

INVESTIGATION COMMITTEE  
of the  
SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

-and-

Laura Watson  
Saskatchewan RN #33981  
PRINCE ALBERT, SASKATCHEWAN

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DECISION  
of the DISCIPLINE  
COMMITTEE of the  
SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

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Appearance for the Investigation Committee:  
Appearance for Laura Watson: Appearance  
for the Discipline Committee: Chairperson  
for the Discipline Committee:

Mr. Roger Lepage  
Mr. Jay Watson  
Ms. Darcia Schirr, Q.C.  
Ms. Lynda Kushnir Pekrul

Date of Hearing: December 12, 2011  
Ramada Hotel & Convention Center  
1818 Victoria Avenue  
Regina, Saskatchewan

Date of Decision: February 13, 2012

## INTRODUCTION

1. The Discipline Committee of the Saskatchewan Registered Nurses' Association (SRNA) convened to hear and determine a complaint of professional incompetence and professional misconduct against Registered Nurse #33981, Laura Watson on December 12, 2011.
2. The charges against Laura Watson arose from a report received by the SRNA on April 22, 2010 from Susan Ball, RN. The letter expressed concern about the nursing practice of Laura Watson during the period of April 1, 2009 to May 1, 2010 while Ms. Watson was employed at Correctional Services of Canada in Prince Albert, Saskatchewan.
3. The Discipline Committee is constituted under section 30 of *The Registered Nurses Act, 1988 (The Act)*. The allegations against Laura Watson were outlined in a Notice of Hearing dated September 14, 2011, charging her with professional incompetence, contrary to Section 25(b) of *The Act* and professional misconduct, contrary to Section 26 (1) and 26(2)q) of *The Act*, and sections A.1, B.3, D.1, D.10, F.2, G.6, and G.9 of the *Code of Ethics for Registered Nurses (CNA 2008)*.
4. Professional incompetence is defined as follows in the Act:

*25 For the purposes of this Act, professional incompetence is a question of fact, but the display by a nurse in the professional care of a client of a lack of knowledge, skill or judgment or a disregard for the welfare of a client of a nature or to an extent that demonstrates that the nurse is unfit:*

*(b) to provide one or more services ordinarily provided as part of the practice of registered nursing;*

*is professional incompetence within the meaning of this Act.*

5. Professional misconduct is defined as follows:

*26(1) For the purpose of this Act, professional misconduct is a question of fact but any matter, conduct or thing, whether or not disgraceful or dishonourable, that is contrary to the best interests of the public or nurses or tends to harm the standing of the profession of nursing is professional misconduct within the meaning of this Act.*

*(2) Without restricting the generality of subsection (1), the discipline committee may find a nurse guilty of professional misconduct if the nurse has:*

*(q) contravened any provision of the Act or the bylaws.*

6. Bylaw XIV is as follows:

**BYLAW XIV – CODE OF ETHICS OF THE ASSOCIATION**

1. The association adopts the Code of Ethics for Registered Nurses prepared by the Canadian Nurses Association, as may be amended from time to time.

7. The relevant provisions of the Code of Ethics in this case are as follows:

**A. PROVIDING SAFE, COMPASSIONATE, COMPETENT AND ETHICAL CARE**

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care as well as with families, communities, groups, populations and other members of the health-care team.

**B. PROMOTING HEALTH AND WELL-BEING**

3. Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons receiving care and those with health-care needs, recognizing and respecting the knowledge, skills and perspectives of all.

**D. PRESERVING DIGNITY**

1. Nurses, in their professional capacity, relate to all persons with respect.

10. Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way.

#### F. PROMOTING JUSTICE

2. Nurses refrain from judging, labelling, demeaning, stigmatizing and humiliating behaviours toward persons receiving care, other health-care professionals and each other.

#### G. BEING ACCOUNTABLE

6. Nurses clearly and accurately represent themselves with respect to their name, title and role.
9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members.

8. The Notice of Hearing set out two charges:

#### Charge Number 1

You, Laura Watson, are alleged to be guilty of professional misconduct contrary to subsections 26(1) and 26(2)q) of *The Registered Nurses Act, 1988* as follows:

A. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to conduct yourself in a professional and respectful manner with other members of the health care team and in particular, Bonnie Roth, Tracy Edmonds, Susan Ball, June Merasty and Nikki Puetz, contrary to Part A.1 of the Code of Ethics (CNA 2008);

B. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to collaborate with other health care providers to maximize health benefits to persons receiving care and you failed to recognize and respect the knowledge and skills of other members of the health care team and in particular, Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz, contrary to Part B.3 of the Code of Ethics (CNA 2008);

C. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to relate to other members of the health care team with respect; you failed to recognize the formal leadership positions and you failed to work with those members of the health care team listed below to resolve differences in a constructive way. The members of the health care team primarily affected by your behaviour are Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz. This is contrary to Parts D.1 and D.10 of the Code of Ethics (CNA 2008);

D. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to refrain from judging, labelling, demeaning and humiliating behaviours toward other health care professionals and in particular, Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz, contrary to Part F.2 of the Code of Ethics (CNA 2008);

E. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to provide orientation, to share your knowledge, and to provide guidance for the professional development of other health care team members and in particular, Susan Ball, Bonnie Roth, Ruth Keeping and the RNs employed on a contract basis, contrary Part G.9 of the Code of Ethics (CNA 2008);

F. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to clearly and accurately represent yourself with respect to your name, title and role by holding yourself out as "Dr. Laura", contrary to Part G.6 of the Code of Ethics (CNA 2008);

#### Charge Number 2

You, Laura Watson, are alleged to be guilty of professional incompetence contrary to subsection 25(b) of *The Registered Nurses' Act, 1988* as follows:

On December 3, 2009, while inmate B was having a grand mal seizure, you interfered with Susan Ball's care of the inmate. You turned him on his back. You interfered with the administration of oxygen. You interfered with the placing of a C-spine collar and with the calling of an ambulance to transfer the inmate to a hospital, all contrary to the minimum standards of competence of a Registered Nurse and with the Emergency Medical Directives of Correctional Service Canada.

**HEARING**

9. When the discipline hearing began on December 12, 2011, neither counsel for the Investigation Committee nor counsel for Laura Watson raised any objection regarding the composition of the Discipline Committee. Further, no preliminary matters or objections were raised.
10. A binder was filed with the Discipline Committee and marked as Exhibit P-1. It consisted of 44 tabs with the key tabs being the following:
- (i) Tab 42 – Agreed Statement of Facts
  - (ii) Tab 43 – List of Particulars which is intended to be part of the Agreed Statement of Facts
  - (iii) Tab 44 – Consent Order.
11. The Agreed Statement of Facts and List of Particulars is attached as Appendix “A” to this decision. As indicated in the Agreed Statement of Facts, Ms. Watson entered guilty pleas to both charges as amended. Further, charge 2 was amended to delete the reference to professional incompetence and in its place, Ms. Watson was charged with and plead guilty to professional misconduct contrary to section 26(1) and 26(2)(q) of the Act.
12. In the end result, the charges as amended to which guilty pleas were offered were as follows:

**Charge Number 1**

**You, Laura Watson, are alleged to be guilty of professional misconduct contrary to subsections 26(1) and 26(2)(q) of *The Registered Nurses Act, 1988* as follows:**

**B. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to collaborate with other health care providers to maximize health benefits to persons receiving care and you failed to recognize and respect the knowledge and skills of other members of the health care team and in particular, Bonnie Roth, Susan Ball, June Merasty**

and Nikki Puetz, contrary to Part B.3 of the Code of Ethics (CNA 2008);

C. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to relate to other members of the health care team with respect; you failed to recognize the formal leadership positions and you failed to work with those members of the health care team listed below to resolve differences in a constructive way. The members of the health care team primarily affected by your behaviour are Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz. This is contrary to Parts D.1 and D.10 of the Code of Ethics (CNA 2008);

D. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to refrain from judging, labelling, demeaning and humiliating behaviours toward other health care professionals and in particular, Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz, contrary to Part F.2 of the Code of Ethics (CNA 2008);

E. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to provide orientation, to share your knowledge, and to provide guidance for the professional development of other health care team members and in particular, Susan Ball, Bonnie Roth, Ruth Keeping and the RNs employed on a contract basis, contrary Part G.9 of the Code of Ethics (CNA 2008);

#### Charge Number 2

You, Laura Watson, are alleged to be guilty of professional misconduct contrary to subsections 26(1) and 26(2)(q) of *The Registered Nurses' Act, 1988* as follows:

On December 3, 2009, while inmate B was having a grand mal seizure, you interfered with Susan Ball's care of the inmate.

13. As indicated in paragraph 3 of the Agreed Statement of Facts, Ms. Watson and the Investigation Committee made a joint submission regarding penalty and that joint submission will be dealt with later in this decision.

**Summary of Evidence:**

14. The evidence regarding the charges was set out in the List of Particulars which is attached to this decision. The List of Particulars referenced numerous documents such as emails and Correctional Service of Canada documentation. All of those emails and documents were included in Exhibit P-1.
15. By way of background, Laura Watson is 49 years of age. She completed her nursing program through Wascana Institute campus in Regina on June 25, 1994 and she has been registered with the SRNA since October 15, 1994.
16. In 2004, Ms. Watson began working at Pinegrove Correctional Centre on a part-time basis. In January, 2011 she took a full time position there. Ms. Watson remains employed at Pinegrove. Ms. Watson was also employed at the Prince Albert Penitentiary as the Committee understands that she worked part-time there from 1996 until 2011 when Ms. Watson resigned in January, 2011.
17. The two charges relate to Ms. Watson's employment at the Prince Albert Penitentiary.

**Charge No. 1**

18. The charge as framed along with the List of Particulars and the evidence supporting those particulars paints the picture for the Discipline Committee. As counsel for the Investigation Committee put it, insubordination was the ongoing problem with Ms. Watson.
19. At the times material to the charge, it appears the Prince Albert Penitentiary faced an ongoing problem with nursing shortages and staff turnover. Rather than working with management to address those problems, it appears Ms. Watson actively criticized management and undermined their decisions. Instead of "resolving differences in a constructive way" as required by the Code of Ethics, Ms. Watson was

critical and undermining. Tab 8 of Exhibit P-1 illustrates that. Her one line email response to Ms. Roth about a work roster sent to all nurses was "I will NOT be a part of this roster . . .". Similarly and at tab 11, Ms. Watson wrote across a work schedule in large capital letters "NO CHANCE IN HELL. Get everyone rotating and I will consider". Ms. Watson engaged in a campaign of "public negativity", to use the words of counsel for the Investigation Committee, about the skills of her colleagues and she made those comments in front of patients and other nurses.

20. Ms. Watson's difficulties were not focused on one particular individual or one particular manager. Rather, her failure to co-operate and work collaboratively extended to a number of individuals.
21. There were also numerous examples of Ms. Watson claiming for overtime that had not been approved. On other occasions (and as illustrated at Tab 7), Ms. Watson refused to work alone on a unit where a number of nurses had called in sick. Ms. Watson refused to work, claiming there was an unsafe work environment even though there were management assurances that she need only do essential services and that processes were in place in the event of an emergency.
22. On another occasion and in March, 2010 (as detailed in an email at Tab 32), Ms. Watson did not make the required arrangements for an approved leave and she was considered AWOL.
23. Because of her behavior and approach, Ms. Watson was the subject of disciplinary action within the workplace. She was also put on a program of performance objectives. She initiated harassment complaints against her colleagues and she was also the target of harassment complaints.

#### **Charge No. 2**

24. While dealing with a specific inmate and a specific incident, the facts presented are really a reflection of Ms. Watson's attitude in working co-operatively with her

colleagues. The only evidence regarding this charge was detailed at Tab 21 of Exhibit P-1 containing this email:

**A medical emergency took place in the a.m. on December 3/09. The offender appeared to be having a seizure. The first nurse on the scene was Sasan (sic) Ball. She appeared to be handling the situation well. Laura ran over and took over the scene. She undermined the decisions of Susan Ball. Following the incident, I asked for a debriefing with all nursing staff involved. Laura attended but challenged x 3 the need for her to attend the meeting. I reviewed the Medical Directive with all staff. It was reported that Laura turned the offender onto his back, not supporting his neck due to the fall. The protocol states the offender is to be placed on his left side. Susan attempted to place a collar on the offender, which was removed by Laura. Also, Susan Ball stated that an ambulance should be called. Laura stated no that Dr. Cantin would be in in 15 mins. The protocol clearly states that if any one of the symptoms are present that an ambulance should be called. The offender met all of the criteria.**

## **ANALYSIS**

25. Ms. Watson has offered guilty pleas to the charges as amended. The Discipline Committee accepts the guilty pleas to the two charges of professional misconduct. The particulars supplemented by the evidence shows a consistent pattern of insubordination on Ms. Watson's part and a lack of respect for the skills and judgment of her colleagues.
26. Laura Watson is a senior registered nurse. The Committee accepts that working in a correctional centre may be stressful and difficult and at the time, the work environment may have been even more stressful because of staff shortages. However, it is against that kind of work environment that adherence to the relevant Code of Ethics as set out in this case is crucial. A work environment of harassment complaints against Ms. Watson and by Ms. Watson against management resulted in staff dissension and poor morale – overall, a poisoned work environment.
27. Counsel for Ms. Watson argued that there was no suggestion that Ms. Watson's nursing skills were substandard and in fact, he read from witness statements

commenting positively on Ms. Watson's skills as a nurse. The Discipline Committee accepts that Ms. Watson is not facing charges of professional incompetence. However and while the evidence is not detailed or extensive, Ms. Watson's behaviours and dealings with her colleagues by questioning their nursing decisions in front of patients at the very least, discredits the respect of the nursing profession.

## **PENALTY ORDER**

28. Counsel for the Investigation Committee and Ms. Watson presented a draft order under section 31 of the Act. As indicated by counsel for the Investigation Committee, the proposed penalty order was designed to address Ms. Watson's behavior and more particularly change her behavior. The order consisted of various elements including supervised practice, monitoring by performance reviews, education and payment of costs.
29. The penalty order was presented as a joint submission. The Discipline Committee is aware of the principles of joint submissions established by case law including the Saskatchewan Court of Appeal decision of *Rault v Law Society of Saskatchewan*. The Discipline Committee finds the joint submission reasonable, consistent with the principles of sentencing orders in discipline cases and particularly consistent with the SRNA's public interest mandate.
30. At the conclusion of the hearing and through independent counsel for the Discipline Committee, counsel was invited to come to an agreement on the educational courses contemplated by the draft Penalty Order. Counsel for the Investigation Committee did provide a number of courses and workshops that appear to be available in Regina and Saskatoon so it appears to the Discipline Committee that there are courses, workshops and conferences available to meet the educational provisions of the Penalty Order.
31. The Discipline Committee therefore makes the following order:

1. Pursuant to section 31(1)(c), Laura Watson may continue to practice under the following conditions:
  - (a) For the next 1,500 hours of registered nursing practice, Laura Watson shall not practice registered nursing except under the indirect supervision of another registered nurse.
    - (i) Indirect supervision means the supervising RN need not be physically present but must monitor Laura Watson's nursing activities by having her report regularly or by periodically observing Laura Watson's registered nursing activities. The supervising RN shall be selected by the employer and be approved by the Registrar of the SRNA.
    - (ii) Laura Watson shall be responsible to file with the Registrar of the SRNA a letter signed by herself, the supervising RN and the employer, confirming compliance and satisfactory completion of the 1,500 hours of indirect supervision.
  - (b) Laura Watson shall provide at least four written performance reviews completed by the supervising RN and the member's employer, with a particular focus on the member's ability to demonstrate the following:
    - (i) The ethical obligation to conduct herself in a professional and respectful manner with other members of the health care team.
    - (ii) The ethical obligation to collaborate with other health care providers and to recognize and respect the knowledge and skills of other members of the health care team.

- (iii) The ethical obligation to recognize the formal leadership positions and to work with members of the health care team to resolve differences in a constructive way.
  - (iv) The ethical obligation to refrain from judging, labeling, demeaning and humiliating behaviours toward other health care professionals.
  - (v) The ethical obligation to provide orientation, to share knowledge and to provide guidance for the professional development of other health care team members.
- (c) The performance reviews may be submitted in the format regularly used by the employer. Unfavourable performance reviews or any further complaints received regarding the member shall be reported to the Investigation Committee for further investigation and action.
- (i) The performance reviews may be submitted at any time but must at least be provided as follows:
    - (A) after having completed 500 hours actual worked hours of registered nursing practice;
    - (B) after having completed 1,000 actual worked hours of registered practice;
    - (C) after having completed 1,500 actual worked hours of registered practice;
    - (D) and after having completed 2,000 worked hours of registered nursing practice.

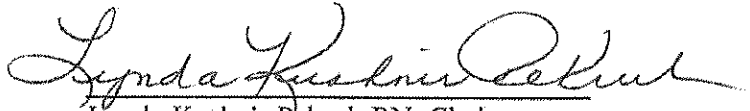
- (d) Laura Watson shall review the Code of Ethics for Registered Nurses (CNA) and upon completion, provide a written document to the Registrar of the SRNA, identifying areas in the Code of Ethics that are relevant to the complaints contained in the Notice of Hearing and Particulars and how the Code of Ethics will guide her future nursing practice.
  - (i) The document shall be submitted within two months of the date of this Order.
  
- (e) Laura Watson shall review the SRNA Standards and Foundation Competencies of the Practice of Registered Nursing and upon completion, provide a written document to the Registrar of the SRNA, identifying and explaining how this publication will guide the member's future practice of nursing.
  - (i) The document shall be submitted within three months of the date of this Order.
  
- (f) Within four months of the date of this Order, Laura Watson shall attend and satisfactorily complete a leadership conference, in-service or workshop approved in advance by the Registrar of the SRNA.
  - (i) The member shall be solely responsible for the costs.
  - (ii) The member shall provide proof of attendance and satisfactory completion to the Registrar.
  
- (g). Within six months of the date of this Order, Laura Watson shall attend and complete a course on respect and dignity approved by the Registrar of the SRNA.

- (i) The member shall be solely responsible of the costs.
  - (ii) The member shall provide proof of attendance and satisfactory completion to the Registrar.
  - (h) Within eight months of the date of this Order, Laura Watson shall attend and satisfactorily complete a course on harassment, intimidation, bullying and professional and harmonious work environments approved in advance by the Registrar of the SRNA.
  - (i) The member shall be solely responsible of the costs.
  - (ii) The member shall provide proof of attendance and satisfactory completion to the Registrar.
2. The Investigation Committee shall, if necessary, assist Ms. Watson in locating appropriate courses as contemplated by paragraphs 1(f), (g) and (h) herein. It is expected such courses shall be available in either Saskatchewan or Alberta and the courses should be a minimum of one day in duration. The Registrar may use her discretion to determine whether one course may meet the requirements of paragraphs 1(f), (g) and (h) or some combination thereof. If the Registrar is satisfied that an extension to meet the requirements of paragraphs 1(d), (e), (f), (g) and (h) is required, such extension should not exceed three months.
3. For so long as a term of this Order remains outstanding, Laura Watson shall report in writing to the Registrar on a monthly basis advising of the member's progress in meeting each term of the Order.
4. For the duration of this Order, Laura Watson shall forthwith report in writing to the Registrar any change in nursing employment including any leave of absence longer than one month.

5. Pursuant to section 31(2)(a)(ii), Laura Watson shall pay the costs of the inquiry and hearing which shall be fixed in the amount of \$5,000.00. Those costs shall be paid in monthly installments of \$417.67 for twelve months with the first payment to be made within 30 days of the date of this Order and every month thereafter until fully paid.
6. Pursuant to section 31(2)(b) of the Act, in the event Laura Watson fails to make payment in accordance with this Order, she shall be suspended from the SRNA until such time as payment is made.
7. Pursuant to section 31(3), a copy of this Order shall be sent to Laura Watson's previous and current employer. In addition, and consistent with the SRNA Council Policy and Bylaws, notification of this Order shall be given to the following:
  - (a) All Registrars of Registered Nurses in Canada, all known Saskatchewan employers of nurses;
  - (b) The editor of Saskatchewan Registered Nurses' Association News Bulletin;
  - (c) Other jurisdictions where she may have practiced;
  - (d) Any other jurisdiction in which the Saskatchewan Registered Nurses' Association considers appropriate to be notified of this decision;
  - (e) The webmaster of the SRNA to be posted on the SRNA website.
  - (f) The College of Physicians and Surgeons for Saskatchewan.
8. For so long as this Order remains in effect, Laura Watson shall disclose the Order to prospective and existing nursing employers.
9. Laura Watson shall forthwith submit her existing RN licence to the SRNA who shall enter upon the licence the existence of this Order.

10. Once all terms of this Order have been complied with, the Registrar shall so advise Laura Watson in writing.
  
11. Any breach of the terms of this Order may be referred back to the Investigation Committee for investigation and possible referral to the Discipline Committee.

Date: February 13, 2012



Lynda Kushnir Pekar, RN, Chairperson  
*on behalf of Members of the Discipline  
Committee*

Neal Sylvestre, RN

Stella Devenney, RN

Mark Schramm, RN

Cyril Kesten, Public Representative

Appendix A

INVESTIGATION COMMITTEE  
of the  
SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

-and-

Laura Watson  
Saskatchewan RN# (33981)  
Prince Albert, Saskatchewan

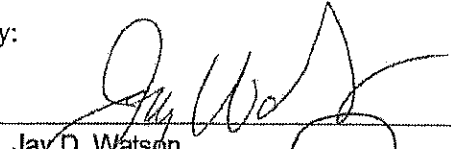
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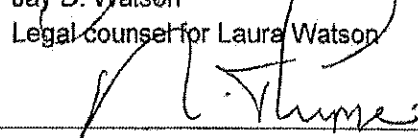
AGREED STATEMENT OF FACTS

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1. Laura Watson pleads guilty to charge 1, parts B, C, D and E of the Notice of Hearing, located at tab 1 of the Book of Exhibits. The Investigation Committee withdraws parts A and F of charge 1.
2. Laura Watson pleads guilty to the first sentence of charge 2 of the Notice of Hearing as follows: "On December 3, 2009, while inmate B was having a grand mal seizure, you interfered with Susan Ball's care of the inmate." The Investigation Committee withdraws the rest of charge 2, commencing at: "You turned him on his back. [...]."
3. Laura Watson and the Investigation Committee make a joint submission regarding penalty. It is contained in the attached draft Consent Order.
4. The Investigation Committee hereby files an Exhibit Book, containing 41 exhibits. Exhibit 1 is the Notice of Hearing. The facts contained in Exhibits 2 to 41, except Exhibit 6, are admitted by both parties.
5. The Investigation Committee has prepared a List of Particulars. It is attached as part of this agreement. Laura Watson admits to the particulars with respect to charge 1, parts B to E.

CONSENTED TO this 7<sup>th</sup> day of December, 2011 by:

  
\_\_\_\_\_  
Jay D. Watson  
Legal counsel for Laura Watson

  
\_\_\_\_\_  
Roger J. F. Lepage  
Legal counsel for the Investigation  
Committee

**LIST OF PARTICULARS FOR CHARGE 1 A TO F**

**A. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to conduct yourself in a professional and respectful manner with other members of the health care team and in particular, Bonnie Roth, Tracy Edmonds, Susan Ball, June Merasty and Nikki Puetz, contrary to Part A.1 of the Code of Ethics (CNA 2008)**

WITHDRAWN

**B. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to collaborate with other health care providers to maximize health benefits to persons receiving care and you failed to recognize and respect the knowledge and skills of other members of the health care team and in particular, Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz, contrary to Part B.3 of the Code of Ethics (CNA 2008)**

**Particulars**

***Exhibit 4 – Email of June 11, 2009 from LW to BR***

Failure to recognize and respect the knowledge and skills of JM and Michelle Herbst Sutton (MHS) to be the in-charge RN;

***Exhibit 7 – Email of August 20, 2009 from BR to Trent Mitchell (TM)***

On August 25, 2009, LW failed to collaborate with other RNs and Management to continue to provide health services;

There were four RNs at work yet LW refused to work, saying it was unsafe;

LW threatened to abandon her post despite assurances from Management that processes were in place in the event of an emergency;

Insubordination was a regular problem with respect to LW;

LW failed to respect the knowledge and skills of BR regarding the management of health care needs and emergencies

***Exhibit 8 – Email of September 20, 2009***

LW failed to collaborate to maximize health benefits due to nursing shortage;

LW always wanted a lot of overtime hours for herself;

LW's failure to collaborate amounted to insubordination;

***Exhibit 9 – Email of September 25, 2009, regarding August 7 refusal to work alone***

LW failed to collaborate with BR;

LW refused to work on the weekend using the process of an evening routine when there was lack of sufficient RNs;

LW failed to respect and recognize the knowledge and skills of BR as the manager who assessed and instructed LW to only provide essential services as though it was an evening shift rather than a weekend shift;

LW intimidated BR and Erica McCulloch, RN (EM)

***Exhibit 11 – Roster placed under BR's door on September 20, 2009***

LW failed to collaborate with BR and JM in preparing new RN roster;

LW failed to respect the knowledge and skills of BR and JM in preparing the new roster;

LW wanted every RN to rotate in all RN positions. This was not possible since some positions, such as Medical Clinic and Methadone Clinic, required continuity of RN care for patient safety;

***Exhibit 13 – Email of November 19, 2009, regarding incident of November 6, 2009***

LW failed to collaborate, and to recognize and respect the knowledge and skills of SB and BR regarding two patients who were to be sent out for medical attention;

LW interfered with SB's care of the patient;

***Exhibit 14 – Email of November 19, 2009***

LW undermined SB's knowledge and skills to DC and Nikki Puetz (NP);

***Exhibit 16 – Email of November 25, 2009***

LW failed to collaborate with BR and respect her knowledge and skills;

LW cancelled drop-in time for offenders without notifying BR;

LW sent one patient out to a hospital in Prince Albert rather than send him to Regional Psychiatric Center (RPC) in Saskatoon as is protocol, without informing BR;

LW sent a patient to an outside hospital against the recommendation of doctor and BR;

On November 24, 2009, LW failed to collaborate with BR and rather than place inmate in three-day isolation as instructed, she medicated him and returned him to General Population. LW failed to recognize BR's knowledge and skills;

***Exhibit 19- Incident of December 3, 2009, regarding inmate seizure***

LW failed to collaborate with and failed to recognize and respect the knowledge and skills of SB;

LW undermined the care being given by SB;

***Exhibit 21***

LW failed to collaborate with SB and recognize and respect SB's knowledge and skills regarding the care of inmate having grand mal seizure;

LW took over the inmate's care from SB while SB was appropriately caring for him in keeping with the CSC policy and emergency medical directives;

**Exhibit 32 - April 1, 2010**

LW was absent without leave (AWOL);

LW failed to collaborate with BR regarding attendance at work as scheduled;

**C. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to relate to other members of the health care team with respect; you failed to recognize the formal leadership positions and you failed to work with those members of the health care team listed below to resolve differences in a constructive way. The members of the health care team primarily affected by your behaviour are Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz. This is contrary to Parts D.1 and D.10 of the Code of Ethics (CNA 2008)**

**Particulars**

**Exhibit 3 - Email of May 20, 2009**

Union and Management worked together to put forward new RN schedule for existing staff. It had nothing to do with suggesting there was sufficient staff. Asked members to vote on proposal;

RNs had been asked earlier for suggestions for new RN schedule. There was no input provided by LW. However, once new RN schedule was submitted for a vote, LW criticized it in writing with email circulated to all RNs. This created conflict and failed to be respectful of the process adopted by the Union and Management;

LW failed to accept formal leadership position of BR, whose job it is to put forward new RN schedule;

LW failed to work with health care team to resolve differences regarding new RN schedule in a constructive manner;

Rather than go to see BR directly to discuss issues constructively, LW sent an email after work hours to all staff;

LW would rarely attend meetings where these issues would be formally discussed but would then choose to undermine the process and the formal leadership positions;

LW criticized the RN schedule but failed to recognize that not all RN positions can be rotated through shifts since some areas require continuity of care for patient safety;

**Exhibit 4 - Email of June 11, 2009**

Shows LW continuing to undermine and criticize JM to BR. This perpetuated LW's ongoing conflict with JM rather than relate to JM with respect or resolve differences constructively;

LW refused to accept Management decisions of who the in-charge RN would be and the formal leadership position of BR in this regard;

LW undermines BR's formal leadership position by implying that LW should have been the acting manager of Health Services when Joele Fidler (JF) went on maternity leave;

**Exhibit 5 – Email of July 20, 2009**

Regarding the overtime issue, LW failed to recognize the formal leadership position of Lucile Duret-Beskal (LDB) as Compensation Supervisor;

The tone of the email shows LW fails to resolve differences in a constructive way;

LW fails to accept her responsibility regarding the overtime problem. She failed to first obtain authorization for putting in overtime. She was also instructing contract staff to call her at home to get overtime when the calls were to go to BR;

**Exhibit 7 – Email of August 28, 2009, regarding incident of August 25, 2009**

LW insisted she knew better than the Warden and BR that there was an unsafe work environment;

LW refused to work, which amounted to insubordination;

LW failed to recognize BR's formal leadership position and failed to work to resolve differences in a constructive way. Instead, she threatened to leave her post;

LW demanded that BR work the floor as an RN rather than recognize her position in doing management duties;

**Exhibit 8 – Email of September 20, 2009, regarding new RN roster**

LW failed to recognize BR's leadership role in setting rosters to deal with nursing shortage issues;

LW failed to resolve differences in a constructive way. She would not speak to BR in person when she had differences of opinion;

**Exhibit 9 – Email of September 25, 2009, regarding incident of August 7, 2009**

LW failed to recognize BR's formal leadership position in deciding to run the weekend as though it was an evening shift, due to a lack of RN staff;

LW demanded that BR work the weekend shift with her and threatened to leave her post;

LW demanded that BR speak to the union;

LW functioned as though she was the boss and instructed BR to do nursing tasks without providing orientation;

LW instructed BR to go to Segregation Unit to do medications without telling her where it is or providing orientation;

**Exhibit 10 – Note on file of September 25, 2009 from Kristin Anderson, RN (KA)**

LW would not recognize BR's formal leadership role in setting staffing levels and scheduling staff to work;

LW would call in to work on a daily basis, even when she was not scheduled to work, to inquire about staffing levels and staff at work;

LW would undermine JM and would phone, even when she was not working, to see if JM was working. This would create upset among nursing staff and cause divisions. This further undermined the authority of BR;

***Exhibit 11 – LW placing new RN schedule under BR's door, September 20, 2009***

LW's writing on the new roster and her behaviour shows LW fails to recognize BR's formal leadership position;

LW failed to work with BR and JM to resolve differences in a constructive way;

***Exhibit 14 – Email of November 29, 2009, about SB***

LW failed to resolve the differences she had with SB in a constructive way;

LW undermined SB to other members of the health care team, such as DC and NP;

LW would also call SB and BR "stupid" and use other expletives;

***Exhibit 16 – Email of November 25, 2009, regarding incidents of November 20-24, 2009***

LW failed to recognize BR'S leadership position and to work to resolve differences in a constructive way;

LW unilaterally cancelled drop-in time for offenders without notifying BR;

LW decided that there was insufficient staff;

As a consequence, BR had to do the assessments herself;

BR placed one ill offender in an isolation cell but LW then sent him to an outside hospital (OSH) contrary to protocol and without informing BR;

LW was seen speaking to the offender and sent him to OSH contrary to BR's and doctor's recommendation;

On Monday, November 23, 2009, LW called in another RN, Carolyn, to come work with her, without consulting BR;

LW refused BR's instructions to go to intake unit to assess new admissions;

LW said she would submit for overtime in November even after BR told her that her overtime had not been approved;

On Tuesday, November 24, 2009, in the morning, LW sent an inmate into General Population rather than into three-day isolation as instructed by BR. This amounts to insubordination;

***Exhibit 19 – Email of December 4, 2009, regarding grand mal seizure on December 3, 2009***

LW interfered with the care SB was giving to an inmate who suffered a grand mal seizure;

LW was ordered to attend a debriefing by BR and it was only on the third time that she listened to BR's order;

At the debriefing, LW did not recognize BR's formal leadership position;

LW failed to relate to TE with respect and asked that she leave the debriefing;

LW failed to work to resolve differences in a constructive way. She was defensive and refused to accept her role in the interference of the inmate's care by SB;

***Exhibit 17 – Note to file of November 27, 2009***

LW failed to be respectful and recognize BR's formal leadership positions and failed to work to resolve differences in a constructive way;

LW instructed BR to do the Doctor's Clinic, give medications to an offender and give medications to units E3 and E4;

LW would assume BR's role as Manager;

BR's role was to do the administrative work and not work on the floor, but LW refused to accept this;

LW was insubordinate and it was determined that she was in need of discipline;

***Exhibit 25***

LW failed to recognize the formal leadership role of TE at the debriefing. LW was angry and demanded that TE leave. LW said "You're not part of Health Services". LW said that she would speak to people in a higher position to have TE removed;

LW failed to resolve differences in a constructive way with respect to TE, BR and SB regarding her interference with the inmate's care;

***Exhibit 27 – Note of January 11, 2010, regarding performance objectives for LW***

LW was asked twice by BR to assist the Doctor's Clinic and she failed to comply;

***Exhibit 33 – Incident of January 21, 2010 (1600 hrs)***

After LW filed a harassment complaint against BR, she was physically separated and moved to the Maximum Unit and told to have no further contact with BR until the harassment investigation was completed. Despite this instruction, LW continued to attend at the Main Unit. On three occasions, she attended BR's office with questions even though she was now being supervised by someone else;

LW failed to respect BR and the directions from her new supervisor, and she failed to recognize the formal leadership positions put in place to supervise her;

***Exhibit 33 – Incident of January 23, 2010***

LW called a contract RN at work to tell her that she would have to work on Sunday, January 24, 2010. The contract RN called BR, who told her she was not to work on the Sunday. This incident shows LW does not recognize BR's formal leadership position and fails to resolve differences in a constructive way by following established procedures. LW continues to usurp the management position that she was never given;

***Exhibit 33 – Overtime Report of January 10, 2010***

LW requested overtime of three hours at time and a half (3 x 1.5) and three hours at double time (3 x 2) for phone calls she received at home. This is due to the fact that LW informed all new contract staff that she is the boss of Health Care Services;

All contract staff were informed by BR to contact BR after hours should issues arise;

These incidents establish that LW does not respect or recognize BR's formal leadership position. She had previously been told by BR to not do this. This amounts to insubordination and usurps the management role;

***Exhibit 33 – Incident of February 5, 2010***

LW was still attending regularly to the Main Unit even though she was placed on the Maximum Unit to effect a physical separation between LW and BR during the harassment investigation. This is a violation of the direct instruction LW had been given by Leanne Skene (LS), who was now supervising LW;

Contract RNs were informed that BR must sign their pay sheets yet LW told them that she could sign them and in fact, she did sign them;

LW refuses to treat BR with respect and recognize her leadership position. Not following BR's instructions constitutes insubordination;

***Exhibit 33 – Incidents of February 23 and 26, 2010***

LW attended at Health Care Services at the Main Unit when BR was there. LW had been instructed to not be there and to have no contact with BR;

LW told Michelle Beyko (MB) that BR had refused to send RNs to assist her at the Maximum Unit. This was false since BR had no contact with LW. These falsehoods undermined BR's authority and created a negative work environment;

LW telephoned BR to approve her overtime when she had been instructed to contact LS, who was now supervising her;

LW sent an email to all senior managers stating that BR had failed to submit the overtime sheets in a timely fashion and that she was not going to receive pay. This was false. Overtime sheets had been submitted on February 3, 2010. It was Pay and Benefits who had made a mistake, yet LW spread falsehoods about BR and failed to follow proper procedures to resolve differences in a constructive way;

LW continued to take overtime calls at home from contract RNs even though they are to call BR;

***Exhibit 30***

In March and April 2010, LW continued to contact BR and attend at the Main Unit even though she had been instructed to stay on the Maximum Unit until the harassment investigation was completed. Her attendance at the Main Unit was noted on several occasions in March and on April 1, 7 and 8, 2010;

**Exhibit 33 – Incident of April 8, 2010**

LW called BR regarding medication. BR asked the pharmacist to return LW's call;

LW had been instructed previously to contact RHQ regarding clinical questions;

LW failed to follow instructions with respect to leadership roles;

**D. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to refrain from judging, labelling, demeaning and humiliating behaviours toward other health care professionals and in particular, Bonnie Roth, Susan Ball, June Merasty and Nikki Puetz, contrary to Part F.2 of the Code of Ethics (CNA 2008)**

**Particulars**

**Exhibit 9 – Email of September 25, 2009 regarding incident of August 7, 2009**

LW exhibited demeaning and humiliating behaviour toward BR, specifically ordering her to stay to work the floor and instructing her to do nursing tasks as though LW was the boss;

LW did this in front of EM (Casual RN), who was intimidated by this humiliating behaviour. EM refused to work again at PA Pen and would not work again with LW;

LW's behaviour drove away RNs from working at PA Pen;

**Exhibit 10 – Note on file of September 25, 2009**

LW's regular calls to staff on her days off were demeaning and humiliating to BR. These undermined BR's authority.

LW would call BR names, such as "stupid";

**Exhibit 11 – Incident of September 20, 2009 regarding the RN roster slipped under BR's door**

LW failed to refrain from judging, demeaning and humiliating behaviours against JM and BR;

LW did not want to allow JM to work at PA Pen anymore;

**Exhibit 12 – Email of October 21, 2009 regarding October 16 incident at Safeway store**

LW failed to refrain from judging, labelling and demeaning behaviour Lana Adams (LA);

LW called at work to tell other staff, KA, that "my name must be mud around there based on the reception Lana gave me";

LW's calls to work, when she is not working herself, are demeaning to other staff, undermine collegiality and create a negative work environment;

LW's behaviour intimidates staff. Staff were fearful of her, including BR and JF;

***Exhibit 13 – Email of November 19, 2009 regarding incident of November 6, 2009***

LW judged, demeaned and humiliated SB in the presence of the two inmates and the guards;

LW publicly undermined SB's care of the patients, thus creating a negative work environment for SB;

LW spoke negatively about SB to other health care staff in the presence of BR. She undermined and intimidated SB;

***Exhibit 14***

LW judged, labelled and demeaned SB to DC and to NP;

***Exhibit 16 – Incidents of November 20, 23 and 24, 2009***

On November 20, 2009, LW's behaviour was demeaning and humiliating to BR when contrary to instructions, LW sent inmate to OSH after BR had told the inmate he would not have to go to OSH;

On November 23, 2009, LW refused to go work on Intake Unit as instructed by BR. This was demeaning and humiliating to BR;

LW said she would submit an overtime request even after BR told her it had not been approved. This was demeaning to BR;

On November 24, 2009, LW was speaking negatively about BR to Shelley Crawford (SC). This was labeling, demeaning and humiliating to BR;

LW failed to place inmate in three-day isolation as instructed by BR. This was demeaning;

LW was confrontational and demeaning to SB, for example, her comment to SB "Go home and stay home";

***Exhibit 19 – Incident of December 3, 2009***

LW took over the care of an inmate from SB. LW demeaned and humiliated SB in front of guards and other RNs;

***Exhibit 21 – Grand mal incident of December 3, 2009***

LW swore at SB while she cared for the inmate: "Take this fucking spinal collar off";

LW took over control of the patient even though SB was first on the scene and was handling the inmate well;

LW's behaviour toward SB was demeaning and humiliating in front of the guards and other RNs;

***Exhibit 25***

LW demonstrated demeaning and humiliating behaviour toward BR and TE during December 3 debriefing;

LW said she did nothing wrong during the December 3<sup>rd</sup> incident and that "other RNs were totally incompetent and stupid" and she does "not know why she has to work with them";

***Exhibit 28, 2009 – Incident of January 18, 2010***

LW demonstrated demeaning and humiliating behaviour toward NP (Nikki Puetz), who was intimidated and bullied by LW;

NP is fearful of LW;

NP left employment in large measure because of LW's abusive behaviour;

***Exhibit 29 – Incident of January 20, 2010***

LW's behaviour toward NP was demeaning and humiliating;

LW raised her voice to intolerable levels and told NP "Don't forget you're just a clerk";

***Exhibit 30 – Email of January 22, 2010***

LW filed a harassment complaint against BR. Policy required that the parties be physically separated and that LW be supervised by someone other than BR until the investigation was completed. This was demeaning and humiliating for BR;

***Exhibit 33 – Email of BR regarding incident of January 20, 2010***

LW was given a direct order by BR to not interfere with work roles of other staff. Shortly thereafter, LW interacted with NP (clerk), who left the unit crying and who ultimately left her employment at PA Pen due in large measure to LW's demeaning and humiliating behaviour;

**E. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to provide orientation, to share your knowledge, and to provide guidance for the professional development of other health care team members and in particular, Susan Ball, Bonnie Roth, Ruth Keeping and the RNs employed on a contract basis, contrary Part G.9 of the Code of Ethics (CNA 2008)**

**Particulars**

***Exhibit 9 – Email of September 25, 2009 regarding incident of August 7, 2009***

LW demanded that BR work the floor with her; however, LW then failed to provide orientation to BR regarding the nursing tasks demanded of her;

LW failed to provide directions to BR regarding the Segregation Unit even though she instructed BR to give medications there;

LW would refuse to provide orientation to any casual or contract RNs, saying it was a waste of time since they would not be there long;

LW was not a team player. She liked to work alone or with people she could control;

LW refused to share her knowledge and provide guidance to BR and the contract RNs;

***Exhibit 13 – Email of November 19, 2009 regarding incidents of November 6, 2009***

SB commenced work on November 3, 2009 and was to become an indeterminate nurse once her documents were filed;

LW was asked by BR to provide orientation to SB and Ruth Keeping (RK), who started at the same time;

LW refused this task and said "It's a waste of time to orientate contract nurses";

LW refused to share her knowledge with SB and RK about the work units at PA Pen but then would criticize SB for not doing things properly;

**F. Between the dates of April 1, 2009, and May 1, 2010, you failed in your ethical responsibility to clearly and accurately represent yourself with respect to your name, title and role by holding yourself out as "Dr. Laura", contrary to Part G.6 of the Code of Ethics (CNA 2008)**

WITHDRAWN