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

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| **PANEL:** | Susan Roger, RN | Chairperson |
| | Dawn Cutler, RN | Member |
| | Renate Davidson | Public Member |
| | David Edwards, RPN | Member |

**BETWEEN:**

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| COLLEGE OF NURSES OF ONTARIO | ) | MEGAN SHORTREED for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| MIGUEL A. ROJAS LEAL | ) | JANE LETTON for |
| Registration No. 06292674 | ) | Miguel A. Rojas Leal |
| | ) | |
| | ) | LUISA RITACCA |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | |
| | ) | Heard: November 26-28, 2018 |

## DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on November 26th to 28th, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

## The Allegations

The allegations against Mr. Rojas Leal (the "Member") as stated in the Notice of Hearing dated September 5th, 2017, are 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 Nurse with Toronto Western Hospital in Toronto, Ontario (the "Hospital"), you sexually abused a client, as follows:

    a. on or about May 28, 2012, you engaged in touching of a sexual nature, or behaviour or remarks of a sexual nature, toward [the Complainant] including:

i. touching [the Complainant's] genitals when there was no clinical purpose to do so; and/or
ii. inviting [the Complainant] to have a drink with you; 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 Nurse at the Hospital, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

    a. on or about May 28, 2012, you breached the therapeutic boundaries of the nurse-client relationship with [the Complainant] by:

        i. touching [the Complainant's] genitals when there was no clinical purpose to do so; and/or
        ii. inviting [the Complainant] to have a drink with you; 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(37) of *Ontario Regulation 799/93*, in that while employed as a Registered Nurse at the Hospital, 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, as follows:

    a. on or about May 28, 2012, you engaged in touching of a sexual nature, or behaviour or remarks of a sexual nature, toward [the Complainant] including:

        i. touching [the Complainant's] genitals when there was no clinical purpose to do so; and/or
        ii. inviting [the Complainant] to have a drink with you; and/or

    b. on or about May 28, 2012, you breached the therapeutic boundaries of the nurse-client relationship with [the Complainant] by:

        i. touching [the Complainant's] genitals when there was no clinical purpose to do so; and/or
        ii. inviting [the Complainant] to have a drink with you.

**Member's Plea**

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

**Overview**

The Member is a registered nurse ("RN") who initially registered with the College on August 29th, 2006. Prior to nursing in Ontario, the Member was registered in Bogotá, Colombia as an RN where he worked for approximately 10 years before arriving in Canada. At the time of the incident

alleged in the Notice of Hearing, the Member was working as an RN in the Emergency Department at Toronto Western Hospital in Toronto, Ontario (the "Hospital").

The parties agree that the Member provided nursing services to [the Complainant] on May 28th, 2012 at the Hospital Emergency Department, and that the Member obtained a urine sample and performed a urine dip test. However the Member denies that he engaged in the conduct set out in the Notice of Hearing.

The College alleges that while the Member was collecting a urine sample from [the Complainant], the Member touched [the Complainant's] genitals where there was no clinical purpose to do so. Further, the College alleges that at the end of [the Complainant's] treatment in the Emergency Department, the Member invited [the Complainant] to have a drink with him.

The parties filed an Agreed Statement of Facts, which the Panel accepted into evidence, together with a Joint Book of Documents. The key issues for the Panel to consider in this case were as follows:

(a) Did the Member commit an act of professional misconduct in that he sexually abused a client?
(b) Did the Member contravene or fail to meet standards of practice of the profession?
(c) Did the Member engage in conduct that would be reasonably regarded by members of the profession as disgraceful, dishonourable or unprofessional?

In the Agreed Statement of Facts, the Member agreed that if the Panel finds that the alleged incident occurred such conduct would amount to a breach of the College's Practice Standard: *Therapeutic Nurse-Client Relationship, revised 2006.*

The Member also agreed that if the Panel finds the alleged comment was made, it does not serve any clinical purpose and would be considered not to be appropriate to the nursing service provided. Such a comment, if it was made, would amount to a breach of the College's Practice Standard: *Therapeutic Nurse-Client Relationship, revised 2006.*

In addition to the agreed upon documents and Agreed Statement of Facts, the Panel heard from four witnesses. Based on the evidence presented, the Panel made findings of professional misconduct in relation to the touching, however the Panel made no findings in relation to the alleged comment. Finally, the Panel found that the Member's conduct would be reasonably regarded by members of the profession as disgraceful, dishonourable and unprofessional.

**Publication Ban**

On November 8th, 2017, during a preliminary motion hearing, College Counsel brought a motion pursuant to section 45(3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, for an order preventing the public disclosure of the name and any identifying information of the complainant, including a ban on publication or broadcasting of those matters referred to in this discipline hearing.

The Panel considered the submissions of College counsel, Counsel for the Complainant and on being advised that Counsel for the Member did not oppose the request, found that an order

preventing the public disclosure of the name and any identifying information of the Complainant, including a ban on publication or broadcasting of those matters referred to in this discipline hearing is appropriate.

## The Evidence

*Agreed Statement of Facts ("ASF")*

The ASF signed by all parties and dated November 26th, 2018 read as follows;

1. The Complainant, [ ] is expected to testify that during a visit to the Toronto Western Hospital ("TWH") Emergency Department on May 28, 2012, the Member:

    a. told [the Complainant] that he needed to provide a urine sample by urinating into a mobile urinal at the bedside;

    b. told [the Complainant] that the Member has to clean [the Complainant's] groin area first;

    c. with antiseptic wipes and his hands, wiped the top and bottom of [the Complainant's] scrotum, his inner thighs, his upper pubis, the shaft and tip of [the Complainant's] penis, and pulled back the foreskin on [the Complainant's] penis and wiped around the head of the penis;

    d. after [the Complainant] urinated, told [the Complainant] that the Member had to clean him again;

    e. again with antiseptic wipes and his hands, wiped the top and bottom of [the Complainant's] scrotum, his inner thighs, his upper pubis, the shaft and tip of [the Complainant's] penis, and pulled back the foreskin on [the Complainant's] penis and wiped around the head of the penis; and

    f. at the end of the visit, suggested to [the Complainant] that they go for a drink together after [the Complainant] had healed, or words to that effect.

2. The Member admits that he provided nursing services to [the Complainant] on May 28, 2012 at the TWH Emergency Department, and that he obtained a urine sample and performed a urine dip test. Otherwise, the Member denies that he engaged in the conduct set out in paragraph 1.

3. The Member admits and agrees that;

    a. cleaning of a patient's genital area is not required for a urine dip test of the type performed on the night in question;

b. where cleaning is required before obtaining the urine sample, it is only where the client is physically incapable of cleaning himself that a nurse would perform cleaning;

c. in that case, the nurse is required to obtain consent before performing a cleaning;

d. there is no clinical reason to perform a cleaning of a patient's genital area after obtaining a urine sample; and

e. as such, a cleaning before and after obtaining a urine sample as described in paragraph 1(a) to (e) does not serve any clinical purpose and would not be appropriate to the nursing service provided. Such touching, if it occurred, would amount to a breach of the College's Practice Standard, *Therapeutic Nurse-Client Relationship, Revised 2006.*

4. Further, the Member admits and agrees that:

*a.* The comment referred to in paragraph 1(f) does not serve any clinical purpose and would not be appropriate to the nursing service provided. Such comment, if it was made, would amount to a breach of the College's Practice Standard, *Therapeutic Nurse-Client Relationship, Revised 2006.*

5. The parties agree that the Standard and Reference Document at Tabs 16 and 17 of the Joint Book of Documents were in force as at May 28, 2012, and are applicable to the allegations made in this matter.

*The Witnesses*

Evidence was heard from four witnesses: the Member's former Manager, the treating emergency Physician, [the Complainant] (also referred to as the "Complainant"), and the Member.

*Witness #1 – [The Nurse Manager], Nurse Manager, Emergency Department*

[The Nurse Manager] has worked in the emergency department at the Hospital in various roles over the course of 20 years. As early as 2012 she was intermittently covering the emergency department as Manager on an interim basis. In addition to her experience as Manager, [the Nurse Manager] testified that she was familiar with staffing on the unit, with the department's documentation, policies, and the College's standards.

[The Nurse Manager] identified documents including the Daily Assignment sheet for Monday May 28th, 2012, the date of the incident at issue. She described the typical staff ratio in the department and walked the Panel through each staff and position covered on the day in question. [The Nurse Manager] confirmed that the Member worked on May 28th, 2012 from 1530 to 2330hrs in the acute area primarily in the "Resus." (resuscitation room) and "Iso." (isolation room) areas. However team nursing applied in all the acute bays. [The Nurse Manager] also provided in-depth knowledge on the layout of the unit and filled in a map with key locations that [was] entered into evidence. [The

Nurse Manager] described the department's Acute, Subacute and Ambulatory areas, along with the ordinary procedure a patient entering the emergency department would follow. [The Nurse Manager] testified that a new patient would initially be assessed at Triage where they would be given a priority, called a CTAS score, which ranges from CTAS #1 (to be seen by ER Physician STAT) and CTAS #5 (to be seen by ER Physician within 120 minutes). [The Nurse Manager] explained that after Triage a patient would be registered by a Ward Clerk and then in ideal circumstances be sent directly into a bed (also known in this hospital as a "bay").

In describing the layout of the Emergency department, particular attention was given to the acute area bays where she described Acute #9, the bay in which the alleged incidents occurred. [The Nurse Manager] testified that the bay was surrounded by 3 interior walls and a curtain at the front of the bay. [The Nurse Manager] explained that the curtain should be closed whenever there is any interaction with a patient.

Under examination, [the Nurse Manager] confirmed that she knew the Member and confirmed that he was employed to work in the Emergency Department of the Hospital until sometime in 2012. [The Nurse Manager] explained that the Member left employment in 2012 as a result of another investigation for a separate issue and that she was not made aware of the incidents alleged in the Notice of Hearing until 2016, during the College's investigation.

[The Nurse Manager] confirmed from her review of the emergency room records filed, that the Complainant's treating physician was [the Physician] and that the Complainant's primary nurse was the Member.

With respect to urine collection, [the Nurse Manager] explained the Hospital's policies as set out in their medical directives and testified that a nurse has the ability via medical directive to perform a urine dip/urinalysis. During examination, [the Nurse Manager] explained that in circumstances that require a urine sample to be taken at the bedside, nurses would typically have to perform a "log roll" when turning someone on their side to collect a urine sample. [The Nurse Manager] advised that for patients who can roll independently they are to do so and then a nurse can hold a cup and obtain the sample. If a log roll is required, then more than one nurse would be needed. When asked if there was a reason to clean a patient's genitals prior to obtaining a urine sample, the witness explained that mid-stream collections only require a patient to urinate and collect a sample mid-stream and as such there would not be any reason for a nurse to clean or touch a patient's genitals.

[The Nurse Manager] also testified that the College's *"Therapeutic Nurse-Client Relationship"* and *"Professional Conduct"* standards are available to staff online on computers throughout the emergency department.

Under cross-examination it was clarified by [the Nurse Manager] that she had not spoken to [the Complainant] and did not witness any interaction between the Member and the Complainant. [The Nurse Manager] also agreed with Member's counsel that the entirety of her knowledge with respect to the incident at issue was based on the records and documents, and that she made her best guess based on the charting.

[The Nurse Manager] testified to what was within her knowledge, freely indicated when she did not know something or could not remember. She testified in a manner that was consistent with the documentation and she appeared to have no reason to mislead or embellish her evidence in any way.

*Witness #2 – [The Physician], Complainant's Attending Physician, Emergency Department*

[The Physician] was the Emergency Department Physician responsible for [the Complainant] on the evening at issue. He confirmed his signature on the emergency department records filed. [The Physician] graduated from the University of Toronto with his BSc in 1984, received his MSc in 1988, and in 1992 he received his Doctor of Medicine. He subsequently received his specialty in Neurology in 1996. [The Physician] explained that he has been working with the University Health Network which includes Toronto General and Toronto Western Hospitals for approximately 22 years.

[The Physician] testified that he did meet the Member through working at the Hospital. He had no recollection of [the Complainant]. His testimony with respect to [the Complainant's] treatment was based on his review of his own treatment notes.

When asked why the c-collar (a collar placed around the neck to keep a patient's head and neck immobile) was applied at Triage, [the Physician] explained that it is not unusual for the Triage Nurse to take extraordinary precautions depending on a patient's presentation. [The Physician] also explained the process he undertakes to remove a c-collar by ensuring there are no suspected head or spinal injuries.

[The Physician] confirmed, based on documentary evidence that at 2159hrs the Complainant was transferred to Acute 9 and that he saw the patient at 2230hrs. [The Physician] discharged the Complainant at 2235 pending the completion of his orders by the Member.

[The Physician] testified that based on the documentation, the urinalysis was not ordered by him and so it was done via medical directive by the nurse in charge of [the Complainant]. When asked if there was any clinical reason to do a bedside urine sample, [the Physician] testified it would be indicated for patients who were incapacitated. In such circumstances, a group of nurses would be required to assist with a "log roll" to get the patient on his or her side. Based on his review of the medical documentation, [the Physician] could see no reason why the Complainant would have been unable to go to the washroom to give a urine sample.

[The Physician] testified in a manner consistent with the medical documentation, he did not embellish and was willing to acknowledge that he had no independent recollection of the patient or the evening in question.

*Witness #3 – [ ], Complainant*

[The Complainant] filed a complaint with the College against the Member on May 13th, 2016, approximately four years after the incident in question.

[The Complainant] testified that prior to attending the Hospital, he was in [ ] and had fallen down a flight of stairs and as a result he sustained some minor injuries. Subsequently he sought treatment in the Emergency Department at [the Facility]. While at [the Facility], [the Complainant] was examined, his wound was cleaned and bandaged. He did not have any tests or imaging done at [the Facility] and he did not require any stitches. Upon his return to Toronto, [the Complainant] told a friend about his fall and subsequent treatment. His friend asked whether [the Complainant] had been given a tetanus shot while at [the Facility]. [The Complainant] had not received a tetanus shot. His friend's question prompted him to walk over to Toronto Western Hospital for further treatment.

[The Complainant] explained that he had told the Triage nurse what happened in [ ] and that he was presenting to Toronto Western for further treatment. [The Complainant] advised that the Triage nurse had asked him a series of questions relating to his symptoms, and measured his blood pressure and temperature. According to hospital documents an ECG was also conducted; however, [the Complainant] admitted that he did not recall having had an ECG at that time. [The Complainant] confirmed that the Triage Nurse put the c-collar around his neck and that he was then "ushered" from the triage area to Acute Bay #9.

In describing his surroundings in the emergency department, [the Complainant] recalled that he was taken to a bay with three walls and one curtain around a stretcher. [The Complainant] testified that the Member entered the bay and began his assessment on [the Complainant]. He testified that the Member asked what seemed to [the Complainant] to be "the standard questions". [The Complainant] confirmed to the Member that he had some back pain, stiffness in his knees, and abrasions on his arms. [The Complainant] did not recall complaining of pain in his groin area or if the Member conducted a neurological exam, as the records seem to indicate.

[The Complainant] was told that the Member would need a urine sample from him. [The Complainant] assumed that he would receive a cup, that he would walk on his own to the washroom and that he would provide his sample unassisted. Instead, the Member told [the Complainant] that because he was wearing a c-collar he had to stay on the stretcher. He was told by the Member to turn on his side and to provide his urine sample from there. [The Complainant] said that the Member was not harsh, however he was insistent that [the Complainant] not move from off the stretcher. [The Complainant] explained that he decided to comply with the Member's instructions, since the Member as the nurse, "is the professional…if that's what's to be done."

[The Complainant] pulled his pants and underwear down while lying on his back. He explained that he was ready to roll over and pee, but that the Member stopped him and said that he (the Member) needed to make sure that the area was clean prior to obtaining the sample. The Complainant explained that the Member took anti-septic wipes and spent "a fairly lengthy amount of time wiping me down". [The Complainant] could not recall the length of time the cleaning took, but could recall that the Member cleaned his penis and scrotum. The Member also pulled back the Complainant's foreskin and wiped the head of his penis. [The Complainant] explained that the Member wiped along the sides of the shaft of his penis one or more times. [The Complainant] explained that the whole experience was "surreal" and that he knew what was going on but froze. He simply tried to get through the cleaning and did not say anything to the Member. Following the cleaning, [the Complainant] explained that he then rolled independently onto his left side and

urinated into a jug. After the sample was taken, [the Complainant] described how he proceeded to roll onto his back and pull up his pants but was told by the Member that he had to clean his groin again. [The Complainant] testified that the Member then proceeded to clean him in much the same manner as he did prior to taking the urine sample. [The Complainant] explained the Member then left to test the sample and [the Complainant] pulled up his pants and waited for the doctor.

Following this incident, [the Complainant] recalled that he was examined by [the Physician]. The doctor removed his c-collar, checked his eyes and ultimately ordered that [the Complainant] be given his tetanus shot. [The Physician] told [the Complainant] to return to the emergency department if there were any changes or if he was experiencing any pain. [The Physician] completed his examination and left the Complainant alone. At this point, the Member returned and advised [the Complainant] that he needed the dressing on his arm injury changed. The Member changed the dressing and then said to the Complainant, "Maybe when you are feeling better we can get a drink?" [The Complainant] testified that he recalled saying in response something to the effect of, "Oh you know…okay…", and that once outside the Hospital, [the Complainant] thought to himself, "What the fuck was that?" He testified that he chalked the whole experience up to "a weird dumb thing happening to a weird dumb guy."

[The Complainant] explained that he decided to complain about the Member after four years, because of what he described was a triggering event that occurred during an exchange on social media with a group of friends in the [ ] community. [The Complainant] explained that he was offended by posts containing phrases like "[ ] rape" and "eat a bag of dicks", which are common within the [ ] community. He spoke with a friend about his concerns over the phrases and upon further reflection realised that he was so offended because of a "lifetime of narrowly escaping the clutch of perverts." After further reflection, [the Complainant] explained that he came to the realization that he did not always successfully escape and that he was in fact sexually assaulted by the Member.

[The Complainant] explained that he came forward to the College because he did not want anyone else to go through what he went through with the Member or this process.

[The Complainant] presented in a forthright manner, his story did not seem to stray in any significant way from the story included in his original complaint letter. He did not embellish or exaggerate his testimony, nor did he try to match his memory with the records and he did not appear to have any particular reason to lie.

*Witness #4 – Mr. Miguel Rojas Leal, Member*

The Member confirmed his registration history with the College and acknowledged that while he had no independent recollection of his interaction with the Complainant, the records confirm that he was on shift the night in question and that he was the nurse in charge of [the Complainant's] care.

The Member acknowledged that he very likely took a urine sample from the Complainant since it is clearly listed on the medical documentation. He explained that he probably asked for a urine sample given that the Complainant was presenting following a fall, where he had experienced some injuries and where the Complainant was complaining of "flank pain". The Member further testified

that if a patient has a c-collar, it is because they suspect possible trauma in the neck and because [the Complainant] was in the acute area it would have been more reason to keep him in the bed. The Member explained to the Panel that he did not recall cleaning [the Complainant's] genitals and could not recall if cleaning would be necessary. His counsel asked when cleaning would be required and the Member responded that it depends on the patient's condition and that if a patient is in a "bad condition," it could be warranted. The Member also testified that according to the record, there was nothing to indicate that cleaning the patient was necessary. The Member denied cleaning the Complainant in the manner described by [the Complainant] and further denied asking [the Complainant] out for a drink at the end of the treatment.

The Member confirmed that he was familiar with the College's Standards of Practice, and in particular, the *Documentation* and *Therapeutic Nurse-Client Relationship Standards*.

The Member also agreed that patients attending an emergency department are in a vulnerable state and that makes the relationship of trust between nurse and patient even more important. College Counsel questioned the Member about the power dynamic between nurses and patients and the Member agreed that there is an unequal level of power.

Counsel for the College established the following timeline of events with the Member:

1. [the Complainant] came into the ER at 2118hrs;
2. saw the Triage Nurse at 2122hrs;
3. had an ECG at 2148hrs;
4. transferred to the acute area at 2159hrs;
5. the Member started his nursing assessment at 2213hrs; and
6. performed the urine dip test at 2228hrs;
7. [the Physician] saw [the Complainant] at 2230hrs;
8. pain meds were dispensed by the Member at 2234hrs and finally;
9. the Client was discharged at 2235hrs.

The Member testified that he did not recall if there was a washroom for patient use in the acute area; however, he stated he had no reason to doubt the early testimony and map filed into evidence, which appears to confirm that a washroom is located close to acute bay #9, where the Complainant was being held. The Member confirmed that the normal protocol of collecting a sample for urine dip is to provide a patient with a collection cup and instructions and to send them to the washroom. After some questioning between College Counsel and the Member, the Member could not conclude entirely if he used a urinal to catch the urine and a separate urine cup for the dip test. However he did agree that a urine dip requires a mid-stream urine catch.

The Member's testimony made clear that he had no independent memory of the Complainant or any events on the date in question. Moreover, the Member relied wholly on documentary evidence. While the Member said that the conduct did not occur as alleged, he did not adamantly deny the serious misconduct.

## Final Submissions

*College Submissions*

Counsel submitted that the Complainant was a man who trustingly went to his local hospital for a routine procedure and what had happened there was completely inappropriate, and abusive. Counsel reminded the Panel that as set out in the Agreed Statement of Facts, there was no question between the parties that if the Panel found that touching had occurred, then that conduct would be a breach of the *Therapeutic Nurse-Client Relationship*. The College went on to request that the Panel also find that the conduct amounted to sexual abuse and that such conduct would be reasonably regarded by members of the profession as disgraceful, dishonourable and unprofessional (DDU).

The College broke down its submissions into 4 parts,

1. Burden and Standard of Proof;
2. Avoiding Improper Considerations;
3. Credibility Assessments; and
4. Allegations of Misconduct.

*Burden and Standard of Proof*

The College confirmed that it bears the burden of satisfying this Panel on a balance of probabilities that the conduct as alleged in fact occurred. The College relied on the Supreme Court of Canada decision in *F.H. v. McDougall,* [2008] 3 S.C.R. 41 for the proposition that the standard of proof (i.e. balance of probabilities) does not change with the severity of the allegations. The Panel must scrutinize the relevant evidence with care and must be satisfied that it is more likely than not that the events in questions took place.

*Improper considerations – Myths & Stereotypes*

The College advised the Panel that it is an error of law to allow myths and stereotypes of either sexual abuse victims or the perpetrators to influence decisions on whether or not the alleged misconduct occurred. Counsel went on to explain that assumptions of why a complainant did not fight back or immediately complain are not appropriate considerations. Neither are questions around the timing of the disclosure. Every complainant will react differently to a traumatic event and will have a different emotional response, which cannot be used to undermine the complainant's memory or testimony with regard to the events.

College Counsel also submitted that there could be potential myths of the perpetrator in that someone in the Member's position would never carry out such misconduct and that because there are no other instances of misconduct before a discipline committee that it is unlikely the Member would commit the misconduct. In defending the College's submission on this point a Divisional court case *College of Chiropractors of Ontario v. Kovacs,* 2004 CanLII 34625 was cited. Within this case, the decision describes in several paragraphs the use of stereotypes and concluded that, *"Rather than focus on the testimony of the parties before it, the majority appears to have used*

*myths and stereotypes about sexual assault victims and perpetrators which have influenced their decision in a manner which does not appear fair to all the interested parties."* Counsel reminded the Panel to focus on the evidence.

*Improper considerations – Delay in reporting*

College Counsel submitted that a delay in disclosing an assault standing alone, can never give rise to an adverse inference against the credibility of the Complainant and cited *R. v. D.D.*, [2000] 2 S.C.R. 275. In that case a young child complained about alleged sexual assaults that occurred 30 months before the reporting. In its reasoning, the Court wrote that, *"The significance of the complainant's failure to make a timely complaint must not be the subject of any presumptive adverse inference based upon now rejected stereotypical assumptions of how persons react to acts of sexual abuse."*

*Assessing Credibility*

Counsel for the College submitted that there are two core elements to witness testimony: credibility which focuses on honesty of the testimony and reliability which focuses on the accuracy of testimony given. College Counsel also reminded the Panel that a panel can accept some or all of a witness' testimony, and can likewise reject some or all of a witness' testimony.

College Counsel submitted that in assessing credibility, the Panel should focus on the following:

1. cogency and believability of the testimony,
2. deficiencies in the evidence and the reason for same,
3. plausibility of the evidence given,
4. whether the witness appears to have exaggerated in any way,
5. inconsistencies in the evidence and whether those inconsistencies are minor or significant,
6. whether the witness has an interest in the outcome of the proceeding, and
7. the demeanor and manner of the individual providing testimony

With respect to [the Nurse Manager], the College submits that she was credible in that she was honest and forthright. She was forthright in particular about what she did and did not know. [The Nurse Manager] was clear she was not present for the events at issue, but was knowledgeable about hospital policies, practices and layout. The College submitted that [the Nurse Manager] was also a reliable witness in that she was reasonable and consistent with the documentation, and gave testimony which was generally consistent with the testimony of [the Physician] and the Member himself.

In regards to [the Physician], College Counsel submits that he presented as a very experienced ER Physician. In terms of credibility, College submitted that he was frank and honest, particularly about the fact that he could not independently remember the Complainant or the specific

interaction. The College submits that his testimony was both credible and reliable and his evidence was internally and externally consistent with [the Nurse Manager], hospital policy and the medical documentation.

Regarding [the Complainant], the College submitted that there have been no submissions in the hearing to suggest he was dishonest or lacking credibility. College Counsel clarified the main issue of focus here is on reliability and that looking at his evidence as a whole including his memory of the essential events, he gave detailed, complete and seemingly accurate evidence. College Counsel went on to say there were no logical gaps, no implausibilities, and that [the Complainant] showed a willingness to admit when he could not recall something. In terms of his manner and demeanor, College Counsel submitted that [the Complainant] was frank and forthright. While recounting what was obviously a difficult event, [the Complainant] showed an emotional response which was appropriate given the subject matter. The Panel was advised that [the Complainant's] version of events was plausible, not exaggerated and finally that [the Complainant] has no interest or motive to lie. College Counsel submitted that for all the above reasons, the Panel should find [the Complainant's] testimony to be extremely credible and reliable.

With respect to the Member, the College submitted that he does, obviously have an interest in the outcome of the proceedings and that both his honesty and his reliability are very much an issue. On the issue of honesty, College Counsel suggested that the Member became evasive and defensive in response to straightforward questions while under cross-examination. Counsel for the College pointed out that on several points, the Member changed his evidence when the answers previously given were inconvenient or inconsistent. In terms of reliability, College Counsel reminded the Panel that the Member could not recall the events at all and that in that respect his evidence was completely unreliable. Counsel argued that compared to the Complainant's recollection and detailed description, the Member's lack of recall was problematic.

*Addressing allegations of professional misconduct*

College Counsel submitted that if the Panel finds that the conduct occurred then there is no question that the conduct was sexual in nature, inappropriate and that the College has met its burden of proof in the circumstances.

Similarly, with respect to the breach of the standards, College Counsel argued that if the Panel finds that the conduct occurred (the touching and/or the verbal comments), then the Panel should have no difficulty finding that such conduct amounts to a breach of the standards.

Finally, in regards to allegation 3, College Counsel submitted that if the Panel makes findings, the conduct would clearly fit all three areas; disgraceful, dishonourable and unprofessional. College Counsel explained the conduct was serious, had elements of moral failing and casts serious doubt on the Member's professional obligations.

*Member's Submissions*

Counsel for the Member reminded the Panel that an Agreed Statement of Facts was reached by both parties about what would constitute professional misconduct, and that the purpose was to hone in on

the essential issue which was: has the College established on a balance of probabilities that the conduct occurred as alleged.

Member's Counsel agreed with the College's submission with respect to the burden and standard of proof and with the caution to the Panel by the College to avoid relying on improper considerations to reach the decision. Counsel did note however, that the delay in reporting did create some difficulties for the witnesses to remember details. For example, Counsel reminded the Panel that neither the Member nor [the Physician] had an independent recollection of the Complainant or the particular visit at issue. Counsel explained that [the Physician] was clear he could only rely on the charting and only put together a vague recollection of the events at issue. Counsel for the Member submitted that the Member himself has no recollection of the events at issue either.

In regards to the preliminary motion hearing, Member's Counsel reminded the Panel that previous counsel sought records that were arguably relevant and that the Panel should not make any adverse decision against the Member for having chosen to bring the motion.

*Assessing Credibility*

Counsel for the Member submitted that [the Nurse Manager] had no direct knowledge of the events that occurred and that she could only confirm the policies and procedures in place at the time. [The Nurse Manager], according to the Member, could only provide commentary on the procedures in the Emergency Department in general and that she could not provide any other relevant details.

Regarding, [the Physician], counsel for the Member explained that he came to testify about the care provided and why the Complainant was at the hospital. Counsel went on to say there were no concerns about his practice at this hearing and that he could not really provide the Panel with any assistance with respect to the alleged incident.

With respect to the Complainant, counsel for the Member acknowledged that there was nothing in his testimony to suggest that he was purposely dishonest. Counsel for the Member however did suggest that the Complainant's testimony was not reliable *enough* to get over the hurdle that it "is more likely than not" that the conduct occurred as alleged. Counsel for the Member argued that the Complainant had his written statement before him while he was testifying. She argued that in the circumstances it was no surprise that the Complainant's testimony was consistent with his written statement.

With respect to the Member, counsel suggested that there was a reasonable explanation as to why the Member's answers appeared to shift in the course of his testimony. Counsel indicated that the Member was testifying in his second language and was asked difficult questions about a situation he could not recall and how he would treat patients in certain situations. Counsel also submitted that College Counsel overstated the external consistency of the other witnesses' testimony. Defence Counsel suggested to the Panel that College Counsel made submissions with respect to the Member's motives, but that he was never examined on his alleged motives. With respect to the issue of whether or not the Complainant may have given a urine sample while on the stretcher,

Member's counsel argued that given that the Complainant had a c-collar and was hooked up to monitors, it was within a range of normal to have differences in practice.

Finally, Counsel for the Member asked the Panel to find that the evidence does not reach the standard of clear, cogent and convincing evidence when taking into consideration the gaps in the various witnesses' memory. Counsel urged the Panel to scrutinize the evidence carefully and suggested that [the Complainant's] testimony was not sufficiently reliable for the College to have discharged its burden. Counsel did acknowledge that if the cleaning took place as the Complainant alleged, then that conduct would amount to sexual abuse.

In reply, College Counsel clarified that minor lapses in memory are to be expected.

In response to the Member's language skills, the College accepted that English is his second language and informed the Panel that there was an inquiry prior to the hearing to see if the Member needed a translator and he declined it.

Finally, in reference to the Complainant's credibility, and him "parroting" his complaint letter, College Counsel reminded the Panel that there were many things [the Complainant] said that were not in the original letter of complaint. College Counsel went on to say that [the Complainant] was able to provide more detailed testimony of the fall that happened in [ ], going to Toronto Western Hospital and how he was touched.

*ILC Advice*

The Panel requested advice from Independent Legal Counsel ("ILC') regarding the next steps for the Panel and any other considerations that must be included in deliberations.

ILC reminded the Panel that the parties' submissions are not evidence and the Panel must focus on the evidence included in the Book of Documents and what the witnesses have said. ILC also reiterated that any evidence heard on the preliminary motion was not before the Panel at this hearing and should play no role in the Panel's decision.

ILC advised that the Notice of Hearing sets out three separate allegations of professional misconduct. Even though the underlying facts are the same, ILC reminded the Panel that they are to make findings on the three separate allegations of misconduct. In order to make a decision, the Panel needs to look at the factual findings and whether or not they amount to professional misconduct.

ILC agreed that the burden is on the College in this case and that the College must satisfy the Panel that the events occurred as alleged on a balance on probabilities. ILC also advised that the Panel must scrutinize the evidence carefully and that the evidence must be clear, cogent and convincing in order to meet the standard of proof.

ILC reminded the Panel that in this case, both parties entered into an ASF and the Panel can treat those facts as undisputed and proven. ILC advised that if the Panel believes the Complainant's version of events then according to the ASF the cleaning of the genitals and the comment would

have no clinical purpose and amount to breaches of the *Therapeutic Nurse-Client Relationship* Standard. ILC also clarified some undisputed facts not indicated in the ASF including;

1. the date [the Complainant] came to the Hospital,

2. that the Member was the nurse that treated [the Complainant], and

3. the circumstances [the Complainant] found himself at the Hospital.

In assessing credibility, ILC indicated that it is not an all or nothing proposition. The Panel, does not have to find all parts of a witness's testimony to be credible and can in fact find some or no parts credible.

**Decision**

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i), 2(a)(i), 3(a)(i), and 3(b)(i) of the Notice of Hearing. With respect to allegations 3(a)(i) and 3(b)(i), the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional by engaging in touching of a sexual nature and breaching the therapeutic boundaries of the nurse-client relationship.

With respect to allegation 1(a)(ii), 2(a)(ii), 3(a)(ii), and 3(b)(ii) having considered the evidence and the onus and standard of proof, the Panel is unable to make findings that the Member committed acts of professional misconduct.

**Reasons for Decision**

The Panel undertook credibility assessments of each witness, using the criteria as set out in *Pitts v. Ontario (Director of Family Benefits, Ministry of Community & Social Services), 1985.* The Panel also considered the evidence of each of the witnesses both individually and taken together with attention to their evidence, explanations for any inconsistencies, and the potential impact any inconsistencies would have on their credibility and reliability.

With respect to [the Nurse Manager's] testimony, she readily admitted that she never witnessed any interaction between the Member and the Complainant and that the entirety of her knowledge was based on documents received from the College and the medical records. The Panel found that any discrepancies in her testimony were not relevant to the allegations.

Regarding [the Physician], he could not independently remember [the Complainant] and had to refer to the Complainant's chart. His testimony was externally consistent with [the Nurse Manager] in relation to hospital policies and his notes in the record.

As discussed above, [the Complainant] presented to the Panel as well prepared, and was able to provide answers to questions both in chief and under cross examination that were clear and forthright. He described the events in a manner consistent with his original complaint. The Panel considered all portions of his testimony and acknowledged there were gaps in [the Complainant's] memory. For example, the Complainant could not remember having an ECG done but confirmed it was in his health records. As well, the Complainant could not remember which arm he was given his tetanus shot or which health professional administered the tetanus shot or his pain medications. Conversely the depth of detail in which the Complainant was able to provide regarding the key issues at hand was specific and clearly articulated. In determining the reliability of the Complainant's testimony, it is also noted that his emotional response and candour was appropriate and made his story even more convincing. It is understandable that when providing details of such a personal and intimate nature he would show hesitance and frustration. Moreover, in assessing credibility the Panel notes that the Complainant seemed to honestly believe what he was saying and had no apparent reason why he would not be telling the truth. The Panel was challenged to weigh the gaps in his memory and determine if his testimony was reasonable and consistent and ultimately came to the conclusion that the Complainant was credible and reasonably reliable.

In terms of the Member's testimony, it was clear that he had no independent memory of the Complainant or any events on the date in question. Moreover, the Member relied wholly on documentary evidence. The Panel acknowledges the Member worked in a busy emergency department and potentially had to see numerous patients during his shift, which potentially could compound issues in memory recall.

The documentary evidence considered in combination with all witnesses' testimony established for the Panel a detailed timeline of events. The Member, according to the notes, entered acute bay #9 at 2213hrs and then left and processed the urine dip at 2228hrs. With no further evidence to complete the timeline during the aforementioned period, the Panel is left with 15 minutes in which the Member could have been alone with the Complainant. According to his testimony, the Member met the Complainant in acute bay #9, conducted a nursing assessment which included checking vital signs, breathing, bowel sounds, skin integrity and pain. The Panel considered the moderate amount of charting by the nurse and that 15 minutes would provide sufficient time for the Member to conduct his assessments and conduct the inappropriate cleaning as alleged.

When taking into consideration the Member's testimony as a whole, the major gap that remains is the circumstance surrounding exactly how the urine specimen was collected. In his examination in chief the Member's counsel asked, *"If you have a patient with a c-collar on and you believe a urine test should be completed, how would you do it?"* The Member responded, *"The Patient was in acute area, normally we keep them in their room. According to the chart he was lying in bed and we explain to the patient what we are going to do."* The Member continued his answer adding, *"The easy way with a c-collar is that we prefer keeping the patient in the room."* The testimony in conjunction with the timelines convinced the Panel that the alleged incident occurred as described by the Complainant.

The Panel considered each allegation individually. With respect to the physical sexual abuse, the witness's oral evidence was supported in large part by the documentary evidence. It was clear, for example, that there was enough time for the Member to have engaged in the physical misconduct,

based solely on the time recorded in the records. The Member's own testimony was that a c-collar patient should be kept in bed for a urine sample, yet it appears the Member took no precaution to secure the Complainant's neck by performing a log roll or by seeking assistance from another nurse. [The Nurse Manager] and [the Physician] offered the Panel alternatives for the patient's urine sample such as that a stable, ambulatory patient could walk to the bathroom or stand at the bedside for a routine urine dip. There was no indication for a mid-stream urine collection and there is no evidence that that type of collection was obtained - only urine for dip analysis. Indeed in examination-in-chief and in cross examination, there was little questioning on this matter. The Complainant was emphatic that the allegation occurred; the Member was certain it did not and the Panel was satisfied that the Complainant's recollection of the events was sufficient and that the events occurred during this time frame.

With respect to the alleged comment, while the Panel found the Complainant credible, the Panel was not satisfied that it could rely on his memory alone with respect to this part of the alleged incident. As such, the Panel could not find that on a balance of probabilities the comments were made as alleged. To be clear, the Panel should not be taken as disbelieving the Complainant with respect to this aspect of his complaint. The Panel simply finds that the College did not meet its burden with respect to this allegation.

Having determined each witness's level of credibility and reliability, the Panel reviewed the College's practice standard: *Therapeutic Nurse-Client Relationship, rev 2006* which states, *"The intent of the nurse does not justify a misuse of power within the nurse-client relationship."* Such behaviours are below the standards expected by the public and set out in various documents published and updated by the College.

The Panel is of the opinion that the Member's conduct was disgraceful, dishonourable and unprofessional. In coming to their conclusion the Panel relied heavily on definitions set out in previous cases. The conduct that occurred on May 28th, 2012 shows a serious disregard for the Member's professional obligations, has elements of moral failing, and casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects nurses to meet.

I, Susan Roger, 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.