DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Mary MacMillan-Gilkinson	Public Member
	Heather Stevanka, RN	Member
	Terah White, RPN	Member
	Chuck Williams	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
LEIGH WARDLAW	)	NO REPRESENTATION for
Reg. No. 0517458	)	Leigh Wardlaw
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: March 19, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on March 19, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

Leigh Wardlaw, (the "Member"), participated in the hearing via teleconference.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated October 19, 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 (the "Act"), and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, in or around June 8, 2016, while employed as a Registered Nurse at Closing the Gap Healthcare in Kitchener, Ontario,

you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that you:

a) failed to administer pain medications to client, [the Client] (the "Client");

b) consumed the Client's medications;

c) misappropriated the Client's medications, including morphine and Ativan; and/or

d) practised while impaired by a substance.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the Act, and defined in subsection 1(6) of *Ontario Regulation 799/93*, in that, in or around on June 8, 2016, while employed as a Registered Nurse at Closing the Gap Healthcare in Kitchener, Ontario, you practiced the profession while your ability to do so was impaired by a substance.

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the Act, and defined in subsection 1(8) of *Ontario Regulation 799/93*, in that, in or around on June 8, 2016, while employed as a Registered Nurse at Closing the Gap Healthcare in Kitchener, Ontario, you misappropriated property from the Client, in particular, you misappropriated vials of morphine and tablets of Ativan from the Client.

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the Act, and defined in subsection 1(18) of *Ontario Regulation 799/93*, in that, in or around on June 2016, while employed as a Registered Nurse at Closing the Gap Healthcare in Kitchener, Ontario, you contravened a term, condition, or limitation on your certificate of registration, imposed pursuant to s. 1.5(1)1(ii) of *Ontario Regulation 275/94*, in that you failed to provide the Executive Director with the details of charges relating to impaired driving caused by drugs; criminal negligence causing bodily harm; breach of trust; 2 counts of possession of a controlled substance; theft under $5,000; and possession of stolen property under $5,000.

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the Act, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, in or around June 8, 2016, while employed as a Registered Nurse at Closing the Gap Healthcare in Kitchener, 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 as disgraceful, dishonourable or unprofessional, in particular, you:

a) failed to administer the Client's pain medication at the ordered time;

b) misappropriated the Client's medications, including Morphine and Ativan;

c) consumed the Client's pain medication;

d) practised while impaired by a substance; and/or

e) failed to self-report criminal charges relating to impaired driving caused by drugs; criminal negligence causing bodily harm; breach of trust; 2 counts of possession of a controlled substance; theft under $5,000; and possession of stolen property under $5,000.

Member's Plea

The Member admitted the allegations set out in paragraphs 1 (a), (b), (c), (d), 2, 3, 4, and 5 (a), (b), (c), (d), and (e) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College and the Member advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads as follows.

THE MEMBER

1. Leigh Wardlaw (the "Member") obtained a certificate in nursing from Conestoga College in 2000. The Member obtained a diploma in nursing from Conestoga College in 2004.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") on January 25, 2001. The Member then registered with the College as a Registered Nurse ("RN") on September 27, 2005. The Member resigned her RPN certificate of registration on February 1, 2013. The Member's RN certificate of registration expired on March 24, 2017.

3. The Member's certificate of registration was voluntarily surrendered between May 15, 2006 and August 16, 2010, after being referred to the Fitness to Practise Committee.

4. The Member was employed full-time at Closing the Gap Healthcare (the "Agency") in a supervisory position from February 14, 2011 to June 9, 2016, when her employment was terminated as a result of the incident below.

THE CLIENT

5. [The Client] (the "Client") was 13 years old at the time of the incident.

6. He was diagnosed with terminal brain cancer and was receiving palliative care at home.

7. The Client's parents hired Paramed/Revera to provide homecare. When Paramed was unable to fill all the required shifts, the Agency provided assistance. The Client was receiving 2.5 mg of morphine subcutaneously every two hours to manage his pain.

8. The Client passed away on June 10, 2016.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incidents on June 8, 2016

9. On June 8, 2016, the Member was assigned to the Client's care from 1300 to 2300.

10. Around 2000, the Client's parents became concerned about the Member's ability to provide care to the Client. She was falling asleep, appeared confused and was unsteady on her feet. They suspected the Member was under the influence of a substance.

11. The Client's parents called Paramed and asked if someone could come to check on the Member. [Nurse A], RN, who was assigned to the Client for the night shift, was sent to check on the Member.

12. When [Nurse A] arrived, the Client's father was outside. He advised that the Member appeared stoned and was not making sense. [Nurse A] entered the home and found the Member in the Client's room, swaying back and forth with her eyes closed. [Nurse A] told the Member she was there to relieve her but the Member responded that she was fine and that she was just tired.

13. At the time, the Client was moaning and appeared to be in pain. [Nurse A] asked the Member when she had last administered morphine to the Client. The Member responded that she had last administered morphine at 2230, but it was only 2150 at the time.

14. [Nurse A] assisted the Member downstairs because she was unsteady.

15. [Nurse A] then checked the Client's chart to address his pain. According to the Medication Administration Record, no pain medication had been administered since 1735. The Member did not make any nursing notes. [Nurse A] administered pain medication to the Client.

16. [Nurse A] then called [Manager], the Client Service Manager for the Agency, who advised that she would come to the Client's home. In the meantime, [Nurse B], RN, from Paramed, arrived to assist. She helped [Nurse A] do the narcotic count and it was identified that medication was missing (2-3 vials of morphine and 30 Ativan pills).

17. Around that time, the Member went outside to her car, despite being told she did not look safe to drive.

18. When [Manager] arrived around 2257, the Member was sitting in her car in the driveway. Her car was blocked by two other cars. She knocked on the Member's window and the Member swore at her and was slurring her words. The Member then tried to reverse her car and drive around the other vehicles, but there was not enough room.

19. The police were called and the Member was arrested for impaired driving. At the police station, the Member was found to be in possession of three unused needles and one used syringe, which were labelled with the Client's name.

20. The Member acknowledges that she misappropriated the Client's morphine and consumed it for her own use, which left the Client without pain medication for five hours. The Member also acknowledges that she practised nursing when she was impaired by a substance.

Criminal Conviction and Failure to Report Charges

21. On June 8, 2016, the Member was charged with:

- impaired driving caused by drugs.
- criminal negligence causing bodily harm.
- breach of trust.
- counts of possession of controlled substances.
- Theft under $5,000.
- Possession of stolen property under $5,000.

22. The Member failed to report the charges to the College.

23. On January 6, 2017, the Member pled guilty to:

- impaired driving caused by drugs.
- Theft under $5,000 (narcotics, morphine).
- breach of trust.
- counts of possession of controlled substances (CDSA possession charge).
- Breach of surety (failed to remain in her residence).

24. On April 20, 2017, the Member was sentenced to:

- 18 months incarceration (time served).
- Probation for two years.
- 2 year driving ban.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

25. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), (b), (c) and (d) of the Notice of Hearing, as described in paragraphs 9 to 20 above, in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession when she:

- Failed to administer pain medication to the Client;

- Consumed the Client's pain medication;

- Misappropriated the Client's medications including morphine and Ativan, and;

- Practised while she was impaired by a substance.

26. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, as described in paragraphs 9 to 20 above, in that she practised nursing while her ability to do so was impaired by a substance (morphine).

27. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3 of the Notice of Hearing, as described in paragraphs 9 to 24 above, in that she misappropriated morphine and Ativan from the Client.

28. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 4 of the Notice of Hearing, as described in paragraphs 21 to 24 above, in that she failed to report to the Executive Director that she was charged with impaired driving caused by drugs, criminal negligence causing bodily harm, breach of trust, two counts of possession of a controlled substance, theft under $5,000, and possession of stolen property under $5,000.

29. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 5 (a), (b), (c), (d) and (e) of the Notice of Hearing, and in particular that her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 9 to 24 above.

Decision

The Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1 (a), (b), (c), (d), 2, 3, and 4 of the Notice of Hearing. As to the allegations in paragraph 5 (a), (b), (c), (d), and (e) of the Notice of Hearing, the Panel finds that the Member engaged in conduct that would reasonably be regarded by members to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports the findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1 in the Notice of Hearing is supported by paragraphs 9 to 20 in the Agreed Statement of Facts. The Member was assigned to provide homecare to a terminally ill 13 year old Client who had been diagnosed with brain cancer. The Member admits that she failed to administer the required pain medications to her Client and, instead, misappropriated them for her own use. This rendered her confused, unsteady and incoherent and left her Client moaning and appearing to be in pain. This is a clear breach of the principles enshrined in the *Professional Standards* document. That standard requires nurses to ensure that the client's needs are the focus of all nurse-client relationships and that clients should not be exposed to any unnecessary risk of harm. By breaching this standard, the Member caused unnecessary pain and trauma to a very ill child and made a difficult situation even worse for a grieving family.

Allegation #2 in the Notice of Hearing is supported by paragraphs 9 to 20 in the Agreed Statement of Facts. The Member admits that she practised nursing while impaired by a substance. The Client's father described the Member as appearing to be stoned and not making any sense. The Member's colleague observed the Member swaying back and forth with her eyes closed. While in that state, the Member failed to acknowledge that she was incapacitated. Instead she stated that she was fine and just tired. A cornerstone of safe nursing practice is that a nurse ensures he/she is competent before performing any duties.

Allegation #3 in the Notice of Hearing is supported by paragraphs 9 to 24 in the Agreed Statement of Facts. The Member acknowledges that she misappropriated the Client's morphine and consumed it for her own use. This resulted in the Client going without pain medication for five hours. The Member was found to be in the possession of three unused needles and one used syringe which were labelled with the Client's name. The Member was not engaged in client centred care when she misappropriated her terminally ill Client's pain medication and supplies and used them for her own benefit.

Allegation #4 in the Notice of Hearing is supported by paragraphs 21 to 24 in the Agreed Statement of Facts. The Member admits that she failed to report the various charges to the Executive Director that arose as a result of the incidents on June 8, 2016. All nurses are required to self-report charges against themselves to the College.

With respect to Allegation #5, the Panel finds that the Member's conduct was disgraceful, dishonourable and unprofessional.

The Member's conduct was unprofessional as it demonstrated a serious disregard for her professional obligations. The Client was in the final stages of brain cancer when the Member deprived him of timely and adequate medication for his pain. The Member's conduct was dishonourable when she misappropriated the Client's pain medication and used it to meet her own needs. She ought to have known that her actions would deprive her Client of his much-needed pain relief and that it would render her incapable of adequately performing her nursing duties. The Member's conduct was disgraceful as the Member's theft and disregard for her professional obligations casts serious doubt on her moral fitness and inherent ability to discharge the higher obligations that the public expects of nursing professionals. This is conduct that has the effect of shaming the Member and, by extension, the profession.

Penalty

Counsel for the College and the Member advised the panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows.

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. Directing the Executive Director to immediately revoke the Member's certificate of registration.

Penalty Submissions

Submissions were made by College Counsel. The Member chose not to comment on College Counsel's submissions.

College Counsel submitted that the mitigating factors in this case were:

- The Member has cooperated with the College thus avoiding a costly and contested hearing.
- The Member participated through teleconference at the hearing.

The aggravating factors in this case were:

- The Member has a prior history with Fitness to Practice.
- The Member has made several unsuccessful attempts to deal with her Substance Abuse Disorder.
- The Client was a terminally ill 13 year old who died two days after the incident.
- The conduct is extremely serious and cannot be excused by the Member's Substance Abuse Disorder.
- The Client's family had to divert their attention from their dying son to the Member and her conduct.

The proposed penalty provides for general deterrence through the revocation of the Member's certificate of registration. This sends a clear message to the profession that this conduct will not be tolerated. It will also discourage other members from repeating these actions.

The proposed penalty provides for specific deterrence through the revocation. This is harsh, but a necessary consequence of very serious misconduct. It is also a result of the fact that the Member has not successfully dealt with her Substance Abuse Disorder.

The proposed penalty provides for remediation and rehabilitation through the reprimand. The reprimand will provide the Member with an opportunity to gain a greater understanding of the consequences of her actions. It will help her to confront her Substance Abuse Disorder and the impact that it had on her Client and, by extension, its effect on the reputation of the membership as a whole.

Overall, the public is protected because the Member will not be able to practise until she can prove that she has successfully dealt with her Substance Abuse Disorder. The public will be assured that this is a profession that is capable of governing itself.

Counsel submitted cases to the Panel from this Discipline Committee. Counsel acknowledged that none of the cases were particularly analogous to this one but that they do represent a range of penalties including revocation.

In *CNO v. Melanie Burton* (Discipline 2013), the member had no prior disciplinary record with the College but had stolen money from a client. The member received a 4 month suspension. In this case, the conduct was less serious.

In *CNO v. Sherry Lee Reaume* (Discipline 2012), the member took an inactivated credit card from a client and withdrew approximately $1000.00. The member did not participate in the hearing. She was given a 6 month suspension.

In *CNO v. Carrie A. Hardy* (Discipline 2016) the member was convicted of failing to report numerous findings of guilt to the College. Her license was revoked.

In *CNO v. Paula Pontin* (Discipline 2010). Although the member had no prior history with the College, her conduct involved a wide range of misconduct. This included misappropriating funds from her employer, falsifying a payment card, falsely representing herself as a nurse after her license had been suspended and forging a prescription for Oxycontin. Her license was revoked.

In *CNO v. M. Colleen McClinton* (Discipline 2006), the member had an extensive record of failing to document wasted narcotics. The member's license was revoked and she was required to pay a fine of $10,000 payable to the Minister of Finance of Ontario.

Independent Legal Counsel stated that the primary goals of the Panel's order are to ensure the protection of the public and to maintain confidence in nursing and self-regulation. He also stressed the importance of general and specific deterrents as well as rehabilitation and remediation. He stated that the College and the Member have reached an agreement on the order and that it has been negotiated by experienced counsels. He stated that the Panel is obliged to accept it unless it was so disproportionate to the offence in question, that to accept it would bring the administration of justice into disrepute or be contrary to the public interest. If the Panel had concerns, it was then obliged to ask the parties to respond to its concerns.

Penalty Decision

The Panel accepts the Joint Submission as to Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. The Executive Director is directed to immediately revoke the Member's certificate of registration.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. Members of the profession will be reminded of the importance of client-centred care. Members with substance abuse disorders will also be reminded of the importance of successfully dealing with their own health concerns so that they do not affect those under their care and their families. The penalty is in line with what has been ordered in previous cases.

The Member had requested that her reprimand be delivered by teleconference. The Panel determined that the reprimand would be most effective if it were delivered in person rather than by teleconference.

I, Dawn Cutler, RN, 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