SUPREME COURT OF PRINCE EDWARD ISLAND

Citation: *Llewellyn v. College of Registered Nurses and Midwives of P.E.I.*, 2024 PESC 41

Date: 20241001
Docket: S1-GS-29927
Registry: Charlottetown

Between:

Tonya Llewellyn

Appellant

And:

College of Registered Nurses and Midwives of Prince Edward Island

Respondent

Before: The Honourable Justice Sophie MacDonald

Appearances:
Catherine A. Fawcett, K.C., lawyer for the Appellant
Douglas R. Drysdale, K.C., lawyer for the Respondent

Place and date of hearing - Charlottetown, Prince Edward Island
April 3, 2024

Place and date of written decision - Charlottetown, Prince Edward Island
October 1, 2024

HEALTH LAW – *Regulation of health professionals – Nurses – Discipline*

The appellant, a nurse, was found guilty of one count of professional misconduct by a Hearing Committee of the College of Registered Nurses and Midwives of Prince Edward Island.

The appellant appealed on five different grounds. In the first ground of appeal, the appellant alleged that the Hearing Committee made a determination of professional misconduct and imposed penalty based on allegations that were outside the scope of the Notice of Hearing. The Court held that the appellant had sufficient notice of all allegations and was given an opportunity to address all issues that arose during the hearing that did not form part of the Notice of Hearing. In the second ground of appeal, the appellant alleged that the Hearing Committee relied upon unreliable/untested/no evidence or failed to consider material evidence. The Court held that on the standard of review of palpable and overring error, the appellant did not meet this high standard to challenge the findings of the Hearing Committee. In the third ground of appeal, the appellant argued that the College had failed to provide reasons for the finding of professional misconduct prior to the parties making submissions in relation to penalty. The Court held that the administrative tribunal is given the authority to determine its own process, and the appellant was provided with sufficient detail to address the issue of appropriate penalty once the determination of professional misconduct had been made. In the fourth ground of appeal, the appellant alleged that the Hearing Committee had failed to meet its statutory timeline for rendering its decision. The Court held that given the public nature of the Hearing Committee, that the provisions in question were directory and not mandatory. In the fifth ground of appeal, the appellant argued that the penalty issued was clearly wrong. The Court held that the appellant had not established that the penalty was unfit. All grounds of appeal were dismissed.

STATUTES REFERRED TO*: *Regulated Health Professions Act, R.S.P.E.I. 1988, Cap. R-10.1

CASES CONSIDERED*: *Canada (Minister of Citizenship and Immigration) v. Vavilov, 2019 SCC 65; ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2022 PESC 36, affirmed in ***Llewellyn v. College of Registered Nurses of PEI***, 2024 PECA 15 ; ***Bruce Liberman v. College of Physicians and Surgeons of Ontario***, 2013 ONSC 4066; ***Venneri v. College of Chiropractors of Ontario*** (2008), 238 O.A.C. 143; ***Swart v. College of Physicians and Surgeons of P.E.I.***, 2014 PECA 20; ***Law Society of Saskatchewan v. Abrametz***, 2022 SCC 29; ***Millenium Pharmaceuticals Inc. v. Teva Canada Limited***, 2019 FCA 273; ***Re Therrien***, 2001 SCC 35; ***The New Brunswick Real Estate Association v. Moore,*** 2007 NBCA 64, leave to appeal refused [2007] S.C.C.A. No. 510;; ***Doiron v. WCB (Prince Edward Island)***, 2018 PECA 20; ***Merchant v. Law Society of Saskatchewan***, 2014 SKCA 56; ***Rahman v. Alberta College and Association of Respiratory Therapy***, 2001 ABQB 222; ***Shaw v. Law Society (Prince Edward Island)***, (1992) 97 D.L.R. (4th) 504; ***College of Nurses (Ontario) v. Eng*** (1995), 84 O.A.C. 314; ***College of Nurses of Ontario v. Klein***, 2019 CanLII 129302

(ON CNO); ***College of Nurses of Ontario v. Fu***, 2020 CanLII 115987 (ON CNO); ***MacDonald***, ARNPEI Professional Conduct Review Committee, Complaint #PE-2013-002; ***MacInnis***, ARNPEI Hearing Committee, Complaint #2018-001; ***Mariwande***, ARNPEI Hearing Committee, Complaint #2019-005; ***Quaidoo v. Edmonton Police Services***, 2015 ABCA 381; ***Law Society v. Merchant***, 2020 SKLSS 6.

MacDonald, J.:

I. Introduction

[1] The Appellant, Tonya Llewellyn ("Llewellyn"), appealed the Notice of Determination and Orders of the Respondent, the College of Registered Nurses and Midwives of Prince Edward Island (the "College"), dated January 16, 2023.

[2] Llewellyn takes the position that the College erred both in respect of its determination of the one count of misconduct and with respect to the sanctions imposed as a result of the finding of misconduct.

[3] The College argues that Llewellyn has failed to establish any palpable and overriding errors made by the College's Hearing Committee. The College seeks a dismissal of the appeal but does not seek costs.

II. Parties

[4] Llewellyn is a Registered Nurse ("RN") licensed by the College to practice as an RN in Prince Edward Island. She graduated from the UPEI school of nursing in 2006 and started practising as an RN shortly thereafter. Llewellyn worked in the emergency department for over ten years. She also worked as a community health nurse. She started working at the South Shore Villa in early May 2021. The South Shore Villa is a community care and nursing home care facility, which has over 60 beds.

[5] The College is a body corporate responsible for the regulation of the nursing profession in Prince Edward Island. Part of the College's mandate is to enforce practice standards among its members and discipline its members as necessary. The College's authority is set out in the ***Regulated Health Professions Act***, R.S.P.E.I. 1988, Cap. R-10.1 (the "***RHPA***").

III. Background

- *Complaint*

[6] The background facts are taken from the Partial Agreed Statement of Facts and the Decision of the Hearing Committee.

[7] On July 18, 2021, Llewellyn was working as the sole RN at the South Shore Villa. One of the residents of the facility, who had experienced a severe head injury in 1981, had a documented history of angry outbursts, use of foul language and slamming of fists when frustrated. There were specific instances of aggressive behaviour between April-June 2021. The resident had a care plan for his aggressive behaviour, which stated that the resident could get frustrated when he couldn't communicate effectively due to expressive aphasia, and particularly if time was not taken to understand him. The resident was approximately 5 foot 7, weighed 150 lbs, had left-sided weakness, and used either a walker or a cane for walking. He received tube feeding via a G-tube during the day and had a pump on a pole that could be wheeled around.

[8] On the day in question, the resident requested medication for loose bowel movements from the Resident Care Worker ("RCW") on duty. The RCW advised the resident that she needed to check with the RN, as per the policy at South Shore Villa. The resident began cursing when he was told by the RCW that she had to get approval from the RN. The RCW left the resident's room to seek out Llewellyn at the nurses' station and to obtain the medication from the medication cart. Llewellyn headed for the resident's room to discuss the medication and his behaviour toward the RCW.

[9] Before Llewellyn reached the patient's room, the resident was out of his room and approached the nurses' station in an agitated state. The resident asked to see the *"head nurse"* several times and Llewellyn advised him she was the head nurse. Her response seemed to further agitate him. Llewellyn asked the resident to return to his room. He ignored her request and continued forward and shoved his walker into her legs (causing bruising) and began to lift his hand toward Llewellyn. Llewellyn was able to block the resident's hand, and she held his wrist to prevent further acts of violence until he turned to go back to his room. He then returned to his room without further incident.

[10] After the resident had returned to his room, Llewellyn returned to the nurses' station and called 911 for police and an ambulance to take the resident to the hospital for an assessment. The police arrived at the facility but were not required to intervene. The ambulance attended and the resident left the facility calmly for an assessment at the Emergency Department.

[11] Llewellyn testified that she made attempts to reach her supervisor and the on-call physician for the South Shore Villa but did not have any success. Her supervisor disputed that attempts were made by Llewellyn to reach her.

[12] The emergency room physician, in consultation with the on-call physician for the South Shore Villa, made the decision to return the resident to the South Shore Villa. After this decision was made, Llewellyn spoke with the on-call physician, and they agreed that a short-term solution for the resident's aggressive behaviours would be a one-time dose of Haldol.

[13] The resident was returned to the South Shore Villa by ambulance at approximately 6:55 p.m. There were two paramedics completing the transport back to the facility.

[14] Llewellyn met the resident outside of the doors of the facility. The paramedics testified that the resident was calm and appropriate during the transfer. They were met outside the front doors of the facility by Llewellyn. Llewellyn spoke with the resident prior to letting the paramedics enter the facility with the resident. She was standing in front of the resident's elevated stretcher while speaking with him. The paramedics reported that Llewellyn was waving her hand at the resident. The paramedics noted that the resident was getting agitated as the interaction was occurring. They felt that Llewellyn was communicating with the resident in a non-therapeutic manner. They interpreted her communication with him as threatening and inappropriate. One of the paramedics stepped in between Llewellyn and the resident and addressed the way Llewellyn was speaking to the resident. They stated that the resident was in an unsafe position on the elevated stretcher. The paramedics were concerned with the resident's safety. The stretcher was repositioned to a safer position and Llewellyn continued to communicate in what the paramedics described as an aggressive manner. They reported that she told the resident that if his behaviour did not improve, she could *"needle him with Haldol"*. Llewellyn then let the paramedics return the resident to his room inside the facility and settle him in. Llewellyn did not attend the resident's room or interact any further with him or the paramedics that evening, as her shift was over.

[15] The paramedics returned to their ambulance and drove down the road a bit to make a call to their supervisor. They proceeded to report the interaction between Llewellyn and the resident. Their supervisor then contacted Llewellyn's supervisor.

[16] Both paramedics described the interaction with Llewelyn and the resident as aggressive and threatening. Llewellyn agreed that she raised her hand while speaking with the resident, but she says only to demonstrate a bulleted list of points. She felt that saying she would *"needle him with Haldol"* was an appropriate reference to the medication, as that phrase is used in emergency services regularly.

[17] A complaint was filed against Llewellyn on July 26, 2021, by Llewellyn's supervisor at the South Shore Villa. Following a meeting of the Investigation Committee, the complaint was referred to a Hearing Committee on May 2, 2022. A Formal Notice of Hearing was issued on June 17, 2022, and a hearing proceeded on that date before the Hearing Committee of the College ("Hearing Committee").

- *Hearing*

[18] At the commencement of the hearing on July 17, 2022, counsel for the parties advised the Hearing Committee that they had agreed to bifurcate the hearing. First, evidence and submissions would be heard in relation to the allegations of professional misconduct, followed by a finding by the Hearing Committee on the issue of professional

misconduct. Second, if necessary, submissions would be heard from the parties in relation to penalty and a finding on penalty would be made by the Hearing Committee. The Hearing Committee agreed to proceed as requested by the parties.

[19] The hearing lasted two days. The Hearing Committee had documents to consider, such as the complaint by Llewellyn's supervisor, Llewellyn's written response, the Agreed Partial Statement of Facts, and other jointly introduced documents. The College called two witnesses: the two paramedics who returned the resident to the South Shore Villa. Llewellyn called two witnesses: the RCW involved with the resident earlier that day and Llewellyn.

[20] The Hearing Committee issued a decision on September 21, 2022, finding Llewellyn guilty of professional misconduct. There was one finding of guilt, and limited details were provided in this initial decision. The parties were then provided with an opportunity to make written submissions in relation to penalty.

[21] On January 16, 2023, the Hearing Committee issued a Notice of Determination and Orders (the "Decision"). In the Decision, the Hearing Committee determined that Llewellyn had contravened Standards of Practice 2.1, 2.3, 2.6, 3.2, 3.4, 3.5, 4.1, 4.4 and 5.8 and Codes of Ethics A.2, A.3, A.5, A.13, C.1 and F.3. They determined that these violations amounted to professional misconduct under Section 57 (1) (a) of the ***RHPA***. The Hearing Committee provided reasons for their finding of breach of each Standard of Practice and Code of Ethics in its Decision.

[22] In determining penalty, the Hearing Committee noted that Llewellyn had a previous complaint and subsequent hearing in which there were conditions placed on her license. The Hearing Committee noted that the conditions resulting from this previous hearing had not been met by Llewellyn and she had been continuing to practice as a registered nurse. The Hearing Committee viewed that this confirmed that she had not taken responsibility/accountability for her previous actions and that this was consistent with her attitude in what she presented at the hearing on this complaint.

[23] The Committee imposed the following penalty on Llewellyn:

1. 4-day suspension;
2. Llewellyn to complete an anger management course;
3. every 6 months for the next 3 years after her suspension, Llewellyn would submit to a workplace audit;
4. Llewellyn to pay $10,000 in expenses of the hearing within 24 months;
5. provide a copy of the Decision to any employer until all conditions had been satisfied;

6. complete the conditions of the previous complaint; and

7. if she failed to comply with any of the conditions of the Decision, the Hearing Committee would review the circumstances and might suspend her or add other orders.

[24] Llewellyn has appealed the Decision, pursuant to Section 59 (2) of the ***RHPA***. Pursuant to Section 59 (4) of the ***RHPA***, the Court on an appeal can confirm, revoke or vary the order appealed from, refer the matter back to the Hearing Committee for further consideration or provide any direction that it considers appropriate.

IV. Standards of review

[25] The standards of review applicable in the review of the Decision by this Court is the starting point.

[26] The parties agree that, in accordance with ***Canada (Minister of Citizenship and Immigration) v. Vavilov***, 2019 SCC 65, in this case now before the Court, the standard of review for questions of law (including statutory interpretation and scope of authority) is correctness, and that for questions of fact and questions of mixed fact and law, the standard of review is palpable and overriding error.

[27] The Court in ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2022 PESC 36 (affirmed in ***Llewellyn v. College of Registered Nurses of PEI***, 2024 PECA 15), confirmed that in conducting a review of a decision of a disciplinary committee of the College that the applicable standard of review is as follows:

> [19] I am satisfied that, in accordance with ***Vavilov***, the applicable standards of review in this case must be determined by applying appellate standards to the decision (para. 37). This means that, in considering questions of law, including statutory interpretation and scope of authority, the standard of correctness is to be applied. For questions of fact, or those of mixed fact and law where the legal principle is not readily extricable, the standard of review is palpable and overriding error.

[28] The Court agrees that these are the appropriate standards of review.

V. Issues

[29] Llewellyn has raised five grounds of appeal, namely:

A. that the Hearing Committee made a determination of professional misconduct and penalty based upon allegations that were outside of the scope of the Notice of Hearing;

B. that the Hearing Committee relied upon unreliable or untested or no evidence, or failed to consider material evidence;

C. that the Hearing Committee failed to provide reasons prior to submissions being made in relation to penalty;

D. that the Hearing Committee failed to comply with the ***RPHA***; and

E. that the Decision is clearly wrong.

[30] Each ground will be reviewed below.

VI. Analysis

A. The Hearing Committee make a determination based upon allegations that were outside of the Notice of Hearing

[31] Llewellyn argues that the Hearing Committee made findings outside of the scope of their legal authority. She points to two different examples of this, namely:

i. the Hearing Committee made findings outside of the Notice of Hearing; and

ii. the Hearing Committee made findings on allegations withdrawn by the College

[32] Each of these allegations will be reviewed below. As this ground of appeal relates to the Hearing Committee's scope of authority, the standard of review is correctness.

i. *The Hearing Committee made findings outside of the Notice of Hearing*

[33] Llewellyn argues that the Hearing Committee made findings of professional misconduct based on events that took place earlier in the day, and not solely surrounding the interaction with the resident when he was being returned to the South Shore Villa.

[34] The Notice of Hearing issued June 17, 2022, indicated as follows:

> The allegations which will be considered at the hearing relate to the following incident:
>
> On July 18, 2021, **while interacting with a resident being returned to the South Shore Villa by EMS personnel**, you engaged in conduct that violated section 57 (1) (a) of the *Act*, the following excerpts of the Nursing Standards of Practice:
>
> 1.4, 1.6
> 2.1, 2.2, 2.3, 2.4, 2.6, 2.7, 2.9
> 3.2, 3.3, 3.4, 3.5, 3.6, 3.8
> 4.1, 4.4, 4.7

> 5.1, 5.2, 5.3, 5.5, 5.8
>
> and the following experts from the Canadian Nurses Association Code of Ethics for Registered Nurses:
>
> A. 1, 2, 3, 4, 5, 6, 7, 8, 12, 13;
> B. 1,4;
> C. 1, 2, 6, 7;
> F. 1,3
>
> [Emphasis Added]

[35] Also forming part of the Notice of Hearing were details regarding commencement time and location of the hearing, as well as attaching as a Schedule the text of the provisions that Llewellyn was alleged to have breached.

[36] The Chair of the Hearing Committee noted in his opening comments that a written Notice of Hearing had been sent to Llewellyn, was provided to the members of the Hearing Committee, and that it described the charges that had been made against Llewellyn which would be the subject of the hearing.

[37] The written notice from the Investigation Committee dated May 2, 2022, which referred the matter to the Hearing Committee, contained slightly different language that did not limit the complaint to incidents around the return of the resident to the South Shore Villa. This notice stated:

> We offer the following information to assist the Registrar to prepare a written notice for the hearing: the misconduct, if any, **relates to Tonya Llewellyn's actions, decisions and comments at the South Shore Villa in Crapaud, Prince Edward Island on July 18, 2021, during her interaction with a resident at the Villa**. The following conduct should be reviewed at the hearing:
>
> a. Tonya Llewellyn's actions, demeanour and attitude at the time the resident was being returned to the Villa by EMS personnel.
>
> [Emphasis Added]

[38] Section 56 (1) (c) of the ***RHPA*** provides the Hearing Committee with the authority to *"hear any matter in addition to the complaint before the hearing committee that arises in the course of its proceedings and that may demonstrate, in respect of the respondent, professional misconduct or incompetence"*. Where the Hearing Committee hears such an additional matter, it must give the respondent a reasonable opportunity to respond to the matter (See Section 56 (2) of the ***RHPA***).

[39] While the Court would have been concerned that the initial Notice of Hearing provided to Llewellyn appeared to be limited to the events that surrounded the return of the resident to the South Shore Villa, a review of the evidence, oral submissions and

written submissions confirm that Llewellyn was given the opportunity to address in detail the interactions with the resident throughout the entirety of the day on July 18, 2021, and in relation to her treatment of the resident throughout her time working for the South Shore Villa. Not only was Llewellyn given the opportunity to address what took place during the entirety of her interactions with the resident, but she in fact also addressed it in detail in her evidence and in her counsel's submissions. As she did not raise the issue of additional events being taken into account by the Hearing Committee without proper notice, Llewellyn cannot now raise it on the appeal of the Decision of the Hearing Committee (See: ***Bruce Liberman v. College of Physicians and Surgeons of Ontario***, 2013 ONSC 4066, at para. 40) and ***Venneri v. College of Chiropractors of Ontario*** (2008), 238 O.A.C. 143, at par. 32).

[40] Llewellyn spent a significant amount of time in her direct examination detailing her interactions with the resident, and in no way limited herself to the interactions on the resident's return to the facility. Llewellyn only called one witness, other than herself, and this witness' testimony was limited to events prior to the return of the resident to the facility. The RCW had no interactions with the resident or Llewellyn around the return of the resident to the facility. The 18-paragraph Agreed Partial Statement of Facts contains only 3 paragraphs dealing with the interaction when the resident was returned to the facility and the remainder details the events that led up to the interaction. Having herself put the additional evidence forward, Llewellyn cannot on appeal argue that procedural fairness was breached in relation to providing her with notice of the evidence that the Hearing Committee would consider. The Hearing Committee's primary goal in disciplinary matters is the protection of the public. If evidence comes before the Hearing Committee during a hearing that the Hearing Committee believes demonstrates a breach of the standards of practice or the ethical standards, it is the duty of the Hearing Committee to address these concerns through their disciplinary process. Section 56 (1) (c) of the ***RHPA*** specifically provides for this situation. Procedural fairness is achieved by mandating that the Hearing Committee must give the member an opportunity to address these additional matters. Llewellyn was clearly given the opportunity to address the additional concerns, and she in fact provided a significant amount of evidence in relation to these additional concerns.

ii. *The Hearing Committee made findings on allegations withdrawn by the College*

[41] Llewellyn also takes the position that the College in fact withdrew some of its allegations at the hearing, when counsel for the College stated that it was not asking the Committee to make findings on all 41 allegations. In its written submissions, counsel for the College stated as follows:

> 56. The College submits that Ms. Llewellyn's actions on the evening of July 18, 2021, constitute professional misconduct under s. 57 (1) (a) of the *Regulated Health Professions Act* (Exhibit #4, tab 3). The investigation committee made findings that Ms. Llewellyn was in contravention of 41 sections of the *Standards of Practice – Registered*

> *Nurses* (the "*Standards*") (tab 2) and the *Code of Ethics for Registered Nurses* (the "*Code*") (tab 1). **The College is not asking the Hearing Panel to make findings on all 41 allegations.**
>
> 57. **The sections of the *Standards* and *Code* that are most relevant to this matter are outlined below.** The bullet points, below each section, briefly connect the lengthy evidence to the applicable sections of the *Standards* and *Code*. The College views the evidence to establish a violation of each of the sections as follows:
>
> [Emphasis added]

[42] The written submissions by the College did not refer to Standards of Practice 2.1 and 5.8 and Code of Ethics A13, and the Hearing Committee made a finding of violation of these sections.

[43] The Court does not agree that the College withdrew any of the allegations against Llewellyn in its submissions to the Hearing Committee. The College chose to concentrate on what it viewed as the most applicable standards of practice to the fact situation. It reminded the Hearing Committee that it did not need to a find a breach of all allegations to find Llewellyn guilty of professional misconduct. It remained open to the Hearing Committee to find a breach of the standards of practice not addressed by the College in its submissions. Llewellyn was provided with notice of the allegations in the Notice of Hearing. The Notice of Hearing included reference to these alleged breaches.

[44] I find for the reasons set out above that the first ground of appeal fails.

B. The Hearing Committee relied upon unreliable or untested evidence or no evidence, or failed to consider material evidence

[45] Llewellyn argues that the Hearing Committee based many of its findings on unreliable hearsay, made findings notwithstanding a lack of evidence or failed to consider material evidence that was properly before it. Llewellyn provides various examples of what she alleges are improper findings.

[46] As this ground of appeal related to a questions of fact, or mixed facts and law, the standard of review is palpable and overriding error.

[47] The analysis of the evidence reviewed by the Hearing Committee must start with a review of the statutory authority for the administrative tribunal to accept evidence. Section 56 (6) of the ***RHPA*** provides that a Hearing Committee is not bound by the strict rules of evidence or the provisions of the *Evidence Act*, R.S.P.E.I. 1988 Cap. E-11. This was further confirmed with counsel at the hearing.

[48] It is also noteworthy that the evidence now being argued to have been improperly relied upon by the Committee was submitted by way of a Joint Book of Documents by

counsel for the parties. Llewellyn never raised concerns regarding hearsay during the hearing or in her submissions.

[49] Parties can't wait until after the decision is rendered to raise concerns about evidence before the Hearing Committee. If concerns had been raised in relation to the reliability or credibility of statements found in jointly submitted documents before the Hearing Committee, the author of the documents (i.e. Llewellyn's supervisor, the on-call physician at the South Shore Villa, etc.) could have been called to provide evidence.

[50] Llewellyn relies on the decision of the Prince Edward Island Court of Appeal in ***Swart v. College of Physicians and Surgeons of P.E.I.***, 2014 PECA 20 ("***Swart***"), in support of this ground of appeal. In particular, Llewellyn argues that the acceptance of hearsay evidence can result in a denial of justice and that committee members are not entitled to rely on their own expertise in reaching conclusions. In reviewing this case, it is important to note that it involved the application of a very different legislative regime. The legislation in the ***Swart*** case stated that the rules of evidence in disciplinary proceedings were those of a civil case in the Supreme Court. Section 56 (6) of the ***RHPA***, as reviewed above, specifically provides for relaxed rules of evidence. Therefore, the principles from the ***Swart*** decision must be taken into consideration with caution.

[51] The Court agrees that administrative tribunals do owe a duty of procedural fairness as set out as follows in ***Swart***:

> [64] In any event, there is a duty of procedural fairness at common law. It is a basic principle that a tribunal considering allegations of professional misconduct or fitness to practice has a duty to conduct its proceedings in accordance with the requirements of natural justice. The autonomy of decision-making in a tribunal in pursuit of its legislative mandate and the protection of procedural fairness to the member of the profession whose right to practice and reputation are at stake must be balanced. On the one hand, it would be wrong to hold the tribunal discharging its quasi-judicial duties to the highest standard of technical performance expected of a court, it being sufficient that the case be heard in a judicial spirit in accordance with the principles of *"substantial justice"*. On the other hand, a tribunal must observe the principles of natural justice, which is only *"fair play in action."* The requirements will vary depending on circumstances of the case, the nature of the inquiry, the rules under which the tribunal is acting, and the subject matter being dealt with.

[52] Section 56 (6) of the ***RHPA*** gives the Hearing Committee wide discretion in considering the evidence presented at the hearing. The Hearing Committee was a specialized administrative tribunal put together for the purpose of adjudicating disciplinary complaints. In doing so, the members could not draw conclusions based on their own training, however, the could and were expected to use this personal knowledge to evaluate the evidence before them. This is described as follows in ***Swart***:

> [66] ...
>
> Utilizing professional expertise of a tribunal also attracts appellate scrutiny. It is generally considered useful to have members of the profession sitting on a disciplinary panel. It is perceived these persons are, because of their background in the best position to judge professional conduct, and to understand the technical evidence that can come before a tribunal. However, tribunal findings must be based on evidence. The natural desire of a committee member to utilize his or her own technical knowledge in assisting with the tribunal's judgment of the case cannot extend to infringing the basic rule that a disciplinary tribunal is to base its decision only on the evidence presented before it. This assures the professional being judged has a proper opportunity to hear the evidence and reply to it. A tribunal finding based on information which has not presented before the tribunal as evidence both amounts to a denial of natural justice and also contravenes the legislative direction that the Committee is to *"hear the evidence and ascertain the facts ..."*. See, for example ***Ridall v. College of Nurses (Ontario)***, 1983 1 Admin. Law Reports 278, at p.288 (Ont.C.A.). A disciplinary tribunal concluded without evidence being presented to it that a nurse made errors that endangered the life of patients assigned to her care. The Ontario Court of Appeal allowed the appeal against penalty and remitted the disposition back to the tribunal. But not every comment in the reasons of a tribunal will vitiate a decision. An appeal court considers the decision as a whole and whether an impugned comment or line of analysis detracts from the integrity of the decision (***DelCore v. College of Pharmacists (Ontario)*** (1985), D.L.R. (4th) 68, (Ont.C.A.), which held that a rhetorical comment by the tribunal affected sanction but not the finding of professional misconduct). The general view is that a decision of a disciplinary tribunal must be based on the evidence presented before the tribunal despite the specialized knowledge of the tribunal members. Personal technical knowledge of a tribunal member can be used only in assessing the evidence, including whether the conduct constitutes professional misconduct or unfitness to practice. Committee members are not entitled to rely on their own knowledge and expertise in support of the conclusion (***Bennet v. Registered Psychiatric Nurses Association (Manitoba)*** 2003 MBCA 69 (Man.C.A.)).

[53] While Llewellyn seeks for this Court to analyze all of the individual conclusions reached by the Hearing Committee in its decision in isolation and find that there was insufficient or improper conclusions reached, the appellate standard of review is clear that this is not the role of this Court. The Supreme Court of Canada in ***Law Society of Saskatchewan v. Abrametz***, 2022 SCC 29, addressed this point as follows:

> [113] One must ask, under a deferential standard of review, is this what appellate courts are called on to do? The "primary role" of the Hearing Committee was "to weigh and assess voluminous quantities of evidence": *Housen*, at para. 18. An appellate court is not free to interfere with factual conclusions merely because it disagrees with the

> weight to be assigned to the underlying evidence: para. 23; *Benhaim v. St-Germain*, 2016 SCC 48, [2016] 2 S.C.R. 352; *Hydro-Québec v. Matta*, 2020 SCC 37, at para. 33. An error is *palpable* if it is plainly seen and if all the evidence need not be reconsidered in order to identify it, and is *overriding* if it has affected the result: *Hydro-Québec*, at para. 33; *H.L. v. Canada (Attorney General)*, 2005 SCC 25, [2005] 1 S.C.R. 401, at paras. 55-56 and 69-70; *Salomon v. Matte-Thompson*, 2019 SCC 14, [2019] 1 S.C.R. 729, at para. 33.

[54] The standard of review in relation to findings of fact is overriding and palpable error. The Federal Court of Appeal in ***Millenium Pharmaceuticals Inc. v. Teva Canada Limited***, 2019 FCA 273, provided some useful comments to take into account when looking at alleged errors in the decision of an administrative tribunal:

> [6] Palpable and overriding error is a difficult standard to meet. In one case, this Court explained the standard as one where "[t]he entire tree [must] fall"; "it is not enough to pull at leaves and branches and leave the tree standing": *South Yukon Forest Corp. v. Canada*, 2012 FCA 165, 4 B.L.R. (5th) 31 at para. 46, approved in *Benheim v. St. Germain*, 2016 SCC 48, [2016] 2 S.C.R. 352 at para. 38. In another case, this Court explained the standard as follows:
>
> > "Palpable" means an error that is obvious. Many things can qualify as "palpable." Examples include obvious illogic in the reasons (such as factual findings that cannot sit together), findings made without any admissible evidence or evidence received in accordance with the doctrine of judicial notice, findings based on improper inferences or logical error, and the failure to make findings due to a complete or near-complete disregard of evidence.
> >
> > ...
> >
> > "Overriding" means an error that affects the outcome of the case. It may be that a particular fact should not have been found because there is no evidence to support it. If this palpably wrong fact is excluded but the outcome stands without it, the error is not "overriding." The judgment of the first-instance court remains in place.
> >
> > There may also be situations where a palpable error by itself is not overriding but when seen together with other palpable errors, the outcome of the case can no longer be left to stand. So to speak, the tree is felled not by one decisive chop but by several telling ones.
>
> (*Mahjoub v. Canada (Citizenship and Immigration)*, 2017 FCA 157, [2018] 2 F.C.R. 344 at paras. 62, 64-65)

[55] Applying this very high standard of review, this Court cannot find that the Hearing Committee made any palpable and overriding errors in its Decision. The Hearing Committee reviewed in its Decision the evidence that it viewed as most important, and made findings of credibility when necessary to determine the facts. It was within the

Hearing Committee's discretion to weigh and assess the evidence, and to determine which evidence it deemed to be most reliable. The Court finds that if there were any conclusions improperly reached based on the evidence, or lack of evidence, they did not have affect the end result.

[56] I find for the reasons set out above that the second ground of appeal fails.

C. The failure by the Hearing Committee to provide reasons prior to submissions being made in relation to penalty

[57] As this ground of appeal relates to the scope of authority of the Hearing Committee, the standard of review is correctness.

[58] The Hearing Committee delivered its guilty finding of professional misconduct on September 21, 2022, without providing reasons for its finding. It sought submissions on penalty before delivering its reasons for the finding of professional misconduct. It rendered its reasons and penalty on January 16, 2023.

[59] Section 58 (4) of the ***RHPA*** provides that a hearing committee, within 60 days of a hearing, shall serve written notice of and reasons for the determination.

[60] The issue of bifurcating the hearing was discussed between the Hearing Committee and counsel for the parties at the beginning of the hearing and at the end of the hearing. The parties requested an opportunity to address penalty after a finding of misconduct had been made. Counsel for Llewellyn acknowledged at the end of the hearing that the reasons on the finding of professional misconduct would come much later. She did not raise any objection or concern about making submissions on penalty without having received reasons for the finding of professional misconduct. In the circumstances, the Court cannot find that the bifurcating of the hearing as requested by the parties was procedurally inappropriate.

[61] The Supreme Court of Canada in ***Re Therrien***, 2001 SCC 35, found that a discipline process was not unfair even tough the finding was made in a single report that addressed findings of fact as well as penalty, as the respondent had been made aware of possible sanctions and had been given an opportunity to address them.

[62] It has been recognized that it is within the discretion of the administrative tribunal to determine whether it requires a single hearing where guilt and possible penalty are addressed simultaneously (See ***The New Brunswick Real Estate Association v. Moore,*** 2007 NBCA 64, leave to appeal refused [2007] S.C.C.A. No. 510).

[63] The Prince Edward Island Court of Appeal in ***Llewellyn v. College of Registered Nurses of PEI***, 2024 PECA 15, found that it was an error of law to require the respondent to a complaint to provide submissions on penalty prior to receiving a determination on responsibility and for the tribunal to focus on her lack of remorse in their penalty. I find

that this case is distinguishable as the Hearing Committee in the case now before the Court did provide notice to Llewellyn on September 21, 2022, that they had made a finding of professional misconduct against Llewellyn. They provided in their written notice to her of the finding the standards that they had found that Llewellyn had breached. The parties were then provided until October 3, 2022, to make written submissions with respect to penalty. Llewellyn provided a nine-page submission on the issue of penalty, setting out in the first page the options open to the Committee under Section 58 of the ***RHPA***.

[64] I find that for the reasons set out above that this ground of appeal fails.

D. The Hearing Committee failed to comply with the mandatory statutory provisions

[65] Llewellyn argues that the Hearing Committee failed to comply with two statutory provisions which should nullify the Decision.

[66] As this ground of appeal is a question of law, the standard of review is correctness.

[67] Llewellyn argues that there was a breach of Section 58 (4) of the ***RHPA*** and of Section 57 (1) (a) of the ***RHPA***. Each will be reviewed below.

i. Section 58 (4) of the ***RHPA***

[68] Section 58 (4) of the ***RHPA*** provides that *"within 60 days after the completion of a hearing, a hearing committee shall serve"* a written notice of and reasons for the determination and a copy of any order made to several listed individuals.

[69] At the request of the parties, the hearing was bifurcated. In the circumstances of this case, the Court finds that the hearing was not completed until the written submissions on penalty were received. The parties provided their written submissions on October 17, 2022. The deadline under the ***RHPA*** for the Hearing Committee to provide its decision and orders was therefore December 17, 2022.

[70] The Hearing Committee was aware of this statutory provision and addressed in its Decision the fact that it had not rendered its decision within the legislated time frame:

> Section 58 (4) of the RHPA requires a hearing committee to serve written notice of and reasons for its determination of guilt or innocence, together with a copy of any penalty orders it chooses to make, on the parties, within 60 days after completion of a hearing. We have done our very best to comply with this timeline, but we are not lawyers. In addition, we encountered a number of practical problems along the way, including the fact that our legal counsel was taken ill for a period of time and unavailable, and we also had some trouble communicating by email for a time. We felt an obligation to be complete and clear in our decision, and this took time. We hope the parties will understand.

[71] The College conceded at the hearing before the Court as well did not meet its statutory requirement under Section 58 (4) of the ***RHPA***.

[72] The Prince Edward Island Court of Appeal looked at a similar issue in ***Doiron v. WCB (Prince Edward Island)***, 2018 PECA 20 (***"Doiron"***). The appellant in that case argued that the administrative tribunal exceeded its jurisdiction by failing to provide a decision within 90 days of completion of the hearing as required by the enacting legislation. There was a two-month delay past the legislated 90-day for providing a decision. While the Court of Appeal noted that the word *"shall"* is generally imperative, the word must be considered with the remainder of the legislation as a harmonious whole (See para. 20). The Court of Appeal accepted the case law that has distinguished between enactments relating to the performance of a public duty and provisions affecting private rights. The following was adopted by the Court of Appeal:

> [122] The same issue was considered in ***Montreal Street Railway v. Normandin***, [1917] 33 D.L.R. 195 (Privy Council). That case dealt with composition of jury list which was several years out of date. The court stated:
>
> > The question whether provisions in a statute are directory or imperative has very frequently arisen in this country, but it has been said that no general rule can be laid down, and that in every case the object of the statute must be looked at. The cases and the subject will be found collected in Maxwell Statutes, 5th ed., p. 596 and the following pages. When the provisions of a statute relate to the performance of a public duty and the case is such that to hold null and void acts done in neglect of this duty would work serious inconvenience or injustice to persons who have no control over those entrusted with the duty and at the same time would not promote the main object of the legislature, it has been the practice to hold such provisions to be directory only, and the neglect of them, although punishable, not effecting the validity of the acts done.

[73] In the ***Doiron*** case, the Court of Appeal noted that while failure to adhere to legislative direction was a concern, the consequence of finding the time-period section mandatory would mean that these cases would have to be tried again. This would only add time and expense to the system and was found not to be advancing the main object of the Legislature nor serving the interests of workers, employers or the administrative tribunal. It was noted that the legislation did not provide for any consequences for the failure to meet the time frame.

[74] The ***RHPA*** provides as its purpose the following in Section 1.1 of the ***RHPA***:

> 1.1 Purpose
>
> > The purpose of this Act is to provide for the regulation of certain health professions where it is in the public interest and self-

> regulation of the health professions is appropriate taking into consideration relevant circumstances and factors.

[75] In granting the authority to a profession to self-govern, it is essential that the profession provide a complaint process that permits their regulatory body to protect the general public from practices that fall below the standards of practice. Similarly to the ***Doiron*** case, there are no consequences to the failure to meet the timeline set out in the legislation and I cannot find that there is any serious prejudice by the failure to meet this timeline. I find that this provision is directory only. The failure to meet the strict 60-day requirement for the rendering of the Decision does not nullify the Decision.

[76] In disciplinary cases involving a missed deadline for providing a decision, the Courts have been consistent that the provision is directory rather than mandatory. The Courts have found that where a discipline committee is performing a public duty, rather than resolving a dispute between two private individuals, the complainant, the public and the profession would all suffer injustice and inconvenience if the provision was regarded as mandatory. (See: ***Merchant v. Law Society of Saskatchewan***, 2014 SKCA 56, and ***Rahman v. Alberta College and Association of Respiratory Therapy***, 2001 ABQB 222)

[77] The decision was 31 days late, which is not an inordinate amount of time considering that the Christmas/New Year's holidays took up part of this time. The Hearing Committee addressed its reasons why the decision was late and provided sufficient grounds to justify an extension in the timeframe set out by the legislation.

*ii. Section 57 (1) (a) of the **RHPA***

[78] Llewellyn argues that the Committee did not comply Section 57 (1) (a) of the ***RHPA***, which states:

> 57. (1) The conduct of a respondent may be found to constitute professional misconduct if
>
> (a) the respondent contravenes this Act, the regulations, the bylaws, standards of practice, code of ethics or practice directions in a manner that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practise a regulated health profession;

[79] Llewellyn takes the position that there are 3 steps to finding a member guilty of professional misconduct:

1. A breach of the ***RHPA***, the bylaws, standards of practice, code of ethics, or practice directions;

2. If there is a breach at step one, the breach must, in the opinion of the Hearing Committee, relate to the respondent's suitability to practice; and

3. If the first two steps are met, then the Hearing Committee "may" find the conduct to be professional misconduct.

[80] Cases have recognized that a finding by a discipline committee of a breach of standards of practice do not automatically result in a finding of professional misconduct (See ***Shaw v. Law Society (Prince Edward Island)*** (1992), 97 D.L.R. (4th) 504, and ***College of Nurses (Ontario) v. Eng*** (1995), 84 O.A.C. 314).

[81] Llewellyn argues that the Hearing Committee stopped its analysis at step one and did not conduct a further inquiry as to whether the breach related to Llewellyn's suitability to practice and whether all of the circumstances supported making such a finding.

[82] The Court agrees with Llewellyn that the finding of a breach of standards of practice does not necessarily result in a finding of professional misconduct. The discipline committee must determine, as directed by the legislation, whether the breach relates to the member's suitability to practice. In making this determination, the Hearing Committee has discretion to review all of the circumstances to determine if the conduct constitutes professional misconduct.

[83] The Court finds that in reviewing the Decision, the Hearing Committee in fact conducted the analysis as required. While the Decision is not separated under these headings, the totality of the Decision confirms that the Hearing Committee did not limit itself to making a finding of breach of a standard of practice and then jump to a finding that there was professional misconduct. The Decision goes in detail through all of the Hearing Committee's concerns with Llewellyn's handling of the resident's care in this case. At no point in the Decision does the Hearing Committee state that due to a breach of a certain standards of practice the finding of professional misconduct is made. The Decision reviews various areas that the Hearing Committee found Llewellyn breached the Nursing Standards of Practice and the Code of Ethics. After a thorough review of the evidence before it, which is found in the Decision, it was open for the Hearing Committee to make a finding of professional misconduct. The Hearing Committee is constituted of lay members and not lawyers. To expect the Decision to be worded in a manner that you would find in a decision of the Court is not a reasonable standard to apply to administrative tribunals.

[84] I find for the reasons set out above that this ground of appeal fails.

E. The Decision of the Committee was clearly wrong

[85] Llewellyn goes through several points that she argues confirm that the Decision is wrong. As Llewellyn is asking the Court to find that the Hearing Committee misapprehended the evidence, the standard of review for the Court to intervene on such a finding is palpable and overriding error.

[86] There are two areas where Llewellyn argues that the Hearing Committee was clearly wrong: in its assessment of the evidence to support the finding of professional misconduct and in its penalty analysis. Each will be reviewed below.

i. *Finding of Professional misconduct*

[87] In relation to the argument that the Hearing Committee misapprehended the evidence in making its finding of professional misconduct, the Court finds that there was evidence before the Hearing Committee to permit them to reach the conclusion that it did. It is not the role of this Court, sitting as an appellate Court, to come to its own conclusions based on the evidence presented. The Hearing Committee supported their findings by referring to evidence before them. The Hearing Committee, as the tribunal of first instance, assessed the credibility of the witnesses and determined that the account of the incident by the paramedics was more credible than Llewellyn's. The Hearing Committee confirmed that they considered Llewellyn's evidence where it contradicted with other witnesses and found that *"she was attempting to put herself in a positive light in response of the accusation against her"*. The Hearing Committee made the conscious decision to accept other witnesses' evidence where it contradicted Llewellyn's evidence. They provided reasons for doing so and this Court cannot and should not disturb such findings absent any palpable and overriding error. No such error is present.

ii. *Penalty*

[88] Llewellyn argues that the penalty imposed was an error as it was based on a faulty finding of misconduct. This ground of appeal has been rejected earlier in this decision.

[89] Additionally, Llewellyn argues that the severity of the penalty imposed by the Hearing Committee was based on Llewellyn's alleged failure to meet past conditions for an unrelated matter. Llewellyn was found guilty of professional misconduct following a hearing in relation to a previous unrelated matter. The decision in relation to that matter was issued June 16, 2020. The penalty imposed by the Hearing Committee had five main components:

1. Registration to practice nursing was suspended for two months;

2. Within 6 months of the decision, complete ethics training with a nursing expert at Llewellyn's own expense;

3. Fine in the amount of $5,000, payable not later than March 1, 2022;

4. Pay to the College $10,000 in respect of the investigation and adjudication of the complaint, no later than March 1, 2022;

5. Provide a copy of the written decision to her employer or to any employer who offers her employment as a registered nurse, with proof in writing. This remains in place until all conditions have been removed.

   (See: ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2022 PESC 36, at para. 56)

[90] Llewellyn appealed the decision of the Hearing Committee, and a decision was rendered by the Prince Edwards Island Supreme Court on August 25, 2022. The appeal was dismissed on all grounds of appeal, with the exception of the penalty which was found to be clearly unfit. The Court varied the penalty of the Hearing Committee by removing the $5,000 fine that was imposed and reducing the costs ordered from $10,000 to $5,000.

[91] Although Llewellyn did appeal the decision of the Prince Edward Island Supreme Court, there was no stay of the decision of the hearing committee or of the Supreme Court decision. Pursuant to Section 58 (5) of the ***RHPA***, an order from a hearing committee is in effect when it is served and remains in effect pending appeal unless stayed by the Supreme Court pending appeal. Therefore, the Court finds that the Hearing Committee did not err in relying on Llewellyn's past record in rendering its penalty.

[92] Llewellyn argued that until the appeal of the first decision was adjudicated, she couldn't comply with the condition that she work with a nursing expert. She advised in her written submissions on disposition that the nursing expert identified by the College would not work with her until the matter was determined by the Prince Edward Island Court of Appeal. If this was the case, it was incumbent on Llewellyn to obtain a stay of the order from the Supreme Court. Section 58 (5) of the ***RHPA*** is clear that any order that results from a disciplinary proceeding is in effect from the date it was issued unless the Supreme Court stays the order pending the outcome of the appeal. By the time counsel for Llewelyn filed submissions in relation to disposition on October 17, 2022, the original decision of the Hearing Committee was over two years old, and the decision of the Prince Edward Island Supreme Court was almost two months old. The written submissions from Llewelyn contained no indication that Llewellyn was working on any of the conditions from the prior discipline order. While it is recognized that the matter was still pending before the Prince Edward Island Court of Appeal at that time, without a stay of the order of the Hearing Committee, the ***RHPA*** is clear that the order was effective and could be properly considered by the Hearing Committee in determining an appropriate penalty for Llewellyn in relation to this new complaint.

[93] Another argument made by Llewellyn is that the penalty is inappropriate as the Hearing Committee failed to consider letters of support filed on behalf of Llewellyn. The Hearing Committee did in fact note in the Decision that it did consider the letters; however, the Hearing Committee did not find them persuasive as they noted that they were not provided in a format that could identify who wrote them, they were not signed by the author, and the Hearing Committee was not aware of what was shared with the authors of the letters. The Hearing Committee has discretion to weigh the evidence presented as it

deems appropriate. It would not come as a surprise that typed letters without signatures and limited or no contact information for the authors (other than their names) might not be given much weight by the administrative tribunal. If Llewellyn deemed that this evidence was necessary for the Hearing Committee to rely upon in determining penalty, she should have called them as witnesses at the disposition hearing. The Hearing Committee must make a determination based on the record before it and is not in an investigative role. As the Hearing Committee considered the letters of support, the Court finds that it did not commit an error of law in making a decision to give them little or no weight. This is the role of the administrative tribunal as the court of first instance, namely, to weigh evidence.

[94] Finally, Llewellyn argues that the penalty imposed by the Hearing Committee was excessive in all of the circumstances. She points to the significant financial penalties for a single person household to be suspended from practicing nursing for a period of four months and to pay the College the amount of $10,000 for investigation and adjudication of the complaint.

[95] The Prince Edward Island Supreme Court in ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2022 PESC 36 (this portion of the judgment was confirmed by the Court of Appeal in ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2024 PECA 15) provided some guidance on the legal test for overturning the penalty imposed by an administrative tribunal:

> [52] I will give consideration to the penalty imposed by the Committee in accordance with the principles and factors highlighted in ***Mitelman***. In order for this court to overturn the penalty imposed by the Committee, I must be satisfied it made an error in principle or that the penalty was clearly unfit. A finding of "clearly unfit" requires that the penalty be disproportionate or fall outside the range of penalties for similar offences in similar circumstances. ***Mitelman*** describes a fit penalty as one which undertakes an assessment of the facts of the particular case, and the penalties imposed in other cases involving similar infractions and circumstances.

[96] The Decision of the Hearing Committee relied on two cases submitted by the College in determining an appropriate penalty, namely:

a) ***College of Nurses of Ontario v. Klein***, 2019 CanLII 129302 (ON CNO):

   The RN was found guilty of professional misconduct in relation to several incidents relating to language and tone of voice used by the member. The member had no previous disciplinary record. The member was suspended for five months, ordered to have two meetings with a regulatory expert to determine if further were necessary, and for eighteen months notify employers of the discipline decision.

b) ***College of Nurses of Ontario v. Fu***, 2020 CanLII 115987 (ON CNO):

The RN was found guilty of professional misconduct in relation to a single incident where she was dealing with an elderly Alzheimer patient. The discipline committee found that she breached nursing standards by not following the patient's plan of care, holding her finger close to the patient's face to quiet her, and making inappropriate comments to the patient. She had no prior record. The member was suspended for two months, ordered to have meetings with a regulatory expert, and for nine months to notify employers of the discipline decision.

[97] Llewellyn provided some case precedents in her appeal of the Decision in support of her argument that the penalty imposed is unfit, namely:

a) ***MacDonald***, ARNPEI Professional Conduct Review Committee, Complaint #PE-2013-002 (March 4, 2020):

The RN was found guilty of professional misconduct as a result of a combination of allegations against her. In particular, she was found to have failed to locate medication requested for a seizuring patient, she inserted a catheter without a appropriate numbing agent, and various other failures within a two-month period, including, failing to properly administer medication, using improper nursing technique, failing to report information in an accurate and timely fashion to colleagues, and failing to complete administrative tasks. The Committee imposed as a penalty that the RN complete a clinical practice assessment, provide a copy of the decision to her employer and future employers, pay a fine of $4,000, and pay $15,000 in respect of the expenses associated with the investigation.

b) ***MacInnis***, ARNPEI Hearing Committee, Complaint #2018-001 (September 28, 2020):

The RN was found guilty of professional misconduct as a result of failing to provide a patient with medication at the required time, incorrectly transcribing a verbal antibiotic and failing to administer it when ordered, and failing to ensure that required documentation was completed prior to obtaining a diagnosis test. The RN had lost her employment as a result of these incidents. The Agreed Statement of Facts confirmed that the misconduct was at the low end of the spectrum and did not involve any intentional malfeasance. It was noted that the member accepted responsibility without requiring a hearing and cooperated in the Agreed Statement of Facts. She was ordered to pay a fine of $500.

c) ***Mariwande***, ARNPEI Hearing Committee, Complaint #2019-005 (October 2, 2020):

The RN was found guilty of professional misconduct after a 3-day hearing. The finding was based on the Committee determining that the member had altered a narcotics record, made derogatory comments to a patient, and yelled at a patient's

> disabled grandson. The Committee found that the member did not seem to understand at the hearing the extent to which her own conduct impacted the events in question. The Committee noted that the penalty determination was impacted by the fact that the incidents happened over a period of time. Another factor was the evidence of a history of poor relationships with many of her peers, although the allegations in relation to this were not proven to have been a breach of the nursing standards. The Committee noted that there were some mitigating factors, such as her difficult financial situation and fiscal obligation to her family that resulted in the Committee believing that financial deterrents would have a potentially negative impact on those dependent on her for her livelihood. The Committee imposed the following penalties: one month suspension, for the member to complete four professional development courses, attend training with a Regulatory Expert, pay a fine of $500 and pay the College $500 for the cost of investigation and adjudication of the complaint.

[98] The Court finds that the cases referred to by Llewellyn do not result in a finding that on a comparative analysis the penalty imposed by the Hearing Committee was unfit. In ***MacDonald***, the Hearing Committee didn't order a suspension, but chose a fine instead, and ordered a higher amount of costs. In ***MacInnis***, the Hearing Committee put great emphasis on the fact that the member had lost her job and that she had admitted responsibility and cooperated throughout the disciplinary process. In ***Mariwande***, the Hearing Committee reduced the financial consequences to the member due to her financial circumstances. While the suspension period was shorter, it also did not appear that the member had a previous related record.

[99] While the Hearing Committee could not find it aggravating that Llewellyn denied the allegations against her, a guilty plea such as in the ***MacInnis*** case can be mitigating (See: ***Llewellyn v. College of Registered Nurses of P.E.I.***, 2024 PECA 15, and ***Quaidoo v. Edmonton Police Services***, 2015 ABCA 381). The fact that none of the members in the relied upon disciplinary cases were subject to prior discipline for similar behaviour distinguishes these cases from the one now before the Court.

[100] The Hearing Committee in the Decision confirmed reviewing submissions from both parties on penalty. They specifically noted that the *"Committee was persuaded to rely on Mr. MacLeod's* [College's counsel] *submission"*. It detailed that it found that the language and tone used by Llewellyn in the interaction with the resident was problematic and relied on case precedent with similar factual pattern. This is an appropriate approach by a Hearing Committee in determining penalty.

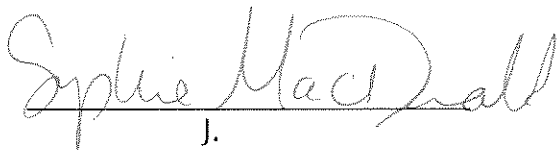
[101] In reviewing the penalty imposed on Llewellyn in this matter, the Court does not find that it was unfit. Based on the concept of progressive discipline (see: ***Law Society v. Merchant***, 2020 SKLSS 6 at para. 81), the penalty imposed by the Hearing Committee reflects a slightly more severe punishment from the penalty on the first discipline matter.

[102] In summary, this final ground of appeal is dismissed.

VII. Costs

[103] The College is not seeking its costs, taking the position that Llewellyn has the right to appeal, and appeals such as this aid in the evolution of the discipline process under the ***RHPA***.

[104] Each party shall bear their own costs.



J.

October 1, 2024