

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 [REDACTED]
[REDACTED], CRNM [REDACTED]**

DECISION



**College of
Registered Nurses
of Manitoba**

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exceeding \$5,000.00 contrary to Section 334(b) of *The Criminal Code of Canada*.

2. On or between January 23, 2019, at the City [REDACTED], in the Province of Manitoba, [the Member] did commit mischief by willfully tampering with hydromorphone bottles without legal justification or excuse and without colour of right which were the property of the [REDACTED] Hospital, of a value not exceeding \$5,000.00 contrary to Section 430(4) of *The Criminal Code of Canada*.”

The Notice of Hearing further alleges the Member’s conduct involves breaches of the College’s Practice Direction; Practice Expectations for Registered Nurses 1, 2, 6, 9, 11, 16 and 19, *The Code of Ethics for Registered Nurses*, Primary Value A, 1, 4 and 12, Primary Value F, Ethical Responsibility 8 and Primary Value G, ethical Responsibilities 1,2 and 5.

This matter was originally set to be heard on June 21, 2021. On June 18, 2021, counsel to the Complaints Investigation Committee (the “CIC”) received an email from the office of Mr. Sheldon Pinx, who was then representing the Member. In that email, Mr. Pinx confirmed that he was satisfied that the Inquiry Committee had jurisdiction over this matter and that the Member consented to the hearing being held at a date beyond 120 days from the date the CIC referred the matter to the Inquiry Committee. On this basis, the hearing was adjourned to a date to be agreed upon or, in the absence of an agreement, to a date to be fixed by the Chair of the Panel. Notice of the adjournment was served on the Member.

When the parties were unable to agree upon a hearing date, the Chair set a new hearing date for January 11, 2022.

On January 10, 2022, the Inquiry Panel received an email from the Member, in essence, asking for an adjournment so that they might secure legal counsel. The Panel convened on January 11, 2022. The Member did not attend the January 11, 2022 hearing. Counsel for the CIC, Mr. Aiello, took no formal position on the request for an adjournment. After considering the matter, the Inquiry Panel agreed to grant an adjournment to a date to be agreed upon or, in the absence of agreement, to a date to be fixed by the Chair of the Panel.

When the parties were unable to agree upon a hearing date, the Chair requested that counsel to the Inquiry Panel, Sacha Paul, assist the parties in scheduling a hearing. On August 17, 2022, the Member advised Mr. Paul that January 16, 2023 was acceptable to them and the matter was set down for continuation of the hearing. The Member was served with a Notice of New Notice of Hearing Date setting the hearing for January 16, 2023, commencing at 9:30 AM. The Member was given the opportunity to attend the January 16, 2023 hearing by videoconference or by telephone.

The Panel convened on January 16, 2023, at 9:30 AM. The Member did not attend in person, by videoconference or by telephone. After waiting 15 minutes, the Chair of the Panel called the hearing to order and requested that Mr. Haight, counsel for the CIC, proceed with the case.

The Panel is satisfied 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*, S.M. 2009, c. 15 (the “RHPA”) had been met. Section 118 of the RHPA permits the Panel to proceed with the hearing in the absence of the Member.

Counsel for the CIC brought to the attention of the Panel two jurisdictional issues that had been raised by the Member. The Panel characterizes these issues as follows:

1. The Adjournment issue. In essence, the Member contended this matter should be adjourned for two reasons:
 - a. because they had not been personally served with documents as required under section 120 of the RHPA, and
 - b. because they were not able to attend the hearing on January 16, 2023.
2. The Time Limits issue. In essence, the Member argues that this proceeding was commenced after the limitation date set out in section 171(4) of the RHPA.

Counsel for the CIC filed affidavit evidence with respect to these two issues. The evidence is contained in the affidavits of Courtney Stephens, dated January 13, 2023 (Exhibit 1) and January 5, 2022 (Exhibit 2). The affidavits include numerous emails and letters exchanged between the parties relating to these issues. Counsel for CIC also provided the Panel with oral submissions.

The Panel then retired and reviewed the exhibits referred to by counsel for the CIC. The Panel is satisfied that disclosure of documents, as required under section 120 of the RHPA, was made to Mr. Pinx who was the Member’s lawyer at that time.

The Member claims they are not available to attend the hearing. They advises that they are starting a new job on January 16, 2023. This hearing has already been adjourned twice. The Member consented to this date. The Member has an obligation to organize their affairs so that they are able to attend the date they agreed to. The request for an adjournment is denied.

On the time limits issue, the Panel notes that section 171(4) of the RHPA is entitled “offenses” and is in Part 13 of the Act. This section specifically deals with the “prosecution” of “offenses”. This provision is applicable to criminal prosecutions before a Judge. The proceeding today deals with Professional Conduct under Part 8 of the RHPA. The panel is satisfied that section 171(4) of the RHPA is not applicable to this matter. The Member’s argument on the Time Limits issue is rejected.

Accordingly, the Panel is satisfied that it has the jurisdiction to proceed.

Not Guilty Plea

The Chair of the Panel instructed counsel for the CIC to assume that the Member had entered a plea of not guilty to the charges in the Notice of Hearing and requested that counsel for the CIC proceed with the case on behalf of the CIC.

Facts

The CIC called Ms. Tracey Legary as a witness. Ms. Legary is the recently retired Manager of Professional Conduct for the College.

Ms. Legary testified as to the College's usual practices and procedures when dealing with complaints that involve parallel criminal proceedings. She testified as to how the CIC deals with health issues such as addiction. She also testified as to her involvement in the investigation involving the Member.

This matter arose as a result of a report submitted by the Clinical Team Manager at the [REDACTED]. The report indicates that there was tampering with hydromorphone vials on January 23, 2019. This led to an investigation by CIC. There were several interviews of the Member at which Ms. Legary was present.

On January 30, 2019, the Member was interviewed in the presence of Ms. Legary. During this interview, the member admitted that:

- a. They began using hydromorphone as a temporary relief;
- b. They took hydromorphone that was being wasted;
- c. They initially began by taking small doses;
- d. They quickly became physically dependent on hydromorphone;
- e. at the [REDACTED] Hospital they began tampering with vials by removing hydromorphone from the vial using a needle, filling the vial with saline, gluing the vial shut and returning the vial to the drawer.

Ms. Legary testified that the Member showed lack of insight into the implications of their behaviour. The Member stated that they never withheld drugs from their patients but lacked insight into the implications of their behaviour on patients being treated by other nurses who might be receiving saline when the other nurse used hydromorphone from a vial that had been tampered with.

On February 6, 2019, the CIC agreed to accept the Member's voluntarily surrender of their certificate of practice.

In late 2019, the Member was charged with theft and tampering by the [REDACTED] RCMP.

On August 25, 2020, the Member was interviewed again. They provided further details regarding the tampering of vials at [REDACTED] Hospital.

On March 18, 2021, this matter was referred to the Inquiry Committee.

On June 25, 2021, the Member entered into an Undertaking with the CIC whereby they agreed, among other things, to undergo random drug screening tests for a period of five years.

In accordance with the Undertaking, the Member had an obligation to pay for the screening tests. Ms. Legary testified that the Member fell into arrears with the independent agency that was conducting the drug screening tests. As a result, drug screening tests were not being provided in accordance with the Undertaking and the CIC interim suspended the Members certificate of practice for breach of the Undertaking. The Members certificate of practice remains suspended to the date of the hearing.

Issues

The Panel has identified the following issues to be determined:

- i) Has the CIC proven that the Member stole hydromorphone and tampered with vials of hydromorphone, as alleged?
- ii) If so, does this behaviour constitute professional misconduct?
- iii) If so, what is the appropriate penalty?

Decision of the Committee and Reasons Therefore

The Panel is satisfied that the Member's admissions to the CIC establish that they stole hydromorphone and tampered with vials of hydromorphone.

In the Panel's view, this is clearly professional misconduct.

By removing hydromorphone from the vials and substituting saline, the Member was engaged in a pattern of deceit. This was irresponsible and could clearly have had an injurious effect on patients being treated in the hospital. The Member failed to recognize that their behaviour could have an injurious effect on patients. This could be potentially life threatening. This was clearly an unsafe practice which the Member failed to report. The Member only accepted responsibility for their actions after they were caught. As a result of the foregoing, the Member was in breach of their obligations under the College's Practice Direction respecting Practice Expectations for Registered Nurses.

The Member's behaviour also constituted a breach of *The Code of Ethics for Registered Nurses*. The Member failed to report unsafe, unethical practice or conditions that interfered with their ability to provide safe, compassionate and competent ethical care. They failed to foster a safe practice environment. They exposed patients to drugs that had been tampered with. They failed to be responsible and honest and to act with integrity. They continued practicing when they were unfit to do so.

With respect to penalty, the Panel makes the following order:

1. The Member be suspended for a period of eight months, commencing upon the date the Member returns to practice.
2. The Member pay a fine in the amount of \$5,000.
3. The Member pay costs in the amount of \$8,000, payable within the first six months following completion of the eight-month suspension.

For clarification, the Panel notes that in order to return to practice the following steps are required:

- The Member must advise the Professional Conduct Department, which will direct them to the College's registration services to initiate the reinstatement process.
- The Member must successfully complete all reinstatement steps required by registration services.
- Upon completing the registration reinstatement requirements, the CIC will review the breach of Undertaking issue and determine if the Member's certificate of practice can be reinstated.
- Should the Member be reinstated, the terms of their undertaking of June 25, 2021 will resume.

Upon all of these steps being completed and the Member being returned to the College's practice register, the eight-month suspension ordered by the Panel would commence.

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

The Member had no prior history of discipline.

The Member voluntarily surrendered their certificate to practice and later was suspended from practice. They have not been practicing for several years which the Panel has taken into account.

The Member is currently interim suspended and, if they ever to return to practice, they will first have to go through the process described above to ensure they are safe to practice.

The Panel notes that the Member has been diagnosed with a substance abuse disorder. However, even though the Member was experiencing a substance abuse disorder, the protection of the public requires that this kind of serious misconduct not be tolerated.

The penalty is generally consistent with similar cases from Ontario which were provided to us by counsel for the CIC.

With respect to costs, the Member's behaviour, including the Member's failure to attend a hearing, which was scheduled to their availability, has resulted in significant delays and unnecessary expense. Accordingly, the Panel is of the view that a substantial award of costs is warranted.

DATED at Winnipeg, Manitoba, the 6th day of February 2023.