IN THE MATTER OF
A HEARING BY THE DISCIPLINE COMMITTEE OF
THE BRITISH COLUMBIA COLLEGE OF NURSES AND MIDWIVES
PURSUANT TO THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183

BETWEEN:

The British Columbia College of Nurses and Midwives

(the "College" or "BCCNM")

AND:

Laura Atcheson

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Dates:	November 9 – 10, 2020
Discipline Committee Panel:	Sheila Cessford, Chair Edna McLellan, RN (T) Dr. Catharine Schiller, RN
Counsel for the College:	Aisha Ohene-Asante
The Respondent	Self-represented

A. Introduction

1. A panel of the Discipline Committee (the "Panel") of the British Columbia College of Nurses and Midwives (the "College" or "BCCNM") conducted a discipline hearing pursuant to section 38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA") on November 9 and 10, 2020 in relation to the Respondent's conduct (the "Discipline Hearing").

2. For the reasons set out below, the Panel determines that the College has proven the allegations set out in paragraphs 1(a) to (f) of the citation dated June 30, 2020 (the "Citation"), to the requisite standard, and that that conduct constitutes professional misconduct.

B. Background

3. On the first day of the Discipline Hearing, the College advised that it was abandoning allegation 2 in the Citation.

4. The particulars of allegation 1 in the Citation are as follows:

> 1. Beginning on or about September 19, 2016 to September 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed patient medical records without authorization, contrary to one or more of the following Professional Standards and/or Practice Standards: the Responsibility and Accountability Professional Standard, the Ethical Practice Professional Standard, and the Privacy and Confidentiality Practice Standard. Specifically,
>
> a) On or about September 19, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient DM, without authorization,
> b) On or about October 3, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient DB, without authorization,
> c) On or about November 2, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient WR, without authorization,
> d) On or about July 4, 2017, you failed to maintain patient privacy and confidentiality when you accessed the medical files of patient LT (baby) and JB (mother), without authorization,
> e) On or about August 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed the medical files of patient GB (baby), without authorization, and
> f) On or about September 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed the confidential medical files of patient IP (baby), without authorization.
>
> The conduct outlined in 1(a) to 1(f) also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

5. The Panel's determination considers the evidence adduced at the hearing, the parties' oral and written submissions, and legal authorities provided.

6. The Discipline Hearing was conducted by video conference.

7. Further to an earlier order of the Panel, the College was permitted to adduce the evidence of its witnesses by way of affidavit (with the right of cross-examination by the Respondent). The College tendered a book of documents into evidence. The

Respondent was provided with the College's affidavits and book of documents in advance of the hearing.

C. Service of the Citation

8. The Respondent did not attend the first day of the Discipline Hearing. The College filed the Citation and proof of service. The affidavit of service confirms that the Respondent was personally served with the Citation on August 10, 2020.

9. The Panel was satisfied that the Respondent received the Citation, and had notice of the date and time of the Discipline Hearing. As such, the Panel was satisfied that the hearing could proceed in the Respondent's absence pursuant to section 38(5) of the HPA, which provides that "if the respondent does not attend, the discipline committee may (a) proceed with the hearing in the respondent's absence on proof of receipt of the citation by the respondent, and (b) without further notice to the respondent, take any action that it is authorized to take under this Act."

10. At 11:06 PM on November 9, 2020, the Panel's independent legal counsel received an email from the Respondent indicating that the Respondent would like to briefly participate in the hearing on November 10, 2020, the second day of the hearing. The Respondent attended the Discipline Hearing on that day, representing herself.

D. Burden and standard of proof

11. The College acknowledged that it bears the burden of proof and that it must prove its case on a "balance of probabilities". That is, the Panel must be satisfied that it is more likely than not that the alleged conduct occurred.

12. The College cites the leading authority of *F.H. v. McDougall*, 2008 SCC 53, in which the Supreme Court of Canada held that "evidence must be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test".

13. The Panel agrees that *F.H. v. McDougall* is the leading authority, and that the College must prove its case on a balance of probabilities.

E. Action by the Discipline Panel

14. Pursuant to section 39(1) of the HPA, on completion of a hearing, the Discipline Committee may dismiss the matter, or determine that the Respondent:

> 39(1) […]
>
> (a) has not complied with this Act, a regulation or a bylaw,
>
> (b) has not complied with a standard, limit or condition imposed under this Act,
>
> (c) has committed professional misconduct or unprofessional conduct,
>
> (d) has incompetently practised the designated health profession, or
>
> (e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

F. Evidence

15. The College tendered the evidence of Veronica Wilcox, a Shift Coordinator at Royal Inland Hospital, by way of affidavit. Ms. Wilcox also testified during the hearing. Her evidence was the following:

    a. From July 4, 2017 to December 31, 2017 she was the Acting Manager of Women's Health and Children's Services at Royal Inland Hospital in Kamloops, British Columbia (the "Hospital").

    b. The Respondent commenced employment with Interior Health as a Licensed Practical Nurse ("LPN") in December 2006.

    c. On October 15, 2007, the Respondent started working in Women's Health and Children's Services at the Hospital in a relief capacity. This position became full-time and permanent on July 17, 2016. The Women's Health and Children's Services ward is located on 3 West and is a female only ward (“3 West”). 3 West provides care to medical, gynecological, and obstetrical patients. LPNs on 3 West are only assigned medical and gynecological patients. LPNs are never assigned obstetrical patients.

d. On December 5, 2017, the Respondent was terminated from the Hospital following a computerized privacy audit and a subsequent investigation which showed that she had breached patient privacy on multiple occasions.

e. All computers on 3 West are accessed through a Tap and Go system. This system requires users to gain access to computers by tapping their unique ID badge on the computer card reader.

f. Once a user has tapped their unique ID badge and gained access to the computer, an audit of that user can identify all patient records viewed by that user. The audit report indicates the date, time, type of record accessed, computer location, and the accessor's unique user ID. All 3 West computers have the location code RIHW3WC. The Respondent's unique user ID was ATCL.

g. On September 15, 2015 and June 7, 2016, the Respondent completed Interior Health's Annual Information Privacy & Security training. This course instructs participants that viewing records of patients not in their care is a privacy breach.

h. Appendix A of the Interior Health Administrative Policy Manual on Privacy and Management of Confidential Information that was in effect throughout the Respondent’s employment at the Hospital makes clear that the review of medical information of a patient not in one's care is a breach of privacy and confidentiality.

i. Patient DM's audit report shows that on September 19, 2016 at around 0544 hours the Respondent's unique user ID, ATCL, was used to view DM's medical records. DM's medical records were accessed from computer 3 located on 3 West, a female only ward. DM was a male patient and therefore not a 3 West patient.

j. Patient DB's audit report shows that on October 3, 2016 at around 1044 hours the Respondent's unique user ID, ATCL, was used to view DB's

medical records. DB's medical records were accessed from computer 1 located on 3 West, a female only ward. DB was a male patient and therefore not a 3 West patient.

k. Patient WR's audit report shows that on November 2, 2016, the Respondent's unique user ID, ATCL, was used to view WR's medical records on two occasions. The first occasion was at around 0454 hours from computer 2 located on 3 West. The second occasion was at around 0650 hours from computer 7 located on 3 West. 3 West is a female only ward. WR was a male patient and therefore not a 3 West patient.

l. On January 25, 2017, an audit that revealed a potential privacy breach involving the Respondent was brought to the attention of the then Women's and Children's Services Manager, Jennifer Thur.

m. On March 14, 2017, the Respondent, her BC Nurses' Union ("BCNU") representative Patti Wright, HR representative Galadriel Jolly, and Jennifer Thur met to discuss the privacy breaches regarding patients DM, DB and WR.

n. On May 22, 2017, the Respondent completed Interior Health's Annual Information Privacy & Security training.

o. Ms. Wilcox testified that all references to LV in her affidavit should be LT. She testified that patient JB's audit report shows that on July 4, 2017 at around 1737 hours the Respondent’s user ID, ATCL, was used to view JB's medical records. Patient JB is patient LV's mother. While JB was a 3 West patient, JB was an obstetrical patient. As an LPN, the Respondent would not have been assigned to the care of an obstetrical patient.

p. Infant patient LT's audit report shows that on July 4, 2017, at about 1738 hours the Respondent's unique user ID, ATCL, was used to view LT's medical records. While LT was a 3 West patient, LT was an obstetrical

patient. As an LPN the Respondent would not have been assigned to the care of an obstetrical patient.

q. Infant patient GB’s audit report shows that on August 10, 2017, at around 2325 hours the Respondent's unique user ID, ATCL, was used to view GB's medical records. GB's medical records were accessed from computer 2 located on 3 West. GB was not a 3 West patient.

r. Infant patient IP's audit report shows that on September 10, 2017, at around 1548 hours the Respondent's unique user ID, ATCL, was used to view IP's patient records for approximately 10 minutes. While IP, a high-profile patient, was a 3 West patient, IP was an obstetrical patient. As an LPN, the Respondent would not have been assigned to the care of an obstetrical patient.

s. On October 30, 2017, Ms. Wilcox, the Respondent, Patti Wright and HR representative Galadriel Jolly met to discuss the privacy breaches regarding patients DM, DB, and WR. At this time Ms. Wilcox was not aware of the privacy breaches involving patients LT, JB, GB, and IP.

t. On November 2, 2017, she requested that an updated privacy audit be conducted. The audit was from March 15, 2017, the date of the previous audit, to November 1, 2017.

u. On November 22, 2017, Ms. Wilcox, the Respondent, a BCNU representative Mona Hinds and Galadriel Jolly met to discuss the privacy breaches involving patients JB, LT, GB and IP. Following this meeting the Respondent was placed on a paid administrative leave.

v. On November 30, 2017, Ms. Wilcox, the Respondent, Patti Wright and Galadriel Jolly met to discuss the Respondent's termination.

w. The Respondent's work schedule shows that she worked on September 19, 2016 (patient DM privacy breach), October 3, 2016 (patient DB privacy breach), November 2, 2016 (patient WR privacy breach), July 4, 2017

(patients JB and LT privacy beach), August 10, 2017 (patient GB privacy breach), and September 10, 2017 (patient IP privacy breach).

x. On December 21, 2017 Ms. Wilcox submitted a privacy breach complaint to the College of Licensed Practical Nurses of British Columbia ("CLPNBC"), BCCNM's legacy college (the "Complaint").

16. During her testimony, Ms. Wilcox clarified that Exhibit Q at paragraph 24 of her affidavit was the incorrect document; however, the first sentence of paragraph 24 remains accurate. She testified that the notes at Exhibits H, M, N and O of her affidavit were Galadriel Jolly's notes. Ms. Wilcox clarified some of the labelling in the audit documents attached to her affidavit, as follows:

    a. At Tab D, "client" refers to "computer".
    b. The numbers after the letter "C" refer to the computers on 3 West.
    c. The reference to "modified" does not mean that a document was altered.
    d. The reference to "start" refers to the first access.
    e. Where the audit documents shows "end" twice, the first refers to exiting the chart, and the second refers to exiting the electronic record.

17. The Respondent testified on her own behalf. She provided the following evidence:

    a. She re-iterated the contents of her email of November 8, 2020, in which she wrote:

> …
>
> The only thing I'd like to say in my defence is:
>
> Yes I did access my relatives files while he was in the emergency as my mother was his POA at time and he wanted her to know what was happening.
>
> The other was a acquaintance that I went to high school with that I barely knew and was concerned why her baby was in the NICU. I never told any one the information I saw while looking at screen.
> There was one other I believe I had looked up when i was on the front desk when the hospice home had called re information.

> I understand fully the 2 things were a breach and apologize immensely for doing so. I can say for certainty that I didn't use any of the information maliciously. I do miss nursing almost every day.
>
> Other than that, to the best of my recollection I never accessed any information that would be considered a privacy breach.

b. In response to the Panel's question asking which specific allegations in the Citation she admits or denies, the Respondent stated that she denies the allegations in paragraph 1(a),(b) and (f) of the Citation, and that she admits the allegations in paragraph 1(c). With respect to paragraph 1(d), the Respondent stated that JB was the baby, and that she was not certain whether she accessed the mother's medical files or just the baby's. The Respondent further stated, "I deny that one unless that is the one I was working on the desk for, which would make sense." In relation to paragraph 1(e) the Respondent agreed the mother of GB is BB.

c. The Respondent also testified that she was aware that the allegations against her were serious, she knew that her actions were wrong, and she apologized.

G. Submissions

18. The Respondent submits she never used any of the information she accessed to harm or hurt any patient. She says that she kept all information confidential except the information which her uncle wanted her mother to know. She also apologized for her actions.

19. The College submits that the Respondent's breach of patient privacy amounts to a breach of professional standards and constitutes professional misconduct.

20. At the times of the alleged privacy breaches the Respondent was a registrant of the CLPNBC. The Professional Standards for LPNs which the College submits the Respondent breached are the Responsibility and Accountability Standard, as well as the Ethical Practice Standard. The College further submits that the Respondent

breached the Privacy and Confidentiality Standard, which explicitly and unambiguously states: "Access information for your assigned clients only."

21. The College submits the elements comprising unprofessional conduct are noted in the Act and have been judicially considered. Section 26 of the Act defines “unprofessional conduct” as including “professional misconduct”. Section 26 defines “professional misconduct” as including, “sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming of a member of the health profession”.

22. Unprofessional conduct can be broadly thought of as conduct “which violates the ethical code or rules of a profession or such conduct which is unbecoming a member of the profession in good standing”.

Re McLellan CRNBC 2018

23. The College relies on *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2. S.C.R. 869 in which the Supreme Court of Canada held that professional misconduct is “conduct which would be reasonably regarded as disgraceful, dishonorable, or unbecoming of a member of the profession by his well-respected brethren in the group – persons of integrity and good reputation amongst the membership”.

24. The College submits that allegations 1(a) to (f) of the Citation relate to privacy breaches. It argues that the privacy of a patient’s personal health information is sacrosanct. Patients must trust that their sensitive personal health information will be handled in a professional manner. Furthermore, patients have the right to the expectation that unauthorized individuals who are not in their circle of care will not breach their privacy.

25. Relying on the cases of *College of Physicians and Surgeons of Ontario* v. *Dr. Garcia* 2018 ONCPSD 35 and *College of Nurses of Ontario v. Evoy* 2019 CanLII 130825, the College submits the nurse client relationship is built on trust and respect. Nurses have a legal and ethical obligation to maintain confidentiality and privacy of patient health information.

26. The College submits that by accessing the patient records of seven patients not in her care, on six separate days, the Respondent repeatedly breached her ethical and legal obligations to maintain patient privacy.

27. The College submits Ms. Wilcox's affidavit evidence establishes that despite the Respondent's employer having met with her regarding her unauthorized access of patients DM, DB and WR's medical records, and the Respondent retaking Interior Health's Privacy and Security course on May 22, 2017, she continued to access the medical records of patients not in her direct care, namely patients JB, LT, GB, and IP. The College says that this evidence is proof of the Respondent's wanton disregard for patient privacy and establishes a *prima facie* case of professional misconduct.

28. The College also argues that in the Respondent's November 8, 2020 email to the Panel she admits to accessing the medical records of a relative. From the March 14, 2017 meeting notes, this relative appears to be patient WR. The College submits the Respondent also admitted to looking up the records because her mother, who was the patient's power of attorney, "wanted to know what was happening". The College says this evidence amounts to an admission by the Respondent that she breached patient privacy to her mother.

29. The College submits that in her email, the Respondent also admitted to accessing the records of an "acquaintance" with whom she went to high school and who she "barely knew". She stated that she looked up the patient records out of concern because the baby was in the neonatal intensive care unit ("NICU"). From the November 22, 2017 meeting notes, this appears to be infant patient GB.

30. The College argues that the Respondent's evidence that to the best of her recollection she did not breach the privacy of any other patient must be rejected. It says the patient audit reports are proof to the contrary. The College submits that without any evidence disputing the validity of the audit reports, the reports amount to proof on a balance of probabilities that the Respondent accessed the medical records of patients DM, DB, JB, LT, and IP, in addition to WR and GB.

31. The College says that allegation 1 of the Citation has been proven on a balance of probabilities, that the Respondent has breached the Professional and Practice Standards imposed by the College under the Act, and that her proven conduct amounts to professional misconduct.

H. Analysis

32. At the time the Citation was issued, the governing body for nursing in British Columbia was the BCCNP. BCCNP is an amalgamation of three pre-existing regulatory bodies, including the CLPNBC. In September 2020, BCCNP and the British Columbia College of Midwives amalgamated to form the BCCNM. In accordance with Part 2.01 of the HPA, BCCNM remains seized of complaints investigated and discipline proceedings commenced by BCCNP. This includes the Citation, which was issued by BCCNP.

Allegation 1

> 1. Beginning on or about September 19, 2016 to September 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed patient medical records without authorization, contrary to one or more of the following Professional Standards and/or Practice Standards: the Responsibility and Accountability Professional Standard, the Ethical Practice Professional Standard, and the Privacy and Confidentiality Practice Standard. Specifically,
>
> a) On or about September 19, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient DM, without authorization,
> b) On or about October 3, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient DB, without authorization,
> c) On or about November 2, 2016, you failed to maintain patient privacy and confidentiality when you accessed the medical file of patient WR, without authorization,
> d) On or about July 4, 2017, you failed to maintain patient privacy and confidentiality when you accessed the medical files of patient LT (baby) and JB (mother), without authorization,
> e) On or about August 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed the medical files of patient GB (baby), without authorization, and
> f) On or about September 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed the confidential medical files of patient IP (baby), without authorization.

> The conduct outlined in 1(a) to 1(f) also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

33. There are three primary components to the above noted allegations. First, the Respondent is alleged to have failed to maintain patient privacy and confidentiality when she accessed patient medical records without authorization on various dates. Second, that conduct is alleged to be contrary to one or more Professional Standards and/or Practice Standards. Finally, the conduct is alleged to constitute unprofessional conduct, or a breach of the Act or bylaws.

34. The Citation refers to both "patient medical records" and "medical files". The College (and the Respondent) did not define those terms or suggest there was any distinction between a "record" and a "file". The Panel considers that, in the context of this case, there is no meaningful distinction as to how those two terms are used. Both terms are used in these reasons to refer to the personal and confidential information held by a health authority about patients.

Access of medical files without authorization

35. The Respondent has made admissions and partial admissions with respect to three of the allegations in the Citation: allegations 1(c), 1(d) and (1e).

36. The Respondent admits and the Panel finds that on November 2, 2016, the Respondent accessed the medical file of a relative, patient WR (allegation 1(c)) and that she thereafter provided that patient's information to her mother.

37. The Panel finds that on July 4, 2017, the Respondent accessed the medical files of infant patient LT and JB (allegation 1(d)). The Respondent admitted to accessing the infant's medical files in allegation 1(d) though stated that the infant was JB. She testified she could not recall if she also accessed the mother's medical file. The Panel accepts Ms. Wilcox's clear and cogent evidence and finds that patients LT and JB were not the Respondent's patients, that the Respondent was working on July 4, 2017, and that the Respondent accessed LT and JB's medical files. The Panel accepts Ms. Wilcox's evidence that references in her affidavit to LV are actually meant to refer to LT. Exhibits I and J to Ms. Wilcox's affidavit indicate that

LT is the baby and JB is the mother. Moreover, Ms. Wilcox's testified orally as to which patient was the mother and which patient was the daughter. The Panel prefers Ms. Wilcox's evidence to the Respondent's given the Respondent's uncertain recollection regarding access to the mother's medical files. The Panel finds based upon the information before it that it is more likely than not that LT is in the infant patient and JB is the mother.

38. The Panel finds that on August 10, 2017, the Respondent accessed the medical file of infant patient GB (allegation 1(e)). In her testimony, the Respondent admitted to accessing the medical file of an "acquaintance" with whom she went to high school and whom she "barely knew". She stated that she looked up the records out of concern because the baby was in the NICU. From the November 22, 2017 meeting notes, this is consistent with being infant patient GB. The Panel further accepts Ms. Wilcox's clear and cogent evidence and finds that patients GB was not the Respondent's patient, that the Respondent was working on August 10, 2017, and that the Respondent accessed GB's medical file.

39. The Panel does not accept the Respondent's evidence that she did not access any other patients' medical files. The Panel accepts the College's submission that the patient audit reports are evidence to the contrary. The Panel finds that the patient audit reports, the validity of which was not disputed by the Respondent, establish that the Respondent accessed the medical files of all patients referenced in the Citation: DM, DB, WR, LT, JB, GB and IP.

40. The Panel accepts all of Ms. Wilcox's testimony and the patient audit reports, and finds that:

    a. The Respondent worked as an LPN in the Hospital's Women's Health and Children's Services ward, which is located on 3 West, and is a female only ward. 3 West provides care to medical, gynecological, and obstetrical patients. LPNs working on 3 West are only assigned medical and gynecological patients, they are never assigned obstetrical patients.

b. All computers on 3 West are accessed through a Tap and Go system. This system requires users to gain access to computers by tapping their unique ID badge on the computer card reader. Once a user has tapped their unique ID badge and gained access to the computer, an audit of that user can identify all patient records viewed by that user. The audit report indicates the date, time, type of record accessed, computer location, and the accessor's unique user ID. All 3 West computers have the location code RIHW3WC. The Respondent's unique user ID was ATCL.

c. Patient DM's audit reports shows that on September 19, 2016 at around 0544 hours the Respondent's unique user ID, ATCL, was used to view DM's medical records. DM's medical records were accessed from computer 3 located on 3 West. DM was a male patient and not a 3 West patient.

d. Patient DB's audit report shows that on October 3, 2016 at around 1044 hours the Respondent's unique user ID, ATCL, was used to view DB's medical records. DB's medical records were accessed from computer 1 located on 3 West. DB was a male patient and not a 3 West patient.

e. Patient WR's audit report shows that on November 2, 2016 the Respondent's unique user ID, ATCL, was used to view WR's medical records on two occasions. The first occasion was at around 0454 hours from computer 2 located on 3 West. The second occasion was at around 0650 hours from computer 7 located on 3 West. WR was a male patient and not a 3 West patient.

f. Patient JB's audit report shows that on July 4, 2017 at around 1737 hours the Respondent's user ID, ATCL, was used to view JB's medical records. Patient JB is patient LT's mother. While JB was a 3 West patient, JB was an obstetrical patient. As an LPN the Respondent would not have been assigned to the care of an obstetrical patient.

g. Infant patient LT's audit report shows that on July 4, 2017 at about 1738 hours the Respondent's unique user ID, ATCL. was used to view LT's

medical records. While LT was a 3 West patient, LT was an LPN the Respondent would not have been assigned to the care of an obstetrical patient.

h. The audit report of infant patient GB shows that on August 10, 2017 at around 2325 hours the Respondent's unique user ID, ATCL, was used to view GB's medical records. GB's medical records were accessed from computer 2 located on 3 West. GB was not a 3 West patient.

i. Infant patient IP's audit report shows that on September 10, 2017, at around 1548 hours, the Respondent's unique user ID, ATCL, was used to view IP's patient records for approximately 10 minutes. IP was a high-profile patient and a 3 West patient. IP was also an obstetrical patient. As an LPN, the Respondent would not have been assigned to the care of an obstetrical patient.

j. The Respondent's work schedule shows that she worked on September 19, 2016 (patient DM privacy breach), October 3, 2016 (patient DB privacy breach), November 2, 2016 (patient WR privacy breach), July 4, 2017 (patients JB and LT privacy beaches), August 10, 2017 (patient GB privacy breach), and September 10, 2017 (patient IP privacy breach).

41. The Panel finds Ms. Wilcox's evidence is clear, convincing, and cogent, and it accepts her evidence. The Panel finds that Ms. Wilcox' evidence establishes that the Respondent worked on 3 West, that she was working on each of the dates in question, and that she accessed patient DM's medical file on September 19, 2016, patient DB's medical file on October 3, 2016, Patient WR's medical file on November 2, 2016, patients JB's and LT's medical files on July 4, 2017, patient GB's medical file on August 10, 2017, and patient IP's medical file on September 10, 2017.

42. The Panel further finds that Ms. Wilcox's evidence establishes that patients DM, DB, WR, JB, LT, GB and IP were not the Respondent's patients on the dates and times when she accessed their medical files.

43. Interior Health's policies establish that access to medical files of patients not under a user's direct care constitutes "unauthorized access". Interior Health Administrative Policy Manual on Privacy and Management of Confidential Information, which was in effect throughout the Respondent's employment at the Hospital, provides detailed definitions of what constitutes patient confidential information, what constitutes access to such information and also the consequences of an employee of the Hospital's breach of patient information. Section 2 provides that "Confidentiality is the duty to ensure that personal information is kept private and is accessible only to authorized persons". The definition of "confidential information" is very broad and includes personal information about an individual. The definition of "access" includes viewing information on paper or in electronic form. Interior Health's policy limits access to personal and confidential information for specific purposes. The relevant policy excerpts are set out below:

> 1.0 PURPOSE
>
> This Policy is intended to provide a consistent approach for protecting the personal information and other confidential information under the custody and control of Interior Health. The Policy also ensures that staff and agents of Interior Health are aware of and acknowledge the ethical and legal obligations, and consequences of non-compliance.
>
> 2.0 DEFINITIONS
>
> Access includes viewing information on paper or in electronic form, or through dialogue.
>
> Clients include patients, residents, and persons in care in Interior Health facilities and programs.
>
> Confidentiality is the duty to ensure that personal information is kept private and is accessible only to authorized persons;
>
> Confidential Information, whether oral, written and electronic or film, includes the following:
>
> a) personal information about any individual that includes their:
> - name, address or telephone number
> - race, national or ethnic origin, colour, or religious beliefs or associations
> - age, sex, sexual orientation, marital status or family status
> - Personal Health Number (PHN}, Identification number, symbol or other particular assigned to them

- fingerprints, blood type or inheritable characteristics
- health care history, including a physical or mental disability
- information about their educational, financial, criminal or employment history
- personal views or opinions, except if they are about someone else
- and anyone else's opinions about themselves

b) business information collected or created by Interior Health that exists regardless of form and includes, but is not limited to:

- information provided to Interior Health by an external vendor or service provider which, if disclosed, would harm the business interests of the third party
- information prepared as part of pending or ongoing litigation, law enforcement investigation, quality assurance review, Workers Compensation Board or Ombudsman investigation
- information related to credentialing, discipline, privilege, quality assurance reviews and external review of quality of care
- in-camera deliberations of Interior Health where such topics as budget strategies, personnel, labour relations, land acquisitions or litigation may be discussed
- unpublished statistical information and internal correspondence related to organizational initiatives
- information supplied in confidence to a mediator or arbitrator to resolve or investigate a labour relations dispute

c) information that, if disclosed without authorization, could be prejudicial to the interests of Interior Health and associated individuals or agencies; and

d) organizational business information that would harm Interior Health's financial interests and/or information that relates to the management of Interior Health that has not yet been implemented or made public; such as information that identifies the security architecture and infrastructure of the organizations' information systems

..

3.0 POLICY

Interior Health has value-based, ethical and legal obligations for the custody and control of personal and confidential information.
Interior Health recognizes:

- the rights of individuals to protection of privacy regarding all aspects of their personal and business information, in keeping with the FIPPA and PHIAPPA.

- its requirement to inform individuals that there are circumstances that may override their right to privacy when personal information will be

shared with authorized individuals.

3.1 Scope

The obligations outlined in this policy apply to all Interior Health (services, programs and agencies) users and information in any format, including but not limited to, conversational, paper, or electronic. This policy applies while in the course of working and conducting business for or on behalf of Interior Health, including when off-duty and extends beyond the completion of the employment or business relationship with Interior Health. While clients and visitors do not fall under the scope of this policy, it is recommended that they be made aware of the nature of the policy and encouraged to uphold its theme of privacy and confidentiality as appropriate.

3.2 Collection, Use and Disclosure of Personal or Confidential Information

Interior Health expects that users will collect, use and disclose personal or confidential information;

- for purposes directly related to the delivery of health care services or for administration or employment purposes, and limit the collection to what is needed to fulfill the purposes identified;

- for any purpose where the individual has explicitly consented to the use of their information: and

Users are expected to comply with all Interior Health policies, procedures and guidelines for the release of confidential information. This includes information for education, teaching, research, quality improvement, or other secondary purposes, coordinated as
follows:

- release of patient health information is managed by the local facility where the service was provided according to standard practices:
- release of all non-health information is managed by the Leader of Policy Development & Freedom of Information; and
- a release of information for research purposes must meet the standards as outlined by the Interior Health Research Ethics Board, FIPPA Section 35 and PHIAPPA Sections 14, 15 and 20.

3.3 Accessing or Sharing Personal and Confidential Information

Before personal or confidential information under the custody or control of interior Health is shared with a third party, the appropriate data access and confidentiality acknowledgement, information sharing agreement plan and/or a contract must be executed by the parties involved. All users must abide by the data access and confidentiality acknowledgement. The Information

> Privacy & Security Office must review all information access agreements for third parties, information sharing agreements/plans and/or privacy schedules.
>
> Users should take all reasonable steps to ensure no unauthorized personnel or third parties are provided with access to records containing personal or confidential information. Any third-party requests for access should be asked to produce identification and their legal authority to access the requested information.
>
> Users are responsible for ensuring that no personal or confidential information is accessed, transferred or stored outside of Canada except with the explicit consent of the individual the information is about or where otherwise permitted by FIPPA legislation. The Information Privacy & Security Office must be consulted before any program is implemented in which personal or confidential information will be transmitted, transported or stored outside of Canada.
>
> …
>
> 3.7 Failure to Comply
>
> Interior Health considers intentional viewing (accessing} of personal and confidential information that is not required to carry out work-related responsibilities or the misuse of such information to be a breach of policy. (For examples of breaches, see Appendix A). Failure to comply with this policy may lead to termination of access, termination of employment, termination of contract. withdrawal of privileges and/or professional sanctions. (Policy Ref: AR0450 Managing Privacy & Security Breaches)

44. Appendix A of the Interior Health Administrative Policy Manual on Privacy and Management of Confidential Information, which was also in effect throughout the Respondent's employment at the Hospital, confirms that the review of medical information of a patient not in the nurse's care is contrary to the policy. Appendix 1 provides as follows:

> APPENDIX A - Examples of Inappropriate Use of Computer Networks and Components
>
> …
>
> 2. Examples of unauthorized access to data include:
>
> - Accessing the records of patients who are not under the user's direct care.
> - Accessing the user's own medical record, unless following Health Records' Release of Information Process

45. The Panel finds that the Respondent's access of patient medical files was to patients who were not under her direct care, was done without authorization, and that as such, she failed to maintain the privacy and confidentiality of those patients.

Professional Standards and Practice Standards

46. The Panel agrees with the College's submissions that by accessing the medical files of seven patients not in her care, on six separate days, the Respondent repeatedly breached her obligations to maintain patient privacy and confidentiality. At the material times, the Respondent was a registrant of the CLPNBC, and her conduct is contrary to CLPNBC's Privacy and Confidentiality Standard.

47. At the material times, CLPNBC's Privacy and Confidentiality Standard provided:

> Privacy & Confidentiality
>
> Practice standards set out requirements for specific aspects of LPN practice. They link with other CLPNBC standards, policies and bylaws and all legislation relevant to LPN practice.
>
> What is Privacy & Confidentiality?
>
> Licensed practical nurses (LPNs) have an ethical and legal responsibility to protect the privacy and confidentiality of clients' personal health information obtained while providing care.
>
> Employers provide the organizational supports and systems necessary for LPNs to meet CLPNBC Standards of Practice.
>
> Principles
>
> 1. LPNs collect and access clients' personal health information only for purposes that are consistent with their professional responsibilities.
> 2. LPNs ensure that clients are aware of their rights and have consented to the collection, use and disclosure of their personal health information.
> 3. LPNs safeguard information learned in the context of the nurse-client relationship and disclose this information outside of the health care team only with client consent or when there is an ethical or legal obligation to do so.
> 4. When disclosure of confidential information is required, LPNs restrict the amount of information disclosed and the number of people

informed.

5. LPNs take action if others inappropriately access or disclose a client's personal health information.

6. LPNs comply with any legal obligation to disclose confidential information that is imposed by legislation or required under a warrant, court order or subpoena.

7. LPNs disclose a client's personal health information to the appropriate authority if there is a substantial risk of significant harm to the health or safety of the client or others.

Applying the Principles to Practice

To manage privacy and confidentiality in your nursing practice, consider the following:

…

- Access information for your assigned clients only.

…

48. The Panel finds that the CLPNBC's Privacy and Confidentiality Standard is the expected and achievable level of performance for LPN registrants against which actual performance can be compared. It is the minimum level of acceptable performance or conduct for LPN registrants, including the Respondent.

49. CLPNBC's Privacy and Confidentiality Standard's explanatory note on how to apply the Privacy and Confidentiality Standard or principles in practice explicitly and unambiguously states: "Access information for your assigned clients only."

50. The Panel finds the CLPNBC's Privacy and Confidentiality Standard makes clear that the Respondent was only authorized to access the information of patients under her direct care.

51. As outlined above, the evidence before the Panel establishes that the Respondent failed to maintain patient privacy and confidentiality when she accessed patient DM's medical files on September 19, 2016, patient DB's medical files on October 3, 2016, Patient WR's medical files on November 2, 2016, patients JB's and LT's medical fileson July 4, 2017, patient GB's medical files on August 10, 2017, and patient IP's medical files on September 10, 2017 without authorization.

52. The evidence also establishes that patients DM, DB, WR, JB, LT, GB and IP were not under the Respondent's direct care on the dates when she accessed those patients' medical files without authorization.

53. As such, the Panel finds that by accessing the medical files of patients of the Hospital who were not under her direct care, the Respondent breached CLPNBC's Privacy and Confidentiality Standard.

54. Accordingly, the Panel finds that the College has established, on a balance of probabilities, the allegations at paragraph 1 of the Citation:

> 1. Beginning on or about September 19, 2016 to September 10, 2017, you failed to maintain patient privacy and confidentiality when you accessed patient medical records without authorization, contrary to one or more of the following Professional Standards and/or Practice Standards: the Responsibility and Accountability Professional Standard, the Ethical Practice Professional Standard, and the Privacy and Confidentiality Practice Standard. Specifically,
>
> (a) On or about September 19, 2016, the Respondent failed to maintain patient privacy and confidentiality when she accessed the medical file of patient DM, without authorization
>
> (b) On or about October 3, 2016, the Respondent failed to maintain patient privacy and confidentiality when she accessed the medical file of patient DB, without authorization
>
> (c) On or about November 2, 2016, the Respondent failed to maintain patient privacy and confidentiality when she accessed the medical file of patient WR, without authorization
>
> (d) On or about July 4, 2017, the Respondent failed to maintain patient privacy and confidentiality when she accessed the medical files of patient LT (baby) and JB (mother), without authorization
>
> (e) On or about August 10, 2017, the Respondent failed to maintain patient privacy and confidentiality when she accessed the medical files of patient GB (baby), without authorization
>
> (f) On or about September 10, 2017, the Respondent failed to maintain patient privacy and confidentiality when she accessed the confidential medical files of patient IP (baby), without authorization.

Professional Misconduct

55. The Citation also alleges that “The conduct outlined in 1(a) to 1(f) also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.”

56. Section 39(1)(c) of the HPA provides that on completion of the hearing, the discipline committee may, by order, determine that the Respondent “(c) has committed professional misconduct or unprofessional conduct.”

57. “Professional misconduct” and “Unprofessional conduct” are defined in section 26 of the Act as follows:

> "professional misconduct" includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession;
>
> "unprofessional conduct" includes professional misconduct.

58. In *Re McLellan* CRNBC 2018, a discipline panel of one of the legacy colleges held that:

> 55. An important feature of professional misconduct, or unprofessional conduct, is that a professional standard of practice may arise from different sources: standards may arise from a profession’s “culture”, such as a common understanding within a profession as to the expected behaviour, or from formal written guidelines published by a regulatory body. One may reflect or influence the other.
>
> 56. The discipline committee may receive evidence on standards from an expert witness, but it may also rely on a written code of conduct or deduce standards from the fundamental values of the profession. Sometimes finding a standard is easy and straightforward, such as where a rule in written code is directly on point. Sometimes finding a standard involves difficulty, such as where a code expresses a standard as a general principle, and the committee must apply a more fact specific standard. A committee may find a more fact-specific standard by deducing the standard from the fundamental values of the profession, or form the values and principles expressed in a written code, and by interpreting general principles using its own expertise. A committee may also consider the rationales accepted and expressed by other panels of nurses or health professionals, which have applied standards in more or less similar circumstances. Finding a standard may be most difficult where different bodies of responsible professional opinion may differ about the propriety of conduct in a specific situation.

59. Unprofessional conduct includes professional misconduct. Unprofessional conduct connotes the breach of a required standard, while professional misconduct is generally accepted to involve an element of moral turpitude. The Panel accepts the definition in *Pearlman* of professional misconduct as "conduct which would be reasonably regarded as disgraceful, dishonorable, or unbecoming of a member of the profession by his well-respected brethren in the group – persons of integrity and good reputation amongst the membership". The Panel also notes that professional misconduct has been described as a "marked departure" from the expected standards of the members of the profession.

60. The Panel finds that the Respondent's conduct constitutes professional misconduct.

61. The Respondent admitted she knew she breached patient privacy by accessing the medical files of patients who were not under her care.

62. The Respondent completed Interior Health's Annual Information Privacy & Security training three times: on September 15, 2015, June 7, 2016, and on May 22, 2017. The course instructs participants that viewing records of patients not in their care is a privacy breach and Appendix A of the Interior Health Administrative Policy Manual on Privacy and Management of Confidential Information makes clear that the review of medical information of a patient not in one's care is unauthorized access that fails to maintain patient privacy and confidentiality.

63. Nevertheless, the Respondent accessed patients DM, DB, WR, JB, LT, GB and IP's medical files on, respectively, September 19, 2016, October 3, 2016, November 2, 2016, July 4, 2017, August 10, 2017, and on September 10, 2017. Each access took place after the Respondent had received at least one privacy training session.

64. On March 14, 2017, the Respondent; her BCNU representative, Patti Wright; HR representative, Galadriel Jolly; and Jennifer Thur met to discuss the privacy breaches regarding patients DM, DB and WR. The patient audit reports show that after this March 14, 2017 meeting, the Respondent continued to access patient medical files without authorization; specifically, JB's and LT's medical files on July

4, 2017, patient GB's medical files on August 10, 2017, and patient IP's medical file on September 10, 2017.

65. The Panel accepts the College's submission that this is clear evidence of the Respondent's wanton disregard for patient privacy and confidentiality.

66. The College referred the Panel to the case of *College of Nurses of Ontario v Evoy*, 2019 CanLII 130825 (ON CNO), in which a discipline panel of the College of Nurses of Ontario held that a nurse who accessed the medical information of persons not under her care and without those persons' consent was dishonourable and unprofessional conduct. The Panel found the evidence supported findings of professional misconduct. The Panel in *Evoy* held the following:

> **Reasons for Decision**
>
> The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.
>
> Allegation #1 in the Notice of Hearing is supported by paragraphs 21 to 44, 51 and 52 in the Agreed Statement of Facts. The Member admits accessing personal health information, without consent or other proper authorization, for patients for whom she was not a member of the health care team or in the circle of care at the time of the accesses, on or about the dates referenced to in the Agreed Statement of Facts. The Member accessed records of family members and other clients, without following the appropriate process or filing the required consent forms for patients or their family members to access the records. The Member admitted that she failed to follow proper procedures to access the records and she did not have a clinical purpose or proper authorization to access personal health information of 11 clients. The Member admits that by improperly accessing personal health information about the clients, she contravened BRDHC's policies, CNO's *Confidentiality and Privacy – Personal Health Information Practice Standard,* and her obligations under the *Personal Health Information Protection Act, 2004*.
>
> Allegation #3 (a) in the Notice of Hearing is supported by paragraphs 21 to 44 and 51 to 53 in the Agreed Statement of Facts. The Member admits that as a result of electronic audits it was revealed she had reviewed the personal health information of her family members, the spouse of a former co-worker and clients who were not in her care. The Member acknowledged that she abused her position as a nurse by making the accesses without following the proper procedure or filing written consent as required. This conduct is both dishonourable and unprofessional.

> The Panel finds that the Member's conduct was unprofessional when she accessed the personal health information of 11 clients without consent or proper authorization. Nurses are accountable for practicing in accordance with the *Professional Standards*, practice regulations, legislation and regulations. The Member's behaviour and actions are dishonest as she breached the clients' right to confidentiality and privacy. Nurses have ethical and legal responsibilities to maintain confidentiality and privacy of all clients, nurses must respect this right.
>
> The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit when she knowingly violated her employer's multiple policies by accessing health information of clients without consent or authorization between 2013 and 2015. The Member deliberately breached the Professional and Practice Standards under the CNO and the *Personal Health Information Protection Act,2004* ("PHIPA") which is the standard in the nursing profession. The Member's dishonourable conduct has an element of moral failing; the Member ought to have known that her conduct is unacceptable and falls well below the standards of the profession.
>
> …

67. The Panel finds that the reasoning in *Evoy* applies equally to the facts of this case. The Respondent's conduct was unprofessional in that she accessed private information of patients who were not in her direct care. The Respondent's actions were dishonest as she breached the confidentiality and privacy of those patients by accessing the medical files without authorization. Her conduct was dishonourable when she violated her employer's policies multiple times by accessing patient information and continued to do so after receiving privacy training and after being confronted about her unauthorized access of three patients's medical files. Accordingly, the Panel finds the Respondent's conduct is a marked departure from the expected standards of the members of the profession and constitutes professional misconduct.

68. As such, the Panel determines that the Respondent committed professional misconduct pursuant to section 39(1)(c) of the Act.

I. Submissions on Penalty and Costs

69. The Panel requests that the parties provide written submissions regarding the appropriate penalty and costs, in accordance with the following schedule:

    a. Penalty submissions must be delivered by counsel for the College to the Respondent and the Panel by April 4, 2022;

    b. Responding submissions, if any, must be delivered by the Respondent to counsel for the College and the Panel by April 25, 2022; and

    c. Reply submissions may be delivered by counsel for the College to the Respondent and the Panel by May 2, 2022.

70. Submissions for the Panel's consideration should be delivered to Susan Precious, counsel for the Panel, and should be delivered electronically to the following email address: susan@preciousgaerdes.com

J. Notice of right to appeal

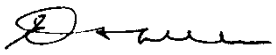
71. The Respondent is advised that under section 40(1) of the Act, a respondent aggrieved or adversely affected by an order of the Discipline Committee under section 39 of the Act may appeal the decision to the Supreme Court. Under section 40(2), an appeal must be commenced within 30 days after the date on which this order is delivered.

K. Directions

72. The Panel directs pursuant to sections 39.3(1)(d) of the Act, the Registrar notify the public of the determination made herein.

Dated: March 14, 2022

Sheila Cessford, Chair



Edna McLellan, RN (T)

Dr. Catharine Schiller, RN