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:

Ming Fung

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Date:	December 7, 2020 (by videoconference)
Discipline Committee Panel:	Sheila Cessford, Chair Edna McLellan, RN (T) Dr. Catharine Schiller, RN
Counsel for the College:	Michael Seaborn
The Respondent:	Appearing on his own behalf

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 hearing to determine, pursuant to section 38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), whether the conduct of Ming Fung (the "Respondent") constituted unprofessional conduct, a breach of the Act or bylaws.

2. For the reasons that are set out below, the Panel determined that the College has proven the allegations set out in the citation dated July 21, 2020 (the "Citation") to the requisite standard and that the conduct constitutes unprofessional conduct.

B. Background

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

> 1.Beginning in or about July 2018 through to November 2019, you failed to respond to BCCNP inquiries and requests for information in a full and substantive manner with respect to the investigation of a complaint against you, contrary to BCCNP bylaw 338 and the Responsibility and Accountability Professional Standard.
>
> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

4. Further to an earlier order of the Panel, the evidence of the College's one witness, Frances Naylor, was tendered by way of affidavit. Ms. Naylor, the College's investigator who investigated the complaint against the Respondent, attended the hearing and was available for cross-examination by the Respondent. The affidavit was provided to the Respondent in advance of the hearing.

5. The Respondent testified on his own behalf and called no other witnesses.

6. The College delivered oral and written submissions. The Respondent delivered oral submissions.

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

C. Service of Citation

8. The College filed an affidavit with proof of service of the Citation in this matter. The documents demonstrate that the Respondent confirmed receipt of the Citation. Service was not raised as an issue in the hearing. The Panel is satisfied that the Respondent was properly served with the Citation.

D. Burden and standard of proof

9. 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.

10. 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".

11. The Panel agrees that the College must prove its case on a balance of probabilities.

E. Action by the Discipline Panel

12. 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,
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> (d) has incompetently practised the designated health profession, or
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> (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.

13. Sections 39(1) (a), (b) and (c) apply to this case.

F. Evidence

14. Ms. Naylor's affidavit provides the following evidence:

    a. She was appointed as an inspector pursuant to section 27 of the HPA.

    b. In May 2018, the former College of Licensed Practical Nurses of BC ("CLPNBC") received a complaint regarding the Respondent from members of the public. The allegations concerned sexual and financial abuse of a vulnerable adult, AL, who was a client of the Respondent in independent living.

    c. An investigation was authorized by the CLPNBC's Inquiry Committee on June 5, 2018.

    d. On September 4, 2018, CLPNBC amalgamated with two other nursing colleges in British Columbia to form the BC College of Nursing Professionals ("BCCNP"), which remained seized of the complaints investigated by the CLPNBC.

    e. In December 2018, Ms. Naylor was assigned to investigate the complaint against the Respondent.

f. In light of information learned during the investigation, on June 26, 2019, the BCCNP Inquiry Committee expanded the scope of the investigation to include the wider nature of the Respondent's relationship with AL.

g. On December 5, 2019, the BCCNP Inquiry Committee directed an own motion investigation into the Respondent's failure to cooperate and effectively communicate with BCCNP.

h. Considerable staff time and other BCCNP resources were expended in making numerous and repetitious requests for information from the Respondent, and in preparing for an in-person interview, which was then cancelled by the Respondent at short notice.

i. The Respondent's lack of engagement with the process caused significant delays to the investigation of the allegations against him. BCCNP was compelled to repeatedly set deadlines for the Respondent's responses and track his non-responses or follow up on his partial and inadequate responses.

15. Attached to Ms. Naylor's affidavit as an exhibit are the CLPNBC and BCCNP communications with the Respondent during the investigation into the complaint. The communications comprise emails, letters, and notes from telephone conversations with the Respondent over the course of 17 months from June 2018 to November 2019. Each discrete communication is at a numbered tab, running from Tab 1 through to Tab 29. Ms. Naylor's affidavit further contains the following summaries of each of these communications or contacts with the Respondent during this period:

Tab	**Date**	**Summary of contact**
1	June 5, 2018	The Former College wrote to the Registrant advising him that a complaint had been received, and that the concerns reported related to professional and sexual misconduct.
2	June 28, 2018	The Former College sent a summary of the allegations to the Registrant and requested his response by July 13, 2018. Registrant informed that an inspector had been appointed to investigate the allegations.

3	July 9, 2018	The Registrant telephoned the Former College and asked for more time to respond to the allegations. A new response deadline of July 20, 2018 was agreed upon to allow him time to consult witha lawyer.
4	July 18/26, 2018	The Former College spoke with a lawyer who advised that he was acting for the Registrant. A revised response date of July 27, 2018 was agreed. The Former College subsequently spoke with the lawyer who advised he had not received instructions from the Registrant so would not be acting for him.
5	August 16, 2018	Registrant telephoned the Former College and gave a verbal response.
6	August 21, 2018	Registrant telephoned the Former College and subsequently, on the same day, provided the Former College with a written response.
7	Sept. 11, 2018	BCCNP asked the Registrant to provide more specific information than that provided in his August 21, 2018 response. He was requested to respond by September 25, 2018. This request by BCCNP included a request for documentation regarding his employment relationship with AL.
8	Dec. 14,2018	BCCNP wrote the Registrant (by email and courier) to follow up on his outstanding response to the September 11, 2018 request for documentation. He was also asked to respond to additional questions and to provide additional documentation. His response was requested by December 24, 2018. This correspondence also notes three attempts during September and October 2018 to contact the Registrant by phone; calls which were not answered or returned. The correspondence provides notice that failure to provide a timely response can result in serious consequences.
9	Dec.18,2018	The couriered copy of BCCNP's December 14, 2018 letter was returned to the College, undelivered. The letter had been sent to the Registrant's address on the register.
10	Dec. 19,2018	BCCNP telephoned the Registrant. He confirmed receipt of the December 14, 2018 email and stated that he would be respondingto this.

11	Jan.2/3, 2019	BCCNP twice called the Registrant to follow up on his overdue response. He did not answer these calls so BCCNP left voice messages. These were not responded to.
12	Jan. 14,2019	The Registrant wrote to BCCNP answering just one of seven questions posed to him, and not providing any of the requested documentation. BCCNP replied to the Registrant highlighting the fact he had omitted to answer these additional questions and requesting his reply by return email to advise when BCCNP could expect to receive his answers to these outstanding queries. The correspondence provides notice that failure to provide atimely response can result in regulatory action.
13	Jan. 29, 2019	BCCNP wrote to the Registrant by both email and courier, documenting the history of its correspondence with him and further requesting his response to the outstanding questions. His response was requested by February 12, 2019, with a warning that the Inquiry Committee could take extraordinary action under section 35 of the *Health Professions Act* in the event of his further non-response.
14	Jan. 30, 2019	BCCNP received confirmation that the couriered copy of this correspondence was delivered to the Registrant.
15	May 13, 2019	Having not received a response to the January 29, 2019 letter, BCCNP wrote to the Registrant again requesting his response no later than May 20, 2019, noting that BCCNP bylaw 338(1) requires cooperation during investigation and reiterating that the Inquiry Committee could take extraordinary action under section 35 of the *Health Professions Act.*
16	May 17/21, 2019	The Registrant replied to BCCNP, querying why we were asking him the additional questions. This was five months after the questions BCCNP asked of him on December 14, 2018, and nearly eight months after those of September 11, 2018. BCCNP replied to the Registrant explaining the relevance of the additional, unanswered questions, and setting a deadline for his response of May 28, 2019. He was again reminded of the potential consequences of his failure to respond.

17	May 23, 2019	The Registrant emailed BCCNP confirming his current employer and suggesting that BCCNP contact AL (who the Registrant knew to be a vulnerable adult with mental health concerns and a terminal illness) to establish the answers to the remaining questions.
18	May 27, 2019	The Registrant telephoned BCCNP. During the call, he stated that the reason he had not replied sooner was that he did not see the questions as being relevant to the investigation. He said he would follow up with a written response.
19	Sept. 20, 2019	BCCNP wrote to Registrant requesting an in-person interview, and requesting the Registrant bring specified documentation to the interview. The letter set out the Registrant's duty to cooperate with the College, and the potential consequences of failing to so. The letter also informed the Registrant of the expanded scope of the investigation. BCCNP set out its intention for the interview to take place between October 7 and 18, 2019. The Registrant's response was requested no later than September 27, 2019.
20	Sept. 27, 2019 (9:11 pm)	The Registrant emailed BCCNP asking if he could respond to BCCNP's questions in writing rather than attend an interview.
21	Sept. 30, 2019	BCCNP emailed the Registrant reiterating the need for in-person interview, providing potential meeting dates over a two week period and requesting a response no later than October 4, 2019.
22	Oct. 4, 2019 (9:27 pm)	The Registrant emailed BCCNP stating he was seeking a lawyer to represent him.
23	Oct. 7, 2019	BCCNP emailed the Registrant acknowledging that he was seeking legal advice and reiterating the requirement for him to attend an interview between October 21 and November 1, 2019.
24	Oct. 29, 2019	The Registrant contacted BCCNP noting that he believed he was missing a letter from BCCNP dated June 28, 2019 and stating that BCCNP had not answered questions from his last contact with the College. BCCNP did not send the Registrant any correspondence on or around June 28, 2019.

25	Oct. 31, 2019	The Registrant emailed BCCNP saying that, after speaking with lawyers, he intended to come for a meeting the following day at "about 1 pm". BCCNP replied saying that a meeting could not be accommodated the following day. BCCNP suggested alternative dates, and requested the Registrant reply by November 5, 2019 advising when the College could expect him.
26	Nov. 5, 2019	The Registrant emailed BCCNP requesting a meeting on Nov. 15, 2019. BCCNP replied advising that it could not accommodate a meeting on that date and offering four other possible dates for the meeting. The Registrant's response was requested by Nov. 8, 2019.
27	Nov. 15, 2019	Out of office email for administrative staff member.
28	Nov. 15/18, 2019	The Registrant emailed BCCNP confirming that he could come for a meeting on November 21, 2019 at "about 2 pm". After clarifying the date (actually Nov. 22, 2019), BCCNP replied to the Registrant confirming its availability for the meeting, requesting that it commence at 12:45pm and providing instructions as to when the Registrant should arrive and directing him to the BCCNP Reception desk. The reply also reminded the Registrant of the documents he was requested to bring to themeeting.
29	November 22, 2019 (12:19pm)	The Registrant emailed BCCNP advising that he had been confused as he had received an out of office email and assumed the BCCNP staff he was due to meet with were away until December 3, 2019. He said he had only just seen the November 18, 2019 email confirming the meeting and that he "cannot attend the meeting in less than one hour time frame". This email was sent 26 minutes before the meeting was due to start. The BCCNP staff requesting the meeting did not have an out of office assistant turned on, however an administrative staff member copied into the correspondence did have such an auto-response.

16. The Respondent cross-examined Ms. Naylor during the hearing. He asked the purpose of her inquiries to him and why she required a response. Ms. Naylor responded that the purpose was to seek information that was relevant to the investigation, and that she was seeking the Respondent's cooperation in accordance with the College's protocols.

17. The Respondent testified on his own behalf and provided the following evidence:

    a. A complaint was made to the College against the Respondent alleging that he had sexually assaulted AL and stolen a significant sum of money from her. The police were involved. After several months, the police investigation was concluded and they closed their file.

    b. The Respondent felt that the College had engaged in a "witch hunt" by investigating him even though the police investigation had concluded.

    c. The Respondent stated that he did not want to respond to Ms. Naylor's questions because, if his answers differed from the information which Ms. Naylor had, Ms. Naylor may "turn around and accuse" the Respondent. The Respondent stated that he did not "want any other accusations" and that is the reason he did not respond to the College's questions.

    d. The Respondent testified that he recognized he had a duty to cooperate with the College, however, he stated that he also believed that he had the right to remain silent under "federal law".

    e. The Respondent testified that when Mr. Seaborn (legal counsel handling the disciplinary proceedings on behalf of the College in this matter) was assigned to the case, the Respondent communicated with him and cooperated with the College.

G. Parties' Submissions

18. The College submits that it has proven on a balance of probabilities that the Respondent failed to respond to its inquiries and requests for information in a full and substantive manner, and that that failure amounts to a breach of the BCCNP Bylaws and nursing standards, and constitutes unprofessional conduct.

19. The College submits that the Panel should consider the totality of the communications with the Respondent in which it is apparent that the Respondent either did not respond, did not fully respond, or deflected the College's requests. The College submits that the Respondent's conduct caused significant delays and resulted in the expenditure of unnecessary resources.

20. The College refers to section 28 of the Act, which sets out the powers and duties of an inspector to investigate and gather information from a registrant:

> 28 (1) During regular business hours, an inspector may, subject to any limits or conditions imposed on the inspector by the inquiry committee, investigate, inquire into, inspect, observe or examine one or more of the following without a court order:
>
> (a) the premises, the equipment and the materials used by a registrant to practise the designated health profession;
>
> (b) the records of the registrant relating to the registrant's practice of the designated health profession and may copy those records;
>
> (c) the practice of the designated health profession performed by or under the supervision of the registrant.
>
> (2) The inquiry committee may direct an inspector to act under subsection (1) or undertake any aspect of an investigation under section 33.
>
> (3) If an inspector acts under this section as a consequence of a direction given under subsection (2), the inspector must report the results of those actions in writing to the inquiry committee.

21. The College also points to the additional powers conferred on inspectors by BCCNP Bylaw 332, which was in force at the material times:

> 332 In addition to the powers and duties of inspectors under section 28 of the Act, an inspector may do one or more of the following in the course of assessing a complaint under section 32(2) of the Act or investigating a matter under section 33 of the Act:

(a) require the registrant to produce, for inspection, examination or copying,

(i) the equipment or materials used by a registrant to practise a designated health profession, or

(ii) records of the registrant relating to the registrant's practice of a designated health profession;

(b) require the registrant to

(i) attend for interview by an inspector or the inquiry committee,

(ii) answer questions and provide information relating to the matter under assessment or investigation,

(iii) cause an employee or agent of the registrant to answer questions and provide information relating to the matter under assessment or investigation, or

(iv) do anything described in section 28(1)(a) to (c) of the Act during the regular business hours in effect at a particular premises or, by agreement with the registrant, at a time outside of those regular business hours;

(c) require the registrant to provide the identity and contact information of the registrant's current employers or supervisors, if any, and consent to those employers or supervisors being contacted by an inspector for the purpose of ascertaining the registrant's current practice setting, unit assignments or job duties, if any.

22. The College submits that the specific obligation of a registrant to cooperate with the College in an investigation or assessment is set out in Bylaw 338, which provides as follows:

> 338 (1) A registrant who is the subject of a complaint being assessed under section 32(2) of the Act or a matter being investigated under section 33 of the Act must co-operate fully in the assessment or investigation including, without limitation, by responding fully and substantively, in the form and manner acceptable to the inquiry committee,
>
> (a) to the complaint, if any, once the complaint or a summary of it is delivered to the registrant, and

(b) to all requests made or requirements imposed by an inspector or the inquiry committee in the course of the assessment or investigation.

(2) A registrant who is required or requested to do anything under section 332 or subsection (1) must comply with the requirement or request

(a) in the case of information or a record, even if the information or record is confidential, and

(b) as soon as practicable and, in any event, by the date and time set by an inspector or the inquiry committee.

(3) For greater certainty, nothing in section 332 or this section requires disclosure of information or a record to an inspector or the inquiry committee if

(a) the information or record is subject to solicitor-client privilege, or

(b) disclosure of the information or record to an inspector or the inquiry committee is prohibited by law.

23. The College submits there is an abundance of case law concerning the duty of registrants of a self-governing profession to cooperate with their regulator. The College relies upon the following cases:

a) *Artinian* v. *College of Physicians and Surgeons of Ontario* (1990 CanLII 6860), a registrant was found guilty of professional misconduct for failing to cooperate with a requested review of patient records by an inspector. The registrant appealed that finding to Ontario's High Court of Justice, Divisional Court, arguing that there was no duty to co-operate, given that the registrant's college, at that time, had no bylaw requiring a registrant to cooperate with an investigation. A panel of three justices disagreed, stating, "Fundamentally, every professional has an obligation to co-operate with his self-governing body."

b) *Law Society of BC* v. *Tak* (2011 LSBC 01), the Law Society's discipline committee quoted with approval the decision of the *Law Society of BC* v. *Dobbin*, 1999 LSBC 27 on the importance of responding promptly to one's

professional regulatory body. The panel said: "…we repeat, responding promptly, candidly and completely to Law Society communications is the cornerstone of our right to self-govern". The College points out that the panel in *Tak* held that the member's failure, while under investigation, to provide certain records and available dates to meet with the Law Society amounted to professional misconduct.

c) *Cusack* v. *Law Society of Ontario* (2019 ONSC 5015), a lawyer refused to provide documentation requested by the Law Society pursuant to an investigation. Speaking generally of the importance of investigations to the role of self-governing professions, the Court held at paragraph 28:

> The Law Society is one of many self-governing professions in the Province of Ontario. It is fundamental to the ability of a self-governing profession to properly regulate itself. Part of self-governance is the ability to discipline its members where professional misconduct occurs. The ability to discipline can only occur where the professional body has the ability to investigate its members when confronted with a complaint. A full and complete investigation provides confidence to the general public that it can rely on a self-governing profession.

d) *Law Society of BC v. McLean* (2015 LSBC 06), a member was alleged to have failed to "respond promptly or substantively to communications from the Law Society". The panel quoted with approval from *Law Society of BC v. Dobbin* (1999 LSBC 27) which held:

> … that unexplained persistent failure to respond to Law Society communications will always be *prima facie* evidence of professional misconduct which throws upon the respondent member a persuasive burden to excuse his or her conduct.

The Panel in *McLean* went on to note at paragraph 73 (a) that, "The Law Society simply cannot discharge its duty to the public without communication with and cooperation from lawyers who are under investigation".

e) *College of Registered Nurses of BC and Cunningham* (CRNBC Discipline Committee, 2017) a registrant's failure to respond to communications from the College constituted "unprofessional conduct" under the Act.

24. The College also submits that confusion about obligations owed to a regulator is not an excuse for non-compliance. In *Law Society of Ontario v. Diamond* (2019 ONSC 3228), the Court said, "Licensees must understand their obligations and comply with them; a confused licensee who has not taken the time and effort to be aware of those obligations may be found to have engaged in misconduct". The College submits that any confusion the Respondent may have been under regarding his obligations to the College cannot obviate his responsibility to have made the effort to understand and fulfil his duty to cooperate.

25. The College also relies on section 26 of the Act, which defines "unprofessional conduct" as follows:

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

26. The College submits "unprofessional conduct" is broadly considered 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 para. 54).

27. The Respondent's submissions were focussed upon his perception that Ms. Naylor intended to "punish" him. He says for this reason, he limited his contact with her. The Respondent argued that he did not have sufficient trust in Ms. Naylor and that cooperation can only occur where there is trust. The Respondent submits that he did answer the College's question about the sexual assault allegation and eventually answered the financial questions as well. The Respondent argued that he tried to limit his responses as much as possible. He argued that he had the right to remain silent and that "federal law" "trumps" the duty to cooperate.

H. Analysis

Allegation #1

28. As noted above, allegation #1 in the Citation alleges:

> 1.Beginning in or about July 2018 through to November 2019, you failed to respond to BCCNP inquiries and requests for information in a full and substantive manner with respect to the investigation of a complaint against you, contrary to BCCNP bylaw 338 and the Responsibility and Accountability Professional Standard.
>
> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

29. 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.

30. Section 338 of the Bylaws that were in force at the time require that a registrant who is the subject of a complaint being assessed or a matter being investigated must co-operate fully in that assessment or investigation:

> 338 (1) A registrant who is the subject of a complaint being assessed under section 32(2) of the Act or a matter being investigated under section 33 of the Act must co-operate fully in the assessment or investigation including, without limitation, by responding fully and substantively, in the form and manner acceptable to the inquiry committee,
>
> (a) to the complaint, if any, once the complaint or a summary of it is delivered to the registrant, and
>
> (b) to all requests made or requirements imposed by an inspector or the inquiry committee in the course of the assessment or investigation.
>
> (2) A registrant who is required or requested to do anything under section 332 or subsection (1) must comply with the requirement or request

(a) in the case of information or a record, even if the information or record is confidential, and

(b) as soon as practicable and, in any event, by the date and time set by an inspector or the inquiry committee.

[emphasis added]

31. The presence of the word “must” in the provision above is notable because the duty imposed on a registrant is mandatory and not permissive.

32. Section 338(1) expressly delineates that a registrant must cooperate “fully” in an assessment or investigation by “responding fully and substantively”. Section 338(1)(b) specifically requires a registrant to cooperate with all requests made or requirements imposed by an inspector or the inquiry committee during an assessment or investigation.

33. Section 338(2)(b) imposes a temporal component to the duty to cooperate. That is, a registrant is required to respond to inspector or inquiry committee requests “as soon as practicable” and in any event “by the date and time set by an inspector or the inquiry committee.”

34. The Respondent acknowledges that he owes a duty to cooperate with the College.

35. The Panel accepts the evidence of Ms. Naylor, as outlined above. Her evidence is clear and convincing and was unshaken on cross-examination. Ms. Naylor’s evidence establishes that the Respondent, who at all material times was and remains a registrant, was the subject of a complaint to the CLPNBC in May 2018. The June 5, 2018 correspondence from Ms. Eva Sajdik, CLPNBC’s Inquiry and Discipline Coordinator, to the Respondent notified him that the College had “received a complaint” related to his professional nursing practice while he was privately employed as a Licensed Practical Nurse, and that “the concerns relate to professional and sexual misconduct”. In addition, Ms. Naylor’s evidence establishes that the Inquiry Committee initiated an investigation on June 5, 2018, and expanded the scope of that investigation on June 26, 2019. Those investigations were

authorized pursuant to section 33 of the HPA. Accordingly, the Panel finds that the circumstances set out in section 338 of the Bylaws, in which a duty to cooperate arises, are present in this case. The Respondent was required to "cooperate fully" in the investigation and to respond fully and substantively to the inspector's (or the Inquiry Committee's) requests as soon as practicable (or by the date they specified).

36. The Panel agrees with the College's submissions that in addition to the express requirements in the Bylaws, there exists a well-established body of cases which have found a duty to cooperate upon a registrant with their self-governing bodies.

37. The Panel does not accept the Respondent's argument that the "right to remain silent" trumps the duty to cooperate. The right to silence under section 7 of the *Canadian Charter of Rights and Freedoms* applies to criminal proceedings in which an accused's liberty is at stake and the government must prove guilt beyond a reasonable doubt. The right to remain silent does not apply to proceedings before this Tribunal.

38. The Responsibility and Accountability Professional Standard in place at the material times required a Licensed Practical Nurse to meet the following standards:

> 5. Is accountable and responsible for own nursing decisions, actions and professional conduct
>
> […]
>
> 9. Understands the role of BCCNP and its relationship to one's own practice

39. As such, the Panel finds that the above professional standard also required that the Respondent be accountable and take responsibility for his own nursing decisions, actions and professional conduct, and understand the role of the BCCNP and its relationship to his practice.

40. The BCCNP's bylaws require registrants to conduct themselves in accordance with the standards of practice and the standards of professional ethics. The bylaws were enacted pursuant to section 19(1)(k) of the HPA. Professional standards were established pursuant to this authority.

41. The Panel agrees with the College's submissions that the above obligations apply to registrants irrespective of whether there is any confusion about them.

42. The Panel finds that the BCCNP inspector or a representative acting on behalf of the Inquiry Committee, made a number of requests of the Respondent pertaining to the complaint made against him and the investigation initiated against him. The relevant communications occurred during the period from June 2018 to November 2019.

43. By letter dated June 5, 2018, BCCNP notified the Respondent of the complaint made against him.

44. On June 28, 2018, Tess Corbett, Regulatory Compliance at BCCNP, wrote to the Respondent setting out the allegations against him and requesting a response to the complaint. The email enclosing the letter states, 'Please find attached a letter requiring your review and response." The letter itself states "An important part of the professional conduct review process is for you to provide information regarding the matter that you believe should be considered by the Committee. The allegations outlined in the complaint and requiring your response are: […]". It also states, "We ask that you provide a written response to the complaint by **July 13, 2018**, and include any additional facts that the Committee should consider when completing their assessment. **Please see the enclosed Guide for Responding to a Complaint** that may help you in writing your response." [emphasis in original].

45. On July 9, 2018, the Respondent requested an extension to respond to the complaint. Ms. Corbett confirmed an extension until July 20, 2018 was granted. A further extension to provide the response was granted until July 27, 2018, on the basis that the Respondent may have retained legal counsel. Subsequently it was confirmed that legal counsel was not going to be representing the Respondent in this matter.

46. On August 21, 2018, the Respondent provided a response to the complaint. The Respondent described AL's medical conditions. He advised that "the police closed the file" regarding the sexual assault allegations due to lack of evidence. The

Respondent confirmed that AL did allege that the Respondent sexually assaulted her. He admitted that when he was confronted about this by another individual, he stated “tell [AL] to shut up”. He described making that statement to release his frustration. He stated it was a translation of slang from Hong Kong. The Respondent stated that AL told him she withdrew the sexual assault allegations against him. The Respondent stated that he did not borrow $50,000 from AL between February 2018 and May 2018. The Respondent described his work hours and staying overnight with AL. The Respondent described a conversation about whether AL would continue to need a wheelchair. The Respondent described his use of the expression “drink tea”.

47. While the Respondent did provide a response, the response was submitted after the deadline imposed upon him, and it did not fully respond to the complaint allegations. Most notably, the Respondent did not respond to the most serious allegation, that is whether he sexually assaulted AL. The Respondent did not address the allegations that he failed to maintain professional boundaries, or that he coerced AL to withdraw her police complaint. He merely confirms that she did so.

48. On September 11, 2018, Ms. Corbett wrote to the Respondent requesting the following information by September 25, 2018:

    1. Copies of timesheets outlining the hours you worked for [AL] between April 2018 and May 4, 2018.
    2. Details regarding payment you received from [AL] for work as an LPN. Please include:
        a. How much you were paid (i.e hourly/daily rate)
        b. How you were paid (i.e. electronic / bank deposit . cheque / in cash);
        c. If you were paid in cash, please explain how this cash was accessed / provided;
    3. Records / proof of income received from [AL] between April 2018 and May 4, 2018.

49. The Respondent did not provide the requested information by the September 25, 2018 due date, nor did he answer or return telephone calls made to him on September 26, October 3, and October 24, 2018.

50. Ms. Naylor took over the investigation. On December 14, 2018, she wrote in follow up to the three above requests, adding four additional requests for information:

    4. Did you have a contract / agreement with [AL] regarding the nursing services you provided for her (be this informal or formal)? If so, please provide details, including documentation.

    5. If you are unable to provide the timesheets requested at point 1, above, please otherwise list the dates and times you cared for [AL] and/or provided her any sort of companionship (such as staying overnight while she slept).

    6. Witness accounts we have obtained from [J] and [R] and [A] indicate that when asked if you had sexual intercourse with [AL], you denied the allegation but stated that you had <u>thoroughly bathed her for one hour</u>. Do you recall making this statement? Does this reflect your normal practice for bathing clients? Was this type of bathing requested and/or required by [AL]? [emphasis in original]

    7. Please confirm all of your current employers so that BCCNP may contact them to provide details of your current practicing, unit assignments and/or job duties.

51. A response to all seven requests was due “no later than December 24, 2018”.

52. Ms. Naylor spoke to the Respondent by phone on December 19, 2018. She confirmed the Respondent had received the correspondence and was aware that the requested information was due by December 24, 2018. The Respondent acknowledged receipt of the correspondence, the requests, and confirmed he would respond.

53. The Respondent did not provide the requested information by the December 24, 2018 due date.

54. Ms. Naylor left voicemail messages for the Respondent on January 2 and 3, 2019 asking that the Respondent call her back.

55. On January 14, 2019, the Respondent emailed Ms. Naylor attaching a brief typed document with some details about AL's bath. The Respondent explained that he observed an odour the day prior and for this reason he spent longer the following day to bathe her. The Respondent explained that he told the individuals identified in the request, in Chinese, that he "spent like/seem an hour long" which is a figure of speech in Chinese but does not actually mean sixty minutes. The Respondent did not answer Ms. Naylor's questions about his normal practice bathing clients or whether this was requested by AL.

56. On January 14, 2019, Ms. Naylor emailed the Respondent acknowledging receipt of the above communication. Her email was marked "high importance". Ms. Naylor stated, "Thank you for your mail and its attachment. However, I note your response only addresses one of the questions posed to you in my letter dated December 14, 2018 (a copy of which is attached for your reference). For ease of reference, the outstanding questions / requests are as follows:". Ms. Naylor expressly stated "**you did not provide any responses to six of the seven questions BCCNP wishes you to answer. Please respond to me by return email to confirm when BCCNP can expect to receive your responses to the outstanding questions / requests**." [emphasis in original]. Ms. Naylor then set out the remaining six requests in the body of her email that had not been addressed by the Respondent as well as confirming that the Respondent had only partially answered the seventh request. She noted that "timely response to all BCCNP correspondence is required and failure to do so can result in regulatory action…".

57. On January 29, 2019, Ms. Naylor followed up by letter to the Respondent. She summarized all contact with the Respondent, reiterated the six outstanding requests and requested an "**immediate response**" to the six outstanding requests by "**no later than February 12, 2019**." [emphasis in original].

58. On May 13, 2019, Ms. Naylor again wrote to the Respondent setting out the six outstanding requests for information. She noted that this letter was a **"final notification that [the Respondent's] response is required by May 20, 2019**" [emphasis in original].

59. On May 17, 2019, the Respondent emailed Ms. Naylor and asked for the reason behind these questions outlined in the letter. The Panel agrees with the College's characterization that this was deflection on the part of the Respondent. Ms. Naylor responded to the Respondent's email on May 21, 2019. She addressed his query about the relevancy of the questions and asked for his response "**within one week**" [emphasis in original].

60. On May 23, 2019, the Respondent emailed Ms. Naylor recommending she speak to another individual about the requests for information.

61. On May 27, 2019, Ms. Naylor spoke with the Respondent by telephone. He provided some information about missing records and about ATM withdrawals of AL's funds. Ms. Naylor asked why the Respondent had not responded to BCCNP's questions. The Respondent stated because questions about his employment "were not related to the complaint."

62. By letter dated September 20, 2019, Ms. Naylor requested an in-person interview of the Respondent. She proposed dates in mid-October 2019, and requested a response to her letter by "no later than **September 27, 2019**" [emphasis in original].

63. On September 27, 2019, the Respondent emailed Ms. Naylor to ask if he could provide a written response instead of verbal responses.

64. On September 30, 2019, Ms. Naylor responded by email stating that an in-person interview was required because the BCCNP had on multiple occasions sought written responses to specific questions but responses were either incomplete or lacking altogether. She proposed an interview during the final weeks of October 2019 and requested a response "by **October 4, 2019**".

65. On October 4, 2019, the Respondent emailed stating he was seeking the assistance of a lawyer who would be in touch with Ms. Naylor. Further communications continued between the Respondent and Ms. Naylor regarding the scheduling of an interview. Eventually, an interview was scheduled for November 22, 2019. On November 22, 2019, the Respondent sent an email indicating that he was confused

as to whether Ms. Naylor would in fact be in the office and that he now could no longer attend the interview that day.

66. The Panel finds that beginning in July 2018 through to November 2019, the Respondent failed to respond to BCCNP inquiries and requests for information in a full and substantive manner with respect to the investigation of a complaint against him. These were repeated queries and requests for information with multiple follow up efforts on the part of the BCCNP. The response provided by the Respondent did not fully and substantively address the complaint allegations and was not submitted as soon as practicable or by the date specified. In the one instance in which the Respondent did provide a reply to one of the seven requests for information (in relation to bathing AL), it was neither a full or substantive response, nor was it provided as soon as practicable or by the dates specified.

67. The Respondent admitted during the hearing that he failed to provide the requested information. He testified that had Mr. Seaborn, rather than Ms. Naylor, handled the matter from the outset, he would have cooperated with the investigation. This admission is inconsistent with the Respondent's evidence that he believed he had the right to remain silent, which the Panel notes was only raised for the first time during the hearing. As noted above, even if the Respondent's belief that he had the right to remain silent was genuinely held at the time, which the Panel finds it was not, that would not obviate the requirement that he was still under a duty to cooperate.

68. The Panel also does not accept the Respondent's submission that the College investigator was on a "witch hunt". The correspondence between Ms. Naylor and the Respondent demonstrates that she was diligently pursuing an investigation and that she did so in a fair and highly professional manner.

69. The Panel also finds that the Respondent failed to maintain the Responsibility and Accountability Professional Standard. By his own comments, he did not cooperate with the investigation, and did not respond fully or substantively to the seven requests for information which were made of him. He did not respond in a timely manner to requests for documents or information, if at all. He did not respond in a

timely manner to phone calls and correspondence. He cancelled a scheduled interview meeting on short notice. Overall, he was uncooperative, and his lack of cooperation hindered the investigator's and Inquiry Committee's ability to move forward with the investigation in an efficient and timely manner and in conformity with their roles and duties under both the bylaws and the HPA. As such, the Respondent demonstrated a failure to be accountable and responsible for his nursing decisions, actions and professional conduct, and a failure to understand the role of the BCCNP and its relationship to his own practice.

70. The Panel finds that the evidence establishes, on a balance of probabilities, that beginning in July 2018 through to November 2019, the Respondent failed to respond to BCCNP inquiries and requests for information in a full and substantive manner with respect to the investigation of a complaint against him, contrary to BCCNP bylaw 338 and the Responsibility and Accountability Professional Standard.

Unprofessional Conduct

71. 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."

72. "Unprofessional conduct" is defined in section 26 of the Act as follows:

> "unprofessional conduct" includes professional misconduct.

73. In *Re McLellan* CRNBC 2018, the Discipline Committee 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.

74. The Panel recognizes that this concept has also been described as being a "marked departure" from the standard to be expected of a competent professional.

75. The Panel was referred to a number of cases by the College in which a failure to have responded or cooperated with a self-regulating body amounted to unprofessional conduct or professional misconduct. The Panel notes in particular, *Re Cunningham* CRNBC 2017, in which the Discipline Committee found that a registrant's failure to have responded to college requests amounted to unprofessional conduct.

76. The Panel agrees with the reasoning expressed in the cases cited by the College about the importance of a registrant cooperating with their self-governing body. Compliance with the duty to cooperate is important not just to ensure that this particular investigation proceeded with dispatch, but also because the College is a self-governing profession, and its primary mandate is to protect the public. The College relies upon the cooperation and compliance of its members during the investigation process in order to effectively regulate the profession in the public interest and for the public's protection. A registrant's failure to cooperate with the College risks undermining the public's confidence in the College's ability to regulate its members.

77. The complaint allegations against the Respondent were serious as they involved allegations of sexual misconduct and professional misconduct towards a vulnerable elderly female patient. The BCCNP made repeated requests for a response to the complaint allegations, for specific information, and for the Respondent to attend an in-person interview. The Respondent's persistent failure to respond fully or at all to the College's queries and requests for information, and his deflection, is a significant

departure from the standard to be expected of a competent nursing professional and constitutes unprofessional conduct pursuant to section 39(1)(c) of the Act.

I. Schedule for Submissions on Penalty and Costs

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

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

    a. Submissions must be delivered by the College to the Respondent and the Panel by February 21, 2022;

    b. Submissions must be delivered by the Respondent to counsel for the College and the Panel by March 14, 2022; and

    c. Reply submissions may be delivered by the College to the Respondent and the Panel by March 21, 2022.

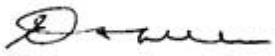
80. Submissions for the Panel's consideration should be delivered to Susan Precious, counsel for the Panel, and should be delivered by email.

J. Notice of right to appeal

81. 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.

Dated: January 31, 2022

Sheila Cessford, Chair



Edna McLellan, RN (T)

Dr. Catharine Schiller, RN