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

BETWEEN:

The British Columbia College of Nurses and Midwives

The College

AND:

Allen Pangburn

The Respondent

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Dates:	June 7 to June 9, 2021
Discipline Committee Panel:	Edna McLellan, RN(T)(Chair) Dorothy Barkley (Public member) Kira Antinuk, RN
Counsel for the College:	Jennifer Groenewold
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 the "BCCNM") conducted a hearing to determine, pursuant to section 39 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), whether the Respondent, Allen Pangburn, failed to comply with the Act, a regulation or a bylaw, whether he failed to comply with a standard imposed under the Act, whether he committed professional misconduct or unprofessional conduct, or whether he practised incompetently.

2. For the reasons set out below, the Panel determines pursuant to section 39 (1) of the Act, that the Respondent committed unprofessional conduct in relation to the allegations in paragraphs 1 and 2 of the citation dated April 23, 2021 (the "Citation") and committed professional misconduct in relation to the allegations in paragraph 3 of the Citation.

B. <u>Background</u>

3. The particulars of the allegations against the Respondent are set out in the Citation as follows:

> The purpose of the hearing is to inquire into your conduct that:
>
> 1. On or about September 6, 2019, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, you did not attend to a resident ("Resident #1") experiencing an acute shortness of breath in a timely manner, or at all, contrary to BCCNM's Professional Standards and/or Practice Standards including: the *Responsibility and Accountability* Professional Standard, *Knowledge Based Practice* Professional Standard, the *Client–Focused Provision of Service* Professional Standard, the *Ethical Practice* Professional Standard, the *Documentation* Practice Standard, *Delegating Tasks to Unregulated Care Providers* Practice Standard, and the *MedicationAdministration* Practice Standard.
>
>   This conduct also constitutes unprofessional conduct, professional misconduct, or breachof the Act or bylaws, under s.39 (1) of the Act.
>
> *2.* On or about September 16, 2019, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, you did not protect the privacy and dignity of a resident ("Resident #2") when you conducted an assessment of a woundon Resident 2's sacral area (the buttock region) without drawing the privacy curtain and while a repair person was carrying out a repair in the room, contrary to BCCNM's Professional Standards and/or Practice Standards, including: the *Responsibility and Accountability* Professional Standard, the *Client–Focused Provision of Service* Professional Standard, the *Ethical Practice* Professional Standard, and the *Privacy andConfidentiality* Practice Standard.

This conduct also constitutes unprofessional conduct, professional misconduct, or breachof the Act or bylaws, under s.39 (1) of the Act.

3. On or about February 24 and 25, 2020, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, you gave a resident ("Resident #3") diazepam instead of the prescribed lorazepam. You did not report this medication error to your manager or most responsible physician as required, and then you created inaccurate and false entries in the Resident 3's clinical record to indicate that the diazepam was ordered by the Resident 3's physician, when in fact, they did not order the diazepam. Your actions were contrary to BCCNM's Professional Standards and/or Practice Standards, including: the *Responsibility and Accountability* Professional Standard, the *Client–Focused Provision of Service* Professional Standard, the *Ethical Practice* Professional Standard, and *Medication* Practice Standard, and *Documentation* Practice Standard.

   This conduct also constitutes unprofessional conduct, professional misconduct, or breachof the Act or bylaws, under s.39 (1) of the Act.

4. The Respondent's registration has undergone some changes over the years. At the time of the subject allegations Mr. Pangburn held practicing registration as a Registered Nurse ("RN") and he was subject to regulation by the British Columbia College of Nurse Professionals ("BCCNP" or the "Former College").

5. On September 1, 2020, BCCNP amalgamated with the British Columbia College of Midwives to form BCCNM. Under Part 2.01 of the HPA, BCCNM remains seized of the complaints investigated and discipline proceedings initiated by the Former College.

C. Virtual Discipline Hearing and Evidence Provided

6. Due to the ongoing COVID-19 pandemic, the Discipline Committee hearing (the "Discipline Hearing") took place from June 7 to June 9, 2021 by video conference on the WebEx platform.

7. The Respondent attended the hearing and represented himself.

8. The Respondent tendered into evidence the following documents:

    i. Email from Paddy Treavor (BCNU) to the Respondent dated February 19, 2020 (marked Exhibit #1)

    ii. Email thread between Michelle Pascoe, Paddy Treavor, Iwan van Veen and the Respondent, dated October 15 and 16, 2019 (marked Exhibit# 2).

    iii. Note of interview with Mona Koopman drafted by Margaret Gauthier (the interview is noted to have occurred on May 7, 2020) [marked Exhibit # 3].

9. The College entered a book of documents into evidence, containing the following documents, which book was marked as Exhibit #4:

    i. Tab 1: Affidavit of Service attaching Citation

    ii. Tab 2: 2019-09-11 Email from RCA re September 6 incident.

    iii. Tab 3: 2019-09-19 Email from LPN re September 6 incident.

    iv. Tab 4: 2019-09-06 Patient Records- Resident #1.

    v. Tab 5: 2019-10-11 Employer Meeting Notes.

    vi. Tab 6: 2019-09-17 Email from RCA re September 16 incident.

    vii. Tab 7: 2019-11-22 Registrant's Statement re September 6 incident.

    viii. Tab 8: 2019-11-22 Registrant's Statement re September 16 incident.

    ix. Tab 9: 2020-01-29 Learning Plan.

    x. Tab 10: 2020-01-30 Learning Plan Follow Up Email.

    xi. Tab 11: Letter of Suspension (r) 2020-04-09.

    xii. Tab 12: 2020-02-25 Statement from S. Gordon.

    xiii. Tab 13: Various Patient Records.

    xiv. Tab 14: 2020-03-13 Employer Meeting Notes.

    xv. Tab 15: 2020-06-26 Registrant's Response.

10. As confirmed by the Affidavit of Service, the Citation was delivered to the Respondent by personal service on April 29, 2021. As such, the College has satisfied the notice requirements set out in section 37(2) of the HPA.

11. The College called the following seven witnesses:

    i. Mr. Iwan van Veen, who was the manager of the Evergreen Extended Care Unit ("Evergreen") at the relevant times. He provided information about the facility generally. Mr. van Veen also provided evidence with respect to how he, as the manager, became aware of concerns regarding the Respondent's nursing practice and what steps he took to investigate and address those concerns.

    ii. Ms. Melody Irwin, who was the Residential Care Coordinator ("RCC") of Evergreen at relevant times. She gave evidence about Evergreen generally, including further information about policies and procedures for registered nurses at Evergreen. Ms. Irwin provided information about the steps she took as the RCC to address the medication error regarding Resident #3.

    iii. Hailey Miller (nee Jahnke), a residential care aid at Evergreen, and Kimberlee Green, a licensed practical nurse ("LPN") at Evergreen, who gave evidence about what they saw and observed when Resident #1 experienced an episode of severe shortness of breath.

    iv. Dawn Schroeder, a residential care aid at Evergreen, who gave evidence about her interactions with the Respondent during the care of Resident #2, when the Respondent is alleged to have failed to ensure Resident #2's privacy.

    v. Ms. Sheila Gordon, a registered nurse at Evergreen, and Dr. Alex Marchenko, a physician at Evergreen, who both gave evidence about Resident #3 and the alleged medication error.

12. The College provided written opening and closing submissions and a book of authorities. The Respondent provided written opening submissions but, despite having been given the opportunity to provide closing submissions, did not do so.

13. The Panel's determination considers the witness testimony adduced at the hearing, the documents tendered into evidence, the College and Respondent's submissions, and the book of authorities provided.

D. Burden and Standard of Proof

14. The College acknowledged that it bears the burden of proof and that it must prove its case on a "balance of probabilities".

15. The College cited several cases, including 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". The Panel accepts the College's characterization of the applicable burden and standard of proof.

E. Action by the Discipline Panel

16. Pursuant to section 39(1) of the Act, the Panel may, on completion of a hearing, dismiss the matters alleged in the Citation, 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. The Practice Setting and the Role of the Registered Nurse

17. The witness testimony provided the Panel with the following details about the practice setting where the events outlined in the Citation occurred.

18. The Evergreen Extended Care Unit is a 75-bed extended care facility. Evergreen is divided into 4 hallways that were given "tree names" including Cedar, Fir, Pine, and Hemlock.

19. Staff assignments are divided between the 4 hallways in the same manner – Cedar/Fir and Pine/Hemlock. Ms. Gordon and Ms. Irwin testified that staff in

permanent positions are typically assigned to one side or the other to promote continuity of care for the residents they care for. Staff may work on the opposite side when picking up overtime, working extra shifts,or if operationally required.

20. With respect to the staffing model, the Panel heard evidence that there are two RNs on duty at all times, two LPNs are scheduled from 7-3 and their primary responsibility is medication administration, as well as personal care for a 6-resident assignment. Two health care aides ("HCAs") per side are responsible for most of the personal care for the residents. There are also other staff members who are involved in the care of the residents including a bath team during the day, recreational therapist, physical therapists, occupational therapists, and other allied health care professionals.

21. Iwan van Veen and Melody Irwin stated that one RN is "in charge" of the facility and both RNs serve in leadership roles within the facility.

G. The College's Principal Submissions

22. In summary, the BCCNM submits that, while caring for residents residing in the Evergreen extended care facility, the Respondent did not protect the privacy and dignity of a resident during an assessment of a sacral wound, that the Respondent did not respond promptly to a report that a resident was experiencing respiratory distress, and lastly, that the Respondent made a medication error on the night shift of February 24/25, by administering Diazepam instead of Lorazepam to a resident receiving end of life care. The College submits the Respondent then called the most responsible physician but did not advise him of the medication error, rather the Respondent asked the physician for an order for Diazepam even though there was already an order for Lorazepam. After this conversation, it is submitted that the Respondent then wrote "telephone orders" in Resident #3's clinical record for Diazepam when it was not ordered by the physician.

23. The College submits the evidence confirms that the allegations in the Citation have been proven on a balance of probabilities, and that the Registrant should be found to have:

    i. failed to comply with the professional standards imposed by the College [s. 39(1)(b) of the HPA]; and

    ii. committed professional misconduct or unprofessional conduct [s. 39(1)(c) of the HPA].

24. The College submits the conduct outlined in paragraphs 1 and 2 of the Citation meets the definition of unprofessional conduct as set out in *Re McLellan* CRNBC 2018, while the conduct outlined in paragraph 3 of the Citation constitutes professional misconduct within the definition set out by the Supreme Court of Canada in *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 SCR 869.

25. The Panel now turns to determination of each of the College's specific allegations in the Citation.

H. <u>Citation - Paragraph 1</u>:

"1. On or about September 6, 2019, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, you did not attend to a resident ("Resident #1") experiencing an acute shortness of breath in a timely manner, or at all, contrary to BCCNM's Professional Standards and/or Practice Standards including: the Responsibility and Accountability Professional Standard, Knowledge Based Practice Professional Standard, the Client–Focused Provision of Service Professional Standard, the Ethical Practice Professional Standard, the Documentation Practice Standard, Delegating Tasks to Unregulated Care Providers Practice Standard, and the Medication Administration Practice Standard."

Evidence

26. Mr. Iwan van Veen's evidence was that he is the manager for long term care for Vancouver Coastal Health in Powell River and in this role, he manages Evergreen. He was notified by staff about the Mr. Pangburn's timeliness with

respect to Resident #1's shortness of breath when he did his rounds. He asked the staff involved to put their concerns in writing by email, which they did.

27. Ms. Milne (nee Jahnke) is an HCA at Evergreen. She provided the following evidence regarding her recollections of the events of September 6, 2020:

    a. She stated that Resident #1 was calling out to her and "she seemed very much in distress." She then informed Ms. Greene, the LPN about Resident #1 who told her to tell the Respondent about it.

    b. Ms. Milne went to find the Respondent who was in another resident's room getting ready to do a wound dressing. He told Ms. Milne that he was busy with the dressing and he would have to put the bed down and the rails up if he left this resident.

    c. The Respondent told Ms. Milne that she should tell Resident #1 he would be there in "eight minutes". Ms. Milne said that the Respondent was seated in a chair facing the resident whose dressing he was doing and was looking at his cellphone.

    d. Ms. Milne returned to Resident #1, Ms. Greene was busy assessing the resident and the other RN on duty attended to bringing the resident's chart. Ms. Milne returned from Resident #1's room to the room where the Respondent was sitting. She also had another health care worker with her. That health care worker offered to stay with the resident so that the Respondent could go to assess Resident #1. The Respondent again said no. Ms. Greene reported that it was a long time before the Respondent attended to assess Resident #1 and may have been about 8 minutes.

28. The Respondent provided the following evidence:

    a. The resident whose dressing he was changing had to be monitored. When a resident falls it is a lot of work for the RN, particularly if the fall is unwitnessed.

b. During his testimony he stated the following:

> I had spoken to Krysten who was a new ACA[1], she had about six month's experience and she's probably about 18 or 19. And very enthusiastic, but I did not feel comfortable with her watching this patient who can just decide to get up and go do something else with an exposed wound on his heel. So I told her no, I was not going to, and that the LPN should assess the patient because at this point I didn't know how serious the patient had become since the time I had seen her about probably 10 minutes or 15 minutes prior.
>
> I also wasn't aware until yesterday that when Krysten came and spoke to me about this that the LPN, Kim Greene, was already assessing the patient. And so a timeline of not responding to the patient, first of all when I heard that her saturations were at 50 percent it was not until much later in the day, I don't recall Kim telling me that initially.

c. He testified that he would not rely on another for an assessment and that was his rationale for not leaving a relatively inexperienced HCA with the resident whose dressing he was performing. In this regard his evidence was as follows:

> And so, that was the reason I said no, because I didn't feel it would be safe to leave patient X with Kyrsten, because he has a history of being difficult, and if he gets something in his mind, he's just going to do it.
>
> He has a fall history of at least once a month, but I don't have any documentation for that. I do know about it, because whenever he fell, an RN has about 72 hours of extensive screening for the patient, to make sure that—because a head injury doesn't necessarily demonstrate itself in the first few hours. It could be a few days. Sometimes even weeks.
>
> So, at this point -- and also too, unbeknownst to me, when in tab 15 page 2, paragraph (c), I was unaware that the LPN was already interacting with the patient. So, this, VCH's concern is that I was not quick to respond to a distress of a patient, when my initial query-- command was to have the LPN assess the patient. An LPN can assess a patient for breathing whether she is there to give pills or not, that's a very basic scope of practice. If there was something beyond her scope of practice, then I would expect to be notified.

d. The Respondent further indicated in his testimony that he used a runner system utilizing an HCA, and also that he delegated the care of Resident #1 to Ms. Green. Since she acted appropriately, there was no breach of the standards. His testimony in this regard was as

[1] The Panel notes that Krysten is a Health Care Aide (HCA).

follows:

> So, the whole reason for this investigation, you know, I totally realize that somebody having saturations in the 50s, and an RN not going there immediately, is something that should be looked at. I agree with that. But I also agree that the interventions that occurred were not detrimental to the patient. Whether I had ran there, or whether Ms. Greene had gone there, the patient's saturations would have been the same and the interventions would have been the same.

29. The Respondent also gave the following evidence:

    a. He agreed that the RN role at Evergreen was, in part, a leadership role.

    b. He agreed that the RN is always responsible for the decision to delegate care to an unregulated health care professional and to an LPN, and that those delegations need to be client specific and done in the best interest of the patient.

    c. He acknowledged that the decision to delegate is complex and must include consideration of client care needs, including specific client factors, task factors, the care environment factors, and the skill set of the persons being delegated to.

    d. Ms. Milne told him that Resident #1 was having trouble breathing and he told her to find the LPN to assess the patient.

    e. He was aware of the importance of doing his own assessments.

    f. He agreed that for a patient in respiratory distress 8-10 minutes without intervention and assessment and without intervention is a significant delay.

30. Notably, the Respondent admitted that he did not see Resident #1 in a timely manner. In this regard, he testified as follows:

> Q Mr. Pangburn, do you agree with me that you did not attend Resident #1 in a timely manner?

A I did not -- I did not see the patient in a timely manner.

Analysis and Findings of Fact

31. The Panel finds the testimony of Ms. Green, Ms. Milne, Mr. van Veen and the Respondent, as outlined above, clear, convincing, and cogent, and it accepts their evidence.

32. The evidence before the Panel demonstrates that the Respondent, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia on September 6, 2019, did not attend to Resident #1, who was experiencing an acute shortness of breath, in a timely manner.

33. The Panel finds that the Respondent's conduct described in paragraph 1 of the Citation has been established by the evidence before it, on a balance of probabilities.

34. Based on the above-mentioned evidence, the Panel also finds that the Respondent's conduct did not comply with the College's Professional Standards for Registered Nurses and Nurse Practitioners Standard 1 "Professional Responsibility and Accountability", Clinical Practice Items 1 and 4; Standard 2 "Knowledge Based Practice", Clinical Practice Items 3, 4, 5, 7 and 8; Standard 3 "Client-Focused Provision of Service", Clinical Practice Items 1, 2, 3, 4 and 6 and Standard 4 "Ethical Practice", Clinical Practice Item 1. These Standards provide the following:

Standard 1: Professional Responsibility and Accountability
Clinical Practice

1. Is accountable and takes responsibility for own nursing actions and professional conduct.
4. Takes action to promote the provision of safe, appropriate and ethical care to clients.

Standard 2: Knowledge-Based Practice
Clinical Practice

3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

4. Collects information on client status from a variety of sources using assessment skills, including observation, communication, physical assessment and a review of pertinent clinical data.

5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.

7. Develops and communicates plans of care that include assessment data, decisions about client planned interventions and measurement of client outcomes.

8. Sets client-centred priorities when planning and providing care.

Standard 3: Client-Focused Provision of Service
Clinical Practice

1. Communicates, collaborates and consults with clients and other members of the health care team about the client's care.

2. Coordinates client care in a way that facilitates continuity for the client.

3. Assigns clients and client care activities to other members of the health care team to meet client care needs.

4. Delegates appropriately to other members of the health care team.

6. Instructs and guides other members of the health care team to meet client care needs.

Standard 4: Ethical Practice
Clinical Practice

1. Makes the client the primary concern in providing nursing care.

35. As noted, the College relies on the case of *Re McLellan* CRNBC 2018, in which a discipline panel of the Former College held that unprofessional conduct is 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."

36. The College submits unprofessional conduct connotes the breach of a standard, rule, or expected behaviour, while professional misconduct is unprofessional conduct that has crossed a more serious threshold [See: *Xu (Re)*, 2019 CanLII 131132 (BC CDS)].

37. The College submits the Respondent's proven conduct outlined in paragraph 1 of the Citation meets the definition of unprofessional conduct as set out in *Re McLellan.*

38. The Panel agrees with the College's submissions in this regard.

39. Accordingly, the Panel determines that by conducting himself in the manner described in paragraph 1 of the Citation, which conduct has been established by the aforementioned evidence on a balance of probabilities, and which conduct constitutes a breach of the College's above-mentioned Standards, the Respondent committed unprofessional conduct pursuant to section 39(1)(c) of the Act.

I. <u>Citation – Paragraph 2:</u>

> ***"2.On or about September 16, 2019, while working as a Registered Nurse on the EvergreenExtended Care Unit in Powell River, British Columbia, you did not protect the privacy and dignity of a resident ("Resident #2") when you conducted an assessment of a woundon Resident 2's sacral area (the buttock region) without drawing the privacy curtain and while a repair person was carrying out a repair in the room, contrary to BCCNM's Professional Standards and/or Practice Standards, including: the Responsibility andAccountability Professional Standard, the Client–Focused Provision of Service Professional Standard, the Ethical Practice Professional Standard, and the Privacy and Confidentiality Practice Standard."***

Evidence

40. Ms. Schroeder, a health care aid who has worked at Evergreen for 15 years, provided the following evidence with respect to this allegation:

    a. The Respondent failed to close the curtain when he assessed Resident #2 and there was a maintenance person in the room who saw Resident #2 in an exposed state.

    b. When the Respondent left the room to speak to an allied health care professional, Ms. Schroder spoke to him in the hallway to remind him to

close the curtains to maintain privacy. She testified that the Respondent just rolled his eyes and walked away from her.

c. She emailed her union shop steward about this incident and then, on their advice, went to speak with Mr. van Veen.

d. She then emailed him her version of events.

e. Ms. Schroeder identified her email and confirmed that the narrative contained therein was accurate and truthful.

41. The Respondent acknowledged that Ms. Schroeder's recollection of events was very accurate. He provided the following testimony with respect to this allegation in response to College counsel's questions during cross-examination:

> Q Thank you. I'd like to move on to the issues around Resident number 2. I understood from your evidence in chief that you've acknowledged that you failed to draw the curtain around Resident #2 when you were assessing her sacral wound. I have that correct?
>
> A Correct.
>
> Q Okay. And that you're fully aware that patient-centred care means ensuring the privacy and dignity of patients receiving an intervention addressing change, just AM care, you'd agree with that?
>
> A Any sort of care.
>
> Q Okay. And that it was your failing in failing -- it was your failure in failing to draw the curtain, correct?
>
> A Yes.

42. Mr. van Veen also testified about the events outlined in the second paragraph of the Citation. His evidence and notes made of a meeting with the Respondent regarding which was tendered into evidence confirm the following:

    a. Dawn Schroeder emailed Mr. van Veen to advise that the Respondent had failed to close the curtain around a resident when he assessed her sacral wound.

    b. Evergreen's Human Resources department became involved, and an investigation meeting was held which the Respondent and his union

representative attended.

c. Notes were kept contemporaneously during the meeting and addressed several issues, including the September 6 and 16, 2019 incidents.

d. During the course of the investigation meeting, which was held on October 11, 2019, Mr. Pangburn was recorded as having made admissions. First, that he failed to draw the curtain around Resident #2 and that Ms. Schroeder pointing this out to him was a “good call”.

e. As the result of the investigation meeting, the Respondent was placed on another learning plan that directly addressed the issues regarding resident dignity and appropriate response to a resident in crisis, and delegation to other staff members. The Respondent was also suspended for three days.

Analysis and Findings of Fact

43. The Panel finds the evidence of Ms. Schroeder, the Respondent and Mr. van Veen, outlined above, clear, convincing, and cogent, and it accepts their evidence.

44. The Panel finds that their evidence confirms, on a balance of probabilities, that on September 16, 2019, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, the Respondent did not protect the privacy and dignity of a resident (“Resident #2”) when he conducted an assessment of a wound on Resident #2’s sacral area (the buttock region) by not drawing the privacy curtain and while a repair person was carrying out a repair in the room.

45. Based on the evidence before it, the Panel also finds that the Respondent’s described conduct did not comply with the College’s Standards, particularly Standard 4 “Ethical Practice” Clinical Practice Items 1, 2 and 5, which provide as follows:

Standard 4: Ethical Practice

Clinical Practice

1. Makes the client the primary concern in providing nursing care.

2. Provides care in a manner that preserves and protects client dignity.
5. Protects client privacy and confidentiality.

46. The College submits the Respondent's proven conduct as outlined in paragraph 2 of the Citation also meets the definition of unprofessional conduct as set out in *Re McLellan.* The Panel agrees.

47. Accordingly, the Panel determines that by conducting himself in the manner described in paragraph 2 of the Citation, which conduct has been established by the evidence on a balance of probabilities, and which conduct constitutes a breach of the College's above-mentioned Standards, the Respondent committed unprofessional conduct pursuant to section 39(1)(c) of the Act.

J. Citation – Paragraph 3:

"3. On or about February 24 and 25, 2020, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, you gave a resident ("Resident #3") diazepam instead of the prescribed lorazepam. You did not report this medication error to your manager or most responsible physician as required, and then you created inaccurate and false entries in the Resident 3's clinical record to indicate thatthe diazepam was ordered by the Resident 3's physician, when in fact, they did not orderthe diazepam. Your actions were contrary to BCCNM's Professional Standards and/or Practice Standards, including: the Responsibility and Accountability Professional Standard, the Client–Focused Provision of Service Professional Standard, the Ethical Practice Professional Standard, and Medication Practice Standard, and Documentation Practice Standard."

Evidence

48. Several witnesses provided evidence regarding this allegation. Their evidence establishes that Resident #3 was an elderly woman who had recently been diagnosed with a low hemoglobin. Her daughter advised the staff at Evergreen that her mother would only be receiving comfort care. After a family conference

with Dr. Marchenko, Resident's MOST level, or goals of care, were changed to "M2" Ms. Irwin explained this meant no CPR, and comfort measures only.

49. During her testimony Ms. Gordon provided some general information about medication administration practices at Evergreen as well as some details about routines at the facility. She said during the day from 0700 to 1500, the LPNs are typically responsible for dispensing the residents' medications. This task is taken over by the RNs after the LPN goes home for the day.

50. With respect to Resident #3, Ms. Gordon testified the Resident #3 was near the end of her life and had been moved to the special room for palliative care. She said it was a private room which she described as "more homey", better suited for family to be with the resident during their last days of life. Ms. Gordon also provided the following evidence:

    a. She was working with the Respondent at Evergreen the night of February 24, 2020 to the morning of February 25, 2020.

    b. She recounted for the Panel her recollections of the night shift of February 24/25, 2020. She stated that after she and the Respondent completed their evening medication pass, they attended to routine chores on the unit, including paging charts and their nightly duty. On Monday nights, it is the task of the RNs on duty to count the ward stock medications and to reorder any medications needed for the week. Ms. Gordon had a specific recollection of having remarked that there were three boxes of Lorazepam (Ativan) in the medication fridge. She remembered saying to the Respondent that she wondered if staff were forgetting that Lorazepam was kept in the fridge and kept on ordering it.

    c. Ms. Gordon remembered that the Respondent was on "first break" that night, which meant he was on break from approximately 2400 – 0200. He advised Ms. Gordon, just prior to going on break, that he had given Resident #3 some Dilaudid (hydromorphone) and Diazepam. She

remembered questioning him about whether he gave the Diazepam to which he responded in the affirmative. Ms. Gordon remembered leaving the comment "at that" and the Respondent went for his break. Ms. Gordon later went to check on Resident #3 and noted her to appear comfortable with a low respiratory rate and not responding to voice which she did not note as unusual. Ms. Gordon opened the medication cart for the Cedar hallway and saw two syringes in the cart – there was one of hydromorphone and the other was Diazepam. Ms. Gordon then consulted the physician's orders and saw there was an order for hydromorphone but not for Diazepam. When the Respondent returned from his break, Ms. Gordon informed him of the apparent medication error to which the Respondent said, "oh shit". Ms. Gordon then went for her break. When she returned at or about 0400 she noted that Resident #3's chart was open at the nursing desk and she noted the new doctor's orders documented on the Residential Terminal/End of Life Care Orders, so she assumed that the Respondent had spoken to the physician. At the end of her shift, Ms. Gordon let the RN Greg Cupell for the Cedar/Fir side know that there had been a medication error and then she went home.

d. At or about 1030 on February 25, 2020, Ms. Gordon had a telephone conversation with the residential coordinator Melody Irwin about the medication error.

e. Ms. Gordon believed that Iwan van Veen may have also been on the call. Ms. Irwin asked Ms. Gordon to come into the facility to fill out an incident report. Ms. Gordon also created a handwritten note that outlined the events of the night shift of February 24/25, 2020.

51. Ms. Irwin also testified. Her evidence was the following:

a. Her role in any workplace investigation is to assist with gathering information and passing it on.

b. Ms. Irwin is a union member and therefore does not take a role in disciplining staff. As part of her review of this medication error she reviewed Resident #3's chart in detail and spoke with Ms. Gordon as noted above.

c. Ms. Irwin stated that she understood from her chart review that the Respondent had likely sought a "covering order from Dr. Marchenko for the administration of the Diazepam that he administered in error to Resident #3.

d. Ms. Irwin said she could not find anywhere in the chart where the Respondent had informed Dr. Marchenko that he had made an error and there was no assessment documented to indicate that the Respondent had assessed Resident # 3 in light of the error.

e. Ms. Irwin described what a "covering order" was. She said it was when a nurse used their clinical judgment, after assessing a patient, and then does a task that is outside of their scope of practice. For example, doing an in/out catheter to obtain a urine sample to send for a C&S (culture and sensitivity) without a physician's order. The nurse would then obtain a "covering order" from the physician after the fact by describing their assessment, rationale, and actions taken. Ms. Irwin said none of those indicia were present in the incident with Resident #3.

f. Ms. Irwin gave evidence that her expectation for nurses who make a medication error involve assessing the patient to ensure that they are safe. The nurse ought to inform the doctor that there was an error so that the doctor can act accordingly and disclose the error to the patient. Lastly, the nurse should fill out a safety learning system report ("SLS") so that if systemic issues were at play in the error, the facility can make any necessary change, or the error can be a source of learning for others.

g. Ms. Irwin stated that she has never given Diazepam subcutaneously

("SC") during her entire career, and she would have to go back to a pharmacology book to see if it could be given by that route of administration.

52. Dr. Marchenko also testified. His evidence was the following:

    a. He provides medical services to the residents of Evergreen Extended Care Unit. He was the physician looking after Resident #3. He told the Panel about his assessment of the resident and his discussion about goals of care when her medical status deteriorated.

    b. On February 24, 2020, he changed Resident #3's goals of care to comfort measures only and wrote new medical orders for Hydromorphone and Lorazepam to deal with end-of-life symptoms.

    c. Dr. Marchenko described the phone call he received from the Respondent. He remembered the Respondent provided an update on Resident #3's status, and indicated that her condition had worsened. He said the Respondent mentioned something about Diazepam but it was confusing because he had just left orders for Lorazepam a few hours previously. The Respondent did not advise him that he had administered Diazepam to Resident #3. The Respondent asked if it was okay to give Resident #3 Diazepam. Dr. Marchenko did not give a telephone order to the Respondent for Diazepam. Dr. Marchenko said Lorazepam is the benzodiazepine of choice in end-of-life care because it has a shorter half-life, and it is easier to adjust the dose to treat a patient's symptoms.

    d. The dose for Diazepam written by the Respondent on the Terminal/End of Life Care Orders was "strange". When he clarified what he meant by those comments, Dr. Marchenko stated that the dose was wrong, it should have been "somewhere around 5 milligrams not 0.5 milligrams."

e. On the morning of February 25, 2020, he received a telephone call from the pharmacists concerned and/or confused about the dose of Diazepam ordered overnight. Dr. Marchenko gave the pharmacist a telephone order to stop the Diazepam.

f. The telephone call from the pharmacist prompted Dr. Marchenko to go to Evergreen right away because there should not have been any Diazepam orders. On arrival to Evergreen, Dr. Marchenko reviewed Resident #3's chart and spoke with the nurse manager. He also wrote a progress note which outlined the events of the past night which reflected his memory of the previous nights' events.

g. On cross-examination, Dr. Marchenko was asked if he remembered the Respondent reading each line of the Terminal/End of Life Care Orders sheet. Dr. Marchenko did not remember this and said that if the Respondent had done that, he likely would have stopped him, as it was 0230 in the morning.

h. Dr. Marchenko was firm about his recollections, in that he did not give an order for Diazepam SC and that the doses written by the Respondent were the same for Lorazepam and would be incorrect. He stated that his last clear statement to the Respondent was to go ahead with the Lorazepam.

53. Mr. van Veen gave evidence that a subsequent workplace investigation meeting took place. He identified the notes taken during the meeting which accurately reflected some of the responses provided by the Respondent. From the notes, it is clear that the Respondent admitted to making a medication error, administering two doses of Diazepam rather than Lorazepam as ordered.

54. As a result of the investigation meeting, the Respondent was suspended for 10 days.

55. The Respondent gave the following evidence:

    a. He admits that he made medication errors when he administered Diazepam 1 mg twice to Resident #3 via a subcutaneous butterfly needle.

    b. He inserted two butterflies into Resident #3’s left upper arm, one for Diazepam and one for hydromorphone.

    c. He realized he needed to call Dr. Marchenko to report the medication error but also to get the End of Life/Terminal Orders sheet filled out because he expected Resident #3 to pass away. He testified that he needed to get some additional order because he expected the patient to pass away and that he was going to have to either call the doctor when the patient passed away to come in or he could call ahead of time and get the rest of the medications or what would be on that order sheet.

    d. He testified that during his call with Dr. Marchenko he verbalized the drug name Diazepam to Dr. Marchenko, and then when he had all of the orders written down on Resident #3’s residential care terminal/end of life care orders, he read each of the orders again to Dr. Marchenko. He said he wrote those orders, only with a verbal interaction with the doctor.

    e. He further testified that during his call with Dr. Marchenko he verbalized the dosage of 0.5 to 1 milligram of Diazepam to the doctor who said okay, and that's when he wrote it down.

    f. He admitted he did not fill out an incident report for his medication error because he expected Resident #3 to pass away and then he could just fill out a single SLS Report. He acknowledged that he ought to have filled out a report.

g. He understood that trust in communication between health care professions was essential and honesty played a large role in that trust.

h. Nurses are human and make mistakes too, but it is critical that errors are dealt with appropriately and promptly.

i. And that a medication error needs to be reported to the physician, manager, family member (or decision maker), and an incident report must be filled out (SLS).

j. He admitted that he made the medication errors when he used Diazepam instead of the ordered Lorazepam at approximately 2000 and 0001 on February 24/25, 2020.

k. He felt that he was under scrutiny in his workplace.

l. He denied fabricating a Diazepam order from Dr. Marchenko.

m. He admitted he did not follow appropriate processes for documenting his medication error, including not reporting it to Resident #3' family or his manager, or by preparing a SLS.

n. At the time of the subject allegations, he had approximately 17 years of nursing experience. When he started working at Evergreen, he was on a learning plan to support his nursing practice.

Analysis and Findings of Fact

56. The College submits that the allegations in paragraph 3 of the Citation have been proven on a balance of probabilities and constitutes professional misconduct.

57. The Panel finds the evidence of Ms. Gordon, Ms. Irwin, Mr. van Veen, and Dr. Marchenko, outlined above, clear, convincing, and cogent, and it accepts their evidence.

58. As already noted, the Respondent admitted that he made the two medication errors alleged when he used Diazepam instead of the ordered Lorazepam at approximately 2000 and 0001 on February 24/25, 2020. He also admitted he

did not fill out an incident report for his medication errors and that he ought to have filled out a report.

59. The Panel finds that the evidence establishes, on a balance of probabilities, that on or about February 24 and 25, 2020, while working as a Registered Nurse on the Evergreen Extended Care Unit in Powell River, British Columbia, the Respondent gave Resident #3 Diazepam instead of the prescribed Lorazepam.

60. Further, the College submits the Respondent's version of events related to his interactions with Dr. Marchenko on the telephone is not credible. The College says the Respondent fabricated the alleged telephone order by Dr. Marchenko to conceal that fact he made two medication errors by giving the wrong drug twice to Resident #3.

61. During the hearing the Respondent maintained that he told Dr. Marchenko of the drug error – despite the fact that there is no documentation to support this report (that, is correcting the MAR and making an SLS report).

62. The College submits that Dr. Marchenko's version of events was trustworthy, sincere, and believable whereas the Respondent's was not. The College submits that Dr. Marchenko's evidence is cogent and "makes sense". It says that Dr. Marchenko's evidence ought to be preferred to the Respondent's evidence using the following framework outlined in *Bradshaw v Stenner*, 2010 BCSC 1398:

> Credibility Assessment
>
> [185] Credibility is a key issue in this case. Based upon the factual analysis above, it is apparent that the credibility of the plaintiff and defendant, as well as their witnesses, has been severely tested in the evidence. Because credibility was so much at issue throughout this trial, I requested counsel to thoroughly review the law with respect to assessment of credibility for me. Both counsel did an excellent job of drawing relevant principles to my attention. It was with these principles in mind that I approached the factual analysis.
>
> [186] Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art

> of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Faryna v. Chorny*, 1951 CanLII 252 (BC CA), [1952] 2 D.L.R. 354 (B.C.C.A.) [*Farnya*]; *R. v. S.(R.D.),* 1997 CanLII 324 (SCC), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).
>
> [187] It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 1993 CanLII 7140 (AB QB), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.

63. The Panel agrees with the College's submissions.

64. The Respondent testified that after the medication error had been pointed out to him by Ms. Gordon, he walked Dr. Marchenko through an entire new medication order sheet, line by line, during their telephone conversation at 230 in the morning.

65. The Panel does not find it reasonable, or believable from a nursing practice perspective, or as a matter of common sense, that a doctor would have tolerated this type of conduct at 230 in the morning after having been woken from sleep. The Panel finds the Respondent's assertion that this is what occurred during their telephone call to be so far-fetched and outside the realm of what could be reasonably expected in the circumstances, that it is implausible.

66. The Panel finds Dr. Marchenko's testimony that he would have stopped the Respondent if he had tried to do that believable, and in conformance with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions".

67. The Panel also does not find it plausible or believable, as a matter of common sense, that Dr. Marchenko would have provided the Respondent with telephone orders for Diazepam, a drug that the evidence before the Panel established is rarely used at Evergreen, and not given via the subcutaneous route, only a few hours after he had left orders for Lorazepam, and that that order would then also be for the wrong dose range that exactly mirrored his Lorazepam order and the Respondent's admitted medication errors.

68. Dr. Marchenko was firm about his recollections, in that he did not give an order for Diazepam SC, and that the doses written by the Respondent were the same for Lorazepam and would be incorrect. He stated that the last clear statement to the Respondent was to go ahead with the Lorazepam.

69. Ms. Irwin's testimony corroborates Dr. Marchenko's version that he did not order Diazepam to be administered subcutaneously for Resident #3.

70. Ms. Irwin testified she could not find anywhere in Resident #3's chart where the Respondent had made a note that he had informed Dr. Marchenko that he had made an error, and there was no assessment documented to indicate that the Respondent had assessed Resident #3 in light of the error. The Respondent himself also admitted he did not follow appropriate processes for documenting his medication error.

71. Ms. Irwin further testified that she has never during her entire career given Diazepam subcutaneously, and she would have to go back to a pharmacology book to see if it could be given by that route of administration.

72. The documentary evidence before the Panel further corroborates Dr. Marchenko's testimony that he did not order Diazepam for Resident #3. The patient records for Resident #3 indicate that the Evergreen pharmacy phoned

the ward in the morning to clarify the order for Diazepam for Resident #3 the Respondent sent. The patient records further show Dr. Marchenko cancelled that Diazepam order and confirmed his original Lorazepam order.

73. The Panel finds the Respondent's testimony, that he informed Dr. Marchenko about the medical errors and that Dr. Marchenko gave him a telephone order for Diazepam SC, inherently unbelievable. It is inconsistent with Dr. Marchenko's testimony, and it is not believable when compared to his testimony, the documentary evidence before the Panel, and the evidence of the other witnesses who testified before the Panel.

74. Dr. Marchenko, Ms. Irwin, and Ms. Gordon are all disinterested parties. The Panel found their evidence cogent, clear and it accepts their evidence. In his testimony Dr. Marchenko did not attempt to pass blame or make the Respondent look bad before the Panel. His testimony about their telephone conversation at 230 in the morning on February 25, 2020 was straightforward, reasonable, objective, and believable.

75. The Panel finds that Dr. Marchenko's version of events, that he did not provide the Respondent with a telephone order for Diazepam SC, is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions".

76. The Panel accordingly finds that the evidence before it also establishes, on a balance of probabilities, that the Respondent fabricated a telephone order by Dr. Marchenko for Diazepam SC to conceal that fact he made medication errors by giving the wrong drug twice to Resident #3.

77. The College submits the Respondent's described conduct satisfies the definition of *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 SCR 869, in which the Supreme Court of Canada defined "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”.

78. The Court in *Pearlman* emphasized that a professional’s conduct should be measured against the judgment of other members of the profession who are competent and in good standing. Accordingly, the College argues, the Respondent’s conduct should be measured against the judgment of a competent Registered Nurse (RN).

79. The College also relies on the case of *Re McLellan* CRNBC 2018, in which a discipline panel of the Former College held that unprofessional conduct is 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.”

80. The College points out that “professional misconduct” is defined in section 26 of the HPA to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession". The College further points out that section 26 of the HPA defines "unprofessional conduct" to include “professional misconduct".

81. The College submits unprofessional conduct connotes the breach of a standard, rule, or expected behaviour, while professional misconduct is unprofessional conduct that has crossed a more serious threshold [See: *Xu (Re)*, 2019 CanLII 131132 (BC CDS)].

82. The Panel agrees with the College’s submissions. Based on the evidence, the Panel finds the Respondent failed to comply with the College’s Documentation Practice Standard (Principles 4,6 and 8), the College’s Professional Standards (Standard 1 “Professional Responsibility and Accountability”, Clinical Practice Items 1, 2, 3, 4; Standard 2 “Knowledge-Based Practice”, Clinical Practice Items 3 and 4; Standard 3 “Client-Focused Provision of Service”, Clinical Practice Item 1 and Standard 4 “Ethical Practice”, Clinical Practice Items 1, 3, 6, 7, 11, 12) and the College’s Medication Administration Practice Standard, Items 2, 3, 12. These Standards provide the following:

Practice Standard for Nurses and Nurse Practitioners – Documentation Principles

4. Nurses document at the time they provide care or as soon as possible afterward. Delays may affect the continuity of care, affect the nurse's ability to recall details about events and increase the possibility of errors. Nurses do not document before giving care. Nurses correct any documentation errors in a timely, honest and forthright manner.

6. Nurses carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk or have complex health problems.

8. Nurses complete a safety event report (sometimes called an incident report) following an event such as a medication error or a fall. The safety event report is not part of the health record. Nurses record facts about any safety event affecting the client on the client's health record.

Professional Standards

Standard 1: Professional Responsibility and Accountability
Clinical Practice

1. Is accountable and takes responsibility for own nursing actions and professional conduct.

2. Functions within own level of competence, within the legally recognized scope of practice and within all relevant legislation.

3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.

4. Takes action to promote the provision of safe, appropriate and ethical care to clients.

Standard 2: Knowledge-Based Practice
Clinical Practice

3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

4. Collects information on client status from a variety of sources using assessment skills, including observation, communication, physical assessment and a review of pertinent clinical data.

Standard 3: Client-Focused Provision of Service
Clinical Practice

1. Communicates, collaborates and consults with clients and other members of the health care team about the client's care.

Standard 4: Ethical Practice
Clinical Practice

1. Makes the client the primary concern in providing nursing care.

3. Demonstrates honesty and integrity.

6. Recognizes, respects and promotes the client's right to be informed and make informed choices.

7. Promotes and maintains respectful communication in all professional interactions.

11. Identifies the effect of own values, beliefs and experiences in carrying out clinical activities recognizes potential conflicts and takes action to prevent or resolve.

12. Identifies ethical issues; consults with the appropriate person or body; takes action to resolve and evaluates the effectiveness of actions.

Practice Standard for Nurses and Nurse Practitioners – Medications Standard

Principles

2. Nurses are knowledgeable about the effects, side effects and interactions of medications and take action as necessary.

3. Nurses adhere to "seven rights" of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.

12. When a medication error or near miss occurs at any point in the process of prescribing, compounding, dispensing or administering a medication, nurses take appropriate steps to resolve and report it in a timely manner.

83. The Panel finds that these Standards present the minimum level of acceptable performance or conduct which the College expects its Nurse registrants should comply with.

84. The Panel further finds that the Respondent's proven conduct presents such a marked departure from the minimum level of acceptable performance or conduct that the College expects of its Nurse registrants that it constitutes professional misconduct.

85. Based on the above-mentioned evidence, the Panel finds the Respondent's proven conduct as described in paragraph 3 of the Citation is conduct that falls within the definition of section 26 of the HPA, that is, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession. The Panel also finds the Respondent's proven conduct disgraceful, dishonorable, and unbecoming of a member of the Nursing profession.

86. Accordingly, the Panel determines that by conducting himself in the manner described in paragraph 3 of the Citation, which conduct has been established on a balance of probabilities by the above-mentioned evidence, the Respondent committed professional misconduct pursuant to section 39(1)(c) of the Act.

K. <u>Order</u>

87. The Panel determines that pursuant to section 39(1) (c) of the Act that the Respondent has:

    a. Committed unprofessional conduct in relation to the allegations in paragraphs 1 and 2 of the Citation; and

    b. Committed professional misconduct in relation to the allegation in paragraph 3 of the Citation.

88. The Panel directs that the Registrar of the College notify the public of the Panel's determination, pursuant to section 39.3(1)(d) of the HPA.

L. <u>Schedule for Submissions on Penalty and Costs</u>

89. The Panel requests that the parties provide written submissions regarding the appropriate penalty and costs.

90. The Panel requests that the parties provide the written submissions in accordance with the following schedule:

    a. Submissions must be delivered by counsel for the College to the Respondent and the Panel within 21 calendar days from the date on which this order was provided to the parties;

b. Submissions must be delivered by the Respondent to counsel for the College and the Panel within 21 calendar days from the date the College provided the Respondent with its aforementioned submissions; and

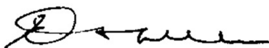
c. Reply submissions may be delivered by counsel for the College to the Respondent and the Panel within 7 calendar days after the Respondent has provide the College with his submissions.

91. Submissions for the Panel should be delivered to Fritz Gaerdes, independent legal counsel for the Panel and may be delivered electronically to the following email: fritz@preciousgaerdes.com.

M. Notice of right to appeal

92. The Respondent is hereby advised that under section 40(1) of the Act, a person 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 of British Columbia. Under section 40(2), an appeal must be commenced within 30 days after the date on which this order is delivered.

Signed and dated: January 7, 2022.



Edna McLellan, RN(T) (Chair)

Dorothy Barkley

Kira Antinuk, RN