**DISCIPLINE COMMITTEE**
**OF THE COLLEGE OF NURSES OF ONTARIO**

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| **PANEL:** | Robert MacKay, Chairperson | Public Member |
| | Tammy Hedge, RPN | Member |
| | Karen Laforet, RN | Member |
| | Desiree Ann Prillo, RPN | Member |
| | Devinder Walia | Public Member |

**BETWEEN:**

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| COLLEGE OF NURSES OF ONTARIO | ) | EMILY LAWRENCE for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| ISAGANI MATEO ESTRELLA | ) | ABBA KATZ for |
| Registration No. AA810007 | ) | Isagani Mateo Estrella |
| | ) | |
| | ) | JOHANNA BRADEN |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | Heard: December 1, 2, 5, 2016 and |
| | ) | January 9, 10, 11, 16, 2017 |

**[September 7, 2017 - Panel note: Following the release of our Decision and Reasons, the parties wrote to identify three typographical errors at pages 4 and 11. At page 4, 4th paragraph, the sentence, "The Member also reported his experience to the police" should read "The Client also reported his experience to the police" and at page 11, the name "[Witness 3]" should be "[Witness 3]". Those typographical errors have now been corrected to the text as set out below]**

## DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on December 1, 2, 5, 2016 and January 9, 10, 11, 16, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

### The Allegations

The allegations against Isagani Mateo Estrella (the "Member") as stated in the Notice of Hearing dated October 7, 2016 were as follows.

**IT IS ALLEGED THAT:**

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*,

S.O. 1991, c. 32, as amended, in that while working as a Registered Practical Nurse at the Humber River Hospital, in Toronto, Ontario, you sexually abused a client, in that on or about October 28, 2014:

(a) you engaged in touching of a sexual nature of a client, [ ] on one or more occasions;

(b) you engaged in conduct of a sexual nature by soliciting [the Client] to accompany you to the bathroom; 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(1) of *Ontario Regulation 799/93*, in that while working as a Registered Practical Nurse at the Humber River Hospital, in Toronto, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that, on or about October 28, 2014:

(a) you touched [the Client] where there was no clinical basis for doing so on one or more occasions;

(b) you solicited [the Client] to accompany you to the bathroom where there was no clinical purpose for doing so;

(c) you failed to properly assess [the Client];

(d) you failed to document your care and assessment of [the Client];

(e) you failed to obtain informed consent of [the Client] to perform care and assessment of [the Client]; and/or

(f) you breached the therapeutic boundaries of the nurse-client relationship with [the Client]; and/or

3. 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(9) of *Ontario Regulation 799/93*, in that while working as a Registered Practical Nurse at the Humber River Hospital, in Toronto, Ontario, you failed to obtain consent to do anything to a client for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose in a situation in which a consent is required by law, without such a consent, and in particular, on or about October 28, 2014:

(a) you failed to obtain informed consent of your [Client], to perform care for and assessment of [the Client]; and/or

4. 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 working as a Registered Practical Nurse at the

Humber River Hospital, in Toronto, Ontario, 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 of the profession as disgraceful, dishonourable or unprofessional in that on or about October 28, 2014:

(a) you touched [the Client] where there was no clinical basis for doing so on one or more occasions;

(b) you solicited [the Client] to accompany you to the bathroom where there was no clinical purpose for doing so;

(c) you failed to properly assess [the Client];

(d) you failed to document your care and assessment of [the Client];

(e) you failed to obtain informed consent of [the Client] to perform care and assessment of [the Client]; and/or

(f) you breached the therapeutic boundaries of the nurse-client relationship with [the Client].

**Member's Plea**

The Member denied the allegations set out in the Notice of Hearing

**Overview**

The Panel was provided with a statement of agreed facts, which both parties submitted were facts that are not in dispute, surrounding the circumstances of the evening in question. Those facts include the following facts about the interactions between the client identified as [the Client] in the Notice of Hearing (the "Client" or "[ ]") and the Member.

1. The Member is a Registered Practical Nurse who has been registered with the College since 2011.

2. From December 11, 2011 to November 11, 2014, the Member worked at the Humber River Hospital, Finch site (the "Facility") in the Emergency Department.

3. The Client went to the Facility on the evening of October 27, 2014. He was 36 years old at the time. The Client was experiencing abdominal pain with burning and tenderness in his lower right quadrant.

4. The Client was admitted to the Emergency Department at the Facility at 00:39 on October 28, 2014. The Member provided nursing care to the Client. Over the course of the night the Member conducted several abdominal exams, and checked the Client for a hernia.

5. The Member has admitted that he did not chart his care of the client contemporaneously and the times set out in the Client's chart do not reflect all the interactions the Member

had with the Client and do not reflect the times when the Member interacted with the Client.

Towards the early hours of the morning, after the Member had performed various abdominal exams on the Client, the Member was about to move the Client from a private room to the hallway, so the Client could be better observed after receiving morphine. Before moving the Client to the hallway to administer the morphine, the Member gestured to the bathroom. The Member says this was an indication that the Client should try to use the bathroom before he was moved from the private room to the hallway. The Client interpreted this as an invitation to go to the bathroom with the Member, as it suddenly dawned on him that the Member had touched his genitals, by stroking his penis and cupping his testicles, and that the Member was gay by the way he smiled and walked. The Client, having realized (he believed) that the Member was gay, now felt as though the Member's earlier actions had been sexual in nature, not clinical.

The Client called his girlfriend (who had been at the Facility with the Client but then left) to come back to the Facility. The Client attempted to launch a complaint while in the ER, but to no avail. He was discharged home. Later that night he returned to the ER with his girlfriend and they wrote a formal complaint.

The ***Client*** also reported his experience to the police. As part of the statement of agreed facts, the Panel was advised that the Member was charged with sexual assault. After [the Client] gave his evidence at the criminal trial, the charge was withdrawn and the Member was found not guilty.

The issues are as follows;

- Did the Member engage in touching of a sexual nature?
- Did the Member solicit the client to accompany him to the bathroom for a sexual purpose?
- Did the Member touch the client when there was no clinical basis to do so?
- Did the Member fail to properly assess and document the care and assessment of the client?
- Did the Member fail to obtain informed consent to perform care and assessment?
- Did the Member breach the boundaries of the nurse-client relationship?

Following consideration of all the evidence, the Panel found that the Member committed acts of professional misconduct by touching the client with no clinical basis to do so, failing to obtain consent to perform care or an assessment, failing to properly assess the client, failing to document care and assessments and breached the nurse-client relationship. The Panel found the Member committed professional misconduct by failing to meet the standards of practice and engaged in conduct that would be regarded by members of the profession to be dishonourable and unprofessional.

The Panel did not find that the Member sexually abused the Client.

## **The Evidence**

The Panel heard testimony from seven witnesses, including [the Client] and the Member, and received fourteen exhibits to consider.

As there is no "physical" evidence in this matter, the parties agreed that this case truly is a "he said/he said" case. The Panel was left to determine credibility and make its findings accordingly.

The Agreed Evidence

In the Statement of Agreed Facts, some of the basic elements of the care provided by the Member to the Client were agreed upon.

1. [The Client] and his girlfriend went to the Facility because [the Client] was experiencing abdominal pain with a burning sensation in his right lower quadrant. [The Client] was admitted to the Emergency Department just after midnight on October 28, 2014

2. The Member first reviewed [the Client's] chart at approximately 01:00.

3. Between 0:18 and 01:53, the Member examined [the Client] and inserted an intravenous line (a saline lock) and administered oral and IV medication pursuant to medical directives, and took blood.

4. [The Client] was examined by the physician on duty at approximately 01:20 and was prescribed a "pink lady" (antacid and lidocaine) and Pantoloc 40 mg. After approximately 20 minutes he was reassessed by the physician on duty with no change in his symptoms.

5. The Member conducted an initial gastrointestinal assessment and he conducted pain assessments at 02:11, 03:03 and 03:27, noting [the Client] was "awake and alert" and "pain well managed according to patient".

6. At 02:30, the doctor reviewed [the Client's] blood work, and ordered an abdominal x-ray, which was normal but revealed a fecal load. At 03:40 the doctor ordered Citromag and a fleet enema.

7. The Member performed a fleet enema at 04:01 in Room 34. He charted that [the Client] had tolerated the administration of the fleet enema well.

8. Around this time [the Client] attempted to have a bowel movement and was able to have a bowel movement. The Member checked to confirm there was no blood in the stool. The Member then placed [the Client] in Room 41. [The Client] continued to report pain.

9. The Member had further interactions with [the Client] in Room 41 after 4:00 am. The details of these interactions are disputed.

10. At 05:29, the Member charted a pain assessment, noting that [the Client] was "awake and alert" and "pain well managed according to patient". However, [the Client] continued to report pain.

11. [The Client's] chart states at 05:40, the doctor ordered a CT of the abdomen, IV morphine, Zofran and Buscopan as a result of continued pain. These medications were

administered at some point between 05:40 and 07:00. Around 05:40 [the Client] was moved from Room 41 to a hallway on a stretcher.

12. [The Client's] chart records that at 06:16, the Member took vitals (which were normal) and charted a pain assessment, noting [the Client] was "awake and alert" and "pain well managed according to patient". In the nursing notes, the Member charted at 06:16 that [the Client] went to the washroom to have a bowel movement but was not productive and that he states he is having abdominal pain with cramping.

13. At 0700 the Member was allowed to leave his shift a half-hour early (which is not uncommon). He gave report to the other nurses assigned to the area.

14. [The Client] had a CT scan that morning, which was normal. He was discharged at 14:27 with a diagnosis of chronic indigestion.

Both parties called evidence to flesh out and explain these agreed facts. Most of the evidence was about what happened between the Member and [the Client] in Room 41.

Evidence in Chief of [the Client]

The Panel first heard from [the Client]. The Client is a male in his thirties, who immigrated to Canada approximately 19 years ago. English is not his first language and while he can communicate for necessary and basic conversations, for the promotion of comfort for [the Client], and to have reasonable assurance that [the Client] understood the questions being asked of him, the majority of his evidence was given through the use of interpreters.

[The Client] testified that the pain that brought him to the Facility was not new to him, he has been experiencing it since approximately 2011, and he takes medication for it. Sometimes this medication helps and sometimes it does not.

[The Client] recalled that after his admission to the Facility there was a short wait, then the Member called [the Client] into a private room and instructed [Witness 2] ([the Client's] girlfriend/fiancée) to wait outside. [The Client] believed that the Member performed four exams on him over the course of the night.

Exam #1

The first exam was in a private room, without [Witness 2] present. [The Client] gave evidence that at this point the Member put stickers on his chest, took blood and was "pushing on my tummy". The Member was touching his belly on the lower right side, below the belly button but above the belt line, as described by the witness. Other than telling the Member that he was having pain, there were no other discussions between the Member and himself. [The Client] stated that the Member requested a urine sample which he provided. [The Client] was then directed to the waiting room, where he waited until the Doctor on staff that evening met with him.

[The Client] stated that he put a gown on as directed, but did not take his track pants and underwear off as he was not comfortable and he "didn't understand what they were going to do".

[The Client] recalled having an x-ray, which he testified that the Member told him and [Witness 2], showed he had "lots of poop", which the Panel understands is medically known as a large fecal load. The Member gave [the Client] something like water to drink and "pushed something into my bum". [The Client] stated that he understood that the enema given was to make his bowels move. [The Client] was unable to recall the time the bowel treatment was given.

[The Client] eventually used a bathroom and had a small bowel movement with what he thought was blood in it. The Member checked the feces and determined there was no blood.

The Member then moved [the Client] into a private room with a clean functional bathroom, as it appeared that the washrooms in the ER that evening were either dirty or had a broken lock on the door. The Member also found a charging cord for [the Client's] phone.

Exam #2

[The Client] testified that once he was in the second private room (which the parties agree was Room 41), he was advised by the Member that the Member would return to check on him in 10-15 minutes. Upon his return the Member gave [the Client] a cup of hot water to drink. [The Client] submits that at this time the Member pressed his belly again, under the belly button. He described the pain as "dancing in my belly". The only discussion that took place at this time was around the pain. The Member then began touching the client on the abdomen, below the pubic hair line, between his thighs, for what [the Client] described as a couple of minutes. There was no discussion during this time. [The Client] was unable to see what the Member was doing as he was laying on the stretcher flat on his back without a pillow. After the touching stopped the Member left the room. At the time of this exam [the Client] was wearing his gown, which was lifted and the Member pushed [the Client's] track pants down, lower than [the Client's] pubic hair line, but [the Client] was unsure if his penis was exposed.

Exam #3

After a period of time, which [the Client] cannot recall how long, the Member returned to the private room with another glass of hot water. [The Client] testified that again, the Member conducted a physical exam. [The Client] described it as checking his belly, then moving to below his belt line, the same place as before. The Member used his fingertips.

[The Client] stated that at this point the Member was not asking questions and there was no conversation. [The Client] could not see what the Member was doing, but felt the Member's fingers on his penis. He described the movement as the Member was pushing his penis towards the right side of his body, with what he thought may have been the back side of the Member's fingers, where the nails are. [The Client] is unsure how long this interaction lasted. [The Client] said nothing to the Member and the Member left the room. [The Client] tried to sleep at this time but was unable to as he was feeling so unwell.

Exam #4

[The Client] testified that the Member returned a fourth time to check on him. According to [the Client] there was no verbal exchange or explanation of what the Member was preparing to do. [The Client] stated that the Member came into the room and began touching [the Client's] "tummy" first above the belt line and then below the belt line. [The Client] stated that at no time

did the Member direct [the Client] to advise if he was uncomfortable with what was happening. [The Client] testified that the Member began touching [the Client's] testicles with the palm of his hand, with his hand cupped, moving his hand "up and down and around and around" with a loose grip for a "couple of seconds". [The Client] further testified that the Member then touched [the Client's] penis. At this point, [the Client] said his pants were down far enough that his penis was partly exposed. [The Client] explained that while the Member was touching his penis he was also pushing his underwear down. [The Client] explained that while the Member was touching his penis the motion was like a pushing motion at the tip. [The Client] could not see what was happening because he was lying flat on his back. During the penis touch, which [the Client] said lasted a few seconds, there was no verbal exchange. [The Client] testified that when the Member was touching his penis, there was a noise in the hallway and the Member stopped touching him and went to the curtain to look out into the hall. [The Client] stated when asked that at no time did he have an erection.

It was [the Client's] evidence that the Member returned from the curtain at this point and stood by the bathroom, opened the door all the way and smiled and motioned for [the Client] to come into the bathroom. At times [the Client] stated that the Member was "in the bathroom" at this point, at other times [the Client] stated the Member was at the doorway. At one point he stated the Member was "halfway". [The Client] consistently said that the Member did not say any words, but smiled and nodded with a head gesture. [The Client] took this to be that he was being invited into the bathroom for a purpose other than to use the facilities. His evidence was that he thought the Member was inviting him into the bathroom for a sexual purpose.

[The Client] testified that this made him angry and he yelled, "what the hell is going on?" at the Member. He says the Member replied, "Sorry" and left the room. [The Client] was left feeling confused. He said he hadn't been sure how to react when he was being touched, but the invitation to the bathroom clarified things in his mind. [The Client] tried to first call his mother, then his girlfriend/fiancée ([Witness 2]), who he managed to get through to. He testified that he told her what happened and that she needed to come back to the hospital right away. After [Witness 2] arrived, the Member came back into the room and gave [the Client] a liquid and an IV medication. The Member took [the Client] to a stretcher in the hallway. The medication made [the Client] feel sleepy and dizzy. [The Client] stated that the Member did not explain to him what the medication was. [The Client] then slept.

In the morning he had a new nurse that was female. [The Client] wanted to report what had happened but he felt ashamed to tell a woman about his experience. He noticed a "short guy" in the hallway and called him over to explain the events from the night before. [The Client] testified that he told this staff member that he wanted to complain and that the staff member said he would get someone, but nobody came back. [The Client] was given a CT scan, met with a new doctor and was then released to go home. [The Client] testified that at this point he was still in pain, and felt violated physically. That night he returned to the Facility with his girlfriend to file a complaint. (Exhibit 2K). [The Client] admitted that this letter was written by [Witness 2], because his English writing skills aren't as good as hers.

Eventually [the Client] had a meeting at the Facility with 2 staff members, and he then filed a report with the police, after talking it over with his mother and other family members. The Member was consequently charged with sexual assault.

[The Client] stated that these events have impacted him severely. He no longer enjoys his life, does not want to be involved with his fiancé's friends and family as they are [from the Member's country of origin]. He is nervous of any person from the [Member's country of origin] which impacts his job as a driver. His relationship with [Witness 2] (who is [from the Member's country of origin]) has suffered as well.

Cross Examination of [the Client]

Counsel for the Member suggested during cross-examination that [the Client] didn't understand everything that was being explained to him during the examinations by the Member. He demonstrated this by asking, for example, the direct question: "did you understand everything that was being said to you?" [The Client] replied "yes," but then the next question asked was about having a hernia, and [the Client] replied that he didn't understand.

There was also a line of questions surrounding the kind of work [the Client] had engaged in. On the day at issue, [the Client] arrived at the Facility after working only one day in a bakery. There was some conflicting evidence given about whether the trays [the Client] had been lifting that day at the bakery were heavy or not. [The Client] was asked about his previous job in a factory. [The Client] agreed he had worked at a factory for nine months, lifting heavy motors. When questioned further, [the Client] was unable to recall what nine months he was there for.

Counsel for the Member then questioned [the Client] about his interpretation of the Member being gay. [The Client] had made statements regarding the Member having a "big gay smile" when inviting [the Client] into the bathroom, and "walking like a gay guy". When questioned if he had a certain way of making conclusions about people based on how they walk and smile, [the Client] agreed that he did. [The Client] admitted that he did not think anything was amiss with the Member's care until the Member invited him into the bathroom, which was when [the Client] says he realized from the Member's walk and smile that the Member was gay.

[The Client] was asked about a statement he made at the Facility when he went back to report the incident. He told the Facility staff at the meeting that he was experiencing some difficulty after the incident with his fiancée, [Witness 2], because she, like the Member, was from the [Member's country of origin]. Initially [the Client] denied saying this, but after review of the notes he conceded that he did in fact say that he had been fighting with [Witness 2].

[The Client] confirmed that at the time of the exams performed on him by the Member, he was fully aware of what was happening, had not had any pain control at that point, and was adamant that at no time did he have an erection.

As described in more detail below, the Panel found [the Client] to be credible on some points of his story, and found that [the Client] truly believes that something improper happened to him in that room. However, as explained below in our reasons, there were numerous inconsistencies in his story that could not be explained away by the use of interpreters. There was an obvious gap in timing in terms of when he was in the room with his fiancé, when and what medications were given and where in the emergency department he was located when he was medicated. There was also an inconsistency in whether or not he had one or more bowel movements.

Examination in Chief of [Witness #2]

[Witness 2] is the common law partner of [the Client]. She is from the [Member's country of origin] originally. [Witness 2] has worked as a PSW and at the time of the alleged incident was working as a nanny. [ ] is her first language, and an interpreter was present, however she indicated that she was comfortable in answering the questions in English and would look to the interpreter only if needed.

[Witness 2] recalled that on the evening in question [the Client] was in a lot of pain at home and wanted to go to the hospital. [Witness 2] drove him to the ER of the Facility sometime between midnight and 1:00 am. This car ride took 5 to 7 minutes. [Witness 2] stayed with [the Client] in the ER until about 4:30 am or 5:00 am. [Witness 2] indicated that during this time she did not meet the Member or have any interactions with him. She recalls that she had to wait outside of the room when the Member was providing care to [the Client]. [Witness 2] was able to recall that [the Client] had a blood test and an IV initiated and that he went for an x-ray which revealed a fecal load. She testified that the Member gave [the Client] something pink to drink and "something in his bum". [Witness 2] was unsure if the medication gave him relief but recalled that [the Client] went to the bathroom but was still in pain after. [Witness 2] could not recall which bathroom [the Client] used, whether it was in the hallway or in the private room. [The Client] was eventually moved to a private room and [Witness 2] decided to go home and try to sleep before having to go to work that morning. She thought she left sometime between 4:30 am and 5:00 am.

[Witness 2] recalled that [the Client] called her shortly after she went to bed, but she was unable to recall what time it was. [The Client] was upset and scared because the nurse had touched his private parts. [Witness 2] said it took her approximately 30 minutes to return to the Facility as she had to get dressed.

[Witness 2], upon her return to the ER, found [the Client] to be very angry. In a tearful recollection of the events [Witness 2] said she was afraid of what [the Client] would do, she was afraid of [the Client] reacting as if he was in his own country, by "beating him or whatever". [The Client] wanted to complain at that time, and [Witness 2] felt as though she had let her fiancé down. [Witness 2] witnessed the administration of the morphine and confirmed that [the Client] was on a stretcher in the hallway. She testified that [the Client] was feeling very bad at this point and had asked for help, that the staff listened but that nobody came back to help him. She then left again, leaving [the Client] alone in the Facility, as she had to go to work.

That evening [Witness 2] took [the Client] back to the Facility to report the occurrence. She confirmed that she wrote the complaint letter, saying that [the Client] couldn't concentrate, and that she was unsure of his reading and writing abilities in English. She said that she wrote what he was telling her, and then read it back to him when she was finished.

[Witness 2] testified that this incident had a big impact on her relationship with [the Client], to the point that they almost broke up. [The Client] didn't want her to socialize with other [people from the Member's country of origin], which was hard for [Witness 2]. [Witness 2] said that she just wants her man back, she wants justice for him.

Cross Examination of [Witness 2]

When questioned about the change in [the Client's] personality towards [people from the Member's country of origin], [Witness 2] said that prior to the events in October 2014, [the Client] had no negative feelings. [Witness 2] said that [the Client] only has negative feelings towards [people from the Member's country of origin], especially males, since his encounter with the Member.

In a line of questions about the ER visit, [Witness 2] was unable to recall having a conversation with the Member about [the Client's] treatment, the CT scan, or [the Client] being designated "NPO" (a medical term meaning [the Client] was not permitted any food or drink). [Witness 2] said that the Member could not look her in the eye. [Witness 2] stated that she was always in the hallway when the Member was in the room and couldn't hear their conversation.

When questioned about [the Client's] English-language abilities, [Witness 2] submitted that [the Client] reads an English newspaper at home and they speak English at home as well. She believes that he understands everything he reads in English. Counsel for the Member then asked a series of questions regarding the amount of time that [the Client] missed work because he was sick. [Witness 2] was unable to recall any details regarding [the Client's] time off, only saying that it depended. She was unable to give an average.

The Panel found [Witness 2's] testimony generally reliable. [Witness 2] was appropriately emotional when discussing the impact this has on her life with [the Client]. The Panel was troubled by some of the lack of details that [Witness 2] could not provide, such as timing, especially considering this event had such a huge impact on her relationship. [Witness 2] was unable to recall clearly what time she was called by [the Client] to come back to the hospital, how long she was home for, and how long it took her to return to the hospital. The evidence of [Witness 2] confirms that [the Client] is in genuine distress about what happened, however, [Witness 2] was not present during the critical events themselves.

Evidence of [Witness #3]

[Witness 3] was the manager of the Emergency Department at the Facility in October 2014. She gave an overview of the layout of the Emergency Department at the Finch site as it was at the time. (Exhibit #2).

She reviewed for the Panel the standards in place at the Facility for gastrointestinal patients (Exhibit #2C-G) which included the Standard of Care Manual for Gastrointestinal Emergencies, medical directives, and focused assessment tools, for example, the pain scale tool. [Witness 3] explained the documentation procedure in the ER is mainly electronic, primarily for the nurses. The doctors use both written and electronic documentation.

[Witness 3] identified [the Client's] chart from the Facility (Exhibit #2J). [Witness 3] used it to explain the various charting and summaries that make up the patient record. This hybrid system uses a paper medication administration record (MAR) and a paper narcotic record located at the narcotic cart. In this case, upon review neither the MAR nor the narcotic count sheet could be located. [Witness 3] believed that at some point she did have the narcotic count sheet in her possession, but it has since disappeared.

[Witness 3] walked the Panel through the Member's charting on [the Client] that night. [Witness 3] testified that it appeared to her from the Member's charting of the pain scale that [the Client] was not having any pain. Later in the shift (0327h), [the Client's] vital signs and a pain scale were completed, but the pain scale documentation was the same as the previous and there was no charting done. In fact, throughout the shift the documentation was not up to the department standards. [Witness 3] conceded that, while this is not common practice at her Facility, poor charting does happen.

On October 29, 2014 [Witness 3] received an email explaining that a client had a concern about being touched inappropriately. [Witness 3] was unable to recall the specifics of the email and College Counsel provided her with a copy to refresh her memory. [Witness 3] was then given Exhibit #2K, the handwritten statement of [the Client] (as written by [Witness 2]), which [Witness 3] recalled having seen. The statement caused [Witness 3] to be concerned that the touching of the private parts was not part of a clinical exam, and did not appear to be appropriate parts of an assessment. She notified human resources and they started an investigation.

[Witness 3] believes that she met with the Member, Human Resources and the Member's union representative on October 31, 2014.

[Witness 3] took notes during the meeting while the Member reviewed his care process as he recalled the events. The Member confirmed that he provided care to [the Client]. [Witness 3] testified that her notes reflected that the Member recalled [the Client] being fully dressed, that the Member palpated and auscultated [the Client's] abdomen, and that [the Client] had an erection, which the Member pushed out of the way while doing the exam. The Member advised [Witness 3] that he moved the erect penis out of the way to do a suprapubic exam. [Witness 3] testified that there is nothing in her notes regarding a discussion around the Member cupping the testicles and that she doesn't recall discussing this accusation with the Member. The general response from the Member at the meeting was denial of the allegations made by [the Client]. According to [Witness 3's] recollection of the meeting the Member admitted to inadvertently touching [the Client's] penis, and he apologised. According to the Member, [Witness 2] was in the room at the time. The Member was placed on administrative leave over the weekend, with plans to have another meeting the following week, after [Witness 3] interviewed some additional employees. The Member was questioned again and his employment was subsequently terminated.

[Witness 3] met with [the Client] in a meeting led by the Patient Relations department, which is common practice when a client launches a serious complaint. [Witness 3] cannot recall if [the Client] was asked any clarification questions, as she did not take any notes at this meeting.

After a second interview with the Member, it was determined that the Member did not document every interaction with the client, and that he left his charting until the end of the shift. This means the charting may not indicate the exact number of times the Member interacted with [the Client] and the extent of those interactions. [Witness 3] testified that upon questioning the Member was unsure if palpating the abdomen of a male patient with an erection was an appropriate action, and when asked about the penis touching he couldn't recall. She said the Member didn't deny it, he just couldn't recall. The Member also could not recall during the interview inviting [the Client] into the bathroom, or if he had his hands inside [the Client's] underwear to touch his testicles. The Member did admit to touching [the Client's] testicles to assess for pain.

The issues with the documentation according to [Witness 3] were that it appears from the assessments that were done that [the Client] was not in pain. Then [the Client] received morphine, indicating severe pain, and there was a lack of documentation to that fact, that the doctor was notified, what actions were taken and the result.

The decision was made to terminate the Member's employment based on the clinical practice issues and in respect to public safety.

The Panel found this witness to be credible, providing factual unbiased testimony in both her examination in chief and her cross-examination.

Evidence of [Witness #4]

[Witness 4] is a Registered Nurse who works as a Charge Nurse at the Facility. He described his responsibilities for the Panel. His list of responsibilities in that role includes ensuring the safety of the staff, patients and their families as well as ensuring proper patient flow within the department. In this role he is expected to deal with patient complaints. If he cannot resolve the complaint on his own he is expected to escalate the complaint up the chain of command.

On the morning of October 29, 2014, during rounds, another nurse came to [Witness 4] and shared [the Client's] complaint of inappropriate touching. [Witness 4] testified that at the time of the complaint he did not know who the nurse involved was, only that a patient ([the Client]) had disclosed to his day nurse that he had been touched. The patient ([the Client]) was on pain medication and an anti-nausea medication. There were no details about the touching given.

[Witness 4] approached [the Client], who was lying on a stretcher in the hallway. [The Client] was drowsy and alone at the time. His eyes were closed. [Witness 4] testified that he introduced himself and asked [the Client] about his complaint. [The Client] replied, "I don't want to talk about it". [Witness 4] said that he didn't want to insist and so he backed off and advised [the Client's] day nurse that if [the Client] wanted to follow up, to let him know. [Witness 4] said that [the Client's] speech was garbled at the time of the interaction.

[Witness 4] did not follow up until 2:00 pm, when he asked [the Client's] day nurse about [the Client] and was advised that [the Client] had been discharged home. [Witness 4] admits that he should have reported the incident but at the time he felt he had no information to report. He was not interviewed by [Witness 3], but was interviewed by Human Resources.

In cross-examination, [Witness 4] described the Member as very friendly, always ready to help other staff and always smiling. [Witness 4] has worked with the Member for two or three years and cannot recall ever hearing of any negative feedback or complaints arising from the Member's care. [Witness 4] confirmed that the department is very busy and while documentation should occur immediately after an action or interaction, sometimes there is a delay.

Evidence in Chief of Expert Witness

The College tendered Carol Farquharson as an expert in the Standards of Practice in Nursing Assessments, Treatment and Documentation as well as the Therapeutic Nurse-Client relationship in the Emergency Department Environment. The Panel reviewed her CV listing her various

positions and qualifications, and after a brief cross examination by defense, and no objection to her qualifications, the Panel accepted Ms. Farquharson as an expert witness qualified to give opinion evidence in the areas set out by College Counsel and agreed to by the Member.

The expert was helpful to the Panel in explaining that it is the nurse's responsibility to create a therapeutic nurse-client relationship and that this is based on trust and respect. It is the responsibility of the nurse to ensure that the client understands everything that is happening to them. In this age of cultural diversity the nurse should watch for physical, nonverbal and verbal cues, and zone in on where the client is at.

Informed consent occurs when the client has an understanding of the action that is occurring, and that what is happening is important or necessary. Not having consent equals a breach of the standards. The nurse obtains this consent by assessing the client's understanding and addressing the client's needs based on the level of understanding. The client should participate in this process. In determining consent there is a need for continued assessment, before moving to the next step the nurse should make sure the client is following along. There are basic principles to be followed in preforming a genital exam. The client may be embarrassed and may not fully understand. The exam should be brief, focused and direct.

It was Ms. Farquharson's opinion that while a hernia exam can be done lying down, it is often performed in a standing position, and that usually after the initial exam, if the findings are negative, there is no reason to do that examination again. Most often an examination for a hernia is done by a doctor or an advanced practice nurse.

Ms. Farquharson was given the clinical records of the Member's interactions with [the Client] and asked to assume certain hypothetical facts (Exhibits #7 and #8). The hypothetical facts generally tracked [the Client's] allegations of how he was touched in his genitals. In Ms. Farquharson's opinion there was no clinical reason to touch the penis of [the Client], as there was no documentation that [the Client] was experiencing any pain or symptoms in his genitals or genital area. In general the expert advised that in her opinion there was no clinical reason for the repeated examinations of [the Client] by the Member, especially since there was no supporting documentation justifying the need for those repeated examinations. She also opined that if the Member examined [the Client] inside his underwear that is outside the realm of appropriate according to the standards of practice. [The Client] should have been in a gown, and should have been given an explanation of what was happening and why. If a nurse finds that a client has an erection, the nurse should not proceed with the examination.

Given the hypothetical facts Ms. Farquharson was given to review, in her opinion the Member committed a breach of the standards in that the touching of [the Client's] genitals was not consented to and was an unwarranted touch, exceeding the appropriate boundaries of the therapeutic nurse-client relationship. The Member was not, in her opinion, applying clinical criteria. The expert found the documentation to be contradictory. The Member did not describe pain in his assessment but conducted a genital exam.

As to the pain charting, the fact that the Member charted that [the Client's] pain was "well managed" at 0616 is contradicted by the doctor ordering a narcotic, which the Member administered. In the expert's opinion there should have been another assessment 30 to 60 minutes after the narcotic was administered and the effect of the medicine recorded.

With regards to the Member gesturing for [the Client] to enter the bathroom, which [the Client] interpreted as a sexual gesture, the expert opined that gestures are open to misinterpretation and that being vague and nonspecific contravenes the standards of practice. In her opinion the Member's actions regarding the bathroom were unprofessional, even without any sexual or improper intention.

Cross Examination of the Expert Witness

Counsel for the Member asked Ms. Farquharson a series of questions regarding whether it would be appropriate to reassess the client if the client had done heavy lifting in the past. Ms. Farquharson testified that would not necessarily change her opinion. The need for reassessment would be indicated by a change in condition. There was no documentation to support that there was a change in [the Client's] condition that would give rise to the need to reassess.

Overall, Ms. Farquharson reiterated that based on the clinical charting, she did not see there was a clinical need to do the number or type of assessments she was asked to assume that the Member performed on [the Client].

Evidence in Chief of [Witness #6]

The first witness called for the Member was [Witness 6]. [Witness 6] has been practicing Emergency Room medicine since 2009. Among various jobs, he works at the Facility in the ER. [Witness 6] identified the Emergency Room chart of [the Client], and confirmed that the writing on the chart was that of another ER doctor's and his own.

The witness testified that [the Client's] initial abdominal exam was vague, and from the exam alone he was not able to come to a diagnosis. He confirmed that his orders were to give [the Client] a "pink lady" (antacid and lidocaine) to drink, after seeing [the Client] at approximately 0140. After about 40 minutes post medication, [the Client] was still having pain so he ordered the abdominal x-ray, bloodwork and an IV. He recalls that at 0230 the bloodwork and urine tests were normal so he ordered some citromag and an enema. At 0540 he ordered a CT scan, morphine and buscopan. He does not recall hearing about any change in [the Client's] pain. He said that based on his usual practice, he must have been concerned that [the Client's] pain was not being well-managed, despite what it might have said on the chart. If [the Client] was not still in pain, it would not have been [Witness 6's] practice to order pain medications such as morphine. On the initial exam of [the Client], [Witness 6] checked [the Client] for a hernia. The doctor did not specifically recall the Member reporting [the Client's] condition to him.

[Witness 6] testified that he was unsure if [the Client] had a full understanding of what was being done in the Facility, and that he wondered if there was a behaviour component to [the Client's] experience of pain, as there seemed to be no physical cause for that would explain the pain as it was being expressed by [the Client]. He recalled that [the Client] would go from stoic to the other extreme. The doctor performed a hernia check in the suprapubic area and does not recall [the Client] having an erection at that time. He was unable to recall whether the Member reported back to him about any of the exams he himself preformed on [the Client].

Cross Examination of [Witness 6]

[Witness 6] admitted that he was very reluctant to testify in this hearing, although no clear reason was given. He was unable to recall what [the Client] was wearing, and couldn't recall specific interactions with [the Client]. Details of the night are fuzzy, for example what time things happened and what nurse he dealt with. [Witness 6] agreed that it's not likely for a hernia to develop during an episode of care. If no hernia is found on an examination there is no reason to go back there unless there was an active complaint.

The Panel found some of [Witness 6's] testimony to be helpful, in terms of what happens in the department with orders, what specific actions he took and what the expectations are of the staff.

Evidence of the Member

The Member is a well-educated individual originally from [ ]. He was first educated in [ ] and completed a Bachelor in Political Science. He moved to Canada in 2004 and graduated in 2011 from George Brown College with his Practical Nursing Diploma.

On the night in question the Member worked a 12 hour night shift. Part of this shift was in the minor treatment area, and at midnight this area closed and he moved to ambulatory care area, called the "Ozone area". The Member recalled providing care to [the Client].

The Member first called [the Client] to a treatment room and began to assess him. [The Client] reported general abdominal pain and specifically mentioned his right lower quadrant. After introducing himself to [the Client], the Member explained to [the Client] that he needed to lift his shirt to expose his chest and that the Member would be putting stickers on his chest to look at his heart. The Member asked [the Client] if he was okay with that. The Member can't remember if [the Client] nodded yes, but it is the Member's belief that he obtained [the Client's] consent. The Member testified that it is his usual practice to advise clients several times during interactions that they are to speak up and advise him if they are not okay with something that is happening. The Member performed the ECG and took other steps with [the Client] in accordance with the medical directives for abdominal pain.

Pain Assessments

At triage [the Client] stated that his pain was an 8/10. The Member had documented that [the Client's] pain was "well managed". The Member explained that to him, "pain well managed" means that the pain is still there and is being looked after, it is not worse. If the pain were a "0" he would write "no pain". The Member assumed that [the Client] was having moderate pain because he was walking in the department and able to have conversations with the Member. The Member testified that most nurses don't use a numeric pain scale, and that his pain assessments are based on his own observations of the client.

Physical Exams

The Member testified that he performed probably three physical assessments on [the Client]. During the first assessment the Member listened to the abdomen for bowel sounds and palpated all four quadrants. He testified that he explained what he was doing to [the Client], and he believes he obtained consent. Counsel asked the Member why he examined [the Client] more

than once. The Member replied, “because he was having pain still.” When asked if he was checking the same places the Member replied, “Yes, sometimes the patients are wrong”.

The Member admits to checking [the Client] for an inguinal hernia. It was the evidence of the Member that he and [the Client] had been chatting about [the Client’s] work in the bakery, and his history of heavy lifting. The Member recalls asking [the Client] if he could check for a hernia, and assumed that [the Client] understood what that was. The Member felt that he had obtained consent but couldn’t recall if [the Client] said yes or if [the Client] nodded. At the time of the exam [the Client] was wearing a gown, track pants and underwear. This was what [the Client] was most comfortable with. The Member applied pressure on the abdomen over [the Client’s] clothing. The Member noticed that [the Client] had an erection and he deflected it with the back of his hand so he could continue his examination. The Member testified that he explained to [the Client] that he was going to move his penis, and that [the Client] did not respond.

The Member stated that what he recalled as the third physical examination took place in Room 41. The Emergency Department was very busy that night, and the Member discovered that after administering the fleet enema to [the Client] that the bathrooms in the Emergency Department were either faulty (door locks) or dirty. The Member decided to place [the Client] in treatment room #41, which is located in the minor treatment area. This room is quiet, private and has its own washroom. [The Client] was placed on a stretcher and the Member borrowed a phone charger from another staff Member so [the Client] could charge his telephone. The third exam occurred in this room.

The Member admits that he listened again to the bowel sounds and then examined [the Client’s] testicles by placing his hand on them over [the Client’s] clothing, pushing on them slightly with three fingers for a brief period, maybe three seconds. The Member said he was checking to see that the pain [the Client] was reporting – pain radiating to the right lower quadrant – had testicular involvement. The Member says he told [the Client] beforehand that he would be applying pressure to his testicles to make sure he didn’t have pain there.

The Member denies grasping [the Client’s] penis and moving his hand up and down. The Member states that at no time during this exam did [the Client] give any indication that he was uncomfortable.

With regards to the alleged invitation to join him in the bathroom, the Member testified that he was going to have to move [the Client] out to the hallway, as [Witness 6] had ordered some narcotics, and because of that [the Client] would need to be monitored more closely. The Member, knowing the bathrooms in the department were not very nice, wanted to offer [the Client] the opportunity to use this private clean bathroom one more time before the move. The Member testified that he was outside of the bathroom door, and gestured to [the Client], pointing at the open door. He says he may have been smiling, as he always smiles. [The Client] responded by either saying no or shaking his head, the Member was unable to recall. The Member recalled that [the Client] did not verbalize any issue or give any nonverbal cues that he was upset.

Upon further questioning the Member testified that by the time he came back to Room 41 with more medication for [the Client], [Witness 2] was present in the room and reported to him that [the Client] had a good bowel movement and that everything was okay. The Member said at no point in caring for [the Client] did he ever ask [Witness 2] to leave the room.

Charting

The Member admits that he left his charting until the end of his shift because he had several patients to look after. He believes the times in the printed "screen-shot" version of the chart that were in evidence at the hearing reflect the times he charted, not necessarily the times the assessments were done. He says he would not have seen this "screen-shot" version of the chart while he was providing care. The Member testified that sometimes he cannot recall if he charted an assessment or not, so he might re-enter the same information more than once.

As for the medication administration, his times in his charting were estimates, however if the MAR was available it would show the accurate time that the medication was given. The Member was confident he filled out the MAR and does not know how it, or the narcotic sheet, went missing.

The Member was asked if he had any explanation as to why [Witness 3] would have recorded that the narcotic sheet showed that morphine was taken at 0400. The Member testified that sometimes when writing quickly, his 4's look like 6's. The Panel found this to be reasonable and believes that the Member did not give the morphine before 0600, after it had been ordered by the doctor.

Subsequent Events

The Member testified that he has been devastated by [the Client's] complaint. He always tried his best to be a good, caring nurse, always smiling even when he didn't feel like smiling. He testified he would never abuse a client, and that the allegations that he did so have been very hard on him.

Cross Examination of the Member

Upon cross-examination by College Counsel, the Member clarified that he did not examine [the Client's] groin during the first encounter. At that time he only did an assessment on [the Client's] belly. The Member testified that the pain assessment shown at 0211 actually took place before that time, and the 0211 reflected the time that he charted.

On further questioning the Member testified that he only asks a client to rate their pain if he himself thinks their pain is more than a moderate level. In this case [the Client] was saying that his pain "was all over the place" but in the Member's view [the Client] was not showing any signs of pain. The Member could not recall the intensity of [the Client's] pain. Further questioning by counsel revealed that the Member saw the patient smiling, so he didn't ask about the intensity of [the Client's] pain. The Member was unable to recall if the three identical pain scale entries were triplicate entries of the same assessment, or not. The Member felt that in the hour and fifteen minutes reflected by the entries in the chart, he probably checked [the Client] more often than what was actually charted. He also testified that if he is busy he does not go back into the chart to see what he has charted already, and identified that he understood this to be a best practice standard. The Member agreed during cross examination that it is best practice to document all findings of exams, even if there are normal findings, but said that this does not happen at this Facility. The nurses give a verbal report to the doctors because they don't look at the nurses charting.

The Member admitted again that during the third exam, he put pressure on [the Client's] testicles and groin, over [the Client's] clothing with a gloved hand. The Member stated that he did this exam because [the Client] was complaining of cramping. He did not document this because he gave the doctor a verbal report. The Member felt that he had obtained proper consent for this exam. The Member admitted that he may have exaggerated [the Client's] pain to [Witness 6] to encourage the doctor to see [the Client] more quickly.

**Final Submissions**

Submissions of the College

College Counsel submitted that there are legal principles to be considered when making findings of misconduct. The first is the application of the standard of proof. The standard to be applied here is the balance of probabilities, That is, is it more likely than not that the conduct occurred.

Credibility is a factor. This case is a clear case of he said, he said. The general medical care itself is not in dispute as the parties have come to an agreement on those facts. The Panel was urged to consider the Agreed Statement of Facts as a roadmap to the events and care in the emergency department. The dispute lies in what happened in Room #41. Counsel brought the Panel to the College's book of authorities (tab 1) which contains excerpts from *A Complete Guide to the Regulated Health Professions Act*, 2016, by Richard Steinecke, and which notes that there are seven factors usually considered for determining the credibility of witnesses. Discrepancies in testimony do not automatically mean that a witness' evidence is discredited, as we cannot expect perfection. The Panel should look at the totality of the evidence, and put themselves in the Client's shoes. Not remembering treatment details is not a sign that he is lying.

College Counsel submitted that [the Client] gave credible, clear direct evidence, much of it in English, and used the interpreter to assist him in an appropriate way. What motivation would [the Client] have to make this up? [The Client's] story has remained unchanged since the incident. Above all, [the Client] has a general belief that he was touched inappropriately, and how this has affected him runs deep. [The Client's] evidence may sound strange, as it can be hard to believe that members of the College would sexually abuse clients in such a risky, strange way. However, College Counsel submitted the case of *R. v. Doodnaught*, 2013 ONSC 8022 shows that people from all walks of life, including health care professionals, can act in ways no one would expect.

With regards to the Member's testimony and credibility, College Counsel submitted that it's troubling that the Member admits to remembering more with the passage of time. The Member's testimony itself was inconsistent. It appeared that he couldn't recall details of what actually happened and supplemented his memory with what he would have done. The Member admits to touching [the Client's] groin area to look for a hernia, and says that in the course of doing so he moved [the Client's] erect penis with the back of his gloved hand. The College submits this narrative should be disbelieved. It does not makes sense that a nurse would check for a hernia in these circumstances, and it does not make sense that a nurse would continue with an inguinal examination when a client had an erect penis. The Member's denial that he touched and grasped [the Client's] penis should be disbelieved.

College Counsel argued that the College has proven that the Member sexually abused [the Client]. Even if the Panel does not find sexual abuse, the College submitted that there is clear and cogent evidence that the Member breached the standards of practice of the profession, failed to obtain informed consent, and engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional. The expert clearly laid out that there was no clinical basis in light of the documentation for touching the patient's genitals, and even if there was there was no documentation justifying it. There would be no therapeutic purpose to stroke a penis or cup a patients testicles during an examination.

College Counsel submitted that this case will require the Panel to consider how to characterize conduct that could be clinical or could be sexual. Some of the Member's actions could have a clinical character, and could have a sexual character. Counsel submitted the following cases for the Panel to consider in resolving how to deal with conduct that could be clinical or sexual, depending on the context:

- *CPSO vs Dr. Stanley Bo-Shui Chung,* 2014 ONCPSD 7; and
- *CPSO vs Dr. Javad Peirovy,* 2015 ONCPSD 30 (after the hearing was over, but while it was deliberating, the Panel also received with consent of the parties a copy of the Divisional Court's reasons regarding the College's appeal from the penalty ordered in that case).

Submissions of the Member

Counsel for the Member submitted that [the Client's] perception of the Member being gay drives this misunderstanding. [The Client] decided that the Member was gay after he gave [the Client] "a big gay smile." [The Client] made these conclusions on scant evidence. Prejudice can cause harm, and the Member's Counsel submitted that this is the case here.

What the Member did in terms of physical examinations were all for legitimate medical reasons. If what the Member did was wrong, then it should have been wrong for the doctor as well. The Member's touching of the patient did not last long, it was a fleeting assessment. The Member admitted to touching [the Client's] testicles because he had a clinical purpose for doing so. This is not contrary to assessing for a hernia. The Member denies that he moved his hand up and down on [the Client's] penis, he merely moved the erect penis aside to conduct his examination. With regards to doing the examinations over the patient's clothing, [the Client] did not want to remove his clothes.

The Member's evidence at the hearing was given clearly. If it is not consistent with what he said during his meeting with [Witness 3], that can be explained. The Member was traumatized by his meeting with [Witness 3] and by the fact that his integrity was being questioned. Over the passage of time some of that trauma was removed and the Member was able to reflect on the incident. Counsel submitted that the Member's testimony was given in a thoughtful, careful manner, and that sometimes memories do come back over time.

While the charting was not perfect, the Member's Counsel submitted it was not professional misconduct. The Member was not able to document in a timely manner due to the number of patients he was caring for that night. He did his documentation as soon as he possibly could.

Counsel for the Member submitted that the Member obtained consent from [the Client] at every contact, before every procedure or examination. The Member obtained consent by words or nonverbal cues such as a head nod. The fact that [the Client] was at the ER itself provides some consent to assessment. [The Client] has a problem with perception, and may not have understood what was being said. Counsel raised the question: is it professional misconduct if [the Client] didn't understand the Member? The Member's constant checking on [the Client] was because the Member was acting as an advocate for the patient. It is reasonable to assume that [the Client] misinterpreted the events given his level of pain, the fleet enema, his exhaustion from not sleeping in two days, and having worked a full day at a new job while not feeling well. He was distressed.

With respect to the *Doodnaught* case submitted by the College, counsel for the Member submitted that this case is entirely different. The criminal charges against the Member were dropped. The Member has an unblemished record, is a good nurse and was co-operative with the College's investigation.

**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.

The Panel found that the Member committed acts of professional misconduct as alleged regarding the following allegations.

- As alleged in paragraph 2 (a), (c), (d), (e) and (f), the Member contravened or failed to meet the standards of practice of the profession in that:
    - he touched [the Client] when there was no clinical basis to do so;
    - he failed to properly assess [the Client];
    - he failed to document his care and assessment of [the Client];
    - he failed to obtain informed consent of [the Client] to perform care and assessment; and
    - he breached the therapeutic boundaries of the nurse-client relationship.

- As alleged in paragraph 3(a), the Member failed to obtain informed consent of his client [the Client] to perform care and assessment.

- As alleged in paragraphs 4(c) and (d), the Member's conduct in failing to properly assess [the Client] and failing to properly document his case and assessment of [the Client] would reasonably be regarded by members as unprofessional.

- As alleged in paragraphs 4(a), (e) and (f), the Member's conduct in touching [the Client] when there was no clinical purpose to doing so, failing to obtain informed consent, and breaching the therapeutic boundaries of the nurse-client relationship would reasonably be regarded by members as dishonourable and unprofessional.

Having considered the evidence and the onus and standard of proof, the Panel was unable to find that the Member had committed acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 2(b) and 4(b) of the Notice of Hearing. Accordingly, the Panel dismisses those allegations against the Member.

**Reasons for Decision**

Nursing is an esteemed and honourable profession, but it comes with a heavy burden. The nurse is not only responsible for the physical wellbeing of the client but also their mental and emotional wellbeing. [The Client] came to the emergency department bewildered and in pain. He trusted in the staff there to "fix" his problem.

(a) Allegation 1 - Sexual Abuse

Many facts were agreed. The evidence of [the Client] is consistent with the evidence of the Member for some key parts of the examinations. For example, the Member admitted that he conducted at least two examinations of [the Client's] groin area. During one of those examinations, he briefly touched [the Client's] penis, over [the Client's] clothes, with the back of a gloved hand, to move what he described as [the Client's] erect penis away so that he could conclude his examination of the inguinal area. Although [the Client] said that his penis was not erect, his recollection of this event is otherwise consistent with the Member's evidence. The Member also admits that he applied what he described as brief touching of [the Client's] testicles with three or four fingers of a gloved hand, over [the Client's] clothing, to check for pain.

However, [the Client] also says that during the final examination in Room 41, the Member engaged in touching that can be described as genital fondling – touching his penis in a pushing/pulling motion from the tip of the penis, pushing up and down from the tip to the shaft two or three times. [The Client] could not see this touching, but he said he could feel it. The Member denied this kind of touching occurred. The Member agreed there would be no clinical reason to engage in this kind of genital touching. If it occurred, it would fairly be described as touching of a sexual nature that is not of a clinical nature appropriate to the care being provided. In other words, it would be sexual abuse. Moreover, if the Panel finds that the Member touched [the Client's] penis in the way he described, it could put a sinister light on the other touching that the Member admits to, and could support a finding that earlier touches of [the Client's] testicles and penis had a sexual rather than clinical character.

In assessing whether the Member touched [the Client's] penis by pushing/pulling it up and down two or three times, the Panel had to consider the credibility of [the Client] and the Member. The Panel understands it can believe all, some or none of the evidence of a witness. The Panel must assess whether a witness is being truthful, as well as whether the evidence of witnesses considered truthful and credible is nevertheless reliable, as truthful witnesses can be mistaken. In determining credibility, the Panel applied the criteria articulated in *Re Pitts and Director of Family Benefits Branch of the Ministry of Community & Social Services,* 1985 CanLII 2053 (ON SC).

With respect to [the Client], the Panel found him to be credible. He truly believes that something bad happened to him that night. However, the Panel had to determine whether [the Client's] honest feelings of being violated came from sexual abuse or poor nursing process during his care. The Panel did not hold the fact that [the Client] denied having an erection against him. It was obvious that he was uncomfortable during parts of his testimony, and needed to talk about things that in his culture are, as he said, very private, to the point where some of those words lack a direct translation. The panel preferred the testimony of the Member, that [the Client] did in fact have an erection. [The Client] was clearly embarrassed by the situation. It is detrimental to the Member's position to admit that [the Client] had an erection, as this is the basis for the findings

on inappropriate touching. It would be unreasonable for the Member to admit to [the Client] having an erection if this wasn't the case.

The Member's testimony was straightforward and clear, however the Panel found that a lot of his answers came across as what he would have done. For example, his testimony was that he explains everything he is doing and is constantly checking in with the client during care. The testimony of [the Client] contradicts this at a lot of points. [The Client] knew the enema was to make him have a bowel movement. This is a very private area for a person, having something inserted into the rectum, and is not a comfortable procedure. [The Client] had no issue or complaint with this being done, leaving the Panel to find that the Member did likely explain this procedure and check in with the client during the administration of the enema. In contrast, [the Client] was uncomfortable with the Member moving his erect penis out of the way during an exam, and with the Member touching his testicles. [The Client] did not have the opportunity to observe what was going on, and it was clear to the Panel that the Member did not explain himself or obtain proper consent while doing so.

Because the Panel had opportunity to observe both the Member and [the Client] giving evidence, the Panel was able to observe the very stark differences between the two parties. The Member is in the position of power and [the Client] was in a vulnerable position, being in pain, worried about his job, and lacking proficiency in English. It stands to reason in the Panel's view that [the Client] was overwhelmed physically, and put his trust in the Member, who overwhelmed him again, whether it was his intention or not.

As to the other acts of touching – putting pressure on the testicles to check for pain, moving [the Client's] penis to check for a hernia, and generally palpating around the stomach and groin area - the Panel agrees with the College that this is a case where the Member engaged in touching that could be characterized as either clinical or sexual in nature. The Panel accepts the Member's evidence that he had no sexual purpose or intention, and that his only intention was to gather clinical findings and assure the Client that his pain was being assessed. The case is similar to the case presented by the College, *CPSO v. Chung*, 2014 ONCPSD 7, where the Discipline Committee of the College of Physicians and Surgeons of Ontario found that even when a doctor is mistaken as to the medical necessity of medical examinations involving sensitive and intimate areas, those examinations may not be of a sexual nature or character.

The touching was done in a clinical care setting, on areas of the body one might expect to be touched given [the Client's] presentation. [The Client] did not have concerns about the touching at the time it happened. [The Client] later interpreted the touching as sexual. [The Client] had been in pain for hours, had had very little sleep during that time, and made the assumption that the Member was gay. [The Client's] assumption about the Member's sexuality impacted how he interpreted what the Member did during the course of his care.

In cross-examination, the following exchange occurred between [the Client] and the Member's counsel.

17 Q. Thank you. So, I take it you have
18 decided Mr. Estrella is gay because of the way he
19 smiles and the way he walks?

20 A. [In English] Yes.

21 Q. Okay. And you have interpreted

22 everything he did to you based on your decision he

23 is gay?

24 A. Yes[1]

This assumption coupled with [the Client's] view of gay men likely led to [the Client's] conclusion that touching he had experienced earlier was sexual. The Panel found that [the Client] had a negative view of gay men. This was clear from several points in his evidence, such as when he defined men who are sexually attracted to women as "correct men" and gay men as "not a correct man". The Panel finds [the Client's] perception of the Member's sexuality, combined with the Member's communication failures and overly thorough examinations, led [the Client] to mistrust the Member's care and assessment.

Having carefully reviewed the evidence before us the Panel found it more likely than not that the touching in the genital area was the Member attempting to gather clinical findings on his yet undiagnosed patient who continued to be in pain. However, the Member did not ensure [the Client] understood what he was going to do, nor did he ensure he had consent to palpate the patient in these sensitive areas.

(b) Allegation 2 - Breach of Standards

The Panel did not find that the Member "solicited" [the Client] to accompany him to the bathroom when there was no clinical purpose for doing so. The Panel finds it is just as likely that the Member was suggesting, through his gestures, that [the Client] use the bathroom before being moved to the hallway, and this action was misinterpreted by [the Client]. However, the Panel finds the other allegations that the Member breached the standards of practice of the profession have been proven.

For allegation 2(a), the Panel found it troubling that the Member checked for a hernia over the pants and underwear of [the Client]. Upon discovering that the patient had an erection, the Member should have stopped his exam. This was the clear evidence of the expert witness, whose opinion the Panel accepts. She testified that her opinion would not change depending on whether the client had an erection or not. While the Panel did not have sufficient evidence to find that the Member touched the genitals of [the Client] in a sexual nature, the Panel did find the touching to be lacking in critical thinking and lacking in communication with the Client. The Member may have felt the need to "do something" to show the Client that he was taking the Client's complaints of pain seriously. However, this should never be a reason to perform unnecessary exams of intimate and sensitive areas, especially without documenting the reason for the assessment and explaining it in clear terms that are understood by the client.

For allegation 2(c), the Panel found that the Member failed to properly assess [the Client] in that he did not accurately conduct a pain scale on [the Client]. The Member relied on his own interpretation of the pain scale system to asses [the Client] from an objective point of view rather

[1] Transcript 2016-12-05 [The Client] in cross examination page 50

than a subjective one. The Member admitted that [the Client] didn't look like he was in a lot of pain, and documented that the pain was well managed, because the Member was doing something about the pain, by advocating for a medication order for [the Client], from the doctor. The panel found that the Member did not ask [the Client] about his pain in a way that would reflect the proper use of the pain scale tool in use at the facility. In addition to this, the panel finds that the Member did not accurately assess [the Client] when he touched the client without clinical basis, and even if the Member believed that he was touching [the Client] with a clinical basis, the Member failed to document his findings.

For allegation 2(d), the Member's defence was that he does not document promptly because he cares about his clients and is so busy with them that he puts off charting until later. The problem is not just that the charting was done late. The charting was done wrong. The Panel accepts that the Member cared about his clients. The Panel found upon reviewing the documentation of the Member that while it may be true that he cared about clients, he had some faulty knowledge of the standards of practice and at times let his own personal views speak for his client. For example the pain scale. Because the Member observed [the Client] smiling, he felt that [the Client's] pain was minimal, and charted it as that. Pain is subjective, and as a nurse the Member ought to have known better than to make assumptions. This is a clear breach of the nurse-client relationship boundaries. By the Member's own admission the Client was tired and distressed from the pain, which contradicts the pain assessment that was not done correctly, and the subsequent charting. Failing to properly chart the Client's pain leads to other problems in the documentation, such as no clear charted explanation as to why morphine was necessary.

For allegation 2(e), the Panel found that the Member did not obtain informed consent from [the Client]. [The Client] did not recall the Member explaining the need for various assessments, especially those that required the Member to touch [the Client] in his groin area. The explanation given by the Member during testimony leaned more towards what he would do, not what he did do. The Client was confused and didn't understand what was being done. The Panel accepts the Client's evidence that many of the exams performed on him had not been properly explained in advance, and that informed consent to them was not given.

For allegation 2(f), the Panel found that the College proved the breach of the therapeutic boundaries of the nurse-client relationship. The Member made assumptions about his Client's pain, failed to communicate with the Client effectively, and performed assessments of sensitive areas when the value and purpose of those assessments was unclear and undocumented. These breaches led the Client to feel confused, angry and violated.

(c) Allegation 3 - Informed Consent

For the reasons given above, the College has proven that the Member failed to obtain informed consent from [the Client].

(d) Allegation 4 – Disgraceful, Dishonourable or Unprofessional

The Panel found that the Member's conduct was dishonourable and unprofessional when he touched [the Client] with no clinical basis to do so, did not obtain [the Client's] consent and breached the boundaries of the therapeutic nurse-client relationship. The Panel also found that the Member's conduct was unprofessional when he failed to properly assess [the Client], and failed to document his care and assessment of [the Client]. It is a very dangerous thing to make assumptions when caring for clients. The Panel was troubled by the admission of the Member

that he exaggerated the Client's pain and condition to encourage the doctor to see [the Client]. This could have led to disastrous consequences, unnecessary medications or procedures. There was no clear path within the charting of why [the Client] needed morphine. The Panel found a disconnect between the testimony of the Member with respect to the frequency of which he interacted and assessed [the Client] however, apparently had no opportunity for timely charting.

In every clinical interaction, the onus is always on the nurse to practice safely, with client focused care in mind. The onus is on the nurse to fully explain procedures, examinations and tests they are about to preform, and obtain consent. The onus is on the nurse to keep checking in during the exam, procedure or test to make sure the clients are still comfortable with what is happening. The onus is on the nurse because the nurse has the power of knowledge and the nurse must make sure that the power dynamic between the nurse and the client is respected. The onus is on the nurse to chart contemporaneously and accurately to ensure the most positive outcomes for the client. This is for client safety, and client safety and wellbeing is the nurse's responsibility.

The parties are directed to make the necessary arrangements to make submissions to the Panel in relation to penalty.

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