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ONTARIO COURT OF JUSTICE

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
(MINISTRY OF LABOUR)

v.

ROYAL OTTAWA HEALTH CARE GROUP

R E A S O N S F O R J U D G M E N T

RENDERED ORALLY BY JUSTICE OF THE PEACE J. DORAN
on July 15, 2016, at OTTAWA, Ontario

APPEARANCES:

G. McGrath — Counsel for the Crown
S. Bird — Counsel for the Defendant

ONTARIO COURT OF JUSTICE

T A B L E O F C O N T E N T S

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REASONS FOR JUDGMENT 1

Legend
[sic] - Indicates preceding word has been reproduced verbatim and is not a transcription error.
(ph) - Indicates preceding word has been spelled phonetically.

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FRIDAY, JULY 15, 2016

REASONS FOR JUDGMENT

DORAN, J.P. (Orally):

This has been an interesting, an informative and a long and challenging journey. There have been a number of interesting and challenging issues that this Court has had to deal with in arriving here today. We are here today for the Court to render its decision on the matters that commenced on November 18th, 2014.

There are volumes of exhibits and case law that have been filed in regard to not only the charges that are before the Court for a decision today but also a number of motions and rulings requested of this Court. I will summarize them; however, I want to assure both counsel that I have read over and over all the materials they have filed as well as the many transcripts of this multi-day trial.

On July 5th, 2012, a patient of the Recovery Program of the Royal Ottawa Mental Health Centre, hereinafter referred to as ROP, became violent and a physical altercation took place involving two registered practical nurses and one personal care attendant.

On June 26th, 2013, the Ontario Ministry of Labour laid three charges against the defendant pursuant to the *Provincial Offences Act* for alleged violations of the *Ontario Health and*

Safety Act. The matter was scheduled for trial and commenced on November 18th, 2014.

This Court has been charged with the task of delivering one of the very first cases litigated under the workplace violence provisions in the *Occupational Health and Safety Act*. There are other prosecutions going on in the province that are at the earlier stages; however, this case dealing with workplace violence may well be the first decision rendered.

Not one person here today would not wish they could turn back the hands of time and change the series of events that unfolded that day in order that we would have a better outcome. There was a very unfortunate assault but the charges don't relate specifically to the assault itself, it's the surrounding issues with respect to the charges under the *Occupational Health and Safety Act*. There were injuries sustained in this event but the charges don't relate to the injuries themselves.

No one would want to belittle the injuries or the seriousness of the assault. It should be noted that this particular assault has had a significant impact on the nurses, the patients, the hospital and everyone involved.

What I'll be providing today is the background of the evidence and the motions that were heard before this Court. I'll then be reviewing the charges, both the Crown and defence positions in regard to those charges. Then we

will be having a break and I will be issuing my decision in regard to each of those charges.

On November 18th, 2014, when the trial commenced, the first witness was called by the Crown. Stephanie Calvert, an investigator with the Ministry, had been employed with the Ministry for approximately nine-and-a-half years. She was first involved with the Royal Ottawa in 2006.

On July 24th, she received a message that a complaint was called into the Ministry of Labour from a worker, saying that there had been a workplace violence incident at the Royal Ottawa Hospital. The worker was concerned regarding the employer's follow-up, investigation and corrective action. She expressed concern for the safety of workers at the institution.

Upon receiving the complaint, the inspector attended the site and spoke to Nicolas Addo, who is the Director of Health and Safety for the Royal Ottawa Mental Health Centre. Her initial investigation in regard to the incident of July the 5th consisted of a fairly vague description of the events. She was told that a patient, hereinafter referred to as Patient X, had become violent. He had attacked more than one nurse, nurses Chun Fan and Kathee Kot. She was also informed that Patient X had approached Chun Fan while she was doing some charting, and that another nurse, Kathee Kot, had become involved, and he had physically attacked both of these nurses.

Her subsequent inquiries indicated that the

individuals involved on the day in question were Chun Fan, one of the injured workers, an RPN, who is a registered practical nurse. She was injured, with no broken bones, but she was punched and kicked in the head, and at the time, the employer reported that they believed she had not lost consciousness.

Kathee Kot is an RPN, a registered practical nurse. She also did not suffer any broken bones but was also attacked, and at the time, they reported they did not believe she had lost consciousness in the attack.

Gifty Baffoe is a PCA, which is a personal care attendant, and she suffered a blow to the head in the incident.

Stella Ofili is another PCA who was involved in the incident but did not suffer any physical injuries.

Dale Evans was a registered nurse on shift at the time. It was reported that she had called the Code White and that she had witnessed part of the incident.

Lidilia Ascencio was another RN that was on shift and she witnessed parts of the incident.

They indicated to the inspector that the patient had started to de-escalate by the time the code responders had arrived from the main hospital. They originally said there were four or more responders but then said that it was six to eight that they believe responded.

The inspector told the Court the joint health and safety committee is a required committee to be

in place at workplaces with more than 50 workers, and there is a joint health and safety committee in place at the Royal Ottawa Mental Health Centre. She requested a number of documents in order to complete her investigation, and that was issued. At Binder #1, page 37:

> The first requirement was a copy of all joint health and safety committee meetings from January 2010 to date.
>
> The second requirement, a copy of all workplace inspection reports from the Royal Ottawa from January 2010.
>
> Requirement number 3 is a copy of all policies, measures and procedures in place at the Royal Ottawa Mental Health Centre and Royal Ottawa Place to protect workers from the risk of workplace violence and in place to respond to incidents of workplace violence.
>
> Requirement number 4 is a copy of the workplace violence risk assessments for all units.
>
> Requirement number 5, a copy of the training plan and the content of all training plans provided to employees working at the Recovery Program at the Royal Ottawa.

Number 6 is a copy of all training records for workers who work in the Recovery Program. Requirement number 7, a copy of all Code White reports for the Royal Ottawa Place from January 2010 to date.

And finally requirement number 8, a written notice of the workplace violence incident that occurred on July the 5th, 2012.

She reviewed the corporate policy and procedures in place at the Royal Ottawa Health Care Centre and the Royal Ottawa Place for the prevention of workplace violence, which was their corporate policy regarding the management of workplace violence.

The scope of this document indicates that it applies to all the staff and it extends to locations outside of the physical environment of the organization which may involve the staff and patients. In terms of the document outlining the scope, it was her understanding that it applies to all employees of the Royal Ottawa Mental Health Care Group and the Recovery Program employees as they are all employees of the Royal Ottawa Health Care Group.

One of the requirements under the workplace violence requirements under the *Occupational Health and Safety Act* is for employers to conduct a risk assessment for workplace violence at the workplace, and further from that, the purpose of that is so that the employers identify areas where

there are risks of workplace violence.

The next step would be to put measures in place to protect the workers. She wanted to know what risk assessments had been done and if they covered the Recovery program as part of those assessments.

As a result of her investigation, she issued a number of orders to the Royal Ottawa which were filed in Binder #1, page 46 to 53, and it was filed with the Court as Exhibit Number 15. She issued a number of orders to the hospital:

> 1. An order requiring the employer's written notice of accident contains the names and addresses of the witnesses;
>
> 2. An order ensuring that workers are informed of a patient with a history of violence; in particular, the patient that was involved with the July 5th incident;
>
> Order number 3 requires employers to ensure that measures and procedures in place for the health and safety of workers are in written form;
>
> Item number 4, an order requiring that – and this is referred to as what we will later hear as the "yellow sticker" program - document procedures. The employer is ordered to ensure that once the program is developed – and that was in order number 3, developing

the program with the yellow sticker program – it includes all workers receive information and instruction about the program.

And item number 5 – and it's interesting in item number 5 - the order is, further in the paragraph:

> There was a delay in calling the code white as workers being attacked could not immediately access communications.
>
> (And the second) When the code white was called (by another worker) responders arrived after a time delay due to ... travel from the adjacent building.

Item number 6 was an issue in regard to the restraints that the hospital was using.

There were recommendations, additions, additional comments that were provided by the inspector at that time but on page 49 of that, there's a list of items that the workers had indicated to her as part of her investigations. I will quote:

> Some of these suggestions are included in this report as advice and feedback to the employer regarding worker suggestions and concerns.

They deal with the second door in the nursing

station so the employees couldn't become trapped, swiped access to the nursing station, location of a safe room, better systems for calling a Code White, more staff in the evening, a security presence, more clear procedures to follow if a patient had a history of violent behaviour, and also in regard to the restraint system that was used after a patient was restrained. She was asked during her testimony:

> Did you make any orders to the employer to change its facility or make physical changes to the workplace, and if not, why not?

And again we're referring to Binder #1, pages 48 to 49. And her response to that question was:

> No, I didn’t write anything that specific. In my report, I highlighted some of the concerns that workers had brought up as part of their statements.

Her role as the inspector is not to tell an employer what particularly to have, just to make sure that they have mechanisms or procedures in place to address an issue or to address the requirements of the legislation. She went on to state:

> When we write an order, we write an order based on a contravention, which is where we have observed something that is not in place

or not as required in the Act or regulations. We would not say specifically what measures the employer has to take, just that they need to comply with the order and make sure they have measures in place so that they're in compliance with the legislation.

She filed with the Court a series of photographs of the Royal Ottawa Place which identified the location of the incident. She also provided a diagram, a layout of the floor plan of the ROP, which was referred to many times during this particular court case, and I will be referring to it on the PowerPoint presentation when we get to a review of the incident and what actually happened on the day in question.

The inspector indicated she had a lot of involvement with the Royal Ottawa over the past eight years, and over that period of time, she indicated that she had seen an evolution of policies and procedures which dealt with workplace violence at the Royal Ottawa.

In reviewing the charges before the Court, the three charges that had been filed, she indicated that charge number 2 is a very broad charge and it includes supervision. However, the Ministry's position is it's not part of the concerns for the Ministry.

She also provided her perspective on the Recovery Unit or ROP. As she understood it, patients went to the Recovery Program with a number of different diagnoses, and the purpose of

that was to help those patients either reintegrate into the community or to start to learn to "function" more independently and to transition them out of the programs in the main hospital for reintegration into the community.

As well, she learned the Recovery Program is a voluntary program. Individuals can come from the community rather than the main hospital setting. It is also designed to help the patient function more in social settings as part of their reintegration.

During her investigation, it was revealed that workers thought that the patients that were going to be placed there were expected to be a bit more stable than in the main hospital in terms of dealing with their illness. Management also said the program was more designed for patients to be somewhat more stable in this unit.

In closing her testimony, she stated that on July 5th, 2012, she did not have any outstanding orders and was not sure if there were any other outstanding orders from other inspectors.

The incident happened on July 2nd, 2012, and as a result of her investigation, the Ministry laid the charges on June 26th, 2013, the last month before the statutory deadline.

I would now like to review the series of events that unfolded, which I'm calling it as the incident of actually what happened, based on the testimony that we've had before us in regard to the incident on July the 5th, 2012, where a patient of the Recovery Program became violent and a

physical altercation took place.

The Court heard from three employees that were assaulted as well as the other two employees on duty that evening. I would like to go through the timeline as the events unfolded that evening as it is the cornerstone on which commenced the laying of the charges and started the journey which culminates today.

We have a diagram of the floor layout of the Royal Ottawa Recovery Unit that was filed as an exhibit. As well, the Court took the opportunity to visit the site and observe first-hand the location of all of the rooms, nursing stations, exits and entrances to the unit. The visit was extremely helpful in following the testimony of the witnesses as well as having a clear understanding of the events as they unfolded on July the 5th.

From November 17th to November 21st, and as well from November 25th to 27th, two registered nurses and one personal care attendant who were the most involved in the altercation giving rise to these charges testified before the Court.

At the beginning of the trial, the local newspaper, the Ottawa Citizen, published a number of articles in regard to the testimony the Court had heard from these witnesses and on November 27th, the defendant requested an adjournment of the trial and brought a motion seeking a ban on any further publication of the proceedings.

In regard to the motion of the defendant for a ban on publication, this Court found that it is

a court of competent jurisdiction. It is quite equipped to adjudicate on the matters before it, based on the totality of the evidence and the testimony.

The Court also noted that, as a result of the local newspaper articles, there is another court at play here, and that is the court of public opinion, and that is the forum in which others must adjudicate but not this Court. That is one that can be directed by competing interests of various groups with varying different interests.

The principle of openness of judicial proceedings is a fundamental right as articulated by the Supreme Court. The motion for a ban on publication was not granted and, as such, the trial continues.

And while today this Court will issue its decision after much thought and review of the facts, the other court, the court of public opinion as indicated, may indeed have a different view of the events and of the decision the Court will render today.

I would like to talk about the individuals involved on July the 5th. We have a diagram and the movements and the actions of the individuals involved but, first of all, we have the individual which we referred to as "Patient X."

A brief background of Patient X, he had been a patient at the Royal Ottawa prior to the incident of July 5th. He was involved in a previous incident while a patient in the Schizophrenia Unit; however, it had been reported

as not severe. It was reported that he had a prior incident of biting in the Schizophrenia Unit. That was filed as Exhibit 12. After his stay in the Schizophrenia Unit, he was released into the community.

The nature of admission into the ROP is that you're not admitted unless you're stable and you have been assessed by a number of doctors who would then approve your admission. As well, admission into the ROP unit is voluntary.

We heard evidence that there were people in the ROP who were acting aggressively and they were immediately removed from the unit.

Patient X had little to no restrictions on his mobility and he had taken part in an unsupervised visit to the local Walmart days before the incident of July 5th.

The evidence of Ms. Fan, one of the individuals subsequently assaulted, testified she had no concerns with Patient X, he did not pose a threat of violence while in the ROP.

Patient X's admission to the ROP, he didn't get in on his first attempt, his second attempt or his third attempt, it was his fourth request for admission where he was assessed and finally admitted to the ROP.

We heard evidence that he was an intelligent individual who had received high marks while attending postsecondary education, and the day in question, he had no restrictions placed upon him. He had just finished his snack and proceeded out of the dining room and was on his way to his room

when the series of events unfolded.

This is a diagram of the – oh, it should be. Technology is great when it works. This is a diagram of the Royal Ottawa Place, and for those of us that have been here for the trial, we're well aware of the various locations, but I will go through the series of events as they happened.

The individuals working that evening in the ROP were Kathee Kot, Chun Fan, Stella Ofili, Gifty Baffoe, and there was two senior registered nurses, Dale Evans and Lidilia Ascencio.

Kathee Kot had worked for the Royal Ottawa for approximately 15 years. She described the Recovery Program as a 32-bed unit which helps people who are dealing with mental health issues as well as people who have had long-term hospitalization. It's a program that helps those people readapt into the community by providing them with psychosocial and support mechanisms. It's a residential unit as well. It is divided into two sections, the north and the south. It's one big long hall, and on the north side, there is a dining room and room for 16 residents, and in the middle, there's a nursing station as well as a medication room, and on the south side, it's a mirror image of the dining room, 16 beds, as well as a Kardex room and other various rooms and offices designated for different staff.

Ms. Kot testified that on the day in question, she was asked to go and touch base with a patient in a different part of the hospital, so she gave report to her co-workers, including a

full report on Patient X. She was gone about 15 minutes in total.

When she returned, Chun told her Patient X was in the dining room having a snack and she indicated that he didn't want his night-time medications. Kot went to see Patient X.

On the diagram, P is referred to as "Patient X," "N" will be referred to as Chun, and Kot will be "N2."

He was taking his medications, it was a significant amount of pills, and at the time he was unresponsive. He was sort of giggling, she stated. He started chewing the pills. He then did an about-face and was darting down the hallway towards his bedroom. She gently tried to get his attention to see if he had taken the pills. She indicated that she just wanted to gently distract him, staying a fair distance away from him. She knew, at that point, things were not good.

He was heading to his room. He went into the Kardex room. This is the Kardex room here. So he takes his pills here, he starts down the hall. Kot approaches from behind and then he goes into the Kardex room.

Kot went to the Kardex room and he was standing behind Chun. Chun was at the table doing her charting. He was standing behind her, asking for a hug and sort of giggling, and she believed he had his hands on her shoulders. Kot tried to distract Patient X gently to come out of the room and provided reality orientation to the patient.

At that time, he charged at Kot, smashed out

with his hand, and smashed the windows in the door. At that time, Kot turned down the hall and she could see Dale Evans in the nursing station. She screamed, “Call a Code White.” In the nursing station, Dale Evans is in the nursing station, Kot is proceeding down a hall, Patient X is following her, and we're going to see what happens with Chun in a minute.

> He was coming towards me, and then a hand went around my neck and then - and I was walking - he was walking me with his hand around my neck, and I think he might’ve been hitting me. And then he - I tried to block the other hand from going around my neck but he got that one - he got both hands around my neck and he was squeezing. And then I remember being on the floor. I sort of was seeing stars and I thought my arm was broken. I don’t know when he threw me on the floor. But I was able - I was on the floor, and then the next thing I remember, I was sitting on a chair in the nursing station, just near where I was thrown on the floor. And at that time I looked down and I saw Chun on the floor. She was lying on the floor.

She heard Stella’s voice. I heard her say, "What the hell is going on in here?" And she ran in. She ran in and tackled him by the waist. "And then I saw Gifty had the other arm." She was trying to get the other arm, but he was harming

her.

> And then I saw one free arm, and I got up and I got his arm and wrapped around and just hung off it. I was running for my life. He was after me. I don't know where the others went to, at that point, or where Chun was, but I was running, and I ran into the nursing station, and I was falling over chairs. I got to the end of the nursing station. I remember sitting on a chair looking out over the nursing station wondering where I was, what was going on, and then I saw Patient X standing there. The phone was there next to me. I called 911. I talked to the operator. I told them we needed help immobilizing a patient.

When we heard the testimony from Chun Fan, who is a part-time RPN, she indicated that on July the 5th, Kathee Kot, another nurse, asked her to look after her patients as she was required to go to a different part of the hospital to deal with another matter.

She described the procedure of what happens on the floor when there is a shift change, and this is Chun's testimony:

> When we change shift, we are all in the Kardex room. Every day, when it is time for shift exchange, in the afternoon, three o'clock, we all sit by the big table. There

> is a big bulletin board and all patients from the south and the north are on the bulletin board. The daytime shift nurse will report every patient's situation and circumstances about their mental health problem and about their mental status. On that day, I didn't remember any patients reporting the status of that patient. In that day, during a shift report, not a single daytime nurse told us of any problem with Patient X.

In regard to the health status of the patient:

> I didn't remember any patients reporting the status of that patient. In that day, during a shift report, not a single daytime nurse told - told overnight shift nurse ... of a problem with Patient X.

We then heard evidence about the "level of responsibility," and that's a number that's assigned to the patients, and she described it as the higher the number is, the more stable the patient is. If the number is the smallest, the lowest, for example one or two, then their mental status or their status is not stable, though the patient's level was six so the patient could go outside. If the patient's level of responsibility is not low, he can go outside to do whatever he wants, to do anything. There was nothing on the white board to indicate that Patient X might not

be stable. Her comment was:

> I don't think his number is the small number, one, two or three. If the number is one, two or three, then ... (they) will have one-to-one service. This is close observation.

She then described the incident as it happened. She was in the Kardex room and she said:

> He came into the Kardex room and asked "Can you give me a hug?" ... I stood up and he - ... I stood up ... and then, all of a sudden, he used his fist to smash the window - sorry, to smash the glass.

The patient smashed the window so the glass smashed all over the floor. They (Kot and Patient X) walked towards the station, the nursing station.

> So I ... follow them. ...all of a sudden - I'm worried there ... might ... (be some) actual incident happen so I had to follow Kathee to help, to provide assistance to ... her.

Chun was following behind the patient and Kathee Kot, and they were approaching the nursing station.

> All of a sudden, I saw Patient X strangled Kathee's neck, ran quickly (towards) ... them, quickly. I yelled loud... "Stop, stop." At that moment, I remember that this is the south, on the wall of the south, of the dining ... (room), there is (an) emergency phone. It's not (an) emergency phone, it's a normal phone, it's a common phone. I opened the door, pick(ed) up the phone, pressed zero. I ... yelled, I shouted, "Code White, Code White."

And you can see where this is. Chun goes into the dining room, picks up the phone and calls for assistance.

> I opened the door, pick(ed) up the phone, pressed zero. I ... yelled, I shouted, "Code White, Code White." I shout ... "Code White, Code White." I saw Kathee being attacked. At that critical moment, I think Kathee's life is ... more important than anything. I don't even have one second to lose, to waste. I run outside. I said, "Stop, stop." Then the patient saw me. I tried to distract... his attention. I wanted to run to him to make him stop. Then he saw me. Then he grabbed my head. He grabbed my head. It seems he swings my head to the door of - the med (room)... When I opened my eyes, I (don't) ... remember if there were any people nearby. ...I saw this patient was chasing -

> Kathee. ... I (don't) ... remember (anything) afterwards.

She indicated when going to make the call (the Code White), she could get straight into the dining room. She was not able to get into the nursing station. However, she indicated the incident happened in front of the door to the nursing station.

After 911 arrived, her testimony indicated she was able to walk and talk to the police as she was looking for her health card.

We heard the evidence from Stella Ofili, a part-time personal care support worker. She indicated that her supervisor the day in question was Dale Evans. She was the individual in charge:

> Her being in charge is anything that is happening, anything we observe, we give (to) her the ... information. Whatever we need, we go to her. She was in charge of everything. I was cleaning up (in) the TV lounge south. The south lounge (which would be over here). I saw Chun run to the patient phone but I did not feel anything. I keep on cleaning while Patient K came up to me and said, "Stella, can you please go and help your co-workers, they are in trouble." I ran out immediately. I looked at my left side, at the south side. I saw the door to the Kardex room, (it) was broken. Everywhere was blood. I was surprised. I look at the north

> side, at my ... side. I saw Chun running and Patient X chasing, chasing her, punching her and kicking her. She was lying on her back on the floor... I ran and I asked, "What is happening" and I grabbed him from the back and push(ed) him out from her. As I grabbed him at the back, he was wiggling himself to get out of my hands. He was trying to reach up at my hand to bite me. I released my right hand. Then he pulled his hand, punch(ed) Gifty on her forehead, immediately he wiggled himself out of my arm. Kathee ran to the nursing station. He chased her into the nursing station and start(ed attacking) ... her. Kathee was screaming ... for help. Then I ran to the nursing station because I (couldn't) leave her like that. Then one of the patients, T, came (to) me and we stood by the door. We opened the door and Patient T screamed, "Stop hitting her, she's a woman. If you want to fight, come to me." He responded to the voice and he looked back and saw both of us.

We heard from Gifty Baffoe, who is a part-time evening personal support worker. She's worked at the facility since 2004 on a part-time basis. She indicated that her supervisor as well that evening was Dale Evans. Oh her first round that evening, she observed Patient X sleeping. She was in the south dining room doing paperwork. She heard a loud noise, which was the glass in the Kardex room

breaking. She went into the hall and saw Patient X assault Kot. She had been in the hall. That's where Patient X was.

She saw the two nurses in charge come out of the nursing station. She saw Chun run to the phone in the dining room and call Code White. The other two nurses were right there. They assaulted Chun in front of the nursing station. One of the nurses in charge was going the other way to the Kardex room. Hesitating for a minute, she saw the other two nurses, then she went forward. She grasped Patient X from behind. Still holding him, she sees someone else approaching. Patient X stuck her in the forehead and then went into the nursing station and attached Kot again. They were moving forward towards the nursing station when another patient intervened. She saw Lidilia in the nursing station when she went to get her binders for the reports earlier in the evening. Evans came out after the orderlies had arrived from the main building. She did not see Lidilia until after the patient had been restrained and they were looking for medication. She had been a participant in a Code White before the incident of July the 5th.

We heard the evidence of Dale Evans, one of the RNs that evening. She indicated that Lidilia Ascencio was the charge nurse for the evening. She testified that she was not the charge nurse for the evening. However, we heard evidence from other individuals working that evening that indeed it was Dale Evans who was the supervisor.

She described the duties of the charge nurse. They make the patient assignments. They start at three o'clock, which is a half-hour ahead of the other people, so usually at three o'clock the nurses make the patient assessment, plus decisions around breaks, problem-solving, any acute situations that arise, and clear any acute problems or events for the evening.

Her best recollection is that she was in the med room. She heard a bang.

> I came out in the hall. I saw the Patient X running and I did not see where he went at that time. I think at that time I went back to the med room or I was out in the hallway area and Kathee Kot came out and yelled, "Attack on staff." So I went and called a Code White. And I did call and say that there was an attack on the staff. And I left that area, left the nursing station and went ... into the hall. And Kathee came first, and then Chun came second, and they went into the nursing station, and I yelled. One person left. I do not know, because it was happening very fast, if that was Lidilia, or I'm not sure of the individual that was, but I was out in the general area, and I yelled, "Shut the door." And that was not done. So they were in the nursing station area and the patient went in, and that's when the assaults took place that I saw. Patient X slipped into the nursing station. Kathee was the

> farthest away. She was assaulted first by holding her neck and either hitting her face and also on the head. ...Chun was next, and I was coming toward them, and (then) he was assaulting Chun. When he was assaulting Chun, he was also glaring at me as I walked forward; intense profound glaring, in a manner that was highly threatening, ... in a way that caused me to fear for my ... safety. I felt it was unsafe for me to try and get in and stop him or I felt it was too unsafe, so I tried to get into the team Kardex room (the one with the broken glass) and I couldn't, and ... I went into the med room to briefly seek shelter. I felt I was about to be the next person, I truly believed.

So we have her evidence. She testified that she was in the nursing station. She tries to get in the Kardex room and then she goes into the med room.

Now, Lidilia Ascencio, I referred to her witness statement in arriving at this decision, and she starts off – and that's Binder #2, page 108. The first question is:

> Could you please describe what happened?
> (Her first answer is): I was with a patient in her room.
> (But later on she was asked): Where were you located when you witnessed the patient attacking the staff?

> I was in one hall. I was coming from the end of the hall and came close to where he was kicking the RPN and trying to think "What can we do?" And then I was walking around behind him going to the nursing station. I'd just came to the nursing station when the patient was coming to the nursing station. I just placed myself behind the door. I was inside the nursing station behind the door.

So that is her location right there. We then heard from some other individuals. One of them was Tania Hoffman who responded to the Code White and was there to help restrain the patient after the situation and the patient had been under control. She described there seemed to be a lack of supervision and anyone directing the Code White responders on the day in question.

After multiple days of trial, the Ministry called their last witness and closed their case. On June 3rd, 2015, defence counsel for the Royal Ottawa Health Group addressed the Court and brought forward their position that the Crown has failed to establish a *prima facie* case with respect to all counts and they requested the Court to issue a directed verdict of acquittal or non-suit with respect to all three of the counts on the Information. They indicated the Crown cannot succeed in this matter because they have not led direct evidence with respect to each of the elements of these offences.

The Court noted that the threshold for a non-

suit is very low. It is whether there is some evidence. It's not appropriate, at this stage, to weigh the evidence. There should be no assessment of credibility or the reliability of the evidence. Those are matters for this Court to determine at the end of the day, not at this stage.

Whether the evidence that the Crown has led is sufficient to prove the offence beyond a reasonable doubt is not an issue at this stage of the proceedings, and whether the defendant is able to show that they were duly diligent is not an issue at this stage of the proceedings.

The inquiry for the purposes of the motion has to be limited to determining whether the Crown has adduced any evidence as to the failure of the employer to provide information or instruction to a worker to protect the health and safety of the worker. At this point, the Court does not ask whether it could conclude the defendant is guilty, draw factual inferences or assess credibility.

The question is "whether the evidence, if believed, could reasonably support an inference of guilt." The limited weighing occurs in light of the standard of proof beyond a reasonable doubt as indicated in *R. v. Arcuri*.

The motion was denied, defence proceeded to present their case, the trial proceeded, and today we are at the end of the line and the Court will issue its decision.

The defence called a number of witnesses. First of all, they called Ms. Daley, the Director of Patient Care Services for the Royal Ottawa

Recovery, Long-Term Care and the Schizophrenia Program. She provided the Court with background to the ROP. She described the program as a foundation or framework of "Illness Management to Recovery" and it's programming in a series of modules that is done in both group and individual sessions, and it addresses things such as medication management, mental illness, stigma, it looks at vocational issues, and it also looks at healthy lifestyles.

The goal of someone who's been entered into the ROP is that they integrate back into the community at the highest level that they are able to function, with the supports in the community that they may require. The patient is referred by a physician. However, they can be referred from the community; for example, the ACT Team. The referral package is the package that they have to complete when they are referred. If the physician refers them, they will arrive in the Recovery Program and they will have an intake meeting on a weekly basis. The interdisciplinary team meets and they go over all of the referrals and the applications. If that person would be able to engage in recovery or would be a good candidate for the program, the person is then seen in consultation by a psychiatrist, and often front-line staff as well, and either accepted or not accepted into the Recovery Program.

The interdisciplinary team at the Recovery Program consists of nurses, psychiatrists, social work, occupational therapy, recreational therapy,

peer support workers and personal care attendants.

She also talked about the review of hospital policies and she indicated that the "Date Reviewed" indicated in any hospital policy would be the date the policy was reviewed, and they come up for regular reviews, and the "Date Revised" would be if some revision was made to the policy.

Ms. Daley indicated that the document which has been identified as the "Prevention and Management of Violence in the Workplace," she was familiar with that document and indicated the staff are trained at orientation and they're also expected to review the policy as it is available on the intranet as well.

She then testified that a Code White is the response and management of a psychiatric emergency. The type of emergencies before calling a Code White or a psychiatric emergency, if there's an incident, a staff member could call a Code White by using 333 on the telephone. It would be announced by switchboard, then overhead, at which time staff would respond and provide assistance as directed.

She was asked who may respond when a Code White is called. The first line of response is registered nurses, orderlies or personal care attendants. Other staff will respond if they are there, such as physicians and perhaps allied health. The scheduled responders are designated, and usually at the beginning of the shift, it's decided who will respond to a Code White if there is one called.

She indicated they are trained on what to do in terms of Code White responses as they receive crisis intervention training. They receive de-escalation techniques through the NCI training in regard to crisis intervention but the calling of a Code White is really an assessment of the risk at the time, and if you are in fear of violence, you are to call a Code White.

She then referred to the program which we'll be talking about later, which is the yellow dot program. She was asked specifically about the yellow dot program and the question was if someone was a patient at the hospital and they had a yellow dot assigned to their file and it was removed and they were readmitted to the hospital at a later date, would that yellow dot follow them or, as the program is now, does it not follow them? She indicated that it does not follow them but what follows them is the progress notes and the history and mental status assessment so that information would be in the documentation. That is something that follows them but the yellow dot would possibly not.

Three doctors testified. Dr. Attwood testified about the nature of schizophrenia and the evidence of the patient population in the Recovery Unit.

Dr. Rogers, who was the treating physician for Patient X, indicated that he wanted to go on medication, she agreed to do that, and he was interested in being admitted to the Recovery Program. She informed him that he would need to

be stable on his meds before they would consider asking them to take him into the program.

Dr. Rogers was doing an assessment of him as to whether or not he would be a good patient in Recovery. Again, she indicated that he's incredibly bright and articulate. She actually doubted that he was doing as well in school as he said so she checked his transcripts and indeed he was an A student.

Dr. Baines took us through the evidence of the nature of schizophrenia, the purpose of recovery, the risk of violence in schizophrenia patients. She is a treating physician. There were ongoing assessments of this patient. Changes in status would be observed and recorded and acted upon. The assessment of Patient X in the program was that he was being assessed daily, shift by shift, and that information was being transmitted through the Kardex meetings, through team meetings and through shift handovers.

That was the case for the Crown. We would then move on to the actual charges that come before the Court. We have charge number 1, which was failing as an employer to develop and maintain the measures. Now, originally "required" was part of that count but at the opening of the court case, that "required" was deleted as a request by the Crown and submitted to the Court, so it's:

> Failing as an employer to develop and maintain the measures and procedures for summoning immediate assistance when workplace

violence occurs.

There were no particulars. However, the issue is: Did the hospital develop and maintain a workplace violence program and did the program include a measure or procedure for summoning help?

The Crown's position is that the evidence of the two patients who ended up intervening to stop the attack is in itself sufficient proof to establish that the employer's program lacked measures and procedures for summoning/calling for immediate assistance when workplace violence occurred; a delay in workers' ability to call for immediate assistance.

With respect to the evidence, we heard evidence that Kathee Kot and Chun Fan were unable to call a Code White immediately because there was no phone in the Kardex room. Chun Fan testified she had to exit the room to get a phone, going around the patient and Kathee Kot, trying to keep a safe distance, and then having to leave Kathee Kot alone with the patient in order to run into the dining room to the patient phone because there was no phone in the Kardex room. There was no phone in the hallway. She had no panic alarm. Evans called the Code White.

On the evidence, Code Whites could only be called using a telephone. The workers did not have personal alarms. There was no red emergency phones, no emergency buttons in the unit, as indicated by Kot, Fan, Baffoe and Lisa Riasyk.

Kot testified she was unable to free herself

to make a phone call while she was being attacked by Patient X. When Kathee Kot was being attacked for the first time, Chun had to run into the dining room to reach a phone. She was unable to correctly dial 333 in the throes of the emergency. She ran into the nursing station. This was after the first attack, so she was already attacked, to get a phone to call a Code White, whereupon she was further assaulted by the patient before she could get to the phone to call for help, but as we heard later, she was able to call 911.

The Crown believes there is a delay in the response that came once Code White was activated. The Crown maintains that, even when it was called, the response to the workplace violence was not immediate. Some of the designated responders were travelling from a separate building. However, there is some inconsistency in the evidence with respect to who arrived first from Long-Term Care or from the main building.

The Crown submits that any inconsistencies in that regard shouldn't be attributed to any credibility issues with respect to the witnesses. When examining the evidence, there are different versions of how things played out that evening. However, the Crown maintains that it was a very traumatic event and would affect people's ability to recall.

The Court is aware that it must look at the credibility of the evidence of the individuals involved, and we will address that later on in our decision.

The Crown believes that the series of events that occurred are evidence that there was no immediate response.

Kathee Kot said that after she was attacked by Patient X the first time, she tried to restrain him. She testified she remembered saying to herself, "Like where are the responders? We aren't doing very well here." As well, she gave testimony about running to the nursing station and being chased by the patient and being attacked a second time.

The witness Ofili testified she was attempting to restrain Patient X from assaulting Fan and Kot ran into the nursing station to make a call because no help was coming.

The Crown believes these comments are indicative of the amount of delay and the lack of immediacy to the response.

Gifty Baffoe testified that, when she first heard the loud noise of the glass breaking, she didn't know what it was at the time, but when she first heard the noise, it took about 15 minutes before the response, for the responders to arrive. We will hear later that there's a different version of her testimony in regard to that but that will be at a later day.

Dale Evans also testified that, after the attacks on Fan and Kot had ended, she was holding the patient for about three to five minutes before the responders arrived. She also stated (Binder 2, page 127):

> One person left. If they could've shut the door, maybe could've shut him out of the nursing station.

She is referring to what might have happened had the door been closed into the nursing station when Kot and Chun had first entered there, being chased by Patient X.

The Crown believes a sufficient amount of time passed before the responders arrived. Kot was attacked not once but two separate times by the patient. Fan sustained a prolonged attack before the responders arrived. Baffoe and Ofili experienced difficulties restraining the patient and ultimately were assisted by another patient before other responders arrived.

The Crown believes that these factors do not assist the employer because there was some reference to the fire alarms. The fire alarms were not part of any program to implement the hospital's workplace violence program. Workers were not told prior to this offence to pull fire alarms in the event that a patient became violent. There was none of the documents related to workplace violence policy suggesting this method of calling for assistance in the event of workplace violence.

With respect to calling out for help, Kathee Kot yelling to Dale Evans, Dale Evans gave evidence that she didn't call a Code White until after the first attack. Kot was being attacked and yelled for assistance then, right before the

second attack in the nursing station.

However Evans indicates at Binder #2, page 127:

> After I called the Code - came very shortly after I called the Code. Then came out of the nursing station.

Calling out to someone for help can hardly be considered part of a program or a measure and procedure developed and maintained by an employer. Again, this is the Crown's position. To consider yelling or screaming as somehow satisfying this requirement would be to render meaningless the requirement of the Act, and would be contrary to the intent and purpose of the Act. The fact that there are phones in offices that may be locked can hardly amount to a measure or procedure. There's also evidence that a second Code White had to be called because there wasn't enough initial responders to manage the situation.

Stella Ofili said that when she was asked about the amount of time that passed from when she first saw Fan to when the responders arrived, she stated:

> They're not coming at this time, there was no responder, it was almost at the end.

And interestingly, in contrast, when asked about the response to a Code White in the main hospital, her response was "immediate."

The Crown states that, while the witnesses may not be entirely uniform on specific timing, there is complete uniformity in their position that assistance was not immediate.

The evidence on the record, there was evidence that two other workers on the Recovery program who intervened in this matter, Baffoe and Ofili, did not respond immediately to the incident. They were not aware of what was taking place initially. Kathee Kot had already been assaulted by the time they were aware anything was wrong and Fan was being assaulted when Ofili found out something was happening.

Baffoe heard the loud noise and went to see what was happening and when she arrived in the hall, the patient was choking Kot, by that point.

Ofili, she saw Fan running to the phone, she didn't know anything was wrong, she didn't know that a Code White had been called. She was ultimately told by a patient.

The importance of immediacy in this context is another factor to be considered in interpreting what this provision means. The Crown believes that the evidence from the doctors accounts with respect to how quickly aggressive or violent situations can arise, and how quickly mental health status can change with patients who are ill, whether it be in the main hospital or in the Recovery Program or even in the outpatient.

The evidence from Karen Daley, the first witness called, talked about the timing to come from the main hospital to the ROP. That's not

Karen Daley, that's the other one, sorry. She gave evidence with respect to her walk from door to door - yes, it was Karen Daley – with respect to her walk from door to door, and despite what may be her evidence in that respect, it’s just the fact remains that, on the evidence, everyone that was involved in the event on July 5th, that a significant time had passed before the responders arrive.

The Crown suggested that a duly diligent employer would have taken the steps well before this event and not after the fact. With respect to due diligence, it’s the Crown's submission that the evidence does not establish that the employer took all reasonable steps to develop and maintain measures and procedures to summon immediate assistance when workplace violence occurs.

They submit the evidence with respect to this is the lack of Code Whites at the Recovery; no mock Code Whites; they could’ve added phones or alarm; a phone to the Kardex room; they could've added alarm buttons or personal alarms for staff or emergency intercoms in the hallway.

With respect to the construction of the provision or the interpretation of the provision, defence has submitted that all they need to do is to have the policy and program, and it’s enough that it contained procedures for summonsing immediate help, there’s no need to establish the effectiveness of the policy under the charge, and they don’t have to establish even that it was implemented.

The Crown maintains that the defence interpretation is contrary to the object of the Act, it's contrary to the workplace violence amendments to the *Occupational Health and Safety Act,* and the requirement should be interpreted as importing an effectiveness requirement, otherwise it is meaningless.

Defence relied upon the *Art Ellis* case which predates the *City of Hamilton* case on statutory interpretation and the *Timminco* case. In the Crown's submission, it is not consistent with the modern approach to the construction of the *Occupational Health and Safety Act* as a public welfare statute.

The *Cementation* case in the book of authorities supports the Crown's position because they believe that an effectiveness component ought to be interpreted as importing an effectiveness requirement.

The *United Independent Operators* case concerns statutory interpretation, in particular interpretation of a provision in the *Occupational Health and Safety Act*. It's a Court of Appeal decision and it provides a roadmap for interpreting the *Occupational Health and Safety Act* and provisions in the statute. At paragraph 29, the Court echoes the language from the *City of Hamilton,* and referring to the *City of Hamilton*, the Court talks about the statute being:

> ...a remedial public welfare statute intended to guarantee a minimum level of protection

> for the health and safety of workers [and accordingly], it is to be interpreted generously, rather than narrowly.

It's consistent with the purpose of the Act and promotes worker safety. That is the object of the Act.

So that is the roadmap that the Court of Appeal sets out in the interpretation of statutory provisions and it's the roadmap that the Crown has asked the Court to adopt in looking at the requirements set out in the immediate assistance provision, to go through the textual, contextual and purposive approach of interpretation.

In terms of textual, it's the plain language of "immediate" that ought to be considered. The dictionary defines "immediate" in the Black's Law Dictionary, excerpted from the 10th edition. "Immediate" is defined as, "Occurring without delay, instant." So that's the plain language of the word "immediate," it means right away and without delay, instant.

If you look at the context of the provision, the immediate assistance provision arises in the part of the *Occupational Health and Safety Act* that concerns workplace violence. The definition section does not include a definition of "immediate" but does include a definition of workplace violence.

The part of the *Occupational Health and Safety Act* that includes the most provisions regarding violence and harassment, this version of

the Act that was in force at the time, and that is provision 32.0.2(2)(b), arises in the context of these other provisions with respect to workplace violence which require employers to develop policies and programs for workplace violence, and those provisions come about as a result of Bill 168 amendments to the Act.

The Crown provided the Court with the *City of Kingston* case. It's an arbitration case of Arbitrator Newman. As indicated at trial, it's a very very long case. It was a grievance arbitration and the arbitrator ultimately upheld the termination, but the interesting part of this is the arbitrator looked at the provisions of the *Occupational Health and Safety Act* in regard to Bill 168, and at paragraph 223, she says:

> The Bill 168 amendments to the *Occupational Health and Safety Act* have changed the law of the workplace in a significant way. They are largely based on the grim conclusions of Coroners' Inquests into workplace deaths in Ontario, such as the death of nurse Lori Dupont at the Hotel Dieu Hospital in Windsor. The theory is that workplace violence is usually foreshadowed. It is, in many cases, predictable. The amendments reflect the view that violence can be prevented if employers, supervisors, and workers, seriously heed signs of danger, communicate clearly, and act with clarity when risk is identified.

> Heightened vigilance in respect of violence requires that an employer be proactive in the identification of potential workplace violence. The employer must identify the risks that arise in its workplace by performing a risk assessment, and must inform the joint health and safety committee of the results of its assessment. It must develop a policy and program that addresses the risks of workplace violence. It must perform the necessary training and implement that program.
>
> The Bill 168 amendments to the *Occupational Health and Safety Act* are intended for a very real and critical purpose. Based on the hindsight provided by inquests into the deaths of ... victims of workplace violence in this province, the amendments are intended to require the workplace parties to heighten their awareness, to sharpen their antennae, and to refuse to ignore the warnings of violence that puts employees in peril. The amendments, if effectively implemented, have real potential to protect the emotional health of workers who are the victims of violence. They also have real potential to save human life. They are, most obviously, to be taken seriously.

The Crown encourages the Court to read the words "summoning immediate assistance" in context and

having regard to the purpose of the Act.

The defence position in regard to count number 1 is the test that the Crown must meet is they must establish all elements of the offence as particularized beyond a reasonable doubt.

Defence referred to the *Saunders* case which was a case where an individual was importing narcotics. The Crown particularized it as heroin and it turned out it was cocaine. The charge was not proven.

Count number 1, they believe that this is a violation of s. 32.0.2(2b), summonsing immediate assistance. 32.0.2(1) requires an employer to develop and maintain a program to implement the policy with respect to workplace violence which is required under 1(a), and (2) says:

> Without limiting the generality...,
>
> include measures and procedures for summoning immediate assistance when workplace violence occurs or is likely to occur.

As well, it's to:

> ...prepare a policy with respect to workplace violence.

The defence position is that there have been no particulars provided with respect to this particular offence so the essential elements that the Crown must prove are:

Did the employer develop and maintain a workplace violence program?

Did the employer's workplace violence program include a measure or procedure for summonsing immediate help, assistance, when workplace violence occurs or is likely to occur?

As indicated earlier, on the very first day when the charges were read, the charge included the word "required." However, the Crown took that out because there is no required measure.

When you look at the drafting of the legislation under this particular charge, there is no requirement for implementation. The degree of implementation or the degree of effectiveness can be found elsewhere but it's not in this charge. Defence believes this is very important with respect to any conviction under charge number 1.

As well, has the Crown established the elements of the offence beyond a reasonable doubt? Counsel believes it is exactly the opposite, the Crown has established beyond a reasonable doubt that they have complied with this section, and they note the corporate policy and procedures on the prevention and management of workplace violence which was filed as Exhibit Number 5, Binder 1, page 264; the corporate policy and procedure on emergency use of restraints, Binder 3, page 264, Exhibit 14; and the respectful workplace policy, which is Binder 1, Exhibit 5,

page 290.

So, in their opinion, the hospital has established a series of policies with respect to workplace violence. The Crown does not dispute that they have the policies in place. However, the focus is on summonsing assistance.

The hospital indicates there is a policy within the framework of the workplace violence policies that the hospital has completed. They have done them in a series which deals with the summonsing of assistance, and they refer to Exhibit Number 5, Binder #1, page 277, the Code White psychiatric emergency policy.

They indicate the evidence of the inspector, the policies were provided to her on her request, and the policies apply to all staff, including those at the ROP.

The inspector indicated that the purpose of the Code White policy is for the employer to have a procedure of what to do in the event of a psychiatric emergency. It includes intervention techniques to manage violence and it had specifics on how to get assistance.

The Code White policy itself in paragraph 6 of that policy talks about the 333 code, it talks about where it goes, directly to the switchboard, it talks about the automatic phones that have a button that when you press a single button, you get a 333 code.

There has been no evidence or no allegation that the hospital does not have a policy which complies with the requirements of the Act. The

focus has been on perceived deficiencies within the policy and the Crown believes that that is not the charge the Court has to deal with.

Having developed a policy, it must be maintained; the evidence of Karen Daley, who testified what "reviewed" and "revised" means. All of the policies had a reviewed and revised date.

Black's 6th dictionary defines "maintain" as:

> Repairs or other acts to prevent a decline, lapse or cessation of an existing state or condition.

Defence believes the policy is reviewed, the policy is revised, it is maintained; that the element of the charge has not been proven by the Crown on any aspect, much less a reasonable doubt. The policy was developed, it was maintained, and it is specific for summonsing help in the workplace. It can be called for anything. It can be called for agitation, it could be a raised voice, the potential of violence. The policy, they believe, addresses it, and that's precisely what the legislation has required under this section.

They referred to the *Art Ellis Construction* case that basically says you can't turn a clause into something that it isn't. In the event of violence, the alternative argument, which is where the Crown wants the Court to go, is that the measures that were in place at the ROP were

insufficient.

If one assumes that there was a requirement to have a very extensive means of communication for summonsing help in the workplace, the evidence by the defence is there are at least 20 phones in the ROP within easy distance of the events, and they refer to Exhibit 28; the evidence of Stella Ofili and Karen Daley, any of them could immediately be connected to the switchboard, if a Code White, by dialing 333. If you dial 333, it's Code White, it triggers an emergency response. There's no need for anyone to ask what's happening, the switchboard knows it's a Code White. All they need to do is determine the location and send help by signalling it out. They also indicated that the nursing station had a single button, 333. One button, one push and a Code White is activated.

The defence believes the inspector was aware of all of this. She testified seeing the phones in Exhibit 29A and B. There was a portable phone also connected to the telephone system which the inspector was aware of.

Ms. Ofili stated that a fire pull station could be used for a Code White. She testified that there were four pull stations. There's another mechanism as well for obtaining assistance, and that's screaming for help. It could be a possible mechanism for summonsing help.

We know that Kathee Kot screamed to Ms. Evans to call the Code White. Ms. Evans said, "I heard Kathee scream and I called the Code White from the

nursing station."

We also know that Ms. Fan called a Code White or attempted to do so. She dialled zero rather than following established procedures but nevertheless she applied the immediate mechanism.

So the Crown (sic) believes, in summary, with respect to this charge, there is no evidence that policies for summonsing immediate assistance were not in place, there is overwhelming evidence that the measures were in place and they were used on that day, and they did in fact affect the summonsing of immediate assistance. They believe that there is no basis in law for this particular charge and they requested the Court to have the matter dismissed.

I will now go to charge number 2. Charge number 2 is the offence of:

> Failing to provide information, instruction and supervision to a worker to protect the health and safety of the worker.

It's under 25(2)(a) of the *Occupational Health and Safety Act*. The particulars as provided by the Crown are:

> The accused failed to provide sufficient information and instruction to protect a worker from workplace violence.

Defence counsel requested clarification regarding count number 2 and they received the indication

back that the Crown believes that s. 25(2)(a) requires an employer to provide information, instruction and supervision to a worker. In this case, the Crown has particularized the charge to allege that the defendant failed to provide sufficient information and instruction to protect a worker. The amount of information and instruction that an employer is required to provide depends on the full circumstances surrounding the incident at issue. The amount of information and instruction provided by the employer must therefore reflect this.

Specifically, the Crown identified several areas in which there were deficiencies in worker training. They particularized these into eight different areas that they identified but if we really kind of summarize the various areas, count number 1 and count number 2 or item number 1 and item number 2 really deal with the training issue. Item number 3, item number 4 and item number 5 deal with the Code White issue. Item number 6, item number 7 and item number 8 deal with the yellow sticker issue.

The Crown's position in regard to these areas, the areas that were identified with respect to the CPI training, it was the evidence that Chun Fan did not receive training from her employer on CPI. This was training on how to deal with violent patients or patients before they become violent, and on the evidence, she worked for three years and had not received CPI training. She didn’t receive the original training, she didn’t

receive the refresher training in the three years that she was there, she didn't get the initial two-day course on non-violent crisis intervention and she didn't get the one-day refresher, and there's direct evidence from her.

There's also evidence from the Ministry of Labour inspector supporting this in the field visits that were filed with respect to this issue. There was documentary evidence, specifically the employer's training records which were filed as exhibits. The evidence with respect to Chun Fan not having received the initial course or the refresher is evidence which, in and of itself, is enough to establish the offence and nothing else needs to be established.

The Crown also believes that there is substantially more evidence that goes to the establishment of this offence, and that's the witnesses described several forms of information and instruction relating to workplace violence that was not sufficient. Specifically with respect to the CPI training, other workers testified that they had not received refresher training in over two years, and while there's no legislative requirement to provide refresher training, when you look at the information and instruction, is that sufficient, you have to look at what's required in the context, and in this particular workplace, the employer, the workplace parties, had decided that refresher training was required either on an annual or a two-year basis.

So the evidence is that that is a reasonable

requirement to have refresher training and yet they did not meet their own standard with respect to several witnesses that testified who had not received the training in more than two years.

Kot had received the initial CPI training 15 years earlier when she first started at the Royal Ottawa, and then she had refresher training once in 2010, based on her evidence.

There is also the Code White training, when we talk about section 3, 4 and 5; another type of training that's relevant to workplace violence. The evidence establishes that the training on Code White procedures was lacking, according to the Crown. The employer did have a written procedure on Code White, but on the evidence, there was virtually no instruction on that procedure.

Some of the witnesses that testified indicated that the focus of the Code White training that they had received was primarily on the use of restraints. There was reference to Code White instruction being provided during the orientation program at the Recovery Program but not everyone received that training. Kot did not receive the orientation session. Ofili attended in 2004 for the main hospital but had not received orientation for the Recovery Program. There was no dedicated Code White training provided beyond what was offered in the orientation program.

Prior to the date of the event, Kot, Fan and Evans had only been involved in a real Code White once or twice but none of the workers except Kot had performed a mock Code White. She had been

involved in one mock Code White in 2010.

Fan had never performed a mock Code White in the Recovery Program or anywhere else in a hospital.

Baffoe could not recall performing a mock Code White.

Ofili never performed a mock Code White until July 5th. She was under the misapprehension when she testified that she could not, as a PCA, call a Code White, that it was the nurse in charge that was the person that had to call the Code White.

Evans had not performed a mock Code White prior to July 5th.

The Crown submits that the deficient training and lack of instruction on Code White is evident from the experience of the Code White responders when they arrived on the Recovery Unit on July 5th.

Tania Hoffman gave evidence about the lack of direction and information that was available to the responders when they arrived at the unit, and that's further evidence that there was a lack of meaningful instruction and supervision to workers in regard to a Code White.

If we look at the yellow dot program, the Crown's position in regard to items number 6 to 8, the yellow dot and information about Patient X, on the evidence, workers, including Kot and Fan, were not given information that Patient X had been violent in the past. The evidence with respect to that is, in and of itself, enough to establish the offence.

The information about Patient X, this charge is not under the provision in Section 32, this is under 25(2)(a) of the Act. We have heard a lot of evidence about the yellow dots or yellow stickers and the clear theme that emerges from this evidence is that there was a lot of misinformation and misunderstanding about their use and meaning.

There's evidence that the yellow dot procedure was used differently in different parts of the hospital. We know that there was no yellow dot on Patient X's file.

Karen Daley testified that the yellow dot procedure was in place at the Recovery Program before the event and yet no workers had received any training on the yellow dot system. The yellow dot system was not documented in writing so it's no wonder there was some misunderstandings around it.

The Crown believes that workers were not given information, instruction and training on the use of this sticker program with respect to how long stickers were to stay on, who had the authority to put a sticker on, who could take a sticker off, what behaviour warranted a sticker or the precautions that were taken when a patient was flagged with the yellow sticker.

Kot said she didn't know of the patient's history of violence. She thought that any time there was a patient who had a Code White, they would have a yellow dot placed on their file.

Fan didn't know Patient X had a history of violence and she testified that, had she known

that he had a history of violence, she would've been more careful and would've been more cautious around the patient.

Ofili also testified that if there was a yellow sticker, staff would not visit the patient alone but would go in twos or threes.

The doctors were somewhat dismissive of the yellow dots. All three doctors agreed that a history of violence was the most important static risk factor, and the literature supports this. There are static and dynamic predictors of risk and the best static predictor of risk is previous history of violence. That person is more likely to have a future history of violence.

Dr. Attwood testified a prior history of violence is the biggest or most prominent static predictor of risk. It changes the person's risk category.

Dr. Baines testified the yellow dots are placed on charts to identify patients who may be at risk of an aggressive act, to notify people who are involved with the person's care there may be safety concerns in working with that individual, and the history of violence alerts you to the fact that there is an increased risk of violence. We know that Patient X had two prior incidents during his stay at the other part of the hospital.

This again is the Crown's position, that it appears on the evidence that all three doctors were not fully aware of the patient's full history of violence. The evidence clearly establishes a deficiency in information or instruction.

It is true there is no legislative requirement for a yellow dot, and that's not the analysis that has to be brought to bear on s. 25(2)(a). The employer has to provide information and instruction that is appropriate to the workplace and the workers and that will protect workers. They had some sort of practice around the yellow dot but did not provide workers with appropriate instructions on the use and meaning of the yellow dot.

They also talked about the skill of engagement as being a possible way of dealing with someone with aggression and there was a comment here by one of the doctors, Dr. Attwood, when he talked about the skill of engagement as a protective measure. He was dismissive of the yellow dot as not being helpful and referred to it as sort of a mood ring for people's behaviour.

I will just go through the defence position in regard to count number 2 and then we will take a brief recess, we will do count number 3, and then I will give my decision. I hope I'm not boring everybody. We've been through this all before.

The defence position in regard to the second charge is under s. 25(2)(a), duty of the employers. There is particularization which includes failure to provide sufficient information and instruction.

Defence takes the position that the Crown seems to rewrite the legislation. "Sufficient" is not in there. There must be "instruction,

information and supervision."

When we look at the particularization, these are not elements of the offence. Were the instruction, training and supervision provided to protect the safety of workers? From the particularization and through the course of these proceedings, supervision was not an issue. It focusses directly on whether information and training was provided to a worker with respect to the potential of workplace violence.

It is possible for there to be a prescribed training course, and that section is 26(1) that says:

> In addition to the duties imposed by section 25, an employer shall,
>
> > carry out such training programs for workers, supervisors and committee members as may be prescribed.

The second part is the Crown has not particularized nor is there any evidence to suggest that CPI training itself is not an acceptable training program.

On the particularization, the Crown is accepting that it is the appropriate form. There is no requirement for refresher training *per se*, as long as the individual has been trained and knows what to do. Refresher training is what the hospital does, it makes sense, but the charge is specific, and the particularization is specific,

and there truly is no requirement for refresher training under the legislation.

Is there any evidence beyond a reasonable doubt that Ms. Fan did not receive CPI training or any other training with respect to workplace violence? Certainly from her evidence, she said she didn't have it but yet we know she and everyone else were scheduled to receive it. She didn't sign in on that particular day for training but her evidence was she didn't sign in for a number of training sessions that she actually did take and attend.

The Crown has led no theory as to why an individual who would be identified in an email saying, "Chun Fan needs refresher training," scheduled on the list, doesn't go. The Crown is simply relying on the fact that there is no sign-in and Ms. Fan saying, "I didn't take it."

Defence believes that the Crown has a number of difficulties with respect to Fan not getting CPI, the fact that there is no requirement for CPI, and even further, there's no requirement for formal training. They referred to *KD Farm*, and the reference is at page 13, paragraph 75. There is no requirement that the training be written down or be formalized, so long as the individual knows it. It can be on the job, it can take any form, as long as the training is provided.

They then referred to the *Aecon* case, paragraph 11, page 4; again, saying that the training does not need to be formal, written; as long as you get the information, you comply with

the section.

Defence indicated that from the inspector, the only evidence of no training was her lack of signature. They indicate she was scheduled for it. She received the training in 2009 when she was a new employee at ROH, through her evidence, the orientation at the ECT, and she's taught how to approach a violent patient, how to communicate and interact with a patient when patients are unstable. Her evidence, she testified during her training in the ECT, and this is a quote of her evidence:

> A man showed us when a patient showed up - showed something how to be grabbed, the patient from the back if the patient was very violent, how we can grab from the back.

She testified that she had a whole day of tidal training but she didn't remember any of it, and the evidence of the course that she says that she never took, however, the defence believes that she knows the information.

She testified that during her orientation, she had one or two hours of how to approach, how to communicate and how to talk gently with a patient. Defence believes that that's part of the CPI training and that's part of the de-escalation techniques that are taught during CPI. She did testify that she had received an hour and a half of Code White training.

When asked about certain questions on how to

approach a patient, she was able to indicate that body position was important, language was important, deflection important. The Crown also believes that her training could have come through the team approach.

The evidence of Ms. Evans, Fan and Ofili indicated it's important to involve other staff, a team approach, you find a team member or a staff member who can help you. It's very important. Fan had testified she had learned different techniques from a senior nurse.

The evidence of nurse Evans, the supervisor, said if she had seen anything that indicated Fan didn't know what she was doing, she would've taken steps. If Fan was not properly able to apply the technique, she would've taken steps.

The charge before the Court is training and information. Not one individual who testified before the Court didn't know what the yellow dot system was about, as one of the parts, so assuming there was a system, there's a specific charge, training and instruction, and not the yellow dot system.

The Crown says an individual didn't know what it was. Everyone who testified was aware of the nature of the yellow dot program, and the defence believed that's enough to dispense with this charge.

Defence then also talked about the evidence that the Court had in respect to Patient X. We know he had a prior incident of biting in the Schizophrenia Unit approximately a year before,

though the evidence is very vague on how severe that accident actually was. It was reported as not severe, which was filed as Exhibit 12, and that was a year ago, and he was followed up on treatment.

What happened to him after that? He was released back into the community. We heard about the nature of the ROP and that you are not admitted to the ROP unless you are stable. There was a great deal of evidence presented to the Court about the admission procedures into the ROP. Defence indicated that if you are acting aggressively in the ROP, you are immediately removed.

We also heard evidence Patient X was on Clozapine and we heard a great deal of evidence with respect to this particular drug. It is known as an anti-psychotic that specifically deals with violent behaviour in order to reduce it. We also heard that he was released to go to Walmart just days prior to the incident that actually happened.

We also heard from Dr. Attwood about the nature of schizophrenia and the evidence of the patient population in Recovery, and evidence from Dr. Attwood about the problems of the yellow sticker. He testified about his assessment of Patient X on admission, and he also assessed Patient X while he was in the program.

Defence summary in respect to count number 2, deficient worker training in the following area, Ms. Fan not receiving the training, they believe that it is not established beyond a reasonable

doubt with respect to the fact she was scheduled for training. The only evidence that she didn't take her training was her lack of signature and her testimony, and that she did know the training that she provided to the Court.

The evidence of mock exercises being conducted in Recovery, the defence believes that there was evidence of that, and that was filed at Volume 1, page 526, which is Exhibit 8 before the Court.

The yellow dot program is not a requirement, and on the evidence would not have been an appropriate tool, and that all workers were aware of the yellow dot. Alternate measures and methods of communicating were available and in fact used.

On the charge as stated and particularized, the Crown has failed to prove the essential elements; this is the defence position. The particularization does not refer to the charge *per se*. It is relevant for the Court to consider, but even if it is relevant, they believe they have met all the burdens placed on them and the Crown has not proven beyond a reasonable doubt that they were guilty of the charge.

We're going to take a break, at this point. When we come back, I'll review count number 3 and then I will issue a decision for the Court. We'll take about 15 minutes. Thank you.

R E C E S S

U P O N R E S U M I N G:

THE COURT: I would now like to address count number 3 from both the perspective of the Crown as well as from the defence and then the Court will be issuing its decision which will bring to closure a long journey. Count number 3, as we see:

> Did commit the offence of failing as an employer to take every precaution reasonable in the circumstances for the protection of a worker...

They were particularized and the Crown believes that several examples of inadequate safety devices, measures and procedures could be found within the Crown brief, and some of these examples include, as we see in 1 through 6, different areas.

Count number 3 is under the general duty clause, which is s. 25(2)(h), and under that count, under that provision of the Act, an employer is obliged to take every precaution reasonable in the circumstances to protect a worker. And in this case, the reasonable precaution specified by the Crown in the circumstances facing the workers in the Recovery Program would've been in place; safety measures, devices and procedures to protect the workers. That was elaborated by the letter and identified the different areas.

The Crown believes that there was no phone in

the Kardex room where the incident first began and if Fan had had access to the phone – there was no phone so she could not call a Code White from where she was. Kot could not reach a phone to call a Code White while she was being attacked. There were no emergency buttons or red emergency buttons in the Recovery Program that could alert responders to an emergency like the red phones that existed in the main hospital.

There was also an absence of personal alarms. All the witnesses were clear that they did not have a personal alarm such as the Ekahau device. The workers in the main hospital were wearing Ekahau tags and that it was an important aspect of their workplace violence prevention there.

The physical layout of the Recovery Program was such that workers could become isolated or trapped. There was only one door in the Kardex room, so right after the patient had smashed the window, there was nowhere for Fan to get out other than she followed the patient out of the room. There was only one door to the nursing station. Kot tried to escape the patient by running into the nursing station and then the patient entered the nursing station after her and she couldn't get out.

We also heard some issues about the doors being able to be locked or unlocked, both the Kardex room and the nursing station, and that a worker needed a key to open the doors and they would not necessarily automatically lock once the worker was inside.

We heard from Dale Evans that she attempted to get into the Kardex room to escape during the assault but was unable to open the door with her key and wasn't sure it was because it was damaged or it was because of her nerves.

Now, there was a series of all of these items that were identified by the Crown in their particularization to the events. Many of these were affected afterwards. Matter of fact, there were changes made to Recovery to address these deficiencies after the fact in relevant terms: the nursing station key lock was replaced with a swipe card, emergency intercom buttons were installed, a phone was placed in the Kardex room, a second exit was added to the Kardex room, workers that didn't have Ekahau tags at the time of the incident were later provided with a comparable service, mock codes were carried out after the incident, and the yellow dot system was documented and modified after the event.

The Crown referred us to the *National Wrecking* case. It's a matter that involved an accident where a steel door that wasn't braced properly killed a worker and there was charges laid against the employer, the supervisor and the worker about the door not being braced properly, about not being stored safely, and the fact that there was no caution sign or tape around it.

There are some interesting things that the judge decides with respect to the issue of foreseeability at page 16 of that decision at paragraph 70. They were raising this because

they're talking about the fact of the skill of engagement. So, as they go on, they talk about it. At paragraph 70, Justice Keast says:

> On a philosophical level the idea of what the average person might think is contrary to the common sense principles of workplace safety in an industrial setting.

The average person wouldn't realize what this was, that there was a danger, or that the pile of steel was bracing or securing this door and it ultimately fell. So the Court goes on to say:

> It is ... contrary to the basic concepts of the *Occupational Health and Safety Act*. It is not the purpose of safety principles to primarily cater to the average. Aside from the problem of trying to define what and who is average, there are many in the workplace who are not average. If workplace safety primarily focuses on the average, there will be many in the workplace who would be vulnerable.
>
> The purpose of workplace safety policy, whether rooted in the legislation or in plain commonsense, is to protect the widest possible group of people, which goes beyond the (level of) average.

The workplace contains an endless variety of

people:

> Different levels of education;
> ...experience;
> ...judgment;
> ...perception;
> Different levels of concentration and focus;
> Different levels of attention and awareness;
> ...analysis;
> ...observation;
> ...understanding;
> Different levels of intelligence.

The defence, in regard to count number 3, they believe that this is the general catchall of every reasonable precaution. It's a very broad clause but at the same time it has its limitations, and the limitation is found in the language of sub (h), "take every precaution reasonable in the circumstances." So it must be reasonable and it must be related to the circumstances. This is where the assault issue does actually play a role in respect to the charges.

The Crown has particularized the hospital failed to implement safety measures and they go through and they listed them.

They refer to the *Brampton Brick* case at page 7, paragraph 18:

> The statute requires the Crown to prove that

> Brampton Brick failed to take every precaution reasonable [and the Court puts in italics] *in the circumstances*, not some broader notion of acting reasonably.

The Court of Appeal has told us that "reasonably" must be modified within the circumstances.

> The inquiry is to be conducted in light of the particular surrounding circumstances. "The circumstances" is an element of the offence and those circumstances must be considered before concluding the precaution lacking was reasonable.

Page 9, paragraph 24:

> In general, the Crown is bound by the particulars set out in the information and must prove [them as] ... alleged. It is not sufficient for the Crown ... simply [to] allege that every precaution reasonable in the circumstances was not taken...

And then at the bottom of the page:

> In a charge under ... 25(2)(h), the onus is on the Crown to prove beyond a reasonable doubt that the precautions particularized in the information are [the] ones that a reasonable employer in the circumstances of the company charged ought to have implemented

for the protection of the worker...

In the *R. v. Peake* case, page 5, paragraph 12, the justice of the peace reviews a series of case law and in paragraph 11:

> In reviewing the *Grant Paving* and *Ontario Hydro* cases, Judge Merredew finds that there must be a preliminary threshold of knowledge or awareness before an employer can be required to meet the case. The prosecution must, at a minimum, lead evidence of apparent danger. Having done so, the defence would then be called upon to defend on the due diligence basis all aspects of its dealing with the safety issue.

I want to talk a little bit about the defence position in regard to count number 3 because their position is that in regard to, first of all, the Code White procedure, it was implemented they believe within a series of seconds. In the circumstances, the number of phones accessible were more than adequate.

Going back to the charge of "in the circumstances," they believe that there were adequate phones and it did not contribute to an unsafe environment in the circumstances. They believe the evidence is the Code White was called virtually instantaneously when Ms. Kot cried for help. Phones with a direct connection to the switchboard were not readily accessible. The

closest phone with a push button was in the nursing station; fractions of a second, perhaps. There's no requirement for direct dialing but the Crown's evidence is there was one in the nursing station.

The personal alarm, the Court heard a number of issues in regard to the Ekahau system. We looked at the JOSH minutes, and there's a number of those minutes that talk about the problems that they were having with the Ekahau system, and there was an indication that it was to be used as a secondary means of defence and not as a primary means of calling for help.

So the defence position was that the Crown had not met its onus of proving beyond a reasonable doubt that the six items that were identified in count number 3 were indeed requirements that should have been in place at the time of the incident, and based on the circumstances, that they were not required.

I am going to close on the counts there. I want to get finally to the decision because I have written my decision, changed it a number of times, rewritten it a number of times, and I'm fairly comfortable with the decision that I am going to be issuing.

The Ministry has had the luxury of looking at the series of events that unfolded from a unique perspective, and that is from after the fact, and determining the appropriate action that should've, could've or would've happened had certain policies and practices been in place.

Based on the inspector's report and their review of all of the circumstances, they laid the charges that we have identified and addressed before the Court. The Court has read and re-read the transcripts and the volumes of case law presented by both experienced counsel who are extremely competent, well-prepared and who have dedicated all of their efforts and resources in presenting their well-thought-out, complete position and persuasive arguments to the Court.

The Court has turned its mind to the legal issues that are before it. The onus of proof lies with the Crown who must establish all of the essential elements of the offence beyond a reasonable doubt and if, at the end of the Crown's evidence, there is a reasonable doubt regarding the proof of the prosecution's case, there cannot be a conviction. This was an unfortunate incident but not every accident or workplace injury implies fault.

The Court notes that count number 1 is the count that forms the base in regard to the matters before the Court. Count number 2 and count number 3 in various forms seem to be the catch-all counts that are included whenever the Ministry lays a charge under the O*ccupation Health and Safety Act.*

In regard to count number 1, the delay in a worker's ability to call for immediate assistance or immediate assistance being provided, a response, the Court has weighed the evidence and determined the credibility of the evidence given by the witnesses as required by a *W.D.* analysis.

It is their actions and testimony that the Court must look at in evaluating and in arriving at its decision today.

We've had the diagram where the incident started. Kot called Evans to call a Code White and it is transmitted immediately from the nursing station. This is completed just seconds before Kot is assaulted.

Some discrepancies in the testimony of Chun: Did she go around Kot and the patient to enter the dining room or did she go directly into the dining room? Her testimony was that she was already out of the Kardex room. She stated that she followed them up the hallway to the nursing station.

The hospital has a policy and procedure on the prevention and management of violence, Binder #1, page 246, section 6.2; based on assessment of the situation, activates a code white, Binder 1, page 277.

The defence maintains there is a policy, it was developed, it was implemented, it is specific for summonsing help in the workplace. It can be called from anywhere. It can be initiated based on agitation, a raised voice, anything with the potential of violence. The Code White policy addresses this matter and that’s what the legislation has required under this section. The Crown lives and dies by the charges and the particularizations that it has provided to the Court.

We're aware of the *Ellis Construction* case that the Court interprets as indicating charges

are what they are and cannot be migrated to include the other sections of the Act. Were the policies in place? Was the Code White initiated immediately?

The second part of the charge, immediate response, the situation the day in question, there are six individuals working on the ward that evening. One is attacked. A Code White is called by Dale Evans just prior to the first physical assault. Chun tries to call Code White and goes to assist. She is attacked. Baffoe and Ofili also respond. So we have six individuals on the ward that night. Three of them are assaulted, one is assisting, so we have four individuals.

The question in the Court's mind is: Where are the other two individuals? Evans in the nursing station calls Code White and goes into hiding. Lidilia Ascencio hides behind the door of the nursing station and allows Patient X to come in to get at Kot. What would have happened had she closed the door after Kot and Chun had entered into the station? Could it have been prevented?

We also hear the evidence of Evans, "If she had closed the door, he would not have been able to get into the nursing station." Six employees are available to respond within a short period of time of the incident starting and only four truly respond.

We've seen the number of phones in the unit; 333, direct connection to the switchboard in the nursing station.

In this situation, the Court finds that there

was no delay in the workers' ability to summons assistance. Evans called from the nursing station. The policy for summonsing assistance was in place and it did summons assistance immediately.

In regard to the position on the second part of count number 1, Stella Ofili, when she was asked about the amount of time that passed from when she first saw Fan to when the responders arrived:

> They were not coming. All this time, there was no responder, it was almost at the end. I know shortly help must come.

However, later on in her testimony, she goes on to say:

> And immediately I saw Dale. I don’t know where she came from. She intervened and immediately the two people came from downstairs.

Now, this is on the ground floor so I think she's referring to the upstairs:

> Other people came immediately from upstairs, two staff. Alex, Christina.

Again, she refers to them as downstairs but the Court is interpreting that as from upstairs.

And immediately the people from the ROH came in immediately.

The Crown believes that their witnesses may not be entirely uniform on specific timing. There is complete uniformity that the reaction was not immediately. The Crown defined "instantaneous." However, the Court looks at the series of events that unfolded.

The Crown would have us believe that the two other workers who intervened in this matter, Gifty Baffoe and Stella Ofili, did not respond immediately to the incident as they were not aware of what was taking place. However, they heard the glass break, they observed Chun running in to call for assistance, all within or just prior to the assaults taking place. How much quicker could they have reacted?

Baffoe heard the loud noise and went to see what was happening and when she arrived in the hall, the patient was attacking Kot. At that point, the Code White had just been called. Ofili saw Fan run to the phone but she didn't know anything was wrong or that the Code White had been called, at that point, however it was just when the first attack was taking place.

We looked at the definition of "immediate: occurring without delay, instant." The plain language version of the word "Immediate" means right away, without delay, instant.

If we look at the context, the provision, the immediate assistance provision arises in the part

of the *Occupational Health and Safety Act* again that contains workplace violence. The definition section does not include a definition of "immediate." Immediate means in an instant, however. It is not defined. The Court must look at the series of events and come to the conclusion of immediate in the circumstances.

The Code White policy is a procedure that is put in place by the hospital which directs staff of what to do in the event of a psychiatric emergency. It contains specific references as to what to do to summons immediate help, and that is contained in section 6.1 of that section.

The inspector testified that when there is a Code White, a response can be called by dialing 333, which connects to a switchboard. The switchboard immediately responds by calling the Code White and it will summons immediate assistance, which can be accomplished by the phone, Exhibit 29A, 29B. Binder 1, page 264, clause 6.2, is the procedure for summonsing immediate help. Again, that's the Code White policy.

The Code White policy again in Binder 1, page 277, the clause under the Code White policy is a "how to do it" for summonsing immediate help. There is no particularization and, in fact, no evidence with respect to the Code White policy. Does it contain provisions for summonsing an emergency immediately?

Kot testified that she called out to Evans, who then was able to summons immediate assistance

by use of the phone. In this situation, there was an immediate calling for assistance. In the space of several seconds, two calls were made: Dale Evans, which got through, and Ms. Fan, who dialed zero rather than 333, does not appear to have initiated a response but was available to call for assistance; the unit responders from the floors above the unit, responders from the other building.

In the context of the Act, summonsing immediate assistance, in the circumstances, the Court finds that the response was immediate. The Court finds that the Crown has failed in its requirement to prove beyond a reasonable doubt that the Royal Ottawa as an employer had failed to develop and maintain the measures and procedures for summonsing immediate assistance when workplace violence occurred at the Royal Ottawa Place Recovery Program as required.

The Court finds that the Royal Ottawa had developed and maintained a workplace violence program and it did include a measure or procedure for summonsing help and, as such, that count will be dismissed because they have not met their onus of proving beyond a reasonable doubt.

I want to move to count number 2 where we have several areas; the particularization in count number 2; 25(2)(a) is used when there is no prescribed training.

And I refer to the *Cementation* case in the Crown's book of authorities. It's a decision of the Court of Appeal. Justice Cronk was

considering the appeal from conviction. The employer was convicted at trial and the conviction was upheld on appeal, and part of the basis for upholding was inconsistency in instruction that the worker was given and also a lapse with respect to supervision on the other count.

The defendant employer sought leave to appeal on the basis the Court had, by incorporating the words "sufficient" and "adequate", raised the threshold of what is required by the legislation, and at paragraph 28, in dismissing the leave to appeal, Justice Cronk, at paragraph 28, states:

> I agree with the appeal judge that the use of the impugned terms was descriptive... It did not reflect any diminishment of the Crown's burden of proof, nor any misstatement of Cementation's onus concerning its due diligence defence. The Crown put it well in its factum:
>
> > [I]n order to satisfy the requirement in ... 25(2)(a) ..., an employer must provide information and instruction that is sufficient to protect the health or safety of ... worker(s). Similarly, the nature of the supervision that the employer shall provide must be adequate to protect the health or safety of the worker. Otherwise, if an employer was permitted to satisfy its obligation under ... 25(2)(a) by providing

> information, instruction or supervision that was neither adequate or sufficient to protect the health or safety of the worker, then an employer could simply provide a token amount of information and instruction or supervision, even if trivial or ineffective...

What the Court is concerned about in regard to count number 2 is the circumstances and also the training issue and the credibility that the Court heard from the evidence of Ms. Fan. Ms. Fan says that she did not take the training as required, CPI training. The inspector testified that there was nothing on record to indicate that she had taken that training. However, her testimony clearly indicated to this Court that she was aware of all the techniques that were required for her to perform her duties.

The supervisor of that particular area also indicated that had she been aware that she was not proficient in these techniques, that she would have made sure that she was trained and that she would've had the requirement of training.

Ms. Fan had attended other training programs within the institution and her policy seems to be, to this Court, that she did not complete or sign in for those work days. The evidence from the hospital is that she was assigned for that day, she was paid for that day, and the Court believes that she did attend that day for the training, regardless of what her evidence is, and we find

that her evidence is somewhat negative in regard to credibility with the information that she provided to the Court.

In regard to receiving refresher training, that was a program that would be nice to have. The hospital, the institution, indicated that they had that as part of their program but it was not a requirement, it was a policy that they were working towards.

When we deal with the Code White issue in regard to count number 3, count number 4 and count number 5 of the particularization in regard to the decision on count number 2, the Code White policy was a policy, we've heard evidence before, it was written, it was maintained, it was reviewed by the hospital, it was in place, and it did function properly, as I indicated in regard to count number 1.

In regard to the opportunity to provide mock exercises, the Court would find that that was a suggestion to further implement the policies but it's not a requirement as required.

If we address the yellow sticker program, count number 6, count number 7 and count number 8, it's a policy that was used in different parts of the institution. There was no written policy in regard to it. The indication to the Court is that it seemed to stem from originally the Schizophrenia Unit, which is prior to the date of the commencement of the Royal Ottawa Place, and in that unit where there is a large number of Code Whites called, there is a high propensity for

violence amongst the patients, that document and the sticker program would've been a useful technique to have.

However, with the Royal Ottawa Place, we did hear evidence that, when one patient leaves the institution and they return, as Patient X did as a voluntary patient, that the yellow dot sticker was not replaced back on his file. It was not a requirement to do that.

So, in regard to the foreseeability and predictability of the event, the Court finds that there was no foreseeability and predictability of lack of training. The hospital submits and the Court finds that it has reached, on a balance of probabilities, that they did what was appropriate in the place and required in regard to this particular count. Again, the Court finds that the Crown has not met its onus that it's required to meet to prove beyond a reasonable doubt that the defendant has met the charges as required. The Crown has not met their onus and, as such, the finding of that count, it will be dismissed.

In regard to count number 3 in regard to safety devices, measures and procedures that were in place, we heard through the evidence that three phones were readily available. In fact, in the circumstances, two different phones were used within seconds of the incident. There was also a portable phone which could've been used, the Code White procedures, the number of phones, the ability to use alternative mechanisms. There were phones with direct connections to the switchboard.

Every phone had a direct connection to the switchboard, it depended on how you wanted to call that, either through a Code 333.

The lack of personal alarms in the circumstances, we heard numerous evidence about the Ekahau system and how reliable they were in regard to the Royal Ottawa Place. There was numerous reports to the health and safety committee that addressed that issue and it certainly was an issue that the hospital was aware of, and they were taking steps to identify other programs that may be used. However, the Ekahau program was not an acceptable program that would've been used or useful in the situation.

The fact that the Kardex room only had one door and the situation and the circumstances that we have addressed, Ms. Fan left the Kardex room. She followed Ms. Kot and Patient X down the hall. She was already out of the Kardex room when she noticed that the incident was happening and she went into the dining room to make the call, another call for a Code White.

Number 5, the Kardex and nursing stations were not secured to prevent access. They did in fact – they could've been locked. We heard evidence that in the Kardex room, the door was left open. There was a line that the patients were not to cross. It could've been locked on the day in question but, for whatever reason, it was left open. The door to the nursing station could've been closed through the actions of Lidilia Ascencio; however, that was not the case

and the second attack took place.

The sixth issue was the Code White responders were located in the main hospital. We clearly heard evidence that there were responders from the Royal Ottawa Place second and third floor. The other individuals did come from the main building, but as I mentioned before, there were six individuals on the floor that night and four of them responded immediately. The other two we'll leave up to someone else, the discussion.

Item number 7, no security guards, there's no evidence that this is a practice that is in other Recovery Units at psychiatric hospitals and there's no suggestion that the presence of a security guard would've made any impact in the particular circumstances.

In regard to the PA system not functioning properly, there's no evidence before the Court that indeed it was not functioning properly because one would wonder how else would the people on Level 2, Level 3 in the main building respond to the Code White had it not been working.

I want to refer back to the inspector's report, Binder #1. Page 46 to 49 identifies many of these items as part of the recommendations that came from staff during her inspection. The orders – and really they form part of the order that she issued as well as a number of recommendations that have come from staff.

Now, the Crown has stated that they should've been in place at the time of the incident. The Court believes that that's taking them from

recommendations and turning them into requirements. In this particular case, the Crown has not come close to proving their case beyond a reasonable doubt and, as such, count number 3 will be dismissed.

I just want to say in closing that, as I mentioned before, the court of public opinion may not agree with the decision that this Court has reached but I want both parties to know I spent hours and hours and hours reviewing this document and I'm very comfortable with the decision. I'm very confident that it's the right decision, given the circumstances. Thank you very much. I appreciate your time.

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CERTIFICATE OF TRANSCRIPT

EVIDENCE ACT, subsection 5(2)

I, Isabelle Olson, Authorized Court Transcriptionist, ACT ID 7056570726, certify that this document is a true and accurate transcription of the recording of R. v. Royal Ottawa Health Care Group in the Ontario Court of Justice held at Ottawa, Ontario.

July 21, 2016

Date

Isabelle Olson