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:

James Christie

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Date:	March 8, 2022 (by videoconference)
Discipline Committee Panel:	Edna McLellan, RN (T), Chair Roland Mitchell, Public Member Samantha Love, LPN
Counsel for the College:	Aisha Ohene-Asante
The Respondent:	Unrepresented by counsel and did not attend hearing
Independent Legal Counsel for the Panel:	Fritz Gaerdes

A. Introduction

1. Pursuant to section 38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA") 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 whether the conduct of James Christie (the "Respondent") constituted unprofessional conduct, or a breach of the Act or bylaws.

2. For the reasons set out below, the Panel determines that by conducting himself in the manner described in paragraphs 1, 2 and 3 of the citation dated November 26, 2021 (the "Citation"), which conduct has been established on a balance of probabilities by the evidence before the Panel, the Respondent committed professional misconduct pursuant to section 39(1)(c) of the Act.

3. The Panel also determines that for the reasons set out below, by conducting himself in the manner described in paragraph 4 of the Citation, which conduct has been established by the evidence before the Panel on a balance of probabilities, the Respondent committed unprofessional conduct pursuant to section 39(1)(c) of the Act.

B. Background

4. 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 as follows:
>
> 1. On or about April 1, 2015, you assaulted JV contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.
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> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.
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> 2. On or about May 25, 2015, you assaulted RP contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.
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> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.
>
> 3. On or about May 25, 2015, you assaulted JS contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.

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

4. Beginning on or about July 19, 2016, you failed to respond to inquiries and requests for information with respect to the investigation of a complaint against you, contrary to your duty to co-operate and the following Professional Standards and/or Practice Standards: *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.

5. The College's evidence was tendered by way of the affidavit of [redacted], the College's investigator who investigated the complaint made against the Respondent. The College provided a Book of Documents, containing the following:

Tabs	**Description** **Description**
1	Citation issued November 26, 2021
2	Affidavit of [redacted] sworn March 2, 2022
3	Affidavit of [redacted] sworn February 25, 2022 (the "[redacted] Affidavit")
	Exhibits A to Q to the [redacted] Affidavit
A	Registration History
B	2015 06 03 IAOU
C	2015 06 05 Information
D	2016 07 19 Letter to Respondent and Xpresspost tracking
E	2016 07 22 Oral Reasons for Judgment
F	2016 11 09 Oral Reasons for Sentence
G	2016 11 27 Times Colonist News Article
H	2019 12 09 Letter from BC Corrections
I	Victoria Police Wanted Poster
J	2017 12 13 Information
K	2019 11 04 Letter from BC Prosecution Service
L	Trial Transcripts
M	Sentencing Transcript

N	2021 03 09 Requests for Response and tracking
O	LPN Professional Standards
P	BCCNP Bylaw 338
Q	BCCNM Bylaw 203

6. The Panel marked the Citation as Exhibit #1, the Affidavit of Service of [redacted] was marked as Exhibit #2 and the remainder of the Book of Documents, that is, the [redacted] Affidavit including its exhibits were marked as Exhibit #3. The Book of Documents, including the [redacted] Affidavit was provided to the Respondent in advance of the hearing.

7. [redacted] was available during the hearing for cross-examination by the Respondent. However, the Respondent failed to attend the hearing and provided no evidence. He did not participate in the hearing at all.

8. The College's counsel also provided oral and written submissions, and legal authorities to the Panel.

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

C. Service of the Citation and Proceeding with the Hearing in the Absence of the Respondent.

10. Shortly before the commencement of the hearing, the College filed affidavit evidence as proof of service of the Citation in this matter. The College's affidavits set out the various efforts the College has made to deliver the citation on the Respondent and to notify him of the discipline hearing.

11. [redacted] affidavit includes the following evidence regarding service:

    a. On November 29, 2021, [redacted] sent an unregistered letter that was successfully delivered to the last mailing address provided by the Respondent. A title search of the address shows that it is registered to the Respondent's parents, with whom he was known to be previously living.

Enclosed with the letter was a copy of the Citation.

b. On December 1, 2021, an email containing the citation was sent by BCCNM paralegal [redacted] to the last email address provided by the Respondent. This email did not return as undelivered. The email address was the same email previously used by the Respondent to communicate with the College of Licensed Practical Nurses of British Columbia ("CLPNBC"), a legacy college of the BCCNM.

c. On January 18, 2021, [redacted] re-sent the citation to the Respondent's last known address by registered mail. Though this mail was returned to the College counsel submitted that it has met the requirement of section 37(2) of the Act in sending the Citation to the respondent to the last address for the Respondent recorded in the registry.

12. The College submitted the evidence contained in [redacted] affidavit is proof that the College has made every attempt to deliver the citation to the Respondent, and that the Respondent should be deemed to be in receipt of the Citation for the purpose of proceeding in the Respondent's absence pursuant section 38(5) of the Act.

13. Further, the College pointed out that the second sentence of the third paragraph of the Citation contains the following notice to the Respondent:

> *If you fail to attend the hearing, the Panel will proceed with the hearing in your absence, and, without further notice to you, may take any action that it is authorized to take under the Act.*

14. The College also submitted that the affidavit of inspector [redacted] contains the following evidence that is relevant and weighed in favor of proceeding in the Respondent's absence:

a. On November 22, 2013, the Respondent was hired into a permanent night position at Selkirk Place Long Term Care Facility ("Selkirk Place").

b. On June 5, 2015, the Respondent was charged with the assault of Selkirk residents E.K., J.V., R.P., and J.S.

c. The assault trial was heard on July 18 and 19, 2016, and on July 22, 2016, the Respondent was found guilty of three of these assault charges. On November 9, 2016, the Respondent was sentenced to 6 months in jail.

d. The Respondent appealed the conviction and the sentence and was let out on non-surety bail pending his appeal on November 16, 2016.

e. While on bail the Respondent fled the country, has been declared absent without leave, remains wanted with an outstanding arrest warrant, and has yet to serve his sentence.

15. The College acknowledged that it is within the discretion of the Panel to decide whether to proceed with the hearing in the Respondent's absence. To this, the College submitted that should a hearing not proceed in the absence of a Respondent that has not only evaded justice for his criminal conviction by fleeing the country, but also has deliberately refused to engage with the College, the College would have no mechanism of taking disciplinary action against such registrants. Such a scenario would result in registrants being able to not only frustrate the public protection mandate of the College and the Act, but also evade disciplinary action for their actions.

16. In addition to not responding to any of the College's correspondence regarding this matter the Respondent has also failed to respond to emails sent to him by counsel for the Panel and failed to attend the pre-hearing conference held in February 2022.

17. The College noted that the Respondent's failure to co-operate with the College forms the substantive part of the fourth allegation on the Citation.

18. The College further submitted that the hearing should proceed because considerable time and resources have been expended in preparing for this hearing, including but not limited to:

a. Many hours of counsel and College staff time have gone into ensuring that all the necessary logistical arrangements to hold a hearing have been attended to, and

b. [redacted] has taken time from her regular duties to participate in the hearing.

19. Further to this, the College argued that it would not be in the interest of justice to essentially reward a respondent's lack of engagement with the College by not proceeding with the hearing. The College submitted that it was in the interest of justice that the Panel direct that the hearing commences in the Respondent's absence.

20. The Panel accepted the College's submissions and directed that the hearing proceed in the Respondent's absence.

21. Section 37(2) of the Act provides:

> Citation for hearing by discipline committee
> 37 …
> (2) The registrar must have a citation either delivered to the respondent by personal service **or sent by registered mail to the respondent at the last address for the respondent recorded in the register referred to in section 21 (2) not fewer than 30 days before the date of the hearing**.
>
> (Bolding added)

22. The evidence before the Panel demonstrated that in compliance with section 37(2) of the Act, the Citation was sent to the sent by registered mail to the Respondent at the last address for the Respondent recorded in the College's register more than 30 days before the date of the hearing. The evidence also showed the Respondent was served with the Citation through ordinary mail and by email, which correspondence was not returned to the College as undelivered.

23. The Panel was accordingly satisfied that the Respondent had both received the Citation, and that he also had notice of the date, place, and time of the discipline hearing, but chose not to attend it.

24. Further, section (4.2)(c) of the Act provides that:

> (4.2) The discipline committee may
> ...
> (c) make any other direction it considers appropriate
>
> if the discipline committee is satisfied that this is necessary to ensure that the legitimate interests of a party will not be unduly prejudiced.

25. Based on the evidence of the Respondent's conduct in evading justice and fleeing from Canada, the Panel was satisfied that proceeding with the hearing in his absence would not unduly prejudice the Respondent's interests, while not proceeding with the hearing would unduly prejudice the College's interest and ability to proceed expeditiously with discipline hearings against its members, and also to adequately protect the public by disciplining members who are alleged to have committed serious professional misconduct.

26. The Panel was therefore satisfied that the hearing should proceed in the Respondent's absence pursuant to section 38(5) of the HPA, and in the interest of justice.

D. Burden and standard of proof

27. 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.

28. 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".

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

E. Action by the Discipline Panel

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

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

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

F. <u>Evidence</u>

32. In her affidavit [redacted] provides the following sworn evidence:

    a. She is employed as a Professional Conduct Review Consultant in the Inquiry, Discipline and Monitoring Department of the BCCNM.

    b. On [redacted] she was appointed by the Inquiry Committee of the British Columbia College of Nursing Professionals ("BCCNP") - a BCCNM legacy college - as an inspector pursuant to s. 27 of the HPA.

    c. On [redacted] she was hired in the role of Professional Conduct Review Consultant for the BCCNP.

    d. The Respondent was first registered to practice as a Licensed Practical Nurse ("LPN") with the College of Licensed Practical Nurses of British Columbia ("CLPNBC"), a BCCNM legacy college, on June 20, 2013. On November 22, 2013, the Respondent was hired into a permanent night position at Selkirk Place Long Term Care Facility ("Selkirk Place"). Selkirk Place is a seniors' residential care facility located in Victoria, British Columbia. At the time of the Respondent's employment, Selkirk Place was divided into two sides. One side was an assisted living facility, whose residents were tenants. The other side was a complex care facility where all the residents required 24-hour care.

    e. On the complex care side, there was a 7-floor building with 6 units named Aston, Bolton, Crofton, Dayton, Eaton, and Gladstone. Residents who suffered from the most advanced state of dementia were assigned to Aston. The Respondent was employed as an LPN in the complex care units at Selkirk Place.

    f. During night shifts, 11:00 p.m. to 7:00 a.m., Selkirk Place was staffed by a Registered Nurse ("RN") who was responsible for the entire building. In addition to the RN, there were LPNs who were each

assigned responsibility for two of the units. In addition to the regulated health care professionals, there were unregulated care aides who provided resident care. Selkirk Place also had an on-call manager who was not present in the building overnight.

g. An LPN at Selkirk Place was considered the team leader on the units they were assigned to and were expected to supervise the staff and resident care on the unit level and report any concerns to the RN as needed. LPNs were responsible for overseeing that resident care needs were met and that resident care plans were being followed by all staff, including unregulated staff like care aides.

h. On June 2, 2015, CLPNBC received a written complaint regarding the Respondent from [redacted], the [redacted] at Selkirk Place. He reported, among other concerns, that the Respondent assaulted residents during the course of his employment at Selkirk Place.

i. He also reported the alleged assault to the Victoria Police Department. On June 3, 2015, CLPNBC contacted the lead investigating detective on the file of the Major Crimes Unit of the Victoria Police Department. That Detective advised CLPNBC that criminal charges against the Respondent were forthcoming.

j. Also on June 3, 2015, CLPNBC provided the Respondent with a formal notice of the allegations made against him and requested that he enter into an Interim Agreement of Undertaking (the "IAOU") which, among other things, converted his registration to a non-Practicing registration pending the conclusion of the investigation. The Respondent consented to and signed the IAOU.

k. In light of Victoria Police Department's ongoing investigation CLPNBC put its investigation regarding the Respondent into abeyance.

l. On June 5, 2015, the Respondent was charged with assault contrary to section 266 of the *Criminal Code* for assaulting four Selkirk Place residents, namely residents E.K. J.V., R.P., and J.S. Residents J.V., R.P., and J.S. resided in Aston unit while resident E.K. resided in Dayton unit.

m. The criminal charges of assault against residents E.K. J.V., R.P., and J.S. were in relation to allegations that:

   i. Between February 4, 2015, to March 31, 2015, while changing E.K., the Respondent slapped the exposed buttocks of resident E.K. twice, before turning E.K. on her back.

   ii. On April 1, 2015, during the process of changing J.V.'s disposable brief, the Respondent struck J.V. in the groin to make J.V., a resident with advanced dementia, more compliant as J.V. did not like to be changed, causing J.V. to scream and moan.

   iii. On May 25, 2015, while changing R.P., a resident with advanced dementia who resisted being changed, the Respondent placed a blanket over R.P.'s face and pressed down on R.P.'s upper body with his body causing R.P. to moan.

   iv. Also on May 25, 2015, while in J.S.'s room to change his disposable brief, the Respondent flicked the head of J.S.'s penis approximately 15 times causing J.S. to scream and moan.

n. The criminal proceeding involving the Respondent proceeded on July 18 and 19, 2016 before the Honourable Judge L. Mrozinski.

o. On July 19, 2016, CLPNBC resumed its investigation, in so doing sent a letter to the Respondent setting out the allegations made by

the complainant [redacted] and requested the Respondent's response to the allegations. This letter was sent to the Respondent by email and Xpresspost. A due date of August 3, 2016, for the Respondent's response was provided. The letter was signed for as received on July 20, 2016. To date the Respondent has not provided a response to the allegations set out in this letter and did not seek an extension of the deadline.

p. On July 22, 2016, Judge Mrozinski gave oral reasons for judgment. The Respondent was found guilty of assaulting J.V., R.P., and J.S. contrary to section 266 of the *Criminal Code.* With respect to the charge of assault regarding resident E.K., the Respondent was found not guilty.

q. On November 9, 2016, Judge Mrozinski gave oral reasons for sentence. The Respondent was sentenced to 6 months jail and 18 months probation.

r. On November 9, 2016, the Respondent was admitted to Vancouver Island Regional Correctional Centre ("VIRCC") to serve his 6-month sentence. According to media reporting, the Respondent appealed his conviction and sentence on November 10, 2016.

s. On November 16, 2016, the Respondent was released from VIRCC on non-surety bail, pending the appeal of his conviction and sentence.

t. The Respondent first reported to Saanich Community Corrections on November 17, 2016, as required by his bail condition. However, on July 17, 2017, the Respondent did not report to Saanich Community Corrections, as required. On October 11, 2017, an arrest warrant was issued for the Respondent's arrest. The Respondent was recorded as absent without leave ("AWOL") on November 24, 2017.

u. On December 13, 2017, the Respondent was charged with one count breach of undertaking or recognizance for failing to report as directed.

v. On January 1, 2018, the Respondent's registration with CLPNBC lapsed. The Respondent is currently classified as a Former Registrant within the meaning of the Act. On September 4, 2018, CLPNBC amalgamated with two other nursing colleges in British Columbia to form the BCCNP. Under Part 2.01 of the Act, BCCNP remained seized of the complaints investigated by the former colleges.

w. On October 1, 2019, Ms. [redacted] was assigned to investigate the complaint against the Respondent.

x. According to BC Prosecution Service, the Respondent's appeal was abandoned on March 28, 2018. However, according to the BC Corrections Branch, the appeal was heard on February 15, 2019, and the original conviction and sentences were reinstated.

y. On February 25, 2019, Crown Counsel entered a Stay of Proceedings on the December 13, 2017, charge for breach of undertaking or recognizance.

z. On November 7, 2019, Ms. [redacted] wrote to the BC Corrections Branch to request confirmation with respect to whether the Respondent had served his sentence and whether the terms of probation had been satisfied by the Respondent. On December 9, 2019, the BC Corrections Branch advised that the Respondent's sentence remained outstanding because the Respondent remains AWOL.

aa. On March 2, 2020 Detective [redacted] of Victoria Police Department updated Ms. [redacted] on criminal matters related to the Respondent. Detective [redacted] advised her that the Respondent fled Canada while out on bail pending his appeal and has not returned to Canada.

bb. On July 27, 2020, BCCNP made an application to the Victoria

Provincial Court to obtain trial and sentencing transcripts of the criminal proceedings involving the Respondent due to a ban on publication pursuant to section 486.5(1) of the *Criminal Code* which prohibited the publication of any information that could identify the victims.

cc. On July 31, 2020, a judge ordered that the requested transcripts be disclosed to BCCNP with victim identities redacted, thereby preserving the ban on publication of any information that would identify the victims.

dd. On September 1, 2020, BCCNP and the British Columbia College of Midwives amalgamated to form BCCNM. Under Part 2.01 of the Act, BCCNM remained seized of the complaints investigated by the former colleges.

ee. On March 9, 2021, BCCNM provided the investigation report, without appendices, to the Respondent for his review and response via his last known email and mailing address. A due date of April 12, 2021, for the Respondent's response was provided. To date, BCCNM has not received a response from the Respondent, and an extension of the deadline was not sought.

ff. The LPN Professional Standards in effect from May 27, 2014, to December 1, 2016 set out the minimum requirements for LPN practice in any setting or nursing domain.

gg. BCCNP Bylaw 338 and BCCNM Bylaw 203 set out a registrant's the duty to co-operate. BCCNP Bylaw 338 was in effect from September 4, 2018 to September 1, 2020. BCCNM Bylaw 203 has been in effect from September 1, 2020 until present.

G. Analysis and Findings

Allegations #1, 2 and 3: Assault Allegations.

33. As noted, allegations #1, 2 and 3 as set out in the Citation are:

> 1. On or about April 1, 2015, you assaulted JV contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.
>
> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.
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> 2. On or about May 25, 2015, you assaulted RP contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.
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> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.
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> 3. On or about May 25, 2015, you assaulted JS contrary to section 266 of the Criminal Code of Canada. This conduct is conduct unbecoming of a Licenced Practical Nurse and is contrary to one or more of the following Professional Standards and/or Practice Standards: *Responsibility and Accountability* Professional Standard, *Competency-Based Practice* Professional Standard, *Client–Focused Provision of Service* Professional Standard, and *Ethical Practice* Professional Standard.
>
> This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

34. The College points out that the Respondent was charged with and ultimately found guilty of assault contrary to section 266 of the *Criminal Code* for assaulting Selkirk residents J.V., R.P., and J.S, and sentenced to 6 months in jail and 18 months probation.

35. The College argues that the Respondent's assault of the Selkirk residents while in his capacity as a nurse was not only antithetical to his duty as a nurse, but also especially egregious due to his position of trust and power over vulnerable elderly dementia residents.

36. The College points out that the standard of proof in criminal matters is beyond a reasonable doubt, which is a higher standard than the standard applicable in this case, which is on a balance of probabilities. The College submits that the Honorable Judge L. Mrozinkski's findings was that the Respondent assaulted residents J.V., R.P., and J.S, and that the Panel's findings of facts with respect to the allegations of assault of residents J.V., R.P., and J.S ought to be consistent with the findings of Judge Mrozinkski.

37. In this regard, The College relies on the following case:

    a. *City of Toronto v. CUPE 2003 SCC 63* ("*C.U.P.E*") where the Supreme Court of Canada concluded that the convictions of a criminal court judge can be assumed to be true and should be respected in subsequent administrative proceedings, except in rare circumstances. The College says that generally, the findings of fact from a criminal trial do not need to be proven again in a disciplinary hearing where the same conduct is at issue and is the subject of the discipline hearing.

    b. *Caci v. Dorkin 2008 ONCA 750*, where the Ontario Court of Appeal found that the trial judge in a civil jury case, where the issue was the negligence of a driver in a motor vehicle accident, properly instructed the jury that the findings of fact from the criminal trial (where the defendant was charged with dangerous driving causing bodily harm) were binding and could not be considered by the jury. In this regard, Justice Rosenburg stated at paragraph 15:

> *In my view, the trial judge properly applied the principles from C.U.P.E. in holding that the verdict in the criminal case and the findings essential to that verdict were conclusive in the civil proceedings. […] MacArthur had been found to have committed dangerous driving, an offence of negligence at least as high if not higher than civil negligence. Further, that negligence had been proved to the criminal standard of proof beyond a reasonable doubt. Finally, MacArthur had a full opportunity to defend the allegation of negligence in circumstances where he had every reason to mount a complete defence.*

38. The College submits that the finding of guilt in the criminal proceeding that the Respondent assaulted J.V., R.P., and J.S. contrary to section 266 of the *Criminal*

Code while in his capacity as a nurse, is clear and cogent evidence that the Respondent engaged in professional misconduct. In the regard the College also relies on the following cases:

a. *College of Nurses of Ontario v Little, 2017 CanLII 84899*, where the member was charged with and pled guilty of assaulting 2 patients in his care and was sentenced to 30 days in jail, and 2-years of probation, the panel reviewed copies of the member's criminal charges, convictions, transcripts of the proceedings, and the probation orders. The panel found the member's conduct to constitute professional misconduct.

b. *Ontario College of Teachers v Piatnitsa, 2015 ONOCT 66* where the member was found guilty of assaulting a child, contrary to section 266 of the *Criminal Code,* and the panel found the member's behaviour was found to have brought the profession into disrepute and to be in conflict with the duty of a teacher to protect students.

39. The College submits the allegations in paragraphs 1 to 3 of the Citation have been proven, on a balance of probabilities, and amount to a breach of the College's nursing standards and constitute professional misconduct.

40. The Panel agrees.

41. The Panel accepts Ms. [redacted] evidence as outlined above. The Panel finds that Ms. [redacted] sworn evidence, including the documentary evidence attached to her affidavit as exhibits, is clear, convincing, and cogent and establishes, on a balance of probabilities, that:

    a. While working as an LPN at Selkirk House the Respondent was from time to time required to assist care aides to change the briefs of R.P., J.V, and J.S who were elderly residents of Selkirk House.

    b. On or about April 1, 2015, while the Respondent and a care aide were beginning the process of changing J.V., an advanced dementia patient of approximately 80 years of age who had some mobility issues and who did not like to be changed, the Respondent asked the care aide if he

wanted to know how to make J.V. more compliant just before the Respondent struck J.V. with some force in the groin. The blow caused J.V. to buckle in pain so that his feet and head lifted up and he screamed and moaned.

c. On or about May 25th, 2015, while the Respondent was assisting a care aide to change R.P. a resident also known to resist care, the Respondent placed a blanket over her face and pressed down on her upper body with his body which caused R.P. to moan.

d. On or about May 25th, 2015, while the Respondent was in J.S.'s room, to effect a change of his brief, the Respondent flicked the head of J.S.'s penis some 15 times causing him to scream and moan.

e. On July 22, 2016, Judge Mrozinski of the Provincial Court of British Columbia held that it had been established beyond a reasonable doubt that the Respondent assaulted R.P., J.V. and J.S. in the manner described above, and convicted the Respondent of assaulting J.V., R.P., and J.S. contrary to section 266 of the Criminal Code.

42. The Professional Standards for Licenced Practical Nurses in place at the material times the Respondent's proven conduct occurred required licensed practical nurses like the Respondent, to practice with responsibility and accountability, competently, to provide client-focused service and to uphold and promote the ethical standards of the nursing profession. The professional standards are the expected and achievable level of performance against which an LPN's actual performance can be compared. It is the minimum level of acceptable performance for an LPN.

43. The Panel finds that by conducting himself in the manner described, the Respondent breached Standard 1 (Indicators 5 and 7), Standard (2 (Indicators 3, 7 and 11), Standard 3 (Indicators 1, 5, 7 and 8) and Standard 4 (Indicators 1 and 3), which provide as follows (bolding added):

> Standard 1: Responsibility and Accountability
>
> The licensed practical nurse maintains standards of nursing practice and professional conduct established by CLPNBC.

Indicators

1. Maintains current registration
2. Maintains own competence to practice
3. Maintains own physical, psychological and emotional fitness to practice
4. Practices within own level of competence, employer policies, the LPN scope of practice and all relevant legislation
5. **Is accountable and responsible for own nursing decisions, actions and professional conduct**
6. Seeks guidance and direction as required
7. **Takes action to promote safe, competent and ethical care for clients**
8. Advocates for and/or helps to develop policies and procedures consistent with CLPNBC Standards of Practice
9. Understands the role of CLPNBC and its relationship to one's own practice

Standard 2: Competency-Based Practice

The licensed practical nurse applies appropriate knowledge, skills, judgment and attitudes consistently in nursing practice.

Indicators

1. Bases nursing practice on current evidence from nursing science, other sciences and the humanities
2. Knows how and where to access information to support and provide safe, competent and ethical nursing practice and care for clients
3. **Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care**
4. Collects information on client status and care needs from a variety of sources using assessment skills and a review of pertinent clinical data
5. Identifies, analyzes and uses relevant decision support tools and data when making decisions about client status and care requirements
6. Documents client assessments, care needs, planned interventions and outcomes in a timely manner
7. **Communicates client status to other members of the health care team as appropriate**
8. Evaluates client responses to care and revises the plan of care as necessary
9. Responds and adapts to changes in the practice environment
10. Shares nursing knowledge with clients, colleagues, students and others

11. **Communicates professionally in interactions with clients, colleagues, students and others**

Standard 3: Client-Focused Provision of Service

The licensed practical nurse provides nursing services and works with others in the best interest of clients.

Indicators

1. **Makes the client the primary focus when providing nursing care**
2. Involves clients in identifying and prioritizing their own health goals and learning needs
3. Supports clients to learn about the health care system and accessing appropriate health care services
4. Understands and communicates the contribution of nursing to the health of clients
5. **Communicates, collaborates and consults with clients and other members of the health care team about client care**
6. Coordinates and facilitates continuity of care services for the client
7. **Supervises, leads and assigns appropriately to other members of the health care team**
8. **Supports and guides other members of the health care team to meet client care needs**
9. Participates in and advocates for changes that improve client care and nursing practice
10. Recognizes and reports the incompetent or impaired practice or unethical conduct of another health professional to the appropriate person or body

Standard 4: Ethical Practice

The licensed practical nurse understands, upholds and promotes the ethical standards of the nursing profession.

Indicators

1. **Demonstrates honesty and integrity at all times**
2. Represents self clearly and accurately with respect to name, title and role
3. **Respects and protects client worth, dignity, uniqueness and diversity**
4. Protects client information and maintains privacy and confidentiality
5. Recognizes, respects and promotes the client's right to be informed and make informed choices
6. Begins, maintains and ends nurse-client relationships in a way that puts the client's needs first

7. Identifies the effect of own values, beliefs, and experiences when providing nursing care

8. Identifies ethical issues, recognizes potential conflicts; takes action to prevent or resolve them by communicating with the health care team and consulting with the appropriate people; and evaluates effectiveness of actions

9. Makes decisions about the allocation of resources under one's control based on the needs of the client

10. Recognizes and respects the contribution of others on the health care team

11. Treats colleagues, students and other health care workers in a respectful manner

44. 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”.

45. 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.”

46. 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".

47. 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)].

48. 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.
>
> (Underlining added)

49. Based on the evidence before it, Panel finds that the Respondent's proven conduct, as outlined above and as described in paragraphs 1, 2 and 3 of the Citation, presents such a marked departure from the minimum level of acceptable performance or conduct which the College expects of its licensed practical nurses that it constitutes professional misconduct. In this regard, the Panel agrees with and accept the reasoning in *College of Nurses of Ontario v Little, 2017 CanLII 84899*, in which the discipline panel found that the conduct of a member who was convicted of assaulting two (2) patients constituted professional misconduct.

50. The Respondent was in a position of trust towards the elderly patients who he assaulted. The evidence shows these patients were extremely vulnerable and there was no consent given by them for his conduct towards them. The Respondent was tasked to care for the elderly patients in question but instead he breached their trust and assaulted them. The evidence establishes he committed the assaults on the patients in front of the care-aide working with him.

51. The Panel finds the Respondent's proven conduct as described in paragraphs 1, 2 and 3 of the Citation conduct that easily falls within the definition of section 26 of the HPA, that is, unethical conduct and conduct unbecoming a member of the health

profession. The Panel also finds the Respondent's proven conduct disgraceful and dishonorable.

52. Accordingly, the Panel determines that by conducting himself in the manner described in paragraphs 1, 2 and 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.

Allegation #4: Failure to Co-operate Allegation.

53. As noted above, allegation #4 in the Citation alleges:

> *4. Beginning on or about July 19, 2016, you failed to respond to inquiries and requests for information with respect to the investigation of a complaint against you, contrary to your duty to co-operate and the following Professional Standards and/or Practice Standards: 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.*

54. In support of this allegation, 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.

55. The College submits the legislative requirement to co-operate with the College's investigation is set out in the British Columbia College of Nursing Professionals (the "BCCNP") 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.

56. The College further argues that case law also supports the notion that there is a common-law duty on registrants of self-governing professions to co-operate with their regulators. In this regard, the College relies on 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 co-operate 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 co-operate 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. McLean* (2015 LSBC 06), where 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* also said 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".

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

d. *Ontario (College of Physicians and Surgeons of Ontario) v. Mrozek, 2018 ONCPSD 17.* As a registrant of a self-regulating profession, the Respondent, while a registrant, has a common law duty to co-operate with the College's investigation and respond in a timely manner

57. The College submits that if it cannot count on prompt, candid and complete replies from registrants when investigating a complaint, it will be unable to protect the public, which it submits, is its paramount duty.

58. As noted, the College submits the case law recognizes a distinction between "unprofessional conduct" and "professional misconduct" based on how the ethical seriousness of the impugned conduct is characterized. Unprofessional conduct connotes the breach of a standard, rule, or expected behaviour (*Re McLellan*, CRNBC 2018 para. 54), while professional misconduct is unprofessional conduct that has crossed a more serious threshold (*Xu (Re)*, 2019 CanLII 131132 (BCCDS).

59. The College submits that it has proven allegation #4 in the Citation, and that the proven conduct constitutes unprofessional conduct.

60. The Panel agrees.

61. The Panel accepts Ms. [redacted] evidence as outlined above. Her evidence is clear, convincing and cogent. The Panel finds that Ms. [redacted] evidence establishes, on a balance of probabilities, that:

    a. The Respondent was the subject of a written complaint that the CLPNBC received on June 2, 2015 from [redacted], the [redacted] at Selkirk Place.

    b. [redacted] complaint to the CLPNBC reported, among other concerns, that the Respondent assaulted residents during his employment at Selkirk Place.

    c. On July 19, 2016, CLPNBC sent a letter to the Respondent requesting his response to those allegations. In particular, the CLNBC's letter requested the Respondent to provide a response as follows:

> ....
> The College of Licensed Practical Nurses of British Columbia ("CLPNBC") has received a complaint outlining issues related to your nursing practice and professional conduct. This letter is to notify you of the particulars of the complaint and the process that will be taken in order to address the complaint. CLPNBC is conducting an investigation of the complaint, which includes collection of documentation related to the incident identified in the complaint, and interviews with the complainant, any witnesses and yourself.
>
> The allegations outlined in the complaint and requiring your response are:
>
> 12. Between May 1, 2015 and June 1, 2015, you flicked resident JS's penis 15 times in order to get the resident to stop reaching into his brief.
>
> 13. Between May 1, 2015 and June 1, 2015, you said to Resident Care Aide RF, "do you want to see how to make them quiet", and then you punched resident JV in the testicles while he was lying quietly in his bed.
>
> ...
>
> 12. Between May 1, 2015 and June 1. 2015, you wrapped resident RP in a blanket to restrain her.
>
> An important part of this process is for you to provide information regarding the matter that you believe should be considered by the Inquiry Committee ("Committee"). In addition to your response, the

> information collected during the investigation will be provided to the Committee for their review and consideration.
>
> (hereinafter, "The Information Request Letter")
>
> …..

d. The Information Request letter #1 was sent to the Respondent by email and Xpresspost and was signed for as received on July 20, 2016.

e. A due date of August 3, 2016 for the Respondent's response to The Information Request Letter #1 was provided in the letter.

f. The Respondent has to date not provided a response to The Information Request letter #1 and did not seek an extension of the August 3, 2016 deadline to do so.

62. As noted, 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
>
> …
>
> 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.
>
> (Underlining added)

63. The Panel finds that BCCNP Bylaw 338 to which the College refers in its submission was not in force in July 2016 when the request for information was first made to the Respondent. The evidence before the Panel shows the BCCNP Bylaw 338 was in effect from September 4, 2018 to September 1, 2020.

64. However, the Panel accepts that there exists a body of case law that establishes an independent common-law duty on registrants to co-operate with their self-governing bodies. The Panel agrees with the reasoning accepted and expressed in those cases cited by the College that a registrant's a failure to respond or co-operate with his or her a self-governing body may amount to unprofessional conduct or professional misconduct.

65. In this regard, the Panel finds the reasoning in *Artinian* v. *College of Physicians and Surgeons of Ontario* (1990 CanLII 6860) and *Re Cunningham* CRNBC 2017 particularly persuasive and also applicable to the facts of this matter. As noted, in *Artinian* the registrant appealed a finding of professional misconduct for failing to co-operate with a requested review of patient records by an inspector, 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 co-operate with an investigation. A panel of three justices disagreed, stating, "Fundamentally, every professional has an obligation to co-operate with his self-governing body." In *Cunningham*, the discipline committee panel of the College's legacy college found a nursing registrant's failure to have responded to the college's requests amounted to unprofessional conduct.

66. As noted, the evidence before the Panel in this matter confirms that the Respondent has not provided a response to The Information Request Letter by the due date of August 3, 2016. Accordingly, the Panel finds that beginning on August 4, 2016, the Respondent has failed to comply with his duty to co-operate with the CLPNBC by not responding to the request for information made in The Information Request Letter with respect to the investigation of a complaint made against him.

67. The Panel considers that compliance with the duty to co-operate 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. A professional governing body 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 co-operate with their self-governing regulator risks undermining the public's confidence in that regulator's ability to regulate its members.

68. The complaint allegations against the Respondent were serious because they involved allegations of assault and/or professional misconduct towards vulnerable elderly patients. The CLPNBC made a clear request to the Respondent for a response to the complaint allegations. The Respondent had a duty to co-operate and to respond to that request. He failed to do so.

69. The Panel finds the Respondent's failure to respond fully or at all to that request for information by the deadline imposed in the Information Request Letter sent to the Respondent presents a marked departure from the duty to co-operate recognized by the case law cited above, including in the *Artinian* and *Cunningham* cases. Accordingly, the Panel determines that by conducting himself in the manner described in paragraph 4 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 duty to co-operate, the Respondent committed unprofessional conduct pursuant to section 39(1)(c) of the Act.

H. Schedule for Submissions on Penalty and Costs

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

71. 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 within twenty (21) calendar days from the date of this determination;

    b. Submissions must be delivered by the Respondent to counsel for the College and the Panel within twenty (21) calendar days from the date on which the Respondent received the College's submissions; and

    c. Reply submissions may be delivered by the College to the Respondent and the Panel within seven (7) calendar days from the date on which the counsel for the College received the Respondent's submissions.

72. Submissions for the Panel's consideration should be delivered to Fritz Gaerdes, independent legal counsel for the Panel, and must be delivered electronically to the following email: fritz@preciousgaerdes.com

I. Notice of right to appeal

73. 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: August 11, 2022

Edna McLellan RN(T), Chair

Roland Mitchell, Public Member

Samantha Love, LPN