret the legislation in light of what is reasonable and practical in the circumstances. The safety issue that presented at the Queen Elizabeth II hospital on 5 South on January 17 and 18, 2011 was very different than the long term negotiations to equip border guards with firearms. If the nurses refuse to communicate and respond to the employer working to address their safety concerns in such exigent circumstances, they cannot be basing their refusal on reasonable and probable grounds.

The Appellant asserted that extra security guards only were brought in after the nurses refused to care for TG. That, and other long term improvements to security, may be true as a result of the nurses' stand in this case. The refusal decision was still premature. The relevant point in time to determine the reasonableness of the belief of imminent danger was when TG arrived. The guards, and their capability, were already in place at that time. Often workers express their concerns about safety without an accompanying formal refusal to work under the legislation. In any event, those concerns expressed by workers in conjunction with a refusal are entitled to be incorporated by the employer into the workplace without them constituting proof of reasonableness of the refusal.

It appeared from the evidence at the appeal hearing that the mere thought of TG returning to 5 South caused panic among these nurses. That panic, along with "groupthink" polarized and governed the nurses' pre-emptive refusal. The nurses very quickly made up their minds that it was an unsafe work environment, largely on the basis of hearing of a previous incident with this patient. They decided at the outset of the event that if TG was returned, they would refuse to care for him. This compromised individual objectivity, so essential in that moment, to assess the whole system of security that was or would be available to contain TG at his worst. The spirit of the legislation is to oblige the worker at that moment to seriously, objectively and in good faith engage with the employer about the safety concerns. There was ample time and opportunity to do this.

Conclusion

This Council was asked to conduct "a review of the matter" (section 37(3)). The OHS officer's investigation of the disciplinary action complaint was thorough. He spoke to all the main individuals involved in this incident and his Decision is reasonable and consistent with the evidence he obtained.

Imminent danger did not exist at the material time of this refusal because this was not an abnormal danger for this psychiatric unit of this designated mental health care facility. Further, if it was an imminent danger it was not a belief that was held on reasonable and probable grounds because when the nurses refused to work (ie. to care for TG), they did not reasonably and objectively inform themselves of the full extent of the risk at that moment and the measures the employer was implementing to address this safety risk.

Accordingly the nurses did not act in compliance with section 35(1) and (2) of the *Occupational Health and Safety Act* and are not entitled to a remedy under sections 36 and 37.

I would dismiss this appeal.

Peter Bowal