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(Winnipeg Centre)
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COURT OF QUEEN'S BENCH OF MANITOBA

B E T W E E N:

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	)	
plaintiff,	)	MARK H. TOEWS
	)	for the plaintiff
- and -	)	
	)	
SEVEN OAKS GENERAL HOSPITAL,	)	MICHAEL T. GREEN
	)	for the defendant
defendant.	)	
	)	JUDGMENT DELIVERED:
	)	May 29, 2017

LANCHBERY J.

[1] The plaintiff is suing the defendant for wrongful dismissal, general damages, income and pension loss, aggravated and punitive damages as well as solicitor and client costs. The cause of action is alleged to have arisen as a result of a January 20, 2012 incident where the plaintiff removed the oxygen supply from an oxygen dependant patient (K.D.). To protect the privacy of the family, the now deceased patient shall be referred to as K.D.

[2] The defendant determined that just cause existed for the termination of the plaintiff's employment due to her actions in removing the oxygen supply from K.D.

SCOPE OF EMPLOYMENT

[3] The plaintiff had 25 years of nursing experience at the time her services were terminated by the defendant. The plaintiff's resume (Exhibit 1 – Tabs 2 - 3) can only be described as impressive. Her professional experience includes patient care, palliative care and ethics training combined with teaching ability.

[4] The plaintiff, in 2004, was hired by the defendant to be the Patient Care Team Manager. She held this position until her date of termination. The description of the plaintiff's duties are as follows:

> In conjunction with the Program Director, carries out the administrative functions of planning; organization; leadership; coordination and evaluation of patient care services; human resources management; fiscal management; information and environment control in assigned Program. Ensures that optimal patient care is provided in accordance with the mission statement, philosophy and objectives of the Program and the Hospital and with all professional standards of care. Develops, implements and evaluates Program policies and procedures. Utilizes clinical knowledge, management and leadership skills. Replaces the Program Director during absences.

[5] Much of the evidence heard during the trial related to the professional standards of a registered nurse. However, to determine whether the defendant acted with just cause, I must analyze whether just cause existed, and that termination was the appropriate remedy considering all of the plaintiff's duties as a Patient Care Team Manager.

NOTICE OF TERMINATION

[6] The reasons for the plaintiff's termination were outlined in the defendant's letter dated March 8, 2012 (Exhibit 1 – Tab 4). The letter reads in part:

> From our discussion with you, you had identified that after the event occurred you recognized the action you took was wrong however you never reported this to your supervisor.
>
> Your decision to hasten the end of a patient's life is not your decision to make and you failed to consult with anyone with respect to this patient's end of life care. It would be an expectation of a Registered Nurse that you would understand the clinical ramification of removing oxygen from an oxygen dependent patient; it is as equally as concerning that you removed the oxygen and immediately left the room. Furthermore removing oxygen that was applied based on physician orders is a direct violation of your role as a Registered Nurse and the CRNM practice standards. You also failed to notify your Employer of this error. Your conduct has demonstrated a lack of insight, extremely poor judgement, specifically for a nurse with over 25 years' experience and who has ethics training. Your actions have confirmed the absence of your understanding of your managerial role as a clinical supervisor of nurses under your direction.
>
> Your conduct cannot be tolerated and is unacceptable and has irrevocably broken the trust the Employer requires for ongoing employment.

BACKGROUND

[7] The facts in this case are not in dispute. There are nuances in the testimony that will be expanded upon during the analysis. However, the facts that led to the termination are as follows:

- K.D. was an oxygen dependent patient.
- K.D. had been hospitalized since September 2011.
- A discharge plan had been developed, but K.D. could not be discharged to her own home.

- On the morning of January 20, 2012, K.D.'s condition had deteriorated to the point that she was nearing the end of her life.
- K.D. did not execute an advanced heath care directive.
- K.D. had a life partner who had earlier indicated to hospital staff that he was unable to cope with K.D. reaching the end of her life and only wanted to be notified when she passed.
- K.D.'s partner was not consulted about K.D.'s end of life wishes.
- The palliative care team had not discussed K.D.'s end of life care.
- On her own initiative, the plaintiff removed the oxygen supply from K.D.
- After removing the oxygen supply from K.D., the plaintiff exited the room. Consequently, she was unable to monitor K.D.'s response to the removal of the oxygen supply.
- The plaintiff left the ward where K.D. was located to complete the rounds in another ward within the hospital.
- Helen Holbrook ("Helen"), the Spiritual Care Coordinator, was in the room when the plaintiff removed the oxygen supply from K.D. and remained in the room for a period of time thereafter.
- Some minutes elapsed before Joe Lelay ("Joe"), an LPN, entered K.D.'s room.
- Joe observed that the oxygen switch was in the off position.

- Helen and Joe testified that K.D. showed signs of distress when she was off the oxygen supply, such as flailing her arms and gasping for air. This is described as "air hunger".
- Joe returned the oxygen switch to the on position.
- Joe remained in K.D.'s room after turning on the oxygen to observe and evaluate K.D.'s condition. Both Joe and Helen testified that K.D. immediately began to settle.
- After K.D. settled, Joe exited the room to continue his appointed rounds.
- After Joe left the room, Helen remained with K.D. for a period of time that may have been as much as ten minutes.
- After this period of observation, Helen left the room and went to the nursing station to initiate a NODA (No One Dies Alone) protocol for K.D. as K.D.'s partner indicated that he would not be returning to the hospital.
- While Helen was at the nursing station the plaintiff returned to the ward and enquired "who put the oxygen back on [K.D.]?"
- Helen advised the plaintiff "that a nurse did".
- The plaintiff acknowledged that placing the oxygen back on K.D. was the correct action to have been taken and indicated that the morphine prescribed by the physician should be administered.

- The plaintiff, Helen and Joe all failed to chart the removal of the oxygen supply from K.D. or that it had been reinitiated.
- K.D. passed the next day.

ADDITIONAL EVIDENCE

[8] The plaintiff testified that upon leaving K.D.'s room, she advised a nurse at the nursing station that K.D.'s oxygen supply had been removed. I do not accept this evidence. The plaintiff was very clear during her testimony as to others on the ward that day, but could not recall the name of the person she had spoken to at the nursing station. There would have been a limited number of nurses on duty that day and this could have been canvassed, but was not. If this conversation had occurred it should have been documented in the patient's chart. It was not. I heard much during the evidence and in argument that "if it is not in the chart it did not happen". I accept that by not placing this information in the chart, the conversation with someone at the nursing station, as testified to by the plaintiff, did not occur

[9] Helen testified as to her thought process in the days that followed the removal of the oxygen supply from K.D. Helen's evidence was that she believed something was amiss. She had difficulty reconciling her spiritual beliefs with what she had witnessed. I accept her explanation that this was a significant ethical dilemma that caused her to relive the incident over and over during the weekend that followed. I also accept that Helen was "working through" her ethical dilemma prior to reporting the incident. I find that Helen was a credible and reliable

witness. Her testimony reflected what one would expect from a spiritual advisor who was struggling with an ethical issue as she lacked experience in what a nurse's duties were at the end of a patient's life.

[10] I accept Helen's evidence as to the proper method to address ethical concerns. Further, I accept that the removal of an oxygen supply was not something that she had observed previously with any patient, and she was unaware of why this occurred. Upon speaking with an expert in ethical issues, Helen was able to determine her next steps. The suggestion was that she should speak with Krista Williams ("Krista"). Krista is a registered and was the Program Director for Family Medicine at the Seven Oaks Hospital. As the Program Director, she was the plaintiff's immediate supervisor.

THE INVESTIGATION

[11] Through a series of events, including Krista's vacation schedule and Krista's need to reschedule a meeting that it was only on February 29, 2012 that Helen was able to share with Krista her concerns about the events of January 20, 2012. Although regrettable, I find the delay in the meeting between Helen and Krista to be understandable.

[12] Upon receipt of Helen's disclosure, Krista arranged to interview the plaintiff in order to secure her version of the January 20, 2012 event. All of this is in keeping with proper investigative requirements. The meeting with the plaintiff occurred on March 2, 2012. The plaintiff confirmed the facts as previously outlined.

[13] A further meeting took place between Krista and the plaintiff on March 5, 2012. Once again, the plaintiff confirmed the facts as I have found them to be. For completeness, there were nuances in the testimony that are outlined in the plaintiff's position regarding whether just cause existed for her dismissal which are not significant to my findings.

[14] A further meeting was held on March 6, 2012 involving the plaintiff, Krista, Vivian Painter, Chief Nursing Officer of the defendant, and Jordan Froese, Human Resources Officer of the defendant. At this meeting, the defendant advised the plaintiff that due to the events of January 20, 2012 her services were no longer required. The plaintiff testified that she was given the choice to either resign or be dismissed.

[15] The plaintiff testified that at this meeting she had requested, and been offered, that if she resigned she would be given a reference. The plaintiff also testified that she was aware the defendant would be reporting her actions to the College of Registered Nurses of Manitoba ("CRNM") for consideration.

[16] In anticipation of what may occur, the plaintiff had already removed her personal belongings from her office. She testified that she had a feeling about what was about to occur and she did not want to be walked out of the building by security carrying her belongings. The plaintiff's evidence was that if she was not terminated she could return her personal belongings to her office.

[17] The next day, Krista and Jordan Froese telephoned the plaintiff to enquire whether she had reached a decision. The plaintiff advised that she was consulting

a lawyer, and was concerned about the reference to CRNM and her ability to maintain her nursing licence.

[18] The defendant determined that as a result of this response, resignation would no longer be afforded to the plaintiff. A letter of termination dated March 8, 2012 was drafted and forwarded to the plaintiff.

CONFLICTING EVIDENCE ON THE METHOD OF OXYGEN DELIVERY

[19] The method employed to deliver oxygen to K.D. was explored during the trial. The plaintiff testified that the delivery method was by full facial mask. She testified that by removing the mask, K.D.'s dignity and comfort would be enhanced as she neared death. The patient chart referenced oxygen delivery by nasal prongs. The plaintiff testified during her examination for discovery that the delivery method was by nasal prongs (read-ins from the plaintiff's examination for discovery transcript (Questions and Answers 91 – 101)).

NURSING STANDARDS

[20] During trial testimony, the following nursing standards were identified:

a) A nurse does not have authority to prescribe or discontinue any medication or service authorized by a physician.

b) Oxygen is a medication.

c) It is proper practice for a nurse to titrate oxygen as prescribed by a doctor.

d) It is proper practice to observe a patient following a change in treatment and document those observations in the patient's chart.

PLAINTIFF'S POSITION AS TO JUST CAUSE

[21] The plaintiff has always maintained that the events of January 20, 2012 are illustrative that she did not intend any harm to K.D. She testified that all she was doing was providing K.D., who was at the end of her life, the opportunity to die with dignity and to experience a compassionate death. The plaintiff testified that K.D. was a smaller woman and had difficulty managing the full facial mask. She and her expert, Dr. Daeninck, testified that a mask may interfere with the interaction between the patient and loved ones. Each testified as to the benefits of palliative care to a patient nearing the end of life.

[22] I accept that there are times when a palliative patient may have the oxygen supply discontinued as they approach death. I find Dr. Daeninck's expert opinion (Exhibit 1 - Tab 9) is confirmatory of this point. Throughout his testimony, Dr. Daeninck referred to palliative care as being a team-based approach. In his testimony and in his report, he stressed the importance of the patient being able to make end of life decisions, and in the event that the patient was unable to make decisions about end of life care, that the substitute decision maker, if one exists, be consulted. If one does not exist, the family will be consulted as to the end of life care.

[23] Dr. Daeninck also testified that a patient might experience difficulties with a breathing mask, such as becoming tangled in the apparatus, or with vomiting into

the mask. He also noted that family members may request removal of the oxygen supply to permit personal interaction with the palliative patient as they near death.

[24] I accept the plaintiff's evidence that she expressed a willingness to learn from the incident. I also accept her evidence that she attempted to contact other health care providers because she was surprised that K.D. would react to the removal of the oxygen supply in the manner she had.

[25] The plaintiff argues that it is this willingness to learn from the incident that should have caused the defendant to discipline her, and that dismissal was not warranted.

DEFENDANT'S POSITION

[26] The defendant argued that based upon the events as described, it was well within its authority to dismiss the plaintiff.

ANALYSIS

[27] Those employed in management serve at the pleasure of the employer. However, it is equally true that a wrongful dismissal claim may be advanced against an employer if the termination circumstances warrant.

[28] The Supreme Court of Canada in ***McKinley v. BC Tel***, 2001 SCC 38, [2001] 2 S.C.R. 161 ("***McKinley***"), considered the situation where a single act of dishonesty could result in the employee's termination. Although the circumstances are not dishonesty per se, the principles enunciated are relevant.

Those principles as stated by the Supreme Court are:

> 48 I am of the view that whether an employer is justified in dismissing an employee on the grounds of dishonesty is a question that requires an assessment of the context of the alleged misconduct. More specifically, the test is whether the employee's dishonesty gave rise to a breakdown in the employment relationship. This test can be expressed in different ways. One could say, for example, that just cause for dismissal exists where the dishonesty violates an essential condition of the employment contract, breaches the faith inherent to the work relationship, or is fundamentally or directly inconsistent with the employee's obligations to his or her employer.
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> 49 In accordance with this test, a trial judge must instruct the jury to determine: (1) whether the evidence established the employee's deceitful conduct on a balance of probabilities; and (2) if so, whether the nature and degree of the dishonesty warranted dismissal. In my view, the second branch of this test does not blend questions of fact and law. Rather, assessing the seriousness of the misconduct requires the facts established at trial to be carefully considered and balanced. As such, it is a factual inquiry for the jury to undertake.

[29] I must determine whether, based on a balance of probabilities, the evidence establishes that the plaintiff's action violated the terms of her contract such that a single action performed by her establishes just cause for her dismissal.

[30] I am aware that the loss of employment has adverse mental and physical health consequences for an employee whose employment is terminated without notice. This is one of the factors I must also consider in reaching my decision.

[31] I find that the plaintiff's actions are as follows:

a) Removal of the oxygen supply from an oxygen dependent patient without a doctor's order to do so.

b) Leaving K.D. without assessing or observing the effects of the removal of the oxygen supply.

c) Failure to document the removal action and any observations in the chart.

d) Failure to report this incident to an immediate supervisor.

[32] This is one of those rare occasions where one could easily employ the legal maxim *res ipsa loquitor*; the plaintiff's actions speak for itself. The plaintiff's actions are an undisputed failure of the professional standards a registered nurse is expected to adhere.

[33] The next question to be answered is whether these actions rose to the level of just cause for termination as the Patient Care Team Manager.

[34] Much of the testimony and submissions concentrated on the actions of CRNM and its appointed Investigation Committee report into the plaintiff's actions. (Exhibits 10 - 12) The Discipline Committee of CRNM did not take disciplinary action against the plaintiff.

[35] I find that the incident in question was investigated by CRNM, and prior to the results of that investigation being placed before the Discipline Committee, the plaintiff was offered, in accordance with CRNM practice, an alternate form of resolution. This was the signing of an undertaking. I accept the plaintiff's evidence that she signed the undertaking (Exhibit 12), although a signed copy of the undertaking was not entered into evidence. The undertaking provided in part for remedial education.

[36] Each party argued the weight I should give to the CRNM reports and the plaintiff's undertaking. I find this to be an ancillary issue. The plaintiff's duties and responsibilities were far more than that of a registered nurse. She was the

Patient Care Team Manager. Therefore, I give the report and undertaking very little weight.

[37] Her duties as set out in her job description state:

> Ensures that optimal patient care is provided in accordance with the mission statement, philosophy and objectives of the Program and the Hospital and with all professional standards of care.

[38] The plaintiff was to ensure optimal patient care. The removal of the oxygen supply from an oxygen dependent patient could never be considered or regarded to be optimal patient care. The decision to remove the oxygen supply was made by the plaintiff alone. Optimal palliative care would have involved the family and the health care team, not a solo action taken by the Patient Care Team Manager.

[39] The plaintiff failed to follow the professional nursing standards of care, whether those are general care, or in denying an oxygen supply to an oxygen dependent patient without instructions from a physician to do so, or in offering what the plaintiff determined to be palliative care without any involvement from K.D.'s family or K.D.'s health care team.

[40] I find that oxygen delivery was by nasal prongs. The only time the possibility of full mask delivery was raised was during the trial. The plaintiff testified at her examination for discovery that delivery was by nasal prongs. I find that the plaintiff's change in her testimony on the oxygen delivery method is a veiled attempt to rationalize her decision to provide K.D. with comfort and dignity at the end of her life. On this point her evidence is unbelievable.

[41] The plaintiff testified that she was unaware that removing the oxygen supply from an oxygen dependent patient could cause death. Such a statement is incredible. K.D.'s chart (Exhibit 1 – Tab 13) contains references where attempts to titrate K.D's oxygen were made to determine if K.D. could be removed from the oxygen supply so she could breathe room air without assistance. This had led to quick, precipitous, unsafe drops in blood gas levels. The plaintiff, Krista, Dr. Daeninck, Vivian Painter (Krista's immediate supervisor who is a registered nurse), and Colleen Simon (the defendant's expert who is a registered nurse) all testified that K.D. could not have maintained proper oxygen levels on room air alone. This conclusion was based on their review of K.D.'s chart. This is why K.D. was described as oxygen dependent.

[42] The plaintiff's evidence was that titration of oxygen levels are performed by a nurse. Titration is the process of adjusting oxygen levels to ensure the maintenance of proper oxygen saturation levels by increasing or decreasing the amount of oxygen flowing to the patient.

[43] The plaintiff's stated knowledge on this topic included an awareness of the effect that changes in oxygen titration would have on a patient's oxygen saturation. Her evidence on this point may have been credible if she had remained in the room following the removal of oxygen to determine the effect on K.D.'s oxygen saturation. I find it difficult to believe that proper titration could ever involve the total removal of an oxygen supply from an oxygen dependant person without a doctor's order to do so and without actively observing and

assessing the patient's reaction to the removal. The plaintiff did neither. Therefore, I find her evidence on titration of K.D.'s oxygen supply not to be credible.

[44] It is most troubling that the plaintiff testified that she wanted to learn from this experience. Her actions were far below the knowledge base one would expect from a nurse with 25 years of nursing experience and who was expected to provide optimal patient care of the highest professional standards.

[45] The plaintiff argued the fact that Helen's and Joe's failure to chart the incident was beneficial to her position. I find it is never acceptable to blame one's mistakes on someone else. The plaintiff was the most senior person involved in the January 20, 2012 incident. The plaintiff removed the oxygen supply. She did not document her actions and she left the room following its removal without assessing or observing K.D. Whether others made the same error is not supportive of the plaintiff's position. What is at issue is whether her failure to chart the removal of the oxygen supply could be considered optimal patient care of the highest professional standard. I find that it was not.

[46] The plaintiff submitted the evidence could reasonably be interpreted that her absence from the room amounted to only 10 minutes from the time the oxygen supply was removed from K.D. until her return to the ward. The issue is not the length of time she was out of the room, but that the plaintiff did not stay in the room to observe K.D.'s reactions to the removal of the oxygen supply. She did not slip out to the nursing station for a second. She left the ward entirely.

Whether it was 10 minutes or 30 minutes, I find that the plaintiff, by leaving the room, was not providing optimal patient care of the highest professional standard. Further, in making this finding I note that Joe reengaged the oxygen supply before her return to the ward, as he had noted that K.D. was in distress.

[47] The plaintiff's resume shows she completed ethics courses and she testified she was aware of ethical issues. I find that by acting on her own initiative when the ethical standard prohibits her to do so, constitutes a violation associated with providing optimal patient care to the highest of standards.

[48] A hospital is responsible to ensure that patients entrusted in its care receive optimal patient care of the highest professional standard. I find that by failing to provide either acute care or palliative care in keeping with those standards, in the circumstances as outlined, are a breach of the contractual relationship between the plaintiff and defendant such that termination was the only option.

[49] I have concluded that it was the cumulative effect of the actions of the plaintiff that is most troubling. At every stage, the plaintiff failed to demonstrate optimal patient care of the highest standard by the unilateral removal of the oxygen supply from an oxygen dependent patient, the failure to remain in the room to assess K.D.'s reaction to the oxygen removal, the failure to document her actions, the failure to report the incident to her supervisor and the lack of appreciation of the consequences of her actions. The plaintiff's actions fall dangerously below nursing standards in general, but for a Patient Care Team Manager, her actions were totally unacceptable. I find her actions were not

demonstrative of optimal patient care as outlined in her contract with the defendant.

[50] The final factor as outlined in ***McKinley*** is proportionality. The Supreme Court stated as follows:

> 53 Underlying the approach I propose is the principle of proportionality. An effective balance must be struck between the severity of an employee's misconduct and the sanction imposed. The importance of this balance is better understood by considering the sense of identity and self-worth individuals frequently derive from their employment, a concept that was explored in *Reference Re Public Service Employee Relations Act (Alta.)*, 1987 CanLII 88 (SCC), [1987] 1 S.C.R. 313, where Dickson C.J. (writing in dissent) stated at p. 368:
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> > Work is one of the most fundamental aspects in a person's life, providing the individual with a means of financial support and, as importantly, a contributory role in society. A person's employment is an essential component of his or her sense of identity, self-worth and emotional well-being.
>
> This passage was subsequently cited with approval by this Court in *Machtinger v. HOJ Industries Ltd.*, 1992 CanLII 102 (SCC), [1992] 1 S.C.R. 986, at p. 1002, and in *Wallace*, *supra*, at para. 95. In *Wallace*, the majority added to this notion by stating that not only is work itself fundamental to an individual's identity, but "the manner in which employment can be terminated is equally important".
>
> 54 Given this recognition of the integral nature of work to the lives and identities of individuals in our society, care must be taken in fashioning rules and principles of law which would enable the employment relationship to be terminated without notice. The importance of this is underscored by the power imbalance that this Court has recognized as ingrained in most facets of the employment relationship. In *Wallace*, both the majority and dissenting opinions recognized that such relationships are typically characterized by unequal bargaining power, which places employees in a vulnerable position *vis-à-vis* their employers. It was further acknowledged that such vulnerability remains in place, and becomes especially acute, at the time of dismissal.

[51] In balancing the factors as required by ***McKinley*** and considering the principle of proportionality, I find that on the standard of proof being a balance of probabilities, the defendant was more than justified in its decision to terminate the

plaintiff's employment. The very nature of the nursing responsibilities the plaintiff performed, accompanied with her supervisory and educational functions, can only be considered as a dereliction of her duties. I make no finding as to reason for the plaintiff's decision to remove oxygen from an oxygen dependant patient as this is not necessary. Whether accidental, deliberate or any level in-between, the action itself is well outside the expected norm. In applying the principle of proportionality, this does not lessen the result.

[52] Patients in any medical care setting have come to expect that they will be treated with care, dignity, compassion, and with respect to the highest professional standards. The plaintiff by her actions violated every one of those expectations. I acknowledge that termination is the ultimate punishment for any employee, especially in circumstances of a single violation. I find that the actions of the plaintiff more than rise to that level and, therefore, just cause existed.

COSTS

[53] The parties may arrange for further time if they are unable to agree on costs.

PROVISIONAL DAMAGE ASSESSMENT

[54] Notwithstanding my findings, I will make a provisional assessment of damages.

[55] Mr. Gregory Gillis, the plaintiff's expert, provided an estimate of the damages incurred by the plaintiff due to her dismissal. (Exhibit 9) Various scenarios where outlined, including for a one-year severance, a two-year

severance, or severance if she had worked until she was eligible for her full pension.

[56] The parties disagreed whether or not the plaintiff was entitled to carry forward her full years of service when she became a member of management. I accept her evidence that the offer included her right to maintain seniority within the health system.

[57] Notwithstanding that she changed employers within the health system, one must consider that in Manitoba the health system is one entity. The Government of Manitoba, no matter the structure imposed by various health unites, is the only payer. The fact that one changes hospitals does not result in loss of seniority. Nor would changing employment from being governed by a union contract to entering management. The health system encourages advancement of this kind. Therefore, the plaintiff accumulated 25 years of service at the date of dismissal.

[58] During submissions, the plaintiff did not concentrate on severance in lieu of notice until she reached eligibility for her full pension. In the event that this position had been advanced, I note that the plaintiff was able to work in a hospital setting after her termination.

[59] I also find that the plaintiff was able to obtain employment outside the health care field, and as required, she mitigated her damages. I am satisfied that she experienced medical problems following her termination and that these problems did not prevent her from seeking full time employment. In fact, the plaintiff had applied, and obtained a position at Health Sciences Centre within

months of her termination. On her own initiative, the plaintiff obtained employment that she believed she was able to perform.

[60] Considering all the factors, I accept the defendant's position that 26 weeks' severance is reasonable given all the circumstances. Therefore, the defendant shall pay to the plaintiff 26 weeks of salary at the rate she was paid at on the date of termination. In addition, the pension loss would be calculated as per Mr. Gillis' revised calculations. As the termination notice is 26 weeks, pension loss would be one-half of the revised Column B, being $25,001.50.

[61] The plaintiff should also be entitled to pre- and post-judgment interest at the prescribed rate.

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Lanchbery J.