IN THE MATTER OF

***THE PARAMEDICS ACT* AND IN THE MATTER OF A COMPLAINT AGAINST CAITLIN FRASER, A MEMBER OF THE SASKATCHEWAN COLLEGE OF PARAMEDICS**

DECISION

Saskatchewan College of Paramedics

DISCIPLINE COMMITTEE

Discipline Committee Members:

Olumide Adetunji, LL.B, B.L., LL.M, Public Representative, Chair

Marie Stimson, ICP

Sergio Silveria, ACP

Joel Gritzfeld

Caleb Williamson

Karen Prisciak, Q.C., Legal Counsel for the Discipline Committee,

Merrilee Rasmussen, Q.C., Legal Counsel for the Professional Conduct Committee,

Chris Boychuk, Q.C., Legal Counsel for Caitlin Fraser.

A. INTRODUCTION

1. On or around August 8, 2018, the Saskatchewan College of Paramedics (the "**College**") received a complaint regarding the conduct of Ms. Caitlin Fraser, a member of the College (the "**Member**"), in regards to the care of a patient. The College received a second complaint on August 15, 2018 concerning the same matter. As contemplated under section 27(1) of *The Paramedics Act* (the "**Act**"), the Professional Conduct Committee ("**PCC**") conducted an investigation, and this culminated in the PCC issuing a written report (the "**Report**") to the Discipline Committee of the College ("**Discipline Committee**") recommending that the Discipline Committee hear and determine the formal complaint against the Member set out in Schedule A of the Report (the "**Formal Complaint**").

2. The Formal Complaint alleges that:

    a. The Member is guilty of professional incompetence and/or professional misconduct contrary to sections 24 and 25 of *The Paramedics Act, 2007*, in that she acted contrary to certain of the Saskatchewan Paramedic Clinical Practice Protocols, compliance with which is required by section 23 of *The Paramedics Act,* and/or failed to provide

acceptable level of care in accordance with the Basic Cardiac Life Support ("BLS") 2015 Guidelines.

3. The Formal Complaint sets out the particulars of the allegation against the Member as follows: On or about August 2, 2018 at approximately 22:35 hours, the Member attended a 66-year old patient who had fallen and had an altered level of consciousness and the Member:

    a. failed to fully assess the patient, contrary to the Standard Approach/Ongoing Assessment Protocol;

    b. failed to administer oxygen, contrary to the Dyspnea Protocol;

    c. failed to call for an ALS intercept, contrary to the Intercepts Protocol;

    d. failed to administer naloxone in an overdose, contrary to the Unconsciousness Unknown Etiology Protocol;

    e. failed to begin cardiopulmonary resuscitation ("CPR"), contrary to the Cardiac Arrest, Cardiopulmonary Resuscitation and Asystole/PEA Protocols;

    f. failed to follow the standard of care in airway management, contrary to the Airway Management Protocols; and/or

    g. failed to resolve differences between Member and partner, contrary to the Conflict Between Health Care Providers Protocol;

4. The Discipline Committee convened on May 6, 2020 *via* phone conference, as agreed by the Parties, to hear and determine the Formal Complaint against the Member (the "**Hearing**"). The Legal Counsel for the Member as well as the Legal Counsel for the PCC acknowledged that the Discipline Committee was properly constituted and had jurisdiction to conduct the Hearing.

5. At the Hearing, the Parties formally submitted an Agreed Statement of Facts and Documents signed by counsel for the PCC on February 5, 2020 and the Member on March 19, 2020 to the Discipline Committee, and advised that the Member was pleading guilty to the Formal Complaint. The Agreed Statement of Fact and Documents was entered as Exhibit A. In the course of the Hearing, the Parties agreed to make a minor revision to section 21(b) of the Agreed Statement of Facts, which provision deals with one of the proposed sanctions agreed to by the Parties. This amended Agreed Statement of Facts and Documents (hereafter referred to as "**Agreed Statement of Facts"**) is attached as an appendix to this decision.

6. At the conclusion of the Hearing, the Discipline Committee indicated its intention to review the Agreed Statement of Facts, including the proposed joint recommendation on disposition, and thereafter issue its decision.

B. FACTS

7. The Agreed Statement of Facts sets out the background facts of the events that led to the Formal Complaint, as agreed to by the Parties. As noted above, this document is attached as an appendix to this decision, hence there is no need to reproduce it here. Suffice to say, the Member agreed that her conduct regarding the events described in the Agreed Statement of Facts constitutes professional misconduct contrary to clause 25(c) of *The Paramedics Act* (the "Act"), in that it breached item 5 of the paramedic's responsibilities to the patient as set out in the Code of Professional Conduct, and thus a breach of the College's bylaws. In consequence, the Member entered a plea of guilty to the Formal Complaint.

8. In light of the unequivocal guilty plea of the Member to the Formal Complaint and the Member's admission of the facts set out in the Agreed Statement of Facts, the Discipline Committee did not deem it necessary to request the Parties to call evidence at the Hearing. The Discipline Committee, therefore, accepts the guilty plea of the Member and takes as proven the facts set out in the Agreed Statement of Facts.

C. ISSUES FOR DETERMINATION

9. The Discipline Committee has identified the following issues for determination:

    a. Whether, in light of the facts and circumstances of this case, the Discipline Committee finds the Member guilty of professional misconduct?

    b. If the answer to the above is in the affirmative, whether the Discipline Committee accepts the joint penalty proposed by the Parties in the Agreed Statement of Facts as appropriate in the circumstances?

D. ANALYSIS

10. As noted above, the Member pleaded guilty to the Formal Complaint. In doing this, she admitted that her conduct regarding the events described in the Agreed Statement of Facts constituted professional misconduct contrary to clause 25(c) of the Act, in that it breached item 5 of the paramedic's responsibilities to the patient as set out in the Code of Professional Conduct.

11. Clause 25(c) of the Act provides that professional misconduct "is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:

    a. …….
    b. …
    c. it is a breach of this Act or the bylaws;

12. Section 10(1) of the *Saskatchewan College of Paramedics – Regulatory Bylaws (as amended as of May 2, 2019)* provides that "Every member shall comply with the Code of Professional Conduct attached as appendix A". The Code of Professional Conduct contains provisions relating to professional standards for members of the College. It is divided into three broad headings namely: (a) "Principles of Ethical Behavior (*sic*) for All Members", (b) Responsibilities to the Patient, and (c) Responsibilities to the Profession. Item 5 of the provisions under the heading "*Responsibilities to the Patient*" provides that all members shall "protect and maintain the patient's safety, dignity and privacy." The Member has admitted that her conduct breached the underlined clause.

13. It should be noted that section 49 of the Act also imposes a direct obligation on members to comply with the Act and the bylaws. It provides that "*Every member shall comply with this Act and the bylaws*." By this, it is clear that all members of the College, including the Member, are bound by the provisions of not just the Act but also the Code of Professional Conduct, which is part of the bylaws of the College.

14. In Saskatchewan, as in other parts of the country, paramedics play a critical role in the health sector, especially in the area of patient care. In many instances, they are the first contact patients have with the medical team that will be responsible for their care. These interactions tend to be in the context of tragic or traumatic incidents, where the patients are usually helpless, dependent and particularly vulnerable. In these situations, the expectation, indeed – the requirement, is that the attending paramedics would do the requisite preliminary assessment of a patient's condition and take appropriate steps in administering the necessary initial treatment, bearing in mind the relevant protocols. Based on the particulars of the Formal Complaint, as noted in paragraph 3 above, it does not appear, in this case, that the Member met the expected level of conduct for protecting and maintaining the patient's safety and dignity, as contemplated in item 5 of the Code of Professional Conduct.

15. The Discipline Committee, therefore, agrees with and accepts the Member's guilty plea to the Formal Complaint, as well as her admission that her conduct regarding the events described in the Agreed Statement of Facts constitutes professional misconduct contrary to clause 25(c) of *The Paramedics Act* (the "Act"), in that it breached item 5 of the paramedic's responsibilities to the patient as set out in the Code of Professional Conduct, and thus a breach of the College's bylaws.

16. Accordingly, the Discipline Committee finds the Member guilty of professional misconduct by reason of her violation of the bylaws, *viz* item 5 of the Code of Professional Conduct.

17. In light of the finding of professional misconduct against the Member, the next issue is the determination of the appropriate penalty.

E. JOINT SUBMISSION ON DISPOSITION

Issue 2: *If the answer to the above is in the affirmative, whether the Discipline Committee accepts the joint penalty proposed by the Parties in the Agreed Statement of Facts as appropriate in the circumstances*?

18. As the Discipline Committee has already found the Member guilty of professional misconduct, the next issue is that of the appropriate penalty. Section 31(1) of the Act sets out the different orders that the Discipline Committee can make where it finds a member guilty of professional misconduct. Section 31(1)(f) of the Act contains an omnibus clause that allows the Discipline Committee to make "any other order that the discipline committee considers just."

19. The Member and PCC made the following joint submission to the Discipline Committee as regards the penalty to be imposed:

    a. The Member will have a formal reprimand issued by the College;

    b. The Member will enroll, at her expense, in the Saskatchewan Polytechnic Bridge & Re-entry Program and Practicum for PCP paramedics, within six months after her return to work from maternity leave and shall satisfactorily complete both the program and the practicum. In the event that Saskatchewan Polytechnic does not offer the Program and Practicum within six months following her return to work from maternity leave, the Member shall satisfactorily complete an equivalent program and practicum as determined by the Professional Conduct Committee;

    c. Until the Member satisfactorily completes the Bridge and Re-Entry Program and practicum described in clause (b), or equivalent program and practicum, she shall work only under the direct supervision of a licensed paramedic;

    d. The Member shall, at her expense, arrange for supervision by a field trainer credentialed at a level of Advanced Care Paramedic or Critical Care Paramedic and approved by the Professional Conduct Committee, to supervise her work for a minimum of 15 shifts including, if she satisfactorily completes the practicum referred to in clause (b), the shifts completed during the practicum, and until the supervisor determines that the Member is competent for independent practice;

    e. The Member shall facilitate arrangements with her employer to provide Patient Care Reports (PCRs) involving the Member to the College for a period of two years after her return to practice from maternity leave, including PCRs selected at random and any PCRs involving:

        i. concerns regarding paramedic competency;
        ii. patient death in the Member's presence;

iii. medication errors;
iv. a negative consequence of care resulting in unintended illness or injury that may or may not have been preventable; and,
v. complaints received by the Member's employer;

and the Member's licence shall be suspended until such arrangements are put in place;

f. The Member shall, at her expense, arrange to have access to a mentor approved by the Professional Conduct Committee, for a period of two years after her return to practice from maternity leave, who is available to discuss questions or concerns and to review skills or knowledge;

g. The Member shall review her knowledge of College Clinical Practice Protocols with the College's Director of Professional Practice and Research every six months at times to be determined by the Director for a period of two years after her return to practice from maternity leave;

h. the Member pay a portion of the costs incurred by the College in the amount of $5,000 within a period of 24 months following the date of the Discipline Committee's Order; and,

i. if the Member fails to comply with any of the provisions of the Discipline Committee's Order within the time provided, that her licence shall be suspended on and from that date and until the provision of the Order is complied with

20. In *Rault v. Law Society of Saskatchewan* 2009 SKCA 81, the Saskatchewan Court of Appeal held that a discipline committee must consider joint submissions on penalty unless it can be demonstrated that they are unfit, inappropriate, unreasonable and/or contrary to the public interest. See also, *Pankiw v. Board of Chiropractors' Association of Saskatchewan* 2009 SKQB 268.

21. The Discipline Committee has carefully considered the joint submissions of the Parties as to disposition and is of the view that the proposed sanctions are reasonable and appropriate in the circumstances. While the conduct of the Member clearly fell short of the standard of conduct required by the College, the Discipline Committee notes that the joint submission pertaining to penalty serve to protect the public interest in that it demonstrates to members of the College and the public that such conduct will not be condoned. Further, the sanctions serve as a general deterrent to dissuade other members from acting in a similar way. Also, by requiring the Member to take the program and practicum noted in sub-paragraph 19(b) above, the penalty aims to provide a learning opportunity to the Member to guide future conduct.

F. ORDER

22. In light of the above, and for the reasons highlighted, the Discipline Committee does not see any reason to depart from the joint submissions on penalty. They are reasonable and

appropriate in the circumstances. Accordingly, the Discipline Committee makes the orders sought and referred to in paragraph 19 above.

23. The Discipline Committee commends the efforts of the legal counsel for the PCC and the legal Counsel for the Member in working together to bring this matter to a satisfactory conclusion.

Dated at the City of Regina in the Province of Saskatchewan this 17th day of July 2020

OLUMIDE ADETUNJI, LL.B, B.L, LL.M

Chair of the Discipline Committee

APPENDIX A – AGREED STATEMENT OF FACTS

IN THE MATTER OF *THE PARAMEDICS ACT* AND
A HEARING REGARDING THE CONDUCT OF CAITLIN FRASER, A MEMBER OF THE SASKATCHEWAN COLLEGE OF PARAMEDICS

AGREED STATEMENT OF FACTS AND DOCUMENTS

I. INTRODUCTION

1. This Agreed Statement of Facts and Documents is jointly submitted by the Professional Conduct Committee of the Saskatchewan College of Paramedics ("the College") and by Caitlin Fraser, a Member of the College ("the Member"), with respect to a complaint relating to the conduct of the Member on August 2, 2018, while the Member was employed as a primary care paramedic with WPD Ambulance. The parties hereby agree that the contents of this Statement are proven and can be accepted by the Discipline Committee as evidence.

II. BACKGROUND AND JURISDICTION

2. Caitlin Fraser, registry number 41435, first registered with the College as a Primary Care Paramedic on October 25, 2015. The Member has no discipline history with the College.

3. Membership in the College, and the conduct of members, is governed by *The Paramedics Act* (the "Act") and the Bylaws made pursuant to the Act, which bylaws include a Code of Professional Conduct ("the Code"). As a self-regulating profession, the College is authorized by the Act to discipline its members for failure to adhere to the requirements of the Act, the Bylaws, or the Code.

4. Pursuant to section 25 of the Act, the Professional Conduct Committee (the "PCC") is required to investigate allegations of professional misconduct and/or professional incompetence received in the form of a written complaint and, on completion of its investigation, to make a written report to the Discipline Committee recommending that either the subject matter of the complaint be referred for a discipline hearing or that no further action be taken.

5. A written complaint was received by the College on August 8, 2018. A copy of the complaint is attached as **Exhibit A**. A second written complaint was received by the College on August 15, 2018. A copy of that complaint is attached as **Exhibit B**. The written complaints were referred to the PCC for investigation as required by the Act. On the completion of its investigation, the PCC reported to the Discipline Committee as required by the Act. A copy of the report of the PCC to the Discipline Committee recommending a hearing, and the formal complaint, relating to the within matter are attached as **Exhibit C**.

6. The Member and the PCC acknowledge that the Discipline Committee is properly constituted and has jurisdiction to hear and determine the formal complaint in accordance with the Act.

II. FACTS

7. On August 2, 2018 at about 22:35 the Member and her partner Benjamin Tarala, PCP (Tarala) were called to attend at the Lighthouse Supported Living facility in North Battleford. The facility provides support to those in need in the community.

8. Tarala was designated as the attending paramedic prior to the call. Upon arrival at 22:36 the Member and Tarala found the patient laying on his side on the sidewalk. The patient was conscious but unable to provide coherent responses to their questions. With assistance, the patient was brought to his feet and moved onto a stretcher, and then moved into the ambulance.

9. Once in the ambulance the Member and Tarala proceeded to evaluate vital signs including blood glucose, oxygen saturation, blood pressure, respiration rate, and pupil responsiveness. Tarala attempted to detect a radial pulse which was unsuccessful. The Member's attempt to detect a carotid pulse was also unsuccessful, although Tarala informed the Member that he was able to feel a pulse. The Member then placed a 3-lead ECG and observed a normal sinus rhythm at 80 beats/min. No printout was made of that ECG.

10. The decision was then made by the Member and Tarala to move the patient to the Battleford Union Hospital. No effort was made to contact Advanced Life Support (ALS). The patient was not provided supplemental oxygen. Defibrillation pads were not placed on the patient.

11. The Member and Tarala departed the scene of the call at about 22:47, the Member driving while Tarala attended to the patient. Transportation was done Code Alpha (non-emergent). During transport Tarala prepared to establish an IV line but had not done so prior to arrival at the hospital. During transport, Tarala did not recognize that the patient's condition had deteriorated and no attempt at CPR was initiated prior to arriving at the hospital.

12. The Member and Tarala arrived at the hospital at about 22:49, by which time the patient was non-responsive, pupils were fixed and dilated, and the ECG indicated a pulse of 35. A printout of this ECG was made.

13. Attempts were made to revive the patient by hospital staff. Ultrasound showed no sign of cardiac activity. The attending physician pronounced the patient deceased at about 22:54. The Member's shift supervisor met with the Member and Tarala shortly thereafter at the hospital

14. Tarala was responsible for preparing the Patient Care Report (PCR). Upon review of what Tarala had prepared at this point, the shift supervisor advised that the PCR needed to be re-done and that they could do this back at the ambulance service offices, and then return the completed report to the hospital when it was ready. Tarala had the Member sign Page 1 of the incomplete report. The Member did not sign the revised report when it was completed.

15. The cause of death was subsequently determined to be due to drug toxicity by opiates methadone and oxycodone. Medical conditions in the patient history including congestive heart failure, chronic obstructive pulmonary disease and coronary artery disease contributed to the death. A copy of the Coroner's report is attached as **Exhibit D**.

16. On September 26, 2018, the Member was notified by email that the Professional Conduct Committee was in receipt of a complaint of professional incompetence or misconduct as a result of the events of August 2, 2018. The Member responded by email on October 25, 2018, providing a summary of the events. The PCC's investigation included interviews with the Member on November 21, 2018. The investigation also included interviews with Tarala, the Member's employer, and four of the Member's colleagues.

17. In the course of its investigation, the PCC requested the Member to agree to a voluntary limitation on her licence to require that she only practice as a paramedic under supervision. The Member accepted this limitation and has been working under supervision since January 28, 2019.

18. Following its investigation, the College advised the Member by letter dated March 4, 2019 that the Professional Conduct Committee had referred the matter to the Discipline Committee for a hearing. That letter is attached as **Exhibit E**.

19. The Member agrees that her conduct regarding the events as described in this Statement of Agreed Facts constitutes professional misconduct, contrary to clause 25(c) of *The Paramedics Act,* in that it is a breach of item 5 of the paramedic's responsibilities to the patient as set out in the Code of Professional Conduct and thus a breach of the College's bylaws.

20. The Member enters a plea of guilty to the formal complaint.

III. JOINT RECOMMENDATION FOR DISPOSITION

21. The Member and the PCC jointly submit that the following penalty be imposed by the Discipline Committee:

    a. The Member will have a formal reprimand issued by the College.

b. The Member will enroll, at her expense, in the Saskatchewan Polytechnic Bridge & Re-entry Program and Practicum for PCP paramedics, within six months after her return to work from maternity leave and shall satisfactorily complete both the program and the practicum. In the event that Saskatchewan Polytechnic does not offer the Program and Practicum within six months following her return to work from maternity leave, the Member shall satisfactorily complete an equivalent program and practicum as determined by the Professional Conduct Committee;

c. Until the Member satisfactorily completes the Bridge and Re-Entry Program and practicum described in clause (b), or equivalent program and practicum, she shall work only under the direct supervision of a licensed paramedic;

d. The Member shall, at her expense, arrange for supervision by a field trainer credentialed at a level of Advanced Care Paramedic or Critical Care Paramedic and approved by the Professional Conduct Committee, to supervise her work for a minimum of 15 shifts including, if she satisfactorily completes the practicum referred to in clause (b), the shifts completed during the practicum, and until the supervisor determines that the Member is competent for independent practice;

e. The Member shall facilitate arrangements with her employer to provide Patient Care Reports (PCRs) involving the Member to the College for a period of two years after her return to practice from maternity leave, including PCRs selected at random and any PCRs involving:

    i. concerns regarding paramedic competency;
    ii. patient death in the Member's presence;
    iii. medication errors;
    iv. a negative consequence of care resulting in unintended illness or injury that may or may not have been preventable; and
    v. complaints received by the Member's employer;

and the Member's licence shall be suspended until such arrangements are put in place;

f. The Member shall, at her expense, arrange to have access to a mentor approved by the Professional Conduct Committee, for a period of two years after her return to practice from maternity leave, who is available to discuss questions or concerns and to review skills or knowledge;

g. The Member shall review her knowledge of College Clinical Practice Protocols with the College's Director of Professional Practice and Research every six months at times to be determined by the Director for a period of two years after her return to practice from maternity leave;

h. the Member pay a portion of the costs incurred by the College in the amount of $5,000 within a period of 24 months following the date of the Discipline Committee's Order; and

i. if the Member fails to comply with any of the provisions of the Discipline Committee's Order within the time provided, that her licence shall be suspended on and from that date and until the provision of the Order is complied with.

DATED AT Regina, Saskatchewan, this 5th day of February 2020

Rasmussen Rasmussen & Charowsky
Legal Professional Corporation

Per: 

_____
Solicitors for the Professional Conduct Committee,
Saskatchewan College of Paramedics

DATED AT Saskatoon, Saskatchewan, this _____ day of _____ 2020

_____
Caitlin Fraser