IN THE MATTER OF: **The Regulated Health Professions Act S.M. 2009 c. 15**

AND IN THE MATTER OF: **An Inquiry Hearing into the Conduct of Kelcie Rerick, CRNM # 402883**

DECISION

College of Registered Nurses of Manitoba

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IN THE MATTER OF: **The Regulated Health Professions Act S.M. 2009 c. 15**

AND IN THE MATTER OF: **An Inquiry Hearing into the Conduct of Kelcie Rerick, CRNM # 402883**

DECISION AND REASONS

Inquiry Panel Members: Jennifer Colvine RN, Panel Chair

Joseph Lovelace, Public Representative

Donald Solar, Public Representative

Counsel to the Panel: Sacha Paul
Thompson Dorfman Sweatman LLP

Counsel to the Complaints Investigation Committee: William G. Haight & Franco Aiello (Articling Student)
Phillips Aiello Barristers & Solicitors

Member: Kelcie Rerick

Counsel to Member: Richard Deeley
Deeley Fabbri Sellen LLP

Introduction

On October 24, 2022 a Panel of the Inquiry Committee (the "Panel") of the College of Registered Nurses of Manitoba (the "College") held a hearing into the charges against Kelcie Rerick (the "Member"), a member of the College.

The charges against the Member and before the Panel were contained in an Amended Notice of Hearing dated September 14, 2022.

At the commencement of the hearing, it was agreed that the Notice of Hearing had been properly served and the time limits set forth in paragraph 116(4) of the *Regulated Health Professions Act* (the "RHPA") had been met. No objections were raised as to the composition of the Panel and the Panel proceeded to hear the matter.

The Member appeared at the hearing with legal counsel. The Member pled guilty to professional misconduct. More specifically, she plead guilty to and admitted the facts found in paragraphs 1 and 2(a), (b), and (c) of the Amended Notice of Hearing.

Counsel for the Complaints Investigation Committee (the "CIC") stayed the charges contained in paragraphs 2(d) and 3 of the Amended Notice of Hearing.

The Panel then heard submissions from counsel for the CIC, as well as counsel for the Member, respecting the background facts giving rise to the matters raised in the Amended Notice of Hearing and the appropriate disposition of the matter.

After hearing submissions of counsel, the Panel adjourned to consider the matter.

The following facts are not in dispute:

1. The Member has been a Registered Nurse ("RN") since 2019.

2. In 2019, the Member started working at [redacted] She started in the "float pool" at the [redacted] In September 2019, the Member started working in the [redacted] The access the Member had to [redacted] Electronic Patient Records ("EPR") at [redacted] remained available to her when she started work at the [redacted]

3. On May 13, 2019, the Member signed a "Pledge of Confidentiality" ("Pledge"). From this Pledge, it appears that the Member attended an orientation respecting *The Personal Health Information Act* ("PHIA"). Amongst other things, the document reads in part:

   "I ACKNOWLEDGE that failure to comply with PHIA and its regulations and/or [redacted] policies or procedures, including any unauthorized access, use or disclosure of personal health information, may result in disciplinary action up to and including termination of employment/contract/association/ appointment, imposition of fines pursuant to PHIA, and a report to my professional regulatory body.

   ...

   I HEREBY DECLARE that I will not at any time access, use, or disclose any personal health information except as may be required:

   - in the course of my duties and responsibilities;
   - in accordance with applicable legislation; and
   - in accordance with [redacted] policies."

4. The Member plead guilty to and admitted that between February 1, 2020 and March 2, 2021 and while she was employed as a RN in the [redacted] in [redacted] she improperly accessed the EPRs of between 200 and 290 patients who were not receiving direct care from her.

5. On August 12, 2020 [redacted] sent an email to [redacted] nurses and others, including the Member. The email subject line reads "WARNING: PHIA and EPR." The importance assigned to the email is "high." [redacted] writes in part:

   "This is a reminder that staff should not be accessing EPR status boards or any other electronic or paper confidential information of patients in other areas of [redacted] or other sites. This includes [redacted] Accessing information that is not required as part of providing direct care to your patient is a breach of PHIA. Sharing this information with others is also

> a breach of PHIA. **These actions are considered to be very serious and may lead to disciplinary action.** [Emphasis in original.]
>
> ...
>
> You have all signed the PHIA pledge. If you are unclear about anything noted above, please contact [redacted] or I. You should also review the LMS module on PHIA immediately."

6. On January 18, 2021, the Member's employer brought to the Member's attention concerns about improper access to EPRs. After this date, the Member did not engage in any further improper access of the EPRs.
7. The details of the Member's access of EPRs from February 1, 2020 to approximately January 18, 2021 are that the Member improperly accessed 46 EPRs on more than one date and viewed one patient's records a total of nine times. Many of the patient records were accessed beyond the Patient View screen resulting in accessing test results, medical orders and allergy information. Between 52 and 84 of the patients whose EPRs were accessed by the Member were not being treated in the [redacted] and were patients in other wards of [redacted]
8. The Member improperly accessed the EPRs but did not disclose the contents of the EPRs to anyone.
9. [redacted] the Member's employer, imposed a 5 day suspension for conduct associated with the improper access of EPRs.
10. As of the date of the hearing, the Member remains employed at the [redacted]

Decision

The Panel is satisfied that the facts submitted constitute professional misconduct as alleged in the Amended Notice of Hearing and, accordingly, the member is guilty as charged in charges 1 and 2(a), (b), and (c).

The Panel heard submissions from counsel. In essence, counsel for the CIC argued for a penalty of a four week suspension plus $5,000 in costs. Counsel for the Member argued that if a suspension was warranted at all, it should be one week. On the issue of costs, counsel for the Member did not speak to a specific sum but did argue that any cost award should include time for the Member to pay.

After considering the submissions of counsel with respect to inquiry, the Panel makes the following Order:

1. The Member's registration is suspended for three (3) consecutive weeks commencing three weeks after the date of this Order; and
2. The Member is to pay costs to the College in the amount of four thousand dollars ($4,000) within 12 months after the date of this Order.

The Panel considers the foregoing disposition to be appropriate for the following reasons:

1. Both counsel to the CIC and to the Member acknowledge that the Member is a good nurse.
2. The two letters of reference provided to the Panel also suggest that the Member is a good nurse. One letter, dated May 23, 2022, provides that the Member "truly cares about her patients and providing safe patient care". The other letter, dated June 6, 2022, reads, "Time and time again I saw families request

[the Member] to be their primary nurse because they felt safe and secure knowing [the Member] would provide excellent care for their loved one". These comments in particular and the letters in general support the conclusion that the Member is indeed a good nurse.

3. The Member plead guilty to the charges, noted above. As noted by her counsel, the Member accepted responsibility for her conduct underlying the charges. Before appearing in front of this Panel, the Member cooperated in the investigative process before the College.

4. The Panel agrees with submissions made by CIC and the Member that specific deterrence is not an issue. The Member appears to have truly learned her lesson. The penalty the Panel imposes recognizes this.

5. Consistent with being a good nurse, the Panel notes that the Member does not have a prior disciplinary record with the College.

6. As noted by James T. Casey in *The Regulation of Professions in Canada*, Vol 2 at p. 14-5, "Given the primary purpose of the legislation governing professionals is the protection of the public, it follows that the fundamental purpose of sentencing for professional misconduct is also to ensure that the public is protected from acts of professional misconduct." Casey goes on to note a number of factors for consideration when determining penalty, including general deterrence of other members of the profession and maintaining public confidence in the ability of the regulator (namely the College) to supervise its members. Finally, the Panel has also considered that penalties should not be "disparate with other penalties imposed in other cases:" (see Casey at p. 14-6).

7. In deciding on a 3 week suspension plus costs, the Panel notes the long period of time in which the Member was engaged in unauthorized access to EPRs. It was a period from February 2020 to January 2021, being 11 months.

8. The Member's pattern of unauthorized access began only about 1 year after her graduation and commencement of work as a Registered Nurse. The Panel acknowledges that the Member's relative inexperience is a mitigating factor.

9. However, the Member should have known better than to engage in this pattern of unauthorized access. The facts demonstrate that she received PHIA training and signed a "Pledge of Confidentiality" in May 2019, being 10 months before the pattern of unauthorized access would begin (in February 2020). In addition, in August 2020 (now being 7 months into the patter of unauthorized access), the Member received an email sent to her and other nurses noting that staff should not be accessing EPR status boards. The email noted that a person could ask their Manager if there was any lack of clarity on maintaining patient privacy. Yet, the Member would continue the pattern for another 5 months (August 2020 to January 2021).

10. It was only when the issue of her own unauthorized access was specifically brought to her attention in January 2021 did the pattern stop. It is the Panel's view that the public expects more of Registered Nurses. The professional obligations on privacy are clear. For example, in the "Practice Direction: Practice Expectations for RNs" indicator 13 provides, "As an RN, you must: (13) Demonstrate professional responsibility in protecting personal health information". The Code of Ethics for Registered Nurses is also express on protecting privacy: see for example, Value E, s. 1, 3, 7, and 8. She was trained on PHIA. She was reminded of PHIA matters in August 2020. She embarked and persisted in unauthorized access until

her specific conduct was at issue. The public demands more from professionals. The Panel has factored this into its assessment of the appropriate penalty.

11. The sheer number of unauthorized accesses is also important. In pleading guilty, the Member admitted to accessing the EPRs of 200-290 patients when the Member had no reason to be viewing such records. These patients deserved privacy and the Member deprived them of this privacy for no legitimate reason.

12. Counsel for the Member divided the unauthorized access into three broad categories.

13. First, the majority of the unauthorized access concerned patients the Member cared for at the [redacted] but had later transferred to [redacted]. We were informed by counsel to the Member that the Member was "guilty of caring too much" by accessing these records. Counsel noted that such conduct was and is inappropriate. The Panel notes that Registered Nurses are in a caring profession. Yet, caring for patients is bounded at all times by professional obligations — professional obligations respecting privacy, which the Member plainly violated. Caring by Nurses must be demonstrated in that RN's clinical practice, not by viewing EPRs for no legitimate reason. The public must be assured at all times that RNs will be professional in their care and not let caring lead to professional misconduct.

14. Second, the Member searched records of patients who could have been admitted to the [redacted] but had not yet been admitted to the [redacted]. This was to allow the Member to obtain information should the patient actually be admitted. The Member's exuberance led her to breach the privacy interests of people who were not in her direct care. The penalty in this case must demonstrate to the public that RNs will always be professional and act consistent with their professional obligations though RNs may be exuberant.

15. Third, the Member was "derelict" in failing to sign out of her computer. It appears that some EPRs accessed were of [redacted] patients. The Member could not explain how such searches occurred, only that she did not sign out of her computer. We are left to infer that someone could have searched the Member's computer to access these adult records. Counsel for the Member acknowledged it was not appropriate to leave her computer open for unauthorized access. This inattentiveness is troubling, and the public expects more in the protection of very sensitive medical information.

16. The Panel reviewed the case of *College of Nurses of Ontario v. Ann H.A. Raeburn-Lewis*, heard August 17, 2016. In this case, the Ontario Discipline Committee of the College of Nurses of Ontario dealt with an RN (of roughly 25 years) who accessed the medical record of one client. This client had a high profile and the Hospital provided heightened privacy protections for this client. Despite this, the Member accessed the records "out of curiosity". The Member in that case expressed remorse. A joint submission on penalty was made by the Ontario College and the Member. The Discipline Committee accepted the joint submission, which included, among other things, a one month suspension.

17. The Panel also reviewed the cases of *College of Nurses of Ontario v. Harjeet Kaur Brar*, heard February 15, 2017 and *College of Nurses of Ontario v. Eurestica Anasarias*, heard June 1, 2017. These two cases are similar to *Raeburn-Lewis*. All are privacy breach cases. All see guilty pleas and joint submissions on sentence. However, the period of suspension in *Brar* is 2 months, while it is 1 month in *Anasarias*. Both *Brar* and *Anasarias* see an RN accessing medical records of a patient with some notoriety or celebrity. However, and in addition, *Brar* saw the RN looking at medical records of a family friend.

18. The Panel declines to impose a four week (or one month) suspension as requested by counsel for the CIC. *Raeburn-Lewis, Brar*, and *Anasarias* are about unauthorized access of a high-profile clients, with whom the RN had no relationship. In the case at hand, the Member was engaged in unauthorized access of (mainly) prior patients she had served. Unlike the three Ontario cases, the Member in the case at hand was guided by her erroneous view of caring too much as opposed to bald curiosity. As such, the Ontario cases provide guidance but suggest a penalty of less than 4 weeks is appropriate.

19. The Panel was provided the Order in the T. Holloway matter. The reasons for the Order, which are available on the College's website, suggest that the member in that case accessed the records of over 1, 700 patients without cause. Further, the member explained that the reason for the access was "gathering information to assist colleagues, reviewing patient information on potential candidates…and obtaining information for her own educational purposes". In the end, the Discipline Committee imposed a 2 week suspension and $3,500 in costs (with 18 months to pay).

20. *Holloway* is instructive, but not binding. Both the case at hand and *Holloway* see RNs gathering unauthorized information because the RNs (wrongly) believed they needed it for professional reasons. However, unlike *Holloway*, in the case at hand, the Member is following past patients for no legitimate reason and left her computer unattended leading to inappropriate access. This suggests that a suspension of more than 2 weeks is appropriate.

21. The Panel heard argument about other cases coming to other Discipline Panels of the College respecting RNs engaged in privacy breaches. We agree with counsel to the Member that these matters are not before this Panel and thus are not relevant.

22. The Panel has reviewed the case of *Ontario College of Physicians and Surgeons v. Moore* 2002 CarswellOnt 8835 in which a professional regulatory body believed that it needed to send a strong signal to the profession that certain conduct would not be tolerated. It did so by "ramping up" penalties from prior cases: see para 11 of *Moore*.

23. In this Panel's view, we agree with *Moore* that we are not fettered by past decisions like *Holloway*: see Moore at para 12. However, it is not necessary to send a "ramped up" message to the Profession simply because there may be other privacy breaches involving RNs. Privacy is always crucial and is important to an RN's professional practice.

24. Finally, counsel for the Member noted the 5 day suspension the employer imposed on the Member as a relevant factor. We have considered this. We note that discipline from an employer is based on different factors than a professional regulator. The College, like any professional regulator, is driven by public protection and maintaining public confidence in the profession. The employer may have more practical needs such as keeping an employee at work and only away from work as long as the employer can bare. As the interests between the College and an employer are not identical, we find that employer discipline is a factor but not determinative of the issue of penalty.

25. On the issue of costs, the Panel imposes $4,000 to be paid in 12 months. We acknowledge that the Member has spent her own money in participating in this investigation process. We acknowledge her counsel's submission that she needs time to pay.

DATED at Winnipeg, Manitoba, the 3rd day of November 2022.