Termination

FINDINGS AND DECISION

IN A DISPUTE
between

EASTERN HEALTH
("the Employer")

and

NEWFOUNDLAND ASSOCIATION OF PUBLIC & PRIVATE EMPLOYEES
("the Union")

Grievor: Mr. George Parsons, LPN

APPEARANCES:
For the Employer:
Presenter: Ms. Donna Strong LLB, Senior Solicitor, HR Consulting Services
Advisor: Ms. Marsha Hiscock, HR Manager, Rural Avalon
Witnesses: Ms. Linda Somerton, RN, Resident Care Manager
Ms. Andrea Whyte, HR Consultant, Rural Avalon
Ms. Lisa Barrett, Recreational Therapy Student
Ms. Patricia Newell, LPN
For the Union:
Presenter: Mr. Gerry Earle, ERO, NAPE
Co-Presenter: Ms. Rowena Best, ERO, NAPE
Advisor: Ms. Sharmaine Pinsent, LPN
Witness: Mr. Melvin Dawe, PCA
Ms. Sharmaine Pinsent, LPN
Ms. Rose Abbott, PCA
Ms. Gayle Boone, PCA
Ms. Alice Murphy, LPN
Ms. Alva Guy-Noonan, LPN
Mr. George Parsons, LPN (Grievor)
Arbitrator: Dr. John Scott

The grievance was heard at St. John's & Bay Roberts, on March 4, 5, 6, 7 & 8, 2008

The Statement of January 9, 2007 Grievance reads: "Violation of the Hospital Support Collective Agreement Article 13, and all other pertinent articles. "Unjust dismissal!"

Requested adjustment reads: "Full redress."

THE PARTIES AGREED THAT:

– the Arbitrator was properly appointed and had authority to hear the case;
– in the event of conflict, the Arbitrator's notes of the evidence and argument as recorded in the final award will prevail;
– parties likely to be affected by the outcome of the hearing have received notice and been informed of their right to appear and/or be represented;
– all matters pertaining to the grievance procedure and all time limits, whether statutory or arising from the collective agreement, were either properly observed or are waived;
– there are no other points to be raised as to arbitrability or other preliminary objections;
– all witnesses were excluded until all their testimony had been heard;
– issues of quantum, if any, would be considered separately and if the parties do not reach agreement within thirty (30) calendar days after publication of the award they will be referred to the Arbitrator for resolution;
– the Arbitrator will remain seised of the matter for period of thirty (30) calendar days after publication of the award should issues of its interpretation arise.

ITEMS TAKEN INTO EVIDENCE:

Consent	#1	The Hospital Support Staff Collective Agreement, expiring March 31, 2008
"	#2	2004 Council for Licenced Practical Nurses Scope of Practice with Code of Ethics
"	#3	Grievance: January 9, 2007
"	#4	Resident Abuse Incident Report, December 19, 2006 (Ms. Lisa Barrett)
"	#5	Resident & Visitor Incident Report December 20, 2006 (Ms. Patricia Newell)
"	#6	Grievor's response to accusations January 3, 2007
"	#7	Parties' agreement to extent time limits
"	#8	Employer Policy Statements
"	#9	College of Licenced Practical Nurses Position Statement, March 2007
"	#10	Council for Licenced Practical Nurses Position Statement on Abuse
LS	#1	Cooperative Performance Evaluation, October 20, 2003
PN	#1	Handwritten report by Patricia Newell LPN, December 20, 2006
LB	#1	Typed Notes of Interview with Lisa Barrett, December 19, 2006
AW	#1	Typed Notes of Andrea Whyte
SP	#1	Calendar for December 2006 with handwritten entries
"	#2	Ms. Sharmaine Pincent's notes of December 20th 2006 meeting
"	#3	Ms. Sharmaine Pincent's notes of December 29th 2006 interviews
GP	#1	Grievor's October 26, 1990 Cooperative Annual Review of Employees
"	#2	Grievor's February 26, 1993 Cooperative Annual Review of Employees
"	#3	Grievor's February 19, 1996 Cooperative Annual Review of Employees
"	#4	Letter: Maxine Percy to Grievor, April 29, 1997
"	#5	Letter: Maxine Percy to Grievor, June 9, 1998
"	#6	Grievor's August 6, 1999 Cooperative Annual Review of Employees
"	#7	Policy & Procedure 111-07d, page 1
"	#8	Policy & Procedure 111-07d, page 3
"	#9	Letter of Termination, January 8, 2007
GP	#10	Notice of Discharge of Bankruptcy, 11 September 2007

ARTICLES FROM THE COLLECTIVE AGREEMENT CONSIDERED

Article 1 - Preamble

1.01 When interpreting this collective agreement, the parties agree that the respective transition Agreement between the Union and the regional Employers attached in Schedule L must be read in conjunction with the collective agreement.

1.02 It is the purpose of the parties of this agreement:

(a) To maintain and improve harmonious relations and to settle conditions of employment among the Employer, employees, and the Union.

(b) To recognize the mutual value of joint discussion and negotiations.

(c) To encourage efficiency in operation to the end that the patients, residents, or other persons using the services of the Employer shall be well and efficiently served. And whereas the parties to this Agreement desire to improve the quality of care provided by the Employer and to promote the morale, well being, and security of the employees.

Now, therefore, the parties agree as follows:

Article 3 - Recognition

3.08 Agreement Overrules Hospital Policy

The provisions of this Collective Agreement shall take precedence over any and all policies, rules, and regulations made by the Employer concerning wages, benefits, or working conditions affecting members of the Union covered by this Collective Agreement.

Article 12 - Arbitration

12.04 Decision of the Board

The decision of the majority shall be the decision of the Board. Where there is no majority decision, the decision of the chairperson shall be the decision of the Board. The decision of the Board of Arbitration shall be final, binding, and enforceable on all parties, and may not be changed. The Board of Arbitration shall not have the power to change this agreement or to alter, modify or amend any of its provisions. However, the Board shall have the power to dispose of a grievance by any arrangement which it deems just and equitable.

Article 13 - Probation Discharge, Suspension and Discipline

*13.01 Probationary Period

*(a) The probationary period, for all employees, shall be an accumulation of 487.5 working hours from the date of employment. For the purpose of this clause, time off with pay, approved by the Employer shall be considered as time worked.

(b) Suspension or Discharge

An employee who has completed his/her probationary period may be suspended or discharged but only for just cause. The Employer shall notify an employee in writing of his/her discharge or suspension within seven (7) calendar days of the Employer being made aware of the event giving rise to such discharge or suspension. If such procedure is not followed, then such action shall be deemed null and void.

(c) Termination of Probationary Employee
The termination of probationary employees for reasons of unsuitability or incompetence, as assessed by the Employer, is not subject to the grievance or arbitration procedure.

13.03 Unjust Suspension or Discharge
Should it be found upon investigation that an employee has been unjustly suspended or discharged, the employee shall be immediately reinstated in his/her former position, without loss of seniority and shall be compensated for all time lost in an amount equal to his/her normal earnings during the pay period next preceding such discharge or suspension, or by any other arrangement as to compensation which is just and equitable in the opinion of the parties or in the opinion of a Board of Arbitration if the matter is referred to such a Board.

*13.05 Adverse Report
The Employer shall notify an employee in writing of any dissatisfaction concerning his/her work within ten (10) calendar days of the event of a complaint. This notification shall include particulars of work performance which led to such dissatisfaction. If this procedure is not followed, such expression of dissatisfaction shall not become a part of his/her record for use against him/her at any time.

The report of an employee shall not be used against him/her after eighteen (18) months have elapsed, providing another warning or reprimand relating to the same or similar offence has not been given within that period. The employee's written reply to such notification of dissatisfaction shall become part of his/her record.

This article shall apply in respect of any expression of dissatisfaction relating to his/her work or otherwise which may be detrimental to an employee's advancement or standing with the Employer. All correspondence pertaining to the adverse report, including the report itself, shall be disregarded and subsequently removed from the personal file after eighteen (18) months. The employee shall be responsible to see that any such documents are removed.

*13.06 Personal Files
*(a) There shall be one (1) official recognized personal file, which shall be maintained by the Employer. An employee shall, after making an appointment, be allowed to inspect his/her personal file and may be accompanied by a representative of the Union if he/she so desires. Where an employee's file is maintained at another facility, the employee shall have the right to request to have his/her file delivered to his/her facility within five (5) working days.
(b) A copy of any document placed on an employee's official personal file which might at any time be the basis of disciplinary action, shall be supplied concurrently to the employee who shall acknowledge having received same document by signing the file copy.

13.08 Performance Evaluations
An employee who feels that he/she has not been given a proper evaluation shall have the right to grieve in accordance with article 11. Performance evaluations shall not be considered an adverse report.

Article 22 - Sick Leave

22.01 Sick Leave Defined

Sick leave means a period of time that an employee has been permitted to be absent from work without loss of pay by virtue of being sick, disabled, quarantined or because of an accident for which compensation is not payable under the Workplace Health, Safety and Compensation Act.

*22.02 Annual Paid Sick Leave

*(a) (i) An employee is eligible to accumulate sick leave with full pay at the rate of two (2) days for each month of service.

*(ii) Notwithstanding Clause 22.02 (a)(i), an employee hired after May 4, 2004 is eligible to accumulate sick leave with full pay at the rate of one (1) day for each month of service.

(iii) The maximum number of days of sick leave which may be awarded to an employee during any consecutive twenty (20) year period of service shall not exceed four hundred and eighty (480) days.

*(iv) Notwithstanding Clause 22.02 (a)(iii), the maximum number of days of sick leave which may be awarded to an employee hired after May 4, 2004 during any consecutive twenty (20) year period of service shall not exceed two hundred and forty(240) days.

MOA - January 12, 2000

1. Schedule "C" of the Collective Agreement shall be amended to include the Pentecostal Senior Citizens' Home as an employer.

2. It is understood and agreed between the parties that employees of the Pentecostal Senior Citizens' Home will be entitled to all the rights and benefits of the Collective Agreement with the following exceptions:...

OPENING STATEMENTS

FOR THE EMPLOYER, Ms. Strong introduced the matter as arising from the January 8, 2007 termination of Mr. George Parsons, a Licensed Practical Nurse (LPN) employed at the Pentecostal Senior Citizens' Home in Clarke's Beach, following allegations of physical and verbal abuse of a resident of the Home.

The Employer undertook to prove both the Grievor's misconduct, on the balance of probabilities, and also to show that the discipline imposed was appropriate. The Employer is a health care facility, and the residents there are very vulnerable, many of them old and mentally compromised. The very highest standards must be maintained in order to ensure that public trust is upheld, as would become clear from the testimony of the first Employer witness.

THE FIRST EMPLOYER WITNESS was Ms. Linda Somerton, Resident Care Manager at the Pentecostal Senior Citizens' Home since July 2001. Ms. Somerton described her extensive work history of 35 years as a practising nurse, 27 or 28 of them in long term care of the elderly. She has had extensive experience staff development work, quality initiatives, home care, and has taught at Memorial University. She was a Nursing Supervisor at St. Pat's Nursing Home from 1978 to 1981, and with the Agnes Pratt Home from 1988 to 1999 and was responsible for staff development at various of these locations, including development of educational models and of programs for nurses and others dealing with challenges in the care of the elderly.

Ms. Somerton testified concerning problems relating to care delivery and strategies for dealing with these issues through education and policy development. Since coming to the Pentecostal Senior Citizens' Home, Ms. Somerton has been responsible for the care of residents, including assessment for admission, care needs and opportunities for the family, residents and staff, including performance appraisals of employees.

All nursing staff, including LPNs, report to Ms. Somerton. Ms. Somerton reports to Ms. Beverly Bellefleur, the Facility Manager. Ms. Bellefleur has been away from the Home since early December of 2007 on sick leave. Ms. Somerton is currently Acting Facility Manager.

Ms. Somerton described the Pentecostal Senior Citizens' Home as having 75 beds with levels 1, 2 and 3 residents distributed over

> ... two different units, the South Wing and the North Wing. The South Wing has 35 lighter care residents, including levels 1 and 2 with some level 3 residents. The North Wing provides 40 residents with care that is generally higher, more demanding, generally at level 3. The two units are very different. Different models of care are required because of different levels involved. Generally speaking, the more medically compromised residents are accommodated on the North Wing. They are not normally competent to manage the normal activities of daily living. Those accommodated on the South Wing are generally more likely to be up and around, and have a greater say in their own care. Therefore a more social model of care is required.

Ms. Somerton described the staffing levels in accordance with Provincial standards, as including Registered Nurses (RNs), Licenced Practical Nurses, and Personal Care Attendants (PCAs). There are a total of 8.4 RN, 16.5 LPN, and 6 PCA full time equivalent employees at the Home. There are also casual employees as required. She also described the distribution of these

staff over the twenty-four hour coverage at the Home, and testified that the LPNs have been expanding the scope of their practice and increasing the range of activity within their approved Scope of Practice.

Ms. Somerton described the distribution of shifts in the Home on the South and North wings. In the spring of 2001 a review of staffing levels was conducted which disclosed that the Home had five LPN/PCA positions more than was required under the Provincial standard. As a result a couple of positions were changed to casual, and the appropriate level of staffing was established by attrition. There has been no under-staffing problems at the Home.

Ms. Somerton then described the reporting procedures.

> Initially LPNs and PCA report first to the RN on duty, who would report to Ms. Somerton. She , in turn, would report to Ms. Bellefleur... The Home expects its LPNs to provide the residents with an optimal quality of care in accordance with all standards, particularly with the professional standards set by the College of LPNs.

She indicated she is familiar with the code of ethics governing the practice of LPNs. Consent #10 is a position statement by the College on abuse, which specifies zero tolerance in this matter. Ms. Somerton pointed to the definition of abuse contained in that document at page 3, as it refers to older and dependent adults.

Ms. Somerton also testified she had contact with members of the College while working at the Agnes Pratt Home, and had provided an educational program for a member subject to disciplinary action for resident abuse. She had been asked to provide the educational program on that occasion by the Council. Ms. Somerton also sat on various professional committees dealing with this issue, and had been involved in providing Province-wide educational services.

She testified that the (Consent #10) position statement is mailed individually to members of the Council, which includes the LPNs. Consent #10 had been distributed by Mr. Paul Fisher, the Chief Executive Officer of the College of LPNs, "approximately ten to twelve years ago", and had been renewed in the interim. Consent #2 also contains two appendices, Appendix A and Appendix C, which deal particularly with issues of unacceptable behaviour. Further, the Code of Ethics is also included as a wallet size folder for the convenience of LPNs in Consent #2, which is sent out annually to LPNs at the time of their renewal of licence on April 1 of each year.

Ms. Somerton noted that the model of care in place in the Home since her arrival is "resident-centred" rather than a "biomedical- or illness-centred" approach.

> The resident-centred approach pays particular attention to the needs of residents and their families, and focuses on quality of care. The resident is at the centre of attention, not the physical or medical conditions.

Ms. Somerton also described her own approach to management of issues and described her role as "not particularly formal." She tries to be accessible in all her dealings with residents and staff. She acknowledged that the staff are busy, and she is "cooperative and collaborative" in supporting their work.

Ms. Somerton confirmed that the LPN Code of Ethics is in keeping with the policies of the Home as set out in Consent #8, which she reviewed in some detail, in particular the policies concerning language, disciplinary action and normal procedures for investigating such matters. Ms. Somerton said that any reports would initially come to herself, or sometimes...

> to an RN on duty. I am usually the one who initiates the procedure in consultation with the Facility Manager. My job is to be sure it stops immediately.

Ms. Somerton said that decisions on discipline are handled by a team that includes Ms. Somerton, herself, the Facility Manager and other expertise within Eastern Health. Prior to unionization and to Eastern Health's involvement, decisions were made by Ms. Somerton, herself, and members of the Board together after consultation with HR resources of the Department of Health.

Ms. Somerton also testified that education is provided in these matters as set out on page 14 of the Consent #8 documents. It is conducted in both formal and informal settings, and through ward conferences which she attends on a regular basis where staff members' difficulties and challenges are raised. Ward conferences are held daily at two o'clock, and Ms. Somerton attends on Mondays on each wing on alternate weeks. "This lets me keep in touch with day-to-day issues and resident care, both generally and specifically." Ms. Somerton has used ward conferences to deliver information, particularly in respect of aggressive behaviour and in the management of aggressive residents. Ms. Somerton also indicated that if she encounters an article that is of interest she will normally post it for discussion. "It's very informal, not a 'sit down and deliver a message' affair. It is more informal."

Ms. Somerton also testified that the philosophy of the Home, as set out on the final page of Consent #8, is respected in administration and management of the Home. These policies are regularly communicated to members of the staff. Staff are notified when revisions are made and are required to review the manual and regularly alerted to anything new in the manual. She also confirmed that some residents are more difficult that others.

> Oh yes, depending on their diagnosis and cognitive abilities. A lot of circumstances make some residents more of a challenge.

Asked if there is any education provided for particularly difficult residents, she said:

> Number one is that, in providing care for any residents especially those who do not understand or are unable to cooperate, you must have adequate help. There are one or two extra staff members, and when the particular care can wait until one or other of the staff are available – whether that means fifteen minutes or two hours – it is important to ensure that adequate resources are used in the provision of the care. The big issue is to make sure that there are appropriate resources. It is protocol that, if you cannot accomplish the care, you first report it to the RN on the unit on the day. There are three different groups on the North wing, and staff are always assigned in pairs. Since my time there, assignment has always been in pairs. This is to ensure proper care both of the resident and of staff members so there are no accidents or injuries. It's the best care all round. For the most part it works, and the care can be accommodated. I know that at 3:20 when they go to five it is a struggle. I know I still go into rooms and say, 'I hope that you're not doing that by yourself', and I am assured that they are not.

Ms. Somerton also confirmed that it is normal in the job of a LPN to know how to manage patients with some level of dementia.

> It is the job expectation, yes: to deal with those who are both cognitively and physically limited.

Asked whether during her period as Resident Care Manager she has ever permitted an atmosphere of physical or verbal abuse to prevail, Ms. Somerton answered: "No certainly not."

Ms. Somerton said she could not first recall when she first met the Grievor.

> I knew that he did a lot of nights, but I think that it was in a ward conference very shortly after I first went there that I first met the Grievor. That's my recollection.

Asked if she had any comment on the Grievor's work habits and demeanor she said:

> I am not on the ward, but from ward conferences and from the RNs I get the impression he was an excellent worker both in quality and quantity. I saw no reports that suggested otherwise. He is very meticulous in his work. He has been

> there a long time, and he was looking forward to retiring. He had – and was aware of – some health issues.

Ms. Somerton explained that by "meticulous" she was referring to

> his attention to detail so that things were exactly as they should be with the residents linen in position so that the next person could do his or her job properly. He was meticulous as to detail and to routine.

Asked how she had first learned of an allegation of abuse against the Grievor on December 18, 2006, Ms. Somerton said:

> I came in and did what I always do once the office is open. I went to the units' reports and to check with the nurse as to what had gone on overnight. The nurse on the North unit, Melanie Fillier, asked to speak to me. She said that earlier that morning Lisa Barrett, a student, had spoken to her about George and a resident, and his treatment of that resident... I immediately called the student, Lisa Barrett, to my office and she recalled to me an incident that had taken place on the 14th of December, the previous Thursday... We had a conversation on the morning of the 18th. The student had been paired with a care group of George Parsons and Ms. Alva Guy-Noonan. That was normal for any student to be paired. Alva went ahead with another resident, and George and Lisa went into resident Mr. A's room to provide care. Lisa said that immediately as they entered George said: "Look at that ff..er there." George went to the dresser to get some clothing, and Lisa went to the bed. Lisa said that George's attitude was "huffy and puffy that morning" as to his demeanor, and that George got a pan and proceeded to wash the resident's face roughly, and that the resident put his two arms up to his face and his fists were clenched. George then grabbed his arms and forced them down to his side and she heard a grinding of his bones and the resident moaned as if in pain. After that the Grievor, with a clenched fist, hit the resident just below the rib cage and yanked the teeth out of his mouth. They proceeded with the care and the Grievor said to the resident: "You're an old dog. I wish you would die. You're only breathing my air. I've got a ff..ing mind to roll you right out on to the floor, and I've got a mind to kill you." At that George pulled him so forcefully to the side that Lisa had to try to catch him from rolling off, and she strained her back....

When asked for clarification, whether the terms "ff..er" and "ff..ing" were used or the actual "f" words, Ms. Somerton said that the actual words were used.

Asked whether Ms. Barrett had to told her anything else, Ms. Somerton said:

> She was concerned. She did not like to see residents treated like this. There were tears in her eyes and she had to catch her breath a couple of times while she was talking to me. She explained that she knew the resident and her family knew the resident prior to his admission to the home, and she felt that he recognized her and was asking her why she was letting this happen.

Asked to describe the resident's condition, Ms. Somerton said:

He's a level 3, requiring full care. His condition is specifically physical: primary diagnosis is Parkinson's disease with increasing rigidity as it progresses. One day he might not be a big challenge, but shortly thereafter it could be reversed, and there is some dementia characterised by hallucinations. His condition has deteriorated since December of 2006... (In December 2006) he was a very challenging resident to care for at the time.

Asked whether the resident spoke, Ms. Somerton said:

Not so as to be able to converse with him. You would not be certain he understood what care was to be given or why.

Asked whether the resident had a hearing problem, she said:

Not that I know of. There is nothing specified...

Asked what decision she had made, she said:

I concluded that the resident could be put in a dangerous situation, and George did not return to work until after the investigation was completed; and I then informed my immediate supervisor, Beverly Bellefleur, and got on with other aspects of the investigation... The next morning – the 19th – Lisa Barrett was interviewed again ... Lisa completed a statement to be sure of the details of the incident. Then we got the help of Eastern Health HR. Lisa completed the abuse form, Consent #4 which outlined the incident as it was reported to me... I filled out the form. Lisa read it and completed it. She saw it and read it. I asked, 'Is it accurate?' She said, 'Yes', and signed it... There was another meeting attended by the confidential secretary who typed up what was said and showed to Lisa and she read through it (LB #1) and signed it as accurate...

I notified George of the general nature of the issue. I think he was scheduled to come in the night of the 18th or 19th. We said for him not to come back. It would be paid leave pending an investigation of the allegation. The investigation took place between Christmas and New Year... There was a meeting with George. Beverly Bellefleur and Rowena and I were there, and either Andrea Whyte or Ms. Hiscock, for Eastern Health, were there. George was questioned concern-ing the incident and the witness's account... To the best of my recollection just about everything was denied. My basic recollection was that the incident was denied. Then there were repeat interviews with various individuals and with co-workers over the following couple of weeks.

Asked whether this was the only incident brought to her attention, Ms. Somerton said:

No. On the 20th, late in the morning, an LPN met me outside and said, 'I've got to talk to you right away.' We went into my office and closed the door. She recounted an incident from the 8th of December – This was on the 20th – and it happened during the PM change-out period. The Grievor was giving care to the same resi-

> dent, and it was in the washroom. At the time the resident could still sometimes stand while he was being cleaned and changed if needed. Ms. Patricia Newell was the LPN. She said that his leg got weaker and she said to George that he's going to fall and George called him 'You old bastard', and grabbed him by the back of his shirt or belt and pulled him very roughly back down into the gerichair. She said to me at the time that she would never work again paired with George... She was a recent graduate, and she said if this is the way George could care for people she was not going to work with him anymore. I asked her to document it and she documented on the form and signed it. It's Consent #5.

Asked whether there was anything else in writing Ms. Somerton said, there was a handwritten account (later introduced as PN #1). Ms. Somerton said there was no description of the resident's actions on this occasion.

> The only account was Lisa's account that he raised his hands in a fist towards his own face and said that he appeared about to fall.

Asked whether had wondered about the employees' truthfulness at the time of these reports, Ms. Somerton said, No. She went on to explain that the resident's family members were not informed until the investigation was completed and the decision made. Asked to describe their response, Ms. Somerton said:

> We spoke to the resident's daughter, our primary contact. She came in and we explained the allegation and the investigation. She did not want her mother notified... She is familiar with the health care system. She requested that if George were to come back to the home she be notified before he did so, and made reference to the fact that the family may want to take action independently... The daughter is an RN with Eastern Health and a member of the Nurses' Union.

Ms. Somerton confirmed that Ms. Newell's report was included in the overall investigation:"Two separate incidents, but within the process." Asked when the Grievor was made aware of both incidents, Ms. Somerton said, "I have to say to that, I can't honestly recall."

Asked whether the resident has any special rules that apply to his care, she said: "There is a cognitive impairment. Staff are good with knowing what works with each resident." Asked whether there are occasions when physical force is required, Ms. Somerton answered:

> ... to protect the safety of everyone present. You can prevent violence, and you can grab someone to restrain him.

Asked whether there are any circumstances in which it is appropriate to use force for the safety of the resident, and if care must be given at specific times, Ms. Somerton said:

> ... Doing a daily care washing is not an emergency. That is routine. If a resident had broken skin, it is very, very important to cleanse the area. There would be perhaps three or four extra changes, but you get the resources to do that without resorting to violence.

Asked whether there had been any complaints from his family about the resident's care, Ms. Somerton said:

> The resident does respond when they come in, just about every day. We've had adjustments concerning his time up and time down to accommodate her visits and we've had to use adaptive clothing. There were some issues, but by and large the family is pleased and appreciative of his care.

Ms. Somerton confirmed that she had seen Consent #6, the Grievor's response to the allegations. "I don't think that it was given to me, but I have read through it after it was submitted, probably during the end of the process of investigation, shortly into the New Year."

Asked about the way Consent #6 asserts that caring for Mr. A is always the same, Ms. Somerton said:

> No. Some days... Usually he is not easy to care for, but I have seen him more of a challenge; some days are worse than others. You certainly could leave him. That's the pattern of his care. So I would not agree with that statement.

Referring to the Grievor's reputation as a tidy person, Ms. Somerton said:

> Things had to be right or he'd "mouth off". In the ward conferences I'd heard references to that, and in one performance appraisal it is brought up. I believe sometimes he is very verbal to other staff if it is not as it should be.

Asked to describe the Grievor's response to the allegations and whether he had apologised at any point. Ms. Somerton answered: "Not to my knowledge. It was denial."

Ms. Somerton confirmed that in early January 2007 the decision was taken that the Grievor be terminated. Asked who had participated in the decision making, and why the decision to terminate rather than to suspend had been taken, Ms. Somerton answered:

> Myself, Beverly Bellefleur, Miss Hiscock, Miss Andrea Whyte; that's to my knowledge. There is zero tolerance for any type of abuse in the Home and in Eastern Health... If I remember correctly it was the nature of the incidents and that there was physical and psychological abuse as well.

Asked whether any consideration had been given to education, and whether that would have been successful, in her view Ms. Somerton said:

> I knew George had had specific training in dementia. It was a different incident relating to patients with dementia ... The information was provided and sections underlined that he should consider. I asked him how he was doing with it, and told him we would need the document back. He brought it back and he told me that he had no questions, and there was nothing he failed to understand... It dealt with types of dementia. It was information on how to deal with bathing and dressing and daily activities and in communication techniques: not necessarily verbal, but including approach and tone of voice and facial expression, and also in diversion and flexibility in delaying tasks, *etc*. It also had to do with caregiver challenges that have to do with cognitive impairment. I questioned him about it, and he said there was nothing that was unclear. That was in the summer of 2005, I think.

Asked how much of this information might have applied to the resident in this case, Ms. Somerton said:

> I think the majority of it. I did not just give texts. I earmarked specific chapters for him ... and specific articles as well. (Nonverbal communication) is very difficult with dementia patients: to grasp what they can understand or interpret. You have to use indirect resources. Tones of voice and demeanor become very, very important.

Asked whether, in her view, the incidents constituted violation of the Home's policy of the LPN Code of Ethics and why these policies are important, Ms. Somerton answered:

> Yes. It did not support safety and the optimal care of the resident. It raised concerns for the physical and psychological safety of the residents that are being cared for. When family members come to the Home, that trust has to be met.

Asked whether, at the end of the investigation, she had been satisfied that the Grievor could uphold that trust, both to the organization and to the families, Ms. Somerton said: "No. No." Asked what the staff reaction to the Grievor's termination had been, Ms. Somerton said:

> They were very upset I think. I can't say that it was everybody. It was such an upset because it was not expected. Something other than termination was expected, someone they worked with so long.

Asked about the impact on Ms. Newell and Ms. Barrett, Ms. Somerton said:

> Lisa Barrett is a student. Starting in the New Year she finished her hours and she was fearful of going back to finish her hours. The PCA in question took her under her wing from the fallout. Patricia Newell had difficulty over on the North Wing. She's casual, with people asking, are you going to report me? So wherever possible she did her shifts on the South Wing, for a month or two months. Now she works normally. Personally, she does not internalize that pressure anymore.

ON CROSS EXAMINATION, Ms. Somerton said that there had been no other complaints from other staff in respect of these incidents. "No. Nothing documented, just what she told me."

Asked whether she had kept notes concerning the investigation of the December 8th and December 14th incidents, Ms. Somerton said, "Only what's in evidence." Asked whether there was any investigation report, she said:

> It was documented. I was referring to the written documents from the people who witnessed the incidents: in particular, the notes from the morning of the 19th that Ms. Barrett had signed.

Ms. Somerton said she had no personal notes in addition to these. She confirmed she had spoken with the Grievor on the phone, and had met with the Union and the Grievor together with Ms. Whyte, but had not met by herself with the Grievor.

Asked whether she recalls a meeting between herself and the Grievor on December 20th, Ms. Somerton said:

> No I don't recall that meeting. I was part of the process. I was not firing him. I did not fire anyone and I did not make the decision. I was just part of the process.

Asked when she had last worked front line in health care, Ms. Somerton answered:

> Between 1998 and 1999 and also during the last general strike, a couple of years ago, and during strikes in between.

Asked whether she had been party to the entire process of investigation from beginning to end, and how fully she is aware of the December 8th allegation, Ms. Somerton answered:

> Yes, if not at every meeting I feel I was aware of it... Other than the account given to me by the LPN there were no other witnesses and none to provide information.

It was pointed out to Ms. Somerton that, according to a report attributed to Ms. Newell (the LPN who reported the alleged Dec 8 incident), others would have had to hear what went on in the room. Asked whether she had made any inquiries of others about what they might have heard, Ms. Somerton answered, "Not specifically, no." Asked what transpired at the meeting with Ms. Newell on December 21st, Ms. Somerton said:

> That was with myself, Ms. Beverly Bellefleur, and Ms. Neville. My recollection is that it would have been on December 20th.

Asked if that was the complete investigation she had conducted into the December 8th allegation, Ms. Somerton answered, "Yes."

Asked how often she had observed care given to Mr. A, Ms. Somerton said: "Over the past couple of years, perhaps six or eight times. I had been in periodically on various occasions."

Asked whether she had seen the Grievor's response (Consent #6), Ms. Somerton said:

> I've seen it, but I was not the person to whom it was delivered. I saw it during the process of the investigation. I can't remember for sure to the date.. I said earlier that both incidents were considered. There's no denying there were two separate incidents and the nature of the investigation had to do with the same type of act.

Asked whether she had concern about the fact that nothing about the December 8th or the December 14th incidents was investigated prior to December 20th, Ms. Somerton said, "No." Asked whether she had expressed concern about delay to Ms. Newell, the LPN who made the allegation about Dec 8th twelve days after its alleged occurrence, Ms. Somerton said:

> Yes we had a conversation. She was relatively new to our facility. She actually said, 'I don't know if it is acceptable here.' My sense was her reasoning justified her action.

Ms. Somerton acknowledged that the *Licenced Practical Nurses Scope of Practice* (Consent #2) specifies (pp. 31-32) that there is an obligation to report such incidents.

Referring to Ms. Barrett's report (concerning the December 14 allegation) that she had heard a noise accompanying the resident's arms being pressed down, Ms. Somerton was asked whether she had checked the resident for physical harm. She said, "I did go over and check on the 18th." Asked whether she had noted her check on the resident's chart, Ms. Somerton said, "We chart by exception." Asked whether she had also checked the resident's abdomen, Ms. Somerton answered, "Yes and there were no problems." Asked whether the incident had been reported to the doctor, Ms. Somerton answered, "No." Asked whether she had thought of calling a doctor on the 18th or 19th, Ms. Somerton said, "I saw no reason to call a doctor." Asked if she thinks there might have been some evidence, she said: "It depends on the primary conditions." Asked whether Ms. Lisa Barrett had provided any other information, she answered:

> Other than what she told me in the incident report. Since she was a student I had to give her direction.

Asked whether she had ever spoken with Lisa Barrett before this incident, she said, "They usually do come in a group. No I did not know her." Asked whether Ms. Barrett had spent some time feeding residents in the home, Ms. Somerton answered: "Not that I know of. I knew her

mother was in, and she used to do that."

Asked again whether she recalls speaking to Ms. Lisa Barrett about her practice of care prior to December, 2006 Ms. Somerton answered: "No, I haven't spoken to her about anything." Asked if she recalls LPNs expressing concern about Lisa Barrett, Ms. Somerton answered, "No." Ms. Somerton was asked if she had ever received complaints about Ms. Barrett interfering in nursing care prior to her being a student at the Home in December 2006. She thought for a moment and answered:

> The only person I was aware of was Lisa's mother. There were some concerns expressed to me concerning Lisa's mother, not about Lisa.

Asked whether it is normal practice that she write up the report and the one making the complaint signs it, Ms. Somerton answered, "Yes it is." Asked whether she had written out the whole content of Consent #4, Ms. Somerton answered: "Yes, but she reported the incident to me." Asked why the document had been prepared on the 19th, the day after the report had first been made verbally, and five days after the date of the alleged incident, Ms. Somerton answered:

> There was follow up with the resident and the Grievor. I started it the next day in the morning, or even on the 18th, and it was signed on the 19th. I would not sign it and date it unless she had signed it.

Asked whether she would agree that Consent #4 constitutes a summary, Ms. Somerton answered, "Yes." Asked whether she had already checked the resident by the time "Description of physical condition of resident" (Consent #4, p. 2) had been written, Ms. Somerton answered: "Yes. Our policy clearly says to check the patient first."

Ms. Somerton was asked about the December 8 allegation made by Ms Patricia Newell, and confirmed that the chair had been in the bathroom. "... it may have been a wheelchair." Asked whether she had investigated the chair, Ms. Somerton answered:

> No. I knew with the residents' chairs, that there often are changes. I knew that from personal experience.

Asked whether, during the meeting with Beverly Bellefleur and herself and Ms. Newell, Ms. Newell had actually told her that the chair was in the bathroom on December 21st, Ms. Somerton answered, "To my recollection she referred to the washroom." Ms. Somerton confirmed that she had received Consent #5, (Ms. Newell's December 20, 2006 *Resident & Visitor Incident Report*).

> Once they're completed they are kept as part of the resident's chart. When it leaves my hands it goes to Resident Manager, but the distribution is back on the chart.

Ms. Somerton also confirmed that Ms. Newell provided a description (later entered as PN #1) that had not been prepared at the initial meeting, and that Ms Newell was a relatively new hire, having started work at the Pentecostal Senior Citizens' Home "within the year 2006."

Asked whether the Grievor had been given any opportunity to state his side of the story, aside from the preparation of Consent #6, Ms. Somerton answered: "There was a meeting. I was present with others, and that was his opportunity to respond."

Asked whether he had responded during the meeting, Ms. Somerton answered, "Yes." Asked what his response was, Ms. Somerton answered: "Denial... In this letter he basically denies. To me that's a denial."

Asked whether she had already spoken with Ms. Lisa Barrett by the time she called Ms. Whyte, Ms. Somerton answered: "I don't know if I called Andrea White on the 18th." Asked what she had told Ms. Whyte, Ms. Somerton answered: "I can't remember. I know I did call Andrea Whyte." Asked again whether she spoke to Lisa Barrett prior to calling Andrea Whyte, Ms. Somerton answered: "To the best of my knowledge, yes."

Asked whether Ms. Barrett had actually told Ms. Somerton that she thought she could almost see the resident asking, 'Why are you letting this happen?', Ms. Somerton answered: "She talked about that feeling. I know it's subjective, but its accurate."

Asked whether Ms. Barrett had told her that she went on coffee break with the Grievor, and if had stayed in the building for the rest of the day after the alleged incident, Ms. Somerton answered, "Yes she did. I had the impression it was the second coffee break." Asked whether she had explored where Ms. Alva Guy-Noonan was, Ms. Somerton answered, "She did not say she was in the room with George and Lisa."

Ms. Somerton confirmed that "Mr. Kippenhook" was also a resident in the room with Mr. A. Asked whether she had checked with who had given Mr. Kippenhook his morning care on the day in question, Ms. Somerton answered: "No. I saw no reason..."

Ms. Somerton testified she had immediately called Ms. Barrett to the office on December 18th, and that Ms. Bellefleur had been involved in the investigation: "Yes, very shortly after I had

informed her, she talked to Lisa." Asked whether she had discussed the allegation with Ms. Bellefleur prior to calling Ms. Whyte, Ms. Somerton answered:

> Yes I'd say so. My immediate contact would be with Beverly, so I would say that I did; but I can't say 100%.

Ms. Somerton confirmed the Grievor is meticulous in his work, and that his performance evaluations are very good. She identified as LS #1 as the Grievor's last performance evaluation. It was conducted in 2003. She confirmed she had rated him

> As I recorded here in October of 2003. The handwriting is mine... His immediate supervisor at that stage would have been RNs... That is accurate to my understanding of him... at the time..."

Asked whether the performance evaluations had been checked during the investigation, Ms. Somerton answered, "No."

Asked whether the policy against swearing and that staff should speak softly as set out in Consent #8 is still in effect, Ms. Somerton acknowledged that it is not always the case. "It occurs. I can tell you that. I can't be specific. If I'd heard it, I'd have taken action.

Asked whether the Employee Manual is still used after unionization took place in 2000, Ms. Somerton said: "From pages 201 to 209 there are some special stipulations concerning the Home." Asked whether procedures for termination are drawn from the Manual or the Collective Agreement, Ms. Somerton answered:

> I don't know... I was part of the investigation process but was not a party to the conversation concerning this incident, so I cannot say.

Asked what is the "written report" referenced in Consent #8 (at p. 6), Ms. Somerton said:

> I guess that is the process that was followed and the information that was gained. I do not have a report. I don't know if Beverly has... In relation to the December 8th incident, the investigation was the interview with the person who witnessed it. I had no one else to interview... In respect to the December 14th incident, it appears that seven or eight witnesses were interviewed.

Asked to explain the difference in investigative procedure, Ms. Somerton answered:

> I interviewed to clarify what was reported to me to protect the resident and anyone who needs protecting. All I can explain to you is my immediate concern. There was a lot interviewed, and I was present; but I personally did not conduct the interviews of all these people.

Asked whether it was Ms. Beverly Bellefleur who had taken the lead in this process, Ms. Somerton answered: "Yes. The ultimate decision was hers in consultation with any resources that were necessary."

Asked whether Mr. Parsons, the Grievor, had come back to work on December 18th, Ms. Somerton said:

> No, he did not come back into the building, as far as... No he did not come back into the building... My recollection was that I contacted George and gave him a general account of what was happening, and that he was off on pay.

When Mr. Earle responded: "That was on the 19th." Ms. Somerton answered: "Was it? Okay. Are you... You must be sure."

Asked whether she would refer to the resident, Mr. A as "docile," she answered: "With dementia and Parkinsons.. no he is a challenge, but he is docile with his family and wife."

Ms. Somerton was asked whether the Employer had observed its own procedures set out in Consent #8 in dealing with the December 8th and 14th allegations, both for the Grievor and for the student, Ms. Barrett. She was asked whether there was a written report. She said:

> There is the incident report. I don't know if there is a written report. I would not have it. I am not the Chief Administrative Officer.

Asked whether Ms. Bellefleur had been seen in the facility during the last couple of weeks, Ms. Somerton answered:

> She is back in a very, very limited ease-back situation. A couple of occasions during the last two weeks... not full working duties... just catching up on correspondence. I don't know what. I'd assume she is medically managed.

Asked whether it was her decision to terminate Mr. Parsons, and whether she actually had input into the termination, or played any part in preparing the actual termination letter she answered:

> I was asked my opinion in light of the evidence, and ... . No., I can't recall seeing (the termination letter) before it was sent to him, no."

ON REDIRECT EXAMINATION Ms. Somerton testified that, with respect to the December 8th incident, all she had done was speak to Ms. Newell. Asked whether she is aware whether others had held other interviews, Ms. Somerton answered, "No." Asked what resources from HR she had engaged, Ms. Somerton answered that she had contacted "Beverly first, and then Andrea Whyte."

THE SECOND EMPLOYER WITNESS was Ms. Patricia Newell, an LPN employed by Eastern Health who has worked part time with the Carbonear General Hospital and with the Pentecostal Senior Citizen's Home for almost two years. She had returned to school in 2004 after a period as a "stay at home mom." Her LPN program had lasted 16 months, and she graduated in December 2005. After graduation she began work in April of 2006 at the Pentecostal Senior Citizen's Home, where she continues to be employed today.

Ms. Newell described her general duties as a LPN, including morning care, feeds, medications and evening change outs, and general resident care.

> The evening change out is after supper. The afternoon change out is about 3:20 in the afternoon... The change out is a hygiene procedure, and the work is normally done either on my own or with some other nursing staff. Normally it is not done by myself but sometimes you are alone. You're supposed to be paired in twos, either with a LPN or a PCA.

Ms. Newell confirmed she knows the Grievor. She had not been paired with him... "a whole lot ... maybe ten or fifteen times; that's about it." Ms. Newell confirmed that she had cared for Mr. A. prior to December 8, 2006.

> Quite honestly, I don't know how often, but quite often: probably once or twice a week. It is different when you're a casual. I'm a casual, so I am called in when I'm needed.

Asked for a description of the level of care Mr. A requires, Ms. Newell answered:

> There are times when he is difficult. It depends on the day. Sometimes he's easy, sometimes he's not. He needs full toilet care. He cannot feed or toilet himself. Some days you can go in and do care and he's very compliant, and other days he's not so cooperative... You go over and try to do some care and you'll know. Sometimes he does not want you to touch him. He'll try and push you away. If he is agreeable he'll let you do the care that needs to be done... He may put up his hands or feet to push you away... (His facial expression) changes. You can tell he's upset; he grimaces and does not want to be touched. When you go to care for him he'll be smiling or he'll grimace... You go in and talk to him for a second. Sometimes he calms down when you talk to him. Sometimes he does not. Sometimes you talk him through what you are doing and sometimes not. Just basically tell him that what you're going to do will 'not take long, and you will be warm and bundled up shortly.'.. There's no special care required: no 'dos or don'ts' for him.

Asked whether there was anything in Mr. A's care that is outside the LPN's scope, Ms. Newell answered:

I don't think so. There are times he's upset and he's liable to take a swing but there are residents who will do that so you watch yourself.

Asked what occurred on December 8th generally, and what she had observed, she said:

It was a twelve hour day, I think, from 7:20 am to 7:20 pm... You go in, listen to report, and then there's breakfast trays: you feed the residents, and then AM care. Then it's cleaning and feeding, and then it's trays and you get a break. At 2 o'clock there is a conference with the nurse, issues of the day; and then breaks start at 2:30. Then, while one group goes on break, they're fed lunch and then change outs at 3:00 or 3:10. Some people go back to bed at that point. Then it's supper and feeds and trays and supper break; and then you change out whoever needs to be changed at 6:00 or 6:30 and then wait for the end of shift.

Asked what she would normally do when there is some difficulty with a resident, Ms. Newell answered:

A lot of them do not cooperate, and you simply have to change them; so you do the best with what you have.

Asked what she would do if someone on the morning change out were being resistant, Ms. Newell confirmed that she

... might leave them for a minute and come back. Some will just deal with the aggression, and do it; and some will leave it and come back.

Asked whether she has ever felt rushed to get things done within a specific time frames, Ms. Newell answered:

No, it's more based on the workers themselves. They want to get things done. The Home has never specified times.

Asked to describe as fully as possible Mr. A's situation on December 8th, she answered:

It was on the afternoon change out, between 3:00 and 3:30. One group had gone to its break and we were paired up, if we could. Myself and George were together. We went into Mr. A's room and he was in his geri chair... The room has two residents' beds, one nearer the window and one nearer the door to the hallway. Mr. A was in the bed nearest the doorway, and opposite the end of his bed on the opposite wall was the door to the washroom. Mr. A was in between the beds facing the bathroom. So we went in and were getting ready, and George said he would get him ready to stand; sometimes he did. He had on trousers and probably a shirt, his day clothes. George said to try to get him to stand, and that made it easier for him and for us. We unloosened the front of his chair and got him to stand. After a minute or so George was trying to get the *Attends* ready. I told George that Mr. A's legs were starting to get unsteady, and I told George that he was going to fall.

> At that point George grabbed him by the waistband of the pants roughly and said, 'Come back here, you old bastard.' At that point he was back in the chair. We put him in the lift and back onto the bed, and we changed him and left him on the bed then.

Ms. Newell said she knew Mr. A was getting unsteady because ...

> his legs got wobbly.... I was in front of Mr. A with my hands under his arms to give him support. Mr. Parsons was on the side of the chair towards the back getting the *attends* ready. He was fully clothed. At that point we had not dropped the trousers.

Asked if, in her view, there was any other way to get Mr. A into the chair, Ms. Newell said:

> Yes. You could have pushed the chair ahead, or just pulled him back gently.

Asked how different this treatment was, and whether Mr. A had been aggressive, she said:

> You don't grab a person forcefully, and you don't speak to a resident that way. So it was different... No (Mr. A was not aggressive,) not while he was standing. He was standing, and I was holding his arms, and he was fine. There was no aggression. He was forcefully pulled back. (Mr. Parsons) reached out and hauled him back by the waist band of the trousers, and it was rough, and he said, 'Come back here, you old bastard."

Asked about the Grievor's tone of voice, Ms. Newell said:

> He was very angry. You can tell by their gestures and the way they say it, their tone of voice... (The Grievor's voice) went up a little, but not a big deal. George speaks louder anyway. Both (he Grievor's) tone and volume were angry.

The Grievor had said nothing to her.

> He went and got the lift and put Mr. A on the lift and put him on the bed, and changed him... (Mr. A) was a little bit aggressive, because I think he got a little bit of a fright. It was not an easy change out. His family wants him in bed for an hour. His family wants that... I think we had the other gentleman changed, and just checked his catheter and ensured he was clear.

Ms. Newell said they had not known the state of Mr. A's *Attends* prior to the change out, and that there was no other staff member in the room at the time, or anywhere near outside the room.

Asked if she had returned to see Mr. A, Ms. Newell said:

> No. I went partnering with somebody else. I just did not want to be a part of what I was part of.

Ms. Newell said she did not continue to work with Mr. Parsons. She did see him later during the shift, but noted nothing different about his behaviour, and had not spoken with him about the

incident afterward. Asked whether she had done anything else about this incident, she said:

> A week or two later I did not know what or how to do it. I was talking to Lisa Green, the nurse, and she told me I had to go to Linda and tell her about what happened. I don't know the date. I went to her office and told her what happened, and that was it until this came about... There was a representative from Eastern Health, and I had to talk to Andrea Whyte and Bev Bellefleur; and I had to speak to them and I told them what I told you....

Ms. Newell said she had filed a report with Ms. Somerton and confirmed that Consent #5 is "the report that I filled out in my handwriting." Asked whether there was anyone else at the interview, Ms. Newell answered:

> Only Paul Fisher. He took the statement. He's with the College of LPNs. I guess George is an LPN, so I gave him a statement... (PN #1) is my statement and my handwriting, yes. It was put with the other incident report. I remember doing it, but vaguely... It was done at the same time as the incident report..."

Asked why she had reported the incident, Ms. Newell answered:

> It played on my mind for a long time. It was not right. That's why I discussed it with Ms. Green. You don't have a right to handle them this way. That's what we were taught in school.

Asked whether there are other rules and guidelines she is aware of, she answered: "Basically, what you'd do yourself as a person."

Ms. Newell said she had not witnessed similar activities while working in other pairs giving care to residents. Asked whether she had noticed the Grievor's behaviour while working in a pair with him before, Ms. Newell answered:

> I don't think I'd been paired with him before that. I'd been part of a team, but not as a pair... I can't remember any other time when I worked with George directly.

Asked whether this sort of behaviour had ever been covered in ward conferences, Ms. Newell answered: "No. Ward consultations deal with day to day issues."

Ms. Newell confirmed that, since that day, she had worked as a casual at the Home and had heard that Mr. Parsons had been terminated. She described her own presence at the Home by saying:

> It was quite difficult. He's got a lot of friends and there were a lot of stares: 'Here comes the witness.' ... 'Here comes the witness.'.. After that, I did most of my shifts on South for a month or more. I guess Linda thought it was best. Everybody knew, and it was tense. Linda has people who come and tell her things. There

> were comments, and basically I was being shunned. It was probably for a month or more that I was on South for shifts. I'm off right now on sick leave, and going back at the end of the month.

Ms. Newell confirmed that she is now comfortable working at the Home.

ON CROSS EXAMINATION Ms. Newell was asked to explain what she meant by saying that "Linda has people who come and tell her things", she said:

> Linda has some staff who talk to her and she listens to them... It makes for interesting times.

Ms Newell said that the RN on night shift organises the pairs on the wing, and that she had worked on night shift in pairs:

> Yes, during orientation. I was orienting there first. I did private home care in Clarke's Beach before that. Yes (I completed the orientation), basically in dealing with policies at the home... You go over policies dos and don'ts.. I looked over (the Policy Manual) briefly. I won't say that I went into it in any detail. (Consent #8, pages 1 & 2 are) familiar but not 100%. I have seen it.

Ms. Newell testified the policy on language use is not observed as stated there and that she has heard offensive language in the Home: "Indeed there is: staff ... family ...

When asked whether she is familiar with the resident abuse policy as it applies to "witnessed abuse," Ms. Newell answered: " have probably read it but I am not familiar with it." The policy is posted at the work sites and is accessible to all. Ms. Newell testified that she has probably seen, but does not recall Consent #8 p. 7. "I probably have read it, no doubt; but as for remembering it, no." Ms. Newell also confirmed that she had seen Consent #8, p. 9 posted. "It's probably on the wall now, on the bulletin board behind the nursing station."

Ms. Newell testified that she had not had PN #1 with her when she went to see Ms. Somerton. "She asked me to do it, and I did it then."

Ms. Newell confirmed that she said that she had spoken to Nurse Greene a couple of weeks after the incident. "It was a day shift... He pulled the resident to the sitting position..." She also confirmed she had told the Grievor that the resident was about to fall. Asked whether she had said anything to Mr. Parsons about the incident, Ms. Newell said: "No, being new there."

Ms. Newell went on to say she'd been "taught things, and this was covered in the course." She also confirmed she had previously seen Consent #2. "Mr. Paul Fisher did a seminar at the

school, and we got Consent #2; and I think one came in the mail."

Ms. Newell remembers meeting with Ms. Andrea Whyte, the Eastern Health HR consultant. Asked whether she had told Ms. Whyte the same story as is reported in PN #1, she responded, "To my knowledge, yes." It was pointed out that Ms. Somerton had said the incident occurred in the washroom. Ms. Newell said: "She is definitely wrong. I knew where I was."

Asked whether she had provided Ms. Whyte with any other statement beyond PN #1, Ms. Newell answered: "Not that I remember." Asked if she would describe Mr. A as "docile", Ms. Newell answered: "I don't know what it means... I would not have used it if I don't know what it means."

Asked whether people in other rooms would have had to have heard the Grievor shouting at the resident, Ms. Newell answered: "I would have said 'if someone was outside the door.'" Asked whether she had used the phrase, "yanked the *attend* off of him", Ms. Newell answered: "No. The *Attends* did not even come off until he was on the bed." Asked whether the Grievor was rough with the resident later in the procedure, Ms. Newell answered:

> "No. The change out was a bit difficult, but no. It was just the grabbing of the pants by the back."

Asked whether, once the change out had finished she had gone off with someone else, Ms. Newell answered: "The pairing is for the morning. You go with anyone in the afternoon."

Asked whether she had ever used the term, "manhandled", Ms. Newell said: "That term could have been used, yes." She also confirmed that the geri chair is on wheels. Asked whether, if the chair's brakes were engaged, the Grievor would have had difficulty pushing the chair forward, Ms. Newell answered: "Yes, he would have had difficulty." Asked whether there was a possibility that the resident might have fallen, Ms. Newell answered, "Yes, there was." Asked whether she knew if other staff members were in the area, Ms. Newell answered:

> I would not know... When you go in you close the door, but they could come in. Nursing tries to knock briefly, and then come in.

Ms. Newell confirmed that Consent #5 is written in her hand, and that there was no reference to the word "grab" in that document. "No, this was the summary, but she told me I had to do the detail. That was PN #1."

Asked whether, on December 20th, she had been aware of another complaint, Ms. Newell

answered: "No. I heard afterwards, but I did not know at the time." Asked to describe the discussion with Ms. Lisa Greene, Ms. Newell said: "I told her what happened, and she told me to go see Linda: no big discussion or anything."

Asked to describe how loud the Grievor's voice was, Ms. Newell said, "He wasn't shouting by no means, but he did raise his voice."

Asked she was sure that the Grievor was to the side of Mr. A's geri chair, she said: "I am positive." Asked whether it is possible for a single attendant to change a resident rather than doing it in pairs, Ms. Newell answered: "Oh yes still today." Asked if Mr. A sometimes resists attention and care with his hands and feet, and whether that happens frequently, Ms. Newell said: "Yes... He will start to push you away, and that's true of other residents."

ON REDIRECT EXAMINATION Ms. Newell confirmed that the *attends* was not removed until "we got him onto the bed." Asked whether Mr. A's trousers were still up when he was moved to the bed, Ms. Newell answered: "Yes. It was yank, yank on the bed. Yes, but not when he was standing."

THE THIRD EMPLOYER WITNESS was Ms. Lisa Barrett. Ms. Barrett confirmed that she was working at the Pentecostal Senior Citizen's Home in December 2006.

> I was posted there on a work term from the college where I am doing the therapeutic recreation program. The program is a two year program. I had one year done, and one year left to go. I had just had a baby.... I think it was a ten week placement. I started at the Home some time in November; the date I can't remember... While I was at the Home I had nothing to do with the therapeutic recreation. In the Home I was as a PCA. It's linked together with the school. The first semester deals with personal care and then later on its geriatric and physio... Yes I had a PCA diploma from grade 12. From age 13 on my dad was sick, so I was caring for him.

At school she had been a student assistant for the mentally challenged. "I had one client for five years and he passed away. The school work was on a grant for about three months." Ms. Barrett graduated from high school in 1994; and graduated with the PCA course in 1996. She then worked in private residences.

Asked whether she had worked with older patients suffering from dementia. She said:

> One had first level Alzheimer's and another had Parkinsons. Others were just elderly. I provided assistance with personal hygiene and bathing.

> During her period at the Pentecostal Senior Citizens' Home Ms. Barrett had worked... basically as a shadow, and then after a few weeks there was hands-on experience with two people. One was a LPN and one was a PCA I think, I'm not sure. I'd stay and observe while they were doing the work. Whoever we were teamed up with did up a report, and they found that we could do more stuff. Mostly I was with two people. Before my work with Mr. Parsons, I was with two people, June Earle and Paul. They were who I mostly worked with.

> Asked if she recalls caring for Mr. A prior to December 14, 2006, Ms. Barrett said:

> Yes, we had him through the prior week, me and Paul and Ms. Earle. We had him, I think, three times that week. I was working days, Monday to Friday 8 to 5.

Asked to describe how Ms. Earle and Paul provided Mr. A's care prior to December 14th, Ms. Barrett said:

> He was not a resident that we had problem with. He wasn't a difficult patient. He has Parkinsons, a bit stiff somehow. His personality is pretty calm. He doesn't like to talk a lot... Some have a full bath. I never had him for a bath. I only had him for bed baths. We washed him head-to-toe in bed. Some days there is a partial bath, hands, face and genital area and then changed.

Asked whether Mr. A had been aggressive at all, Ms. Barrett answered, "No not at all." Asked whether she recalls how Ms. Earle or Paul had approached him, Ms. Barrett said:

> Paul and June just went in a said, 'good morning' and joked around. Yes, he was stiff in the morning, but he was pleasant; and Paul and June would talk to him. Paul used to call him 'Skipper", and ask about his wife: just normal conversation.

Asked whether Mr. A had responded, Ms. Barrett said: "Not much. Maybe just referred to his wife by name. Most days he was pretty quiet.

> Asked whether she had ever worked as part of a team with the Grievor, she answered:

> I worked with him in grade 12 on the co-op program. I was there in grade 12 and when I finished school I was hired on there for a summer at the Home... Yes I worked at the Home twelve years ago... I think a few times I was paired with him. Mr. Parsons was in the group I worked with.

Asked to describe Mr. Parsons' work attitude from that past experience, Ms. Barrett answered:

> I can't really remember the 12 years ago. We were all as a team. I never had much dealings with him then. But when I was there with the Therapeutic Recreation program I only worked with him that one ... time. That was the team he was on, but the only shift I had any one-on-one dealing with him was that one with Mr. A. Otherwise, I worked with June and Paul.

Asked whether, in her experience, she has had to deal with difficult clients who are resistant to care, Ms. Barrett answered:

> Well the point is you are supposed to be teamed up with... and you keep really calm and in a pleasant manner. When I was with Paul and June ... and that morning it was Alma and George; and Alma went on to other residents, and I was with George.... I got to work at 8:00 – it was a bit early -- and listened to the tape that the night nurse left, and then got teamed up different teams for different residents. I was told I was with George and Alma...is that her name? I think she has her LPN. Yes. It was just a typical morning. Mostly you try to get the residents done before breakfast trays... We went into Mr. A's room. There was another resident with him; and usually – who I was with was Paul and June – the curtain is usually there. We were told to close it. That did not happen that morning. It wasn't closed. George seemed irritated that morning. I don't know why. George went to Mr. A's dresser and got his socks and things and while he was getting his stuff George was in a bad mood and said: "I got that fucker today." ... I don't know who he was talking to: himself I guess ... same level as I am talking to you today, and it was 8 or 10 feet away.

Asked whether she had heard clearly, Ms. Barrett said:

> Yes, it's not a large room. Mr. A was in the bed closest to the door. I was by Mr. A's head, and I was putting the rail down. George came over, and ... we were starting to do his personal care. George started washing his face in a rough manner. It was a partial bath, hands, feet and genital area and chest for the tray to come.

Asked whether she had prepared the basin and cloth, Ms. Barrett said:

> Mr. Parsons got it. Mr. A got really agitated when he was washing his face. He gets very upset with this. George was trying to get his shirt off, and Mr. A's hands were up at his face. George forced his hands down to the bed. George took his hands and pushed the two hands down. Mr. A was really upset. Then George tried to wash his genital area, and George punched him in the rib cage, here (pointing to a point on her own body) ... You could see water in his eyes. He was all tensed up. Mr. A was keeping his hands up, and George was doing the personal care, and then with the flat part of his closed hand he smacked him right where the rib cage is. Mr. A curled up in a ball and moaning. George continued cleaning his genital area... Then he had to take out his dentures to be washed. They were really taken out in a rough manner. George was calling Mr. A an 'old dog', and he was 'breathing his air.' Then George said he was going to 'roll him off the fucking bed' and had 'a fucking mind to kill him', and pushed him to my side, and I thought he was going to.... I thought he was going to fall out of the side of the bed. The rail was down, so I tried to stop him. I had to take a pill for my back.

Ms. Barrett confirmed she saw tears in the corner of Mr. A's eyes.

> Then Mr. A had to be put in a chair to give him his breakfast tray. Through it all he got dressed and we got his shirt on... After the striking with the fist he was just closed up in a ball.

Asked whether Mr. A was aggressive after that, Ms. Barrett answered, "No." Asked whether she had said anything to Mr. Parsons or whether Mr. Parsons had said anything to her, Ms. Barrett answered:

> No I was just there as a student. We were drilled and drilled. If it is difficult you, have someone to help you. I didn't say anything. After that, Mr. A was done and I was completely floored... After Mr. A was done it was break time. I did my own thing and kept my distance, and went on with Alva.

Asked whether she had said anything to Alva about what had happened, Ms. Barrett said, "No."

Asked whether she had worked with Mr. Parsons later that day, Ms. Barrett said, "No." Asked whether he had ever spoken with her about the incident, Ms. Barrett said:

> No. We were all on break in a little room... and he said nothing.... After the weekend I was teamed up with Sandra Antle. She's an LPN or a PCA, I am not sure... I told her, and she told me to go tell Melany, so Melany came in so I told. Melany said she had to go to talk to Ms. Somerton. I said I was worried about other people on the team. She went to tell Ms. Somerton, and 15 minutes later Ms. Somerton buzzed over... That was right after the weekend.

Asked whether she had a meeting with Ms. Somerton, Ms. Barrett said:

> She was very, very upset. She didn't know about it... I told her that it was a couple of days as I was a student. She appeared understanding. I gave her my statement, and it was typed up and then I had to reread the statement and sign it.

Ms. Barrett was shown Consent #4, and said:

> I guess it's a complaint sheet. I never seen this... That is my signature, yes.... That was filled out that morning. I had to give a statement, and that was typed up. This here was written up by Ms. Somerton. I signed it, yes... It was typed by Miss Doris Dorey. I signed it (LB #1). While I was talking, Ms. Somerton was writing, and Doris was there, and typed it up, and I was told to read it, and be sure it was what I gave them; and I signed it. Yes, LB #;1 that is what happened.

Asked whether, during her time at the Home in December of 2006 and previously, she had ever seen a group member act in this, or any similar, way towards a resident, Ms. Barrett said, "No." Asked to explain why she had reported the matter, Ms. Barrett said:

> I felt bad, and when it happened... I was confused. If I was in school I would go to a teacher... or to Ms. Somerton. Sandra Antle saw it was upsetting me. She came

> to me. It had to be told.

Asked why, in her view, "it had to be told," Ms. Barrett answered:

> Obviously, it was a situation where a resident was being abused... to avoid some worse outcome for the resident... Personally, I learned that there is a way to deal with difficult residents, not by being verbally and physically abusive.

Ms. Barrett continued to work at the Home until the second week of January. She ended her work term there because, "I had to go back to school." Asked how it had been during the period before she went back to school, and whether there was any difficulty in working in pairs, Ms. Barrett answered:

> It was difficult at times. Certain people on certain teams felt distant. They were no longer talkative. I got the cold shoulder. I wasn't talked to... I was with Sandra Antle from then on to the end.

ON CROSS EXAMINATION Ms. Barrett answered questions about the morning of the alleged incident.

> ...Yes I was paired with Mr. Parsons and Alva. We do so many residents before breakfast. I don't know who we had before Mr. A.

Asked when they had provided care for Mr. A that morning, Ms. Barrett answered:

> Before breakfast.. He was washed and prepared for breakfast before the breakfast came, around 8:30.

When it was pointed out that in LB #1 she describes the incident as having taken place, "... after breakfast at approximately 9:30 or 10:00 am", she said: "I'm pretty sure it was breakfast time."

Ms. Barrett was reminded that she had testified on direct examination that Ms. Somerton had "buzzed over" that morning in "15 minutes". She responded: "When I got back off break, she had called." Asked whether she remembers a doctor's appointment, Ms. Barrett answered:

> Yes, I was pregnant, but it was in 15 minutes that she buzzed me, (not in 15 minutes) that I went to her.

Asked whether she had anything written with her when she went to see Ms. Somerton, Ms. Barrett said: "No I told Sandra, and she got Melany, so I told both Sandra and Melany."

Asked to describe the order in which care had been provided to Mr. A, Ms. Barrett said: "We washed his face, and put on his shirt, and then did his genitalia." Asked to describe where the Grievor had struck Mr. A, Ms. Barrett answered: "At the area of the rib cage."

When it was pointed out that the sequence set out in LB #1 does not correspond with the testimony she had just provided, Ms. Barrett answered: "This is the first time I've seen it since then." She confirmed she had stayed in the meeting with Ms. Somerton while the document was being typed.

> Ms. Somerton took down my statement, and Ms. Dorey was to type it, and I was called back.

Asked whether, therefore, there had been a handwritten version of of LB #1 in addition to the typed version in evidence, Ms. Barrett said:

> Yes, I had to read the handwritten. Yes, I think I signed that handwritten one too; and then I signed the one that Ms. Dorey typed.

Ms. Barrett was asked what she meant by describing Mr. A as having curled up in a ball and was reminded that Mr. A was a victim of Parkinson's. She answered:

> We read about Parkinson's in school. He was not in a fetal position. He was on his back and curled up in a ball.

Asked how, with Mr. A in that position, they had still managed to secure his *attends* and pants, Ms. Barrett answered: "I really can't remember. Yes, it was a difficult task to get him dressed."

Asked whether she thought that it was odd to put on his shirt prior to washing him, Ms. Barrett said:

> I did see June and Paul do it: the top of the resident, then towel; and then the bottom, then towel.

Ms. Barrett confirmed that the Grievor had struck Mr. A. with the flat ball of his closed hand. Asked to describe her position in the room during this period, Ms. Barrett said:

> I was to his left. George was on the window side, and I was on the corridor side... The curtain was not closed. Alva went and done a resident. George said, I am going to do Mr. A, and she went on to a resident's room.

Ms. Barrett could not recall the name of the other resident in Mr. A's room. Asked whether she had seen anyone come in to do the other resident, Ms. Barrett said:

> No, there was no one with the other resident when we were with Mr. A. I don't know. He might not have been on the same list.

Asked whether she had had anything to do with the other resident, Ms. Barrett said, "No." Asked whether she is sure, Ms. Barrett said: "Not that I can remember."

Asked whether she had known Mr. A and his family previously, Ms. Barrett answered:

> Yes, before he went into the Home I used to look after him in his home. Yes, he has a daughter. I think she's a nurse...

Ms. Barrett also testified that prior to working at the Home in November and December 2006 as part of her therapeutic recreation program, "I would feed a lady there... I started school in that summer." Asked whether Ms. Somerton was there at the time she used to feed a resident, Ms. Barrett answered

> The daughter of the lady I was helping feed said she'd spoken to Ms. Somerton about me helping out while she was on holiday, and that Ms. Somerton had said, okay. So far as I can recall Ms. Somerton did not speak to me during summer 2006, not that I have any knowledge of, no.

She had been paired with two other LPNs during the two weeks prior to her experience with the Grievor, and that for that two weeks "Mr. A was okay." Asked whether June and Paul could confirm that, Ms. Barrett answered, "Yes."

Asked where Mr. Parsons was standing when he was washing Mr. A's face, Ms. Barrett answered, "He was up by his face, the opposite side of me." Asked whether the bed rails were up or down, Ms. Barrett answered, "Down." Asked whether that applied to both of the bed rails, Ms. Barrett answered, "Yes." Asked whether she had put both bed rails down, Ms. Barrett answered:

> I put mine down and I guess George put his down... both bed rails were down; yes they were down.

Asked whether she had ever seen Mr. A raise his arms in the way that he had that morning, Ms. Barrett answered:

> Not when Paul and I did it... When he put his arms down to the bed, I actually heard scrunching.

Asked whether they had managed to get his pants on, Ms. Barrett answered: "Yes; so his arms were not broken."

Asked whether she recalls a meeting that had occurred a couple of days after December 19th, Ms. Barrett answered: "I can't recall the dates. People came in, and I went with them in Ms. Somerton's office."

Asked if she was certain that the blow had been actually in Mr. A's rib cage, Ms. Barrett

answered: "No I said in the 'rib cage area.'"

Asked about the injury to her back, Ms. Barrett said:

> I went to the nurse and told her I hurt my back helping Mr. A, and she gave me a pill, and wrote it up.

Asked whether she had needed any follow-up treatment for her back, Ms. Barrett answered, "No, it was just that day."

Asked whether she was given a copy of the handwritten statement, Ms. Barrett answered, "Yes. I just put it in my folder." Ms. Barrett also confirmed that the only thing she actually wrote on Consent #4 was the date and her signature.

> Doris Dorey was there when I was describing the striking as being in the rib cage area. Beverly Bellefleur came in when I was talking to Linda the next day to talk to people who came. I assume she was writing. Everyone had folders.

Asked whether she had done anything about the resident, Ms. Barrett said:

> I was a student and didn't know. Sandra and Melany went in and checked his chest area. Yes, I was present when they checked him. Melany told Ms. Somerton that she had checked him and LB #1 was written after that checking took place. There was no bruise on his chest. When we went to check him it was three or four days after it happened... Mr. A is average build.

Asked whether it is credible that she had actually viewed all of this and failed to report it, Ms. Barrett again said: "I was a student." Asked whether she was able to contact her teacher, Ms. Barrett answered: "Yes, I called the teacher at the school, and she wasn't there. She was supposed to come to the home the next week." Asked whether she had told her teacher about this, Ms. Barrett answered" "She knew about this, yes."

When it was pointed out to Ms. Barrett that a blow such as she described could have caused internal bleeding, Ms. Barrett answered: "At that moment I did not know. I had to tell someone." It was pointed out to Ms. Barrett that she had not told Alva but did tell Sandra on the Monday morning, Ms. Barrett answered, "Yes, I was confused." Asked whether she had gone to coffee break with the Grievor, Ms. Barrett answered, "I can't say precisely yes or no."

Ms. Barrett confirmed that she knew Ms. Newell "from the Home," but had not discussed this matter with her at all on the day of the hearing. "I did not even know she had the complaint when the college man came for the interview."

> She again reviewed the details of her meeting with Ms. Somerton.
>
> She buzzed over, and told them to tell me to come over when I returned. I did, and she told me to sit down, and got Ms. Dorey to come as a witness. She took my statement. I read it, and signed it. I asked if I was going to be interviewed, and was told not to talk with anyone, and if I had a problem to tell her. The next meeting was with Beverly and Ms. Whyte and Linda Somerton, and one other who interviewed me...

Asked whether the other was Ms. Hiscock, Ms. Barrett answered, "Not to my knowledge."

ON REDIRECT EXAMINATION Ms. Barrett confirmed that she had spoken to Mr. Paul Fisher. Asked whether what she has at home might have been a statement relating to Mr. Fisher, Ms. Barrett answered, "I am not sure. It could be." Asked whether what she has at home is a handwritten version, Ms. Barrett said "I can't remember."

THE THIRD EMPLOYER WITNESS was Ms. Andrea Whyte, HR Consultant with Eastern Health. She has worked with the Board since 1999, and with the nursing home since 2004. Between 1999 and 2004 she was staffing officer and, for a year, an HR technician, all in the Carbonear area. Prior to that she had completed a B.Com. at Memorial University. As an HR consultant Ms. Whyte had "a blended set of responsibilities including work with Workers Compensation and advising certain facilities within the area." Her most recent job assignment had been to the Pentecostal Senior Citizens' Home where she had responsibilities in respect of discipline, in particular in conducting investigations and advising on appropriate action. The normal investigative process, in Ms. Whyte's experience, was...

> to prepare reports on the situation, interview all involved including co-workers. If a complaint is verbal, we want it in writing and a verbal report as well. After reading the written statements we meet with them, clarify, and take further statements, and then we go from there. I guess we meet the person who the complaint is about, and co-workers and managers... I guess if it is more routine I'd go from start to finish in consultation with the Manager. If it is more serious my manager and other managers are involved. I report to Marsha Hiscock.

Ms. Whyte confirmed that in December 2006 she had been involved in the investigation of Mr. George Parsons. When asked to describe the process used in that investigation Ms. Whyte identified AW #1:

> These are the notes I made during the investigation... I typed them up. I made them as it was going on in December 2006. They were kept on the computer and

printed off. Normally they would only call me if there was an issue for direction...

Linda Somerton called me on the 18th. A nurse had come forward who had talked to a student about an LPN being abusive verbally and physically to a resident. At that point Linda had not spoken to the student herself. Linda had called me to ask advice. I talked to Marsha, and called Linda back. The first issue was to decide if Mr. Parsons should work that night, and she needed to make that decision and to get the student's complaint in writing before we could go further with the investigation.

The next day was the 19th. We'd hoped to meet with him that day, but could not reach him. Linda said that she would call him to say that he was suspended for the night of the 19th, but she had not contacted him on the night of the 18th. She asked him to meet with us on the 20th, the next day. On the day of the 20th Mr. Parsons denied it completely.

Asked whether the facts were presented to him, Ms. Whyte answered:

Not in detail. He knew the resident and the dates, but could recall nothing in particular. He said he could remember nothing concerning Mr. A or any other resident. Asked if he had gotten angry, Mr. Parsons mentioned his heart problem and Ms. Somerton said she knew about that.

With respect of the report of Ms. Newell's complaint, Ms. Whyte said she is not certain whether the incident was in the morning or the afternoon. "I knew it was a change out." Her attention was directed to the reference in AW #1 to what others might have heard. She said:

I asked that and I recall Ms. Newell saying that other people must have heard what was going on because Mr. Parsons's voice was raised.

Ms. Whyte confirmed that she had gone to the Home during the investigation and had seen the resident's room which she described.

Linda called George and asked him to meet us on the 22nd. We asked him about this complaint, and to tell us what had happened, and again he said he knew nothing. We provided Rowena and George with details, and they asked for time to talk.

Asked whether they had provided the Grievor with full details, Ms. Whyte said, we provided the written copies of the LB #1 and PN#1 reports. Ms. Whyte did not think that Consents #4 & #5 were provided to the Grievor... "When they came back they asked for time to respond in writing."

Asked whether there was any comment on the care provided Mr. A, Ms. Whyte answered: "No. There was no comment at all." Asked whether Ms. Barrett had demonstrated where the blow had been struck, Ms. Whyte answered:

> Yes, where the ribs come to a V, and she put her fist in that area. She did not talk in great detail about the force of the blow. She spoke more of the scrunching sound of the arms going down. She did not detail much about the blow.

Ms. Whyte confirmed that Consent #6 is the Grievor's written reply.

> We told Rowena and Mr. Parsons that we would be interviewing the co-workers. We were given copies of the schedules, and we interviewed all who had worked with Mr. Parsons on the same days: the 8th and the 14th. Seven co-workers were identified who had worked on one or both those days. We had a number of questions that we asked.

Asked whether any of the co-workers had said that they had paired with Mr. Parsons on those days, Ms. Whyte answered: "Yes, I don't recall who." Asked whether any individual had cared for Mr. A in partnership with Mr. Parsons on any of those days, Ms. Whyte answered: "I don't remember." Asked what the outcome of that part of the investigation had been Ms. Whyte said:

> Two had said that in the morning of the 14th the report was long and the breakfast trays were late and some staff were edgy and irritated.

Asked whether there was any comment to the effect that Mr. Parsons seemed edgy, Ms. Whyte said: "Yes. One said that Mr. Parsons had observed that it was busy that day."

Asked whether any of those interviewed had made any comment about incidents that they had experienced with Mr. Parsons, Ms. Whyte said:

> A couple of people mentioned that he was very particular about his work, and sometimes he would get irritated because it was hard to do it right. One co-worker mentioned that she had consulted him on numerous occasions about his attitude, and there would be heated discussions. One of them was on that 14th of December... Lisa had hurt her back and he shouldn't be using a student to help him with Mr. A. Mr. Parsons had told her to 'shut up', and that was it: nothing further... We asked about care for Mr. A, and all said that he was hard to deal with. He was rigid and stiff, but that if you spoke to him he would be helpful or that you could leave him for a while. All those interviewed had cared for Mr. A at some point. Most people did comment he could be difficult to work with. Some people mentioned that talk calmed him down, and made it easier to care for him.

Asked whether the investigation had turned up anything else, Ms. Whyte said: "Not that I can think of, no." She confirmed she had spoken with Ms. Barrett and Ms. Newell, and had spoken to Mr. Parsons. The co-workers were interviewed on the 29th of December. Asked what she had done with the information collected, Ms. Whyte said: "We interviewed all, and got the written statements; so we then spoke to the Director of HR, and I was less involved at that point."

Asked who reviewed her reports, Ms. Whyte said:

> Ms. Hiscock, myself and Linda and Beverly, to see if there was anything that we had missed. We had conversations with Heather (Hanrahan, Director of Human Resources) in St. John's. I was involved in some conversation on the information.

Asked whether anyone had gone through the file, and whether there was consideration of prior complaints, Ms. Whyte answered:

> I believe Linda had provided that. I was told that there was a prior incident. I saw nothing on the file, not myself.

Ms. Whyte confirmed that the time limits were extended in order to accommodate the information gathering process. Asked whether she had a part in the disciplinary decision, Ms. Whyte answered:

> I was involved in the conversation for clarification if needed, but not involved in the conversation on the final decision.

Asked whether Mr. Parsons had ever acknowledged he had done anything wrong, Ms. Whyte answered, "No." Asked whether he had offered any justification, Ms. Whyte answered, "No." Asked whether, in her investigation and questioning of Ms. Barrett and Ms. Newell, she had made any estimate as to how truthful they were, Ms. Whyte answered:

> I assumed it was truthful. I know how difficult it was for them to come forward knowing how the reaction would be, and that they would not come forward if it had not happened. They stated in the interview what they had written. They were more concerned for the resident, and that it not be allowed to continue. That was their main focus.

ON CROSS EXAMINATION Ms. Whyte testified"

> I have never seen (the Grievor's) personnel file. It was reviewed by his manager, Ms. Linda Somerton. She referred to another incident. I did not look at his file.

Asked whether the other incident had been taken into consideration, Ms. Whyte answered: "Not by me. I can't speak for anyone else."

Asked whether she had learned whether Mr. A had ever been assessed after the incident, Ms. Whyte answered:

> It was never mentioned that he was, and I never asked. Ms. Somerton said a PCA contacted her office, and that was Sandra Antle... Yes, Sandra Antle had had a confrontation with Mr. Parsons.... She also reported that Melany Fillier had reported the matter. A statement from Melany Fillier was taken after the 18th.

> Linda had asked for it, and it came after. It was handwritten and signed by Melany... Ms. Newell said that the Grievor had grabbed him. I guess they needed to move him from the chair to the bed.

Ms. Whyte also confirmed that Mr. Parsons "did work the night of the 18th. Ms. Somerton knew he was working that night." She also confirmed that Ms. "Sharmaine Pinsent was present at that first meeting, but that no details, just generalities had been provided the Union."

Asked when she had completed AW #1 she said: "During the investigation." Asked whether there were any handwritten notes, Ms. Whyte said, none. Asked whether she had prepared the notes after the meeting, Ms. Whyte answered: "Yes. Perhaps the next day." Asked whether the events were fresh in her mind, Ms. Whyte said:

> Yes. I had taken handwritten notes in the interview, and then into the computer. I took handwritten notes that I then destroyed.

Asked whether that is normal process, Ms. Whyte said, "Yes."

Asked to describe the December 18th contact, Ms. Whyte said:

> A nurse had come forward concerning an incident involving a home support student. I was told that's what she was.

Asked who had told her that, Ms. Whyte answered, "I assume Linda Somerton." Asked whether Ms. Somerton had told her who the nurse was, Ms. Whyte answered:

> No, she did not reference Lisa Barrett or Mr. Parsons... She stated that she'd had a similar issue on the 18th before any investigation. She had been personally involved as far as I know. She was speaking from personal knowledge.

Ms. Whyte confirmed the Grievor had worked the night of the 18th, and that there was no supervisor on night shift:

> Linda told me that it was more serious than she first thought and confirmed, prior to the meeting on the 20th, that there was now a second incident. We wanted to know why there was a delay... Patricia said that she found it very difficult to report on a co-worker. As far as I can remember the incident report came in voluntarily.

Asked how the Grievor had reacted, Ms. Whyte said:

> He sounded a little surprised. There was no overt reaction. We were very general. There was nothing detailed at the time.

It was pointed out to Ms. Whyte that she had used the word "docile" in AW #1 in the reference to Mr. A, but that Ms. Newell had testified she did not use that work "docile". Ms. Whyte said: "Any word she said I have in quotation marks. The word she used meant docile." Asked whether she had learned that Mr. A was "docile" from the Grievor's co-workers, Ms. Whyte said, "No."

Asked whether Ms. Newell had described how the Grievor was standing, Ms. Whyte answered: "I don't know! I don't know. He grabbed him by the clothing. I don't know." Asked whether she had asked for clarification, Ms. Whyte answered, "I don't recall."

When told that Ms. Somerton had testified that this entire incident had happened in the washroom, Ms. Whyte said: "That's the first I heard of it. I understand that they were near the bed." Asked whether there had been an investigation of whether Ms. Newell had worked other shifts after the incident with the Grievor, Ms. Whyte answered, "Not by me."

Asked whether Lisa Green had given a statement or been interviewed, she said, "No." Asked whether she had, therefore, taken Ms Newell's word on that aspect of the report, Ms. Whyte said: "We asked her why she had delayed so long, and she said that it was difficult to report." Asked whether her delay in reporting had ever been dealt with, Ms. Whyte answered, "Not by me." Asked how long the interview with Ms. Newell had taken, Ms. Whyte said: "I don't know; perhaps half an hour. It did not take the full hour."

Asked whether she had the PN #1 statement with her at the meeting of the 21st, Ms. Whyte answered, "I'm not sure." It was pointed out that there appears to be "a lot more in AW #1 than what Patricia Newell actually wrote in PN #1", Ms. Whyte answered: "I did not question her on that. No."

Asked whether Ms Lisa Barrett, herself, had used the expression "as if to defend himself" during her interview, Ms. Whyte said: "She was concerned rather about the problem about a broken arm." Asked to recall how Ms. Barrett had described the blow, Ms. Whyte said: "I remember it was a fist." When it was pointed out that, in testimony at this hearing, Ms. Barrett described the blow as having been delivered by the palm of the closed hand, she answered: "To my knowledge Linda knows more of Lisa Barrett than I did."

Ms. Whyte also confirmed that Ms. Sandra Antle had been interviewed, as had a Ms. Joanne Mercer, but that there had been no written statement taken from Ms. Antle.

Ms. Whyte confirmed that, during the meeting of December 22nd: "George denied it... He was generally the same as on the first meeting: fairly flat."

Asked whether she had ever seen the original handwriting from which LB #1 had been typed, Ms. Whyte answered, "No." Asked who had typed LB #1, she answered:

> I assume Lisa. She signed it at the bottom. I assumed that she had typed it because she signed it at the bottom. Yes.

Asked when she had first seen Consent #4, Ms. Whyte answered:

> I can't remember. I assume I reviewed it before the meeting of the 21st. Anyway I assumed it was Lisa that wrote this one.

Asked when she had first seen Consent #6, Ms. Whyte answered:

> I don't know. I assume Ms. Hiscock got it from Mrs. (Rowena) Best. I knew it was due by the 5th which was our agreement.

Asked if she had any dealings with Mr. Parsons or reviewed his performance evaluations, Ms. Whyte said, "I didn't, no... His co-workers said that he was very particular about his work."

ON REDIRECT EXAMINATION Ms. Whyte again testified that in this investigation "We were focussed on the incident that Lisa and Pat had reported in relation to Mr. Parsons." Ms. Whyte confirmed that she was not the decision maker in respect of the discipline imposed:

> I perceived that I would not make the final decision. That final decision was at a higher level. My responsibility was to get all the information needed for that decision: the two incidents on December 8th and 14th, and what should be done about the complaint... I did not review his personnel file, but I believe it was reviewed.... No one asked me to give the full picture. I was not asked for a recommendation. My involvement had ended after the 29th meeting... Most of it ended. We had all the interviews and written documents. My role diminished after that. After that there were a lot of decisions that ... others had.

Asked to describe her recollection of Ms. Barrett's description of the blow, Ms. Whyte said: "I remember a fist: yes, fingers first. But that's what I remember."

THE FIRST UNION WITNESS was Mr. Melvin Dawe, who has been a PCA at the Home for 28 years. Mr. Dawe testified he had "worked with Mr. Parsons fair number of times" during that

period. Asked whether he had observed the Grievor's nursing practices, Mr. Dawe answered: "To my knowledge, he is second to none. He is very friendly with the residents."

Asked whether he knows why he is here today, Mr. Dawe said: "Only hearsay. Staff members are talking about it." Asked whether the Employer had interviewed him in 2006, Mr. Dawe said, "No. I was supposed to, and then they said they didn't need it. I was not involved in any incidents." Mr. Dawe does not recall working on the 8th or the 14th of December of 2006. Mr. Dawe has cared for Mr. A.

> To do him one on one is almost impossible. With two it is hard enough. He pulls. He kicks. He is really a two-person job. He's got a lot worse since then; but then he would hang on to the rail and two people would have to do him. There is difficulty in bathing him and clothing him. When you care for him, his arms are up here fighting you off and grabbing you and pinching your arms with the arms and legs going, regardless of who.

Mr. Dawe testified he had "seen Lisa Barrett there" but had not worked with her.

> No. She was assigned with the ladies most of the time. She was there before feeding some residents. Mrs. Roberts for sure... I think her mother was there too.

Asked whether management would know this, Mr. Dawe answered, "I assume so."

He testified that a PCA is "not permitted to chart but can read charts which are actually charted by LPNs and nurses." Asked whether Consent #8, page 2, Restrictions on the use of Foul Language, are obeyed, Mr. Dawe said:

> That's not observed in there. They're not angels... I've heard foul language from everybody... No, not everybody. There are a number of people who don't.

Asked if he would have any problem with Mr. Parsons caring for him if he were, himself, to be a resident in the Home, Mr. Dawe answered:

> Absolutely none. He is one of the best to work with. He takes pride in his work. Yes sir, he doesn't mind going the extra mile.

ON CROSS EXAMINATION Mr. Dawe testified he had not been working on either December 8th or December 14th. Asked how he would describe Mr. A's condition in December 2006 and whether, particularly, he could stand at that time, Mr. Dawe answered:

> Somewhat, with two persons helping him. In 2006 he was down in the bed, and he's always a man who didn't like staff doing him at the best of times. Every now

> and then he is okay. Even today, sometimes fine in the morning, and then in the evening he'd knock the head off you.

Asked whether it would make sense in such circumstances to wait and come back later to provide the care, Mr. Dawe said: "I've never heard of it, but I guess so."

Mr. Dawe confirmed that the Grievor took pride in his work and was very particular. Asked whether the Grievor would tell a staff member off if he found their work less than satisfactory, Mr. Dawe answered: "Yes, doing beds. When George Parsons was doing beds he didn't like wrinkles." Asked whether Mr. Parsons got frustrated from time to time, Mr. Dawe answered: "Oh yah; as a joke, yes."

Asked if there is foul language used, Mr. Dawe answered: "We're not angels." He confirmed he had heard swearing by his co-workers, including Mr. Parsons. He thought that there was

> ... not a whole lot in the corridor, only in the down time, down in the lunch room and every now and then on the floor.

He said he had never heard swearing in a resident's room. Asked whether he has heard swearing in reference to a resident, Mr. Dawe said: "You probably hear now and then." He had "probably" heard Mr. Parson's use "bastard" and the "f word". Asked whether he would say that Mr. Parsons swore a lot, Mr. Dawe answered: "He doesn't swear more than anyone else in there. Yes, mam, he swears. Yes."

Mr. Dawe is aware that a PCA is not permitted to abuse a patient, either psychologically or verbally. Asked whether, in his view, forcing a resident's limbs roughly down to the bed would constitute abuse, Mr. Dawe answered: "No, mam; not all the time... Lots of times you have to hold him (Mr. A)."

THE SECOND UNION WITNESS was Ms. Sharmaine Pinsent, who testified that she has worked at the Pentecostal Senior Citizens' Home as an LPN for a number of years. She has served as Local Union President "for eight or nine years, stepped down last year." She represented Mr. Parsons as Local President. "The Union started at the Home in 1999, and in 2000 we were part of it." Ms. Pinsent signed the MOU (Consent #1 p. 209) governing the inclusion of the Pentecostal Senior Citizens' Home into the Hospital Support Staff Collective Agreement. The

Home had not previously been unionized...

> but we always got the same benefits, but no Union representative. There was a lot of dissatisfaction at work. Bev Bellefleur was the facility manager at the time.

Ms. Pinsent identified as SP #1 a photocopy of a calendar for December 2006 with some indications of the twelve hour day shifts or eight hour day shifts and night shifts she had worked at the time. Ms. Pinsent confirmed she had not worked on December 8th or the 14th, but had worked the night of the 15th. She also testified that she was off duty on December 22nd, but had met with the Employer and Mr. Parsons. Ms. Pinsent described her duties as Local President, as upholding the contract. She had...

> got a call from head office from either Ms. Best or Mr. Earle to deal with the problem. Mr. Parsons approached me.

She had started at the Home in June of 1993. Asked whether there was an orientation at the time, Ms. Pinsent said:

> It was very vague at the time. It has changed now. It involves much more than a meeting with Doris Dorey... You are required to read through the policy manuals and are expected to review all new or revised policies. You have to read and review them; and, if you don't, you get a note in your cheque saying you have not reviewed them. That's been the practice for a number of years now. I don't know how long. You have to review and sign that you have reviewed... The (Consent #8) policy document is required to be read on the first night of orientation.

She also confirmed that she is familiar with the "witnessed abuse" provisions Consent #8, p. 6), and that:

> all are required to have knowledge of it. It sets out how I am to proceed if I witness abuse. If I witness abuse I remove the resident from the danger and go immediately to a supervisor.

Asked whether she would wait a number of days before doing anything, Ms. Pinsent answered, "No." Ms. Pinsent also confirmed that:

> Administrators have talked about this policy, including Linda Somerton, Paul Fisher. There was a session in 2005 or 2006... This is the same policy under both alleged abuse and under the other policies in this document.

Asked whether Consent #8 (p. 2) policy governing behaviour in the Home is adhered to. Ms. Pinsent said:

In terms of speaking softly and keeping noise to a minimum, no. The language policy is not adhered by any staff, visitors or residents.

Asked if Ms. Somerton or Ms. Bellefleur have enforced this policy, Ms. Pinsent answered, "No."

Ms. Pinsent also testified that the RN on night shift plans and assigns the partnering or pairing of staff for the next morning. Asked whether partners are ever separated during the day, Ms. Pinsent answered:

> Yes, 80% of the time. In the morning you are expected to get the work done, get the corridors cleaned so that there are no carts around. You are expected to get the change-outs done early and the corridors cleaned. Ms. Bellefleur has called RNs back from break to deal with this rather than to speak to the frontline people. She is Ms. Somerton's boss... The Local Union has discussed this with the management more than once.

Asked whether she has personally cared for Mr. A, Ms. Pinsent said:

> I am normally on South, but some days one of the South's staff goes to the North to help out with change outs. That's the only time I have ever done it.

Ms. Pinsent confirmed again that she is familiar with the requirements of the Code of Ethics and particularly with the need to report.

> Mr. Fisher has told us we are not to leave the building. We could be facing suspension or a different type of discipline if we did... The college has disciplinary authority in such matters.

Ms. Pinsent recalls attending a meeting with Mr. Parsons on December 20th. Present were Ms. Pinsent, herself, Mr. Parsons, Ms. Andrea Whyte and Ms. Linda Somerton. Ms. Pinsent confirmed that she took handwritten notes of the meeting and identified SP #2 as a copy of those notes. "I keep these notes, just notes to myself, taken at the time of the meeting." Asked why she keeps such notes of meetings, she said: "I keep handwritten notes in any meeting I'm in."

Ms. Pinsent confirmed that, with reference to the December 14th complaint, 9:30 to 10:00 was specifically identified as the time frame. She also confirmed that Mr. Parsons had denied any knowledge of the incidents. No mention was made of the fact that Mr. Parsons had worked on the night of the 18th. She was not given copies of the written complaints. Asked whether the name of the resident involved was actually given, Ms. Pinsent answered:

> It's not in my jot notes, and I would normally have it there. I am not sure we were ever told the name. The meeting was a ten minute or a five minute meeting. It was very short, and it was the first information concerning the charges. George said that he knew nothing about it.

Asked why Ms. Somerton might have asked Mr. Parsons about any personal and/or health problems as is noted in AW #1, Ms. Pinsent answered: "George does have a heart condition, and the Employer is very aware of this." Ms. Pinsent went on to say:

> That's basically what happened. Mr. Parsons was very shocked, yes. Afterwards we talked, and he was really shocked. After we left the meeting, shocked, floored, did not know what they were talking about.

Ms. Pinsent said he had not got upset with the Employer during the meeting, and had not made any comments. "No. He did not know what was happening or what they were talking about. He was really floored, really." Asked whether he had been provided with any explanation, Ms. Pinsent said: "No; just that morning care was involved as noted in SP #2." Ms. Pinsent said that from December 2007,

> ... since Ms. Somerton has been in charge, it's been better in terms of the pressures to get work completed in the morning; but Ms. Bellefleur was there in December 2006... Your whole day is structured. There is so much to do that it is not always possible to walk away and leave the care to be done later if it is difficult.

Asked whether there had been meetings with the Employer other than the December 20th meeting, Ms. Pinsent answered:

> Only when George was terminated; but I attended meetings with other employees, and kept notes. Yes, I always keep minutes. It goes back to when we were first unionized and my handwritten notes were used in evidence. I consider it quite important.

Ms. Pinsent identified as SP #3 a collection of handwritten notes taken at the time of interviews with other staff on December 29, 2006.

Ms. Pinsent confirmed she had seen C #10 before, but had not received it in the mail. When informed that Mr. Fisher had told Ms. Somerton it had been sent in the mail, Ms. Pinsent said: "I did not get it in the mail. It's an old document. I graduated in 1991, and it was old then." She did receive Consent #9 in the mail.

It came in our licence this year. We get the code of ethics every year. Mr. Parsons was terminated a year before Consent #9, but we get a Code of Ethics every year... The College requires immediate action when there is abuse involved. Twelve days is not acceptable. It's not acceptable to go home without reporting. Mr. Paul Fisher told us that.

Ms. Pinsent confirmed that Ms. Newell is also a member of the same college. She also confirmed she is familiar with Consent #5, the incident report completed by Ms. Newell on December 20th relating to an incident dated December 8th.

Ms. Pinsent said she was aware that Ms. Lisa Barrett had been a student at the time of her report (Consent #4), and that she had been in the facility working there previously. "She came in to help to feed a resident on the north wing. It was very common knowledge." Asked if she found it strange that Ms. Somerton could not recall that fact, she said:

It should be strange, yes... No one can just feed residents because of swallowing reflexes and dietary restrictions.

Ms. Pinsent had not been aware that Ms. Barrett had been in the Home 12 years previously. She had no knowledge of Ms. Lisa Barrett, other than as noted above, aside from speaking with her casually. She was aware that the staff on north wing had spoken about her presence, and had spoken to her about it as a Union representative. "I instructed them to speak to Linda, as it was outside of the Union contract."

Ms. Pinsent described the day Mr. Parsons was terminated.

It was in the afternoon, very difficult day. The staff were very upset. Co-workers were crying... Nobody (could believe it)... I remember going to the staff room. It was very, very difficult. He worked there thirty-three or thirty-four years. He and Gayle are our longest employees at the Home.

Asked how long the meeting lasted, Ms. Pinsent answered:

Five minutes, maybe ten. He was terminated and that was it, Marsha Hiscock, Beverly and Linda. There was no introductions at all, just 'out the door.' Myself, George and Rowena ... I'm not sure if Andrea White was there. (Mr. Parsons's) response was pitiful. He was in complete shock. There was no discussion. It was later in December. I don't recall the date. The meeting on SP #2 was December 22nd, and then the investigation, and then on December 29th we met with the employees, a full week later. Yes it was during Christmas. The Union had agreed to extend the time limits.

ON CROSS EXAMINATION Ms. Pinsent testified that:

> The termination meeting may have been in early January. I was at the meeting. I never took notes – not long enough there to take notes at that meeting.

Asked if Mr. Parsons had received copies of PN #1 and LB #1 by the time his termination, Ms. Pinsent answered:

> Yes, at the December 22nd meeting. I was not there at that meeting... At the December 20th meeting George was floored. He didn't know who they were talking about.

Ms. Pinsent was asked to review AW #1 dealing with the December 20th meeting, which reads, in part:

> "George stated that he knew nothing about it, he could not remember anything happening with (naming Mr A.) on December 8th or 14th, in fact he could not remember what he might have said yesterday."

Asked to explain how this fits Ms. Pinsent's testimony that Mr. Parsons did not know which resident they were talking about, Ms. Pinsent said:

> After the meeting we did not know who or what was being talked about. It was just "a resident".

Asked whether she herself had not asked who the resident was, Ms. Pinsent said:

> No, because they said there was a written statement. They said they were not in a position to reveal the name ... I don't recall asking. My (SP #2) notes were all that I jotted down. If the resident's name had been mentioned I'm sure it would have been there. I would have put it down from my past experience. If it was mentioned it would have been there, even though the notes are not in great detail.

Asked whether Ms. Pinsent recalls Ms. Somerton asking whether the Grievor had health problems, Ms. Pinsent answered, yes I do and acknowledged that question was not noted on SP #2. "I'm not saying that it was a complete record." Ms. Pinsent confirmed that SP #3 are her notes from the meetings on December 29th and also confirmed that she has no notes of other meetings that were held. "No I was not there." Ms. Pinsent also said the Code of Ethics had been

> ... in place for ten years or more. They sent out the little pocket version. It's in our licences... We've getting "the Scope" at least five years. I believe it came through the mail, yes. All licensed LPNs receive the Scope of Practice.

Ms. Pinsent said had seen Consent #10.

> Yes it is in the filing cabinet at the Home in a file marked 'LPNs'. There's some really old material in it... The policy manuals are located on shelving above the desk on the South wing but on the North I believe it is behind the desk... In 2005 and 2006 there were seminars held by Mr. Paul Fisher from the ARNNL dealing with reporting of abuse, and all had to attend, RNs, LPNs included. It was both about abuse and its reporting, and the role of the LPN and the RN in the reporting. It was not just about abuse. Verbal and physical abuse were both discussed in general terms, and the Code and policy, yes; and they talked a great deal about accountability.

On behaviour in the Home and the use of foul language, Ms. Pinsent testified that

> This policy is not adhered to. I have heard vulgar language in different areas, including the lunch room and the corridors from residents, family and staff alike.

Asked if she can recall anyone who was caring for a resident using vulgar or making threatening comments, Ms. Pinsent sai: "No. Vulgarity is not often in the corridors, very unusual. That's in the lunchroom." Asked whether she had heard Mr. Parsons use the word "bastard", She said:

> No. I've heard him say 'shag off' or 'f... yourself'. The staff would be teasing him or goading him on. George is openly gay, and a lot of people don't agree with that lifestyle. A lot of people would goad him. There's lots of inappropriate comments with regard to his sexuality.

Asked whether she had ever heard him raise his voice, Ms. Pinsent answered, in the lunchroom, talking, that's about it."

ON REDIRECT EXAMINATION Ms. Pinsent confirmed that Mr. Parsons's use of such language was directed to staff and he was usually responding to comments from other staff.

THE THIRD UNION WITNESS was Ms. Rose Marie Abbott who has been a PCA with the Pentecostal Senior Citizens' Home for the last three years and nine months, and has worked with the Grievor as a PCA as a casual temporary. "I never worked a big lot with him; mostly nights."

Ms. Abbott described Mr. Parsons's work as "excellent", and his treatment of residents as

> Really, really good, excellent and similarly as a co-worker excellent again. He's a really good worker, really caring for the residents, never a problem with his work.

Asked whether she had been interviewed by the Employer and Eastern Health about the matters at issue, Ms. Abbott said: "Yes, by Linda and Bev, and people from Eastern Health, and

Sharmaine..." Ms. Abbott confirmed the notes in SP #3. She could not recall being on the North wing on December 8th. Nothing stands out in her memory from the December period. "No, I only heard about it after the dates here." With reference to AW #1, Ms. Abbott said she had not heard Mr. Parsons shouting at Mr. A. Asked whether she was, in fact, on the North wing on that day, Ms. Abbott answered: "Yes, apparently so."

Asked about her comment (recorded in SP #3), that Mr. Parsons was perhaps "too caring" or cared "too much" for residents, Ms. Abbott said: "George wouldn't have any wrinkles in their clothes or anything like that."

Asked if she ever heard Mr. Parsons curse on a resident or shout at a resident or swear at a resident, Ms. Abbott said:

> I have not heard of that then or any other time. You might hear a person swear any time anywhere, but not on a person or anything like that.

Ms. Abbott finished her PCA in May, and was hired as of June. "I did my work term there." She confirmed her statement as recorded at the end of SP #3 that if she had observed any abuse she would report it. "If I saw anything, I would report it right there and then." Asked whether she would wait twelve days to do so, Ms. Abbott said:

> No. Right there and then. Mr. A has been in the Home since I worked there; before actually... He is really hard to work with: hands raised, resisting care and you do have to try to clean him up, but with his kicking and slashing out at you... Usually he is grabbing at you. If you're bathing him, it's the same way. He is resisting care and he's making sounds, grumbling, mumbling, things like that.

Asked if there are times he accepts care, Ms. Abbott answered, "Not very often." Asked whether Mr. A could be described as "docile", Ms. Abbott answered, "No... gentle, he's not."

Ms. Abbott said that Ms. Lisa Barrett:

> grew up along side of me. She was there on her work term. I did not interact much with her in the work place, and never had occasion to work with her. I was never paired up with her, but she was there in the building... She was there previously, prior to December 2006. Yes she used to come in and do feeds.

When it was pointed out to Ms. Abbott that a management witness had said she was not aware of that fact, Ms. Abbott said:

> I could not approve anything with my very own father and he moved in there this week. I couldn't approve anything with him except through procedures... Ms. Barrett is very loud and outspoken. If you're around you had to hear her...

As a PCA Ms Abbott is not authorized to make entries on a resident's chart, but "I can look at the charts and I'm allowed to take glucose levels and chart that."

Asked about Mr. Parsons' demeanor and if she would suspect him of resident abuse, said:

> I like working with George. He's very caring, and that's the main objective here: caring for the residents. , Ms. Abbott said, I'd never say it would happen.

She said she would have no problem if he were to return to work at the Home:

> No, none whatsoever, and my father is there... He is particular, especially about their clothes; they're lying on it all night – so as not to mark their skin. We care, all of us care, about the residents not being abused. George is a little step ahead of us.

Asked whether Mr. Parsons would call attention to any deficiency in work, Ms. Abbott answered: "He'd say, come on now we've got to fix that."

Asked whether comments are sometimes made to Mr. Parsons in the staff lounge, and whether he reacts or not, Ms. Abbott answered: "Like you would. He's human. He's got feelings. Yes." Asked whether he would tell someone where to go, Ms. Abbott answered: "Yes, like I would myself."

ON CROSS EXAMINATION Ms. Abbott testified that she is ... "a casual, so I work as I'm needed, nights or days. I've probably worked more days over the three years and nine months I've been there." Asked whether she bathes residents at night, Ms. Abbott said:

> Not full tub baths at night, no; and the residents are settled by ten or ten thirty in the evening... now a bit earlier because extra workers on the North side.

Ms. Abbott confirmed she had worked "mostly nights with George." She confirmed that:

> Now Mr. A is getting worse, since last summer, especially when you're washing him. And is more resistant. In December 2006 some days he'd be better than other days: sometimes then, but he's been a resistant resident as long as I've been there.

It was pointed out that SP #3 records Ms. Abbott as saying that "nobody curses and swears at the Home." She was asked whether she regards that comment as accurate. "What I'm talking about is not vulgar language. There is more of the "f" word and "C" word...(referring to

the use of the Holy Name)" Asked whether she would regard the use of the word "bastard" as cursing or swearing, she said, "No." She said she believes someone did ask her about this in the December 29th meeting.

ON REDIRECT EXAMINATION Ms. Abbott clarified her shift pattern.

THE FOURTH UNION WITNESS was Ms. Gayle Boone, a PCA at the Pentecostal Senior Citizens' Home for 35 years. "Mr. Parsons was there when I went there."

Asked whether, as a PCA, she had worked with Mr. Parsons, Ms. Boone said:

> Yes I certainly did and hope to again...He's a pleasure to work with, and as a co-worker, he's very good; everybody loves him. He's a perfectionist. You can't make a bed like George. The residents all love him... It's like they're his own. (When she heard of his termination,) I was shocked, and did not believe it.

Ms. Boone was not interviewed about Mr. Parsons. Ms. Boone described him Mr. A as ...

> very aggressive on times, wouldn't let you near him. I wouldn't do him myself. He fights with you, kicking the sponge out of your hand, like last night... Washing his face, sometimes you'd have to leave and come back. His legs going, and he is very strong. Sometimes he is scrunched into a ball, even to change his *attends* ... No, he's not big, but he's a strong man. Someone would have to hold him if I was washing him, and he's bawling out all the time.

Asked if this was true in December 2006, Ms. Boone answered: "Quite often at that time," but she agreed that "there were times when you'd not have a lot of trouble with him."

Ms. Boone described the regular daily routine of washing and dressing and getting residents up into their chairs. The staff are detailed as groups of two to deal with twelve to fourteen patients each. Ms. Boone also described the daily routine, starting at 7:20 AM.

> The morning break is 10:00 to 10:15 for half of the staff and from 10:15 to 10:30 for the other half and at 11:45 the noon trays come out. On Tuesday morning there is a schedule for church and Sunday both morning and evening.

Ms. Boone recalls a student, Ms. Lisa Barrett, who worked there in December of 2006. She did not work with Ms Boone, "but I did know her when she used to come to feed another resident." Asked whether Ms. Somerton was there, and whether it was possible that Ms. Somerton knew Lisa was there at that time, Ms. Boone answered: "Oh yes. We'd complain to her." Asked whether she personally made a complaint to Ms. Somerton, Ms. Boone answered:

> It's in report. She comes, so I can't see her saying it when I know for a fact when we complain to her about it.

Asked what someone should do if one observes an LPN doing something inappropriate, she said:

> Ms. Somerton used to say: 'If it isn't written down it didn't happen, so make sure you write it down.' That's Linda, time and time again. You'd expect to see it in the chart, everything is there. Basically, if a family member comes in she needs to be able to say what happened... Pat Newell is an LPN and she does chart, and a nurse has to chart... Especially the last two years for sure it is drilled into our heads about charting.

Asked about the use of foul language in the home, Ms. Boone said: "No more than elsewhere, but not in residents' rooms." Ms. Boone has heard nurses swear.

Asked what her reaction would be if Mr. Parsons were to be returned to his job, Ms. Boone answered: "I can't wait. If I thought George Parsons would take care of my mother I'd rest easy... Not a problem."

Asked whether she would report abuse if she observed it, Ms. Boone answered: I'd report it after I had spoken myself. I'd certainly report it. Asked whether she would go away for a day before doing so, Ms. Boone answered: "Not to leave the resident in danger; and the Employer expects me to report it right away."

ON CROSS EXAMINATION Ms. Boone testified that Mr. Parsons addresses the male residents by calling them "'Mister'. Some of them like that."

Asked whether there are times when she would leave a patient and come back later, Ms. Boone answered:

> From time to time, yes; but you can't leave him in a mess. If I can't dress him I'll leave him and come back later.

Ms. Boone confirmed she had been instructed to do that. She also confirmed there were times when Mr. A was more cooperative, and that he has become more difficult since December 2006.

> Yes as he has grown older he's more difficult and more times he is left in the bed. Sometimes he was left in the bed in December 2006 too, but it is more so now.

Ms. Boone said the Grievor is something of a perfectionist.

> Certainly he has got to have the bed just right. He'd let you know if you didn't do it right, certainly. George takes pride in his work... I was on George's team. I worked on his team. 90% of the time I was his buddy.

THE FIFTH UNION WITNESS was Ms. Alice Murphy, an LPN since 1995 at the Pentecostal Senior Citizens' Home as a temporary full time employee. She has worked with Mr. Parsons as an LPN, and is currently on the North wing as a casual, but has worked on both wings. "I got his position." Asked to describe the Grievor's demeanor and care of residents and his interactions with co-workers, Ms. Murphy said, "Excellent on all counts." Ms. Murphy was not interviewed by the Employer concerning allegations against Mr. Parsons despite the fact that she had worked on the North wing with him. Asked to describe Mr. A's December '06 condition, she said:

> He was combative, hard to do, striking out and kicking out, a very hard person to do... hands and feet going and he's bawling. Back then it was audible sounds... There were times when Mr. A could be more cooperative.

Ms. Murphy said she was aware of a student in 2006...

> She used to come and feed residents there... We had a conference about if she choked a patient, who would be responsible. It was put to her in a ward conference. I was off when she was there as a student. I was there when she and her mother were doing the feeding.

Asked whether the Consent #8, (p. 2) policies on behaviour and language use in the Home are observed, Ms. Murphy answered: "No. We laugh and joke and carry on." Asked if the prohibition against offensive language is enforced, Ms. Murphy answered: "Sweet Jesus, no. It's a part of my speech." She testified she has never been reprimanded.

Ms. Murphy was part of the negotiating team that brought the Union to the Home. Asked whether discipline is managed under the Collective Agreement or the Employer Manual, Ms. Murphy answered, "the Collective Agreement I assume."

Asked if she would have any problem if Mr. Parsons were to be returned to his job, Ms. Murphy answered: "I'd go back on the casual list for him tomorrow." Asked what would happen if the Grievor were dissatisfied with her work, what he might do, Ms. Murphy answered: "He would stop it and he would go to an RN and she'd take it beyond that." Asked whether he would wait for ten or twelve days, she said: "No. Do it right away. It's our duty as LPNs to do that."

Ms. Murphy has the right to chart and confirmed that she would certainly note it in the chart. "Ms. Somerton always said, 'If it's not in writing, it did not happen.' Everyone knows that. A few years back Paul Fisher was out, and it was mentioned then: 'chart, chart, chart.'" Asked whether a LPN has to be told that he or she is obligated to chart, she answered, "If you need to be told, you shouldn't be there."

Asked what she would do if she observed a resident receive a blow and having his arms forcibly put down on the bed, and how she would react, Ms. Murphy said: "Report it, and then note it as a LPN; just as usual. If there's any rough handling, if you see it you report it."

ON CROSS EXAMINATION Ms. Murphy was asked whether forcing a patient down onto the bed would constitute resident abuse, she answered, "Yes."

She confirmed that Mr. Parsons had no problem expressing dissatisfaction with things in the Home.

She also noted that "On the floor I'd hear swearing. It would be at the nursing station, in the hall or just in general conversation. I swear a lot, and others swear as well." Asked whether this was so in residents' rooms, Ms. Murphy said: "I've never ever heard anyone swear on a resident." Ms. Murphy also confirmed that:

> In 2006 there were times when Mr. A was more cooperative. I know he has deteriorated. In December of 2006 we used to have to leave him and try to come back, but he's mood would not change. You can't leave him in faeces and urine, so sometimes in the day I've got to take a beating. It's during his care that he is combative. He's better some days than others.

Ms. Murphy confirmed that she has seen Consent #2 at the Home and specifically on the North wing but does not have a copy of C #2 herself. She received "a copy of the ethics card in my licence this year. I could have got it in previous years. I know I got it this year." She cannot recall seeing Consent #10 previously, but she knows that abuse is not tolerated.

Ms. Murphy was not, herself, at work at the Home on either December 8th or December 14th, 2006. Asked whether Mr. Parsons swears, Ms. Murphy said: "Yes, I guess so. Yes, I've heard him swear, yes in the work place. Yes, no more than the rest of us, a lot less I'd assume."

THE SIXTH UNION WITNESS was Ms. Alva Guy-Noonan, LPN at the Pentecostal Senior Citizens' Home in Clarke's Beach, who has worked with Mr. Parsons from time to time on the same team. "I am a permanent half time: 37.5 hours over a two week period." She was working with Mr. Parsons on the same team in December 2006. Asked how he interacts with her as a co-worker, Ms. Guy-Noonan said: "Good, yes and he has a good rapport with residents and families." Asked how he normally addresses residents, she said:

> We all have different ways with addressing: maybe 'Uncle' or 'Duckie'. Many times they will say, 'Don't call me 'Mister' or 'Mrs', and often it's first names.

Ms. Guy-Noonan was interviewed by Employer representatives. Present were "the CEO, Ms. Beverly Bellefleur, and the Director of Nursing, Ms. Linda Somerton, and two Eastern Health people and Sharmaine Pinsent." Asked if she had been questioned about certain dates and recalls anything unusual at work on those days, Ms. Guy-Noonan said: "No, nothing stood out." She confirmed that SP #3 (p. 1) describes the meeting to which she is referring. She recalls she was asked about events on December 14th and December 8th. "I said I worked the 14th paired with George Parsons. He was my co-worker for that (entire) day." The coffee breaks are between 10:00 and 10:15 and then between 10:15 and 10:30, She testified that Mr. Parsons would be "on his own" while she was on break. Asked what she would be doing during the period when she was alone, Ms. Guy-Noonan said: "You'd do a lighter care resident yourself." There are other occasions on which she would take care of a resident by herself. "Oh yes. Those 4 or 5 you do alone you split up." Asked if she provided care to Mr. A with Mr. Parsons on December 14, 2006, she said: "No there was a student there at the time. That was the only time I saw that student."

Asked whether she finds the mornings busy, Ms. Guy-Noonan said: "Yes, extremely heavy workload; from 7:30 until noon it's very busy." Asked how many residents she had cared for that morning, Ms. Guy-Noonan said: "Normally it is about 14, depending on the group."

Ms. Guy-Noonan said nothing stood out in her memory about that day. Asked whether the other person sharing the room with Mr. A, Mr. Kippenhook, had made any unusual comments, Ms. Guy-Noonan said:

> Nothing stands out. She and George did the heavier care, and I did the lighter care. At break time she and George went on break.

Asked whether the student, Ms. Barrett, could have approached her on that day, Ms. Guy-Noonan said, "Yes." Asked whether she had been aware of Ms. Barrett's presence in the Home on an earlier occasion, Ms. Guy-Noonan said: "yes, she used to come in to assist with the care of other residents." Asked who had authorized that, Ms. Guy-Noonan said: "I would think that Linda Somerton approved it. Right at the entrance is the door to her office."

Asked to describe Mr. A as a resident, Ms. Guy-Noonan said:

> Of all of the residents, he is one of the more difficult to give care to, and was in 2006... The care plan is updated by the RN but the LPNs, Ms. Somerton, and Ms. Bellefluer also have access to the care plan and the chart. The care plan is built up out of the individual needs, diet and mobility of the resident. All are noted in the care plan. Care plans are discussed at the ward conferences where Ms. Somerton sits in every week, on Monday on the North wing and on Thursday on the South wing. Georgina Coveyduck (the Social Worker) sits in as well on times. All of them would be familiar with the discussion concerning residents.

Ms. Guy-Noonan described training provided in the care of patients who are resistant.

> The training involves instruction in how to hold arms and legs... You do what you have to do so that they do not get hurt, and you don't get hurt... That is part of the LPN training, yes.

Asked whether Ms. Barrett had said anything, Ms. Guy-Noonan said: "I don't recall any conversation with her at all." She said she had not heard any loud noises on the morning of the 14th or cursing or swearing, and that LPNs, housekeeping and maintenance people are normally among ongoing traffic, and that "anyone could enter a resident's room unannounced at any time."

Asked to describe her own experience in dealing with Mr. A, Ms. Guy-Noonan said:

> There were times you could do him yourself, and sometimes I would need two people with me... He's very defensive. As soon as you go near him, he pulls back.

Asked why she would not just simply leave the patient and come back later, Ms. Guy-Noonan answered:

> You can't just leave him. His family is coming. He has to be changed out. You have to turn him over. The bedrail is up on the side he's facing. He'll be pushing against that for all his worth...

Asked whether a resident might fall to the floor, Ms. Guy-Noonan answered: "Not while the rail is up. He'd have to get over it. I've never seen it."

Asked who is responsible for charting, Ms. Guy-Noonan answered, "The PCA will pass on to an LPN and LPNs and RNs are responsible for the charting."

Ms. Guy-Noonan confirmed she had seen Lisa Barrett when she was feeding patients and had a conversation with her.

> It was just a matter of her approach. In her feeding she was being maybe a little too fast. I was very surprised to she her there in a student capacity. I did not expect to see her working in that environment.

Ms. Guy-Noonan confirmed that if Mr. Parsons were upset about something "he'd probably say." Asked if she had any difficulty working with the Grievor, Ms. Guy-Noonan said:

> He'd be my choice pick. If I had to choose for someone to care for a relation belonging to me, I'd choose George. He's so particular with his care. It's just exceptional, the bed sheets and everything to perfection.

Asked whether support of residents is part of the normal training, Ms. Guy-Noonan said:

> Yes. It's more than just cleaning and feeding. LPNs express compassion and respect; and conversational skills are important. Sometimes, just sitting with them, looking at a book.

Asked to think back on her care of Mr. A in 2006, Ms. Guy-Noonan said:

> Sometimes he'd recognize me. I've known him for many years and he's got worse, but even today he'll make a comment that I realize he does recognize me.

Asked if there are times in this kind of work that one has to make slight deviations from the book, Ms. Guy-Noonan said: "Sometimes you have to use common sense, and that's not always written in a book."

Referred to Consent #8 (p. 2), Ms. Guy-Noonan confirmed that staff do not always speak softly and that she has...

> heard all kinds of language in there, not just from LPNs, but from all staff. For some people, it is just their personality; that includes nurses and residents and visitors. I don't know of any workplace where you don't hear it.

Ms. Guy-Noonan confirmed she would act as set out in Consent #8 (p. 6) if she were to observe resident abuse, and that she would report such an observation when it happened. Asked

why she might not wait some days, Ms. Guy-Noonan answered: "It would be fresh in your mind, and you would be liable to the Employer and to yourself." Asked whether she would note the matter in the patient's chart, Ms. Guy-Noonan said:

> Oh yes. At every ward conference you are reminded of documenting: 'document, document, document.' In the medical report... as well... For abuse, I'd go and report and get my notes on paper right away. If I saw something like that, I'd be so upset I'd not be able to do anything anyway.

Ms. Guy-Noonan is familiar with Ms. Patricia Newell. Asked who assesses a resident if an allegation is made, Ms. Guy-Noonan answered: "I assume that it would be the RN reporting to Ms. Somerton who would report to the doctor and the doctor to do the assessment."

ON CROSS EXAMINATION Ms. Guy-Noonan confirmed she knows Mr. A and his family, including his wife and daughter.

> They visit daily for a couple of hours. His wife comes in the evening. They visit at various times, but Mr. A's wife is most regularly an evening visitor. His daughter is usually at supper time... Sometimes he does respond to his family. He always has.

She confirmed she has been an LPN for sixteen years. "I did work other places as well." She has sometimes been assigned to the South wing for a shift but her permanent status is on the North wing.

In Ms. Guy-Noonan's view the normal approach to Mr. A is that:

> You go in and access him; and just the way he looks, you will be able to tell if he is cooperative. Even at breakfast you know if he is cooperative, you can sometimes get a read from him. If he is to be difficult, I will wait for a co-worker to be with me and we would do him together.

Ms. Guy-Noonan agreed that this means there could be a delay. Asked whether it would be necessary to have their face washed if a resident were being very difficult, Ms. Guy-Noonan said:

> Of course it would... There are times I would let a shave go, but you cannot leave their eyes in discomfort. I would walk away for the time, but I would come back and do it. Yes I would wash his face.

Ms. Guy-Noonan also confirmed that Mr. Parsons provides residents with emotional support: "We all have to do that."

Asked if she is aware of Mr. A's family complaining of Mr. A's care, she said: "If he is not out of bed, they will ask." Asked whether they acknowledge that he can be difficult, Ms. Guy-Noonan answered, oh ya. "They would understand." Asked whether she had heard Mr. Parsons swear, Ms. Guy-Noonan said:

> I probably have: downstairs, not up on the floor. Perhaps more on break. I can't recall any particular incident. Some people just in conversation or in frustration. I don't swear. There are those who do.

ON REDIRECT EXAMINATION Ms. Guy-Noonan said that in her view it is a form of abuse to leave a resident without being cleaned up.

> AM care begins at 7:20, before that residents would have been done between 5:00 and 6:00 am... It could be as long as three hours. There could be skin breakdown. It is best to get it off.

THE FINAL UNION WITNESS was the Grievor. Mr Parsons testified that he had started work at the Pentecostal Senior Citizens' Home on March 7, 1973 and graduated with his LPN in 1989. He has also done glucometer and wound care courses in the continuing education. Mr. Parsons has worked at the Home for his entire career. He has worked nowhere else.

Mr. Parsons identified as GP #1 his *Cooperative Annual Review of Employees* dated October 26, 1990 which he had signed on that date. On all counts Mr. Parsons scored 4 out of 5, both on his own estimation and on the Employer's evaluation. GP #2 is theevaluation completed on February 26, 1993 in which Mr. Parsons's own evaluation was surpassed on a number of accounts by the Employer's evaluation. The same pattern was revealed in the February 19, 1996 evaluation which Mr. Parsons identified as GP #3, and in the August 6, 1999 evaluation which Mr. Parsons identified as GP #6. Asked why he continued to evaluate his own performance at "4" rather than "5" on many of these evaluations, Mr. Parsons said: "I always looked at 5 as a fashion show. I did not think I deserved the 5."

Mr. Parsons confirmed the evaluations were found on his personnel file and that LS #1 is a similar performance evaluation dated October 20, 2003 signed by both himself and Ms. Linda Somerton who was then Department Head and is now Resident Care Manager. That evaluation showed the quality of his work as exceptional and, in several categories, Mr. Parsons had scored the highest possible rating. He confirmed he was aware of his rights under Article 13.08 on

performance evaluations. He is aware the Union had requested to review his file. Asked whether the Employer had reviewed his file at the time of termination, Mr. Parsons answered, no.

Mr. Parsons is also aware of his rights (under Article 13.05) that anything on his record older than eighteen months cannot be used against him, and similarly of his rights under Article 13.06. He is aware that Article 3.08 specifies that the Collective Agreement overrules Employer policy. He confirmed that Consent #8 is to be found at both nursing stations, and that (at p. 3) it specifies that "any action taken shall be in accordance with the procedures outlined in the Employer Manual."

Mr. Parsons testified he was diagnosed in 1995 with a heart problem which required him to be off work for eleven months. There was no difficulty with his sick leave. He identified as GP #4, a letter congratulating him on "your perfect attendance record for the fiscal year 1996/1997. "Yes, that was after the diagnosis. Yes and I went back to work." He also identified as GP #5 a similar letter dated June 9, 1998 congratulating him on "maintaining a perfect attendance record for a second year in a row."

Asked if he is aware of any difficulties arising out of his interactions on the floor with residents or with the team, Mr. Parsons answered: "Not that I know of." Asked whether he has ever had issues with a colleague named Sandra Antle, Mr. Parsons answered: "I wasn't aware of any issues with her, but I have had one or two..." Asked whether he holds a grudge, Mr. Parsons said: "Oh no. I never did." Asked whether he recalls Lisa Barrett from her period in the home prior to December, 2006 Mr. Parsons answered: "She was only in to feed a resident with family permission." Mr. Parsons confirmed the LPNs were aware of the resident and acknowledged that he was himself surprised when he heard Ms. Somerton's response about not having been aware of Ms. Barrett's earlier time in the Hone. "Ms. Somerton would have to have approved it."

Asked whether he was aware of any issue that developed while Ms Barrett was assisting with the feeding of a resident in the Home, Mr. Parsons answered:

> There was some interfering with other nursing staff and other families who were coming in, and saying to some families things like, 'I don't know why staff can't get you mother to eat. I can get her to eat.'

Mr. Parsons said he had heard these comments himself, and that they were reported to Ms. Somerton. When he was reminded that Ms. Somerton appeared not to be aware of this at all, Mr. Parsons said:

> She had to know it. It was brought up in ward conferences... At that time Georgina, Beverly, and Linda were all there. Yes we told the senior nurses. I did not see her called to the office, but I was told that she and her mother were called to the office.

Asked whether he had occasion to make a comment to Ms. Barrett while she was doing the feeding, Mr. Parsons said:

> Yes, because of the reflex and it was necessary to be careful with sweets because conflict with meals and medications and not to feed to fast... She never responded at all so far as I know. It was just a conversation, and I wasn't mad at her or anything. I never interacted with her mother. I just saw her there.

Mr. Parsons said Ms. Barrett had been in the Home "almost every day during the week and weekends."

Mr. Parsons confirmed that he is aware of Consent #8 and its requirements, and testified that if he saw any abuse: "I'd put a stop to it right away, and speak to the person, and then go further." Asked why he would speak to the person, Mr. Parsons answered: "To stop the action." Mr. Parsons confirmed that Consent #8 requires (p. 6 item #7) that the supervisor, department head or facility manager ensures completion of the resident abuse incident report. Similarly section #8 references ensuring that the written report is completed. Mr. Parsons said: "You write up the nurses notes", and confirmed that Consent #s 4 and 5 are both incident reports. He said that "you read the policy manual during orientation and the policy and procedures are read at home." As far as Mr. Parsons recalls Ms. Patricia Newell "started at the Home in spring or summer of 2006" and therefore had "5 or 6" months to familiarize herself with the policy.

Mr. Parsons had seen Consent #10 "at the Home, and "so far as I know. it was not mailed to me." He has also seen Consent #2. "It's in my licence... this year. I have not read it, but I have been getting the little card for some time now." Mr. Parsons confirmed that his licence has to be renewed by March 31st each year, and he is not eligible to work without it.

Mr. Parsons's attention was directed to AW #1 and SP #1. He confirmed he was working "on December 13th and 14th and then off on the 15th, 16th, 17th and 18th, but back to work on the 18th and 19th, the two nights I was supposed to be on." He said he had not been told by Ms. Somerton not to report for work on the 18th, and confirmed that he had worked on the night shift on the 18th. He also testified that Ms. Somerton had not called him on the 18th. Mr. Parsons said that no issue had been made of his presence when he worked the shift on the 18th, and confirmed that he had been told

> ... sometime between 4:30 and 5:00 pm on the 19th, not to report for work that evening. I phoned her, and she said not to report to work. She added: 'We'll discuss that tomorrow... Bring a shop steward with you.' I got to worry about that all night.

Mr. Parsons described the meeting which, as confirmed by AW #1, took place on December 20th. Mr. Parsons said he had not been given any more precise information than that there were co-workers' complaints. He had not been told the name of the resident allegedly involved. Mr. Parsons described Ms. Somerton's asking him

> .. if I could remember 'anything about it', and I said, 'About what?'; and she did not say who and did not say when.

Mr. Parsons confirmed that Ms. Somerton had asked him about his health. Asked whether he had been provided with any more details, Mr. Parsons answered: "No. I was not told the resident, or dates, or who reported; and I was not told what I was to respond to."

Asked what he did after the December 20th meeting, Mr. Parsons said:

> I went home. I talked to Sharmaine for about 15 minutes. I never had a clue what was going on. By this time I knew it was physical and verbal but didn't know who against.

It was pointed out to Mr. Parsons that Ms. Pinsent 's notes, SP #2, of the December 20th meeting refer to the reports of the co-workers as being "explicit". Mr. Parsons was asked whether he had seen any written notes. Mr. Parsons answered, "I saw nothing." Mr. Parsons said he had not been aware of the meetings the Employer had held on December 21st with Ms. Newell and Ms. Barrett as noted in AW #1.

Reviewing AW #1 notes of the December 21st meeting, Mr. Parsons was asked whether he had said "old bastard" to Mr. A. Mr. Parsons answered, "No, I did not." Asked whether he had used any other foul language, Mr. Parsons said: "No, I didn't." Asked whether he would describe Mr. A as "docile", Mr. Parsons said: "No ... in December 2006 he could stand on times, but very rare." AW #1 reads, in part, as follows:

"December 20, 2006 ...

Linda and I met with Mr. Parsons and his union representative, Charmaine (*sic*) Pinsent at 1 p.m. Linda told George that there were 2 serious written complaints from co-workers regarding alleged verbal and physical abuse by him towards a resident, Mr. ... <AW # 1 names Mr. A at this point>, on December 8th and December 14th, 2006. George stated that he knew nothing about it, he could not remember anything happening with ... <AW # 1 names Mr. A at this point> on December 8th or December 14th, in fact he could not remember what he might have said yesterday. Linda asked if he was having any personal and/or health problems that may be affecting his work. He stated that he had a heart condition (which Linda was aware of), but stated no other problems. We told him that we would have to investigate the incidents further, and until that time he would remain on a paid suspension.

December 21, 2006

Linda, Bev, and l met with Patricia Newell, LPN, at 2 p.m. Pat reported that on December 8th, 2006, during change-out time, she worked with George Parsons on ... <AW # 1 names Mr. A at this point> . Pat stated that George called ... <AW # 1 names Mr. A at this point> "an old bastard", and used other foul language. He was very rough with ... <AW # 1 names Mr. A at this point> (she used the word "manhandled"), who is a very docile man. Pat and George pulled ... <AW # 1 names Mr. A at this point> to a standing position from his geri chair, to move him to the bed to change him. He became unsteady, and Pat thought he might fall. George grabbed him at the back and pulled him back into the geri chair. They then used a lift to move him to the bed. Pat stated that George yanked the Attends off of ... <AW # 1 names Mr. A at this point> when changing him, and was generally rough and verbally abusive during the whole change-out process.

Pat thinks people in other rooms would have had to have heard George shouting at ... <AW # 1 names Mr A at this point>, and knows that if the other staff on the unit were being truthful, they would admit that George behaves this way on a regular basis. Pat and George moved to the next resident (<AW # 1 names another resident at this point>), where George acted similarly. After that, Pat refused to do any more change-outs with George, and refuses to do any shifts with him in the future. Pat did not report the incident right away, as she was grappling with the decision to report a co-worker. She reported it to Lisa Green, RN, last weekend (either December 16 or 17). Lisa told her to report it to Linda. She reported it to Linda on December 20th.

Linda, Bev and 1 interviewed the student, Lisa Barrett, at 3 p.m. Lisa stated that she was paired with George to do a partial bath for ... <AW # 1 names Mr. A at this point>. George was acting

irritated and annoyed and cursing on ... <AW # 1 names Mr. A at this point>, before the morning care even began (using words like "bastard", "old dog", "f—er" and "you are only breathing our air"). She said George roughly washed his face, after which ... <AW # 1 names Mr. A at this point> put his hands in front of his face, as if to defend himself. George them forcefully pushed his arms down to his sides, and Lisa heard a scrunching noise... <AW # 1 names Mr. A at this point> ... groaned. George then punched him in the rib cage. <AW # 1 names Mr. A at this point>... became more tense, and George yanked out his dentures. He then pushed him roughly to the side, and Lisa caught him because she thought he was going to fall out of the bed. George then said that he "had a mind to kill him". George went on to the next room like nothing had happened.
Linda called George and asked him to meet with us on December 22nd , at 10:30 a.m. I notified Rowena Best of same."

Mr. Parsons confirmed he had been standing to the side of Mr. A's chair, and that the chair wheels were locked. Asked what he had to do in the circumstances set out in the first para. of the December 21st portion of AW #1, Mr. Parsons said, "I'd have reached in and got him by the belt, and sat him down rather than have him on the floor."

Mr. Parsons confirmed that Ms. Newell had been there approximately "5 months as a casual: not a lot of time, because as a temporary she is called in on an 'if needed' basis." Mr. Parsons went on to testify that:

> We had been told to do that grabbing the belt in school. I couldn't get at the brakes. We were told that if the person is unsteady, hold him by the belt, one on each side. Now we've got a proper belt to use. I trained in 1988.... 'BIPP' ... that's for back prevention. Yes that procedure is taught in BIPP.

Asked whether he had "yanked the *Attends* from the resident, Mr. Parsons said: "I don't know what "yanked" means other than you have to tear the tags off."

Mr. Parsons' attention was directed to the observation recorded in AW #1 that: "Pat thinks people in other rooms would have had to have heard George shouting at <Mr. A> and knows that if the other staff on the unit were being truthful, they would admit that George behaves this way on a regular basis." Mr. Parsons was asked whether, in his estimate, people would have heard such language, Mr. Parsons answered: "Yes, they would." Mr. Parsons also noted that on the following line, "Pat and George moved to the next resident ... where George acted similarly." "It would not be <the other resident named in AW #1). (She) is in room 27. This is room 35."

Mr. Parsons also confirmed that Ms. Newell's statement, PN #1, makes no reference to the "next resident" named in AW #1, and no reference to Mr. Parsons acting "similarly", and no reference to people hearing him.

Asked whether he would regard this as "an explicit report" Mr. Parsons said: "No, I would not. No." Asked whether Ms. Newell had refused to work with him, Mr. Parsons said: "No." Asked whether she was paired with him and why, Mr. Parsons answered: "No, she came over from South wing for the last 4 hours with us." Asked whether she had refused to work with Mr. Parsons for the period of the 12th and 13th, Mr. Parsons said, "No she did not."

Mr. Parsons's attention was directed again to AW #1 in the third paragraph of the entry for December 21, 2006 where a description of Ms. Lisa Barrett's allegation is recorded. Mr. Parsons testified: "I washed his face as I normally wash faces there. He was resistant for care... She (Ms. Barrett) was only there a couple of weeks." Referring to Ms. Barrett's description as reported in AW #1 of the resident putting "his hands in front of his face, as if to defend himself", Mr. Parsons said: "That's the way he is."

With reference to AW #1 describing Mr. Parsons as "then forcefully pushed his arms down to his side, and Lisa heard a scrunching noise... <Mr. A> groaned", Mr. Parsons said:

> I have no idea what she is talking about... 'Scrunching'? I don't know what she's talking about... He always groans. I probably moved his arms, yes.

Asked whether he had "punched" the resident, Mr. Parsons answered: "No, I didn't. Certainly I did not." Asked, with reference to the claim that he had removed Mr. A's dentures in a rough way, Mr. Parsons said:

> How do you yank out dentures? I did take them out, and left them in the container for his daughter to put them in at lunch for fear he would hurt his mouth.

Asked whether Mr. Parsons had pushed the resident roughly, Mr. Parsons answered:

> When we went into the room at 10:00 am, Alva was on break. I told Lisa that maybe she should wash Mr. Kippenhook, and suggested she have a conversation with him and tell him what kind of day it is. I'd do Mr. A because he's more difficult than Mr. Kippenhook.

Mr. Parsons confirmed that one could carry on a conversation with Mr. Kippenhook, and that he had not given care to Mr. Kippenhook that morning.

> I did not do Mr. Kippenhook. Lisa ... did Mr. Kippenhook. I did not put the rails down. I always work with bedrails up. I say I'm old school, and do not work with the bedrails down.

Asked whether he would turn a resident on to his side if the bedrail were down, Mr. Parsons answered: "No I would not."

Mr. Parsons's attention was directed to LB #1 which speaks of the incident as having occurred "after breakfast at approximately 9:30 to 10:00 am." Mr. Parsons said: "It was 10:00 am that Alva went to break, and I said, we'll be here till you get back." It was pointed out to Mr. Parsons that in her earlier testimony Ms Barrett had said was that it had been before the trays had been circulated, Mr. Parsons answered:

> No it was ten o'clock. She was doing Mr. Kippenhook... The only thing she helped with was to pull up his pants. Then I got the lift and put him in his chair.

With reference to the allegation that he had punched the resident in, or below, the rib cage, Mr. Parsons noted that "It is very easy to break bones and there might be bruising" and agreed that the xyphoid process "is very easy to break." Mr. Parsons confirmed that organs like the lungs and liver might also be involved, and there might be internal bleeding.

Asked whether Ms. Barrett had mentioned hurting her back, Mr. Parsons said:

> She did tell Sandra Antle she hurt her back. Sandra said, maybe she had better not do residents. I said that Ms. Somerton had put her there to do residents, but I did agree and said, 'If you feel hurt, you better not do any more residents.' Lisa went with me to break. I did not know anything else after that until I saw them (LB #1 and PN #1).

Mr. Parsons said he first saw LB #1: "When I went out to meet Rowena to the Home on the 22nd. Mr. Parsons's attention was directed to the AW #1 description of the meeting on the 22nd. He confirmed that those present were Ms. Marsha Hiscock, Ms. Linda Somerton, Ms. Andrea Whyte, Ms. Rowena Best and Mr. Earle.

> We'd been given no copy. Ms. Best said, 'How can he respond, not knowing what was said?' That's when they brought copies to the staff house. We were provided with them at Rowena's request.

Mr. Parsons provided a written reply by January 5th, as agreed with the Employer. Consent #6 is a copy of that written reply which he, himself, had prepared and submitted on January 3, 2007. Consent #6 is a handwritten document that reads:

"January 3/2007

To whom it may concern

Re: Accusations of Physical and Verbal abuse

Please be advised that I have never physically abused any person in my life. The resident in question is probably the most difficult resident we have which (*sic*) resists in everyway when we come trying to provide care putting his arms up and making fists which makes providing care very difficult. This is not a resident you can leave and go back to because providing care is always the same. Someone new working in the same room would very easily think of this as physical abuse no (*sic*) used to the situation or working in long term care.

When it comes to taking this residents (*sic*) teeth out, this is also a very difficult thing to do and also trying to get the teeth back in his mouth, many times they are left out for a family member to put in even his own daughter says he is very difficult. When it comes to rushing around, we all rush around during am care when trying to do some residents before breakfast trays come out.

I have never verbally abused a resident in my life. I know I am outspoken and do mouth off to staff if things are not as tidy as I like.

I have giving (*sic*) my life to nursing and service to the Pentecostal Home for almost thirty-four years, and have enjoyed my years of service and consider myself to be efficient and thurer (? *sic*)... in all my care of residents at the Pentecostal Senior Citizens' Home. I consider myself to be an excellent LPN and try to provide the best care possible.

I am truly appalled at these false accusations which have been made against me no (*sic*) of which are true and am stressed to the limit to think that someone would take my character in this manner.

I am asking you to please consider my years of service to the residents of Pentecostal Senior Citizens' Home and again state to you that none of these accusations are true.

Whatever the outcome of these investigations my name has been tarnished and that I will never change.

Thank you

George Parsons"

Describing Consent #6, Mr. Parsons said: "Yes, I signed it in my handwriting and gave it Marsha Hiscock, I think." There was no discussion, he was not questioned about this statement. Mr. Parsons went on to say:

> No matter when you went, Mr. A resisted treatment: not every day, but that day was no worse than any other day for me. His daughter is a nurse. She'd be very upset if he was not done for her to feed him at 11:30. You provide care and talk to the resident, which I do all the time. You're expected to have the job done. They're in bed all night. They have to be washed, and get the soiled clothes off. You can't leave wet stuff on elderly people. It's easy for the skin to break down.

Mr. Parsons confirmed that in December 2006 Mr. A was not able to get out of bed and get to the bath on his own. He was incontinent as to urine and faeces. By the time he was doing Mr. A ...

> On that morning he'd probably had it on about five hours... If you don't change it, the skin breaks down ... and he does not move so he's got to be moved. It is very hard to heal skin in an older person. (Mr. A) is unable to turn from side to side on his own.

Asked what would happen if he were not changed at that point, Mr. Parsons said:

> It would be an hour or two probably to get back to him. If his daughter came in she'd not be pleased if the *Attends* were not changed. I'd expect it off him, no matter how they got it off.
>
> Asked for his understanding of Ms. Barrett's comments, he said:
>
> Her interpretation of the situation was totally wrong. She did not know him to deal with. That's why she was put with us, to learn. Yes he could resist by holding that rail, but I'd never put that rail down.

Mr Parsons confirmed that the Employer had never met with him to discuss his response, and that he next saw the Employer...

> It was on January 8th. I was terminated from my position. Ms. Somerton, Ms. Beverly Bellefluer, Ms. Marsha Hiscock, Ms. Andrea White, Rowena Best, Sharmaine Pinsent and myself were there. The meeting might have been five minutes. They said they had investigated and found that it was true as far as they were concerned, and I was through. I was shocked, floored. I did not know what to say. I expected Beverly and Linda to look at me. They did not look at me. They got up and walked out, and did not look back. Rowena and Sharmaine stayed with me a little while, and I went back to St. John's.

With reference to the Consent #8 policies, Mr. Parsons confirmed he does swear and that "others do as well. The policy doesn't apply." Asked whether Ms. Somerton is aware of that fact, Mr. Parsons said:

> Oh yes, she is. I spoke to her one day about some foul language and she said, 'What the staff are saying among themselves is none of my business.'

Asked whether he would be able to work well with co-workers if he were to return to work, Mr. Parsons said:

> These allegations here today are false. I have no idea why they were made. Yes, I do not hold ill will; I do not. If I saw her here I'd say 'hello.' I have no problem working with her.

Asked whether he would have problems working with Ms. Newell, he said: "No I do not, even though she made these allegations I'd still work side by side with her."

Mr. Parsons confirmed that Mr. Kippenhook "was over by the window, and that he could engage in conversation.

> The curtain was not drawn because Lisa was doing Mr. Kippenhook, and I was supposed to be watching what she was doing... Mr. Kippenhook would be able to see whatever he was doing... Yes. any of the staff or others could easily come into the room at any time.

Mr. Parsons confirmed that GP #9 is his letter of termination, and confirmed that its author, Ms. Beverly Bellefleur, was not present at this Arbitration hearing. He said; "I have no way of knowing" Ms. Bellefleur actually saw his written response, Consent #6, but that Ms. Bellefleur had had no discussion with him at the time of termination.

Asked what he understands was intended by the statement in GP #9 alleging that he had struck the resident in the "torso", Mr. Parsons said, "I have no notion." Mr. Parsons confirmed his understanding that the "torso" refers to that portion of the body that includes everything from the groin to the neck, including the back and sides.

Mr. Parsons confirmed his view that GP #9 summarizes, in the second paragraph, the Employer's reasons for termination, but that Ms. Bellefleur does not reference a violation of the Code of Ethics or of policy and procedures.

Mr. Parsons confirmed he has been an employee of the Pentecostal Senior Citizens' Home for thirty-four years. "I will be 56 in August. I was going to go at 60 with only twelve years but I was terminated without any group benefits."

Mr. Parsons testified he has significant medical costs and that he has had to stop using some medications. "The other drugs cost $180, but I can live without a stomach but not without a heart." Mr. Parsons Employment Insurance "ends this month," after which he expects that he "will have to apply for social assistance." Mr. Parsons identified GP #10 as a notice of discharge in bankruptcy.

Mr. Parsons also testified that:

> For the first three months I wasn't able to sleep or eat since it would all keep going around in my head. My doctor has referred me to a psychiatrist since I feel I'm going out of my head. I try to hide things, saying I was on extended sick leave. Only last Friday I had to tell. The family has been very supportive. The family all know. They knew before the arbitration. I found it difficult to listen to the allegations. It is not in my nature to hurt anyone. I am almost ashamed to be seen. People don't know if it's the truth.

Asked if he has any final comment, Mr. Parsons said:

> The day me and Rowena got the letter of termination, I expected more from Beverly and Linda. I even asked them before, a long time ago,would they wake me a night in the Home. They never even said, 'Take care of yourself.' I've never seen anything so hateful and ugly in my life as when they got up and walked out of that room... I am now waiting for a pacemaker change. I have 27% of my pacemaker left.

Asked whether, after all of this disappointment, he would be able to work at the Home with Ms. Bellefleur and with Ms. Somerton, Mr. Parsons said: "I have not got any ill will. If they spoke to me I'd speak back."

ON CROSS EXAMINATION Mr. Parsons reviewed the details of December 20th meeting, and confirmed that no one had provided any names. Mr. Parsons was also asked to review evidence concerning his familiarity with the procedures under Consent #8, reporting of witnessed abuse.

He was also asked to review his direct testimony about the alleged incidents on December 8th and 14th. Concerning the December 8th allegation that he had addressed the resident as "you old bastard" Mr. Parsons said:

> I never said it to him or to anyone. I would not have said that in a resident's room. I never have, to my knowledge... but yes anything is possible.

When about the December 14th allegation, Mr. Parsons said:

> I would have washed him like I washed any other resident. I don't wash anyone roughly. I found him no different that morning than any other morning.

Asked about the possibility of leaving a resident, if there is difficulty, and coming back later Mr. Parsons answered:

> No. They need their morning care; that's it. Mr. A is always somewhat resistant; not a lot sometimes, but more some days. He is always somewhat resistant.

When it was put to Mr. Parsons that Ms. Barrett had said that she had hurt her back, he said:

> She had to hold Mr. A over to pull up his pants. He was on his side. She was on the opposite side of the bed. She was holding him over so I could get the trousers on.

Asked what care Ms. Barrett had provided Mr. Kippenhook, Mr. Parsons answered: "She washed and changed him. He never got out of bed. It was a partial bath." Asked whether he saw her doing this, Mr. Parsons said:

> I could see her out of the corner of my eye. He had a catheter in. She had Mr. Kippenhook finished when she helped me. By the time she had finished Mr. Kippenhook I got her to come over to help me with his pants. He was resistant with his legs.

Mr. Parsons confirmed he had responded to the allegations in writing and that he had responded to the two statements by the complainants provided to him. Asked why he had not said in that response that Ms Barrett did not assist him but provided care to Mr. Kippenhook, Mr. Parsons said: "I have no idea. I was responding to the allegations." When it was pointed out that he had the documents before him, which were very specific, and that it seems strange he would omit to say that she was not helping him, Mr. Parsons answered:

> I have no idea. I was replying to the allegation of physical and verbal abuse. I was mystified. I did not know what to be writing or how to write it.

Asked if he was aware that Mr. A's daughter would likely be in at lunchtime, Mr. Parsons said: "She was in the past, yes." Asked about his removing the *Attends*, Mr. Parsons said: "I did not rip it off, but you are expected to get it off by just taking the tabs off."

Asked for his definition of physical abuse, Mr. Parsons said, "anything that would injure a resident, hurting the resident, causing injury." Asked for his definition of verbal abuse, he said:

"It could be saying anything: swearing at the resident, calling the resident names. Sometimes if you say, 'my darling'. Mr. Parsons agreed that verbal abuse includes something that might cause offense.

He confirmed he had seen Consent #10 at the Home, and reviewed portions of Consent #10 and of the pocket version of the Code of Ethics. He confirmed he is aware of the provisions of both documents.

Asked if he feels frustrated when things get backed up, and if it doesn't bother him if things get behind, he answered: "No. Routine morning care is morning care... No, it most certainly does not."

Mr. Parsons was asked whether he asked to respond in writing, he said: "They asked me to respond. I was ordered." Asked to comment on his suggestion in Consent #6 that "Someone new working in the same room would very easily think of this as physical abuse..." Mr. Parsons said: "I was talking in general terms about what someone might have concluded, and you could write it up and have someone fired. Asked whether it would have to be extreme behaviour to be confused for abuse, Mr. Parsons answered: "No, not extreme. Someone could interpret it as physical abuse. Yes most certainly could."

ON REDIRECT EXAMINATION Mr. Parsons testified that he would provide the same response today as he provided on January 3rd.

ARGUMENT

FOR THE EMPLOYER Ms. Strong reviewed the evidence, beginning with that of Ms. Linda Somerton, and noting particularly her considerable education in the field and her 35 years experience training staff in the needs of long term care residents. She also noted that Ms. Somerton attended ward conferences on a regular basis.

Ms. Strong also reviewed Ms. Somerton's evidence about provincial standards as they apply to the Pentecostal Senior Citizens' Home and LPNs' professional standards Code of Ethics concerning abuse, which is not tolerated in any form. Ms. Somerton's "client-centred care" philosophy goes beyond "bed and body care", as she described it, involving "the whole person."

Ms. Somerton also emphasized the importance of communicating policies to all nursing staff and providing training in dealing with difficult clients. She emphasized the need to ensure adequate resources, which may occasionally require leaving a resident and returning later to provide care. Ms. Somerton is aware that the Grievor had a good employment record and was meticulous in his work. She noted training that she had provided the Grievor concerning care for those with dementia, and in particular, how to approach them using non-verbal communication.

Ms. Somerton also described the incident of December 14th as it was reported to her on December 18th by Ms Barrett, followed on the next day by a second incident that occurred December 8th and was reported on December 19th. The same resident was involved. She confirmed him to be a challenging patient who suffered Parkinsons disease with attendant rigidity and some dementia, with a changeable mood for whom it is appropriate to come back and try again if it is difficult to provide care on the first occasion. The danger of excessive force is the risk of injury. Any rough handling or hitting or swearing or abuse is never tolerated.

Ms. Somerton also recalled her interview meetings with both the complainants and with the Grievor and that he had offered no apology or explanation. She also reviewed her recollection of interviewing the Grievor's co-workers during the next couple of weeks, and gave a summary of his January 3rd statement which formed part of the decision-making process.

Ms. Somerton also described Ms. Barrett's emotional state in reporting the December 14th incident, saying that she was visibly emotional, and that Ms. Barrett did not work on the day following the December 8th incident.

Ms. Somerton also testified that when she informed Mr A's family members of what had happened they wanted to know when Mr. Parsons returned to the workplace in order to make decisions over their father's care.

Ms. Somerton also testified that the decision to terminate had been made by Ms. Bellefleur and by Ms. Somerton, herself, after interaction with Andrea Whyte and Marsha Hiscock of Eastern Health Human Resources.

The reasons for the termination, in Ms. Strong's summary, include the fact that the Home has zero tolerance for abuse, particularly physical abuse, the Grievor's response to earlier training

about his approach to residents, and, finally, concern for the psychological and physical safety of residents since a high percentage suffered from some degree of dementia. To permit the Grievor's continued employment was felt to breach the trust to those who had entrusted care to the Home.

Ms. Strong then reviewed Ms. Newell's testimony. She had been employed as casual LPN at the Home since April 2006 and worked with Mr. Parsons 10 or 15 times on nights before Dec. 8, 2006, the first time she had been paired with him, a fact that Ms. Strong sees as significant.

Ms. Newell had worked on the North wing and had previously provided care for Mr. A on one or two occasions. She testified that there are occasions when you can do Mr. A and then other days you can "see it in his face" he does not want it, and that on those occasions he puts up his hands and feet. On occasions it works if you talk to him and talk him through it.

Ms. Newell described the routine of the Home, and what had happened during change-out on the afternoon of December 8th when she had been paired with Mr. George Parsons. Mr. A could stand at that time in order to be changed and washed, but when he became unstable she called this to Mr. Parsons attention, who grabbed him by the waist and pulled him back roughly into his geri chair. Ms. Newell described the Grievor's language as being in a raised voice when he said, "come back here, you old bastard."

Asked why she come forward as she did with this report, Ms. Newell said she was concerned about appropriate handling of residents in view of what she had seen in her training. She acknowledged it taken one or two weeks before she actually reported it to Lisa Green, the RN. In Ms. Newell's view, people don't speak to people like that, just simply as persons; and she knew that, as a person, what she had seen was wrong. She described it as difficult to report on a co-worker, and testified that she had not been aware of the previous complaint against Mr. Parsons lodged the day before.

Ms. Strong then reviewed the testimony of the work-term student in the Therapeutic Recreation Program at the Home, Ms. Lisa Barrett, who had worked there 12 years before. She had been at the Home during the previous summer to help feed a resident at the family's request.

She testified she had her PCA qualification, and that she had worked with elderly persons providing private care for approximately five years in the past, one with Altziemers and one with

Parkinson's Disease. She had worked with two other members of the Nursing staff at the Home, and had no difficulty in that assignment in the period up to December 2006. She noted that the two she had worked with tended to approach the residents and talk to them. One used to call Mr A, "Skipper", and he liked it. The attempt was to keep Mr. A calm. She acknowledged that he sometimes acted up, but they could sometimes keep him controlled as well.

She described events on the morning of December 14, 2006 when she had been assigned to work with Mr. Parsons and Ms. Alva Guy-Noonan, who had gone ahead to work in another area while she and Mr. Parsons went in to care for Mr. A. Ms. Barrett testified that Mr. Parsons seemed irritable that morning, and described his rough handling of the change-out process and his language which confirmed the same words she had used in LB #1.

She testified she had witnessed rough washing of Mr. A's face and genital area, and the fact that Mr. A had put up his arms as if to protect his face. She also described the forceful putting down of Mr. A's arms, and testified that the Grievor had hit Mr. A in the rib cage area with a flat fist. She also said the rough handling continued when Mr. Parsons rolled Mr. A roughly to the side of the bed in such a way, according to her testimony, that she was worried the resident might fall to the floor. She had put the bedrail on her side down, and had to protect the resident from falling out of bed. She also described the resident's reaction, indicating discomfort and groaning, and how Mr. Parsons left the room after this as if nothing had happened, and did not speak about it afterwards.

Ms. Barrett testified she was floored by what she had seen and that, while she did not report the matter immediately, it bothered her over the weekend and then after a conversation with Ms. Sandra Antle, reported it to the nurse. Ms. Barrett testified she had not been sure if she should speak to someone at the Home or to her teacher. She reported she thought it was abusive, and that it could be worse for the resident if she did report it.

Ms. Strong then reviewed the testimony of Andrea Whyte, Eastern Health HR Consultant, who described her investigation as involving interviews with Ms. Barrett and Ms. Newell, and seven of the Grievor's co-workers who were on the same shift with him on December 8th and/or 14th. It also involved meeting with the Grievor and his Union representative, who were given

detailed information at the meeting of December 22nd, including the written statements of both complainants. It was also arranged that the Grievor would respond to the allegations. That written response was presented on January 3rd. Ms. Whyte testified that two members of staff indicated that December 8th had been a busy morning and that they were behind because the breakfast trays were late. It became clear that the Grievor is very particular and that he had told one worker, Sandra Antle, to 'shut up' that morning when he was asked why he had paired himself with a student.

Ms. Whyte testified that both Ms. Barrett and Ms. Newell knew that it would be difficult to register concern with the behaviour of a co-worker, and that there were no discrepancies in their accounts each time they had given descriptions. In her view for or both complainants the issue was concern for the residents.

Ms. Whyte described the disciplinary decision as primarily determined by others including Beverly Bellefleur, Linda Somerton, and Ms. Marsha Hiscock, and also the Director, Ms. Heather Hanrahan. Ms. Whyte, testified she was not the decision-maker on discipline. She had described the Grievor as a surprised, but that there was no overt reaction and no apology at any time. She testified that there was complete denial of the allegations against him at all times.

Ms. Strong also summarized the evidence of the Union witnesses beginning with Mr. Melvin Dawe, a PCA at the Home for 28 years, who had not been on duty either December 8th or December 14th. Mr. Dawe agreed that Mr. A had deteriorated since December 2006, and that perhaps between 20% and 30% of the time Mr. A is receptive to care, and that sometimes it works if you go back as his mood is changeable.

Mr. Dawe confirmed there is cursing and swearing at the Home from PCAs, RNs and LPNs, but mainly in the lunchroom. He also agreed that he probably heard the words, "bastard", "Jesus" and "fuck" used.

In reviewing the testimony of Ms. Sharmaine Pinsent who had been an LPN since 1993, Ms. Strong pointed out that she had not been on duty on December 8th or the 14th of December 2006. She testified that Mr. Paul Fisher had provided mandatory training concerning resident abuse and reporting, and that LPNs receive a pocket size version of the Code of Ethics with their

licenses each March.

She testified that the language policy is not adhered to by residents, family or staff, But that inappropriate language is used primarily in the lunchroom. She had attended the interviews of some co-workers, but not with the others. Ms. Pinsent confirmed that she had heard Mr. Parsons use the "f" word in response to goading he had experienced at work.

Rosemary Abbott testified that she had been a PCA for over 3 years at the Home, that she mostly worked nights, and had worked nights with Mr. Parsons. She confirmed that Mr. A can be a hard resident to provide care for but sometimes is receptive to care and had mood swings.

Ms. Gayle Boone was a PCA of 35 years service at the Home. She adamantly denied hearing any swearing during the 35 years that she worked there. Ms. Strong suggested that her evidence was exaggerated, and as her credibility was suspect, it should not be given any weight.

Ms. Alice Murphy testified that she had worked at the Home since 1995, and that Mr. A was somewhat cooperative on occasions. Ms. Murphy admitted to hearing swearing and to having heard the Grievor swear at the Home.

Ms. Alva Guy-Noonan, a 16 year LPN at the Home, testified that sometimes you can do Mr. A's care easily; sometimes he responds, but on other times he can be difficult. Ms. Guy-Noonan has heard offensive language used by all staff and finds Mr. Parsons to be particular about care for residents.

Mr. Parsons himself testified that if he observed resident abuse he would speak to the person involved, and put a stop to what he was witnessing. Mr. Parsons is aware of the policy statement, Consent #10, and had seen it at the Home and had also received the pocket Code of Ethics in the mail. He is also familiar with Consent #8 policies.

The Grievor confirmed he had been informed of allegations of physical and verbal abuse against him on December 20, 2006, and had stated adamantly that he had not been told when the two alleged incidents had occurred, and did not know when. He repeated that testimony on two occasions. When it was then pointed out that Ms. Pinsent's notes identified the two dates, he changed his story. In Ms. Strong's view, this is self-serving testimony, and in her submission, it

should inform the Arbitrator's view of the Grievor's whole evidence. His evidence is self-serving and colours his remaining evidence.

Mr. Parsons testified that in caring for residents, and specifically for Mr. A, his face washing was done the same way all the time. He also said "you have to get the *Attends* off no matter what it takes." In Mr. Parsons's estimation Mr. A is always resistant to care. But this is contrary to evidence from all the others who testified. Other staff members testified that while he can be difficult, there are times when his is receptive of care. In Ms. Strong's view, this discrepancy is significant.

Mr. Parsons testified that on December 8th he probably used Mr. A's belt and pulled him back into the chair. This is consistent with the evidence provided by Ms. Newell. Ms. Newell, however, would describe the action as more forceful; but the substance is in agreement. Mr. Parsons denies saying, 'you old bastard', but does not deny that he swears at work.

Mr. Parsons agrees he washed Mr. A's face on the morning of December 14th, "and probably moved his arms down." He also admitted that Mr. A probably groaned, and that he had removed Mr. A's dentures. Ms. Barrett assisted him to put Mr. A's pants back on. Mr. Parsons explained the process of turning Mr. A to the side to get his pants on, and said that Lisa Barrett was helping at the time. He also acknowledged that he was aware, at break time that Ms. Barrett had hurt her back assisting with Mr. A's care.

Ms. Strong encouraged the Arbitrator to review Mr. Parsons's testimony of these events in comparison with Ms. Barrett's. Ms. Strong maintains that, while the sequence of events is accurate and consistent between the two testimonies, each differs in their interpretations. Mr. Parsons, she noted, speaks about concern he had about Mr. A's daughter who had been upset in the past if he was not dressed. Mr. Parsons considers Mr. A to be someone you cannot leave and come back to, since as his daughter may come at lunch time.

Mr. Parsons testified that Ms. Barrett was doing the other resident's care in the room, but does mention this in his Consent #6 submitted on January 3rd. When asked about this on cross examination he clearly knew he had left this out of Consent #6. The fact is, he did not give evidence on direct examination that Ms. Lisa Barret had actually done that care.

Ms. Strong also asked the Arbitrator note the Grievor's understanding of physical and verbal abuse. In fact, it is quite clear that he acknowledged in his own response, dated January 3rd, how he understands that Ms. Barrett might have interpreted his behaviour as abusive that morning.

Ms. Strong invited the Arbitrator to consider Brown and Beatty *Canadian Labour Arbitration* (4th ed.) at para. 3:5100 on the issue of weighing the evidence and deploying a qualitive rather than a quantative approach. Credibility, in the Employer's submission, lies at the core of this case. It turns on the question of what the Arbitrator believes occurred on December 8th and December 14th. What did, and did not, happen? That is the nub of the matter.

At para. 3:5110 Browne & Beatty deal with the issue of assessing credibility. It should be noted that both Patricia Newell and Lisa Barrett had the clear ability to see and hear what was happening on both those days. There were no other distractions. They heard and saw what they heard and saw. Thus, their evidence is cogent in those respects.

Second, there is much agreement as to the facts of what occurred. All participants agree on the facts as to the sequence. George Parsons, himself, confirms he grabbed Mr. A and pulled him back into the chair. For Ms. Newell it was too harsh, but for Mr. Parsons it was not. While Mr. Parsons denies any form of abuse, and denies using foul language in his provision of care, it is compelling evidence that two separate witnesses report that on two occasions, dealing with the same resident, his use of the same word, "bastard". That is telling evidence.

It should be noted that both witnesses said they were hesitant to report. Both showed confusion and concern. They responded as most would, recognizing the effects of squealing on a co-worker. The intervals of a number of days is consistent with what they said. There was no evidence that either had come forward as a result of any ill will against Mr. Parsons or that there was some spite towards him. They did it quietly, and after struggling within themselves.

There is evidence that Ms. Barrett worked in the Home some months prior to her student placement there in December 2006. Ms. Barrett does not deny this. Mr. Parsons said he held no grudges against her and Ms. Barrett said that she knew of Mr. Parsons, but there was no sense of any past baggage concerning Mr. Parsons. Ms. Barrett had nothing to gain or loose by reporting

it. She saw what she saw and reported it because she felt obliged to report it.

In respect of any discrepancies between Ms. Somerton's and Ms. Whyte's testimony, in contrast to the testimony of Lisa Barrett and Patricia Newell concerning events of December 8th and December 14th, it is clear that preference should be given to the two direct witnesses who were there at the time. What Ms. Somerton and Ms. Whyte have to offer is obviously hearsay on that detail, and Ms. Newell and Ms. Barrett is to be preferred on that.

Ms. Strong went on to review various authorities, acknowledging the onus is on the Employer to prove its case, on the balance of probabilities, that the Grievor's dismissal for physical and verbal abuse is established and should be sustained.

Ms. Strong pointed to the fact that the law recognises that expectation varies from industry to industry and that there is a heavier onus where there are vulnerable clients than where the abuse relates to co-workers. In health care, there is an even higher standard to be met.

There are two levels of consideration. The resident/client issues have to be taken into account, and since this is a healthcare issue there is an even higher standard. All residents and patients are vulnerable in a healthcare situation. Where there is a reduction of autonomy there is an even higher vulnerability and a higher standard. On the South wing, for instance, residents have more autonomy. On the North wing, however, there is little or no autonomy. The arbitral jurisprudence in this matter shows that to be a very central issue in this matter. Termination has been upheld for fairly minor incidents of this sort because of the very, very high standard.

Ms. Strong directed the Arbitrator's attention to the following cases: *St Clare's Mercy Hospital* and the *Newfoundland Association of Public Employees* (Mr. Daniel Chafe, Grievor) 1988 C.L.A.S.J. 503640, 10 C.L.A.S. 74 Newfoundland Scott, 1988; Hoyles Escasoni Complex and the *Newfoundland Association of Public Employees* (Grievor: Ms Doe, pseudonym) 1989 C.L.A.S.J. 678454, 13 C.L.A.S. 3 Newfoundland majority: Scott, Orsborn, dissent: Rowe; *Kennedy Lodge Nursing Home and S.E.I.U., Loc*. 204, Re, [1991] O.L.A.A. No. 14, 18 L.A.C. (4th) 38, Ontario, E.N. Davis, 1991; *Hoyles-Escasoni Complex* and - the *Newfoundland Association of Public Employees* (Grievor: Ms Linda Giles) 1989 C.L.A.S.J. 668707, 12 C.L.A.S. 78 Newfoundland majority: Scott, Rowe, dissent: Orsborn; *Sun Country Health Region*

and C.U.P.E., Loc. 5999 (Dartige) (Re), [2004] S.L.A.A. No. 6, 133. L.A.C. (4th) 160 B. Pelton, Q.C.,]. Holmes, B. Schatz; 6) *Versa-Care Centre of Brantford v. Christian Labour Assn. of Canada* [2005] O.L.A.A. No. 744 , R.L. Levinson 2005; *Cassellholme Home for the Aged v. Canadian Union of Public Employees, Local* 146 (Morabito Grievance) [2006] O.L.A.A. No. 445 File No. MPA/Y601014, Ontario Labour Arbitration, L. Slotnick; *Maple Villa Long Term Care Centre v. Service Employees International Union, Local* 532 (Betonio Grievance) [2004] Q. L.A.A. No. 839 2004; *White Eagle Nursing Home,* and *Service Employees International Union Local* [2006] O.L.A.A. No. 627 R.L. Levinson 2006.

In the instant matter it is very clear that the issue of mitigation does not arise since there is no indication of acknowledgement or of consequent rehabilitation. There is clear evidence in the arbitral jurisprudence (Tab 6) that "rough treatment is itself abusive" in certain circumstances. Ms. Strong also pointed out that a failure to acknowledge any charges is a strong element in this case.

In her closing comments, Ms. Strong invited the Arbitrator to review carefully the facts as presented in the Employer's case. Mr. Parsons has totally denied the events described by the witnesses as to the care he provided on April 8th and 14th to Mr. A.

Mr. Parsons said that he would observe the Employer's policy on resident abuse, but the evidence does not support this. He has acknowledged that new and inexperienced person might view what they had observed as abusive. That is what he wrote in response to the allegations and confirmed in his own evidence. It must therefore be asked what he thinks physical abuse is. Ms. Newell was a new LPN, but her evidence is that she knew what she saw to be abusive. She came to this with fresh eyes which should be seen as credible.

Ms. Barrett was not inexperienced. She has a lot of experience in these matters, both in private situations and in the Home itself. It is beyond doubt that they saw what they saw. They were appalled, and felt compelled to come forward. It is true that it did take them time to come forward. But Mr. Parsons, on the other hand, did not even recognize as abusive what he felt were legitimate practices. The plain fact is that Mr. Parsons has become complacent, and perhaps did not care as much as he should whether his actions were abusive or not. Many of the witnesses

that have appeared were experienced workers. Only one was a three year worker. A new lens, however, provides a valuable light.

Ms. Strong urged the Arbitrator not to reinstate Mr. Parsons, but to uphold the dismissal. The Grievor's response shows lack of insight into the abusiveness of his own actions. He would have profited by responding more positively to the learning opportunity afforded him in the previous year or two. Even with that education, he has not kept in step. The discharge must be upheld, especially in the North wing situation. He should not return to the Home. Rough handling is abusive.

FOR THE UNION Mr. Earle took serious objection to Ms. Strong's allegations of complacency towards staff or any healthcare employee, which he took to be implicit in her final comments. To raise complacency as a general allegation against the workers in this or any home is disrespectful, in the Union's submission.

Mr. Earle reviewed the Employer's jurisprudence, and then turned to make the Union's argument. He registered disbelief that the Employer would rely for closing argument on four witnesses including a senior manager at the Home, an HR consultant with Eastern Health, a non-employee, and an employee of five months service. He also rejected Employer consul's claim that the Grievor had failed to testify on direct examination that Ms. Barrett had cared for the other resident in the room with Mr. A. The fact is that the Employer did not even investigate this with the other resident, who the evidence shows, could speak.

The December 8th incident is inexplicable. The evidence seems to be that the Grievor was told the resident was about to fall, and that he responded by pulling him back into his geri chair rather than allowing him to fall to the floor. The need to protect the resident is the issue.

Why was Ms. Sandra Antle not called? It is also misleading to represent it that Ms. Barrett was returning to work on the Monday. The alleged incident occurred on the preceding December 14th, which was a Thursday. Friday, the 15th, was also a work day, yet the report is initiated on the Monday the 18th. She testified to that fact, herself. It is also remarkable that there is no evidence from the Employer that it interviewed other staff about Ms. Barrett's testimony that involved them.

The Arbitrator should note the Employer's suggestion that Lisa Barrett's evidence is to be preferred to Ms. Whyte's. There is not one witness advanced to confirm that the Grievor was "irritated" on the morning in question. The Arbitrator should note the Employer also argued that Ms. Newell's testimony is to preferred to Ms. Whyte's and Ms. Somerton's. Ms. Strong also argued that Ms. Newell's evidence was to the effect that the Grievor said, "come back here, you old bastard." It should be noted, however, that this appears only in Andrea Whyte's notes which, according to Ms. Strong, we should discredit.

It is not at all clear that Ms. Strong is right to assume that anyone read Mr. Parsons's written response. There is no evidence that anyone did. There is also no evidence to support the claim that Ms. Newell refused to work with the Grievor. She is a temporary employee. She works shifts. Was she scheduled or not? Was she recalled? There is no evidence on this. These matters might have been cleared up had there been an investigation done and tested in evidence.

Ms. Strong also said that Ms. Somerton testified the LPN had reported the matter to her; but the evidence is that the matter was reported to her by an RN.

The standard of probability the Employer must meet in discipline is simply commensurate with the seriousness of the allegations and the severity of the consequences the Grievor faces. The authorities are unanimous that in order for this discipline to be upheld reliable, clear, cogent, convincing, and substantial evidence must be adduced. Evidence of the alleged complaint must be present, and the proof must be clear. The allegation of abuse is the most grievous possible in the healthcare system. A man's future and his whole career lies here on this supposed evidence. The Employer bears the onus of proof. If that onus is not met in clear, cogent, convincing evidence of wrong doing, there must be a presumption of innocence.

Mr. Earle pointed to at Article 2.01 of the Collective Agreement which clearly sets out what governs discipline. He then reviewed a number of cases drawn from the jurisprudence: *Hoyles-Escasoni Complex* and the *Newfoundland Association of Public Employees* (Grievor: Ms. Linda Giles) 1989 C.L.A.S.J. 668707, 12 C.L.A.S. 78 Newfoundland majority: Scott, Rowe, dissent: Orsborn; *Health Care Corporation of St. John's* v. *NAPE*, (Grievor: Yvonne Walsh) D. Curtis, G. Curnew, D. Alcock 2003;); *NAPE v. Newfoundland and Labrador Health Boards*

Association, Grievor - Victoria Gillis R. Kearley, R. Diamond, J. Clarke, 2003; *Gillis* vs. *Council for LPN's, Newfoundland and Labrador Supreme Court*, Barry J. 2004; *Newfoundland and Labrador Health Boards Association v. Newfoundland Association of Public Employees (Grievor: Madonna Ireland)* J. Stanley, D. Taylor, Dennis M. Browne, Q.C. 1999; *Ontario Store Fixtures and United Brotherhood of Carpenters and Joiners of America, Local* 1072, 35 L.A.C. (4th) 186, MacDowell, Armstrong, Werry 1993; *Riverview Nursing Home and United Food and Commercial Workers Union, Local* 175, 26 L.A.C. (3d) 385 D.H. Kates 1987; *Digby Town and Municipal Housing Cooperation and Service Employers International Union, Local* 902, 20 L.A.C. (3d) MacLellan, Quigley, McDougall 1985; *United Steelworkers of America, Local 3257, and the Steel Equipment Company Limited* 14 L.A.C. 356 Reville, Park, White 1964

Was there a crime for a penalty to fit? The allegations on the basis of which Mr. Parsons was terminated are set out in GP #9. The letter of termination was not entered by the Employer since they did not call the author of this document, Beverly Bellefluer.

Mr. Earle pointed out that the letter of termination describes the Grievor as having struck the resident "in the torso" with his fist. "Torso" is not the word used by any witness, and the Union submits that an adverse inference should be drawn as to the author's unavailability for cross examination on this point alone. There is some reason to believe Ms. Bellefleur is back at work, at least in some limited capacity. There is no factual evidence concerning whether or not she could attend this hearing. The onus is on the Employer, not only the Union, to present her here. Mr. Parsons wants the opportunity to examine the author of this termination letter to explore her reasons and her belief as to why the termination should stand. This right is borne out by the arbitral jurisprudence (tab 2) drawn from leading cases.

Clearly as Brown and Beatty *Canadian Labour Arbitration* (4th ed.) at para. 7:4000 shows, the best evidence rule must be observed. Has the Employer discharged its onus in this matter? It has not.

Lisa Barrett remembers a written document on which LB #1 was based, which she believes she signed and was then given with the typed (LB #1) version. Where is the original? When did the alleged incident occur: after breakfast or, as she testified on redirect examination at

this hearing, before breakfast? There is simply no one that has given any evidence that the Grievor was "irritated" that morning. Furthermore, it must be remembered that there is a second resident in that room. The curtain was not drawn. That's in evidence. It is not plausible that events of this could have occurred without his observing. Anyone could have walked in. Ms. Somerton could have walked. Housekeeping could have walked in. This was normal morning care with lots of staff in close proximity. Mr. Parsons's explanation is very much more plausible. Someone had to have taken care of Mr. Kippenhook. The Employer's investigation has not even asked that question. Who did Mr. Kippenhook? What was going on during this period with Mr. Kippenhook. This is not clear and cogent evidence.

Mr. Parsons's testimony is that the rails were up in order to prevent the resident from falling to the floor. It is important to note that Ms. Barrett, herself, did not seek medical attention or note her alleged injury to her back. Ms. Barrett concluded her comments by saying that George went on as though nothing had happened. But it should also be noted that Ms. Barrett did exactly the same thing. In fact, she went to coffee with him. That is when she brought up about her back. It is not possible to go to coffee with someone if this had occurred. Why did she not get Mr. A checked if she thought that there was any possibility he had been injured? What kind of person would see a punch in the abdomen or rib cage, knowing that there could be internal damage to vital organs and not secure medical attention? Ms. Barrett had five years experience in personal care.

It is important to compare PN #1 with Mr. Parsons's commentary. PN #1 has twelve lines. Ms. Somerton, for some reason, said that the incident occurred in the washroom. This it totally contradicted by the evidence of the participants. Furthermore, it is clear that the BIPP program provides training in precisely the manoeuver that Mr. Parsons used in securing the resident in his chair in the events that Ms. Newell was concerned about. Misperception is what is going on here.

The inadequacy of AW #1 as documentary evidence is quite remarkable. Why are there no notes beyond this? Ms. Newell is an employee, and would have been aware of policy and of her obligations. As an LPN she should not have questioned for a moment what to do. The

complaint process would not have allowed her to leave the building. It is her responsibility to stop abuse, but she did no such thing.

It should be noted that Consent #4 was not completed by Ms. Barrett, but by Ms. Somerton and then signed by Lisa Barrett. Consent #4 shows that the alleged incident occurred during change-out, but in testimony at this hearing it was before breakfast. It should also be noted that the location of the alleged blow was in the abdomen. Most important, there is no mention whatsoever of arms moved and her later concern over whether they were broken or not.

Ms. Somerton testified she checked the resident; but we have to ask, Did she? If so, did she chart anything? Consent #4 reads "incident not known at time of occurrance (*sic*)." We know from testimony that no physician was notified. Here is something that was described as a punch which is not reported to a physician. There are serious questions that have to be asked. Why was this not reported to an outside authority? RCMP has a presence in Bay Roberts. They would have done a proper investigation.

Consent #8 requires a report which was completed properly by Ms. Newell. The staff person fills it out. That is what the policy requires. The problem is that Ms. Newell should have done this far earlier than twelve days after the event. If the report had been done at the time of the incident it could have been properly checked. Brown and Beatty *Canadian Labour Arbitration* (4th ed.) at para.7:2500 addresses Standard of Proof and confirms that "clear," "cogent," "reliable" and "substantial" properly "describe the quality of evidence employers must adduce to justify whatever sanction they imposed." . None of these adjectives apply to LB #1 or PN #1. The evidence is conflicting. The investigation was inadequate. The severity of the penalty is ungrounded. There are no grounds for discipline.

It is reasonably clear to the Union that Ms. Somerton had already decided what was to happen. Ms. Somerton refers to something that occurred in 2003. That needs to be shown. To what are they referring? There has been opportunity to ask Ms. Bellefleur what she grounded her decision on. This is not the Union's case to present. It is not clear why Ms. Somerton would have made this comment about another incident in a phone message as recorded by AW #1. Ms. Somerton also testified that she had secured the safety of the resident. The fact remains, however,

that Mr. Parsons did work the night of the 18th with one other LPN, no one else in the building, and the same resident on the North wing. It is obvious why the Employer asked in argument that we not pay too much attention to Ms. Somerton's evidence.

Ms. Somerton said that she did not even know that Ms. Barrett was in the building the previous summer. No one can just show up and start feeding patients. The issue was raised at ward conferences and brought to her attention. Mr. Parsons, himself, confirmed it and he further expressed some concerns to Ms. Barrett himself. Ms. Guy-Noonan, a very credible witness, confirmed that Ms. Somerton would have had to have know since front line staff had concerns about the way Ms. Barrett was acting.

Ms. Sharmaine Pinsent's very credible evidence as to what transpired on December 20th when the complaints were not provided to the Grievor or to the Union. The resident was not named. The dates are here on the notes. If Sharmaine put them down, they were said. Mr. A's name was not given at that time. So what was Mr. Parsons supposed respond to? Two complaints relating to one of forty possible residents on the unit. What could the response be? We have not been provided with Ms. Whyte's original handwritten notes. It is incredible that she would have destroyed her handwritten notes prior to the arbitration, and deny the Union the opportunity to examine the notes as they were taken. That destruction of such notes should, itself, have been investigated.

The question is, is the Employer stretching this out in order to fire Mr. Parsons. We don't know and we are never going to know. It is crucial to note that Ms. Newell flatly denied para. 2 of AW #1 on the stand. So why would Andrea Whyte write this? It certainly is not in Ms. Newell's statement. Ms. Strong is quite right to suggest that the Board prefer Patricia Newell's testimony over that of Ms. Whyte's and Ms. Somerton's.

The investigation simply failed to demonstrate anything. Ms. Newell reported the matter to an RN on either the 16th or the 17th. An RN held the matter back for several days. Why? Ms Green was not called. There must be an adverse inference drawn on this as well. Ms. Green was not given an opportunity to explain, but the onus is on the Employer in this matter.

The allegation is made and relied upon. Mr. Kippenhook, so far as we know, was not

even asked what, if anything, he observed. The Employer testified it interviewed co-workers, but they provided no evidence of that investigation. Nor did they explain why they did not interview the nurses and the domestic staff on duty that day.

There is no evidence of anything on the chart: not a note, not a sentence. And yet if it was not written down "it didn't happen", we are told. This was totally not documented. Did it happen? The Employer says it did. At the December 22nd meeting the Grievor repeatedly said he knew nothing. Therefore he has nothing to apologize for. He did nothing wrong. December 22nd is the first time he sees the complaints. It is unclear who received Mr. Parsons's response. The Union does not even know if Beverly Bellefluer reviewed it. The Union has not had an opportunity to ask if she took it into account when she fired the Grievor.

Mr. Parsons has faced the ultimate discipline, termination, yet we have seen nothing else on which to base that termination. There was no final report of any investigation. The only document on which it can be based is AW #1. But Ms. Whyte says the original handwritten notes were destroyed. AW #1 constitutes a very serious allegation. We have nothing of what Ms. Somerton might have written to Beverly Bellefluer when she made the decision to terminate. The evidence of Ms. Barrett and Ms. Newell do not meet the test of clear, cogent, convincing and reliable evidence.

In order to support the Employer's case additional witnesses could have been called. They were not called. Ms. Sandra Antle was not called. Yet it was Ms. Sandra Antle to whom Lisa Barrett first went. Ms Antle then went to the RN, Ms. Melany Fillier, who went to Ms. Somerton. But there is nothing in the report about that chain of events. The Employer failed to call Ms. Antle. Ms. Fillier was not called, and we do not know the substance of her conversation with Ms Antle. Much of this comes from Ms. Somerton, whose testimony the Employer asks be discounted. Where is the RN to whom Ms. Newell first spoke, Ms Lisa Green?

Mr. Parsons has been denied the opportunity to cross examine any of these witnesses. But the onus is on the Employer to show his guilt, not on the Union to show his innocence. The Arbitrator must draw appropriate adverse inferences as the arbitral jurisprudence suggests.

The Employer did not even meet with the Grievor on this matter. Ms. Somerton said that

Ms. Barrett reported Mr. A had looked up at her as if to say, "Why are you letting this happen?" But that was not Ms. Barrett's testimony. Ms. Somerton simply did not have the facts. She did not know of the complaints about Ms. Barrett when she had been in the Home earlier in the year feeding a resident; yet witnesses testified they were concerned for the safety of the resident whom she was feeding and were asking whose responsibility it would be if the resident should choke. That's Alice Murphy's evidence.

The most severe punishment has been imposed upon the Grievor on the basis of a totally inadequate foundation. The termination cannot stand for lack of investigative credibility by the Employer. The Employer did not enter the interview notes. The Union entered Ms. Sharmaine Pinsent's notes, but where are the original Employer documents? There was no final report, and no evidence from these interviews. An employee of thirty-four years service was determined guilty and tossed out the door. The Union has a right to demand better. Did Ms. Bellefluer understand Mr. Parsons's response? We don't know. We have not been able to examine her.

Ms. Whyte testified that it was reported the trays were late on the morning of December 14th. Yet neither those staff who testified, nor AW #1, reports that fact. There is simply no factual evidence concerning late trays.

The second resident in Mr. A's room was not interviewed.

The investigation did not check whether Ms. Barrett knew of the second complaint.

Where did the term "docile" originate?

There are references in both complaints to Mr. A putting his arms up; but this is what all witnesses say he regularly does. Mr. A is curled up in a ball because that's what his medical condition forces him to do. That is the clear, cogent evidence.

All of this is precisely what Mr. Parsons says in Consent #6. It may indeed look like physical abuse. But how could Ms. Newell, on the basis of five months of experience in home care, not say something to Mr. Parsons if it really was abuse? This is not plausible. She did nothing. This is not credible. She went to coffee on break. This is not plausible.

It is hard to believe the Employer appears not to have reviewed the personnel file.

Perhaps someone who did not give evidence reviewed it.

It speaks volumes that those that did testify from the staff were willing and happy to have the Grievor tend to their own loved ones.

The Arbitrator should bear in mind that PN #1 differs dramatically from AW #1 and that C #4 was not written by the witness, herself, but that C #5 is written by a witness.

Mr. Earle continued by reviewing each of the cases in the Employer's submission of authoritiesand concluded by calling attention to the fact that Mr. Parsons bears no ill feeling. The termination cannot be upheld. Mr. Parsons has been unflinching and unchanging in his insistence that he is not guilty of any of the allegations made against him. That fact, itself, must be borne in mind.

The Union respectfully requests that the grievance be upheld in full and that Mr. Parsons be made whole in terms of reinstatement and recovery for lost wages, overtime, statutory time, lost benefits, annual and sick leave, and seniority including the reinstatement of his health plan and recovery of losses due to health costs he has had to bear. Furthermore, an apology from the Employer is required, and an award for mental stress and loss on the basis of damages should be considered

IN REBUTTAL ARGUMENT Ms. Strong insisted that her comments concerning credibility of Ms. Whyte and Ms. Somerton were not to be taken generally, but were very specific to the issues of the incidents as reported by Ms. Barrett and Ms. Newell, whose testimony was to be preferred because they were the direct eye witnesses. Ms. Strong insisted that their overall testimony was clear and cogent. In the Employer's view the balance of probabilities test has been met.

With respect to the Union's concerns that witnesses have not been made available, Ms. Beverly Bellefluer has been on extended sick leave and away from the Home since December. She appears to be checking correspondence currently, but nothing more than that in terms of her easeback to work. The Employer has not failed to call witnesses. The Employer is simply not in a position to do so. Ms. Bellefleur is unavailable and under medical care.. Furthermore, the materiality of her evidence is very much in doubt. She was not in Mr. A's room on the 8th or 14th of December. Only the two who were there can speak to the matter. She signed the letter of

termination, but there is no difference in the facts involved. The word "torso" is not significant. Ms. Bellefluer has no material evidence to provide. If there is any inference that can be drawn it must relate specifically to the evidence that she might be able to provide. Furthermore, it is open to the Union to subpoena any evidence it feels it needs.

Ms. Whyte simply typed up her handwritten notes, and then threw out the handwritten notes. There is nothing to indicate that this evidence in question is other than what was in her final report. AW #1 is the final report. There is no other final report. The Employer did review the Grievor's personnel file, and there is nothing in evidence to say that it did not do so.

Ms. Strong concluded by denying she had made any suggestion that complacency is a feature of the health care workers. She was suggesting that, on the evidence, complacency was a possible explanation of this particular Grievor's behaviour.

CONSIDERATIONS

Powers: Article 12.04 reads in part:

> The Board of Arbitration shall not have the power to change this agreement or to alter, modify or amend any of its provisions. However, the Board shall have the power to dispose of a grievance by any arrangement which it deems just and equitable.

Onus: The Employer acknowledges that it bears the onus to show just cause for discipline, on the balance of probabilities, and that termination was appropriate discipline in the circumstances.

I will consider below the Employer's argument that the arbitral jurisprudence recognises healthcare as a field where a legitimately high expectation of practice prevails, and that any assessment of whether the discipline was appropriate must take this into account.

The Appropriate Standard of proof is the civil standard of "balance of probabilities" as set out in Brown and Beatty *Canadian Labour Arbitration,* 4th ed., para. 3:2500:

> The standard of proof specifies the degree of probability that must be established by the evidence, before the party who bears the burden or onus of proof is entitled to succeed. The two standards of proof most commonly utilized are the civil standard of "balance of probabilities" and the criminal standard of "beyond a reasonable doubt". In most grievance arbitrations, however, arbitrators apply the civil standard of proof, as described in the following terms:

> It must carry a reasonable degree of probability, but not so high as is required in a criminal case. If the evidence is such that the tribunal can say: "we think it more probable than not", the burden is discharged, but if the probabilities are equal, it is not.

I notice further that at para 7:2500 the same authorities offer the following:

> The standard of proof employers must meet in proving that they acted in accordance with the terms of the collective agreement in exercising their disciplinary powers is the same civil standard that is used in all arbitration cases. Employers must prove, "on a balance of probabilities", that employees who have been disciplined did, in fact, act in ways that warranted being treated as they were. At one time, some arbitrators (including one who became Chief Justice of Canada) required employers to meet the higher criminal burden of proving their case "beyond a reasonable doubt" where the alleged misconduct possibly involved criminal liability, but this view did not prevail. Instead the civil standard has become a flexible, variable formula that changes with the circumstances of each case. As a general principle, the degree of probability employers must meet in each discipline case is commensurate with the seriousness of the allegations and the severity of the consequences faced by the employee. As a result, unless the agreement specifies otherwise, *in cases involving allegations of particularly reprehensible misconduct, such as criminal or quasi-criminal behaviour, when an employee's reputation and future job prospects are at stake arbitrators typically use words such as "clear", "cogent", "convincing", "substantial", and "reliable" to describe the quality of evidence employers must adduce to justify whatever sanction they imposed.* The standard remains, however, something less than the criminal standard so that it is possible for an employee to be acquitted of a criminal charge, but be found to have acted in a way that justified discipline. (emphasis added)

At issue between the Parties is the Union's complaint that the Grievor was unjustly dismissed from his employment at the Pentecostal Senior Citizens' Home as a Licensed Practical Nurse.

Positions of the Parties:

The Employer led evidence and argument to demonstrate its just cause termination of the Grievor when its "investigation into the allegations of physical and verbal abuse toward a resident" satisfied the employer that the Grievor's "actions on December 8th and 14th, 2006 constituted verbal and physical abuse..." (GP #9).

Employer witnesses testified to the expertise of the professional administrative staff, the policies and philosophy in place at the Home, and provided accounts of the alleged incidents, as well as their reporting and investigation.

The Employer argued that the evidence established, on the balance of probabilities, that the abuse did occur, and argued that termination was appropriate in the circumstances and in view of the high expectations prevailing in the healthcare field. The Employer acknowledged that assessment of the evidence will involve assessment of the relative credibility of the witnesses, and argued that the Grievor's testimony was self serving and therefore suspect.

The Union challenged the Employer's evidence as inconsistent on its face, and inadequately and inappropriately investigated. The Union claimed that the allegations themselves were without merit by virtue of delays and other circumstances surrounding their reporting. Further, in the Union's submission, in its failure to call the author of the letter of termination (GP #9) for cross examination the Employer failed to meet the basic standard of clear, cogent, convincing and reliable evidence that the arbitral jurisprudence requires for its position to be sustained.

The Union argued that the Employer has failed to meet its onus, and that the Grievor should be reinstated and made whole in all respects.

Review of the Evidence and Arguments: I note that Brown and Beatty Canadian Labour Arbitration (4th ed.) Reads as follows at para. 3:5100:

> **Weighing the Evidence**
> An arbitrator has complete discretion in evaluating each piece of evidence that has been adduced and in drawing inferences therefrom, subject to the single limitation that there must be some evidence to support a finding of fact. The arbitrator must evaluate the evidence in his best judgment, and put such weight to that evidence as he deems fit. As stated by one arbitrator:
>
> > [E]vidence is not to be considered upon a quantitative basis but rather upon a qualitative basis. In other words, it has to be sifted, tested and scrutinized with the utmost care and after an anxious consideration of the total testimony the tribunal must make up its mind as to what parts to accept and what parts to reject.

I have carefully reviewed the Parties' positions presented in their evidence and argument as set out above in this Award, and examined the arbitral jurisprudence and authorities they provided in light both of the Collective Agreement and the presenters' submissions. I note that the allegations are of both physical and verbal abuse. I deal first with the general issue of the allegations of abuse, and then deal with each of the two aspects separately:

1.0 *Has the employer shown just cause* for its conclusions: a) that the Grievor's "actions on December 8th and 14th, 2006 constituted verbal and physical abuse..." (GP #9); and b) for his termination?

1.1 *High Expectations of Health Care Workers:*

I note, in particular, the recognised and legitimate argument that healthcare employers must sustain very high expectations of healthcare workers, proportionate to the trust vested in them in view of to the reduced levels of autonomy of those for whom they care, and the increased levels of their vulnerability. I recognise that arbitral jurisprudence (including *Sun Country Health Region and C.U.P.E., Loc. 5999 (Dartige) (Re)*, [2004] S.L.A.A. No. 6, 133. L.A.C. at para. 60) reflects this view. In *Kennedy Lodge Nursing Home and S.E.I.U., Loc.* 204, Re, [1991] O.L.A.A. No. 14, 18 L.A.C. (4th) 38, Ontario, E.N. Davis, 1991 where the Arbitrator notes at para. 4:

> It is evident that the handicaps residents labour under require a high standard of understanding by the staff as well as specialized skills and techniques in handling.

And, at paragraph 27, citing *Re Government of BC and B.C.G.E.U.* (1980), 26 L.A.C. (2d) 71 (Hope) at p.75:

> It is generally accepted that standards of conduct reasonably required of employees will vary according to the occupation and industry in which the individual is employed. It appears to be recognized by arbitrators that in the health care industry a much higher standard of performance is required of employees than would be so in the manufacturing industry, for instance, because of the aspect of public trust involved in the care and treatment of the patients entrusted to the institution.

I also note the the comments of Arbitrator Slotnick in *Cassellholme Home for the Aged v. Canadian Union of Public Employees, Local* 146 (Morabito Grievance) [2006] O.L.A.A. No. 445 at paras. 22-24, as follows:

22 The first principle to note from the cases is that for an allegation of patient abuse or resident abuse to be substantiated, there must be clear, cogent, strong and reliable evidence of the grievor's misconduct. In my view, the evidence of Ms. Snow and Ms. Lafantaisie, each of whom is a credible witness who directly witnessed the events, satisfies this test. My conclusion, then, is that the grievor was in violation of the home's resident abuse policy on February 21, 2006.

23 Another clear principle is that workers in the health care field are held to a standard that is higher than in other workplaces. A passage quoted in many of the cases, from *Re Baptist Housing Society (Grandview Towers) and Hospital Employees Union* (1982).6 6L -C (3d) 4N (Greyell) at

page 437, sums up the view:

> A much higher standard of conduct is expected from employees in the health care field than in other occupational fields. In this industry arbitrators are required to have regard not only to the interests of the grievor and of the employer but also must have regard to the public interest. Both employer and employee are reposed with a public trust for which they are held accountable.
>
> The public trust is onerous. In broad terms it is a charge of responsibility for the physical and emotional comfort of a member of our society who is unable to live independently. The institution and no less its employees, in addition to regular duties assume a role which may best be described as similar to that of a "surrogate" family. This is particularly so in a facility such as Grandview which strives to be a "home" for elderly residents. Because of the public trust reposed in him, when an employee enters the health care field he must do so with considerable ability to understand human frailty and with a gargantuan tolerance of aberrant and unpredictable behaviour that often attends the infirm or elderly.

24 For the reasons expressed in the passage above, it is normal to find arbitrators upholding dismissal where abuse has been proven, unless there are significant mitigating factors.

I accept, too, that the Employer has demonstrated that the employees have been made aware, through various training, educational, and informational procedures (including Consents # 2,8,9,10) , of these high expectations and of disciplinary consequences for failing to meet them. I note that this awareness was also demonstrated in the LPNs and PCAs who testified.

I also accept that the Pentecostal Senior Citizens' Home's policies, and philosophy of care as explained by Ms. Somerton, appear to conform to the Code of Ethics and policy statements issued by the College of LPNs, and that the College has itself provided training seminars for staff in respect of resident abuse and the necessity of full and prompt reporting. The evidence of all witnesses suggests that the values lying behind Consent #8 are respected with regard to residents, apart from those relating to the use, in the common and recreational areas, of restricted language.

2. *Credibility:* The Employer suggested that determination of this matter turns on assessing the credibility of those involved. With respect, it is clear to me that the matter turns not simply on credibility in the sense of whether someone is lying or not, but also, and perhaps more precisely:

1) on the relative reliability of various participants' judgements as to what may have happened;

and, 2) especially in the instant circumstances of delayed reports, on "their respective capacities and opportunities to perceive, recollect, and communicate matters with

respect to which they give evidence" (Sheraton, 26 L.A.C. (2d) 122 (Brunner, 1980) quoted in Palmer and Palmer *Collective Agreement Arbitration in Canada,* ed. 3, p. 72);

and, 3) on the critical investigative and deliberative procedures the Employer used to test the relative weight of those judgements in making the disciplinary decision it made.

2.1 I note that Consent #6, the Grievor's written response to both allegations, makes the point that if viewed by someone not "used to the situation or working in long term care", "Someone new working in the same room would very easily think of this as physical abuse." Employer Counsel suggested that this comment itself was tantamount to an admission that his December 8th and 14th actions and words had been abusive, since Ms. Barrett and Ms. Newell had considered them abusive. In the Employer's submission, the two complainants saw what they saw, and the inference I am invited to draw is that their perceptions are, therefore, unimpeachable grounds for the Employer's disciplinary decisions.

With respect this is not, in my view, a simple credibility contest between the Grievor and two credible witnesses. I accept that, as Employer counsel cogently argued, the witnesses "saw what they saw". What I find must be carefully examined in the instant circumstances is whether their judgement is to be preferred to the Grievor's on the question of whether what they saw was verbally and/or physically abusive.

There is a crucial issue here. The Grievor's point, as I read it, is that both those who perceived his actions as abusive were "new" to the "long term care" environment and were not "used to the situation." Thus, in the Grievor's submission, their perceptions would "very easily" – but incorrectly, in his submission – be that his actions were abusive. The Grievor appears to be asking that Management officers exercise their judgement, based on Management officers' greater familiarity with the long term care environment than is available to the two complainants. He is asking Management to recognise his actions as not abusive, but as they would have been seen by those more experienced in managing a resident whose condition requires more vigorous care than is appropriate for others.

The issue put in play by Consent # 6 is experienced judgement, and decisions grounded in an evidence-based, assessment of established, appropriately tested facts. As in *St. Clare's Mercy*

Hospital and the *Newfoundland Association of Public Employees* (Mr. Daniel Chafe, Grievor) 1988 C.L.A.S.J. 503640, 10 C.L.A.S. 74 Newfoundland, Scott, 1988 at p.17, "It is not so much a question of determining .... which witness is the more credible... but which witness' judgement of the matter is to be preferred, because of its probable superior reliability." This requires some consideration of circumstances materially affecting the judgement of all those involved.

2.2 *"opportunities to perceive, recollect, and communicate":* Palmer and Palmer *Collective Agreement Arbitration in Canada*, (ed. 3, p. 72) quotes *Sheraton,* 26 L.A.C. (2d) 122 (Brunner, 1980) as follows:

> The assessment of the credibility of a witness is very often a most difficult and delicate task... regard should be had to... the character of their evidence ... their respective capacities and *opportunities to perceive, recollect, and communicate matters with respect to which they gave evidence,* the consistency of their testimony, the inherent probabilities of their respective accounts, the presence or absence of bias, interest or other motive .. (emphasis added)

I also note that Brown and Beatty *Canadian Labour Arbitration* (4th ed.) offers the following at

> 3:5110 Assessing credibility: One of the most important aspects of deciding the sufficiency and weight of evidence is assessing the credibility of witnesses. An exact definition of "credibility" is not possible, but it has been expressed in these terms:
>
> > One of the most enlightened guides on this aspect of a trial Judge's functions appears in a judgment of the late O'Halloran, J.A., delivered in the British Columbia Court of Appeal in Faryna v. Chorny , [1952] 2 D.L.R. 354 . What the learned Jurist there stated is so apposite in the present case that I feel impelled to quote the following extract from his reasons which appear at pp. 356-8:
> >
> > > "If a trial Judge's finding of credibility is to depend solely on which person he thinks made the better appearance of sincerity in the witness box, we are left with a purely arbitrary finding and justice would then depend upon the best actors in the witness box. On reflection it becomes almost axiomatic that the appearance of telling the truth is but one of the elements that enter into the credibility of the evidence of a witness. *Opportunities for knowledge, powers of observation, judgment and memory, ability to describe clearly what he has seen and heard*, as well as other factors, combine to produce what is called credibility... . A witness by his manner may create a very unfavourable impression of his truthfulness upon the trial Judge, and yet the surrounding circumstances in the case may point decisively to the conclusion that he is actually telling the truth. I am not referring to the comparatively infrequent cases in which a witness is caught in a clumsy lie.

> "The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions. Only thus can a Court satisfactorily appraise the testimony of quick- minded, experienced and confident witnesses, and of those shrewd persons adept in the half-lie and of long and successful experience in combining skilful exaggeration with partial suppression of the truth. Again a witness may testify what he sincerely believes to be true, but he may be quite honestly mistaken. For a trial Judge to say 'I believe him because I judge him to be telling the truth', is to come to a conclusion on consideration of only half the problem. In truth it may easily be self-direction of a dangerous kind.
>
> "The trial Judge ought to go further and say that evidence of the witness he believes is in accordance with the preponderance of probabilities in the case and, if his view is to command confidence, also state his reasons for that conclusion. The law does not clothe the trial Judge with a divine insight into the hearts and minds of the witnesses. And a Court of Appeal must be satisfied that the trial Judge's finding of credibility is based not on one element only to the exclusion of others, but is based on all the elements by which it can be tested in the particular case."

Where a witness is less than candid, this may result in the board either rejecting his position or not giving full support to it. *However, where both witnesses have told conflicting versions, albeit candidly , the arbitrator must nevertheless choose between those two versions and not rely upon the burden of proof to make a decision.* In any event, when an arbitrator makes a finding of credibility, it is incumbent upon him to give reasons explaining the basis of that conclusion. (emphases added)

The issue before me requires, in part, that I assess Ms. Newell's and Ms. Barrett's "opportunities for knowledge, powers of observation, judgment and memory, ability to describe clearly what he has seen and heard" as these factors may have informed their reports of Mr. Parson's actions and words that grounded the Employer's discipline for abuse.

2.2.1 *The December 8th matter:* I note unchallenged evidence (AW #1) that, on "either December 16 or 17" Ms. Newell, a recently qualified LPN with approximately five months experience at the Home as a casual employee, "reported ... (an incident she observed on December 8th) to Lisa

Green, RN", and further that Ms. Green reported the matter to Ms. Somerton a few days later again on December 20 (AW #1). I note Ms. Newell's own testimony, on direct examination by the Employer, as to why she had delayed reporting the matter to the RN, Ms. Green, that:

> It played on my mind for a long time. It was not right. That's why I discussed it with Ms. Green. You don't have a right to handle them this way. That's what we were taught in school.

Allowing something to play on a one's mind for a long time does not provide satisfactory "opportunities to perceive, recollect, and communicate" accurately what "she saw" and to test it for accuracy.

Allowing something to play on a one's mind for a long time also does not provide satisfactory "opportunities" for the one accused "to perceive, recollect, and communicate" his understanding of what "she saw", or to offer any timely explanation or clarification.

Finally and most important, it is clear that allowing something to play on a one's mind for a long time does not provide satisfactory "opportunities" for the Management officers who are responsible, under Article 13.01(b), for imposing a discharge "only for just cause" to be able to determine whether the cause for dismissal is "just" or not. In such circumstances, it is particularly important to take special care to test the validity of any reports.

2.3. *The December 14 matter:* I note unchallenged evidence that on Monday, December 18, Ms. Lisa Barrett, a student in a local college Recreational Therapy programme who was completing a work term at the Home, had a conversation with Ms Sandra Antle about what she had seen while working with Mr. Parsons on Thursday, December 14th. On Ms. Antle's advice, she reported the matter to Ms. Melanie Fillier RN on the same morning (December 18th), who then reported it to Ms. Somerton.

I note again the delay – although somewhat shorter – which compromised everyone's capacity "to perceive, recollect, and communicate" and judge what actually happened. And again I note Ms Barrett's comment when asked to explain why she reported the matter when she did:

> I felt bad, and when it happened... I was confused. If I was in school I would go to a teacher... or to Ms. Somerton. Sandra Antle saw it was upsetting me. She came to me. It had to be told.... Obviously, it was a situation where a resident was being abused... to avoid some worse outcome for the resident... Personally, I

> learned that there is a way to deal with difficult residents, not by being verbally and physically abusive.

I note that, according to Ms. Somerton's testimony Ms. Barrett had explained to her that:

> She knew the resident and her family knew the resident prior to his admission to the home, and she felt that he recognized her and was asking her why she was letting this happen.

2.3.1 The evidence is that Ms. Barrett had not previously been paired with the Grievor during her placement at the Home, and that her only previous experience of this work in the Home setting was with a "Paul and June". I was given no evidence of the level of care or of resident difficulty Ms. Barrett had observed during her time with "Paul and June". Ms. Newell testified that "I don't think I'd been paired with (the Grievor) before that. I'd been part of a team, but not as a pair... I can't remember any other time when I worked with George directly."

I note that both Ms. Barrett and Ms. Newell described their reactions to the care they had seen Mr. Parsons provide, by contrasting it with what they had "learned." The contrast between the actual healthcare environment and their learning environment echoes Mr. Parsons' own point in Consent # 6. I note, in this context, Ms. Somerton's testimony concerning Ms Newell's report:

> Yes we had a conversation. She was relatively new to our facility. She actually said, 'I don't know if it is acceptable here.' My sense was her reasoning justified her action.

Thus, Ms. Newell herself acknowledged to Ms Somerton the possibility that the difference in environment, which the Grievor notes in Consent #6, may be relevant to what she saw.

In Ms. Barrett's case, I note that the experience was further coloured by the fact that she and her family knew Mr. A prior to his admission to the home, and that she felt he recognized her. Ms. Barrett said she "felt bad".

Ms. Newell was also disturbed by what she saw. It "played on (her) mind for a long time." I note also that what she saw was variously described by Ms. Newell herself. Her summary account in Consent #5, which references the Grievor's being "aggressive with" Mr. A, his use of the phrase "old bastard", and his being "just rough with residents", differs from PN#1, which again records the use of "old bastard", and details the Grievor's having "grabbed" Mr. A "and sat him down roughly in his geri chair" when told the resident was about to fall, and his roughness

"in undressing" Mr. A. Both accounts differ from the account in AW #1 which adds references to "other foul language", to Ms. Newell's description of Mr. A "very docile", and to Mr. Parsons' having "yanked the Attends off of" Mr. A.

While the accounts differ, I note that there is a consistent core in all of them relating to the use of the language like "old bastard" and "roughness" in the Grievor's treatment of Mr. A.

2.4 In reaching my assessment of Ms. Newell's and Ms. Barrett's "opportunities for knowledge, powers of observation, judgment and memory, ability to describe clearly what he has seen and heard" as factors informing their reports of Mr. Parson's actions and words, I recognise the probability, raised implicitly in Mr. Parson's response (Consent #6), that what they were "feeling bad" about was the sometimes very difficult and very challenging realities of actual healthcare work when compared with what they had experienced in the learning environment.

I must add, specifically with reference to Ms. Barrett's testimony, that I have limited confidence in her grasp of the importance of precise and accurate reporting of facts. I find her testimony less than completely reliable based on her uncomfortable and impatient demeanour as a witness during the Hearing process.

In my view, Ms. Newell's and Ms. Barrett's various accounts in evidence, as reviewed above, raise serious questions about the reliability of their judgements as to what they were observing.

3. *But "they saw what they saw" ...* The evidence provided does not show which element or elements of the complainants' accounts the Employer relied upon in reaching its judgement as recorded in GP #9, or whether it was the consistent core concern over language and roughness in those accounts to which the Employer was responding.

Nonetheless, even if the circumstances of the reports make any disciplinary decision difficult and problematic, it remains the case that the Employer was faced with the fact that two persons, apparently without ulterior motive and apparently independent of one another, had reported what they both interpreted as the Grievor's abusive behaviour toward Mr. A.

The Employer carries a very high fiduciary burden to ensure that Mr. A and all residents are secure from such abuse. It cannot, and must not, ignore or dismiss the allegations. It did not

ignore or dismiss the allegations.

But was the Employer justified, based on the uncontested fact of the two allegations themselves, in dismissing the Grievor despite the problems and questions surrounding the reporting and investigation of those allegations?

In order to make this determination I must first address the fact that the alleged abuse took two forms, physical and verbal.

3.1 *Physical abuse?*

3.1.1 The evidence of physical abuse in respect of December 8th relates to: 1) the Grievor's "being aggressive" (Consent #5) with the resident; and 2) having "grabbed" the resident "and sat him down roughly in his geri chair" (PN #1) when informed he was becoming unsteady (Ms. Newell's testimony and AW #1) when he "could have pushed the chair ahead, or just pulled him back gently" (Ms. Newell's testimony); and 3) being "rough in undressing" the resident (PN #1). AW #1 adds details that the Grievor "yanked the Attends off of" the resident and "was generally rough ... during the change-out process."

I note that, when asked on cross examination about certain facts as recorded in AW #1, Ms. Newell testified that she had not, in speaking with Ms. Whyte, used the phrase, "yanked the Attends off of him." She said: "No. The Attends did not even come off until he was on the bed." She also testified on cross examination that the Grievor was not rough with the resident later in the procedure: "No. The change out was a bit difficult, but no. It was just the grabbing of the pants by the back."

I also note that in her testimony, Ms. Newell described the Grievor's reaction when told the resident was unsteady as follows: "George grabbed him by the waistband of the pants roughly and said, 'Come back here, you old bastard.'" I note this is the first reference to the waistband. The waistband is significant, as becomes clear on the Grievor's testimony, since it is the item of clothing LPNs are trained to use to steady those who are unsteady.

I also note that the phrase "old bastard" is used in a fuller conversational context, and not simply in a gratuitously insulting manner as might be inferred from a reading of PN #1 and/or Consent # 5. (I will comment further on this point below.)

Ms. Newell also acknowledged on cross examination that, given his location relative to the resident, and with the geri chair's brakes on, the Grievor "would have had difficulty" pushing the resident's geri chair forward.

3.1.2 The evidence of physical abuse in respect of December 14th relates to: 1) "rough handling" (Consent #4 & LB#1); and 2) the Grievor's having "struck resident in abdomen" (Consent #4 & LB #1); and 3) having washed the resident's face "very roughly" (LB #1); and 4) having "forced" the resident's "arms ... down" with a "scrunching sound" audible (LB #1); and 5) having "yanked" the resident's "teeth out"; and (6) having rolled the resident so as to risk his falling out of the bed with the side rail down.

AW #1 differs from the above accounts in describing the Grievor as having "punched" the resident "in the rib cage." I note that, in her testimony at the hearing. Ms. Barrett modified the description of the blow, saying it was delivered by the flat of the Grievor's closed hand at a point just below the resident's rib cage.

In summary, I conclude that the testimony concerning physical abuse that emerged at the hearing is not persuasive. The startling reference to the Grievor's use of his "fist" (LB #1), is both less dramatic and less convincingly abusive when Ms. Barrett redescribes it as the flattened palm of his closed hand used in the context of the Grievor's virtually single handed struggle to provide care to a vigorously resistant resident. I also find the description of the Grievor's having forced the resident's arms down with an accompanying "scrunching sound" to be unpersuasive when seen in the context of the Grievor's virtually unassisted efforts to provide the care required.

The Employer argued repeatedly that the care was not, in fact, "required" to be given at that time, and might have been postponed until the resident was less resistant or more assistance available. I found the evidence of Ms. Guy-Noonan telling on this point. I am not persuaded that this position has much weight in the instant situation, and note, for comparison *Versa-Care Centre of Brantford v. Christian Labour Assn. of Canada* [2005] O.L.A.A. No. 744 , R.L. Levinson 2005 where (para. 11) there was no regard for co-worker whose presence was expected.

The other allegations of "yanking" and "rough handling" are, with respect, not persuasive as proof of abusive behaviour when used by a person of such limited institutional experience as

Ms. Barrett was when first exposed to the virtually single-handed management of a resident whom all witnesses, including most Employer witnesses characterised as at least difficult.

Her allegation that the Grievor rolled the resident roughly to the side of the bed where she had put down the rail is, again, not persuasive. Ms. Barrett, on her own admission, had lowered the rail. The Grievor's uncontested evidence is that he does not lower the bed rails, and that he did not do so on that occasion. There is some ambiguity as to what precisely caused Ms. Barrett's back problem, and what, if any, risk the Resident faced.

I find, therefore, that the evidence provided both by Ms. Newell and by Ms. Barrett does not sustain a charge of physical abuse against the Grievor.

3.2 *Verbal abuse?* I will address below questions relating to the Home's policies on language use. I will focus here on the issue of verbal abuse for which the Grievor was disciplined.

3.2.1 The evidence of verbal abuse in respect of December 8th relates: 1) to the Grievor's calling the resident an "old bastard" (Consent #5 and PN #1); and 2) to the reports (in AW #1) that "George called (the resident) 'an old bastard', and used other foul language", and "was verbally abusive during the whole change out process."

I note that Ms. Newell was asked at the Hearing, whether she had in fact told Ms. Whyte (AS #1) that "people in other rooms would have had to have heard George shouting at" the resident, Ms. Newell answered: "I would have said 'if someone was outside the door.'"

Further, as noted above, Ms. Newell's testimony at the Hearing on the use of the phrase "old bastard" revealed that when Mr. Parsons used the phrase it was as a form of address in the fuller, and perhaps somewhat urgent, conversational context of securing Mr. A against falling, and not simply as a gratuitous insult as might be more naturally inferred from a reading of PN #1 and/or Consent # 5.

3.2.2 The evidence of verbal abuse in respect of December 14th relates to: 1) the Grievor's having made "demeaning remarks to resident" (Consent #4); and 2) "George started cursing and swearing ("got that "f........er" there....) And "George called him a "bastard"...", and "George said, 'you old dog, and I wish you would die and called him a "bastard again saying "you are only breathing our air ... his exact words", and saying " (LB #1 and AW #1) "I got a "f....ing" mind to

roll you right out on the "Jesus" floor today .... I got a mind to kill you." (LB #1)

The phrase "demeaning remarks to the resident" (Consent #4) appear to summarise the fuller account in LB # 1 (as reported to some extent again in AW #1). I have reservations about the accuracy of the account provided in LB #1 on several grounds.

First, the initial quote "got that "f........er" there...." appears to be addressed not to the resident, but to someone else. We have no evidence whether, if it was said, it was said to the resident or whether the resident heard it. Therefore, it is not clear whether it was actually or potentially verbal abuse of the resident.

Second, the allegation that the Grievor used the term "bastard" more than once in reference to the resident is not provided with any context. As we saw in analysing the same word's use when clarified in Ms Newell's testimony, a general reference to the term's use does not in itself provide immediately compelling evidence of abuse.

Finally, and most important, I am puzzled by the last alleged quote ("I got a "f....ing" mind to roll you right out on the "Jesus" floor today .... I got a mind to kill you.") in view of the unchallenged evidence that the Grievor works with the sides up, and had not put his side down. The comment as reported, therefore, lacks complete consistency with this fact. No evidence was adduced on whether he was made aware, or knew at the time, that Ms. Barrett had lowered the bed rail on her side. Neither Party explored this final quote in detail during examination of the witness. I again confirm my earlier noted concern specifically with reference to Ms. Barrett's testimony. I have limited confidence in Ms. Barrett's grasp of the importance of precise and accurate reporting of facts.

In summary, I am not persuaded on the evidence provided that the Grievor's language to the resident was abusive. If he did use the term "bastard" on December 8th, there is evidence that it was used, not as a gratuitous insult, but in the heat of an urgent situation occasioned by the need to respond quickly to a danger to the resident. I do not intend, by this remark, to sanction inadvertent acts of verbally abusive language or complacency about inappropriate language use. I mean only to recognise context as pertinent to reasonable understanding of what may be said.

3.3 I find, therefore, that the evidence provided by Ms. Newell and by Ms. Barrett does not sustain a charge of physical and verbal abuse against the Grievor.

3.4 Therefore, while it may be true to say that Ms. Newell and Ms. Barrett "saw what they saw", I find that it is not the case that what they say they saw can safely be described as "verbal and physical abuse" (GP #9).

3.5. *The Policies of the Home*? According to GP # 9, the Grievor was not disciplined for any violation of the Licensed practical Nurses' Code or violation of the policy on language use, but for "verbal ... abuse". From the evidence of the Union witnesses, it is clear that Consent #2 policy on language use is ineffectual at best.

4.0 *Failure to Discharge Onus?* The Union argued throughout that the case turns on whether the Employer has discharged its onus by providing the "clear", "cogent", "convincing", "substantial", and "reliable" evidence that Brown and Beatty *Canadian Labour Arbitration* (4th ed.) says, at para 7:2500, is required for the Employer's case to succeed. I now turn directly to that issue.

4.1 *This case raises an issue related to onus.* Two persons, new and relatively inexperienced in a difficult and demanding profession as practised in an institutional setting, were prompted, finally, to report something they saw. I will assume here, absent evidence to the contrary, that both did so without collusion or malice, and out of a concern both for the safety of residents, and with regard for professional standards involved and their own moral sensibilities.

But such reports can only be safely made, and only have value, if they are received, appropriately evaluated, and acted on in a way that sustains and protects those same moral sensitivities and professional standards and the people acting in accordance with them. Informed and alert judgement based on diligently investigated evidence is required in order to determine whether there is just cause for discipline as a result of such reports.

All witnesses testified to the appropriately high importance attached to preventing of all forms of abuse in the healthcare field generally, and in the Pentecostal Senior Citizens' Home in particular. All the evidence shows that everyone involved knows that any resident abuse must be immediately stopped and reported, not only because that is what the Employer's policy manuals and the Profession's codes say, but because it is what human beings require of one another.

Everyone – including, perhaps especially, those who are new to the healthcare professions and relatively inexperienced in healthcare institutions – must be encouraged to report what they see if they have any questions about client safety. As the Employer pointed out, such fresh eyes are crucially important in guarding against complacency in all fields, but perhaps especially in fields like long term care, where the work is so repetitious and yet so demanding physically, emotionally, and personally. In order for all to be encouraged to report all must have confidence that those responsible within Management will have the mature insight and institutional and educational resources that enable them to make critically informed professional judgements when issues and questions about abuse arise.

Simply put, zero tolerance for abuse does not license reduced Employer responsibility for critical exercise of evidence-based judgement in assessing allegations of abuse. Under this Collective Agreement Article 13.01(b) the Employer can discharge "only for just cause". It is for the Employer to determine whether the cause is just or not. It cannot safely adopt a "fire now, find out later" approach. I raise this issue here not because I have evidence that such a "fire now, find out later" approach was adopted in the instant matter, but to ensure completeness in my review of dynamics that may be involved in circumstances such as those raised in the instant matter. The high standards that healthcare employers rightly demand of their employees, and the arbitral review process with its onus test, do not mean that Employers can prudently pass along the responsibility of exercising judgement on the question of whether just cause exists.

4.2 *The jurisprudence* consistently holds, as noted above, that, in the words of Arbitrator Slotnick in *Cassellholme Home for the Aged v. Canadian Union of Public Employees, Local 146 (Morabito Grievance)* [2006] O.L.A.A. No. 445 at para. 22

> The first principle to note from the cases is that for an allegation of patient abuse or resident abuse to be substantiated, there must be clear, cogent, strong and reliable evidence of the grievor's misconduct.

4.2.1 *Best Evidence?* I am surprised and somewhat disturbed by the quality of some of the documentary evidence provided: in particular with the fact that the handwritten original of the AW #1 notes were destroyed by Ms. Whyte and therefore unavailable for review at the Hearing and that a handwritten original version of LB #1 which was attested to by Ms. Barrett, was not tendered. The best evidence is important, as is clear from *Brown and Beatty Canadian Labour*

Arbitration (4th ed.) at para. 7:4000. This is especially so in a termination matter.

4.2.2 *Adverse Inference*? I note that Brown and Beatty *Canadian Labour Arbitration* (4th ed.) Reads, at para. 3:5120 "Failure to call a witness:"

> Arbitrators generally have adopted the same view as the civil courts with regard to the conclusions to be drawn from the failure of a person to be called as a witness who could have been called and who could have given evidence of matters within his knowledge. Thus, where a party can, by his own testimony, throw light on a matter and fails to do so, an arbitrator is entitled to infer that such evidence would not have supported his position...As well, failure to call a witness who is available to be called, where the evidence is material, can lead to the same inference being drawn and the uncontradicted evidence by the other party accepted.

I note that the Facility Manager of the Home and author of the termination letter, Ms. Bellefleur, did not appear despite information that, although she has been on sick leave since last December and remains under a doctor's care, she is currently at the Home doing ease-back duties.

Ms. Bellefleur was described by Ms. Somerton as having participated in the investigation of the allegations, and it is her signature that appears on the termination letter. Ms. Somerton said she had immediately called Ms. Barrett to the office on December 18th, and that Ms. Bellefleur had been involved in the investigation: "Yes. Very shortly after I had informed her, she talked to Lisa." I have no doubt that Ms. Bellefleur might have provided evidence material to issues before me. In particular she might have spoken to the circumstances leading to the letter of termination, and, in view of my earlier expressed concern with the credibility of Ms. Barrett's evidence, to the content and character of Ms. Barrett's allegations.

I also note that neither Ms. Antle nor Ms. Fillier nor Ms. Green were called as witnesses to allow examination of their recollections of the complainants' accounts of what she had seen. On the evidence provided, they were the first, to be told. Ms. Somerton was the beneficiary of subsequent retellings. Further, Ms. Antle, Ms. Fillier, and Ms Green might have been able to throw light on any possible deliberate or chance, intended or unintentional links between Ms. Newell's report (of the Dec 8th matter) to Ms. Green on "either December 16 or 17" and Ms. Barrett's conversations (about the Dec 14th matter) with Ms. Antle, Ms. Fillier and Ms. Somerton on the 18th that preceded Ms. Newell's report to Ms. Somerton on the 20th. Ms Green might also have thrown light on the delay in reporting what she had learned from Ms. Newell on "either

December 16 or 17" until December 20th. In short, there were a number of salient and material issues that their testimony might have clarified. I was not informed of any circumstances that would have made them unavailable. I was given no evidence as to whether the Employer had explored any of these questions with Ms. Antle, Ms. Fillier, or Ms. Green in the course of its investigation prior to making the just cause judgement that it was "satisfied" (GP #9) the Grievor had abused Mr. A.

4.2.3 I infer therefore that evidence that might have been provided by these would not have supported the Employer's position in this mater.

4.3 *I also note evidence* that the Employer had not explored Mr. Kippenhook's possible knowledge of the events that Ms. Barrett described, despite evidence that he was in the room at the time, and that the curtain was not drawn.

I also note a number of points in the evidence which do not give confidence that careful attention was paid by the Employer to the details of the reports made. I note in this regard Ms. Somerton's confusion over the location of events reported by Ms. Newell (in the bathroom or Mr. A's room itself?). Also, Ms. Barrett's confusion over events she earlier reported as happening at sometime around 10:00 AM and now testifies happened before breakfast compounds my earlier noted lack of confidence in the accuracy of her testimony. Further, the number of substantial but unanswered questions of detail arising out of AW #1 as revealed on cross examination confirms my sense of insecurity about the Employer's evidence in this matter.

4.4 *I find, therefore,* with respect, that in the instant matter, the Employer's evidence presented at this Hearing was not "clear, cogent, strong and reliable." I conclude that the Employer has not met its onus. There is no reasonable preponderance of credible evidence established to justify the Employer's determination that the Grievor's "actions on December 8th and 14th , 2006 constituted verbal and physical abuse" (GP #9). The evidence is not sufficiently cogent to make it safe to sustain its discharge of the Grievor.

DECISION

In light of the foregoing considerations, I find that:

> **The grievance is sustained. The termination is set aside and the Grievor is to be reinstated in his former position with no loss of benefits or seniority. He is to be fully compensated for his losses. I remain seised should the Parties be unable to resolve questions of quantum that may arise.**

Respectfully submitted as the decision of the Arbitrator.

John A. Scott, Arbitrator

May 26, 2008