DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Grace Isgro-Topping	Chairperson
	Deirdre Armstrong, RN	Member
	Anne McKenzie, RPN	Member
	Karen Breen-Reid, RN	Member
	Jerry Dobie	Public Member

BETWEEN:

	)	
COLLEGE OF NURSES OF ONTARIO	)	
	)	KAREN JONES for
	)	College of Nurses of Ontario
- and -	)	
	)	
ROBERT ASHTON	)	KATE HUGHES
Registration No. 9329335	)	for Robert Ashton
	)	
	)	PHILIP TUNLEY
	)	Independent Legal Counsel
	)	
	)	Heard: February 22, 2007 &
	)	March 16, 2007

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on February 22, 2007 and March 16, 2007 at the College of Nurses of Ontario (the "College") at Toronto. The panel was properly constituted with five members on February 22, 2007. Upon resuming on March 16, 2007, one public member was unable to attend. The hearing continued with four panel members.

The Allegations

The allegations against Robert. G. Ashton, RN (the "Member") as stated in the Notice of Hearing (Exhibit #1) dated January 31, 2007, are as follows:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that on or about July 4, 2004, while employed as a registered nurse at [the Correctional Centre], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession with respect to your assessment and/or treatment and/or documentation of regarding [the client].

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(37) of *Ontario Regulation 799/93*, in that while employed as a registered nurse at [the Correctional Centre], you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, could reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in particular,

a) on or about July 4, 2004 you:

i) failed to adequately assess and/or treat [the client];
and/or

ii) documented observations regarding the client that you had not personally observed as though the observations were your own; and/or

iii) [Withdrawn].

b) during the period July 5, 2004 to August 18, 2004 you misrepresented to one or more persons the observations you made and/or the assessment you completed regarding [the client] on July 4, 2004.

3. [Withdrawn]

College counsel informed the panel that allegations #2(a)(iii) and #3 have been withdrawn.

Member's Plea

The Member admitted the allegations set out in paragraphs numbered 1, 2 (a)(i)(ii) and (b) in the Notice of Hearing. The panel conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal. A written plea inquiry (Exhibit #2) dated February 22, 2007 was received.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, dated February 22, 2007 (Exhibit #3) which provided as follows:

THE MEMBER

1. Robert Ashton ("Member") worked as a corrections officer in Ontario from 1974-1989. He graduated from [ ] with a Registered Nurse Diploma in 1993 and became a Registered Nurse member of the College of Nurses of Ontario ("College") that same year. The Member worked as an orderly from 1993-1994, then was employed by a nursing agency for three years working exclusively in [correctional] facilities as a

Registered Nurse. From 1996-1999, the Member worked as a Registered Nurse for [] for the [ ] Jail. From 1999 to present, he has been employed full-time as a Registered Nurse with [] at the [Correctional Centre]. He is presently on leave from [the Correctional Centre].

2. The Member has no prior discipline history with the College.

3. Had the Member testified, he would have said that prior to July 4, 2004, he had never witnessed a code situation at a correctional facility, and he had never initiated CPR on a client.

THE FACILITY

4. [The Correctional Centre consists of two facilities that are next door to each other]. [Facility A] is a minimum-security correctional facility [ ]. [Facility B] is next door, and is a medium security facility [ ]. It is two to three minutes from the main entrance of [Facility A] to the main entrance of [Facility B]. On weekdays, there are two RNs on site at [Facility A] and three or more RNs on site at [Facility B]. On weekends and holidays, there is a single RN responsible for both institutions.

5. The procedure in a medical emergency on the weekend at [Facility A] is to call the RN at [Facility B]. If the [Facility B] RN is unavailable, corrections staff call 911.

THE CLIENT

6. The client, [ ], was a 63 year old man serving a life sentence. As of July 4, 2004, [the client] had been incarcerated at [Facility A] for 5 years. [The client] was eligible for day parole and had been in the community on two escorted visits.

EVENTS OF JULY 4, 2004

7. [The client] was scheduled to visit with his [friend] at 1100 hours on July 4, 2004. He did not appear for the appointment, although he was repeatedly paged. He had not been seen since 0900 hours.

8. Corrections officers went to check on [the client]. At 1130 hours, they found [the client] in his room hanging by a rope around his neck from a towel rack on the back of a door. There is a discrepancy between different witnesses as to whether the door was locked or unlocked but blocked.

9. The corrections officers cut [the client] down and laid him in a prone position. Correctional Services Canada policy required the corrections officers to initiate CPR and continue until medical assistance arrived. Had corrections officers testified, they would have said they obtained a mask for starting CPR. Another officer paged the Member, who was on duty at [Facility B].

10. The Member arrived at [the client's] house approximately four minutes after receiving the call. All of the officers left the room and the Member entered to assess the client. The Member did not have his emergency bag with him, which weighed over thirty pounds.

11. The Member assessed [the client] and decided that CPR was futile as he judged [the client] was dead and "non-salvageable."

12. The Member left the room after he decided [the client] was dead. The Correctional Supervisor had the site secured and she initiated a Major Incident Checklist and Contingency Plan. The Member was careful not to disturb anything as he knew there would be an investigation into the matter.

13. Approximately 15 minutes later, an ambulance arrived. The Member permitted the emergency medical services personnel to assess [the client]. He remained in [the client's] room during their assessment. The emergency medical services personnel found [the client] to have no respirations or heart sounds. His pupils were fixed at 4 mm. His face and neck were cold and a nylon rope was tight around his neck, imbedded deeply into the flesh. His torso was cool, not cold. He was asystolic. The emergency medical services personnel did not initiate CPR and they left the facility.

14. The Member documented the following in [the client's] medical chart:

1134 Call previously received (approx. 1130) re inmate hanging, request RN to attend scene. Picked up by van @ [Facility B] and brought to House [] and room of [the client].
Inmate found on floor (head proximal to door) on his back, legs straight out/together. Right arm on floor adjacent along body, left arm bent across chest. Inmate was not breathing/unresponsive. O/E no pulse – pupils fixed 4, non-reactive to light. Cyanotic. Cooling of extremeties, torso warm. ¼ inch rope indentation around anterior neck. Able to move limbs. Bruising of L elbow/axilla. No CPR attempted.

1148 Attended with ambulance attendant to inmate's room. Shirt cut pads placed/asystole. No attempt to shock/revive.

15. The Member also completed an [] Statement/Observation Report" at 1240 hours, in which he documented:

Shortly before 1130 hrs., call from [Facility A] advising of an inmate found hanging and requesting R.N.'s presence. Van waiting at [Facility B] and R.N. taken to house [].

Directed to room of [the client]. Inmate was supine on floor, adjacent to the bed, head proximal to door entrance. Rope still around his neck with associated skin indentation and discoloration. Officers report inmate initially on stomach and rolled over in anticipation of CPR.

Inmate unresponsive to voice/touch. Pulse/breathing absent. Skin color cyanotic, pupils fixed (4) – unresponsive to light. Able to move extremities, extremities cooling arms bilaterally. Significant bruising/discoloration noted at/around left elbow.

No CPR initiated. Assessment completed approx 1134 hrs. with minimal disturbance to position.

16. The Member met the Chief of Health Services ("Chief") on July 6, 2004, who expressed a concern that the Member's documentation was insufficient to justify a decision not to start CPR.

17. On July 13, 2004, the Chief met with the Member, provided him with a copy of the College's Practice Standard: Resuscitation (Revised 1999) ("Standard") and asked him to review them.

18. The College's Standard provides, amongst other things, that nurses should not initiate basic Cardio Pulmonary Resuscitation ("CPR") if the client exhibits obvious signs of death (vital signs absent plus rigor mortis, tissue decay, etc.). According to the Standard:

> It is generally acknowledged that resuscitation in situation of unwitnessed arrest is not successful. In this situation a nurse must use expert clinical judgment. If the nurse is not confident that withholding CPR is appropriate under the circumstances, CPR should be initiated.

19. The Chief met again with the Member on July 19, 2004 and asked him to provide comments in writing as to how his actions were congruent with the Standard. On July 20, 2004, the Member provided the following to the Chief:

> In the situation involving [the client], I determined him to be dead/non-salvageable and did not attempt resuscitation based on my knowledge and skill to assess the presence of absence of vital signs. In this case, I assessed
>
> a) Unresponsiveness
> b) Apnea
> c) Pulse less
> d) Fixed dilated pupils
>
> In addition, the more conclusive signs of death present were:
>
> a) Generalized cyanosis
> b) Hypothermia
>
> Based on these findings, CPR was not initiated as it was deemed a futile treatment.

20. A Board of Investigation ("Board") was appointed by the [Correctional Centre] on July 29, 2004 to provide a report to the [Correctional Centre] into [the client's] suicide, as is required in all sudden deaths.

21. The Board met with the Member on August 16, 2004. The Member was asked to explain to the Board how he had determined [the client's] pupils were unresponsive to light. The Member explained that he did not have his first-aide bag with him so did not have a light. He said he had tested light responsiveness by opening the inmate's closed eyelids and seeing if ambient light in the room caused a pupil reaction. There was no reaction as they were fixed. The Member also said he had not made the measurement of 4 [millimeteres]

regarding pupil size, as that measurement had been taken by the ambulance attendants after their arrival some 10-15 minutes later. According to the Member, the inmate's pupil size had not changed between his initial assessment and the ambulance attendants' assessment.

22. The Member also told the Board he had moved the inmate's arms and legs and that no rigor mortis was present. He did not check the patient's jaw as he was not aware at that time that the first signs of rigor mortis typically becomes evident in the smaller muscles there.

23. The Member also said he was surprised by the depth of the indentation and discoloration caused by the ligature around the patient's neck.

24. On August 18, 2004, the Member telephoned the Board's Chair saying he wanted to "clear up a misunderstanding" he might have left. The Member noted that his charting, his [] Statement/Observation Report and his interview with the Board likely gave the impression that he had examined the inmate's pupils as part of his initial assessment upon arrival at the scene. The Member wished to correct that. He said he had not examined the pupils at all, although he was carrying a flashlight on his belt and would have been equipped to do so. Instead, he had recorded the information reported to him by the ambulance personnel when they assessed the inmate after their arrival some 10-15 minutes later.

25. The Member also stated that his observations of the ligature indentations in the inmate's neck were also made after the arrival of the ambulance personnel. He said it was only after the ambulance crew loosened the ligature that he noticed its depth.

ADMISSIONS

26. The Member admits that he has committed an act of professional misconduct in that he failed to maintain the standards of practice of the profession with respect to his assessment and documentation regarding [the client] on July 4, 2004. He also admits, based on his documented assessment, that he failed to maintain the standards of practice of the profession with respect to his treatment of [the client] on July 4, 2004. The Member therefore admits to having committed acts of professional misconduct as set out in paragraph 1 of the Notice of Hearing.

27. The Member admits that his conduct was relevant to the practice of nursing, and that having regard to all the circumstances, would reasonably be regarded by members as dishonourable and disgraceful, as set out in paragraph 2 of the Notice of Hearing, and in particular:

    a) on July 4, 2004 he:

        i) failed to adequately assess and treat [the client], based on his documentation regarding [the client]; and

ii) documented observations regarding [the client] that he had not personally observed as though the observations were his own.

b) during the period July 5, 2004 – August 18, 2004, he misrepresented to one or more persons the observations he made and the assessment he completed regarding [the client] on July 4, 2004.

OTHER

28. The College withdraws allegations numbered 2(a)(iii) and 3 as set out in the Notice of Hearing.

Discussion

After deliberating and reviewing the Agreed Statement of Facts ("ASF"), the panel requested submissions from both Counsels for the College and Member with respect to paragraph 27 of the ASF concerning how they determined that the Member's actions were disgraceful and dishonourable. Prior to hearing submissions, the panel chair read into the record the panel's understanding of their definition of these terms (reference: Discipline Committee meeting minutes, March 23, 24, 2004). Neither Counsel for the College nor for the Member was familiar with the Discipline Committee definitions, therefore panel consulted ILC.

ILC stated that dishonourable, disgraceful and unprofessional are legal terms taken from the statutes. If the Member did not have full understanding of these terms and agreed to their use in the ASF, then the Member should be given an opportunity to amend the ASF.

The panel was presented with an amended version of the ASF, dated March 16, 2007 (Exhibit #5) which amended paragraph 27 to reflect that the Member's conduct was unprofessional.

Decision

The panel considered the amended Agreed Statement of Facts (Exhibit #5) and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed an act of professional misconduct as alleged in paragraphs 1, 2, (a) (i) (ii) and 2(b) of the Notice of Hearing in that;

1. The Member has 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 on or about July 4, 2004, while employed as a registered nurse by [] at [the Correctional Centre], the Member contravened a standard of practice of the profession or failed to meet the standards of practice of the profession with respect to [his] assessment and/or treatment and/or documentation of regarding [the client].

2. The Member has 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 by [] at [the Correctional Centre], the Member engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, could reasonably be regarded by members as unprofessional, and in particular,

a) on or about July 4, 2004, the Member:

i) failed to adequately assess and/or treat [the client]; and

ii) documented observations regarding the client that he had not personally observed as though the observations were his own; and

b) during the period July 5, 2004 to August 18, 2004 he misrepresented to one or more persons the observations he made and/or the assessment he completed regarding [the client] on July 4, 2004.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty had been agreed upon. The Joint Submission as to Penalty (Exhibit #4) provides as follows:

1. Requiring the Member to appear before the panel to be reprimanded; and

2. Directing the Executive Director to suspend the Member's certificate of registration for 30 days; and

3. Directing the Executive Director to impose the following terms, conditions, and limitations on the Member's certificate of registration:

i. That the Member provide evidence of successful completion of a course or courses in assessment, documentation, and ethics that have been approved of by the Director of Investigations and Hearings ("Director"), within 12 months of the date of the panel's decision in this matter;

ii. That within 45 days of the date of the panel's decision in this matter, the Member meet with a College Practice Consultant. The Member will provide the Practice Consultant with the results of a Self-Reflective exercise that focuses on the issues of assessment, documentation, and the initiation of CPR. The Member review with the Practice Consultant the results of the exercise and the College's Standards of Practice, and discuss the issues that arose in this case as they relate to the Member and his practice.

iii. Until the Member has completed 24 months of practice following the date of this Order, the Member shall only practice nursing where he has provided his employer's chief nursing officer, or equivalent, with a copy of the Agreed

Statement of Facts and Joint Submission on Penalty or, if available, the Discipline Committee's Decision and Reasons;

iv. The Member will provide a letter from the employer to the Director within 14 days of the Member engaging in professional practice following the date that this Order becomes final, confirming:

(i) receipt of the Agreed Statement of Facts and Joint Submission on Penalty, or Decision and Reasons; and

(ii) an agreement to notify the Director immediately upon receipt of any reasonable information that the Member has failed to meet a standard of practice of the profession.

Counsel for the College stated that the proposed penalty provides for protection of the public, is fair, and is consistent with previous decisions of this College. It is a deterrent to this Member and the membership at large. It ensures that members know they must adhere to the standards of practice of the College. It provides remediation, education, and supervision for the Member.

Counsel for the Member added that the Member has not had any previous issues or disciplinary history with the College or with his employer. A significant amount of time has passed since this event and the Member is eager to move forward with his career. The learning component and requirement for monitoring protects the public and ensures that the Member meets the College standards of practice.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly orders:

1. The Member to appear before the panel to be reprimanded; and

2. Directs the Executive Director to suspend the Member's certificate of registration for 30 days; and

3. Directs the Executive Director to impose the following terms, conditions, and limitations on the Member's certificate of registration:

   i. That the Member provide evidence of successful completion of a course or courses in assessment, documentation, and ethics that have been approved of by the Director of Investigations and Hearings ("Director"), within 12 months of the date of the panel's decision in this matter;

   ii. That within 45 days of the date of the panel's decision in this matter, the Member meet with a College Practice Consultant. The Member will provide the Practice Consultant with the results of a Self-Reflective exercise that focuses on the issues of assessment, documentation, and the initiation of CPR. The Member will review with the Practice

Consultant the results of the exercise and the College's Standards of Practice, and discuss the issues that arose in this case as they relate to the Member and his practice.

iii. Until the Member has completed 24 months of practice following the date of this Order, the Member shall only practice nursing where he has provided his employer's chief nursing officer, or equivalent, with a copy of the Agreed Statement of Facts and Joint Submission on Penalty or, if available, the Discipline Committee's Decision and Reasons;

iv. The Member will provide a letter from the employer to the Director within 14 days of the Member engaging in professional practice following the date that this Order becomes final, confirming:

(i) receipt of the Agreed Statement of Facts and Joint Submission on Penalty, or Decision and Reasons; and

(ii) an agreement to notify the Director immediately upon receipt of any reasonable information that the Member has failed to meet a standard of practice of the profession.

Reasons for Penalty Decision

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for his actions and has avoided unnecessary expense to the College.

I, Grace Isgro-Topping, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

______________________________	______________________________
Chairperson	Date

Panel Members:

Deirdre Armstrong, RN
Anne McKenzie, RPN
Karen Breen-Reid, RN
Jerry Dobie, Public Member