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IN THE MATTER OF THE *HUMAN RIGHTS CODE*,
RSBC 1996, c. 210 (as amended)

AND IN THE MATTER of a complaint before
the British Columbia Human Rights Tribunal

BETWEEN:

RR

COMPLAINANT

AND:

Fraser Health Authority and IL and VG

RESPONDENTS

REASONS FOR DECISION

Tribunal Member:

Shannon Beckett

On their own behalf:

RR

Counsel for the Respondents:

David J. Bell and Aleksandar J. Petrovic

Counsel for the Intervener, BC Nurses Union:

Derek G. Knoechel and Claire Lee

Date of Hearing:

July 22-26, 29-31, August 1, 7, 8, 19, and 22,
2024

Location of Hearing:

Videoconference

Written Closing Submissions:

October 29, 2024

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I INTRODUCTION

[1] RR was employed by Fraser Health Authority [FHA] as a registered nurse. She says that while she was working in the Acute Care for the Elderly [ACE] Unit at Abbotsford Regional Hospital, FHA refused to accommodate her back injuries and advancing cataracts. She also says that her supervisors and colleagues, including IL and VG, bullied and harassed her in relation to her disabilities. I will refer to FHA, IL and VG together as the “Respondents”.

[2] The Respondents deny discriminating. They say that it was clear from the time that RR started working on the ACE Unit that she was unable to practice safely as a nurse. They say that despite multiple, progressive attempts at supporting RR with mentorship and training, she continued to make numerous, significant, medical errors which put the safety of the patients at risk. The Respondents say that the interventions they took with respect to RR’s nursing practice were necessary, proportional, good-faith efforts to support RR and integrate her into the ACE Unit. They deny RR was ever bullied or harassed in relation to her disabilities. The Respondents further say that at all relevant times RR was medically cleared by her physicians to work as a full scope nurse, and she never requested accommodation for either her back or eye issues.

[3] To resolve this complaint, I must decide:

- A. Whether RR’s cataracts condition and back injuries amounted to physical disabilities for the purposes of the *Human Rights Code* [Code];
- B. Whether the Respondents’ interventions into RR’s nursing practice and/or the conduct of specific nurses on the ACE Unit amounted to discriminatory harassment;
- C. Whether RR otherwise experienced adverse impacts in employment that were connected to her disabilities; and
- D. Whether any conduct by the Respondents that adversely impacted RR in relation to her disabilities was justified.

[4] For the following reasons, I find RR has not proved that the Respondents discriminated against her based on her physical disabilities. While RR has proved she had both vision and back

disabilities while she was working on the ACE Unit, she has not proved that she experienced discriminatory harassment or that her back disability was otherwise connected to any adverse impacts she experienced in her employment. To the extent that RR has proved that her vision disability was connected to two discrete adverse impacts she experienced in her employment, the Respondents' have proved their conduct which adversely impacted RR was justified. In particular, the Respondents have proved that despite being provided with multiple opportunities to do so, up until September 2017, RR never advised the Respondents that she had vision limitations arising from her advancing cataracts that required accommodation. When she did finally make them aware of her advancing cataracts, she was appropriately accommodated.

[5] I apologize to the parties for the length of time it has taken me to issue this decision.

II BACKGROUND

[6] In this section of the decision, I outline the chronology of events between the parties that gives rise to the issues in the complaint.

[7] RR was originally educated as a nurse in the Philippines. After moving to Canada, she began working as a registered nurse [RN] for Vancouver Coastal Health Authority. Between 2010 and 2016, RR worked in the Patient Assessment and Transition Home [PATH] Unit of Abbotsford Regional Hospital, within FHA.

[8] Several of the Respondents' witnesses testified that the PATH Unit provides care to medically stable patients who do not need acute care or daily assessments from nurses. RR testified that sometimes medically acute patients would be sent to the PATH Unit, but not all the time.

[9] In July 2016, the PATH Unit was relocated to Mission Memorial Hospital. As a result, displaced nurses previously assigned to the PATH Unit were given a choice to move to other Units within Abbotsford Regional Hospital. RR chose to stay at Abbotsford Regional Hospital and was assigned to the ACE Unit.

[10] The ACE Unit is a specialized unit that provides acute care services to elderly patients with complex care needs. Patients in the ACE Unit typically have more than one serious illness, and in many cases suffer from dementia or other serious cognitive conditions. Everyone agreed that the patients on the ACE Unit are among the most vulnerable patients in the hospital.

[11] RR started working on the ACE Unit on July 12, 2016. At the time, Carl Dragt was the manager and Carly Orchison was the Clinical Nurse Educator [CNE]. A CNE is a nurse with specialized training who supports other nurses to improve the quality of patient care and to ensure competency. CNEs do not have managerial authority over other nurses.

[12] It is clear from the evidence of all the witnesses, including RR, that RR had a difficult transition onto the ACE Unit.

[13] RR testified that as soon as she started, she and other nurses who were new to the Unit were bullied and harassed by nurses who had more seniority on the Unit. In particular, RR testified at length about being bullied by Karen Koch, who was a Patient Care Coordinator [PCC] on the ACE Unit. PCCs are experienced nurses who hold leadership positions on Units. At FHA, PCCs do not have managerial authority over other nurses, but they coordinate patient care, including by assigning tasks to other nurses on the Unit. RR testified that Ms. Koch constantly bullied and harassed her, and that after she complained to management about the toxic work culture on the ACE Unit, Ms. Koch engaged in a pattern of discriminatory harassment against her to try to get her fired, or to try to get her nursing license cancelled.

[14] Mr. Dragt testified that as soon as RR started working on the ACE Unit, he began receiving reports from multiple different staff about her nursing practice. He testified that RR was appointed to the ACE Unit without having to participate in a hiring process, and that he felt she did not have the requisite training or experience to work in the ACE Unit.

[15] An August 4, 2016, email from Ms. Orchison to Mr. Dragt indicates that on August 3, Ms. Orchison met with RR to discuss some concerns about RR's nursing practice. In the email, Ms. Orchison advised Mr. Dragt that during the meeting she and RR came up with a learning plan. The attached learning plan set out that RR needed to improve her practice in the following

areas: critical thinking, teamwork, delegation, documentation, organization, and communication.

[16] RR testified that she viewed the Respondent's initial and ongoing requests for a learning plan as disciplinary in nature. It is clear from RR's evidence at the hearing that she did not believe she needed a learning plan at any point while she was working on the ACE Unit.

[17] On August 12, 2016, RR injured her back at work, and had to take a medical leave of absence. She made a successful WorkSafe BC claim in relation to this injury. She returned to work in September 2016. Upon her return, she was on a temporary Gradual Return To Work [GRTW] plan .

[18] RR testified that in December 2016, she attempted to transfer to the PATH Unit but that her transfer was "blocked" by Mr. Dragt. She did not provide any evidence in support of her testimony, and Mr. Dragt denied blocking any transfer. He testified that he would not have been able to do so under the applicable collective agreement. Further, he testified that he did not want to keep RR on the ACE Unit, so had no reason to block her if she wanted to transfer.

[19] On January 11, 2017, RR met with a different CNE, Maryna Koechlin, for the purpose of discussing issues Ms. Koechlin had identified with respect to RR's nursing practice. Ms. Koechlin documented the issues discussed in the meeting and emailed her notes to Mr. Dragt on January 12. Ms. Koechlin's notes set out numerous, significant concerns with RR's nursing practice including charting errors, medication errors, concerning communications with patients, and improper use of medical equipment on patients.

[20] On January 12, Mr. Dragt emailed Justin DePodesta, an FHA Human Resources Client Partner, and asked him what the process was to "pull [RR] from service". Mr. Dragt advised Mr. DePodesta that "as per 3 PCC's and 2 CNE's" RR was not safe to provide patient care, even if she was moved to a different unit.

[21] On January 12, RR sustained another back injury, which resulted in her taking a medical leave as of January 14. RR filed another successful WorkSafe BC claim in relation to this injury.

[22] On January 13, before going on medical leave, RR met with Mr. Dragt and her BC Nurses' Union [BCNU] representative to discuss the practice concerns identified by Ms. Koechlin. At the meeting, Mr. Dragt advised RR that he cancelled her next three shifts and she would be on paid leave until they decided on next steps. The result of the meeting was that RR agreed to see her doctor for a full health assessment, including both a physical and cognitive assessment. In an email dated January 16, Mr. Dragt told Mr. DePodesta that at the meeting, RR explained that she was a good nurse, but that other nurses on ACE were "out to get her", and that her errors had been due to fatigue and high patient turnover on ACE.

[23] Following this meeting, Mr. DePodesta and Nicole Sloboda, an FHA Disability Management Client Partner, worked with a BCNU Labour Relations Officer to draft a medical questionnaire for RR's doctor. Ms. Sloboda testified that this kind of letter is called a "nexus letter", and its purpose is to determine whether there is any medical reason to explain the existence of a nurse's practice concerns.

[24] On January 16, three days after her meeting with Mr. Dragt, RR made a Respectful Workplace complaint. In the complaint, she alleged that on January 11 she was yelled at and threatened by another RN. She also alleged that since the second day of her orientation she had been yelled at and harassed and threatened by the person who oriented her, and that bullying and harassment was widespread on the ACE Unit. Mr. Dragt testified that he was made aware of the complaint, but that he held it in abeyance while RR was on medical leave, as requested by RR's BCNU steward, Parveen Gill.

[25] On or about January 20, RR submitted two Professional Responsibility Forms [PRF] to FHA and the BCNU. The bottom of the PRF form states that it is a problem-solving process to address nurses' concerns relative to patient care including nursing practice concerns, safety of patients and nurses, and workload issues. RR testified that she used the PRF process to document issues she was experiencing on the ACE Unit to protect herself from unfair criticism or discipline. In the January 20 PRFs, RR set out details of her high workload and what happened on her shift on January 11 and January 12. She also raised concerns about other

nurses bullying her. In particular, she alleged that senior nurses had been “congregating” at the nursing station and gossiping and being hostile to new staff.

[26] By early March 2017, FHA had received the medical letter back from RR’s attending physician Dr. Bin Lim. However, the letter was not the same letter that was drafted and agreed upon by FHA and BCNU representatives. RR had altered the letter to add several paragraphs of additional information under each of the questions posed to the physician.

[27] During the hearing RR was questioned extensively about whether and why she altered the letter. Many times RR denied altering the letter, and refused to acknowledge that the letter that she provided to her doctor was different from the letter her BCNU representative and FHA had agreed to. Eventually, RR admitted she changed the letter because she wanted to give her doctor all the information so that he could understand that she did not agree with the allegations in the letter.

[28] Ultimately, Dr. Lim did not answer any of the questions posed in the letter. Instead, he wrote “unable to comment on its relationship” in response to the question “is there medical evidence to show a clear distinction that the diagnosed medical condition has a causal relationship to the behaviours exhibited?”

[29] On March 7, Ms. Sloboda wrote to Mr. Dragt and Mr. DePodesta and advised the nexus letter had been altered. She said that as a result, she could not confirm if there was any medical nexus between the performance issues at work and any medical condition. She advised that the matter was now returned to the labour relations/human resources process for next steps.

[30] On March 21, RR was medically cleared to return to work from her lower back injury and started work on a GRTW plan. On March 22, she filed another Respectful Workplace complaint. In it, she alleged that on her first day back to work (March 21), Ms. Koch yelled at her and attempted to intimidate her. At the hearing, Ms. Sloboda testified that the March GRTW was unsuccessful, and RR went back on medical leave.

[31] As of May 4, 2017, RR was medically cleared to return to work with some physical limitations. In an Occupational Fitness Assessment [**Assessment**] completed by Dr. Behzad Borji after assessing RR on May 4, Dr. Borji set out that RR had some physical limitations in relation to walking, continuous sitting, continuous standing, lifting, pushing/pulling, and bending/stooping. With respect to vision, the only limitation Dr. Borji indicated was that RR used reading glasses.

[32] On May 17, 2017, Ms. Sloboda emailed RR, Mr. Dragt, Mr. DePodesta, Ms. Gill, and others involved in RR's return to work. She advised that she and Nicole Ng, a BCNU Disability Management Program representative, had reviewed the May 4 Assessment and confirmed RR was cleared to return to work with some temporary residual restrictions for "a couple weeks" to be careful lifting above 30lbs. She also advised she spoke directly with RR and went through the medical recommendations set out by Dr. Borji, and that RR and her BCNU representatives agreed she was cleared to return to work with no GRTW plan.

[33] By May 22, RR had returned to work on the ACE Unit. At that time, Jocelyn Klemes was the interim manger covering for Mr. Dragt, and VG was the interim CNE covering for Ms. Koechlin. On May 24, Ms. Klemes pulled RR from service and put her on paid leave due to practice concerns. The email correspondence documenting Ms. Klemes' decision to pull RR from practice did not specify the nature of those concerns.

[34] On May 27, RR filed another Respectful Workplace complaint. This complaint was in relation to her shift on May 22, wherein she alleged Ms. Koch had overloaded her with eight patients and she did not have time to do charting, admissions, or discharges. She said she was still in learning mode, and the workplace was toxic. On May 31, RR filed another PRF, in relation to her shift on May 22. In the PRF, RR set out that patient demand was high that day and that she did not have sufficient time to complete her charting.

[35] On June 12, RR attended a meeting with IL, who was, at that time, acting manager of the ACE Unit. Ms. Gill was present at the meeting as RR's BCNU steward. During the meeting, it was agreed that RR would participate in eight supernumerary "buddy" shifts with VG. IL testified

that the purpose of the buddy shifts was to give RR personalized support from a CNE, and to ensure patient safety. RR testified that she was falsely led to believe that these shifts were for the purpose of mentoring her and supporting her learning and practice but that in reality, the shifts were a form of improper surveillance designed to collect information and sabotage her nursing practice.

[36] Between June 13 and 26, RR completed the eight shifts with VG. VG testified that during the shifts, she observed numerous, significant concerns with RR's nursing practice that put patients at significant risk of harm. She testified that she brought all the practice concerns to RR's attention, but RR was not receptive to VG's suggestions about how to improve practice and reduce errors.

[37] VG reported her concerns about RR's practice to IL and Treena Caning, Clinical Director of Medicine at Abbotsford Regional Hospital. On June 26, RR met again with IL, VG, and Ms. Gill to discuss the ongoing concerns. At the meeting, everyone agreed that RR would be provided with seven additional buddy shifts with a nurse that RR specifically chose as someone she trusted.

[38] RR completed the seven additional shifts between June 27 and July 11. On one of the shifts in early July, RR administered nitroglycerin spray [**Nitro Spray**] to a seriously ill patient without receiving a doctor's order, documenting the patient's condition, or escalating the patients' care before she left her shift. When IL found out about the Nitro Spray incident, she asked VG to audit RR's other patients' charts to see if RR had completed her charting properly. VG reviewed the charts and noted numerous, significant errors.

[39] On July 14, 2017, IL pulled RR from service and placed her on modified duties. In an email to Mr. DePodesta and Ms. Caning, IL explained she was concerned about RR's ability to practice independently. She told them she would hold a meeting with RR to review any health reasons for RR's practice issues, and that she would follow up with another meeting to discuss assessing RR's competency to practice through a CAEN (Competency Assessment and Enhancement for Nursing) assessment at Kwantlen Polytechnic University.

[40] On July 17, IL met with RR. IL's handwritten notes from that day indicate that she advised RR she was on modified duties because there were still gaps in RR's learning. Her notes also indicate she could not share her specific concerns because RR's BCNU representative was not present.

[41] RR called in sick the following day and never returned to work with FHA.

[42] An Assessment completed by Dr. Borji on August 29, 2017, indicates that RR visited him on July 19, and the reason for her absence from work was "stress in the workplace". He stated that "chest pain" was her primary diagnosis. He indicated RR could participate in a GRTW plan immediately, but that "ongoing work stress" was a barrier to her return to work. With respect to any physical restrictions or limitations Dr. Borji indicated RR had no restrictions or limitations, including with respect to vision or lifting issues.

[43] Another Assessment completed by Dr. Stephen Peach on September 4, 2017, indicates, again, that RR had no physical restrictions or limitations, including with respect to vision and/or lifting. In this Assessment, Dr. Peach attributed RR's symptoms of depression and anxiety to "workplace stressors".

[44] RR made a WorkSafe BC claim in relation to the July 17, 2017, medical leave. Initially it was rejected. However, RR appealed the decision to the Workers' Compensation Appeal Tribunal [WCAT]. On April 25, 2023, WCAT issued its decision in her favour. The WCAT decision was about RR's psychological condition. In it, WCAT held that RR had adjustment disorder and a major depressive episode, and that workplace stressors were the predominant cause of both. The WCAT decision did not address, or make material findings in relation to, RR's alleged vision or back issues.

[45] On September 13, 2017, RR met with Ms. Gill, Ms. Ng, and Ms. Sloboda to discuss her return to work. Ms. Sloboda testified that the focus of the meeting was on RR's anxiety and the barrier her anxiety posed in her return to work. The result of the meeting was that RR was provided with a medical questionnaire to provide to her doctor.

[46] On September 25, 2017, Dr. Peach completed the medical questionnaire. In it, he reiterated that RR was experiencing anxiety due to workplace stressors. However, he also indicated, for the first time, that RR had advancing cataracts. He advised the treatment plan for the cataracts was an ophthalmology referral.

[47] RR received cataract surgery in February and March 2018. She made a successful long term disability [LTD] claim in relation to her cataracts condition, and received LTD benefits until May 2018.

[48] On November 10, 2017, while RR was on leave awaiting cataract surgery, IL submitted a letter of concern to the BC College of Nurses and Midwives [College¹] about FHA's concerns with RR's practice issues. RR testified that as a result of IL's letter, the College suspended her license to practice as a nurse.

[49] Following an investigation by the College, in July of 2019, RR and the College came to a Consent Agreement which restored RR's license to practice as a nurse on the following conditions:

The Registrant has voluntarily agreed to terms equivalent to a condition on practice, including: limited employment to a single non-acute area of practice; not to be the sole RN on duty; not to work in the "in charge" position; and not to work night shifts. The Registrant has agreed to undergo a six-week fulltime period of mentorship prior to commencement of providing independent patient care; to develop and engage in a learning plan with the employer, and to undergo sensitivity training and/or counselling.

[50] The Consent Agreement expressly referenced the following practice issues, which closely mirrored the issues that the Respondents had observed with RR's practice while she worked on the ACE Unit:

Medication administration, documentation, aseptic technique, proper wound swab culture taking, time management, communication, management of patients with nasogastric tube feeding, accurate heart

¹ For simplicity in this decision, I have referenced the current name of the regulator for nurses (College), even during time periods when the name of the regulator was BC College of Nursing Professionals.

rate taking and documentation in the context of a new onset atrial fibrillation, proper c-difficile isolation precautions, and adequate management of a patient with continuous bladder irrigation.

[51] For reasons explained in the next section, the Consent Agreement concludes the temporal scope of the complaint. I set out the following details about what happened after the Consent Agreement in order to provide context for the analysis of the temporal scope of the complaint.

[52] In September 2019, FHA sent RR a letter advising it considered her leave of absence to be unsupported by medical evidence. The letter advised that RR did not currently hold a nursing license because she had allowed her registration to lapse, and that the restrictions on her ability to practice precluded her from working as an RN. FHA told RR she had until November 29, 2019 to find a position within FHA that she was capable of performing.

[53] In April and July of 2020, FHA sent follow up letters and offered RR a position as a Health Care Aide at Mission Memorial Hospital. Initially, RR accepted the Care Aide position, but she did not complete the steps that were required for her to be able to move into the position. FHA gave RR until August 6, 2020, to complete the required steps, advising her that if she did not, it would consider her to have resigned. RR did not complete the required steps, and on August 11, 2020, FHA sent her a letter advising that it deemed she had resigned.

III PRELIMINARY ISSUE – SCOPE OF COMPLAINT

[54] The parties disagree about the temporal scope of the complaint.

[55] The Respondents submit that the appropriate period is between July 12, 2016, when RR started working on the ACE Unit, and July 3, 2019, when RR and the College entered into the Consent Agreement. The Respondents submit this is because RR's allegations of discrimination are about the time she worked on the ACE Unit, and IL's submission of the letter of concern to the College afterwards.

[56] RR submits that the temporal scope of the complaint extends to September 2020, when her employment was terminated and she lost all of her employment benefits.

[57] I find that the appropriate timeframe for assessing discrimination in this complaint is between July 12, 2016, and July 3, 2019. RR's complaint (including amendments) alleges she was discriminated against when she was bullied and harassed when she worked on the ACE Unit, and when the Respondents submitted the letter of concern about her to the College. It does not include any allegations about what happened after IL submitted the letter of concern. The adverse impacts RR says she experienced as a result of the alleged bullying and harassment on ACE and the Respondents' submission of the letter of concern are all within the scope of this complaint. As suspension of RR's nursing license and the eventual imposition of conditions on her license flow from the submission of the letter of concern, those events are all within the scope of this complaint. Therefore, I find that allegations of discrimination from when RR started working on the ACE Unit, up to and including when RR agreed to the Consent Agreement with the College in July 2019, are all within the temporal scope of this complaint.

[58] I agree with the Respondents that the scope of this complaint does not include allegations about FHA's offer of the Care Aide position, or its eventual determination that RR had resigned. In fact, these allegations are the subject of a separate discrimination and retaliation complaint that RR filed on June 9, 2021. On May 1, 2024, the Tribunal decided that RR's discrimination complaint in relation to these allegations could not proceed. However, it accepted the part of RR's complaint that alleged retaliation [the **Retaliation Complaint**] in relation to these allegations.

[59] RR's Retaliation Complaint has not been joined with the present complaint, and the Retaliation Complaint is at a different stage than the present one. Although at the hearing the parties provided evidence about events after the Consent Agreement, including evidence about the Care Aide position and FHA's eventual determination that RR had resigned her position with FHA, that evidence is only relevant to the possible determination of remedy if RR is successful in proving her complaint.

[60] Finally, although this decision considers RR's discrimination allegations in relation to the Respondents' submission of the letter of concern to the College, I did not hear evidence about the specific nature of College's investigation, nor was it necessary for me to make findings in relation to the specifics of that investigation. In an earlier decision, I discussed the confidential nature of College investigations, and held that the *Health Professions Act* prohibited certain documents that related to the College's investigation of RR from being disclosed or used in this proceeding: *RR v. Fraser Health Authority and Others*, 2024 BCHRT 193. For the purposes of this complaint, my analysis of RR's allegation about the Respondents' reporting her to the College is limited to evidence relating to what informed IL's decision to submit the letter of concern, and the resulting Consent Agreement.

IV ANALYSIS AND DECISION

[61] To prove her complaint, RR must demonstrate that her cataracts condition and/or back injuries were disabilities for the purposes of the *Code*. She will also have to show that the Respondents adversely impacted her in her employment in some way that was connected to her cataracts condition and/or back injuries.

[62] RR argues that while working on the ACE Unit, she was exposed to a pattern of discriminatory harassment by her colleagues and managers in relation to her eye and back disabilities. She says that after she complained about the toxic work culture on the ACE Unit, Ms. Koch bullied and harassed her and the Respondents intervened in her nursing practice in an effort to sabotage her employment. She says that Ms. Koch and the Respondents knew she had eye issues and back issues and could not complete the work they were asking her to do, but they intentionally overloaded her with work and exposed her to undue scrutiny to try to sabotage her job and cancel her nursing license.

[63] In what I understand to be a related but alternative argument, RR says that her eye and back issues caused her to be slower at performing her work, and in particular, to have difficulty looking at a computer to do her online charting. She says she had difficulty performing certain

tasks assigned to her that had to do with her vision, ability to lift, and ability to repeatedly bend and stoop, and that the Respondents failed to accommodate her.

[64] I will begin by considering RR’s evidence about her physical disabilities. I will then consider whether Ms. Koch’s conduct or the Respondents’ interventions into RR’s nursing practice amounted to discriminatory harassment. Finally, I will consider whether RR’s vision or back issues were otherwise connected to any adverse impacts she experienced in her employment, and if so, whether the Respondents met their duty to accommodate her disabilities to the point of undue hardship.

A. Has RR Proved she had Physical Disabilities at the Relevant Time?

[65] The *Code* does not define “disability”, but the Tribunal interprets the term liberally to achieve the purposes of the *Code*: *British Columbia Human Rights Tribunal v. Schrenk*, 2017 SCC 62 at para. 31. The purposes of the *Code* include the removal of barriers that people face in certain areas of daily life because of their disabilities. Those barriers may arise from actual functional limitations associated with a disability, or society’s perception of, or response to, the disability. People with disabilities have long faced exclusion and marginalization based on stereotype, ignorance, and fear: *Eldridge v. British Columbia (Attorney General)*, [1997] 3 SCR 624. It is that exclusion and marginalization, founded on generalizations and prejudice, which the *Code* seeks to eliminate.

[66] To decide whether a condition is a “disability”, the Tribunal will consider the degree of impairment, any functional limitations, and the social, legislative, or other response to that impairment and/or limitations: *Morris v. BC Rail*, 2003 BCHRT 14, at para. 214. It considers factors like “whether the condition entails a certain measure of severity, permanence and persistence”: *Viswanathapuram v. Canadian Alliance of Physiotherapy Regulators*, 2017 BCHRT 29 at para. 40.

[67] The Tribunal has held that it is not necessary that a medical condition be permanent to amount to a disability for the purposes of the *Code*: *Wali v. Jace Holdings Ltd.*, 2012 BCHRT 389, at para. 82. However, simply because a person is on a medical leave from work due to a medical

condition does not mean the condition will automatically amount to a disability under the *Code*: *Goode v. Interior Health Authority*, 2010 BCHRT 95. Employees may be absent from work for a variety of temporary illnesses that do not necessarily constitute disabilities: *Goode* at para. 105.

[68] The Respondents deny that RR's cataracts condition or back issues were significant enough to amount to disabilities within the meaning of the *Code*. I disagree. As I explain below, the evidence demonstrates that while RR was working on the ACE Unit, her advancing cataracts impaired her vision, and she experienced a number of back injuries requiring her to take several medical leaves of absence. I am satisfied that RR has proved that her cataracts condition and back injuries amounted to physical disabilities within the meaning of the *Code*.

1. *Cataracts Condition*

[69] RR says that while she was working on the ACE Unit, she had advancing cataracts that made it difficult for her to see properly, especially when looking at computer screens. At various points during the hearing RR characterized her condition as being "legally blind", or having her visual acuity measured at "20/200".

[70] The Respondents acknowledge that the evidence demonstrates that RR had an advancing cataract condition by at least September 2017, which was later addressed surgically. However, the Respondents argue that RR's cataract condition did not rise to the degree of impairment and functional limitation required to ground a finding of disability within the meaning of the *Code*.

[71] While I do not accept RR's evidence that she was legally blind, I find she had advancing cataracts as of July 2017 which functionally limited her in certain aspects of her job as a nurse. I further find that her cataracts condition was non-transitory and significant enough to require surgery to correct.

[72] At the hearing, RR provided four surgical booking forms indicating she was scheduled to undergo cataract surgery in July and August of 2017, and in February and March of 2018. RR

testified she did not get the surgery in 2017 because she wanted to get a second opinion before committing to the surgery. However, she testified, and medical documents confirm, that she did ultimately get the surgery in February and March 2018.

[73] RR also provided an ophthalmologist report dated September 29, 2017, which indicates that RR's vision complaints at the time were that her vision was bothering her when she was looking at something near, and her night driving was becoming difficult. The report also indicates that RR had reported that she "recently made a medication error that she [felt was] related to her poor vision". After assessment, the ophthalmologist found that RR had visually significant cataracts present in both eyes, resulting in "acuity reduction impairing her working". Partway through the report, the Ophthalmologist described the measurement of RR's vision at the time and documented that "[t]he best corrected acuity was on the 20/25 right and 20/25 on the left. Her acuity drops with glare to 20/200 OD and 20/60 OS." Other than describing herself as legally blind, RR did not provide any evidence explaining the significance of the preceding measurements.

[74] I do not accept RR's oral evidence that she was so severely impaired as to be legally blind. This evidence is inconsistent with the evidence that at the time she was driving daily between her home in Vancouver and the hospital in Abbotsford. Further, RR's evidence that she decided not to get the cataract surgery in 2017, instead waiting a further six months before she underwent the surgery, appears to indicate her vision impairment was not so severe as to require immediate correction to be able to continue with her employment and regular day-to-day activities.

[75] RR's evidence that she was legally blind is also inconsistent with the medical evidence from her doctors at the time, who did not flag her vision as an issue until late September 2017, when Dr. Peach identified that she had advancing cataracts and he had referred her to an ophthalmologist. Prior to this time, RR's medical leaves were all in relation to her back injuries. The only indication in the medical information from RR's doctors before September 2017 that RR had any vision issues, was the May 4, 2017, Assessment from Dr. Borji which indicated RR used reading glasses.

[76] Nevertheless, I accept RR's evidence that she did have advancing cataracts leading up to her medical leave in July 2017, and that her vision impairment was significant enough to require surgery to correct. Further, that RR had initially booked surgery to correct her cataracts condition in July 2017, indicates that at some point prior to July 2017 she had sought medical diagnosis and treatment for the condition. This demonstrates that RR's cataracts condition was not brief or transitory.

[77] In addition, as of September 2017, which was only two months after she was working on the ACE Unit, the ophthalmologist reported that under "glare" and "low light" conditions, RR's vision impairment was "significant" and "impairing her working". This is consistent with RR's testimony that while she was working on ACE, she was having difficulty reading electronic patient charts because of the glare from the computer screens.

[78] RR did not need to be legally blind for her vision impairment to amount to a disability for the purposes of the *Code*. In the present case, her job required her to see and read a variety of important written information in various light conditions, she required reading glasses, and even with corrected vision (which I interpret to mean with corrective lenses), she had significantly reduced visual acuity in low light or glare. In this context, even if RR was not legally blind, the evidence demonstrates that her cataracts condition functionally limited her ability to perform certain aspects of her work that required her to see and read, at least under low light or glare conditions.

[79] On the whole of the evidence, I am satisfied that during the time she was working on the ACE Unit, RR had a cataracts condition which caused a visual impairment that was significant, non-transitory, and functionally limited her ability to perform certain aspects of her work as a nurse. As such, I find RR's cataracts condition amounts to a disability within the meaning of the *Code*.

2. Back Injuries

[80] With respect to her back injuries, the evidence demonstrates that RR experienced two separate back injuries while she was working on the ACE Unit. The first back injury took place

on August 12, 2016. RR made a successful WorkSafe BC claim for this injury, and remained off work until September 20, 2016, when she returned to work on a GRTW Plan.

[81] On January 12, 2017, RR experienced another injury to both her upper and lower back. Again, she made a successful WorkSafe BC claim in relation to this injury. She originally attempted to return to work on a GRTW plan on March 21, 2017, but she was unable to complete the GRTW and went on medical leave again. The May 4 Assessment indicates that although she was cleared to return to work, RR had a lifting and pulling/pushing restriction of between 25-30 lbs, and that she could only sit and stand continuously for 15 and 30 minutes respectively. It also indicates that with respect to bending or stooping, RR could only do 10 repetitions per hour.

[82] FHA does not dispute that at the time she worked on the ACE unit, RR had back injuries that resulted in her being medically unable to work as a nurse for periods of time. However, again, it argues that RR's back conditions did not rise to the degree of impairment and functional limitation required to ground a finding of physical disability.

[83] Again, I disagree. This Tribunal has found that a back injury can amount to a disability where the injury: limits an employee's ability to work, requires an absence from work, is supported by medical evidence, and results in receipt of WorkSafe BC benefits for a period of time: *Singh v. Dodd's Furniture (No. 2)*, 2021 BCHRT 85, at para. 49-51.

[84] In the present case, the medical evidence is that RR experienced two significant back injuries while she was working on the ACE unit, both of which resulted in lengthy medical leaves, and both of which resulted in successful WorkSafe BC claims. The January 2017 injury, in particular, resulted in a medical leave of over 4 months. This is not an insignificant length of time. Further, less than four months before the January injury, RR had been off work for over a month with another back injury. The medical evidence shows that RR was placed on a GRTW plan when she returned from her first leave, and was functionally limited in various areas of her nursing practice (sitting, standing, lifting etc.) when she returned from her second leave.

[85] I am satisfied that RR's back injuries had a degree of permanence and persistence, and, at times while she was working on the ACE Unit, limited her ability to lift, bend, push and pull. In these circumstances, I find that RR's back injuries amount to a disability for the purposes of the *Code*.

[86] I move on next to consider whether and to what extent the Respondents' various interventions into RR's nursing practice amounted to discriminatory harassment.

B. Has RR Proved she Experienced Discriminatory Harassment?

1. General Principles

[87] Harassment is generally understood as a pattern of negative conduct that causes a person harm. In the human rights context, discriminatory harassment is negative conduct, connected to a person's protected characteristic(s), that harms them in an area of life protected by the *Code*. In other words, the *Code* does not protect against harassment, even severe harassment, that is unconnected to a person's protected characteristic(s).

[88] Not all negative comments or acts in the workplace contravene the *Code*: *D.D. v. The Hotel and others*, 2020 BCHRT 109, at paras. 35-36, citing *Lobell v. University Women's Club of Vancouver*, 2014 BCHRT 185 and *Brito v. Affordable Housing Societies and another*, 2017 BCHRT 270. The inquiry is fact specific, considering such factors as the nature of the conduct, its context, the nature of the relationship between the parties, and the impact on the complainant.

[89] In the employment context, employment relationships often require an employee's performance to be managed, supported, or otherwise directed by an employer. Sometimes, unequal power dynamics can contribute to an employee feeling bullied or harassed by the people exercising power over their employment. However, an employee's subjective perception, on its own, is not enough to establish discriminatory harassment: *Gaucher v. Fraser Health Authority and others*, 2019 BCHRT 243, at para. 62. Discriminatory harassment requires

a contextual analysis that considers the employee's subjective feelings in light of the overall working context.

[90] Having said that, interactions in the workplace must be considered carefully. There are countless, often subtle, ways a person can be treated adversely in relation to a protected characteristic, and sometimes conduct which appears legitimate and neutral on its face, can take on discriminatory undertones: *Gaucher* at para. 63; *Kersten v. VIHA and others*, 2023 BCHRT 108, at para. 49. In all cases, attention must be paid to the distinction between reasonable conduct arising from management of a workplace, and conduct that is degrading or otherwise demeaning of an employee's dignity: *Gaucher*, at para 62.

2. *Allegations of Discriminatory Harassment*

[91] RR says that after making complaints about senior nurses and the toxic work culture on the ACE Unit, her colleagues and supervisors purposely tried to sabotage her employment. In particular RR alleges that after she made complaints about Ms. Koch and other nurses' bullying and harassment, Ms. Koch overloaded her with work she knew RR could not perform because of her disabilities, and unfairly influenced the managers on ACE to make them think she had practice issues that she did not. RR also alleges that Mr. Dragt, IL, and VG exposed her nursing practice to undue scrutiny in an attempt to discredit her and have her nursing license cancelled.

[92] As I explain below, the evidence demonstrates that the Respondents' interventions into RR's nursing practice were reasonable, good faith efforts to support RR and protect the safety of the vulnerable patients on the ACE Unit. That RR subjectively experienced these interventions negatively does not mean the interventions amounted to discriminatory harassment. Further, the evidence does not support RR's subjective belief that individual employees, including Ms. Koch, purposely exploited her vision and back disabilities to sabotage her employment.

[93] For clarity on this latter point, discrimination based on disability does not require proof of intent to discriminate or awareness of a specific disability. However, in the analysis of discriminatory harassment, I have addressed RR's specific argument in the context that it was

made, namely, that Ms. Koch and others had awareness of her disabilities and this awareness played a role in the conduct that RR believed to be harassing. Later in these reasons, I consider RR's overlapping but alternative argument, that the Respondents treated her adversely for making mistakes that were connected to her disabilities, and in doing so failed to accommodate her disabilities. Within this alternative argument, I assess whether any adverse impacts RR experienced in her employment were connected to her disabilities, regardless of whether the Respondents were aware of those disabilities or harassed her based on them.

[94] I begin analysis of RR's allegations of discriminatory harassment by considering the evidence about RR's experience on the ACE Unit from July 2016 to January 2017, while Mr. Dragt was the manager and when RR first started working with Ms. Koch. I then consider the evidence about RR's experience on the ACE Unit between March 2017 and July 2017, while Ms. Klemes and IL were the acting managers on ACE, and while VG was assigned to work with RR.

3. RR's Nursing Practice up to January 2017

[95] RR testified that when she started working on the ACE Unit, she was immediately exposed to a toxic workplace. She said that a group of senior nurses banded together and bullied her and other new nurses. She said the more senior nurses would yell at the new nurses, refuse to properly orient them to the Unit, give them work that the senior nurses should have been doing, and otherwise treat them badly. She also said that Ms. Koch verbally harassed her and purposely tried to sabotage her employment.

[96] RR testified that Mr. Dragt was not medically trained, so he had no way of assessing her professional competence. She testified that he listened to the unfounded gossip about her that was coming from Ms. Koch and other nurses, and acted unfairly by trying to impose an unnecessary learning plan on her and eventually asking her to undergo a cognitive assessment. RR testified that Ms. Koch and the other senior nurses targeted her for speaking up and complaining about the toxic work environment on the ACE Unit, and that Mr. Dragt's request for a cognitive assessment was an attempt to "gaslight" her in relation to her complaints.

[97] Mr. Dragt testified that soon after RR started on the ACE Unit, he began to receive complaints about RR's nursing practice from a variety of people from different units. He said he received reports about charting errors, medication errors, and concerns that RR was not able to adequately manage IV's. He testified that the concerns were serious and rose to the level of patient safety and quality of care concerns. He says he initially tried to manage the concerns by providing RR with extra buddy shifts, but that it became clear that more support was needed.

[98] Mr. Dragt testified that as a result of the ongoing concerns with RR's practice, he spoke with two CNE's, first Ms. Orchison and then Ms. Koechlin, about putting together a learning plan with RR and getting her to complete a Competency Assessment, Planning, and Evaluation [CAPE] tool. He and other witnesses testified that a CAPE tool is a self-guided, self-evaluated, series of learning activities that explore nursing competencies in a number of areas.

[99] Mr. Dragt testified that RR was resistant to collaborating with the CNE's on the learning plan and completion of the CAPE tool. He testified RR indicated she wanted to "fight" the learning plan, which concerned him because in his view she needed additional support to be successful on the ACE Unit.

[100] Mr. Dragt testified that RR's practice concerns continued and escalated, despite the support the CNEs were trying to provide. He said that in January 2017 he received an email from Ms. Koechlin outlining numerous serious concerns with RR's nursing practice. Ms. Koechlin's January 12, 2017, email set out the following practice concerns:

- Ineffective communication with colleagues.
- Failure to flush an IV line before administering antibiotics and telling a patient it was ok to do so after patient pointed out RR had forgotten to do so
- Telling a patient she could not have two of her pain medications at the same time despite the patient advising she regularly takes the medications at same time and will be in pain crisis if she did not take medication at same time. When patient told RR she was not considering her needs, RR threatened to inform the care team that a psychiatric consult was needed for the patient.

- Chart checks were not completed properly resulting in a patient getting two doses of hydromorphone medication in error.
- Incorrect process for several medical procedures leading in one case to a patient being covered with bilious fluid overnight.
- Incomplete and incorrect documentation for many patients.

[101] After receiving this email, Mr. Dragt testified he decided to take the more serious step of pulling RR from practice due to patient safety concerns. He testified that at the time, more than one PCC had reported concerns with RR's "cognitive and higher executive" functioning. He testified that it was his job to follow up and investigate concerns that could put patients at risk of harm, and that was why he asked RR to undergo a medical assessment.

[102] When RR put her theory to Mr. Dragt that he only asked her for the medical assessment, CAPE tool, and learning plan because of unfounded gossip from Ms. Koch, Mr. Dragt was steadfast in his evidence that he was not acting on unfounded gossip and that he did not target or attempt to gaslight RR for any reason. He reiterated that the reason for his conduct was that numerous people, not only Ms. Koch, had complained to him about RR's practice, and he had a responsibility to ensure patient safety on the ACE Unit.

[103] RR testified that list of practice issues identified by Ms. Koechlin were "false allegations". However, in her testimony RR did not specifically address most of the conduct set out in Ms. Koechlin's January 12 email or explain how the concerns were false. Rather, she testified that the work environment on ACE at the time was toxic, and nurses were yelling and aggressive and there was not enough time to get all of her work done. She also testified that some of the mistakes that she had been accused of were "little things". She gave the example of forgetting to change an IV cap. RR further testified that there were many other nurses who regularly made mistakes, but they were never singled out or disciplined for their errors like she was. In both PRFs she filed in January, she stated, "no one is perfect, we all make mistakes", and suggested that newcomers like herself should be able to learn from their mistakes.

[104] In my view, RR's evidence did not meaningfully address the Respondents' evidence that the reason they intervened in her nursing practice at this time was because she was not performing up to the standard required for safe practice.

[105] I do not accept RR's assertion that the practice concerns set out by Ms. Koechlin were fabricated, or otherwise false allegations. In her testimony RR did not explain how or why this was the case beyond alleging the people who reported her errors were out to get her. Further, in the January PRF's she acknowledged that she made mistakes.

[106] In addition, in her alterations to the nexus letter that set out several of Ms. Koechlin's specific concerns, RR implicitly acknowledged various errors, though she minimized the significance of the errors or deflected responsibility for them. For example, with respect to the charting error that led to the medication error, RR wrote that the actual medication was administered by another nurse, and that her error in charting was due to how busy the shift had been. Further, she stated that no harm was done to the patient because the dose of the medication was small, and she had observed worse medication errors by other nurses.

[107] In my view, this explanation does not excuse RR's error, or support her position that the error was fabricated. She implicitly acknowledges that it was her charting error that led to the medication error. Further, regardless of whether she was too busy to properly chart, or other nurses had made more serious errors, that does not mean she did not make the error. Finally, that it was her opinion that the patient did not experience harm does not discount the potential harm that could have occurred, or any harm that did actually occur, and it does not mean she did not make an error.

[108] I also do not accept RR's testimony that the conduct set out in Ms. Koechlin's email amounts to "little" mistakes that had been exaggerated by the senior nurses and Ms. Koch. As a CNE, Ms. Koechlin's role was to educate and support nurses to be able to practice safely and in accordance with the professional standards set by their nursing regulator. In her January 12 email, Ms. Koechlin identified concerns, that even from a layperson's view, appear to be more than minimal errors. For example, it appears to be highly improper for RR to have threatened

an elderly patient with a psychiatric evaluation when the patient was expressing dissatisfaction with RR's decision about the patient's medication. RR did not explain the reason for her conduct in this situation. It is clear from the evidence that Ms. Koechlin considered RR's conduct to be significant and concerning enough to document and report to management.

[109] Given my findings about the existence and seriousness of the concerns, I accept Mr. Dragt's evidence that the learning plan and request for completion of a CAPE tool were good faith efforts by him and the CNEs to support RR's safe practice. I do not accept RR's evidence that Mr. Dragt was unduly influenced by Ms. Koch or other senior nurses against her. Rather, the evidence shows that other people, including Ms. Koechlin and Ms. Orchison, had identified legitimate and concerning issues with RR's practice.

[110] Further, given RR's resistance to accepting the support that Mr. Dragt and the CNEs were offering through collaboration on learning plans, I find it was a reasonable exercise of Mr. Dragt's authority as manager to temporarily remove RR from practice to investigate whether there was some medical reason that would explain the observed practice concerns.

[111] I accept RR's evidence that she viewed that support as unnecessary and disciplinary. However, given the serious and repeated errors RR was making, by not meaningfully engaging with Mr. Dragt or the CNEs in working on a learning plan, RR limited the Respondents' ability to support her practice and help her safely integrate into the ACE Unit.

[112] With respect to RR's evidence that the senior nurses' and Mr. Dragt's conduct was retaliation for her complaining about the work environment, this does not make sense in the full context of the evidence. RR did not file her first Respectful Workplace complaint until January 16, and she did not file her first PRFs until January 20. Mr. Dragt's alleged retaliatory conduct took place before RR filed these complaints. He had worked with Ms. Orchison and Ms. Koechlin to put a learning plan and CAPE tool in place as early as fall 2016. Further, it was during the January 13 meeting that he asked RR for the physical and cognitive assessment. Similarly, according to RR's own evidence, the alleged harassing conduct of Ms. Koch and the senior nurses took place from the time she started working on the ACE Unit. Mr. Dragt's

conduct in relation to the learning plan, CAPE tool, and medical assessment could not have been in response to complaints that RR had not yet filed. Similarly, the alleged harassing conduct of the other nurses started well before RR filed any complaints about the work culture on the ACE Unit.

[113] Even if Mr. Dragt and the senior nurses' conduct could be seen as retaliation for RR speaking up about the working conditions on the ACE Unit, that does not explain how their conduct was connected to RR's vision or back issues. Discriminatory harassment requires a connection between a person's protected characteristic(s) and the harassment. RR's evidence about her time on ACE leading up to January 2017 centred on alleged bullying and harassment she says was targeted toward her because she was new to the ACE Unit and had spoken up about the toxic work culture. Further, her evidence was that Ms. Koch and the other nurses bullied and harassed **all** the new nurses, not just her. In this context, RR's evidence did not demonstrate a connection between the harassment and her vision or back issues.

[114] Further, RR simply asserted that Ms. Koch purposely assigned work to RR to exploit RR's vision and back issues. The evidence did not support this assertion. Further, it was not only Ms. Koch who was assigning RR work at the time, but a variety of people. I find it unlikely that all the people who assigned work to RR at the time were "out to get her" by assigning her work that they knew she could not complete because of her disabilities.

[115] For the above reasons, I find RR has not proved that either Ms. Koch alleged bullying or Mr. Dragt's interventions into her nursing practice between July 2016 and January 2017, amounted to discriminatory harassment. I accept that RR subjectively perceived Ms. Koch's and Mr. Dragt's conduct as such. However, RR has not proved her allegation that Ms. Koch purposely tried to sabotage her employment. Further, the full context of the evidence demonstrates that Mr. Dragt's intervention into RR's nursing practice was a reasonable and good faith exercise of his management of the ACE Unit, and was intended to support RR's practice and protect patient safety.

[116] I move on to consider the evidence about RR's nursing practice while Ms. Klemes and IL were acting managers of the ACE Unit.

4. RR Nursing Practice from March 2017 to July 2017

[117] For this period, RR alleges that Ms. Koch overloaded her with patients to sabotage her work, and that IL and VG targeted her and tried to sabotage her work by putting her nursing practice "under a microscope" and exposing her to undue scrutiny and criticism. In all cases, RR says that these and other people acted against her in retribution for her complaints about the toxic work culture on the ACE Unit.

[118] Again, I find the Respondents' various interventions into RR's nursing practice at this time were good faith efforts to support her practice and protect patient safety. Further, RR has not proved any connection between any alleged harassment and her vision and back issues.

Alleged Harassment by Ms. Koch

[119] As set out above, after Mr. Dragt pulled RR from practice in January 2017, she went on medical leave due to a back injury. RR testified that after returning from her medical leave on March 21, Ms. Koch yelled at her and bullied her and that is why her GRTW failed. On March 22, RR filed another Respectful Workplace complaint alleging that on her first day back to work (March 21), Ms. Koch yelled at her and attempted to intimidate her. She stated she was feeling harassed, bullied and "on watch" with Ms. Koch and her counterparts. She specifically stated that she was "just returning back to work and these ongoing stressors such as the PCC yelling at me and attempting to intimidate me is very challenging to manage now with my current recovery".

[120] RR further testified that when she returned to work on May 22, 2017, Ms. Koch overloaded her with eight patients in addition to her own four patients. RR testified that no normal nurse could handle such a heavy patient load, and Ms. Koch's conduct led to RR's inability to perform well on her shift and resulted in her being unfairly pulled from practice by Ms. Klemes. RR testified that Ms. Koch never told Ms. Klemes that she had overloaded RR with patients.

[121] Ms. Koch was not called as a witness at the hearing, so I do not have her direct evidence about RR's allegations that she overloaded RR with patients and was otherwise rude and bullying towards RR. However, I find I do not have to determine whether Ms. Koch engaged in this conduct towards RR while RR was working on the ACE Unit. This is because even if I accept RR's evidence about Ms. Koch's conduct which she says amounted to bullying and harassment, RR has not demonstrated the conduct was related to her vision or back issues.

[122] In her evidence, RR testified that she believed Ms. Koch was targeting her when she came back to work in March (and thereafter) because she had spoken up about the toxic work environment and Ms. Koch in particular. In an email to the Respectful Workplace inbox in July 2017, RR stated that after she made a Respectful Workplace complaint against Ms. Koch in January 2017, Ms. Koch "went after me and determine to ruin my career". She further testified that "many" other nurses had left the ACE Unit because they were afraid of Ms. Koch, and that she was not the only one Ms. Koch targeted. Further, in a bullying and harassment questionnaire RR submitted to WorkSafe BC on July 27, 2017, RR indicated that Ms. Koch (as well as other senior nurses) were harassing "new staff". This evidence indicates, at most, that if RR was targeted, it was because she was new, and because she had complained about the toxic work culture on ACE.

[123] Further, in her March 22 Respectful Workplace complaint, RR emphasised that it was Ms. Koch and other senior nurses' yelling at her and attempting to intimidate her that formed the basis for her complaint. She wrote that the hostile conduct was impacting her health. In her May 22 PRF, RR indicated that senior nurses were complaining to an unnamed PCC behind her back, and that was creating a toxic work environment. In neither of these complaints did RR indicate that her vision or back issues were connected in any way to the conduct of the PCC or other senior nurses. In fact, the conduct RR was complaining about in these documents centred around verbal harassment and an overall toxic work environment, not any exploitation of her impaired vision or back issues.

[124] With respect to the allegation that Ms. Koch overloaded her with patients on her first day back to work on May 22, even if this were the case, again, this does not demonstrate the

requisite connection between Ms. Koch's conduct and RR's vision impairment or back issues. RR's evidence was that **no nurse** could have handled that patient load. Further, the evidence does not support that Ms. Koch was aware of RR's vision impairment or back issues. At the time, RR was not on a GRTW, having agreed with her Union and FHA that it was not needed. RR did not provide evidence of how Ms. Koch could have known about any specific limitations RR had with respect to vision or her back issues. Though it is possible Ms. Koch may have known that the reason RR went off work in January and March was due to back issues, I was not provided evidence about what Ms. Koch knew about RR's back issues or vision issues and I will not speculate about that here. To the extent that RR's evidence was that Ms. Koch purposely overloaded her as a means of exploiting her vision and back issues, I find RR has not proved this.

[125] The disconnect between Ms. Koch's alleged harassment and RR's vision issues was made more evident during RR's cross examination, when the Respondents pointed out that none of her complaints of bullying or harassment mentioned her vision issues. In response, RR stated "why would I mention that? It's a different issue", and stated that those complaints "had nothing to do with [her] eyes".

[126] On the whole of the evidence, I find RR has not proved that any alleged harassment perpetrated by Ms. Koch after January 2017 was connected to her disabilities.

Alleged harassment by IL and VG

[127] RR alleges that after she was pulled from practice in May 2017, IL and VG, acting on instructions from Mr. Dragt, engaged in a campaign to sabotage her work by putting her under "1 on 1 surveillance", "illegally auditing" her patient charts, and fabricating a complaint about her to the College. With respect to VG, RR gave evidence that VG was a recent graduate and newer CNE who did not have enough experience to be able to judge RR's practice. With respect to IL, RR gave evidence that IL only pretended to offer RR support, but was out to get RR from the beginning. RR was not clear in her evidence about why she believed IL and VG were acting against her to sabotage her work. In her closing submissions RR states that she did not

understand their motives, but she expressed the view that they (and others) had “hatred in their hearts” and their conduct was “pure evil”.

[128] The evidence does not support RR’s evidence about being harassed by IL and VG. Instead, it demonstrates that IL made a sincere effort to try to support RR in her nursing practice, including by allowing RR to start fresh without being constrained by previous learning plans, and by allocating significant resources to RR’s orientation and education. The evidence also demonstrates that from the time she returned to work in June 2017, RR continued to make numerous, significant errors that put patient safety at risk on the ACE Unit, and that the interventions IL and VG made into RR’s practice were commensurate with the patient safety concerns associated with RR’s practice.

[129] As set out above, after being pulled from service by Ms. Klemes on May 24, RR and her BCNU steward agreed that when she returned to practice she would participate in eight supernumerary shifts with VG. RR testified that during the shifts, VG would not let her move freely on the unit, and restricted her communications with certain individuals. She said VG was always following her around and documenting what she was doing, and this caused her significant stress. She said it was also embarrassing for her, as a senior nurse, being observed so closely by a very junior CNE in front of her colleagues.

[130] VG testified that during the shifts she did not restrict RR’s movement on the unit, but that she tried to support RR in attending to patients appropriately. Further, she said that in accordance with the plan between herself, RR and IL, she tried to act as a buffer between RR and the other nurses that RR said were bullying her. VG testified that while working with RR she personally observed numerous, significant practice concerns that put patients at significant risk of harm. In a series of emails to IL and Ms. Caning between June 16 and 26, VG identified the following concerns and discussed them in detail:

- Inadequate medication and identification checks
- Failure to follow up with a serious medication need relating to a patient’s blood pressure
- Failure to introduce herself to other nurses or patients

- Failure to flush an IV line
- Failure to assess patients
- Failure to listen to a Doctor's orders about discharging a patient
- Failure to sterilize a finger before performing a glucose check
- Repeated, significant, inadequate charting
- Lack of understanding about how to properly complete charting despite repeated one on one teaching
- Consistent lateness when returning from breaks
- Failure to complete assigned tasks
- Failure to check in with nurses about her patients after breaks
- Improper hand sanitizing technique
- Failure to stop a tube feed when indicated
- Failure to properly swab a wound to collect a specimen
- Failure to give medication and document medication administration

[131] VG testified that the concerns she reported to IL and Ms. Caning were not small matters, but very serious concerns that could have led to severe outcomes, including patient death, in several cases. She further testified that many of RR's serious practice errors happened repeatedly, even after she had discussed the concerns with RR directly and educated RR on the proper procedures.

[132] For example, VG testified that on numerous occasions, she observed RR not bringing the Medical Administration Record to a patient's room when giving a patient medication. She testified that it was proper practice for nurses to consult the Medical Administration Record before administering medication so they could check that the patient was the right patient, the medication was correct, and there were no allergies. She said this procedure is crucial to prevent medication errors that could be serious or fatal for patients.

[133] RR did not deny that she regularly failed to bring the Medical Administration Record into patients' rooms and perform proper medication checks. However, in response, she testified that on one occasion she prepared Tylenol for two patients in the same room who were both

getting the same dose of Tylenol. She said there was no chance for error so she did not need to follow the standard procedure for medication checks.

[134] RR's evidence does not persuade me that VG was exaggerating her concern about RR's medication administration or that she was acting in bad faith for reporting RR's conduct as problematic. RR only spoke to one discrete case, whereas VG reported that she observed RR not following proper procedure on multiple occasions. Further, VG testified she had spoken to RR on numerous occasions about the importance of following proper procedure to minimize risks to patients. That she did so was documented in the contemporaneous emails VG sent to IL about her shifts with RR. Whether RR believed there was no risk of error in a given case, she did not follow proper procedure. Given VG's role was to support RR and educate her on proper procedure so that she could practice safely on the ACE Unit, it was reasonable and appropriate for VG to report RR's conduct in repeatedly either forgetting or choosing not to follow proper procedure.

[135] Another example VG testified about was that RR did not stop a nasogastric [NG] tube feed while a patient was lying in a horizontal position. VG testified that a NG tube is inserted into a patient's nose when they cannot swallow on their own. She said that if a patient with an NG tube is placed on their back with the NG tube feed running, there is a high risk of aspiration (the feeding material accidentally getting into the lungs), which can lead to serious consequences such as pneumonia. VG testified that after she observed RR had not properly stopped the NG tube feed, she spoke to RR about the proper procedure, and then RR went on to continue to make the same mistake two or three times over the next 15 minutes.

[136] RR testified that the concern about the NG tube feed was unfounded because she unplugged the machine before laying the patient flat. However, VG testified that she heard the NG pump running when RR was dealing with various patients. I find it more likely that VG, whose job it was to observe RR and identify where she was having difficulties, was accurate in her assessment that the NG feed was still turned on. This is particularly the case given RR appeared to be testifying about one incident whereas VG testified about observing RR make the same mistake on several occasions. Further, RR's evidence was that her shifts with VG were

highly stressful for her and she was very distracted by VG's presence watching over her. In any event, the NG tube feed concern was only one of many concerns that VG testified in detail about.

[137] Another example was VG's testimony that RR did not wash her hands with soap and water after visiting a patient with a highly contagious c-difficile infection. RR testified that she used hand sanitizer with the patient which was sufficient to protect against the spread of the infection. She further testified that she did not touch any faeces, so there was no risk of transmission. VG strongly disagreed with RR's testimony. She testified that the particular bacteria is not visible to the naked eye, and can live on surfaces such as bedrails and curtains for 90 days. VG said the patient's condition was posted clearly on the door, and anyone entering the room had to put on a hospital gown and gloves to minimize the chance of transmission. She further said that after visiting the room, a person was required to wash their hands with soap and water because hand sanitizer was not effective at killing infectious spores. When asked about the risks to other patients from improper handwashing procedure, VG testified that it was potentially fatal for patients on the ACE Unit to become infected with c-difficile.

[138] In this situation, again, I prefer VG's evidence to RR's. I do not find RR was lying or purposely being misleading in her evidence, but as with the majority of her evidence, she minimized the effect of her failure to comply with proper procedure or best practices. I accept VG's evidence about hand washing being the proper procedure in cases involving c-difficile infection. I find that in her role as CNE she would have more expertise in proper procedures and best practices than RR. Further, although she was a more junior CNE at the time, her testimony about proper c-difficile procedure was echoed by IL, another senior nurse, as well as the College Consent Agreement which identified "proper c-difficile isolation precautions" as a concern with RR's practice.

[139] Throughout her written correspondence to IL and Ms. Caning, and numerous times during her testimony at the hearing, VG repeated her observation that RR was not receptive to VG's suggestions about how to improve practice and reduce errors. She testified that she had

brought all her concerns to RR directly before reporting them. Further, she said that she specifically advised RR about the proper procedures and ways to minimize risks to patients, but that RR refused to engage with her or change her practice based on what VG was saying. VG testified that it was RR's failure to recognize the seriousness of her practice errors and improve her practice, even after significant education and support, that led her to advise IL and Ms. Caning that she was seriously concerned about RR's ability to practice safely. She emphasised that these concerns were present when RR had a case load of 1-2 patients, and not even a full load of 5 patients, which was the normal nurse-to-patient ratio on the ACE Unit.

[140] IL echoed VG's concerns with respect to the seriousness of the practice issues that VG raised at the time. She testified that improper medication checks could lead to significant poor outcomes, up to and including death, and that she was surprised that RR, as a senior nurse, was having to be regularly prompted to do these routine medication checks. She further testified that improper handwashing techniques for patients infected with c-difficile could cause significant harm to other patients on the ACE Unit, and she was concerned that RR appeared to not be able to understand the risk or problem with her practice.

[141] IL testified that she was very concerned about RR's failure to acknowledge the practice issues VG had been raising with her. She said that if a nurse refuses to take accountability and acknowledge her errors, there is no way to remediate the practice concerns. IL testified that she was afraid each shift that RR worked that a patient might die, and she was grateful it never happened while RR was on the ACE Unit.

[142] A theme that emerged out of RR's evidence was her view that she performed adequately, and simply because she had not done a given task the specific way a CNE, PCC, or manager on ACE instructed, does not mean she did the task incorrectly or made a mistake. With respect, it was clear from RR's own evidence and the evidence of the Respondents' witnesses that on the ACE Unit in particular, it was crucial to minimize risks to patients by following proper procedures and best practices. RR agreed about the vulnerability of the patients on ACE, and that a major role of a nurse on the Unit was to minimize risks. Given her admissions, it is unclear to me why RR did not adopt the best practices and proper procedures

set out by multiple different people on the ACE Unit while she was working there. She testified she often did not have time to follow best practices while on the ACE Unit because her workload was so heavy, but issues such as turning off the NG tube feed machine or double-checking medication information do not appear from the evidence to be time consuming tasks. Further, the evidence demonstrates that she did not have a full compliment of patients when she was working with VG.

[143] After RR completed the eight supernumerary shifts with VG, she met again with IL, VG, and Ms. Gill on June 26 to discuss the ongoing concerns with her nursing practice. Contemporaneous notes taken at the meeting indicate that RR raised concerns about feeling like she had been overly scrutinized on the eight shifts, and had been unable to perform to her full potential. The result of the meeting was that RR would be provided with seven additional buddy shifts with a nurse that RR had chosen as someone she trusted. The meeting notes indicate that Ms. Gill voiced opposition to FHA putting RR on a learning plan, stating it was premature.

[144] RR completed the seven additional shifts between June 27 and July 11. On one of the shifts in early July, the Nitro Spray incident happened. With respect to the incident, RR testified that she had found a patient slumped in the hallway and that the patient was complaining about chest pain. She administered the Nitro Spray and the patient got better. RR testified that she acted in accordance with what the College said was within the scope of what a registered nurse was allowed to do, and that the covering order she received after the fact made it clear that she did the right thing. She said it was her view that she likely saved the patient's life.

[145] Both VG and IL testified that RR's conduct in relation to this patient was extremely concerning to them. IL testified that FHA has a chest pain protocol that RR did not follow, and that it is outside of the scope of nursing practice to administer Nitro Spray without a doctor's order. She said there are multiple, serious, contraindications associated with Nitro Spray, including that a patient's blood pressure can drop dangerously low. IL further testified that it was particularly concerning that RR found the patient in such a serious deteriorating condition, but did not document what she found or what she did so that the next shift would be aware of

how serious the situation was. She also expressed significant concern that RR did not escalate care for the patient. IL testified that chest pain can represent multiple serious medical conditions, and the fact that RR did not consult anyone about it or document it so that others would be aware represented a very serious and possibly life-threatening failure in RR's nursing practice.

[146] VG testified along the same lines as IL. She said that whether or not there was a policy from the College that allowed registered nurses to administer Nitro Spray without a doctor's order, FHA policy was that a doctor's order was required. She said that when working at FHA, a nurse is required to follow FHA policy. Further, she said that when she was looking into the incident, she found RR had only tried contacting a doctor one time, and did not try again until many hours after she administered the Nitro Spray. VG testified that RR's failure to document the issue was "catastrophic", and that it was lucky the patient survived, given that RR did not contact a doctor about the patient until after 7 a.m. the following day. She said that RR should have escalated care including by potentially calling a "Code Blue" (a hospital emergency alert signifying that a patient needs immediate life-saving attention) in relation to the patient. VG testified that she was particularly concerned about this incident because the week prior, she had provided RR with detailed information about when and how to escalate care.

[147] When VG became aware of the Nitro Spray incident, she emailed IL and Ms. Caning about it. In her email, VG expressed she was significantly concerned about RR's ability to practice nursing, and that it was her view that RR was putting patients at risk. She also asked IL and Ms. Caning whether they needed to consider reporting RR to the College. Ms. Caning responded, copying Mr. DePodesta, expressing that she was very concerned about the incident and did not feel that RR was safe to practice. It was decided that FHA would send RR for an assessment of her nursing skills through Kwantlen Polytechnic University. To do so, Mr. DePodesta advised that VG would have to produce "everything done to date and [RR's] deficiencies in practice standards". He also agreed they may need to report RR to the College.

[148] Both IL and VG testified that after the Nitro Spray incident, IL asked VG to audit RR's patient charts to determine whether RR had completed her charting appropriately. VG testified

that she identified numerous errors in RR's patient charting, including very serious errors that could put patients at risk. At the hearing, the Respondents entered 89 pages of VG's handwritten notes on RR's patient charts into evidence. The notes identify numerous errors in charting, as well as numerous places where VG indicated RR failed to document patient information. The notes also identify many of the same practice issues that VG conveyed to IL and Ms. Caning between June 16-26.

[149] IL testified that she pulled RR from service and placed her on modified duties on July 14 because by that point, she felt RR was unsafe to practice independently.

[150] On the whole of the evidence, I find RR has not proved that IL and VG's interventions into her nursing practice between June and July 2017 amounted to discriminatory harassment. On the contrary, the evidence demonstrates that the concerns IL and VG raised with respect to RR's practice at the time were legitimate, non-trivial, and warranted IL and VG's escalating interventions.

[151] With respect to RR's evidence that the interventions were unwarranted because no patients were harmed, I observe that whether or not a patient was harmed in a particular circumstance is not an answer to the question of whether RR's practice in June and July 2017 was safe or appropriate. A failure to check that a patient is receiving the right medication on one day may not result in harm, but the same mistake on a different day may lead to a dire outcome. I accept the evidence provided by IL and VG, that best practices in nursing exist to mitigate risks to patients, and that nurses must follow FHA's policies and best practices to do their best to reduce the risk of harm to the vulnerable patients on the ACE Unit. RR's conduct in failing or refusing to follow FHA policies and best practices demonstrated a gap in either her knowledge of the policies and practices, or her ability and willingness to understand the importance of the policies and practices.

[152] Further, with respect to RR's argument that IL, VG, and others targeted her on purpose because she was slower due to her back and eye issues, RR being slow does not explain the numerous mistakes she made while nursing. The concerns raised by FHA as requiring significant

intervention and, ultimately, a complaint to the College, were not related to the pace at which RR was working. They were related to RR's decisions not to follow FHA handwashing protocols or best practices relating to how to manage IV and SC lines, as well as her improper swabbing of a patient wound to collect a sample, and her refusal to document the different assessments, findings and interventions she made in relation to her patients.

[153] RR was provided with what amounts to her own designated CNE to help educate her about best practices and FHA policies, and still, she repeated the same errors, even after receiving individual instruction from that CNE. I do not accept RR's evidence that IL and VG were out to get her, and that the plan for the supernumerary shifts with VG was a disguised attempt to document her out of a job. This is nothing more than a bare assertion and RR did not provide any evidence, beyond her subjective belief, demonstrating that either IL or VG's efforts to support her practice were disingenuous. On the contrary, the evidence demonstrates that IL took RR's concerns about bullying and harassment on the ACE Unit seriously, and that was one of the reasons she allowed RR a "fresh start", and why she allocated significant resources to try to support RR's successful integration into the ACE Unit.

[154] Further, the evidence demonstrates that the concerns that VG and IL raised with respect to RR's nursing practice during and after the eight supernumerary shifts were not exaggerated. By the time RR started back on the ACE Unit on June 13, numerous, legitimate practice issues had already been identified by multiple CNEs, PCCs, nurses and managers. RR argued that those previously raised concerns were tainted by Ms. Koch's personal bias against her. However, the practice concerns that arose on the eight supernumerary shifts were personally observed by VG, and were similar to the concerns that had been identified by other people previously.

[155] In addition to the above, I note that the Consent Agreement between RR and the College sets out the same concerns that were raised by IL and VG in June and July of 2017. RR's evidence was that the College did an extensive investigation into IL's letter of concern, and that RR was able to provide her own explanations for the listed concerns. Nevertheless, even following the investigation, the College Consent Agreement still placed extensive restrictions on RR's ability to practice as a nurse, and indicated those conditions were meant to remediate her

practice issues. I am not suggesting that the College investigation or order are determinative of the harassment issue here. I would have reached the same conclusion without considering the Consent Agreement, but it also reflects that RR's practice issues were significant and concerning.

5. *Conclusion on Discriminatory Harassment*

[156] For the above reasons, I find RR has not proved that the interventions the Respondents took in relation to her nursing practice amounted to discriminatory harassment. Although I accept that RR subjectively felt as though she was being targeted and harassed, the evidence demonstrates that the Respondents intervened in her nursing practice reasonably and in good faith to support her practice and ensure patient safety. Further, RR has not proved that any perceived harassment she experienced was connected to her disabilities.

[157] I move on to consider what I understand to be RR's related, but alternative argument; that her vision and back disabilities impacted her ability to perform her nursing work at the relevant time, and the Respondents failed to accommodate her. To consider this argument I first consider whether RR has proved that she experienced adverse impacts in her employment that were connected to her vision and back disabilities. If she has proved such a connection, I next consider whether the Respondents met their duty to accommodate her.

C. Has RR Proved she Experienced Adverse Impacts Connected to her Disabilities?

1. *Adverse Impacts in Employment*

[158] Although I have found that the Respondents' interventions into RR's nursing practice did not amount to discriminatory harassment, that is not the same as a finding that RR was not adversely impacted in her employment while working on the ACE Unit. As explained above, most of RR's arguments about how she was adversely impacted centre around what she characterizes as intentional bad treatment and bullying. However, there are some adverse impacts RR says she experienced that are extricable from her arguments about bullying and harassment. As I explain below, I find that even though they did not amount to discriminatory

harassment, two of the Respondents interventions into RR's nursing practice – when they pulled her from service and when they reported her to the College – nevertheless adversely impacted RR in her employment.

[159] The Respondents do not directly address the question of whether and how RR was adversely impacted in employment, instead focussing their submissions on whether she has proved a connection between her disabilities and any adverse impacts she may have experienced. Beyond denying RR was bullied or harassed, I do not understand the Respondents to dispute that RR experienced adverse impacts in employment.

[160] RR testified that she was devastated by the Respondents' conduct in pulling her out of service. RR testified that when Mr. Dragt pulled her from service and insisted that she undergo a cognitive assessment before she could return to practice, she was embarrassed and felt like she was being "gaslit", meaning manipulated into questioning her own mental health. She further testified that on the other two occasions she was pulled from service, she felt humiliated, as she was a senior nurse who was being singled out in front of other nurses and prevented from working against her will.

[161] Although the witnesses used the language "pulled from service/practice", what happened on these occasions was that RR was suspended with pay. There is no question that being suspended without pay can amount to an adverse impact in employment. Further, the Tribunal has held that paid suspensions may also amount to an adverse impact in employment: *Ivanakis v. Rio Tinto Alcan Inc. and others*, 2023 BCHRT 163.

[162] In my view, that RR was paid during her three suspensions does not mean she was not adversely impacted in employment. Remuneration is not the only benefit associated with a person's employment. It was clear from RR's testimony that she is very proud of her nursing career, and her profession is tied closely to her identity and sense of purpose. I accept RR's evidence that being suspended, even with pay, adversely impacted her in employment.

[163] In addition to the adverse impact from being pulled from service, RR testified at length about how IL's letter of concern resulted in the College suspending her nursing license for a

lengthy time, impeding her ability to work. She said that when her license was suspended, she was unable to work in her chosen profession, and unable to support her daughter to attend university. Although it was the College that suspended RR's license, the suspension was a direct result of IL's submission of the letter of concern. The evidence at the hearing demonstrated that the suspension was not lifted until July 2019, so RR remained unable to practice nursing because of the College suspension for a significant time, even after she no longer required medical leave in relation to her cataracts. In my view, IL's submission of the letter of concern adversely impacted RR in her employment.

[164] I move on next to consider whether these adverse impacts were connected to RR's vision or back disabilities.

2. *Connection Between Adverse Impacts and Protected Characteristics*

[165] As I have set out above, the reason RR was pulled from practice, and the reason the Respondents submitted the letter of concern about her to the College, was because of numerous serious issues the Respondents had identified with her nursing practice. The question before me at this stage, is whether RR has demonstrated that those practice concerns were connected to either or both of her vision and back issues.

[166] The evidence demonstrates most of the practice issues identified by the Respondents did not have to do with RR's eye or back issues. The subject matter of most of the practice issues did not relate to RR's stated limitations from her disability; namely her ability to see, lift, push, pull, or repeatedly bend/stoop. For example, RR did not testify that any of these limitations impacted her ability to use proper hand sanitizing techniques or her ability to properly care for a patient during an NG tube feed. It is clear from the evidence that the Respondents' overarching concern with RR's practice was that she was unwilling to acknowledge her errors or change her practice to improve.

[167] Nevertheless, discrimination does not require a protected characteristic to be the sole or even the dominant cause of an adverse impact: *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training*

Center), 2015 SCC 39 at para. 52. It is sufficient in this case if RR's vision and/or back disability was only one factor of many.

[168] Ultimately, I find that RR has proved her vision disability was connected to several of the practice concerns, but she has not proved that her back issues were connected.

Vision Issues

[169] RR testified that she was having difficulty performing her nursing role due to her eyesight leading up to July 2017 when she went off work on medical leave. In particular, she said she had difficulty working on computers and doing online charting due to the glare from the computer. She testified that when she came to the ACE Unit, online charting for patients had been recently implemented. She said that when she was documenting her patients' medical updates in their electronic charts, and in particular during her training with VG on how to properly chart, she struggled with being able to see properly. She said she frequently had to spend extra hours before and after her nursing shift trying to finish her charting. RR also testified that she often asked other nurses to double check the medications she was administering to her patients, because she was worried that she was going to make a mistake.

[170] In the analysis of disability above, I have found that RR's advancing cataracts functionally limited her ability to perform some of her nursing tasks such as reading patient charts. I have also highlighted the September 29, 2017, ophthalmologist report in which RR indicated to her doctor that she believed that a recent medication error she made was attributable to her poor eyesight. I further accept RR's evidence about the difficulty she was having with charting specifically because of the glare from the computer screens, and her evidence about repeatedly asking other nurses to double check she was giving the right medication. Given there is no dispute that the Respondents' concerns with RR's charting and medication errors she made factored into their decisions to pull her from practice and report her to the College, I find that RR has proved the requisite connection between her vision disability and the adverse impacts she experienced.

Back Issues

[171] I come to a different conclusion with respect to RR's back issues. RR testified that her back issues caused her to have difficulty lifting heavy patients and performing repetitive tasks that required repeated bending and stooping. This evidence is supported by the limitations Dr. Borji set out in the May 4 Assessment. RR said that because of her back issues, she was slower at looking after her patients, and had to ask for help with the heavier tasks. In the assessment of disability above, I have found that RR was functionally limited by her back disability in certain areas of her nursing practice. I accept her evidence that she had to ask for help with heavier tasks, and that as a result, she was slower at completing those tasks. I also accept that because of her limitations she was likely slower overall at looking after her patients.

[172] However, I find that RR has not proved that her functional limitations relating to her back disability were connected to the Respondents' decisions to pull her from practice and report her to the College. As I have already identified above, the Respondents' concerns with RR's practice were not related to the pace at which RR was working. When RR was pulled from practice and reported to the College, it was due to concerns with her charting, communication with patients, improper use of medical equipment, inadequate medication checks, medication errors, improper sterilization techniques, improper swabbing techniques, improper administration of medication without a doctor's order, and failure to escalate care for a very sick patient.

[173] While at one point VG documented that RR "failed to complete assigned tasks", it does not appear that VG's concern with RR's failure to complete her tasks was due to RR's pace. Rather VG's evidence about her concerns about RR not completing tasks focussed on RR's failure to chart specific information about patients even after she told VG she had done so. Further, VG testified that she was aware RR had recently come back to work after being off with a back injury, but that she and RR did not do a lot of physical patient care and she was available to help RR with any physical patient care issues. Thus, it is unlikely that her reference to RR's failure to complete tasks was related to RR being slower because of her limits with respect to physically looking after patients.

[174] Ultimately, I accept RR's evidence that she had physical limitations with respect to her back and that she did not perform some of the more physical work on the ACE Unit as fast as other nurses. However, I find she has not proved that her physical limitations in relation to her back factored into the Respondents' decisions to pull her from service or report her to the College.

[175] Given my finding that RR has proved a connection between her vision disability and the adverse impacts she experienced in employment, I move on to consider whether the Respondents have proved that their conduct in suspending RR from service and reporting her to the College was justified.

D. Was the Respondents' Conduct that Adversely Impacted RR Justified?

[176] To justify their conduct, the Respondents must satisfy the test for a *bona fide* and reasonable justification under s. 13(4) of the *Code*. To do so, they must prove (1) they suspended RR from service and reported her to the College for a purpose rationally connected to the performance of her job, (2) they did so in an honest and good faith belief that it was necessary to the fulfillment of that legitimate purpose; and (3) their conduct was reasonably necessary to the accomplishment of that legitimate purpose; meaning there were no reasonable or practical steps they could take to avoid adversely impacting RR. This third element encompasses the Respondents' duty to accommodate RR to the point of undue hardship: *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union (Meiorin Grievance)*, 1999 CanLII 652 (SCC), [1999] 3 SCR 3, at para 54.

[177] With respect to the third element of the test, it is not only an employer who has a role to play with respect to accommodation. An employee has an obligation to make their employer aware that they have a disability that requires accommodation: *Central Okanagan School District No. 23 v. Renaud*, 1992 CanLII 81 (SCC), [1992] 2 SCR 970. Where an employer has no way of knowing that a complainant requires accommodation, there are no "reasonable or

practical” steps they can take to avoid the adverse impact: *Klewchuk v. City of Burnaby (No. 6)*, 2022 BCHRT 29, at para, 372.

[178] The Respondents say that they intervened into RR’s nursing practice, including by suspending her and reporting her to the College, because they were seriously concerned about the safety of the vulnerable patients on the ACE Unit. The evidence from all the witnesses, including RR, was that the patients on the ACE Unit are among the most vulnerable patients in the hospital, and patient safety is of paramount importance when working with them. Further, in the analysis of discriminatory harassment above, I have already found that the Respondents’ concern that RR’s nursing practice put patients at serious risk of harm was legitimate, and that they intervened into her practice in a good faith effort to support her and protect patient safety.

[179] Therefore, the Respondents have proved the first two elements of the justification defense: (1) that they pulled RR from practice and reported her to the College due to patient safety concerns, and that patient safety is rationally connected to the performance of RR’s job as a nurse; and (2) that they pulled RR from practice and reported her to the College in an honest and good faith belief that doing so was necessary to protect patient safety.

[180] As I explain below, I further find that the Respondents have proved the third element of the test. This is because despite being provided with multiple opportunities to do so, up until September 25, 2017, RR never advised her managers, human resources representatives, disability management representatives, or even her union, that she had vision limitations arising from her advancing cataracts that required accommodation. Absent RR telling them, the Respondents did not know, and could not reasonably have known that RR had vision issues that required accommodation. Therefore, there were no reasonable or practical steps they could have taken to avoid adversely impacting her by removing her from practice.

[181] Further, even after September 25, 2017, when RR’s Doctor advised the Respondents that she had advancing cataracts, I do not find that FHA ought reasonably to have questioned whether RR’s cataracts were connected to the practice concerns they had identified. This was

because RR consistently advised the Respondents the practice concerns were embellished or fabricated, and the only reason she was having difficulty at work was because she was being bullied. Further, and in any event, the majority of the practice concerns the Respondents had identified did not have to do with RR's vision. Because the Respondents had no reason to know that RR's vision issues required accommodation beyond an approved medical leave, there were no reasonable or practical steps the Respondents could take to avoid adversely impacting RR by submitting the letter of concern to the College.

[182] The following reasons explain my findings in relation to the third element of the justification defense.

[183] RR' evidence was that she made the Respondents aware of her vision disability and need for accommodation in four ways:

1. through email correspondence with Mr. Dragt which advised of an upcoming ophthalmologist appointment;
2. through the May 4 Assessment which referenced her need for "raughling" glasses;
3. through a conversation with VG in which she advised VG she had cataracts and might require surgery; and
4. through the September 2017 letter from Dr. Peach advising the Respondents that RR had advancing cataracts and was being referred to an ophthalmologist,

[184] I deal with each in turn.

1. Email Correspondence with Mr. Dragt

[185] RR testified that in the context of her correspondence with Mr. Dragt about his request for a physical and cognitive assessment, she told Mr. Dragt that she had an upcoming ophthalmologist appointment. In support, she points to an email chain between herself and Mr. Dragt in early February 2017.

[186] On February 3, 2017, Mr. Dragt emailed RR and asked her about the status of the medical assessment that FHA had requested she undergo. He also reminded RR that she and the BCNU had agreed to meet with him prior to her return to work to discuss whether the medical assessment revealed anything that would impact her ability to perform her nursing duties on the ACE Unit.

[187] On February 6, RR replied as follows:

Carl: I'm following the instruction. My GP is semi-retired. **My Ophthalmologist appt will be March 13.** Sorry for delayed response, just found this email went to junk mail. [emphasis added]

[188] On February 7, Mr. Dragt wrote back and advised that RR could not return to work until she provided the "health and cognitive medical assessment", and told her that "the Ophthalmologist appointment is above and beyond this".

[189] I accept that RR advised Mr. Dragt on one occasion that she had an upcoming appointment with an ophthalmologist. However, this was not sufficient to bring the Respondents' attention to her vision disability or its need for accommodation.

[190] Mr. Dragt testified that he did not know why RR had mentioned an ophthalmologist appointment in her email. He further testified, and RR does not dispute, that when he met with her on January 13 to discuss any possible health reasons for her practice issues, RR never raised her vision as an issue that she was having difficulty with. In addition, after her February 6 email, RR never advised Mr. Dragt about the reason for the ophthalmologist appointment, the outcome of the appointment, or the fact that she had advancing cataracts.

[191] It is also important that the physical and cognitive assessment that Mr. Dragt had requested from RR was the Respondents' direct response to concerns that there may have been some health-related explanation for RR's practice issues. The medical assessment and nexus letter was designed to allow RR to raise her vision issues as something that needed to be accommodated. Instead, RR altered the nexus letter and frustrated the Respondents' attempt at investigating whether there were any health issues that required accommodation. In her

alterations to the letter, which RR testified were meant to explain the context for the allegations against her to her doctor, RR did not include any information about her difficulty seeing due to her cataracts.

[192] Through Mr. Dragt's January 13 meeting with RR, and through provision of the nexus letter to RR's treating physician, the Respondents did their due diligence by directly asking RR whether there were any health-related issues connected to the practice issues they had been observing. RR did not raise her cataracts condition as a health-related issue that may have been connected to the practice issues. Instead, she denied having any practice issues or deflected responsibility for the observed issues. In this context, RR's one brief mention of an ophthalmologist appointment in her February 6 email, before completion of the nexus letter, was not sufficient to make the Respondents' aware she had a vision disability that may have required accommodation.

2. Vision Limitation Regarding "Raughling" Glasses

[193] In addition to her email to Mr. Dragt, RR points to the May 4 Assessment and says that Dr. Borji indicated in that document that she uses "raughling" glasses, not "reading" glasses. RR testified that raughling glasses are special glasses that reduce blue light glare.

[194] I reject RR's evidence on this point. First, the word appears to me to be "reading" and not "raughling". Second, there is no explanation beside the words reading/raughling glasses, which I would expect to be the case if there were specialty glasses that were required to accommodate RR's vision. Third, RR did not provide any documentary evidence, such as a prescription or doctor's note explaining what raughling glasses are, nor did she explain whether or how she used them. Finally, as the Respondents point out, an internet search of the word raughling or similar words in the context of glasses, glare, or lenses does not yield anything resembling the word raughling.

[195] Even if the May 4 Assessment did reference that RR used raughling glasses, that would not be enough to bring the Respondents' attention to the fact that RR had a vision disability that required accommodation. The only vision limitation set out in the May 4 Assessment was

the use of glasses. Many people use corrective lenses. There was no indication from Dr. Borji that RR had cataracts and could not read or see properly. In fact, RR has not provided evidence demonstrating that anytime before the medical questionnaire filled out by Dr. Peach on September 25, 2017, any of her doctors indicated she had any physical restrictions or limitations associated with her vision.

[196] The August 29 Assessment completed by Dr. Borji indicated RR's medical condition was due to stress in the workplace, and there was "no restriction in her [physical] function". Similarly, the September 4, 2017 Assessment completed by Dr. Peach indicated that RR's medical leave was due to anxiety and depressive symptoms, and she did not have any physical restrictions or limitations.

[197] The lack of medical information indicating any limitations with RR's vision was confirmed by Ms. Sloboda, who testified that the Respondents did not receive any medical information or notification of RR's cataract issues until September 25, 2017, which was about two months after RR stopped working on the ACE Unit. She testified that as soon as the disability department found out about RR's cataracts and upcoming surgery, RR was permitted to remain off work and supported in her application for LTD benefits.

3. Comments to VG about Cataracts

[198] In addition to the above, RR points to her evidence that during the eight supernumerary shifts, she told VG that her eyes were burning, and requested an accommodation to a different Unit. VG corroborated RR's testimony and said that on one occasion RR told her she had cataracts that might require surgery, and that she wanted to transfer to a different Unit. VG testified, and RR did not dispute, that she told RR that she did not have the authority to transfer RR to a different unit, and that RR should talk her manager, IL, about her situation.

[199] I am not persuaded that this exchange, in isolation, or together with other evidence, demonstrates the Respondents either knew or ought to have known that RR had vision issues that required accommodation.

[200] First, VG was not RR's manager or supervisor, nor did she hold responsibility with respect to FHA's human resources or disability departments. It is clear that by June 2017, when RR was working with VG, RR knew how to report her physical limitations to the appropriate people within FHA. She had reported two back injuries and been accommodated with medical leaves for both of them, so I find it unlikely that RR believed that by telling a CNE about her cataracts she was properly informing her employer about a need for accommodation.

[201] Second, the evidence demonstrates that RR never spoke to IL, anyone from the Respondents' human resources or disability department, or even her own union representatives about her need for an accommodation for her vision issues.

[202] RR met with IL twice in June 2017, on the 12 and 26, to discuss her practice issues and what could be done for her at work to support her to succeed. IL testified that RR did not raise her vision issues at either of those meetings.

[203] Ms. Gill was also present at the June meetings. She had difficulty remembering what took place at the meetings. However, when she was taken to her meeting notes, she confirmed that if something was not documented in her notes, then it was not discussed at the meeting. Further, in cross-examination, she testified that she was unaware of any medical information relating to RR's cataracts condition having been provided to the Respondents before the September 25, 2017 letter from Dr. Peach.

[204] Contemporaneous notes taken by both FHA representatives and BCNU representatives during the June 12 and 26 meetings do not reference RR's vision issues or cataracts. In fact, the notes of the June 12 meeting indicate that RR raised concerns about her comfort level with online charting and mentioned that she believed others were having similar issues. RR does not appear to have raised this issue in the context of vision issues, but rather in the context of the new online charting system. According to the notes, IL responded to her concerns with suggestions about how working with VG would give her the opportunity to work with the new charting system and develop her skills using it.

[205] The notes documenting the June 26 meeting set out, again, that online charting was raised as an issue with RR's practice. The notes detail that RR thought she was doing okay, but needed a bit more support on the care planning part of charting. In contrast, IL and VG raised concerns with RR's failure to chart important information in relation to patients. Despite the lengthy discussion of the online charting issue, the notes do not contain any information about RR's cataracts, vision issues or need for accommodation.

[206] The evidence demonstrates that the Respondents provided RR with multiple opportunities to identify any health issues that were impacting her work while she was working with VG on the ACE Unit. Despite these multiple opportunities to raise her vision issues, RR did not do so. As such, even though she mentioned her cataracts to VG on one occasion, and said she may need surgery, that is not enough to override what she advised her managers, disability management representative and union representatives, which was, effectively, that the only reason she was having issues on the ACE Unit was because she was being bullied and harassed, not because she had any issues with her ability to see.

4. *Dr. Peach's September 2017 Letter*

[207] There is no dispute that after September 25, 2017, at least the FHA disability department was aware that RR had advancing cataracts and had been referred for an ophthalmological assessment. Given FHA, as RR's employer, was aware that RR had an advancing cataracts issue when IL submitted the letter of concern to the College approximately one month later, the question arises as to whether there were any reasonable or practical steps FHA or IL could have taken at the time to avoid adversely impacting RR through submission of the letter of concern. I find there were not.

[208] First, I find more likely than not that IL was unaware of RR's advancing cataracts when she submitted the letter of concern to the College. She testified that the FHA disability department dealt with employee's medical information, and that as RR's manager, she was not provided with specific medical information about the nature of RR's disability when she went on leave. Her testimony was supported by email correspondence between her and the FHA LTD

case manager in late October 2017. In that correspondence, IL responded to a question about the nature of RR's disability and advised that she was unaware of RR's disability at the time. Further, a September 15, 2017 email from Ms. Sloboda to IL indicates that Ms. Sloboda advised IL that RR would be off for a minimum of eight more weeks, and that she had filed a complaint with WorkSafe BC alleging bullying and harassment. IL testified that she knew from Ms. Gill that RR was seeing a cardiologist, and that she believed at that time that the likely reason RR was off was due to the alleged bullying and harassment.

[209] Even if IL had been aware that RR had advancing cataracts, and given that at least the disability department of FHA was aware of RR's cataracts condition, there was still no reason for IL, or anyone at FHA, to question whether RR's cataracts condition required accommodation beyond allowing her to take a medical leave until her eye issues resolved. This is because RR never indicated, before or after September 2017, that her cataracts condition was affecting her practice.

[210] As I have already set out, RR was provided with numerous opportunities, before September 25, 2017, to advise IL, the FHA disability department, the FHA human resources department, her BCNU disability management representative, or her BCNU steward that her cataracts condition was contributing to her performance issues, but she did not.

[211] In fact, even after RR went on medical leave, and she met with IL, and FHA's and BCNU's disability management representatives on September 17, 2017, for the purpose of specifically addressing the medical issues that were preventing her from coming to work, RR did not raise her cataracts or need for any accommodation of her vision issues. Contemporaneous notes taken by the BCNU disability management representative indicate that during the meeting RR requested an accommodation out of the ACE Unit so she could avoid the stress and anxiety that had been causing her cardiac symptoms. The notes do not contain any mention of RR's vision issues.

[212] The context leading up to September 25, 2017, when FHA learned about RR's cataracts condition, was that RR had been continually advising the Respondents and her own union that

the performance issues they were concerned about were fabricated or embellished, and the only reason she was having difficulty at work was because she was being bullied. Further, by this time, it was clear that the majority of RR's practice issues, and the Respondents' main concerns with RR's ability to practice safely, did not have to do with her ability to see. In this context, when FHA did learn that RR had advancing cataracts, there was no reason to question whether RR's practice concerns were connected with her cataracts issues, and it was reasonable for FHA to accommodate RR by allowing her to remain on medical leave and supporting her in her application for LTD benefits. In my view, at that time, there were no other reasonable or practical steps FHA or IL could have taken to avoid the adverse impact on RR of submitting the letter of concern.

[213] I reach the same conclusion even if I were to find that IL or FHA ought to have understood that there could be a connection between some of RR's practice issues and her advancing cataracts. IL reported RR to the College based on numerous serious concerns with her practice, only two of which, medication errors and difficulty with computer charting, were connected to her vision issues. Even if IL had been aware by November 10 that RR had advancing cataracts that could have affected some of the charting errors and some of the medication errors, that would not have explained any of the other very serious concerns with RR's practice. Nor would it have explained the overarching concern that RR was unwilling or unable to acknowledge her errors or take steps to improve her practice.

[214] IL testified that the reason she submitted the letter of concern about RR was because she was leaving her temporary assignment as manager of the ACE Unit and had not yet had an opportunity to work with RR to remediate the numerous significant practice issues that had been identified on the eight supernumerary shifts and seven buddy shifts. She testified that she felt she had a professional obligation as a fellow nurse to report her concerns with RR's nursing practice because those concerns represented a danger to the public. This duty is formally set out in s. 32.2 of the *Health Professions Act*.

[215] The plan for RR after completion of her buddy shifts had been to send her for a formal skills assessment at a Kwantlen Polytechnic University, and IL testified that was her preferred

approach to dealing with RR's ongoing practice issues. However, RR went on medical leave before that assessment and did not return before IL was set to leave as manager of ACE.

[216] I accept that IL understood she had duty to report RR's conduct that posed a serious danger to patients, a duty that would not have been any different even had IL known some of RR's errors may have been connected to her vision issues. IL did not hastily or carelessly report RR's conduct to the College. On the contrary, IL held off on reporting RR until after she had made numerous meaningful attempts to support RR in her practice and discover any underlying reasons for the ongoing practice concerns. Unfortunately, even after multiple, escalating interventions into RR's practice, there were still numerous, unresolved practice concerns that had the potential to cause serious harm, including death, to patients on the ACE Unit. Most of these concerns had nothing to do with RR's ability to see. In this context, and given RR refused to even tell IL or anyone at FHA that she had cataracts that were impacting her ability to see, IL and FHA accommodated RR to the point of undue hardship. There were no additional reasonable or practical steps they could take to avoid adversely impacting RR by submitting the letter of concern.

[217] I make one final point before concluding the analysis of the Respondents' duty to accommodate RR's vision disability. Throughout the hearing and in her submissions, RR argued the Respondents should have accommodated her specifically by transferring her to the PATH Unit. The evidence supports that she asked both Carl Dragt and IL to be transferred to the PATH Unit before she went on leave in July 2017. However, the evidence also supports that she asked to be transferred specifically because she was being bullied on the ACE Unit and she needed to be moved away from the people who were bullying her. RR did not provide her managers with any indication that her request for a transfer was due to any issues with her vision. As such, RR's request to be transferred to the PATH Unit was not made in relation to her vision disability, which is the only disability I have found required accommodation. My analysis above with respect to RR's failure to bring her vision disability or need for accommodation to the attention of the Respondents is equally applicable to her argument here that she should have been accommodated specifically by being moved to the PATH Unit. Further, it is difficult to

understand how a move to another unit – simply because it is less acute – would have been a reasonable accommodation given that it would not address the issue of medication or charting errors that may be related to a vision issue.

5. Conclusion on Respondents' Justification Defense

[218] For the above reasons, I find the Respondents have justified their conduct in suspending RR from service and reporting her to the College. As such, they have proved they did not discriminate against RR.

E. Respondents' Application for Costs

[219] The Respondents apply for an order for costs against RR. They say that in her closing submissions RR cited 13 cases that do not exist, and they incurred unnecessary time and expense in attempting to locate and respond to those cases. The Respondents say that when they entered the cases into the language model ChatGPT, summaries that were very similar to the cases RR cited were produced. As a result, they submit that the 13 cases were likely generated through the use of generative AI and do not exist.

[220] In her reply submissions, RR did not respond to the Respondents' application for costs, or the allegation that she referenced and relied on cases that do not exist.

[221] I searched for the 13 cases, by name and by citation, and was not able to locate them. For several of the cases, a valid neutral citation (without party names) existed, but when I read the case, it did not contain the same parties, factual context, or stand for the same legal propositions as set out by RR in her submissions.

[222] The Tribunal may exercise its discretion to award costs under s. 37(4) of the *Code* if it finds there has been improper conduct in the course of a complaint or a breach of a rule or order. This is a punitive power that is meant to safeguard the integrity of the Tribunal's process: *Terpsma v. Rimex Supply (No. 3)*, 2013 BCHRT 3 at para. 102. It aims to punish and deter conduct "which has a significant impact on the integrity of the Tribunal's processes, including conduct which has a significant prejudicial impact on another party": *McLean v. BC (Ministry of*

Public Safety and Solicitor General) (No. 3), 2006 BCHRT 103 at para. 8. Although it is not necessary for conduct to be intentional to amount to improper conduct within the meaning of s. 37(4), a party's intention may nevertheless be a relevant consideration: *McLean* at para 8.

[223] The use of AI tools by parties to assist in the presentation of their cases has increased dramatically over the past several years. This has yielded both positive and negative consequences. On the positive side, people who are self-represented before the Tribunal may have better access to information about legal tests and precedents, and how their specific situation may have been handled by the Tribunal in the past. On the negative side, it has become widely recognised that AI tools frequently generate false information, including fake cases, which can appear to be legitimate.

[224] Recently, the Tribunal has cautioned parties about the responsible and appropriate use of AI tools in the Tribunal's process. In *Duarte v. City of Richmond*, 2024 BCHRT 347, the Tribunal stated that parties appearing before the Tribunal must carefully assess the information that AI tools produce before using such information in the Tribunal process, and that deliberate attempts to mislead the Tribunal, or even careless submission of fabricated information, can form the basis for an award of costs under s. 37(4) of the *Code*. The Tribunal emphasised that the integrity of the Tribunal's process, and the justice system more broadly, requires parties to exercise diligence in ensuring that their engagement with artificial intelligence does not supersede their own judgement and credibility: at para 53.

[225] Similarly, the BC Court of Appeal has recently held that although parties may use AI tools to assist them in the Court's process, "like any litigation aid, the human behind the tool remains responsible for what comes before the Court": *Wu v. Murray*, 2025 BCCA 365, at para. 14.

[226] In the present case, I do not believe RR purposely attempted to mislead the Tribunal or the Respondents. Further, the Respondents have not alleged that RR has breached any Tribunal rule, order, or policy. The Tribunal does not yet have a published policy regarding the use of AI tools in its process, or information cautioning parties about its use. Although the Tribunal has

published one decision that talks about the improper use of AI tools in closing submissions, I do not expect that RR, as a self-represented person without legal training, would have known about that decision.

[227] Further, although RR included numerous fake cases in her submissions, and although the Tribunal and the Respondents were required to expend resources to establish that the cases were not valid, it cannot be said that either the Respondents, or the complaint resolution process more generally, were significantly prejudiced. In the present situation, it was RR who was most prejudiced by her use of the fake cases. This is because the Tribunal could not rely on the majority of the legal propositions she cited, or the factual contexts from the fake cases that she said resembled the context in her own complaint.

[228] Ultimately, in these circumstances, I do not find that RR's inclusion of the fake cases amounts to improper conduct warranting an order of costs. As such, I decline to exercise my discretion to award costs against RR for improper conduct. These reasons should not be taken to condone the inclusion of fake cases with a party's submissions or suggest that in other cases an order for costs would not be appropriate.

V CONCLUSION

[229] For the above reasons, I dismiss RR's complaint against the Respondents, and I deny the Respondents' application for costs against RR.

Shannon Beckett
Tribunal Member