DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Grace Fox, NP	Chairperson
Terry Holland, RPN	Member
Susan Roger, RN	Member
Mary MacMillan-Gilkinson	Public Member
Margaret Tuomi	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	MEGAN SHORTREED for College of Nurses of Ontario
- and -	)	
	)	NO REPRESENTATION for Elizabeth Tracy Mae Wettlaufer
ELIZABETH TRACY MAE WETTLAUFER REGISTRATION # 9581737	)	
	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: July 25, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on July 25, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

Elizabeth Tracy Mae Wettlaufer (the "Member") was not present. Counsel for the College provided the Panel with evidence that the Member had been sent the Notice of Hearing on June 26, 2017 and that she was unlikely to send a representative to the hearing. The Panel was satisfied that the Member had received adequate notice and therefore proceeded with the hearing in the Member's absence.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated June 23, 2017 are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation* 799/93, in that while employed as a Registered Nurse, you abused a client verbally, physically or emotionally, by administering overdoses of insulin to the following clients with the intent to harm and/or cause their death:

    a. on or between June 25, 2007 and December 31, 2007, to Clotilde Adriano at Caressant Care Nursing Home, in Woodstock, Ontario ("Caressant"); and/or

    b. on or between June 25, 2007 and December 31, 2007, to Albina Demedeiros at Caressant; and/or

    c. on or about August 11, 2007, to James Silcox at Caressant; and/or

    d. on or between December 22, 2007 and December 23, 2007, to Maurice Granat at Caressant; and/or

    e. on or between September 1, 2008 and December 31, 2008, to Wayne Hedges at Caressant; and/or

    f. on or between January 1, 2008 and December 31, 2009, to Michael Priddle at Caressant; and/or

    g. on or between October 13, 2011 and October 14, 2011, to Gladys Millard at Caressant; and/or

    h. on or between October 25, 2011 and October 26, 2011, to Helen Matheson at Caressant; and/or

    i. on or between November 6, 2011 and November 7, 2011, to Mary Zurawinski at Caressant; and/or

    j. on or between July 13, 2013 and July 14, 2013, to Helen Young at Caressant; and/or

    k. on or between March 22, 2014 and March 28, 2014, to Maureen Pickering at

Caressant; and/or

l. on or between August 23, 2014 and August 31, 2014, to Arpad Horvath at Meadow Park Nursing Home, in London, Ontario; and/or

m. on or between September 1, 2015 and September 30, 2015, to Sandra Towler at Telfer Place Long Term Care Facility, in Paris, Ontario; and/or

n. on or about August 21, 2016, to Beverly Bertram at the client's home in Ingersoll, Ontario, while working for Saint Elizabeth Health Care; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation* 799/93, in that while employed as a Registered Nurse, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, by administering overdoses of insulin to the following clients with the intent to harm and/or cause their death:

a. on or between June 25, 2007 and December 31, 2007, to Clotilde Adriano at Caressant Care Nursing Home, in Woodstock, Ontario ("Caressant"); and/or

b. on or between June 25, 2007 and December 31, 2007, to Albina Demedeiros at Caressant; and/or

c. on or about August 11, 2007, to James Silcox at Caressant; and/or

d. on or between December 22, 2007 and December 23, 2007, to Maurice Granat at Caressant; and/or

e. on or between September 1, 2008 and December 31, 2008, to Wayne Hedges at Caressant; and/or

f. on or between January 1, 2008 and December 31, 2009, to Michael Priddle at Caressant; and/or

g. on or between October 13, 2011 and October 14, 2011, to Gladys Millard at Caressant; and/or

h. on or between October 25, 2011 and October 26, 2011, to Helen Matheson at Caressant; and/or

i. on or between November 6, 2011 and November 7, 2011, to Mary Zurawinski at

Caressant; and/or

j. on or between July 13, 2013 and July 14, 2013, to Helen Young at Caressant; and/or

k. on or between March 22, 2014 and March 28, 2014, to Maureen Pickering at Caressant; and/or

l. on or between August 23, 2014 and August 31, 2014, to Arpad Horvath at Meadow Park Nursing Home, in London, Ontario; and/or

m. on or between September 1, 2015 and September 30, 2015, to Sandra Towler at Telfer Place Long Term Care Facility, in Paris, Ontario; and/or

n. on or about August 21, 2016, to Beverly Bertram at the client's home in Ingersoll, Ontario, while working for Saint Elizabeth Health Care.

Member's Plea

Given that Ms. Wettlaufer was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

Ms. Wettlaufer was found guilty in the Ontario Superior Court of eight counts of 1st degree murder, four counts of attempted murder and two counts of aggravated assault. In all cases, she administered overdoses of insulin to 14 clients in her care. Eight of those clients died as a result of Ms. Wettlaufer's actions. Her victims were vulnerable and/or elderly patients living in long-term care or requiring care in their homes.

Ms. Wettlaufer resigned her certificate of registration on September 30, 2016 and was no longer a member of the College at the time of her conviction however the conduct in question did occur when she was a member.

The Panel received extensive documentary evidence confirming Ms. Wettlaufer's deliberate conduct and her admission of guilt made to her attending clinician at the Centre for Addiction and Mental Health ("the CAMH"), the police, the College investigator and the Court during her criminal trial.

Ms. Wettlaufer was a registered nurse from 1995 until her resignation in September 2016. She is now serving a life sentence having pleaded guilty to intentionally overdosing patients between 2007 and 2016.

The Panel found Ms. Wettlaufer committed professional misconduct by administering overdoses of insulin to the clients with the intent to harm and/or cause their death, and engaged in conduct that would be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

The Evidence

The Panel received into evidence nine exhibits. Five of the exhibits were documents created for or were related to Ms. Wettlaufer's criminal proceedings. College Counsel provided the Panel with the Ontario Superior Court of Justice Record of Indictment, the Member's Agreed Statement of Facts on Guilty Plea, and a partial transcript of the proceedings before Justice B. Thomas. The evidence, including Ms. Wettlaufer's admissions to the Court, established her premeditated intention to kill and/or harm her clients.

The evidence presented also included significant information about each of Ms. Wettlaufer's victims. College Counsel reviewed the victims' circumstances for the Panel.

The Panel heard that, after being admitted to CAMH on September 16, 2016, Ms. Wettlaufer informed her psychiatrist that she had harmed several of her clients. On September 24, 2016, she disclosed that she had overdosed clients with the intention to cause their deaths. This admission was reported to the police by Ms. Wettlaufer's psychiatrist. On September 30, 2016, Ms. Wettlaufer resigned her certificate of registration with the College. On October 6th, 2016, criminal charges were laid against Ms. Wettlaufer with further charges added in January 2017.

In January 2017, the police requested that the College limit its investigation to enable the criminal investigation to proceed unimpeded. On June 1, 2017, the Member pleaded guilty as charged to 1st degree murder, attempted murder and aggravated assault.

The Inquiries, Complaints and Reports Committee ("the ICRC") received the Agreed Statement of Facts prepared in connection to the criminal proceedings on or about June 1, 2017. Upon receipt, the ICRC referred this matter to the Discipline Committee without further delay.

Final Submissions

College Counsel reminded the Panel of their continuing jurisdiction over Ms. Wettlaufer, even though she resigned her certificate of registration prior to the Discipline hearing. Ms. Wettlaufer admitted that she overdosed 14 of her patients, with the intention of causing their deaths. She did this all while she was a member of the College. She admitted to abusing these frail, vulnerable clients, and in some instances, standing by as they may have struggled. This act of intentional, deliberate abuse was described in detail in the Agreed Statement of Facts filed in the criminal proceedings. It was also described in grisly detail in Ms. Wettlaufer's own handwritten statements she prepared for the police.

The Panel was asked to further find that Ms. Wettlaufer's conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. The College described

Ms. Wettlaufer's actions, which have brought shame on the profession being both heinous and criminal.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities and based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1 and 2 of the Notice of Hearing. The Panel finds that the Member physically abused her clients by administering overdoses of insulin with the deliberate intention to harm and/or cause their death. In particular, the Member's actions resulted in the deaths of eight clients in her care and the attempted harm of six others.

Further and without hesitation, the Panel finds that the Member's conduct would be regarded by members of the profession as unprofessional, dishonourable and disgraceful.

Reasons for Decision

This matter is shameful and unprecedented. It is the most egregious example of abuse and disgraceful conduct that this Panel has ever had to consider.

The Panel received overwhelming evidence confirming Ms. Wettlaufer's deliberate intentions to harm her patients. Ms. Wettlaufer admitted to this horrible conduct in her criminal proceedings.

There can be no doubt that Ms. Wettlaufer's actions constitute professional misconduct in the most egregious manner possible. Ms. Wettlaufer preyed on her victims, knowing that they were vulnerable and wholly unable to defend themselves against her murderous actions. This conduct is unprofessional, dishonourable and disgraceful. Ms. Wettlaufer has brought shame to her former profession.

In the course of the hearing, the College asked the Panel to make an order allowing for the release to the media and public of the exhibits filed without the need for a separate motion. The Panel made the order as requested. The exhibits were made available immediately after the conclusion of the hearing.

Penalty

Penalty Submissions

The College asked the Panel to issue an order revoking Ms. Wettlaufer's certificate of registration. In submissions, the College urged upon the Panel the need to strongly denounce Ms. Wettlaufer's reprehensible actions. The College explained that deterrence and public protection were of paramount concerns.

While the College usually looks to an admission of guilt as a mitigating circumstance, in this case given the nature of the conduct, Ms. Wettlaufer's admission is of little significance.

The Panel heard that Ms. Wettlaufer had two prior interactions with the College. Firstly, in late 1995, Ms. Wettlaufer's employment was terminated after her employer found that she had taken a medication from her place of employment and that she then reported to work in a "dazed" state. There were no allegations of client harm at that time. In response to this report, the College initiated a health inquiry into the Member's capacity. There was evidence to suggest mental health and substance abuse issues. The matter was referred to Fitness to Practice Committee and on May 9, 1997, Ms. Wettlaufer admitted incapacity and submitted to terms, limitations and conditions on her certificate. These conditions included remaining alcohol and drug-free, remaining under supervision of a physician attending drug support specialist and group meetings, employer notification and submitting to urine sampling. Ms. Wettlaufer complied with her conditions, which were ultimately lifted in May 1998.

The second interaction Ms. Wettlaufer had with the College was as a result of a mandatory employer report the College received on or about May 1, 2014. Ms. Wettlaufer was reportedly terminated from Caressant Care, her place of employment on March 31, 2014. The employer notified the College that the termination occurred as a result of a medication error that put a client at risk. Specifically, it was reported that Ms. Wettlaufer administered insulin to one resident that belonged to another. In the course of its investigation, the College contacted the Director of Nursing at Caressant, who reported that Ms. Wettlaufer never denied the incident and took ownership for the error. The College determined that no further investigation was required. Given that the matter was not dealt with by the ICRC or referred to the Discipline Committee, the College was under a statutory duty to keep confidential the information about Ms. Wettlaufer's termination.

Penalty Decision

The Panel orders that the Executive Director immediately revoke the certificate of registration of Elizabeth Wettlaufer.

Reasons for Penalty Decision

The Panel received excerpts from the impact statements prepared by the family and friends of the victims and previously submitted to the Ontario Superior Court. These statements contain messages of love and admiration for Ms. Wettlaufer's victims. They also profoundly spoke to the devastation, shock, and anger felt by the victims' loved ones once they learned of the true cause of their deaths.

It is a privilege for members of this College to be the guardians of the public trust. The heinous actions by this one member have violated the public's confidence in the nursing profession and placed a stain on the many dedicated professionals who care for their clients with knowledge and compassion.

There is no other appropriate penalty in this case. Ms. Wettlaufer has lost the privilege of serving as a member of this profession. She breached the public trust in the most serious way possible.

I, Grace Fox, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.

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Chairperson	Date