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

BETWEEN:

The British Columbia College of Nurses and Midwives

(the "College" or "BCCNM")

AND:

Maryna Byelkova

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

,

Hearing Dates:	November 23-27, 2020; January 8, 22, 2021
Discipline Committee Panel:	Sheila Cessford, Chair Dorothy Jennings, RPN Jackie Murray, RN
Counsel for the College:	Michael Shirreff Greg Cavouras
Counsel for the Respondent:	Jeremy Shragge

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 pursuant to section 38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), to determine whether Maryna Byelkova (the "Respondent") failed to comply with the College's standards, failed to comply with the Act or the College's Bylaws, or committed professional misconduct or unprofessional conduct.

2. For the reasons that are set out below, the Panel finds that the allegations set out in the Citation dated May 30, 2019 (the "Citation") were proved to the requisite

standard. The Panel has determined that the Respondent committed professional misconduct in relation to each of the allegations which were proved.

B. BACKGROUND

3. The Citation was issued by the British Columbia College of Nursing Professionals ("BCCNP"). On September 1, 2020, BCCNP and the British Columbia College of Midwives amalgamated to form the BCCNM. Part 2.01 of the HPA provides that the BCCNM remains seized of complaints investigated and disciplinary proceedings that were initiated by BCCNP.

4. The Respondent was a registrant at all material times set out in the Citation. She subsequently became a former registrant. The Panel retains jurisdiction over former registrants under the HPA. Section 26 of the HPA defines "registrant" to include "former registrant" for purposes of Part 3 of the HPA. Part 3 of the HPA deals with the College's inquiries, investigations and discipline.

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

    1. In 2017, you provided care to family members on one or more of the following occasions:
        a. May 14, 2017 – you inserted a peripheral intravenous catheter ("IV") into your mother in the Emergency Room of the Peace Arch Hospital ("PAH");
        b. July 1, 2017 – you inserted an IV into your father, and administered a bolus of normal saline to your father, while at your father's home;
        c. July 2, 2017 – you administered Zofran and Toradol to your father through his IV, while at your family's home; and/or
        d. July 2, 2017 – you administered Maxeran to your father at PAH through his IV.
    2. You accessed your family member's personal and/or health information at PAH on one or more of the following dates:
        a. February 16, 2017; and/or
        b. July 29, 2017.

    It is alleged:

    1. that you failed to comply with BCCNP's standards for the practice of nursing by registrants and standards of professional ethics for registrants, including:

a. Standards 1, 2 and/or 4 of BCCNP's Professional Standards of Registered Nurses and Nurse Practitioners,
b. the "Conflict of Interest" Practice Standard,
c. the "Boundaries in the Nurse-Client Relationship" Practice Standard,
d. the "Privacy and Confidentiality" Practice Standard,
e. the "Scope of Practice" Standard, and/or
f. the "Medication Administration" Standard;

2. that you have not complied with the Act and/or the BCCNP's Bylaws; and further, or in the alternative,
3. that you have committed professional misconduct or unprofessional conduct.

6. On the first date of the hearing, the Panel granted the College's request to amend the Citation. Specifically, the date in paragraph 2 (b) of the Citation was amended from "July 29, 2017" to "June 29, 2017". The date contained in the Citation was a typographical error and the Respondent was provided with notice of the correct date in advance of the hearing. The Respondent consented to the amendment of the Citation.

7. The hearing took place via video-conference with Charest Reporting as the hearing administrator.

8. The College called the following witnesses:

a. Nicola Chalke;
b. Oliver de la Paz;
c. Megan Lum;
d. Beverley D'Cunha;
e. Jeff Yu;
f. Jessie Saran;
g. Lorna Jackson; and
h. Lori Quinn.

9. The College also submitted the Affidavit of Gillian Morgan.

10. The Respondent testified on her own behalf and called the following witnesses:

    a. Olena Byelkova;

    b. Artur Byelkov; and

    c. Linda Mitton.

11. The parties also jointly submitted the "Agreed Statement of the Evidence of Laurie Wynes".

12. The College and the Respondent delivered oral and written submissions. The parties delivered written closing submissions to the Panel from March to May 2021. On July 31, 2021, the Respondent delivered a further decision for the Panel's consideration.

13. The Panel's determination takes into account the evidence adduced at the hearing and the parties' oral and written submissions.

C. SERVICE OF CITATION

14. The College submitted proof of service of the Citation in this matter. Service was not raised as an issue. The Panel is satisfied that the Respondent was properly served with the Citation.

D. BURDEN OF PROOF

15. The College bears the burden of proof and must prove its case on a "balance of probabilities". The leading authority, *F.H. v. McDougall*, 2008 SCC 53, states that the "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test."

E. LAW

HPA

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

> 39(1)…
>
> (a) has not complied with this Act, a regulation or a bylaw,
>
> (b) has not complied with a standard, limit or condition imposed under this Act,

(c) has committed professional misconduct or unprofessional conduct,

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

(e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

17. Section 16 of the HPA sets out the College's duties to at all times serve and protect the public and exercise its powers and discharge its responsibilities under all enactments in the public interest.

18. Section 19(8) of the HPA provides that registrants must not practise a designated health profession except in accordance with the bylaws of the College. The College enacts its professional standards by way of bylaw.

19. Bylaw 8.01, which was in place at the material times, stated "Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics." That bylaw was enacted pursuant to section 19(1)(k) of the HPA.

20. The College has established both professional and practice standards pursuant to this authority. The Professional Standards for Registered Nurses and Nurse Practitioners ("Professional Standards") set out the expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance. There are four Professional Standards as follows:

    a. Professional Standard 1, Professional Responsibility and Accountability

    b. Professional Standard 2, Knowledge-Based Practice

    c. Professional Standard 3, Client-Focused Provision of Service

    d. Professional Standard 4, Ethical Practice

21. There are also Practice Standards which set out standards in specific areas. The ones that are applicable to this case are:

    a. Boundaries in the Nurse-Client Relationship (the "Boundaries Standard")

b. Privacy and Confidentiality (the “Privacy and Confidentiality Standard”)

c. Conflict of Interest (the “Conflict of Interest Standard”)

22. The College’s standards are not aspirational but set out minimum standards that registrants are required to meet.

23. The Boundaries Standard provided:

> 1. Nurses use professional judgment to determine the appropriate boundaries of a therapeutic relationship with each client. The nurse — not the client — is always responsible for establishing and maintaining boundaries.
>
> 2. Nurses are responsible for beginning, maintaining and ending a relationship with a client in a way that ensures the client’s needs are first.
>
> […]
>
> 8. At times, a nurse must care for clients who are family or friends[5]. When possible, overall responsibility for care is transferred to another health care provider.
>
> 9. At times, a nurse may want to provide some care for family or friends. This situation requires caution, discussion of boundaries and the dual role[6] with everyone affected and careful consideration of alternatives.
>
> 10. Nurses in a dual role make it clear to clients when they are acting in a professional capacity and when they are acting in a personal capacity.
>
> Footnotes:
>
> 5 For example, in an emergency or in a small community.
>
> 6 A nurse in a dual role has both a personal and professional relationship with a client. While not desirable, a dual role is often unavoidable, particularly in small communities.

24. The College submits that the overall premise of the Boundaries Standard is that a nurse must not care for a family member unless there are exceptional circumstances.

25. The Respondent argues that the College’s interpretation is unfounded and there is no such ‘bright line’ in the standard’s wording.

26. The Respondent submits that unlike sections 8 and 9, sections 3 and 4 of the Boundaries Standard contain outright prohibitions. Section 3 prohibits nurses from entering into a friendship or romantic relationship with a client. Section 4 prohibits nurses from entering into sexual relations with a client (with or without consent). The

Respondent submits that the wording of sections 8 and 9, which deal with family members, contain ambiguous language and boundaries which are not clear cut.

27. The Respondent argues that the footnote to section 9 is ambiguous as it states "While not desirable, a dual role is often unavoidable, particularly in small communities. Note that this may be prohibited in certain circumstances." The Respondent argues that this last sentence is unclear as to whether the word "this" refers to a "dual role" or a "dual role in a small community". That sentence, however, was not contained in the version of the Boundaries Standard that was in force at the material times. In any event, the Panel does not agree that there is any ambiguity in the interpretive footnotes or in the meaning of sections 8 and 9 of the Boundaries Standard. The Panel agrees with the Respondent that sections 8 and 9 are framed differently than sections 3 and 4, however, the Panel does not agree that difference renders sections 8 and 9 unclear or fails to establish a general requirement to refrain from providing care to family members.

28. The Panel finds that it is clear from the ordinary meaning of the words and their context that the Boundaries Standard required that a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being in a small community. Where possible, nurses must transfer care to other health care providers. In unavoidable circumstances, the situation required caution, a discussion of boundaries and the dual role, and careful consideration of alternatives. The existence of a general rule and an exception is evident from the use of the words "At times", "a nurse *must* care", "when possible", "care *is* transferred", "unavoidable" circumstances, "emergency" situations and "small communities".

29. The Respondent's narrow technical arguments about the wording in the Boundaries Standard also ignore that the Discipline Committee has a wide berth in applying the standards that apply to the nursing profession. As noted in *Lyons v. Alberta Land Surveyors' Association*, 2017 ABCA 7:

> [4] Professional disciplinary proceedings usually involve the interpretation of the statute establishing the profession, related statutes (such as the *Surveys Act*), and the rules or codes of conduct of the profession. The governing bodies of the

> profession have expertise in the interpretation of these provisions, and in deciding what amounts to unprofessional conduct. As stated in *Dunsmuir v New Brunswick*, 2008 SCC 9 at para. 44, [2008] 1 SCR 190 deference is extended to the tribunal's interpretation of "its own statute or *statutes closely connected to its function*" (emphasis added). The core issue here is what amounts to "unprofessional conduct", not the direct interpretation of a statute. The courts extend deference to professional bodies on all these issues, and generally review their decisions on a reasonableness standard: *Law Society of New Brunswick v Ryan*, 2003 SCC 20 at para. 42, [2003] 1 SCR 247; *Doré v Barreau du Québec*, 2012 SCC 12 at paras. 44-5, [2012] 1 SCR 395. The appellant has not demonstrated that there is anything unreasonable about the concurrent findings of the Discipline Committee and the Council that the appellant's conduct amounted to unprofessional conduct.

30. Moreover, the Discipline Committee sets the professional standards for the profession and those standards are both written and unwritten. In assessing whether conduct constitutes professional misconduct or unprofessional conduct (which is discussed in further detail below), the Panel is guided by the content of the College's bylaws and standards and uses its own judgment and expertise. In *Salway v. Association of Professional Engineers and Geoscientists of British Columbia*, 2010 BCCA 94 (cited in *Complainant v. British Columbia College of Nursing Professionals (No. 1),* 2020 BCHPRB 74 which is relied upon by the College), the Court of Appeal held there is significant deference to disciplinary tribunals' interpretations of their professional standards, whether those standards are written or unwritten:

> [30] The jurisprudence, therefore, would seem to dictate that courts adopt a **significant degree of deference to disciplinary decisions of professional tribunals concerning the interpretation of their professional standards, regardless of whether those standards are written or unwritten**. This degree of deference accords with the reasonableness standard of review.
>
> …
>
> [32] The reasonableness standard of review acknowledges that there is "a range of possible, acceptable outcomes which are defensible in respect of the facts and law". Reasonableness requires courts to give deference to a professional body's interpretation of its own professional standards so long as it is justified, transparent and intelligible. The pre-*Dunsmuir* decisions relied on by the respondent, including *Reddoch,* no longer set the standard for professional misconduct as conduct that is dishonourable, disgraceful, blatant or cavalier. Rather, **it is the disciplinary body of the professional organization that sets the professional standards for that organization.** So long as its decision is within the range of reasonable outcomes—i.e., it is justified, transparent and intelligible—it is not for courts to substitute their view of whether a member's conduct amounts to professional misconduct.

[emphasis added]

31. Having regard to all these considerations, the Panel finds that the standard at the material times required that a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being in a small community. Where possible, nurses must transfer care to other health care providers. In unavoidable circumstances, the situation required caution, a discussion of boundaries and the dual role, and careful consideration of alternatives.

32. The Conflict of Interest Standard provided:

> A conflict of interest occurs when a nurse's personal, business, commercial, political, academic or financial interests, or the interests of the nurse's family or friends, interfere with the nurse's professional responsibilities or a client's best interests. A conflict of interest may exist whether or not a nurse is actually influenced by the competing interest. The conflict of interest may affect nurses in any practice setting.
>
> […]
>
> 1. Nurses identify and seek to avoid actual, potential or perceived conflicts of interest.

33. The Panel finds that there is a conflict of interest which arises between a nurse's professional role and their status as a family member. That tension may lead to confusion or impair a nurse's judgment, objectivity, or ability to provide proper care. A nurse is required to identify and avoid that conflict of interest.

34. The Privacy and Confidentiality Standard provided that:

> 10. Nurses access personal and health information only for purposes that are consistent with their professional responsibilities.

35. In addition, the Privacy and Confidentiality Standard set out express guidance on access to family members' information:

> Accessing Information
>
> Do not access personal and health information for any purpose that is inconsistent with your professional responsibilities. This includes your own, a family member's or any other person's information.

Professional Misconduct and Unprofessional Conduct

36. Section 26 of the HPA contains the following definitions:

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

37. The term unprofessional conduct is defined in the HPA to include professional misconduct. Professional misconduct is defined to include others forms of misconduct. No other definitions are provided. Unprofessional conduct is broader than professional misconduct.

38. In *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 SCR 869, the Supreme Court of Canada held that professional misconduct is a "wide and general term" which encompasses "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." This standard has been adopted by the College's Discipline Committee including in the recent decision of *BCCNM v. Perry* (February 4, 2021).

39. The concept of professional misconduct has also been defined in *Law Society v. Martin*, 2005 LSBC 16 as a "marked departure" from the expected standard:

> [140] The real question is whether on the facts before us, it can be found that the Respondent, in reviewing and approving the Reyat children's accounts, acted in a manner that was a marked departure from the standard expected of a competent solicitor acting in the course of his profession, and therefore amounted to professional misconduct.

40. The Respondent argues that the marked departure test is guiding in the legal profession and suggests that it is not broadly applied in professional regulation in British Columbia. The Panel does not accept this submission. The decision has been

widely cited by numerous different regulators in British Columbia. The decision was applied by this Discipline Committee recently in *BCCNM v. Perry* (February 4, 2021).

41. The Panel also does not accept the Respondent's submission that the *Martin* test to meet is one of "gross culpable neglect". Those words appear in the decision however, the *Martin* decision did not hold that "professional misconduct" is defined as "gross culpable neglect." The Panel finds that is not the test for the College to meet to establish professional misconduct in this case.

42. The Respondent also argues, with reference to *Pearlman* and *Stuart v. British Columbia College of Teachers*, 2005 BCSC 645, that a finding of moral blameworthy conduct is required in order to establish professional misconduct. The Panel does not accept this argument. It is inconsistent with the Court of Appeal's reasoning in *Salway* (set out above). The *Martin* decision also addresses this argument and notes that professional misconduct captures broader conduct:

> [151] It is clear that lawyers can be found guilty of professional misconduct even if behavior cannot be said to be "disgraceful or dishonorable".
>
> [152] This Panel finds that it is not helpful to get bogged down in whether the conduct complained of was "dishonourable" or "disgraceful". The Panel agrees with Counsel for the Respondent who pointed out that the Black's Law Dictionary definition of "dishonourable", which includes "bad management, mismanagement, malfeasance or culpability, neglect of an official in regard to his affairs, improper conduct, wrong behaviour" could apply to a wide variety of behaviours.
>
> [153] The words "dishonourable" and "disgraceful" imply moral turpitude of an intentional nature even though the definition cited above could conceivably cover many forms of conduct which are simply negligent.

43. The Respondent relies upon *Carruthers v. College of Nurses of Ontario*, 1996 Canlii 11803 (ONSC) for the proposition that not every error in judgment of a registrant constitutes a breach of the standards of practice and not every breach of the standards of practice constitutes professional misconduct. The Panel agrees with those principles, but the Panel notes that *Carruthers* upheld a finding of professional misconduct in relation to a registrant who failed to meet professional nursing standards. The more complete quote situating the principles relied upon by the Respondent states:

> In finding the appellant guilty of professional misconduct for having failed to maintain the standards of practice of the profession, the majority, in my respectful view, was fully cognizant of the fact that
>
> (i) it is not every error in judgment of a registrant that constitutes a breach of the standards of practice; and,
>
> (ii) it is not every breach of the standards of practice that constitutes professional misconduct.

44. The College referred to several cases of professional misconduct involving health professionals who treated family members. In *Hancock v. College of Registered Nurses of Manitoba*, 2021 MBCA, 20, the Discipline Committee of the College of Registered Nurses of Manitoba found that a registrant committed professional misconduct by providing nursing care to her mother-in-law in circumstances that were avoidable. The registrant's mother-in-law was admitted to the clinic where the registrant worked. The registrant's supervisor told her not to be involved in her mother-in-law's care. The registrant spoke to a physician about her mother-in-law's care and accessed her mother in law's electronic medical records several times. The Manitoba Court of Appeal dismissed the appeal and upheld the finding of professional misconduct (as well as the penalties which were imposed).

45. In *The College of Physicians and Surgeons of Ontario v. Rai,* 2016 ONCPSD 1, the Discipline Committee found that an emergency physician committed professional misconduct by examining his partner in a non-emergency situation:

> The College's policy, "Treating Self and Family Members," states that physicians should not treat themselves or family members except for minor conditions or in an emergency situation, and only when another health care professional is not available. These conditions were not present when Dr. Rai did a Pap test and ordered blood work for Ms. A at a clinic visit in August 2007. As stated in the College's policy, when a physician treats someone with whom they have family relationship, there is a risk that the relationship will affect the doctor's ability to provide quality care. In general, physicians should refrain from treating family members or their partners. The Committee finds that, when examining Ms. A in a non-emergency situation for a Pap test and other blood work for fatigue, Dr. Rai engaged in behaviour that was disgraceful, dishonourable or unprofessional. Therefore, the allegation of professional misconduct is proved in relation to this single clinic visit.

46. The College cites *The College of Physicians and Surgeons of Ontario v. Garcia*, 2017 ONCPSD 6 in which the Discipline Committee found that a family physician prescribed medications, an IUD and provided a medical service to an individual with whom he was involved in a personal relationship. The panel found that the conduct amounted to professional misconduct, and summarized the following principles from the caselaw:

> As stated in the College's policy, when a physician treats someone with whom they have a family or a personal / emotional relationship, there is a risk that the relationship will affect the doctor's ability to provide quality care. In general, physicians should refrain from treating family members or their partners.
>
> Previous Discipline Committees have provided the following reasons for making a finding of professional misconduct in such circumstances:
>
> - The College Policy is clear: care should be provided to family members only for minor conditions or in urgent/emergency situations and only when another physician is not available (*Rai*, para. 93; *Moore*, para. 6);
> - Treating family members creates confusion in an individual's mind about whether the member, in providing the incidental medical treatment, is acting in a personal or professional role (*Abouelnasr*, para. 4; *Moore* para. 11);
> - When a doctor treats family members, a serious conflict arises as emotional and dependency issues cloud the dynamics of the situation and can lead to difficulties (*Irvine* para. 28);
> - There is a risk that the familial or intimate relationship will affect the doctor's ability to provide the patient with proper care. Treating family members raises issues of professional objectivity and cloud a physician's judgment (*Rai*, para. 93; *Moore*, para. 12; *Vasovich*, para. 10);
> - It represents a failure to maintain appropriate professional boundaries (*Moore* para. 11);
> - Treating family members may impair a good relationship with a patient's family doctor (*Moore* para. 12).
>
> It is this Committee's opinion that the above reasons equally apply when there is a close personal and romantic relationship such as it finds to be in this case.

47. The College also cites O*ntario (College of Physicians and Surgeons of Ontario) v. Moore*, 2013 ONCPSD 19 in which a physician was found to have committed professional misconduct by providing medical treatment to her daughter.

48. The Respondent submits that these authorities do not support the College's interpretation of the Boundaries Standard as the rules that govern Ontario physicians and surgeons are very different. The Panel recognizes the decisions cited above are from other jurisdictions and involve different regulatory regimes. Nevertheless, the Panel finds the cases to be useful as they discuss broader principles of professional misconduct of health care professionals who provided care to their family members.

Credibility

49. The College submits that the Panel should be guided by the following passage from *Faryna v. Chorny*, 1951 CanLii 252 (BCCA) in the assessment of witness credibility:

> The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistencies with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.

50. The College also cites *Bradshaw and Stenner*, 2010 BCSC 1398:

> [186] Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Faryna v. Chorny*, 1951 CanLII 252 (BC CA), [1952] 2 D.L.R. 354 (B.C.C.A.) [*Farnya*]; *R. v. S.(R.D.),* 1997 CanLII 324 (SCC), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).

51. The Respondent suggests that there are instances in which the College asks the Panel to make findings of credibility where in fact the issue is one of reliability. The

Respondent relies upon the following passage from *Edwards v. Stroink*, 2015 BCSC 1318 for the distinction between those two principles:

> [37] The credibility of a witness is not the same as the reliability of a witness. Credibility has to do with a person's veracity or truthfulness, whereas reliability deals with the accuracy of the witness's testimony. Accuracy involves consideration of the witness's ability to accurately observe, recall and recount events in issue. Any witness whose evidence on an issue is not creditable cannot give reliable evidence on the same point. On the other hand, a finding that a witness is credible does not translate automatically into a finding that what that witness says about an event is accurate and reliable. That is, a credible witness may very well give unreliable evidence.

52. The Respondent also relies upon *Mather v. MacDonald*, 2016 BCSC 948 and notes that an honest witness may provide inaccurate information.

53. The Panel agrees with the authorities cited by both parties with respect to the assessment of credibility and reliability.

F. EVIDENCE

Nicola Chalke

54. Nicola Chalke was the College inspector who was appointed to investigate the complaint regarding the Respondent. She testified about the College's investigation process.

55. Ms. Chalke identified a number of the documents generated during the course of the investigation.

56. Ms. Chalke testified that she made notes during a telephone conversation with Sim Johal. She confirmed that her notes accurately reflected the conversation with Nurse Johal.

Oliver de la Paz

57. Oliver de la Paz was a portfolio manager at Fraser Health Authority. Part of his responsibilities included supporting Meditech, the electronic record system.

58. Mr. de la Paz testified about how the Meditech system operates. You must be an employee of Fraser Health Authority in order to access Meditech. Each employee has their own unique user identification which is password protected. Fraser Health

Authority has policies relating to the access of electronic records to ensure confidentiality. When a user accesses the Meditech system, the initial access screen is the EDM patient tracker. This is a listing of all patients in the emergency department listed by bed number. Key information about each patient is set out such as their name, age, sex, and reason for visit. The assigned physician and nurse are also listed. From the main page, a user can then navigate to different areas including staff assignment and comment. If the user clicks on "comment", a box opens which allows them to enter information regarding that patient. It is also possible to access a patient's Enterprise Medical Record and imaging files.

59. Mr. de la Paz reviewed the results of the audit reports (which are summarized in more detail as part of Ms. Wynes' evidence). In the audit report, a reference to "EMR/Imaging" refers to the user having accessed the patient's imaging panel. Mr. de la Paz testified that the EMR itself is a more detailed document which contains historical patient information including data from prior visits to the hospital. Mr. de la Paz confirmed that the audit report shows the Respondent accessed Mr. Byelkov's EMR and imaging files on June 29, 2017.

60. Mr. de la Paz was asked on cross-examination about whether there are instances in which a person accesses the Meditech system using a user ID and user name other than their own. He acknowledged this occurs. Mr. de la Paz explained that the expectations in those instances is that the unauthorized access is reported to the health authority's privacy office.

Megan Lum

61. Megan Lum testified that she is a registered nurse at PAH. She joined the surgical unit at PAH in 2015. In 2018, Nurse Lum worked in the PAH emergency department. She is a clinical nurse educator.

62. Nurse Lum testified that she met the Respondent at PAH where they worked together in the emergency department. They had a cordial working relationship.

63. Nurse Lum was the flow coordinator in the emergency room on June 29, 2017. Nurse Johal was the charge nurse. There were two other nurses working that day, one of

whom was the Respondent. Nurse Lum's responsibility as flow coordinator was to oversee the flow of patients in Zone 2 of the emergency room.

64. Nurse Lum testified that the Respondent approached her and said that her father was on his way to the hospital because of a headache which he had been experiencing for several days. The Respondent asked Nurse Lum if she would triage her father when he arrived at PAH. Nurse Lum told the Respondent she had not yet completed the triage course. Nurse Lum suggested the Respondent speak to Nurse Johal to ask whether Nurse Lum could perform the triage as a favour. The Respondent spoke to Nurse Johal who said it was fine for Nurse Lum to triage the Respondent's father. Nurse Lum testified that she triaged Artur Byelkov, the Respondent's father, in the hallway next to the Zone 2 computer. Nurse Lum testified that as flow coordinator, she would typically not be involved in triaging patients. Nurse Lum identified the clinical records from Mr. Byelkov's visit to PAH on June 29, 2017. The records include notations made by Nurse Lum of her observations of Mr. Byelkov which are set out in the emergency short stay assessment. Nurse Lum testified that she discussed her triage assessment with Nurse Johal who agreed that Mr. Byelkov should be assigned to Zone 2 of the emergency room. Nurse Lum testified that she did not have any discussion with Mr. Byelkov about not having triage training. She also denied speaking to Mr. Byelkov about breaching Fraser Health Authority protocols.

65. Nurse Lum testified that after Mr. Byelkov was assigned to Zone 2, the Respondent told Nurse Lum that she was going to "pop a line in" (meaning, insert an IV) and start a migraine protocol on her father. Nurse Lum testified that a migraine protocol is one litre of normal saline, 15 to 30 mg of Toradol and 10 mg of Maxeran. Nurse Lum testified that she pulled the Respondent into a private room as she wanted to have a private conversation with the Respondent about the conflict of interest in treating a family member. Nurse Lum testified that she told the Respondent she should not be treating family members. Nurse Lum testified that she was also concerned that there was no physician's order for a migraine protocol at this point. Nurse Lum told the Respondent that medication should not be administered to Mr. Byelkov without a physician's order. Nurse Lum also warned the Respondent that she should not

access her father's medical records. Nurse Lum shared a personal story with the Respondent of when she made a similar error herself. Nurse Lum testified that that the Respondent appeared to understand what Nurse Lum was communicating to her.

66. Nurse Lum testified she then spoke to the physician who provided a verbal order for Toradol while Mr. Byelkov waited to have a CT scan. Nurse Lum administered the Toradol to Mr. Byelkov while he was seated in a chair in Zone 2. She denied forcing him to take the medication.

67. Nurse Lum was not involved with Mr. Byelkov's subsequent care. He was discharged following a CT scan.

68. Nurse Lum strongly denied ever forcing medication on Mr. Belkov.

69. Nurse Lum met with Jessie Saran, a Fraser Health Authority manager, approximately two weeks later to review the circumstances around Mr. Byelkov's June 29, 2017 visit to PAH. Nurse Lum testified that Mr. Saran's notes from that meeting accurately reflect what was discussed during their meeting. Nurse Lum also testified about a similar conversation she had with the College's investigator, Nicola Chalke, in January 2018.

70. Nurse Lum testified that Mr. Byelkov filed a complaint in 2018 against her with the College alleging that she forced him to take Toradol and an antibiotic against his wishes during his June 29, 2017 stay at PAH.

71. On cross-examination, Nurse Lum agreed that Mr. Saran's notes do not reference a migraine protocol and only refer to the Respondent's intention to place an IV and administer fluids. Nurse Lum acknowledged she could not recall if she specifically refenced the migraine protocol to Mr. Saran.

Beverley D'Cunha

72. Beverley D'Cunha is a registered nurse. She joined Fraser Health Authority in 1993. She is a flow coordinator in Zone 2 of the emergency room at PAH. Nurse D'Cunha testified about the flow of patients in the emergency room including that the total complement of nursing staff typically working in Zone 2 during every shift is four

nurses. Each nurse has their own computer for charting. Nurse D'Cunha had known the Respondent professionally for about one year prior to assuming her role as flow coordinator.

73. Nurse D'Cunha testified that on July 2, 2017 she was working as flow coordinator. The Respondent was not working that day. Nurse D'Cunha testified that the other nurses working in Zone 2 that day were Lorna Jackson and Jeff Yu. Nurse D'Cunha testified that the Respondent accompanied her father to the emergency room on July 2, 2017. He already had an IV placed in his arm upon arrival. After being triaged, Mr. Byelkov was seated in a recliner chair about 20 feet from the nursing station.

74. Nurse D'Cunha testified that the Respondent approached the nursing station and asked whether her father could be given some Benadryl. The Respondent told Nurse D'Cunha that she had given her father Maxeran and Toradol by IV at home but they were not working. Nurse D'Cunha testified that the Respondent was specific about telling her those medications had been administered by IV. Nurse D'Cunha told the Respondent that she could not give Benadryl without an order and Mr. Byelkov had not yet been seen by the physician.

75. Nurse D'Cunha testified she spoke to an emergency room physician for guidance. The physician advised Nurse D'Cunha that the Respondent's actions were highly unethical and someone needed to speak with the Respondent. Nurse D'Cunha testified she then had a private conversation with the Respondent in a storage room behind her desk. Nurse D'Cunha told the Respondent that it was unethical for her to be treating her father at home, that she should not have been giving him medication, and that she should not have administered an IV to him.. The Respondent listened to Nurse D'Cunha, stared at her with a blank look and simply stated, "but he was sick."

76. Nurse D'Cunha testified that she was approached by Nurse Jackson. Nurse Jackson said she was concerned as the Respondent told her that she gave her father medication and IV fluids at home. Nurse D'Cunha and Nurse Jackson discussed where the Respondent may have obtained the equipment and medication.

77. Nurse D'Cunha also testified about a conversation she had with Nurse Yu. He told Nurse D'Cunha that he had drawn up medication for Mr. Byelkov which the Respondent took out of his hand and administered to her father through IV.

78. Nurse D'Cunha testified that prior to Mr. Byelkov's discharge the physician had ordered a further bolus of fluid. The Respondent told Nurse D'Cunha, "if that's all you are going to give me, I can do it at home, I can give him the fluids at home." When Nurse D'Cunha told the Respondent that she could not administer the fluids at home and that Mr. Byelkov would not be discharged with an IV in his arm, the Respondent became frustrated.

79. Nurse D'Cunha reported the Respondent to the Fraser Health Authority in relation to these events. She met with Mr. Saran on July 7, 2017.

Jeff Yu

80. Jeff Yu is a registered nurse. He graduated in 2017 and was mentored by the Respondent. Nurse Yu works in the emergency department at PAH.

81. Nurse Yu testified that he was working in Zone 2 with Nurse Jackson on July 2, 2017. The Respondent was not working that day.

82. Nurse Yu testified that the Respondent accompanied her father to the hospital on July 2, 2017. Nurse Yu had a conversation with the Respondent at the nursing station in which the Respondent told Nurse Yu that her father had a headache and had received Toradol and Zofran already but was still feeling ill. The Respondent did not tell Nurse Yu how those medications were administered. The Respondent asked Nurse Yu if there was anything that he could do to help. Nurse Yu spoke with the emergency physician who provided a verbal order for Maxeran to be given by IV. Nurse Yu wrote the order down in the chart. On his way back from the medication room with the Maxeran, the Respondent came up to Nurse Yu and took the medication from him. The Respondent told Nurse Yu that she would give the medication to her father. The Respondent took the supplies and gave the medication to her father. Nurse Yu testified that he was taken aback. Nurse Yu told Nurse

Jackson and Nurse D'Cunha what had taken place. Nurse Yu testified that he did not chart the Maxeran being given to Mr. Byelkov.

Jessie Saran

83. Jessie Saran is a manager at PAH. Mr. Saran was the Respondent's manager in the emergency department at PAH during the material times.

84. Mr. Saran testified that he received a complaint about the Respondent from Nurse D'Cunha. He testified about his investigation at Fraser Health Authority which included interviewing Nurse D'Cunha, Nurse Yu, Nurse Lum, and Nurse Johal. Mr. Saran testified that he also met with the Respondent. At the conclusion of the investigation, the Fraser Health Authority decided to terminate the Respondent. Mr. Saran was involved in communicating that decision to the Respondent.

85. Mr. Saran identified Fraser Health Authority's Policy on Confidentiality and Security of Personal Information policies which applied to the Respondent. He testified that the Respondent would have signed a Confidentiality Agreement as all employees at the health authority are required to sign the agreement.

86. Mr. Saran testified that he received the audit report setting out the Respondent's access to Mr. Byelkov's medical records.

87. Mr. Saran testified that the Respondent initiated a Human Rights Tribunal complaint against him as well as a civil action.

Lorna Jackson

88. Lorna Jackson completed her nursing training in the United Kingdom and moved to British Columbia in 2005. She works in the recovery room and emergency room at PAH. Lorna Jackson testified that she had not met the Respondent prior to July 2, 2017.

89. Nurse Jackson testified that she was working on July 2, 2017 in Zone 2 with Nurse Yu and Nurse D'Cunha. Nurse Jackson performed an assessment of Mr. Byelkov. Initially, it was just Mr. Byelkov who was present. Nurse Jackson asked Mr. Byelkov how he was feeling, what medications he had taken, and why he was at the hospital. The Respondent arrived part way through the assessment. Nurse Jackson asked

the Respondent about the medications her father had taken as he did not know the medication names or dosages. The Respondent told Nurse Jackson that she had given her father two medications at home by IV. Specifically, 15 mg of Toradol and 4 mg of Zofran. The Respondent also told Nurse Jackson that she had inserted an IV in her father the day before. Nurse Jackson recorded her conversation with the Respondent in the clinical record. Nurse Jackson's original handwritten note at 1210 states in part "temporal h/a (constant 8/10) - taken Toradol 15 mg & Zofran 4 mg & Maxeran 10 mg IV by daughter. Assoc nausea. IV in situ." Nurse Jackson confirmed that these notes were written by her at approximately 1210. Nurse Jackson testified that the information about Mr. Byelkov having a headache came from him, the report of nausea came from him, Nurse Jackson observed the IV in situ herself, and the information about the medications came directly from the Respondent.

90. Below the 1210 entry is an additional "note" which states "Toradol 15 mg + Zofran 4 mg given @ home 0930. Maxeran 10 mg IV @ 1210 by daughter – advised daughter not to administer medication & charge RN (Bev aware). See short stay." Nurse Jackson testified that it was not her normal practice to make this type of note but did so because she was surprised about the information. Nurse Jackson testified that she repeated the information back to the Respondent as she wanted to confirm the medication names, dosages and that they were administered by IV at home. The Respondent confirmed the information was correct. Nurse Jackson recorded that the Maxeran was given at 1210 hours because the Respondent told Nurse Jackson that she had just given it to her father. Nurse Jackson made the chart entry at 1210 and thought it would be best to indicate the closest time. Nurse Jackson testified that she repeated back to the Respondent "you've already given it" and the Respondent confirmed "yes".

91. Nurse Jackson testified that she told the Respondent not to administer medication to her father. Nurse Jackson told the Respondent that it was not her job to administer the medication and that there was no record of the medication that the Respondent had administered to her father. Nurse Jackson testified that it was unsafe as the Respondent was initially not present when she was speaking to Mr. Byelkov and Nurse Jackson could have administered the medication to him which would have

resulted in Mr. Byelkov receiving a double dose. Nurse Jackson testified that the Respondent did not appear to be concerned.

92. Nurse Jackson testified that she crossed out the entries in the Zone 3 chart and re-wrote the information in the emergency short stay assessment form for Zone 2. She said those notes were made shortly after her initial assessment with Mr. Byelkov. The Zone 2 chart contains the following entry: “Today pt feeling worse – daughter (RN) sited IV yesterday & gave Zofran 4 mg IV & Toradol 15 mg IV @0930….” Nurse Jackson testified about her further clinical records and her practice of checking off the medication orders which had been carried out. Nurse Jackson charted that the Maxeran had been given by the Respondent at 1210 hours and not one of the nurses on shift.

93. Nurse Jackson testified that she had a conversation with Nurse D’Cunha right after her interactions with the Respondent. Nurse Jackson described her concerns with the Respondent having administered medication to her father.

94. Nurse Jackson testified that approximately 18 months after July 2, 2017 she was informed by the College that Mr. Byelkov had made a complaint against her alleging falsification of information and perjury with respect to her clinical records for July 2, 2017. Mr. Byelkov and the Respondent also reported Nurse Jackson to the RMCP and initiated a civil action against her.

95. On cross-examination, it was suggested to Nurse Jackson that her original notes indicate that Toradol and Zofran were “taken” as opposed to “given” by IV. It was put to Nurse Jackson that she only charted the IV route with respect to the Maxeran and not the other two medications. Nurse Jackson firmly denied that suggestion. Nurse Jackson testified that the word “IV” in her notes referred to the route for all three medications. Nurse Jackson firmly rejected the suggestion that the Respondent never told Nurse Jackson that the Toradol and Zofran were administered by IV, and that if the Respondent had said that Nurse Jackson would have recorded that information in her note. Nurse Jackson testified that if there had been a route other than by IV, she would have written that down. Nurse Jackson acknowledged she could not recall the Respondent’s exact words, but she was

adamant that the Respondent told Nurse Jackson that the Respondent had administered all three medications to her father by IV. Nurse Jackson was pressed on the notes and did not waver in her recollection of her communications with the Respondent or what her chart notes stated and meant.

Laurie Wynes

96. As noted above, Laurie Wynes did not testify as a witness. Her evidence was admitted by way of an agreement statement. Ms. Wynes was an Information Privacy Office analyst at the Fraser Health Authority. She conducted audits which showed electronic access to Meditech. Ms. Wynes conducted an audit on the Respondent's access of her father's medical records.

97. Ms. Wynes conducted the audit on January 25, 2019 and created an audit report based upon the results. The audit report identified every time the user ID "MBYELKOVA" and username "Byelkova, Maryna" accessed Artur Byelkov's medical records. The audit report records that there were six times that Mr. Byelkov's information was accessed. Specifically, on February 16, 2017 at 7:21:56 pm, 07:31:43 pm and 07:32:43 pm, and on June 29, 2017 at 03:33:41 pm, 05:14:46 pm and 05:14:45 pm.

Lori Quinn

98. Lori Quinn has been a registered nurse since 2006. She has worked in nurse education and training. Nurse Quinn has also been an instructor, and has taught courses including emergency nursing care practice in Canada. Nurse Quinn has also held nursing leadership roles including head of nursing operations. She continues to work as an RN with shifts in the emergency department. The Panel qualified Nurse Quinn as an expert in registered nursing with specialty training in emergency and critical care. The Panel admitted an expert report dated September 10, 2019 which was prepared by Nurse Quinn.

99. Nurse Quinn's expert opinion was that Mr. Byelkov's condition on July 1 and 2, 2017 did not constitute an emergency to be treated without consultation with an emergency physician at an emergency department. In her report she defined an

emergency as “any urgent condition perceived by the patient as requiring immediate medical or surgical evaluation or treatment OR an unexpected serious occurrence that may cause a great number of injuries, which usually require immediate attention.” She testified that there is no specific standard that she is aware of in the profession which defines an emergency. In arriving at this opinion, Nurse Quinn considered a number of factors outlined in her report, including that Mr. Byelkov had access to emergency resources and had stable neural vital signs and vital signs.

100. Nurse Quinn testified that Toradol is available in 15 mg or 30 mg doses to be administered by IV, and only comes in 10 mg tablets.

The Respondent

101. The Respondent testified that she was 30 years old at the time of the hearing. She was born in Ukraine and immigrated to Canada in 2005. She obtained a B.Sc. in Nursing from BCIT in 2015. The Respondent began to work as a surgical nurse at PAH in February 2016. In September 2016, the Respondent began working as a nurse in the emergency department at PAH. In November 2016, she began working full time at PAH. The Respondent testified that she went into nursing because she wanted to pursue something in healthcare that is challenging and diverse with lots of room for growth. She appreciated that nursing offered the combination of education, research, bedside nursing and the ability to make a difference in peoples’ lives. The Respondent testified that she has no history of professional discipline prior to these proceedings.

February 16, 2017

102. The Respondent testified that on February 16, 2017 she was working the night shift in Zone 2 of the emergency department at PAH. Her father came to the emergency room at approximately 1900 hours because of an ingrown toenail which was becoming infected and left knee pain from trauma. Mr. Byelkov texted the Respondent in advance to alert her that he was coming to the hospital. The Respondent testified that Mr. Byelkov was triaged at approximately 2030 or 2040 and sent to Zone 3.

103. The Respondent admitted that she was responsible for one of the entries set out in the audit report. Specifically, she admitted that she placed a comment on her father's patient tracker at 1921 hours. She believes this entry was made prior to him being triaged and recorded a comment about his weight bearing status. The Respondent testified that her purpose in doing this was to supplement his information, to be efficient and to communicate with the emergency room staff. She expressed that she wanted to avoid having to leave her patients to go to triage and communicate that information directly with staff. The Respondent denied otherwise accessing her father's electronic records on that date.

104. The Respondent testified that she did not access her father's medical records and denied the other instances outlined in the audit report. She testified that she was aware of Fraser Health Authority's policy and "if I was intentionally wanting to look at my dad's medical files, I would do that through another person's computer."

105. The Respondent testified that she had a practice of leaving her computer open. She described it as being "routine" and the "culture" on the unit that nurses share each other's computers. The Respondent testified that sometimes it is more efficient not to log out another user but to simply record the relevant patient information while another employee was logged into the computer. The Respondent testified that she did not view anyone do that on the dates in question but stated that "it could have happened."

May 14, 2017

106. The Respondent testified that on May 14, 2017, she brought her mother, Olena Byelkova (Mrs. Byelkova), to the emergency room at PAH.

107. Mrs. Byelkova had been experiencing abdominal pain over the course of the preceding few days which was getting progressively worse and had radiated to her left flank.

108. The Respondent testified that Mrs. Byelkova told her that she had taken 30 mg of Toradol and Dilaudid. Despite the medication, her mother's pain was not improving so they decided to go to the emergency room. The Respondent testified that she

did not see her mother take the medication. The Respondent testified that she asked her mother what she had taken just before they left for the emergency room.

109. The Respondent and her mother arrived at PAH just before 11:00 a.m. on May 14, 2017. Her mother was triaged into Zone 2. The Respondent and Mrs. Byelkova were then approached by Nurse Johal, the flow coordinator in Zone 2. Nurse Johal told them which exam room to go to. The Respondent did not witness Nurse Johal perform an initial assessment on her mother.

110. The Respondent testified that after Nurse Johal placed Mrs. Byelkova in the exam room, she did not speak to Mrs. Byelkova. Rather, Nurse Johal spoke to the Respondent. The Respondent testified that Nurse Johal told her that she should probably do her own assessment of her mother and communicate to Nurse Johal if there were any changes from triage or if something urgent arose. Nurse Johal expressed to the Respondent that she was extremely busy and overwhelmed because she was working with two new graduates. The Respondent testified that Nurse Johal stated, “If you want anything done, you should do it yourself.” The Respondent understood Nurse Johal to be telling her that if she wanted any assessment of her mother performed efficiently and effectively, the Respondent should assume care of her mother.

111. After the discussion with Nurse Johal, Mrs. Byelkova had bloodwork drawn and a urine sample was taken. A physician, Dr. Dan Crompton, then came by to see Mrs. Byelkova. He ordered an abdominal CT scan with contrast.

112. The Respondent testified that following Dr. Crompton’s visit, a nurse named ‘Olena’ came to visit the Respondent’s mother. Nurse Olena was a registered nurse working in PAH’s emergency department. She was a new graduate. Nurse Olena came to start an IV for the contrast dye to be injected for the CT scan. The Respondent testified that Nurse Olena looked at Mrs. Byelkova’s arms and was trying to find a good vein. She was speaking to Mrs. Byelkova in Russian. Nurse Olena asked the Respondent to help her find a good vein to insert the IV catheter. Nurse Olena put the tourniquet on Mrs. Byelkova’s arm and palpated her arm but said she could not find anything. The Respondent then palpated and found a vein. The Respondent

testified that she tried to help Nurse Olena feel the vein but Nurse Olena said that she could not feel the vein. Nurse Olena told the Respondent that she did not feel comfortable poking the vein.

113. A porter also came into the room to ask if Mrs. Byelkova was ready for her CT scan. The IV had not yet been inserted at that time. At that point, Mrs. Byelkova said to the Respondent "just please do it". Mrs. Byelkova told the Respondent that she wanted the Respondent to place the IV in the interests of time and because she did not want to be poked more than necessary.

114. The Respondent testified that she confirmed with her mother whether she wanted the Respondent to insert the IV. The Respondent then explained in Russian that because her veins move a lot and are tiny, there is a high chance that they could burst or the Respondent could burst a different vein. The Respondent testified that is the biggest risk and she explained that risk to her mother. Mrs. Byelkova had had IVs inserted many times and knew what to expect so the Respondent testified that she did not go into too much detail. The Respondent asked her mother whether she was certain she was comfortable with the Respondent, as her daughter, inserting the IV as she could call someone else to do it. Mrs. Byelkova confirmed she wanted the Respondent to insert the IV. The Respondent then inserted the IV and her mother went for the CT scan. There was no one else present when this occurred other than the Respondent, Nurse Olena and the porter.

115. The Respondent testified that she did not have any discussion with Nurse Johal that day after the Respondent inserted the IV in her mother's arm.

116. The Respondent was not working on May 14, 2017. The Respondent admitted to inserting an IV into her mother on May 14, 2017. The Respondent did not assist with any other patients in the emergency room that day. The Respondent agreed that two other nurses were involved in her mother's care on May 14, 2017: Nurse Olena and a nurse named "Mike" in addition to the flow coordinator, Nurse Johal. The Respondent agreed that Zone 2 had a full complement of nurses on May 14, 2017.

117. While the Respondent testified that Nurse Johal stated, "if you want anything done, make sure you do it yourself", the Respondent acknowledged she did not have a

specific conversation with Nurse Johal about inserting an IV in the Respondent's mother. The Respondent denied going to speak to Nurse Johal about this issue before taking steps to insert the IV into her mother as Nurse Johal had told Nurse Olena that the Respondent had permission. When asked to explain why there was no discussion between the Respondent and Nurse Olena about Nurse Johal inserting the IV, the Respondent stated that Nurse Johal was "tied up with somebody" and had relayed through Nurse Olena that the Respondent could do it.

118. An email from Nurse Johal to Mr. Saran dated July 17, 2017 states:

> The first incident was when she brought her mother into the ER. Her mother needed an IV for a CT scan. Maryna was told that I will come in shortly and insert the IV. When I did go into the exam room, room 25, the IV had already been inserted. Maryna said, 'Oh I just did it.

119. The Respondent agreed the email above relates to the events of May 14, 2017 and that her mother had been in room 25. The Respondent denied the statement in the email indicating that the Respondent had been told Nurse Johal would insert the IV. The Respondent also denied that Nurse Johal entered the room to insert the IV and found that the Respondent had already done it. The Respondent testified that Nurse Johal's email of July 2017 is inaccurate with respect to the events of May 14, 2017.

120. On cross-examination, the Respondent was also asked about notes dated June 21, 2019 which Ms. Chalke made based upon a conversation she had with Nurse Johal. The Respondent testified that the following statements from those notes were inaccurate: "Ms. Johal stated that she recalls the registrant bringing her mother in. She stated at no point did she tell the registrant that she was too busy" and "She stated that she has had family in the hospital and is more than aware that "you are not to care for your family members"." The Respondent also denied the following statement recorded in Ms. Chalke's notes, "Ms. Johal recalled telling the registrant, 'I'll be right back to put the IV in.'"

121. The Respondent was asked on cross-examination about the conversation she had with her mother about her dual role (though she did not use those words) as daughter and nurse, and the risks and benefits of inserting the IV. The Respondent denied the proposition that this conversation did not take place.

June 29, 2017

122. The Respondent was working the day shift in Zone 2 at PAH on June 29, 2017. The unit was busy and understaffed. Nurse Lum was the flow coordinator that day. The Respondent testified that she was the only other nurse working that day. There was a student nurse assisting with Zones 1 and 2. The Respondent did not recall her name. Nurses from other zones also assisted during breaks. The Respondent could not recall who those nurses were. The Respondent denied Nurse Lum's evidence that another RN was assigned to Zone 2 with the Respondent on June 29, 2017.

123. The Respondent's father texted the Respondent to inform her that he was coming to PAH. Soon after, as Nurse Lum was checking the patients who had been triaged to Zone 2, she noted one of them had the Respondent's last name. Nurse Lum asked the Respondent if she was related to the patient. The Respondent told Nurse Lum the patient was her father.

124. The Respondent testified that Nurse Lum then offered to triage the Respondent's father to expedite him. That was not part of Nurse Lum's role as a flow coordinator. The Respondent said she welcomed Nurse Lum's offer and responded, "Yes, thank you." The Respondent denied Nurse Lum's evidence that it was the Respondent who asked Nurse Lum to triage her father. The Respondent testified that her father has been to the hospital on other occasions, and the Respondent has never asked a flow coordinator to triage her father.

125. After offering to triage the Respondent's father, Nurse Lum told the Respondent to speak to the charge nurse to ensure she was aware of and in agreement with that arrangement. The charge nurse was Nurse Johal. The Respondent testified that she spoke with Nurse Johal who told her, "yeah, that's okay." The Respondent then moved her father from the waiting room and to Zone 2. Nurse Lum triaged the Respondent's father. The Respondent was not involved in the triage process. Nurse Lum told the Respondent that she would assume care for the Respondent's father. The Respondent denied telling Nurse Lum that she intended to "pop a line in" her father. The Respondent denied Nurse Lum told her not to access her father's patient records.

126. The Respondent denied accessing her father's patient records during any of the three instances on June 29, 2017 that were recorded in the audit report. The Respondent denied having given her user ID or password to anyone. The Respondent testified that sometimes she would leave her Meditech screen on her computer open. She testified that Zone 2 was a fast-paced zone and logging in and out did not make sense. The Respondent testified that it was possible she left her screen open on June 29, 2017. Each nurse in Zone 2 was assigned to a specific computer. On occasion, on a shift, the Respondent would use one of the other computers to which she was not assigned. The Respondent testified she would use whichever computer was closest to her. If the previous user had not logged off, sometimes the Respondent would not log them off and sign back in with her own name.

127. The Respondent was taken to her father's patient record for June 29, 2017 and the entries for medications. The Respondent did not dispute Nurse Lum's evidence that the initials next to "Toradol" were made by Nurse Lum. The Respondent testified the initials next to "Amoxi" were from someone other than Nurse Lum, though the Respondent was unable to identify who that was.

128. On cross-examination, the Respondent testified that Nurse Lum told her later in the day that she had not completed triage training and Nurse Lum asked the Respondent to "keep it on the down low." Nurse Lum told the Respondent that she was grateful for the opportunity to practice triaging. The Respondent did not take any steps to speak to a supervisor about this issue because the Respondent was relatively new and Nurse Lum had done this as a "favour". When asked to explain why it was a favour if the Respondent had not asked Nurse Lum to triage her father, the Respondent explained that she meant Nurse Lum had offered to do this "out of the goodness of her heart".

July 1, 2017

129. The Respondent testified that on July 1, 2017 she administered IV fluids to her father while at home.

130. The Respondent testified that Mr. Byelkov had been discharged from the hospital on June 29, 2017. When the Respondent returned home from her shift, her father described feeling nauseous. He vomited once or twice that night.

131. On June 30, 2017, the Respondent was working a day shift at PAH, Mrs. Byelkova underwent surgery at PAH, and Mr. Byelkov was home with the Respondent's daughter and sister. After returning home from work on June 30, 2017, the Respondent had a conversation with her father at approximately 8 p.m. He described intermittent nausea and vomiting but described feeling better.

132. The Respondent testified that on July 1, 2017, Mr. Byelkov's condition was worsening with increased vomiting, nausea and weakness. He was lying downstairs on a couch. The Respondent testified that she assessed her father at approximately 7 p.m. She took his blood pressure with a manual cuff and stethoscope and measured his temperature, respiratory rate and heart rate. The Respondent described him as being hypertensive and with a heart rate which was a little fast for him. The Respondent told her father that he should go to the emergency room but he told the Respondent that he did not feel that bad.

133. The Respondent testified that she reassessed her father at approximately 10 p.m. or 11 p.m. He described feeling worse with stronger nausea. The Respondent brought Mr. Byelkov a bucket and he threw up. On reassessment, Mr. Byelkov had lower blood pressure and a higher heart rate. His respiratory rate was the same. The Respondent palpated his stomach and checked his mouth which she observed as being drier than earlier. The Respondent testified she had a further conversation with her father that his symptoms were not resolving and she insisted that he should go to the emergency room. The Respondent testified that her father refused to go because Mrs. Byelkova required the Respondent's help and if Mr. Byelkov went to the hospital, Mrs. Byelkova would insist that the Respondent accompany him. This would leave Mrs. Byelkova alone with her daughter and granddaughter. Mr. Byelkov said to the Respondent, words to the effect of, "what else are they going to do other than push more shots on me?" The Respondent answered that the emergency room staff would need to hydrate him and give him fluids through an IV, and administer

medication which would also likely be administered through an IV. Mr. Byelkov refused to go to the emergency but said words to the effect of “I’m not going but if there’s anything you can do for me now would be the good time.”

134. The Respondent testified that she was concerned that the antibiotics her father was taking orally were not staying in his system because he was vomiting. She also testified that he was getting dehydrated. The Respondent described being very concerned about her father. The Respondent described this as an “urgent situation” and determined that she would administer her father saline solution through an IV. The Respondent testified that she had purchased IVs and saline bags and supplies to initiate an IV. When asked where she purchased those supplies, the Respondent responded, “I have couple of friends who are physicians and I bought it from a friend of mine.” She then stated this friend is a naturopathic doctor.

135. The Respondent testified that on the evening of July 1, 2017, she looked up the College standards, including the Boundaries Standard, on the internet before proceeding to administer an IV on her father. The Respondent testified that she looked up to confirm whether she could insert an IV for hydration without an order. The Respondent testified that she also reviewed the Boundaries Standard to confirm that she could treat a family member. She testified that she had a conversation with her father about assuming a dual role as nurse and daughter and the risks of the procedure. The Respondent testified that she told her father that it was a ‘one time thing’. The Respondent inserted an IV in her father’s arm and gave him saline solution. She testified that she continued to assess her father overnight. The Respondent testified that she went to bed at approximately 3:00 or 4:00 a.m. and got up the next morning at 7:00 a.m. to make sure that her father was alright. The Respondent testified that she disconnected the tubing to the bags and wrapped up his IV site when she went to bed.

136. The Respondent testified on cross-examination that she documented her assessments of her father on a “piece of paper” but that those notes are no longer available. When asked why the notes were no longer available, the Respondent stated that she “didn’t need it afterwards.”

137. The Respondent testified that the next morning, July 2, 2017, she heard her father throwing up. Her mother said that Mr. Byelkov needs to go to the emergency department. Mr. Byelkov refused to go. Mr. Byelkov told the Respondent that he had taken pills and then threw them up. The Respondent told him that the medication would not be effective if he threw it up. The Respondent testified that her father told her that he took Zofran and Toradol. The Respondent testified that the Zofran was given to her in a “to go pack” when she was in the emergency department with Norwalk virus on June 14, 2017. She knew that this was 4 mg of Zofran. The Respondent testified that she knows that is where the medication came from because her father said that he emptied the envelope which had her name on it. The Respondent denied giving her father Zofran. The Respondent did not know where her father obtained the Toradol. She testified that it could have been medication he was given when he had some dental work done or he could have brought it back from the Ukraine. The Respondent testified that her father took 15 mg of Toradol because he said he took 1.5 pills. The Respondent denied administering either medication to her father by IV.

138. The Respondent insisted that her father go to the emergency department. Ultimately, he relented and the Respondent took her father to the emergency room at PAH. They arrived at the hospital at approximately 11 a.m. The Respondent testified that her father was triaged relatively quickly and was moved into Zone 3. He was then moved to Zone 2. The Respondent testified that Nurse D’Cunha was the charge nurse on Zone 2 that day. Nurse Jackson and Nurse Yu were also working on the unit.

139. The Respondent testified that she had a conversation with Nurse D’Cunha but she did not tell Nurse D’Cunha that she had administered medication to her father at home.

140. The Respondent testified that she did not speak to Nurse Jackson as Nurse Jackson did not come to see her father.

141. The Respondent testified that she approached Nurse Yu. The Respondent asked if Nurse Yu had seen Nurse Jackson. The Respondent said that her father was

throwing up, no one had come to see him and he needed medication for his pain. Nurse Yu told the Respondent that he would speak to the physician in Zone 2 to obtain some medication. The Respondent described the unit as being busy and Nurse Yu as being flustered and overwhelmed. The Respondent testified that she said to Nurse Yu words to the effect of, “hey do you want me to do some care. If you need any help with my dad, I don’t want to be a pest, just let me know.” The Respondent testified that after Nurse Yu returned from the medication room, she again asked him if he wanted any help. The Respondent testified that Nurse Yu stated words to the effect of “yeah that would be great, if you can do it that would be good.” The Respondent testified that she then took her father’s vitals, mixed the Maxeran and administered the medication to her father by an IV push. The Respondent testified that her father’s vitals were recorded by a machine called the Dynamap. The vitals were printed from the machine.

142. The Respondent testified that Nurse Jackson did not assess Mr. Byelkov until after he had been assessed by the physician, Dr. Clark. The Respondent told Dr. Clark that her father had taken Zofran and Toradol by tablet at home and thrown them up prior to coming to the hospital. The Respondent testified that she told Dr. Clark she had administered the Maxeran. The Respondent testified she told Nurse Jackson that her father had “taken” Zofran and Toradol at home but did not tell her the medication route. The Respondent testified that she told Nurse Jackson she had administered the Maxeran to her father. She estimated that conversation took place at approximately 1230.

143. The Respondent testified that she had a conversation with Nurse D’Cunha asking if Dr. Clark had ordered Benadryl for her father. Nurse D’Cunha told the Respondent to wait for Dr. Clark. Dr. Clark then ordered more hydration through IV. The Respondent relayed a conversation at the nursing station in which the Respondent says she asked Nurse Jackson whether she needed any help. Nurse Jackson told her to let her do her job. Nurse D’Cunha reiterated a similar statement to the Respondent. The Respondent testified she was just trying to be helpful and knew they were visibly busy. The Respondent testified that she could give her father the water at home and she just wanted to “free up a bed”. Nurse D’Cunha told the

Respondent that it is not ethical for the Respondent to treat her family and if she were to take any supplies home it would be viewed as stealing. The Respondent's father was subsequently discharged at approximately 3 p.m.

Olena Byelkova

144. Olena Byelkova is the Respondent's mother. She was trained as a psychologist. She presently does not work.

145. Mrs. Byelkova testified that during the morning of May 14, 2017, she was experiencing severe pain on her bottom left side. She testified she had been experiencing that pain for a couple of hours. Mrs. Byelkova testified that she took Toradol and Dilaudid at home.

146. Mrs. Byelkova testified that the Respondent drove her to PAH on May 14, 2017. They arrived at the hospital at approximately 11 a.m. Mrs. Byelkova went through registration, had her blood pressure and temperature taken, and after approximately 20 minutes, she was moved to a room in Zone 2.

147. A lab worker took a blood sample from Mrs. Byelkova for analysis. Following that, Nurse Johal briefly came into the room. Nurse Johal did not speak with Mrs. Byelkova. She spoke only with the Respondent. Mrs. Byelkova testified that Nurse Johal told the Respondent that they were very busy and that there was only Nurse Johal and two other nurses. Mrs. Byelkova testified that Nurse Johal told the Respondent words to the effect of "if you want things done quickly and well, do it yourself because we're busy."

148. Subsequently, a physician came into the room and told Mrs. Byelkova that she required a CT scan. Nurse Olena"[1] then came into Mrs. Byelkova's room and told Mrs. Byelkova she needed an IV placed. Nurse Olena spoke in Russian with Mrs. Byelkova. Nurse Olena told Mrs. Byelkova that her veins were difficult and that she was afraid to insert the IV because she may miss it. Mrs. Byelkova testified that the

[1] Nurse Olena was referred to variously during the proceedings as Elena, Yelena and Olena. For consistency, the Panel refers to her as Nurse Olena.

Respondent inserted the IV in her arm. Mrs. Byelkova was then brought to the CT scan.

149. On cross-examination, Mrs. Byelkova agreed that she had advised triage that she had taken two Dilaudid pills at 10:30 a.m. on May 14, 2017 and 30 mg of Toradol. Mrs. Byelkova denied telling triage that she had taken the Toradol by injection. When presented with the clinical record from that day which notes “30 milligrams Toradol IM”, Mrs. Byelkova denied having taken the drug intra-muscularly and said she took it by pill. She testified that she either purchased the Toradol in Ukraine or she obtained it from her husband who received it from a dentist in British Columbia. The Toradol pills were 10 mg tablets and she took three pills on May 14, 2017. The Dilaudid had been prescribed for her husband in relation to his leg.

Artur Byelkov

150. Artur Byelkov is the Respondent’s father. He completed studies in navigation and operation from Odessa State University and worked as a deck officer on ships. Since 2013, Mr. Byelkov has worked for Seaspan. He is a senior marine manager. Mr. Byelkov testified about the first aid training he received in connection with his marine work. Mr. Byelkov testified that he has been trained in inserting IVs during an emergency at sea and has had occasion to insert IVs “a couple of times” in the course of his career.

151. Mr. Byelkov testified about the events of June 29, 2017. His daughter was working at Zone 2 in PAH that day. He went to PAH emergency department due to a headache. Mr. Byelkov testified that Nurse Lum triaged him that day. He was placed in Zone 2. Nurse Lum was primarily responsible for Mr. Byelkov’s care that day. He testified that he found her to be forceful with medication.

152. Mr. Byelkov testified he was seen by the physician. Mr. Byelkov did not report that he was suffering from a migraine. Mr. Byelkov’s diagnosis was ultimately related to his sinus.

153. Mr. Byelkov also testified about the events of July 1, 2017. He testified that he experienced headache, nausea and vomiting. Mr. Byelkov’s wife was at home

recovering from abdominal surgery which she had undergone a day prior. The Respondent was checking on Mr. Byelkov throughout the day. She assessed him at approximately 7 p.m. and took his blood pressure manually and took his temperature. The Respondent told her father to go to the emergency department. Mr. Byelkov testified that he refused to go because he did not want to leave his wife, youngest daughter and grand-daughter at home. Mr. Byelkov testified that he asked the Respondent to administer saline to him via IV. He testified that he told the Respondent "okay, I know that you can do that. You're very good on that because I have a lot of good feedback about you, my dear, so I would like -- I'm really afraid to go to Emergency Room, so I would like you to give me saline." Administer, sorry." Mr. Byelkov testified that the Respondent had a conversation with him about being his daughter and also acting as nurse. When asked whether the risks or benefits of inserting an IV were discussed, Mr. Byelkov indicated that he already knew the risks. The Respondent told her father that if he did not improve he would need to go to the hospital. The Respondent administered saline via IV. Mr. Byelkov testified this made him feel better and he fell asleep.

154. Mr. Byelkov testified that when he woke up the next morning he took medication. He took 1.5 tablets of Toradol. When asked about that dose, he said that he knew the maximum dosage for eight hours was up to 30 mg which was 3 tablets of Toradol. He did not want to take the maximum dosage so decided to take the “average”, or 15 mg which was 1.5 tablets. Mr. Byelkov testified that he either obtained the Toradol from his periodontist or during his travels overseas where no prescription is required: “For example, in Russia and Ukraine and from my homeland, without any prescriptions required. So I've been and my wife brought in 2000s when she visited Ukraine she brought all this -- she bring some medication because this kind of medication such as Zofran and Toradol have been a part of my family communal medicine cabinet for years. So this is the sources what I got it.” Mr. Byelkov testified that he also took 4 mg of Zofran. He found an envelope in the medicine cabinet at home with the Respondent’s name on it. Mr. Byelkov denied that the Respondent provided either medication to him. Mr. Byelkov testified that after he took the

medications, he began vomiting and he saw the tablets in the toilet bowl. The Respondent was asleep at this point.

155. Mr. Byelkov testified that both the Respondent and his wife insisted that he go to the hospital. By this point, Mr. Byelkov agreed. The Respondent drove her father to PAH. Mr. Byelkov was initially triaged to Zone 3 and then moved to Zone 2. He took medication by mouth and vomited.

156. Mr. Byelkov testified that Nurse Yu attended with some medication and told the Respondent that he was busy and that Dr. Clark had prescribed medication for her father. Mr. Byelkov testified that Nurse Yu asked the Respondent to administer the medication because he was busy. The Respondent agreed and Nurse Yu left. Mr. Byelkov testified that he then had a discussion with the Respondent about her administering the medication to him. Mr. Byelkov testified that the Respondent assessed him. He provided his consent for her to proceed.

157. Mr. Byelkov testified he had limited interactions with Nurse Jackson. He testified that Nurse Jackson's only involvement was that she administered some saline, Toradol and Zofran by IV.

158. On cross-examination Mr. Byelkov acknowledged that the Respondent played a significant role in the complaints he made against Nurse Lum and Nurse Jackson. He had no explanation for why he made those complaints many months after the events in question. He agreed that the Respondent had a power of attorney over him including with respect to medical decision-making. Mr. Byelkov agreed that he attended PAH on June 29, 2017 in circumstances that were not an emergency. Mr. Byelkov admitted that his condition on July 1, 2017 was not life threatening and that it would have been possible for him to go to PAH. He described his condition as "serious but not life threatening." Mr. Byelkov testified for the first time on cross-examination that he took Toradol and Zofran on both July 1, 2017 and July 2, 2017. He testified that he used a kitchen knife to cut the Toradol tablet in half on July 2, 2017. Mr. Byelkov testified on cross-examination that his wife observed him taking the medication. He said she came down from their upstairs bedroom and saw him self administer the medication.

Linda Mitton

159. Linda Mitton was the Respondent's shop steward and agent during the Fraser Health Authority disciplinary process.

160. Ms. Mitton testified that she swore an affidavit in the proceeding on behalf of the Respondent. Ms. Mitton observed that the Respondent found it very difficult to acknowledge any wrongdoing. Ms. Mitton testified that Mr. Saran expressed to her that the Respondent's job was in jeopardy. She also testified that it is uncommon for a manager to express to a shop steward that a nurse's job is in jeopardy prior to the completion of an investigation.

161. Ms. Mitton testified that in some cases, nurses and hospital staff might not log off their computers. She was aware of cases in which staff have used a computer where a user did not log off. On cross-examination Ms. Mitton agreed she had no knowledge as to whether that occurred in this case. She also agreed that to use another staff member's credentials on the computer is contrary to the health authority's policies.

G. ANALYSIS

Allegation 1 (a)

> 1. In 2017, you provided care to family members on one or more of the following occasions:
>
> a. May 14, 2017 – you inserted a peripheral intravenous catheter ("IV") into your mother in the Emergency Room of the Peace Arch Hospital ("PAH");

162. The Respondent confirmed in her written submissions, "It is not disputed that on May 14, 2017, Ms. Byelkova provided care to her mother in the emergency room of PAH, by inserting an IV in her mother's arm to facilitate the administration of the contrast dye required for a CT scan than [sic] had been ordered" and "The College and [the Respondent] agree with the core factual allegation in Count 1(a) of the Citation, namely that on May 14, 2017, [the Respondent], "inserted a peripheral intravenous catheter ("IV") into [her] mother in the Emergency Room of the Peace Arch Hospital". It is common ground that [the Respondent] was not on shift that day."

As such, the Respondent admits the facts set out in allegation 1 (a) of the Citation, but disputes that those facts amount to any misconduct.

163. The Respondent's position with respect to this allegation is that she had permission from Nurse Johal and that Nurse Olena had requested the Respondent's assistance with inserting the IV into her mother's arm. The Respondent submits that there is nothing incredible about the Respondent's evidence and that it was uncontradicted by any evidence, documentary or *viva voce*. The Respondent argues there was no obligation on her to have called Nurse Olena as a witness.

164. The Respondent submits that the Panel should place no weight on the hearsay evidence relating to Nurse Johal. The Respondent submits that there is no reasonable basis for the Panel to prefer her hearsay evidence "without knowing anything about Ms. Johal, without seeing her under cross-examination, without having her respond to the specific statements attributed to her by [the Respondent] and without having her explain her choice not to immediately report [the Respondent]."

165. The College submits that even if the Respondent's evidence is accepted that Nurse Johal gave the Respondent permission to insert the IV into her mother's arm, and that Nurse Olena asked for assistance, those events would still not offer the Respondent an excuse for breaching her professional obligations. It is incumbent upon every College registrant to consider and assess their own professional obligations. A registrant cannot avoid professional responsibility by claiming that they were given permission to act in an unprofessional manner. The College relies upon the following statement in the Professional Standards in that regard:

> Individual nurses, as self-regulating professionals, are responsible for acting professionally and being accountable for their own practice. All nurses are responsible for understanding the Professional Standards and applying them to their practice, regardless of their setting, role or area of practice. The policies of employers or other organizations cannot relieve individual nurses of accountability for their own actions or their primary obligation to meet these Professional Standards.

166. The College further submits that even if the Panel were to accept all of the Respondent's evidence, it would still not amount to Nurse Johal having given the

Respondent any permission to insert the IV. At most, she may have made a casual statement that if the Respondent wanted things done efficiently with her mother, she would have to be involved with her mother's care. The College submits that the "permission" is not established on the evidence. Moreover, at the relevant times, Nurse Olena was at Mrs. Byelkova's bedside and ready to place the IV.

167. The College submits that the Respondent's evidence and her mother's evidence about what happened is not credible. In particular, the evidence given by both witnesses about the discussion in which the Respondent reviewed her professional obligations with her mother was not believable. Nurse Olena was present and ready to provide the necessary care. The College submits that what most likely happened is that the Respondent believed she could do a better job inserting the IV in her mother than Nurse Olena and took that step with her mother's agreement.

168. The College notes Mr. Saran's evidence that it would be unusual and inappropriate for hospital staff to be working at the hospital when they are not on duty. The College submits that this is a dangerous practice that should not be endorsed.

169. The College submits that there is no evidence beyond the Respondent's that Nurse Olena was incapable of inserting an IV or refused to do so. If it was in fact difficult to insert an IV into Mrs. Byelkova's veins, the College says this only underlines the imprudence of the Respondent's actions.

170. The College submits that it is implausible that Nurse Johal granted the Respondent permission to insert an IV in her mother. Communications from Ms. Johal to the health authority and the College disprove this took place. An email between Nurse Johal and Mr. Saran records that Nurse Johal told the Respondent she could come in shortly to insert the IV. When Ms. Johal arrived in the room, the Respondent told her she had already inserted the IV. Ms. Chalke's contemporaneous notes record that Nurse Johal stated that she "absolutely did not" tell Nurse Olena to tell the Respondent to put in the IV. The College submits that it would have preferred to call Nurse Johal as a witness, and took many steps to do so but Nurse Johal now lives in England and the College did not have the ability to compel her to testify at the hearing. The College submits that the two records described above should be

introduced into evidence. Hearsay evidence is admissible on the basis of necessity when a witness is not available and the statements are reliable. In addition, the Panel has an overriding discretion to admit evidence it deems necessary and reliable and is not bound by the strict rules of evidence. The College submits that the statements in this case are reliable and should be admitted into evidence to demonstrate a complete lack of permission by Nurse Johal.

171. The Panel finds that on May 14, 2017, the Respondent's mother had taken two Dilaudid and 30 mg of Toradol at home. Subsequently, the Respondent brought her mother to the emergency room at PAH. The Respondent was not working at PAH on May 14, 2017.

172. The Panel finds that the Respondent's mother was triaged and then moved to a room in Zone 2. The Panel is not persuaded that the PAH was particularly busy on May 14, 2017. A full complement of nursing staff was working in Zone 2 during the material times; namely, the flow coordinator, Nurse Johal, as well as Nurse Olena and a nurse named "Mike". All three members of Zone 2 nursing staff saw the Respondent's mother and were involved in her care during her May 14, 2017 hospital visit.

173. The Panel finds that the Respondent inserted an IV into her mother's arm as her mother was going to be given contrast for a CT scan which had been ordered.

174. Accordingly, the Panel finds that in 2017, the Respondent provided care to a family member on May 14, 2017, when she inserted an IV into her mother in the emergency room of the PAH. The Panel finds the conduct alleged in paragraph 1(a) of the Citation is admitted by the Respondent, and in any event, is proven on a balance of probabilities by the College.

175. With respect to allegation 1(a) of the Citation, the College asks the Panel to make a determination that Respondent's conduct amounts to professional misconduct because it represents a marked departure from the conduct ordinarily expected of registered nurses in British Columbia.

176. The Respondent argues:

> 180. The operative question, properly stated, is whether, in all the circumstances, [the Respondent], committed gross culpable neglect or, put differently, acted unethically, disgracefully or dishonourably when she inserted the IV into her mother at PAH on May 14, 2017.

177. The Panel has already addressed above in its reasons that this is not the test to be applied.

178. The Panel does not find that Nurse Johal gave the Respondent permission to insert an IV into Mrs. Byelkova's arm. The Panel finds this account to be implausible. The Respondent admitted that she did not have a specific conversation with Nurse Johal in which Nurse Johal gave the Respondent permission to insert the IV into her mother's arm. The Respondent maintains Nurse Johal granted that permission via a separate conversation that Nurse Johal had with Nurse Olena. However, by the Respondent's own account, Nurse Johal gave that permission to Nurse Olena before Nurse Olena tried to locate a vein on Mrs. Byelkova's arm, before Nurse Olena found Mrs. Byelkova's vein to be 'difficult', and before Nurse Olena asked the Respondent for assistance. As noted, in the Respondent's submissions, "a nurse named Olena (Lavrukh) came to see [the Respondent]'s mother and, in [the Respondent]'s presence, stated (in Russian) that her mother looked like a difficult poke and that she had discussed this with Ms. Johal already." Mrs. Byelkova's evidence is consistent with the Respondent's as to the chronology that Nurse Johal had granted permission for the Respondent to insert the IV prior to Nurse Olena having attempted to find a vein on Mrs. Byelkova. While their evidence is consistent on this point, the Panel finds it implausible that Nurse Olena would have discussed the Respondent's mother being a "difficult poke" before she had the opportunity to ascertain that fact by examining the Mrs. Byelkova's arm and attempting to find a vein. Moreover, there is no notation in the clinical record by Nurse Olena of these events. In addition, the Respondent did not call Nurse Johal or Nurse Olena, the two individuals who are said to have discussed the permission upon which the Respondent relies. The Panel agrees with the Respondent's submission that she "is under no obligation to prove anything", but that does not change the fact that the

evidence that has been placed before this Panel of any communication between Nurse Johal and Nurse Olena is weak and implausible.

179. The Panel is also persuaded by the Respondent's argument that Nurse Johal's delay in reporting the incident for months demonstrates that Nurse Johal did not find the conduct to be "sufficiently concerning" and "thought so little of it." The Panel is not prepared to draw those inferences and any delayed reporting of the Respondent's conduct by another nurse does not assist the analysis about the Respondent's conduct.

180. The Respondent relies upon *Jones v Rossner*, 2020 BCSC 2056, and asks this Panel to draw "an adverse inference against Nurse Johal" for not appearing as a witness. The Panel agrees with the College's submission that where an adverse inference is drawn it is against the party for failing to call a witness and not the potential witness themselves. The Panel declines to draw an adverse inference against the College for not calling Nurse Johal as a witness. In this case, there is a legitimate explanation for her absence. The College introduced affidavit evidence setting out its numerous attempts to contact Nurse Johal for the purpose of calling her as a witness and she refused. The College proposed calling Nurse Johal as a witness by video-conference or telephone in order to accommodate the fact that she was in England. The affidavit attached email responses from Nurse Johal which demonstrate that she did not want to participate in the discipline hearing for various reasons, and ultimately confirmed she would not participate. The College asked Nurse Johal to reconsider her position. She still refused noting that was her "final decision". The Respondent did not dispute that evidence or dispute the College's position that an order compelling Nurse Johal to attend the discipline hearing would not be effective given that she was in England. The Panel is not persuaded by the Respondent's argument that the College could have obtained an affidavit from Nurse Johal. The suggestion that Nurse Johal would have agreed to participate in that manner is purely speculative. Moreover, the Respondent would likely have sought to cross-examine her on her any affidavit (given that the absence of cross-examination on the documents is one of the Respondent's primary reasons for opposing the introduction of those documents). This would have required Nurse

Johal's further attendance under oath in any event, something she clearly declined to do. While the Respondent submits that Nurse Johal was "not equally available to both parties", she does not say why that is. It is not apparent to this Panel that Nurse Johal was not also available to be approached by the Respondent about testifying as a witness.

181. The Panel has considered whether to admit the two documents recording statements made by Nurse Johal regarding the May 14, 2017 events. The Panel agrees with the College's submission that it is not bound by the strict rules of evidence and it is open to the Panel to admit the evidence that is necessary and reliable. In addition, the evidence is admissible as a hearsay exception on the basis that the witness is unavailable and the statements are reliable. The Respondent did not dispute that the College attempted to call Nurse Johal as a witness and did not dispute that the College could not compel her as a witness because she was in England.

182. The Panel finds that the documents are reliable. There is no dispute about their authenticity. The email from Nurse Johal to Mr. Saran was dated July 17, 2017, which is shortly after the events in question. Ms. Chalke's notes were taken contemporaneously. In addition, the statements were made to Nurse Johal's employer and to her regulatory body, both environments in which there is a heightened expectation of honesty and accuracy. Nevertheless, the Panel does have some fairness concerns about admitting the records for the truth of their contents. It would be in Nurse Johal's interest that she is not found to have given permission to an off duty nurse to deliver care to a family member as that could attract professional consequences. Had Nurse Johal testified, one would expect her statements to have been vigorously cross-examined. In addition, while the email to Mr. Saran is authored by Nurse Johal, Nurse Johal did not create the second document – they are Ms. Chalke's notes of statements made by Nurse Johal. The Panel has decided that the documents are necessary and reliable and will be admitted but they will be given little weight. The little weight the Panel does give them is that the records in existence do not support the Respondent's version of events.

183. The Panel also finds it unlikely that Nurse Olena requested assistance from the Respondent with inserting an IV into Mrs. Byelkova's arm. The Panel finds it inconsistent that Nurse Olena would have asked the Respondent for assistance in locating a good vein and inserting an IV in Mrs. Byelkova's arm, if, as the Respondent and her mother maintained, Nurse Johal had already told Nurse Olena that the Respondent was permitted to insert the IV altogether. Moreover, the Respondent submits that "The procedure was minor, routine for an ER nurse, low risk and took mere seconds." If that is the case, Nurse Olena, a registered nurse on duty in the emergency room at that time, could have performed the procedure herself, even if she was a new graduate. Again, there is nothing in the clinical record regarding Nurse Olena having experienced issues inserting the IV and asking the Respondent for assistance.

184. The Panel finds the Respondent's testimony lacked credibility and did not have a ring of truth to it. The Panel finds it unlikely that the Respondent had a discussion with her mother about her dual role as a nurse and a daughter, and about the risks and benefits of inserting an IV. If the Respondent took the care to have such a conversation, one would have expected her to also have made some record of that conversation. The Respondent made no note of any kind of the communication. The Panel also finds it unlikely this conversation took place given the Respondent's testimony about the rushed moment when she inserted the IV in her mother's arm. The Respondent testified that when the porter came in the room, Mrs. Byelkova said to the Respondent "just do it". The Respondent testified that one of the reasons she did insert the IV in her mother's arm was "in the interests of time." The Panel finds it is more likely that the Respondent and her mother simply preferred that the Respondent insert the IV herself and that the Respondent did just that.

185. Even if Nurse Johal permitted the Respondent to insert the IV, and/or if Nurse Olena asked for assistance from the Respondent, this would not assist the Respondent. The granting of permission or request for assistance by other staff members do not alter the Respondent's professional obligations.

186. The Panel does not find that the Respondent's arguments that she was transparent and well intentioned assist her. The Respondent submits that she did not attempt to conceal her actions because she inserted the IV in plain view of Nurse Olena and the porter assist, or that her actions were *bona fide* because she was motivated solely by her mother's concerns and the need for to promptly get her mother to the CT scan. Neither of these reasons are acceptable bases for the Respondent to depart from her professional obligations.

187. The Panel agrees with the College's submission that the Professional Standards are clear on this point. It is a registrant's responsibility to act professionally and be accountable for their own practice. All nurses are responsible for understanding the Professional Standards and applying them to their practice, regardless of their setting, role or area of practice. The policies of employers or other organizations cannot relieve individual nurses of accountability for their own actions or their primary obligation to meet these Professional Standards.

188. As set out above, the Boundaries Standard at the material times required a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being in a small community. Where possible, nurses must transfer care to other health care providers. In unavoidable circumstances, the situation required caution, a discussion of boundaries and the dual role, and careful consideration of alternatives.

189. The Panel does not find that the circumstances of May 14, 2017 were unavoidable circumstances. To the contrary, they were entirely avoidable. The events in question took place at the emergency department of a hospital in an urban setting during which a full complement of nursing staff was working. The circumstances did not constitute an emergency and Mrs. Byelkova was not located in a small community.

190. Even if the Panel had found that Nurse Johal did grant permission for the Respondent to insert the IV or if Nurse Olena had requested assistance, neither of these circumstances would assist the Respondent as they do not constitute the "unavoidable circumstances" contemplated in the standard.

191. Moreover, the Panel finds that the Respondent did not proceed with caution or give careful consideration to alternatives and she did not transfer care to other health providers, something that would have been possible given the full complement of nursing staff on the unit on May 14, 2017.

192. Even if the Respondent did have a discussion with her mother about her dual role, which the Panel finds to be unlikely as outlined above, this would not assist the Respondent as she failed to meet the other aspects the standard required of her.

193. The Panel finds that the Respondent's actions are also contrary to the Conflict of Interest Standard which required that she identify and avoid conflicts of interest with family members. The Panel is not satisfied that the Respondent avoided the conflict of interest with her mother.

194. As set out above, a registrant is in breach of the College's Bylaws when they do not conduct themselves in accordance with the College's standards of practice and standards of professional ethics.

195. The Panel finds that the Respondent committed professional misconduct. Her actions were a clear violation of the College's standards in relation to boundaries and conflicts of interest. The Panel is well aware that not every error in judgment constitutes a breach of a standard of practice, and not every breach of a standard of practice constitutes professional misconduct. In this case, the Respondent took it upon herself to provide nursing care to her mother while her mother was in the hospital. Her actions of delivering care to a family member in the hospital where she worked and while she was off duty represents a marked departure from the conduct expected of a registered nurse. Her actions were flagrant and serious. The Respondent's conduct was similar to the professional misconduct in the decisions cited by the College which are outlined above.

196. While the Panel has found that the Respondent's conduct establishes a breach of the Boundaries Standard, a breach of the Conflict of Interest Standard, a breach of the Bylaws and amounts to professional misconduct, the Panel also notes that the second half of the Citation alleges these determinations in the alternative.

Accordingly, the Panel has decided to make a single determination of professional misconduct.

197. The Panel finds that in 2017, the Respondent provided care to a family member on May 14, 2017 when she inserted a peripheral intravenous catheter ("IV") into her mother in the emergency room of the PAH. The College has proven this allegation to the requisite standard. The Panel has determined that the Respondent committed professional misconduct.

Allegation 1 (b)

> 1. In 2017, you provided care to family members on one or more of the following occasions:
>
> b. July 1, 2017 – you inserted an IV into your father, and administered a bolus of normal saline to your father, while at your father's home;

198. There is no dispute about the conduct alleged in this paragraph of the Citation. The Respondent admitted that she inserted an IV into her father's arm and administered saline to him at home on July 1, 2017. The Respondent's closing submissions state: "The College alleges, and [the Respondent] acknowledges, that on the evening of July 1, 2017, whilst at home, she inserted an IV into her father and administered two 500ml bags of standard saline solution."

199. The Respondent submits that she was faced with an "impossible situation" and in all the circumstances, chose a reasonable course of action.

200. The Panel finds that there are numerous issues with both the Respondent's testimony and Mr. Byelkov's testimony about these events. The Respondent described careful and regular nursing assessments throughout the evening. She testified that she took her father's vitals and recorded this information in writing. The notes that the Respondent says she took no longer exist. She did not append them to Mr. Byelkov's medical records at the hospital or provide them to the nursing staff. This is inconsistent with her actions on February 16, 2017 in which she justified accessing Meditech and leaving a comment because of the importance of communicating continuity of care information about her father to the emergency room staff. The Respondent's July 1, 2017 notes were no longer available a matter

of weeks later when she was made aware of the health authority investigation against her. The Panel finds it improbable that the Respondent would have taken the care she says she took to perform and record her detailed assessments but not take the same care to preserve and append the records she created.

201. The Panel finds it inconsistent that the Respondent says the circumstances were urgent yet at the same time she testified that she took the time to review her professional obligations in the College's standards online to determine that it was appropriate for her to treat her father. Likewise, the circumstances were not urgent enough for the Respondent to take her father to the emergency department at PAH which is located only minutes from the family house, or to take alternative steps to call the nurses line at 811, or call an ambulance if she was unable to leave herself. It is also unclear why the Respondent would have needed to take the time to carefully review the College's standards, or why she would have told her father it was a "one time thing", if she did indeed find herself in an urgent situation. The Panel finds it unlikely that the Respondent had a discussion with her father about her dual role.

202. The Panel finds the evidence about Mr. Byelkov's reluctance to go to the emergency room to be unlikely and inconsistent with other evidence before the Panel. Both of the Respondent's parents had no apparent issues attending PAH multiple times for a variety of health reasons. Mr. Byelkov had attended PAH only a couple of days prior to July 1, 2017. In addition, he had previously attended the emergency department for matters that were not emergent. Mr. Byelkov himself admitted that his condition on July 1, 2017 was serious but not life threatening.

203. The Respondent alleges that Nurse Lum's evidence should be discounted in its entirety because it is being introduced as "similar fact evidence" and in an attempt by the College to demonstrate the Respondent's propensity to commit the type of conduct alleged in the Citation. The College submits it introduced the evidence to demonstrate the Respondent's state of mind about her professional obligations as well as the prior warning she had received about treating family members. The Panel has not considered Nurse Lum's evidence for any propensity purpose. Nurse Lum's

evidence about Mr. Byelkov's condition and attendance at PAH on June 29, 2017 is relevant to Mr. Byelkov's testimony of being reluctant to attend the emergency room. Nurse Lum's testimony is also relevant to the Respondent's knowledge of her professional obligations and the warning she received not to treat family members. The Panel found Nurse Lum to be a credible witness. She was clear and consistent, and readily made admissions which were contrary to her own interest such as her own prior errors.

204. The Respondent's evidence that Mr. Byelkov was afraid that hospital staff would "push shots on him" is inconsistent with his declared training and familiarity with medical care generally and IVs specifically. It is also inconsistent with Mr. Byelkov's evidence that it was he who asked that the Respondent insert an IV in his arm.

205. The Panel does not accept the Respondent's or Mr. Byelkov's evidence that he did not want to attend the hospital because of his wife's health condition or the presence of his younger daughter and granddaughter. This is inconsistent with Mr. Byelkov's evidence that his wife got up from her bed and came downstairs on July 2, 2017 and witnessed him self-administer medication. In addition, the Respondent's younger sister was 14 years old at the time. The Panel acknowledges that Mr. Byelkov may have had some sense that the emergency room would be busier on July 1, 2017 being a holiday, however that does not change the Panel's findings. The Panel does not accept the Respondent's argument that Mr. Byelkov was reluctant to return to the hospital on July 1, 2017 because he had an unpleasant experience on June 29, 2017 as this did not prevent Mr. Byelkov from attending the hospital on July 2, 2017. The Panel preferred Ms. Lum's evidence vehemently rejecting that she forced medication on Mr. Byelkov over Mr. Byelkov's evidence that Nurse Lum was forceful with him on two instances. Mr. Byelkov's evidence on those points was vague and implausible.

206. The Panel agrees with the Respondent's submission that there were some issues with Nurse Quinn's report including her definition of an emergency. The Panel however agrees with the evidence of the expert Nurse Quinn that the circumstances of Mr. Byelkov's illness on July 1 and 2, 2017 did not constitute an emergency. As

noted above, the expert considered Mr. Byelkov's access to emergency resources. This is not the case of a patient who was located in a remote or isolated area. Rather he was in an urban centre and close to hospital emergency services. Moreover, the expert opined that Mr. Byelkov's vital signs were in fact stable. These factors apply equally whether an emergency is assessed based upon Mr. Byelkov's perception of his condition or based upon the Respondent's stated perception that her father was in an urgent situation.

207. As set out above, the Boundaries Standard at the material times required that a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being located in a small community. Where possible, nurses should transfer care to other health care providers. In the unavoidable circumstances, a dual role was required to be approached with caution, a discussion of boundaries and dual role, and careful consideration of alternatives.

208. The Panel does not find that the circumstances of July 1, 2017 were unavoidable circumstances. The circumstances did not constitute an emergency and Mr. Byelkov was not located in a small community. He was located minutes from the emergency room at PAH. The Respondent did not call 811 or for am ambulance. The Panel does not accept the Respondent's argument that she was in "an impossible situation." The Panel finds that the Respondent did not proceed with caution or give careful consideration to alternatives and she did not transfer care to other health providers.

209. Even if the Respondent did have a discussion with her father about her dual role, which the Panel is not persuaded occurred, this would not assist the Respondent as she failed to meet the other aspects the standard required of her.

210. The Panel finds that the Respondent's actions are also contrary to the Conflict of Interest Standard which required that she identify and avoid conflicts of interest with family members. The Panel is not satisfied that the Respondent avoided the conflict of interest with her father.

211. As set out above, a registrant is in breach of the College's Bylaws when they do not conduct themselves in accordance with the College's standards of practice and standards of professional ethics.

212. The Panel finds that the Respondent committed professional misconduct. Her actions were a clear violation of the College's standards in relation to boundaries and conflicts of interest. The Respondent took it upon herself to provide nursing care to her father in circumstances which were avoidable and represents a marked departure from the conduct expected of a registered nurse. A registered nurse cannot give a parent an IV at home, even when that IV is saline. The Panel rejects the Respondent's argument that the College needs to amend their standards for such a rule to exist. The Panel disagrees for the reasons set out earlier regarding the interpretation of College's standards. The Respondent's actions were flagrant and serious. The Respondent was aware of her professional obligations and had been warned just days before not to deliver care to her father.

213. The Respondent argues that "there is no suggestion that Mr. Byelkov was harmed by the insertion of the IV or the infusion of the normal saline." This consideration may be relevant at the penalty stage of the proceedings but is not relevant to the conduct allegations in the Citation.

214. The Panel does not accept the Respondent's argument that her actions were transparent as she "could have easily removed the saline lock that morning, to cover up what she had done, prior to her father attending at PAH." The Panel takes no comfort in the suggestion that the conduct could have been done covertly and considers the Respondent's actions were not marks of transparency but were flagrant disregard of her professional standards.

215. As to the Respondent's argument that her actions if blameworthy call out for re-education not prosecution, the Respondent has admitted the conduct at issue but denied any professional wrongdoing. It is not open to the Panel at this stage to impose a remedial penalty and decline to make a conduct finding under the Citation. The Respondent can make any arguments she wants about the appropriate penalty at that stage of the proceedings.

216. As noted above, while the Panel has found that the Respondent's conduct establishes a breach of the Boundaries Standard, a breach of the Conflict of Interest Standard, a breach of the Bylaws and amounts to professional misconduct, the Citation alleges these determinations in the alternative. Accordingly, the Panel has decided to make a single determination of professional misconduct.

217. The Panel finds that the Respondent provided care to a family member on July 1, 2017 when she inserted an IV into her father and administered saline to her father, while at her father's home. The College has proven this allegation to the requisite standard. The Panel has determined that this conduct is marked departure from the conduct expected of a registered nurse and constitutes professional misconduct.

Allegation 1 (c)

> 1. In 2017, you provided care to family members on one or more of the following occasions:
>
> c. July 2, 2017 – you administered Zofran and Toradol to your father through his IV, while at your family's home; and/or

218. The Respondent does not admit the conduct in this allegation and submits that the College has failed to meet its burden of establishing that she administered Zofran and Toradol to her father on the morning of July 2, 2017.

219. The Respondent submits that the College's allegation relies upon the evidence of Nurse Jackson and its position rests on a fundamental confusion between the notions of reliability and credibility. The Respondent submits that Nurse Jackson accurately recorded but misapprehended what the Respondent told her. Specifically, the Respondent relies heavily upon the use of the word "taken" 15 mg of Toradol and 4 mg of Zofran as opposed to "administered". Both witnesses agreed that the Respondent did not tell Nurse Jackson that the medication route was oral. The Respondent is adamant however that she used the word taken "in relation to how her father received Zofran and the Toradol". The Respondent submits that all that can be said of Nurse Jackson's testimony is that she understood the Respondent to be saying she administered Toradol and Zofran by IV. The Respondent submits that the absence of the word "IV" in the original notes is notable because immediately

below, Nurse Jackson charted “Maxeran 10 mg IV by daughter at 12:10”. The Respondent submits that no weight should be placed on the modified notes as they are less reliable records of what the Respondent stated to Nurse Jackson.

220. The Respondent submits that Nurse D’Cunha’s testimony cannot be accepted. She testified that the Respondent told her she administered Maxeran and Toradol at home through IV however not even the College alleges that the Respondent administered Maxeran to her father at home on July 2 2017. The Respondent submits that Nurse D’Cunha’s unwillingness to make any concessions on that front undermines her credibility as a witness. In addition, the Respondent submits this information is missing from an affidavit she swore on February 1, 2019 in a BCHRT proceeding. Nurse D’Cunha swore that she did not tell Mr. Saran which specific drugs the Respondent informed her she had given to her father at home. The Respondent submits this suggests that the Respondent never told her which medications she gave to her father. Moreover, the Respondent argues it is more likely that this information came from Nurse Jackson. The Respondent also alleges that Nurse D’Cunha has an ”axe to grind” with the Respondent and that it is clear she has a “dim view” of her. Finally, the Respondent argues that her account of the interactions at the nursing station ring truer.

221. The Panel agrees with the College’s submission that the Respondent’s evidence and Mr. Byelkov’s evidence about the medication taken on the morning of July 2, 2017 was not credible. After hearing Nurse Quinn’s evidence that Toradol is only available in 10 mg tablets, Mr. Byelkov and the Respondent mentioned for the first time that Mr. Byelkov cut a Todarol pill in half with a kitchen knife on July 2, 2017. The Panel finds this level of caution and precision to be unlikely and inconsistent with other evidence. The pills were taken from a family medicine cabinet with medications for many family members and from many sources. Mr. Byelkov had no reservations about taking Zofran from the communal cabinet in a package with the Respondent’s name on it and ingesting medication that was not prescribed for him. The Panel finds it is unlikely that Mr. Byelkov was concerned about taking the maximum dosage of the drug when he was experiencing what he describes as a serious situation, and what the Respondent has argued was an urgent situation. Mr.

Byelkov testified that he increased the Toradol dosage that he took on July 2, 2017 from that which he took on July 1, 2017. He acknowledged that he did not however increase the Zofran dosage. The Panel found Mr. Byelkov's explanation for increasing the dosage of one medication but not the other lacked credibility. Mr. Byelkov stated on cross-examination that Toradol is anti-inflammatory and that his throat became swollen during vomiting so he wanted to decrease the pressure.

222. The absence of any packaging for the Toradol medication and any Pharmanet record of prescription to Mr. Byelkov of Toradol or Zofran are also problematic. The Panel acknowledges that this does not necessarily rule out the Respondent's and Mr. Byelkov's version of events but it does demonstrate that Mr. Byelkov did not have a prescription for Toradol at the time he took it.

223. The Panel finds that the Respondent's and her father's versions of what occurred on July 1 and 2, 2017 are not plausible or likely. The Panel finds that the most likely evidence is that which was given by Nurse D'Cunha and Nurse Jackson.

224. The Panel found that both Nurse D'Cunha and Nurse Jackson presented as credible witnesses. Their evidence was clear and convincing.

225. Nurse D'Cunha did not waver in her evidence that the Respondent told her she administered IV medication to her father at home. This is also consistent with Nurse D'Cunha's evidence about reporting the matter shortly thereafter to Fraser Health Authority.

226. Nurse Jackson's evidence was extremely compelling. She was a very clear and believable witness. She was clear in the sequence of events and her account is supported by her contemporaneous notes in the clinical record. The Panel does not accept the suggestion that Nurse Jackson made up the events or falsified the records. There was no reason for Nurse Jackson to do so.

227. The Panel recognizes that there is an inconsistency between the testimony of Nurse D'Cunha who said the Respondent told her she gave her father Maxeran and Toradol by IV at home; and Nurse Jackson who testified those medications were Toradol and Zofran. Where those two witnesses differ, the Panel prefers the

evidence of Nurse Jackson. She was clear, consistent, specific and unwavered in her account of exactly what the Respondent told her. Nurse Jackson's account is consistent with her contemporaneous notes which records that the medication which the Respondent gave to her father by IV at home were Toradol and Zofran. Nurse Jackson verified with the Respondent whether her note of the medication names, their dosages and that the medications were given by IV at home was correct.

228. The Panel does not accept the Respondent's submission that Nurse Jackson's evidence presents a reliability rather than a credibility issue as she misapprehended but accurately recorded what the Respondent said. Her evidence was both credible and reliable. The cross-examination of Nurse Jackson was vigorous and she was adamant in both her recollection of the conversation and her record of that conversation. The Panel does not find that she misapprehended what the Respondent told her.

229. With respect to the Respondent's arguments about the difference between Nurse Jackson's original notes and her Zone 3 notes, the Panel agrees that the two entries are not identical. While the entries are not identical, the Panel accepts Nurse Jackson's explanation for both entries which she made. The Panel notes that there is nothing in either note that suggests that the medication routes were anything other than by IV.

230. Nurse D'Cunha and Nurse Jackson's evidence that the Respondent told them she administered the medication to her father at home is also consistent with the Respondent's own evidence of administering an IV dose of Maxeran on July 2, 2017 to her father at the hospital.

231. As set out above, the Boundaries Standard at the material times required that a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being located in a small community. Where possible, nurses should transfer care to other health care providers. In the unavoidable circumstances, a dual role was required to be approached with caution, a discussion of boundaries and dual role, and careful consideration of alternatives.

232. The Panel does not find that the circumstances of July 2, 2017 were unavoidable circumstances. The circumstances did not constitute an emergency and Mr. Byelkov was not located in a small community. He was located minutes from the emergency room at PAH. The Panel finds that the Respondent did not proceed with caution or give careful consideration to alternatives and she did not transfer care to other health providers.

233. Even if the Respondent did have a discussion with her father about her dual role, which the Panel is not persuaded occurred, this would not assist the Respondent as she failed to meet the other aspects the standard required of her.

234. The Panel finds that the Respondent's actions are also contrary to the Conflict of Interest Standard which required that she identify and avoid conflicts of interest with family members. The Panel is not satisfied that the Respondent avoided the conflict of interest with her father.

235. As set out above, a registrant is in breach of the College's Bylaws when they do not conduct themselves in accordance with the College's standards of practice and standards of professional ethics.

236. The Panel finds that the Respondent committed professional misconduct. Her actions were a clear violation of the College's standards in relation to boundaries and conflicts of interest. The Respondent took it upon herself to provide nursing care to her father in circumstances which were avoidable and represents a marked departure from the conduct expected of a registered nurse. A registered nurse cannot administer IV medications without an order to a parent at home. The Respondent's actions were flagrant and serious. The Respondent was aware of her professional obligations and had been warned just days before not to deliver care to her father.

237. As noted above, while the Panel has found that the Respondent's conduct establishes a breach of the Boundaries Standard, a breach of the Conflict of Interest Standard, a breach of the Bylaws and amounts to professional misconduct, the Citation alleges these determinations in the alternative. Accordingly, the Panel has decided to make a single determination of professional misconduct.

238. The Panel finds that in 2017, the Respondent provided care to a family member on July 2, 2017 when she administered Zofran and Toradol to her father through his IV, while at her family's home. The College has proven this allegation to the requisite standard. The Panel has determined that this conduct is marked departure from the conduct expected of a registered nurse and constitutes professional misconduct.

Allegation 1 (d)

> 1. In 2017, you provided care to family members on one or more of the following occasions:
>
> d. July 2, 2017 – you administered Maxeran to your father at PAH through his IV.

239. The Respondent admits the conduct in this allegation. In her written submissions she states, "The College alleges, and [the Respondent] acknowledges, that on July 2, 2017, whilst she was off duty, [the Respondent] administered IV Maxeran to her father."

240. As noted above, the Respondent testified that she administered an IV dose of Maxeran on July 2, 2017 to her father at the hospital. The Respondent did not chart her administration of that medication.

241. The Respondent argues that her actions do not rise to the level of misconduct because "As with the insertion of the IV into her mother's arm on May 14, 2017, the delivery of the Maxeran to her father represented a quick, routine procedure that was, by all accounts, done competently; furthermore, it had been ordered by a physician."

242. The Panel prefers the evidence of Nurse Yu to the Respondent regarding those events. Nurse Yu was a compelling witness. His evidence that he was taken aback by the Respondent removing the medication from his hand and administering it to her father is plausible and likely. It is not likely that the Nurse Yu asked the Respondent to administer the medication because he was busy and overwhelmed. To the contrary, Nurse Yu had already taken the initiative to obtain a verbal order and draw the medication. He was on his way to Mr. Byelkov to administer that very medication when he was intercepted by the Respondent.

243. As set out above, the Boundaries Standard at the material times required that a nurse not care for family members unless unavoidable circumstances were present such as an emergency or being located in a small community. Where possible, nurses should transfer care to other health care providers. In the unavoidable circumstances, a dual role was required to be approached with caution, a discussion of boundaries and dual role, and careful consideration of alternatives.

244. The Panel does not find that the circumstances of July 2, 2017 were unavoidable circumstances. The circumstances clearly did not constitute an emergency and Mr. Byelkov was not located in a small community. Mr. Byelkov was located in the hospital and under the care of other nursing staff when the Respondent administered Maxeran by IV to him.

245. The Panel finds that the Respondent's actions are also contrary to the Conflict of Interest Standard which required that she identify and avoid conflicts of interest with family members. The Panel is not satisfied that the Respondent avoided the conflict of interest with her father.

246. As set out above, a registrant is in breach of the College's Bylaws when they do not conduct themselves in accordance with the College's standards of practice and standards of professional ethics.

247. The Panel finds that the Respondent committed professional misconduct. Her actions were a clear violation of the College's standards in relation to boundaries and conflicts of interest. The Respondent took it upon herself to provide nursing care to her father in circumstances which were entirely avoidable and represent a marked departure from the conduct expected of a registered nurse. An off duty registered nurse cannot administer IV medications to a parent in the hospital. The Respondent's actions were flagrant and serious. The Respondent was aware of her professional obligations and had been warned just days before not to deliver care to her father.

248. As noted above, while the Panel has found that the Respondent's conduct establishes a breach of the Boundaries Standard, a breach of the Conflict of Interest Standard, a breach of the Bylaws and amounts to professional misconduct, the

Citation alleges these determinations in the alternative. Accordingly, the Panel has decided to make a single determination of professional misconduct.

249. The Panel finds that in 2017, the Respondent provided care to a family member on July 2, 2017 when she administered Maxeran to her father at PAH through his IV. The College has proven this allegation to the requisite standard. The Panel has determined that this conduct is marked departure from the conduct expected of a registered nurse and constitutes professional misconduct.

Allegation 2 (a)

> 2. You accessed your family member's personal and/or health information at PAH on one or more of the following dates:
>
> a. February 16, 2017; and/or

250. The Respondent admits that she placed an electronic comment on her father's patient tracker on Meditech on February 16, 2017. She submits that no wrongdoing flows from her bone fide conduct. She argues that she was trying to add information not extract it. She also submits that she was in compliance with Fraser Health Authority's personal information policy as she was providing a direct service to the person to whom the information belonged (i.e. her father). The Respondent suggests her conduct is akin to her picking up the phone and providing the triage nurse with information about her father's gait.

251. The Respondent submits that aside from that one instance, the College's entire case on allegation 2(a) and 2(b) of the Citation is entirely circumstantial. The Respondent submits that the question for the Panel is whether it was the Respondent who accessed her Meditech file or someone else in the emergency room doing so while logged in under the Respondent's credentials. In that regard, the Respondent acknowledges her carelessness in not logging out of Meditech when she left her assigned computer however she argues that this does not amount to professional misconduct.

252. The College submits that the audit report prepared by Ms. Wynes shows very clearly that Mr. Byelkov's records were accessed on three occasions on February 16, 2017

by the Respondent's user ID which in turn required the Respondent's password. All three accesses were made on the same device at PAH.

253. The College submits that the timing of the access is relevant. All three accesses on February 16, 2017 occurred shortly after Mr. Byelkov arrived at the hospital at 1919 hours and well before he was triaged. The College argues that there was no rational purpose for any other nurse within the hospital to access Mr. Byelkov's electronic medical records at that time.

254. The College submits that the Respondent attempts to draw a distinction between accessing her father's medical records and accessing the records available through Meditech. The College argues this is inconsistent with the evidence of Mr. de la Paz and Fraser Health Authority's policies which establish that accessing a patient's Meditech file is how one accesses the patient's medical records.

255. The College submits that the Respondent's evidence that she could have accessed her father's medical records in a more covert manner is not disputed but does not assist her position. The College submits that the Respondent's access is entirely consistent with her other actions which demonstrate her active desire and insistence to be involved in the medical treatment of her parents both at home and at the hospital.

256. Fraser Health Authority's confidentiality agreement set out the Respondent's obligations to maintain her user ID confidential. Fraser Health Authority's Confidentiality and Security of Information Policy required that all patient information is kept confidential and was only to be used by individuals who require access to it in order to provide direct services to that person. Fraser Health Authority employees are responsible for all activity performed with their personal user ID and are prohibited from performing any activity on another employee's ID. Any employee who suspects their user ID has been compromised is required to report that information.

257. The Panel accepts the Respondent's admission that she placed an electronic comment on her father's patient tracker on Meditech on February 16, 2017. The Panel finds that the Respondent accessed her father's electronic medical records

on three occasions on February 16, 2017. The audit report which was admitted into evidence is reliable and uncontroverted evidence that the Respondent's user ID and password were used to access Mr. Byelkov's medical records.

258. The Panel accepts the uncontested evidence of Ms. Wynes which was submitted by way of an agreement statement. The Panel finds that Ms. Wynes conducted the audit on January 25, 2019 and created an audit report based upon the results. The Panel finds that the audit report identified every time the user ID "MBYELKOVA" and username "Byelkova, Maryna" accessed Artur Byelkov's medical records. The Panel finds the audit report records that there were six times that Mr. Byelkov's information was accessed. Specifically, on February 16, 2017 at 7:21:56 pm, 07:31:43 pm and 07:32:43 pm, and on June 29, 2017 at 03:33:41 pm, 05:14:46 pm and 05:14:45 pm.

259. The Panel also accepts the evidence of Mr. de la Paz who the Panel found to be credible, consistent and compelling. The Panel accepts Mr. de la Paz's evidence set out above including how the Meditech system operates and that the audit report shows that the Respondent accessed Mr. Byelkov's EMT and imaging files on June 29, 2017.

260. The Panel does not accept the Respondent's theory that someone other than her could have gained access to his medical records if she did not log out from her terminal. The Respondent and Ms. Mitton testified about knowledge that staff have used a computer where another user did not log off. There is no evidence that the Respondent did fail to log out of her computer on February 16, 2017 or on June 29, 2017. There is only evidence that this has occurred at the hospital before (with other unnamed individuals on unnamed dates), and the Respondent's speculation about the possibility that it occurred in this instance.

261. The Panel finds it more likely that it was the Respondent who accessed her father's medical records on all three instances. First, the Respondent's access denials are unpersuasive given that she admitted that she did indeed gain access one time that very day. While the Respondent attempts to draw a distinction between accessing her father's medical records and entering a comment, the Panel considers these to

be differences without any meaningful distinction. Whether the Respondent is adding information to her father's records or extracting information from it, the access is prohibited because she was not providing direct nursing services to her father as a patient. She was not charged with his care at the hospital on the relevant dates. Second, the Panel agrees with the timing considerations referenced by the College. All of the accesses were done after Mr. Byelkov's arrival at the hospital and before he was triaged. There is no apparent reason for someone other than the Respondent to have accessed his medical records – using the Respondent's credentials – at those times. Third, the Panel agrees with the College's argument that the Respondent's suggestion that she could have accessed the records in a more covert manner does not assist her, particularly given that she did not access the records in a covert manner during the instance which she has admitted. The Panel agrees with the College's submission that the Respondent's conduct is consistent with her other actions which demonstrate her active desire and insistence to be involved in the medical treatment of her parents both at home and at the hospital.

262. While it is possible that someone other than the Respondent could have also accessed her father's medical records on the occasions set out in the audit report, the Panel finds it more likely that the Respondent gained access to her father's medical records using her own credentials as set out in the audit report.

263. As noted above, the Privacy and Confidentiality Standard provided that nurses access personal and health information only for purposes that are consistent with their professional responsibilities. In addition, the Privacy and Confidentiality Standard expressly provided that nurses must not access personal and health information for any purpose that is inconsistent with their professional responsibilities. This includes a family member's information. The Panel finds that the Respondent's access to her father's electronic health records represented an access of his personal and health information for a purpose that was inconsistent with her professional responsibilities. The Respondent also failed to comply with her employer's policies on confidentiality and privacy.

264. As set out above, a registrant is in breach of the College's Bylaws when they do not conduct themselves in accordance with the College's standards of practice and standards of professional ethics.

265. The Panel finds that the Respondent committed professional misconduct. Her actions were a clear violation of the College's Privacy and Confidentiality Standard. The Respondent's access to her father's medical records was not at a momentary lapse. There were repeated intrusions. The Panel agrees with the reasoning at paragraph 65 of the *Hancock* decision that the Respondent's misconduct "involved "a clear violation of a practice expectation that goes to a foundational facet of the nursing relationship with a client"."

266. As noted above, while the Panel has found that the Respondent's conduct establishes a breach of the Privacy and Confidentiality Standard, a breach of the Bylaws and amounts to professional misconduct, the Citation alleges these determinations in the alternative. Accordingly, the Panel has decided to make a single determination of professional misconduct.

267. The Panel finds that the Respondent accessed her father's personal and/or health information at PAH on February 16, 2017. The College has proven this allegation to the requisite standard. The Panel has determined that this conduct is marked departure from the conduct expected of a registered nurse and constitutes professional misconduct.

Allegation 2 (b)

> 2. You accessed your family member's personal and/or health information at PAH on one or more of the following dates:
>
> b. June 29, 2017.

268. The Respondent does not admit to any access of her father's medical records on June 29, 2017.

269. The College's submissions with respect to allegation 2(b) are the same as those outlined above in allegation 2(a).

270. The Panel finds that the Respondent accessed her father's personal and/or health information at PAH on June 29, 2017 for the same reasons as outlined in allegation

2(a) above. The Panel has determined that this conduct is marked departure from the conduct expected of a registered nurse and constitutes professional misconduct for the same reasons as outlined in allegation 2(a) above.

H. ORDER

271. The Panel finds that the College has proved all of the allegations in the Citation to the requisite standard.

272. Pursuant to section 39(1) of the HPA, the Panel has determined that the Respondent

    a. Has committed professional misconduct in relation to the allegation at paragraph 1 (a) of the Citation;

    b. Has committed professional misconduct in relation to the allegation at paragraph 1 (b) of the Citation;

    c. Has committed professional misconduct in relation to the allegation at paragraph 1 (c) of the Citation;

    d. Has committed professional misconduct in relation to the allegation at paragraph 1 (d) of the Citation;

    e. Has committed professional misconduct in relation to the allegation at paragraph 2 (a) of the Citation; and

    f. Has committed professional misconduct in relation to the allegation at paragraph 2 (b) of the Citation.

273. 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.

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

I. SCHEDULE FOR SUBMISSIONS ON PENALTY AND COSTS

275. The Panel directs that the parties provide written submissions regarding the appropriate penalty and costs in accordance with the following schedule, or on a schedule otherwise approved by the Panel:

    a. Submissions must be delivered by counsel for the College to the Respondent and the Panel no later than November 28, 2022;

    b. Submissions must be delivered by the Respondent to counsel for the College and the Panel no later than December 19, 2022; and

    c. Reply submissions may be delivered by counsel for the College to the Respondent and the Panel no later than January 9, 2022.

276. Submissions for the Panel should be delivered to Susan Precious, counsel for the Panel and may be delivered electronically.

Dated: November 9, 2022

Sheila Cessford, Chair

Dorothy Jennings, RPN

Jackie Murray, RN