COLLEGE OF REGISTERED NURSES OF ALBERTA (the "**College**")

DECISION OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

RE: CONDUCT OF **KELSEY KERN,** R.N. REGISTRATION #**106,202**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

September 4, 2024 (Joinder Preliminary Application)
October 15, 16, 17, 2024
November 18 & 20, 2024
January 22, 23, 24, 2025

INTRODUCTION

A hearing was held on September 4, 2024, October 15, 16, 17, 2024, November 18 and 20, 2024, and January 22, 23, 24, 2025 via Microsoft Teams videoconferencing and in-person by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**") to hear a complaint against Kelsey Kern, R.N. registration #106,202. The Hearing Tribunal met for deliberations on January 24, February 27 and March 5, 2025.

Those present at the hearing were:

a. Hearing Tribunal Members:

Kimberly Boyko, RN Chairperson
Bonnie Bazlik, RN
Vince Paniak, Public Member
Andrew Otway, Public member

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. CRNA Counsel:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Kelsey Kern (sometimes hereinafter referred to as "the **Registrant**")

e. Registrant's Labour Relations Officer:

Silvie Montier

f. CRNA Staff:

Marina Skoreiko, Hearings Coordinator as Clerk supporting Chair of the Tribunal in procedural management of virtual proceeding technology.

g. Additional Participants:

Ms. Chantel Nygaard
Kelly Cochrane, Court Reporter

PRELIMINARY MATTERS

Preliminary Application in Advance of the Hearing

In advance of the hearing, a preliminary application to join two hearings into one hearing was made by the Labour Relations Officer for the Registrant's Ms. Kern and Ms. Nygaard (the "**LRO**").

a. Joinder

The application made to the Hearing Tribunal, in advance of the hearing, was an application to have the two separate hearings scheduled for Ms. Kern and Ms. Nygaard (together referred to as the "**Registrants**") joined together. The Registrants made the application, which was opposed by Conduct Counsel.

The joinder was requested by the Registrants on the basis that the Allegations for both Registrants were stemming from the same incident, and therefore the Hearing Tribunal would be able to consider the conduct of both Ms. Kern and Ms. Nygaard in one hearing, rather than having the same facts repeated in two separate hearings. The LRO submitted that a joinder was the most efficient and expeditious way to proceed. Conduct Counsel opposed the application.

As the master of its process, the Hearing Tribunal has the discretion to hear the two matters jointly. In this instance, although the actions and roles of Ms. Kern and Ms. Nygaard differed, the incidents in question involved the same parties, the same patient, the same location during the same time period, and arose out of the same occurrence or series of occurrences.

After considering the submissions of the parties, the Hearing Tribunal granted the joinder request, confirming to all parties that the hearing would take place starting on October 15, 16, 17 & 18, 2024, and would cover the Allegations against both Ms. Kern and Ms. Nygaard. The Hearing Tribunal advised the parties that in its view, although the hearings would be joined, there would be two separate decisions issued, one for Ms. Nygaard and one for Ms. Kern. The parties agreed with this approach.

As such, this decision will only be related to the Allegations of unprofessional conduct for Ms. Kern.

b. Preliminary matters during hearing

Conduct Counsel and the LRO confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was open to the public. No application was made to close the hearing. Members of the public were present at various times during the hearing.

ALLEGATIONS

The allegations in the Notice to Attend a Hearing related to Ms. Kern ("**Allegations**") are as follows:

1. On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they did one or more of the following:
    a. Failed to recognize fetal and/or maternal distress on one (1) or more occasion;
    b. Failed to read an electronic fetal monitoring strip accurately on one (1) or more occasion;

c. Failed to confirm or consult with a physician on atypical and/or abnormal findings on the electronic fetal monitoring strip on one (1) or more occasion;

d. Failed to palpate the maternal pulse and/or adequately palpate the maternal pulse on one (1) or more occasion.

It is further alleged that the Registrant's conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the *Health Professions Act*, R.S.A. 2000, c. H-7 (the "**HPA**"), including:

The conduct underlying Allegation 1 contravenes one (1) or more of the following: the *Canadian Nurses Association (CNA) Code of Ethics* ("*CNACE")*; and the *CARNA's Practice Standards for Regulated Members (2013)* ("*CPSRM")*.

EVIDENCE

The following documents were entered as Exhibits:

Exhibit #1 – Agreed book of exhibits

Tab A: Nygaard Complaint dated March 27, 2023
Tab B: Kern Complaint dated March 27, 2023
Tab C: Nygaard Notice to Attend April 18, 2024
Tab D: Nygaard Notice to Attend April 22, 2024
Tab E: Nygaard Notice to Attend September 18, 2024
Tab F: Kern Notice to Attend May 28, 2024
Tab G: Kern Notice to Attend September 18, 2024
Tab H: Resume of Nygaard
Tab I: Ongoing education for Nygaard
Tab J: Resume of Kern
Tab K: Ongoing education for Kern
Tab L: Patient Health Records
Tab M: Electronic Fetal Monitoring Strips
Tab N: Practice Support Document
Tab O: Operative Report
Tab P: Infants Health Records
Tab: Q: Case Review
Tab R: Practice Standards
Tab S: Code of Ethics
Tab T: Documentation Standards
Tab U: Tolac Policy

Exhibit #2 – Nygaard CRNA Complaint

Exhibit #3 – Kern CRNA Complaint

Exhibit #4 – Philips Avalon Monitor Manual

HEARING APPLICATIONS

Objection by the LRO

Following the entering of Exhibit 1, the LRO advised that she objected to the labelling of Exhibit 1, Tabs A and B. She noted it was not a complaint; it was an inquiry. It does not say who is being complained against. The LRO further objected that there was no complaint in the Agreed Exhibit Book. She asked for the matter to be dismissed on the basis that there was no complaint.

Conduct Counsel noted that there were more fulsome complaints made on April 5, 2023, against both Registrants. He proposed to submit them into evidence at that time or through his first witness, [redacted]

The LRO maintained her objection that there was no complaint. She stated that the complaint was required to be before the Hearing Tribunal at the outset and that the Hearing Tribunal could not hear from a witness where a complaint did not exist.

Independent legal counsel for the Hearing Tribunal noted on the record that there is no requirement in the HPA that the complaint be before the Hearing Tribunal at the outset of the hearing. She noted it was not unusual to start the hearing, call witnesses and put exhibits, including a complaint letter into evidence, through a witness, including where there was no Agreed Exhibit Book.

The LRO indicated that the witness cannot give evidence to prove an allegation if there is no allegation. A Hearing Tribunal cannot listen to testimony of a witness if they do not know what the complaint is about. She stated there was no allegation in the letter. No case law was provided to support this position.

The Hearing Tribunal adjourned in-camera and reconvened to advise of its decision. The Hearing Tribunal found that the documents at Exhibit 1, Tabs A and B met the requirements for a complaint under section 54 of the HPA. The letter at Tab A is a letter from patient [redacted] and lists the Registrant Chantel Nygaard, the date of the incident and describes the concerns. [redacted] asks whether the standard of care was met. Similarly, the letter at Tab B is a letter from patient [redacted] and lists the Registrant Kelsey Kern, the date of the incident and describes the concerns. [redacted] asks whether the standard of care was met.

In addition, the Hearing Tribunal held that further exhibits could be introduced through witnesses. The Hearing Tribunal did not agree with the LRO that a complaint must be placed before the Hearing Tribunal before the Hearing Tribunal starts to hear witness evidence. The process is that a Notice of Hearing will be entered at the outset of the hearing. This is the document that lists the allegations that are before the Hearing Tribunal. After this, the Complaints Director bears the onus of proving the case, by calling witnesses and entering exhibits, which can include the complaint. The letter of complaint does not list the allegations. That is done in the Notice of Hearing. There was no authority or case law provided by the LRO to support the position she was advancing. The Hearing Tribunal determined that it would continue with the hearing and if the LRO wished to pursue this issue further, she could do so in closing submissions.

The Hearing Tribunal reconvened and advised the parties of its decision. The Chair advised that, if the LRO wished to pursue the issue of jurisdiction of the Hearing Tribunal, she could further address this in her closing submissions.

Moving the Hearing to an In-Person Hearing:

During the course of the October hearing dates, several technology problems occurred. Several breaks were taken to ensure that the Registrants, the LRO and witnesses could see and hear the proceedings and had access to the documents or were able to see documents being shown on the screen.

However, to ensure the hearing proceeded smoothly, it was determined on October 17, 2024, that the proceedings would be held as a hybrid hearing moving forward, with the Hearing Tribunal, independent legal counsel, Conduct Counsel and the LRO present at the CRNA offices. Given that the Registrants lived outside of Edmonton, they were provided the option to attend virtually so long as they had appropriate connectivity. Public observers were also permitted to attend virtually or in-person. Ms. Nygaard attended in-person for her testimony on January 22, 2025, and Ms. Kern attended in-person for her testimony on January 23, 2025.

Witnesses:

The following individuals were called as witnesses:

[redacted] complainant
Angela Curran
Dr. Cheyanne Vetter
Dr. Werner DeVos
[redacted] spouse of [redacted]
Dianne Mailloux
Chantel Nygaard
Kelsey Kern

The following is a summary of the evidence given by each witness:

[redacted]

[redacted] is a Licensed Practical Nurse [redacted]. She was admitted to the Facility on September 20, 2022. She was scheduled to have delivery induced. She had previously had a cesarean section ("**C-section**") in 2019. [redacted] testified that she was hooked up on the electronic fetal monitor and had a Foley induction started at approximately 1900h on September 20, 2022.

[redacted] was treated by both Ms. Nygaard and Ms. Kern while at the Facility. [redacted] only interaction with Ms. Nygaard was during [redacted] labour and delivery on September 21, 2022. [redacted] had previously worked with Ms. Kern at the Facility. She identified her complaints against each of Ms. Nygaard and Ms. Kern and these were marked as Exhibits 2 and 3, respectively.

[redacted] first interaction with Ms. Nygaard was at approximately 0700h on September 21, 2022, in her labour and delivery room. Her last encounter with Ms. Nygaard was at approximately 1900h on September 21. [redacted] found Ms. Nygaard to be quiet. She came into the room, introduced herself to [redacted] and for the majority of the time remained at her desk next to the bed, charting throughout her shift.

[redacted] testified that she laboured throughout the day and at approximately 1630, she began pushing and with the first push, she was screaming and was complaining of a “band ripping” or “snapping” across her abdomen. Ms. Nygaard kept getting her to push and [redacted] complained of pain.

[redacted] testified that from there, she was extremely exhausted and going in and out of consciousness. Ms. Nygaard was checking to see if [redacted] contractions were continuing. [redacted] stated that she did not recall exactly what time it was noted that the contractions stopped. Ms. Nygaard was at one point manually palpating for contractions and asking [redacted] husband to give her apple juice.

[redacted] could not recall observing Ms. Nygaard looking at the electronic fetal monitoring strips but believes she did, as this was her responsibility at the time.

[redacted] first encountered Ms. Kern at her bedside at approximately 1900h, in her labour and delivery room. [redacted] baby was ultimately stillborn via C-section at 2111 on September 21 after a confirmed uterine rupture.

[redacted] stated that post-delivery, Ms. Kern had conversations with her regarding the stillbirth protocol. Ms. Kern told them that they had a right to an autopsy but that the physician strongly recommended against it.

[redacted] requested her chart in March 2023. In reviewing the chart, she stated that she noticed that the electronic fetal monitoring strip was “extremely abnormal”.

In cross-examination, [redacted] confirmed that another nurse also looked after her during Ms. Nygaard’s lunch hour. That nurse sat bedside and monitored the electronic fetal monitoring strips.

[redacted] indicated that her concerns included that there was no attempt at intrauterine resuscitation, manually auscultating for her pulse, she does not know if a physician was consulted about the abnormal electronic fetal monitoring strips and her specific symptoms, there was no urgency or trying to push her into getting a C-section as [redacted] was not presenting as a patient in a normal labour and delivery situation. She noted there was no differentiating between her pulse and the fetal pulse as they were being charted the exact same on the electronic fetal monitoring strip. She noted that no scalp electrode was placed on the fetal scalp to pick up the fetal heart rate. While that is the responsibility of the physician to place, a nurse should advocate to the physician if there is a concern with the electronic fetal monitoring strip. [redacted] only recalled that Ms. Nygaard palpated her abdomen for contractions, not her pulse.

[redacted] reviewed the electronic fetal monitoring strips, which she believed showed abnormalities like identical fetal and maternal heart rates, questioning if they were actually capturing the fetal heart rate accurately. However, she acknowledged limitations in her ability to interpret the full strips.

[redacted] stated that while there was a discussion with Dr. Vetter regarding a vaginal delivery attempt initially, whether the delivery was by C-section or vaginal, did not weigh heavily for her either way. She stated that she asked for a C-section and was told no, it was too high-risk. It was not until 2050h that the physician called for a C-section due to the fetal heart rate not being picked up. [redacted] also stated that prior to Dr. Vetter going to lunch, she was slowly progressing and Dr. Vetter said they would see how she progressed during that period. When Dr. Vetter came back, [redacted] had dilated some more and so Dr. Vetter let her continue to labour. [redacted] testified she asked for a C-section when she felt the band ripping or snapping.

[redacted] felt that Ms. Nygaard failed to advocate for an expedited C-section. [redacted] described that she went in and out of consciousness during labour and does not recall Ms. Nygaard's full actions. [redacted] confirmed that Dr. Vetter was in the room when she screamed about the band ripping.

[redacted] stated that she only clearly remembers Ms. Kern coming to the bedside. [redacted] did not recall exactly what she did between that time and when she went to move the tocodynamometers ("**TOCO**") on her abdomen as she realized there was an appropriate heart rate being picked up.

In terms of her memory, [redacted] stated she remembers things happening, but not exactly when they happened. She noted that from when she asked for the C-section onwards, the events are all "mushed" together.

Angela Curran

Angela Curran, a Registered Nurse and fetal health surveillance instructor, has over 20 years of experience in obstetrics, including working as a rural obstetrical practice lead and clinical nurse educator. She has taken numerous courses related to fetal health surveillance, obstetrical triage acuity scales, and managing obstetric risks effectively. Ms. Curran has taught fetal health surveillance for six years and noted she taught Ms. Kern and likely Ms. Nygaard as well.

Ms. Curran was asked to review the electronic fetal monitoring strips and documentation from the case as part of a chart review for an adverse outcome and to do an educational review for the Facility. She reviewed the entire chart of the mother and newborn, including the partogram (labor and delivery documentation) and electronic fetal monitoring strips.

Ms. Curran noted that her review was to do with the timeline rather than looking at specific nursing practice or performance. Ms. Curran used the Alberta classification system that is put out by the Maternal Newborn and Child Strategic Clinical Network. She identified the Practice Support Document (Exhibit 1, Tab N) which assists in interpreting electronic fetal monitoring tracings which notes parameters to look at for every 15-minute segment. You determine if the tracing is normal, atypical or abnormal based on parameters such as baseline fetal heart rate, variability, accelerations, and decelerations. She noted the interpretation will guide health care practitioners in determining whether they need to take any additional interventions or not. She noted that a new guideline came out in 2019, but Alberta took some time to create the Practice Support Document.

Ms. Curran identified the partogram used for labour and delivery documentation and noted that the primary nurse is responsible for charting on the partogram. It is the overall clinical picture as to what is going on throughout the labour and birth process. She noted that the maternal heart rate and the fetal heart rate are both to be documented, just to double check that there are two distinct heart rates. A notation of "N" is a shorthand version for normal. "AT" would be a classification of atypical and "AB" would be an abnormal classification.

Ms. Curran identified the electronic fetal monitoring strip. She identified that there are two lines, the fetal heart which is a darker line and the maternal heart which is a lighter line, which is recorded using the saturation probe ("**SpO2**") on the mother's finger. The squares indicate movement in the abdomen. The bottom shows the contraction monitor, which measures pressure in the abdomen. The electronic fetal monitoring strip also notes the SpO2 and the mother's pulse, being the average heart rate. Questions marks on the electronic fetal monitoring strip are a heartbeat coincidence alarm alerting the medical profession to confirm that they have two patients with two distinct heart rates.

Ms. Curran found discrepancies between her classification of the electronic fetal monitoring strips and the charting in the partogram. According to her timeline, the fetal heart rate was classified as abnormal at various points, contrary to the normal classifications charted in the partogram. Additionally, the electronic fetal monitoring strips showed periods where the fetal and maternal heart rates overlapped, triggering question marks on the monitor, indicating uncertainty about whether two separate heart rates were being monitored.

Ms. Curran emphasized the importance of physically listening to the fetal heart rate with an ultrasound monitor auditorily and palpating the maternal pulse to ensure two distinct heart rates are being monitored. She stated that nurses should take action, such as communicating with the physician or using an internal fetal monitor, when the monitor indicates uncertainty about monitoring two separate heart rates.

Ms. Curran reviewed the electronic fetal monitoring strips, specifically her interpretation of the fetal heart rate baseline, decelerations, and the presence of two overlapping lines on the electronic fetal monitoring strips. Ms. Curran explained that the two overlapping lines represent the maternal heart rate and the fetal heart rate, and that the monitor's question marks indicate a potential issue in distinguishing between the two.

Ms. Curran noted that the squares on the electronic fetal monitoring strips can indicate fetal movement, but they actually determine any sort of movement anywhere in the uterus. There can be cases where there is known fetal demise but there are boxes on the electronic fetal monitoring strip. She acknowledged that it is not the best technology, but it is all that is available at the moment. Contractions are picked up by a different monitor, the TOCO.

Ms. Curran acknowledged that you are putting everything together. In the specific moment of time, something may not be concerning, but it is necessary to look at the overall clinical picture over the course of time to see what is going on. A contraction can create a deceleration as can movement by the mother. Ms. Curran noted that decelerations are problems and warrant persistent and vigilant monitoring, taking into consideration the overall clinical picture and looking at what is going on with the labour progress, the mother, the risk factors, how the mother is dilating, what is going on with the baby and the vital signs for the mother.

Ms. Curren stated that, in order to understand the overall clinical picture, it is important to be in the room at the moment. Ms. Curran noted this is one of the restrictions of reviewing a case based only on documentation. She was not in the room and so there are many things that she does not know in terms of what was going on in this case.

Ms. Curran testified that when there are two overlapping lines, intervention measures should be taken to determine that there are two patients, including palpating for the maternal heart rate and listening to the fetal heart rate. The maternal heart rate monitor on the mother’s finger is only picking up the mother’s heart rate. She noted the importance of communicating with the physician. The internal lead can also be placed to determine if the fetal heart rate is being traced. She stated that the best thing to do is to palpate maternal pulse and listen to your auditory beats to know that they are beating differently.

Ms. Curran stated that it is virtually impossible to get hours upon hours of a maternal heart rate that matches exactly the same as the fetal heart rate. She acknowledged that the SpO2 probe may not always pick up a reading. The technology is not the best technology. Ms. Curran noted

that if the lighter line is recording on the electronic fetal monitoring strip the SpO2 has to be on and that the TOCO records contractions, not the mother's heart rate.

Ms. Curran noted that the cardiac monitor put on [redacted] in the operating room for the C-section had her heart rate at 150 beats per minute, and that there is a correlation between the two different monitors to say that the maternal heart rate was tachycardic.

A nurse in the room would be looking at the fetal heart rate, the mother's heart rate and contractions. However, in her review, she focused on the fetal heart rate and did not pay close attention to the contractions.

Ms. Curran was questioned about the number of vacuum delivery attempts made in the case, which she indicated was nine. She cited best practice guidelines recommending a maximum of three vacuum "pop-offs" before considering a C-section.

Based on her review of the electronic fetal monitoring strips, Ms. Curran provided her opinion on the approximate timing when the fetal demise likely occurred, suggesting it was around 1700h based on the fading fetal heart rate (darker line) and concerning uterine activity patterns on the electronic fetal monitoring strips.

The Hearing Tribunal questioned Ms. Curran about the difference between classifying fetal heart rate patterns as "atypical" or "abnormal." Ms. Curran explains that an atypical classification warrants vigilance and monitoring but not necessarily immediate intervention, while an abnormal classification typically requires prompt delivery action.

The Hearing Tribunal sought clarification from Ms. Curran on the specific monitoring equipment used to obtain the tracings on the electronic fetal monitoring strips, such as ultrasound transducers, pulse oximeters, and TOCO for monitoring contractions. Ms. Curran noted that the ultrasound monitor that is monitoring the fetal heart, is on the patient's exterior abdomen and is the darker line on the tracing. The SpO2 records the mother's pulse and heart rate and is the lighter line. The TOCO is also placed on the exterior of the abdomen and measures pressure changes in the uterus and contractions and is the line with the "little mountains".

Dr. Cheyanne Vetter

Dr. Cheyanne Vetter is a family physician, with training in surgical skills, obstetrics and endoscopy. She has worked at the Facility since 2020, when she finished her residency. She described the unit at the Facility as having one active labour room, three postpartum rooms and an operating room in the Facility.

Dr. Vetter was the most responsible physician for [redacted] care. On September 21, 2022, [redacted] was induced on an oxytocin infusion. The nursing shift is one-to-one with the patient. During the day shift, there is another nurse on shift with labour and delivery training.

Dr. Vetter noted that she had multiple interactions with Ms. Nygaard during the course of the day shift. Ms. Kern came in at shift change and took over from Ms. Nygaard. Ms. Nygaard and then Ms. Kern were responsible for monitoring the fetal and maternal heart rates.

Dr. Vetter was asked about the electronic fetal monitoring strip and noted that the electronic fetal monitoring strip was alarming in that there might not be a fetal heart rate. Dr. Vetter testified that

at 1700, they knew they did not have a great strip. Ms. Nygaard was adjusting the monitor to get a better tracing.

Dr. Vetter was asked about what was conveyed to her by the Registrants during several time frames. She noted that Ms. Nygaard and then Ms. Kern conveyed that the fetal heart rate was normal and that the maternal heart rate was normal by palpation.

In cross-examination, Dr. Vetter noted that it was [redacted] who had raised the possibility of a vaginal delivery. Dr. Vetter confirmed being aware of risks of a vaginal delivery after a previous C-section.

Dr. Vetter stated that she assessed [redacted] midday and thought the progress was slow. At that time, she stated to [redacted] that a C-section was a reasonable option or giving it a little bit more time would also be reasonable. [redacted] indicated that she wished to keep trying a little bit longer and see what happened, and if there was no progress, then they would do a C-section. After lunch, Dr. Vetter checked [redacted] and she was progressing well. Dr. Vetter did not bring up the C-section at that time. She suggested a C-section later when [redacted] was actively pushing. Dr. Vetter testified that before she applied the vacuum, she gave [redacted] the choice of a vacuum or a C-section. [redacted] wished to proceed with the vacuum attempt.

Dr. Vetter made multiple attempts at vacuum-assisted vaginal delivery. She attempted more than three and testified that this is not common. She asked for the operating room to be on standby at that time. When the vacuum attempts failed, she consulted another physician, Dr. DeVos, before proceeding to a C-section after difficulties finding the fetal heart rate.

During the last vacuum attempt, Ms. Kern reported that the fetal heart rate was normal. When they were getting ready for the operating room, Ms. Kern informed Dr. Vetter that she could not find a fetal heart rate. At that point, Dr. Vetter went back and re-assessed and they got an ultrasound machine (often referred to as a Doppler) into the room. When they could not find a fetal heart rate, they went directly to the operating room for a “stat” section. Dr. Vetter testified that a decision had already been made after the failed vacuum attempts to do a C-section, but was made “stat” (that is, immediate) due to the loss of the fetal heart rate.

Dr. Vetter disputed the suggestion made by [redacted] that she had repeatedly requested a C-section earlier due to severe pain. She denied telling [redacted] that a C-section was too risky. Dr. Vetter testified that there is never a time where it is too high risk to do a C-section and that she did not consider it too risky to do a C-section in this case. Dr. Vetter denied being told by [redacted] that she felt a band ripping across her abdomen during labour. Dr. Vetter testified that [redacted] told her this the next day. If [redacted] had reported that during labour, that would have been a sign of a uterine rupture and they would have gone to the operating room. Dr. Vetter testified that [redacted] was conscious during the attempts at pushing and denied having to wake her up or asking the nurse to wake her up to push.

Questions were raised about the interpretation of certain fetal heart rate tracings and whether nursing staff accurately conveyed readings to Dr. Vetter. Dr. Vetter noted the electronic fetal monitoring strips had a question mark on them, which is an indication of an alarm. Dr. Vetter also noted that the maternal and fetal heart rates look the same on the tracings. Dr. Vetter noted that in looking at the electronic fetal monitoring strip, it raises the question of whether the maternal heart rate and the fetal heart rate are the same tracing, which can be verified by taking the mother’s pulse. Dr. Vetter recalled asking Ms. Nygaard to check [redacted] pulse by palpation and Ms. Nygaard reported that it was normal. If the mother’s pulse by palpation is different than the pulse on the electronic fetal monitoring strip, then this confirms you have two separate heart rates, a fetal and a maternal heart rate.

Dr. Vetter was asked about the tracing when the vacuum attempts were done and noted the tracing made sense during those vacuum attempts.

Dr. Vetter recalled Ms. Nygaard advising her that the fetal heart rate was normal but that the contractions were spacing.

In re-examination, Dr. Vetter confirmed that at pulse noted at the bottom of the electronic fetal monitoring strip tracing is the maternal pulse.

Dr. Werner DeVos

Dr. DeVos is a medical doctor at the Facility doing general practice, anesthesia, obstetrics, and maternal medicine.

Dr. DeVos described the obstetrical unit at the Facility as a rural hospital unit with 2 to 4 rooms, one operating room, and physicians covering obstetrics and anesthesia.

Dr. DeVos testified that he was called to provide anesthesia management and an epidural for [redacted] on September 21, 2022. He described his interactions with [redacted] primarily as an anesthesiologist. He had interactions with Ms. Nygaard and Ms. Kern regarding the patient's pain control and need for anesthesia top-ups throughout the labour.

Dr. DeVos explained that he would ask the Registrants about the baby's and [redacted] condition, but no concerns were relayed by the Registrants whenever he had to change the medication rate or anesthesia level.

In cross-examination, Dr. DeVos noted that he was in the room for some time during pushing. He did not recall [redacted] asking for a C-section while he was in the room. Dr. DeVos recalled that Dr. Vetter thought a C-section was a good idea and inquiring if [redacted] wanted to go for a C-section but [redacted] wanted to try to avoid a C-section. Dr. DeVos testified that this was the reason he was requested to evaluate her as an obstetrician.

Dr. DeVos testified that in hindsight, he felt the fetal heart rate monitoring may have been misinterpreted at times during the labour.

In response to questions from the Hearing Tribunal, Dr. DeVos noted that when he was asked to provide a second opinion, he did an evaluation and attempted to apply the vacuum unsuccessfully, at which time he recommended a C-section. That was changed to a “stat” section after Ms. Kern had trouble confirming the fetal heart rate.

Dr. DeVos described what a manual check of the mother’s heart rate entails, to ensure that the heart rate on the tracing is the fetal heart rate and not the mother’s. Ms. Nygaard confirmed [redacted] heart rate earlier in the day to him. Later, Ms. Kern could not confirm the fetal heart and called for Dr. Vetter. Attempts were made with an ultrasound machine and that is when a “stat” C-section was called.

[redacted]

[redacted] works as a hydrovac operator, town councilor, and volunteer firefighter. He and his wife [redacted] were at the Facility for the birth of their son. [redacted] testified that he did not recall a lot from September 21, 2022.

[redacted] testified that Ms. Nygaard's care of his wife seemed normal and routine. He did not recall any concerns being raised by Ms. Nygaard about the fetal status, and she conveyed that everything was progressing normally during her shift.

[redacted] described [redacted] as being in a great deal of pain during labour and made a hand motion towards her lower section saying something had "ripped or snapped," and her pain seemed to worsen progressively. [redacted] appeared to be in and out of consciousness. [redacted] stated that the Registrants did not seem concerned, with the message being that it was normal for childbirth.

[redacted] stated that Ms. Kern initially appeared to be providing normal care. However, approximately 45 minutes into her shift, she seemed to realize something was wrong and left the room, presumably to alert others. From that point, the care provided changed.

In terms of [redacted] level of consciousness, [redacted] described that [redacted] would be talking a little bit audibly and then all of a sudden her eyes would be closed. Then she would come back and be in pain.

[redacted] was asked about his recollection of discussions of a C-section. [redacted] testified that, towards the end, two options were discussed, being a C-section or continued pushing.

Dianne Mailloux

Dianne Mailloux is a Registered Nurse and received a diploma in 1994. Ms. Mailloux was working as the charge nurse on the acute care floor, which includes labour and delivery, at the Facility on September 21, 2022, from 0700 to 1915h. While she had a patient load as charge nurse, in 2022 she was not working as a primary labour and delivery nurse that day, but would cover breaks.

Ms. Mailloux relieved the primary labour nurse, Ms. Nygaard, for breaks during [redacted] labour, although she testified that she did not recall how many breaks she covered. During these breaks, Ms. Mailloux monitored the fetal heart rate, contractions, and [redacted] condition. She interpreted the electronic fetal monitoring strips and found no significant concerns, describing the readings as normal. Ms. Mailloux noted that she also visited with [redacted] during the break as she knows her very well.

Ms. Mailloux reviewed the patient chart and noted that it appeared that she took over from Ms. Nygaard around 1300h. Ms. Mailloux identified [redacted] vitals, the pain scale and fetal heart rate. [redacted] was receiving an epidural at this time. She confirmed that she was aware of the monitor used at the time. Ms. Mailloux recalled covering the evening break at 1607h. Ms. Mailloux did not recall if [redacted] was in a lot of pain, but they were visiting together and talking so she thought that [redacted] must not have been in pain. They had a very calm interaction and [redacted] was very excited for the arrival of her baby. She stated that [redacted] was not in and out of consciousness and believed that [redacted] was there during the 1607h break. She did not recall [redacted] mentioning any concerns. Ms. Mailloux noted that [redacted] was adamant that she wanted the baby naturally, if that was at all possible.

Ms. Mailloux was asked if she stayed in the room after the dinner break when Ms. Nygaard came back. She stated that she did not believe that she did and thought she would have gone back to the floor as she was the charge nurse.

Ms. Mailloux attended a staff meeting which ended at approximately 1930h, although she did not recall the exact time. Upon returning to the unit, she went to [redacted] labour room to see if the baby had been born. The physicians and Ms. Kern were there and there was a discussion of having a C-section. She wished them luck and headed out. As she was going down the hallway, Ms. Kern came down the hallway and asked her to come back. Ms. Kern informed her that she could not find the fetal heart rate. Ms. Mailloux attempted to locate it but was unsuccessful and so she told Ms. Kern she would go get Dr. Vetter and get the ultrasound machine. They were unsuccessful in finding a heart rate and so they went straight to a C-section. She assisted Ms. Kern in getting the patient ready for the operating room.

Ms. Mailloux reviewed her documentation and the partogram. She noted that you cannot assess what is happening based only on the electronic fetal monitoring strip, you need the entire picture of what is happening with the patient, for example, is she anxious, is she on the ball, lying down, or is she having a contraction.

Ms. Mailloux noted that if there is a break in the readings or the monitor seems to not be working properly, they may try to adjust the equipment. She noted that the equipment does not always work. Ms. Mailloux noted that she did not know what the question marks were on the electronic fetal monitoring strip and could not recall seeing those previously or being taught what these represented. She agreed that having the two lines showing the heart rates overlapping for hours would not be normal and that she would communicate that to the physician.

Ms. Mailloux testified that if the electronic fetal monitoring strip is not normal you would need to reassess the fetal heart rate and mother’s pulse. She would palpate the mother’s heart rate and use a Doppler to check the fetal heart rate. She would also call the physician to come check on the patient.

An operative report by Dr. DeVos, was shown to Ms. Mailloux, which stated that the fetal heart tracing was temporarily found by Dr. Vetter but was then lost, leading to the emergency C-section. Ms. Mailloux testified that she could not confirm if Dr. Vetter had found the fetal heart rate.

The Hearing Tribunal sought clarification on specific entries, timelines, and Ms. Mailloux's presence during certain events. Questions were raised about Ms. Mailloux's documentation on the partogram (a detailed record of labour progress). While she confirmed charting some entries, she could not definitively identify all her charting due to similarities with Ms. Nygaard's handwriting.

Chantel Nygaard

Ms. Nygaard is a Registered Nurse with a Bachelor's degree in Nursing. She graduated in 2017. She had been a labour and delivery nurse for 5 years at the time of the incident in September 2022. She had taken a short-term contract working at the Facility. She had received training in fetal health surveillance and interpreting fetal monitoring strips. She had just retaken the course prior to her contract at the Facility.

Ms. Nygaard identified the monitor manual used at the Facility, which was marked as Exhibit 4.

On September 21, 2022, Ms. Nygaard was the primary labour and delivery nurse for [redacted]. Ms. Nygaard was responsible for monitoring [redacted] labour progress and interpreting the electronic fetal monitoring strips. She was working the day shift.

The monitor was used on [redacted] with the ultrasound transducer that plugs into it the TOCO monitor, a blood pressure cuff and SpO2 monitor.

Ms. Nygaard noted that if the mother is being repositioned, is bouncing on the ball, is having a vaginal examination, is uncomfortable or coughing, this can affect the electronic fetal monitoring strip. The mother being repositioned, pushing and contractions can also affect the fetal heart rate.

During her testimony, Ms. Nygaard explained in detail how she interpreted the electronic fetal monitoring strips, including the significance of various patterns, lines, and symbols. She explained her interpretation of the electronic fetal monitoring strips as normal, despite question marks and overlapping lines appearing at times. She noted that you need to be in the room knowing what is happening and assessing the patient and the conversations that are being had.

Ms. Nygaard noted that she took three breaks. Dianne Mailloux covered for her. Around the lunch break, Ms. Nygaard got an epidural top up for [redacted] was not in a lot of pain nor was she screaming in pain prior to her supper break. The supper break was from 1607h to 1637h. After Ms. Nygaard's supper break, [redacted] was uncomfortable and then she was reassessed. She was fully dilated and having rectal pain and so Ms. Nygaard called Dr. Vetter to reassessed [redacted] The plan was to get adequate pain control and then reassess her. Ms. Mailloux stayed after the dinner break, as she was a friend of [redacted] Ms. Mailloux stayed until her evening meeting.

[redacted] did some trial pushes and it was decided she would be set up for delivery. Ms. Nygaard testified that [redacted] did not go in and out of consciousness. Ms. Mailloux had not reported any concerns about consciousness to Ms. Nygaard and said that [redacted] was excited for her delivery. [redacted] never screamed or complained about any band ripping across her abdomen. The fetal heart rate was normal during her shift between 125 and 140 beats per minute, with a normal rate between 110 and 160 beats per minute. [redacted] husband never expressed concerns.

Dr. Vetter had offered a C-section to [redacted] at the lunchtime reassessment, but [redacted] refused it. Dr. Vetter mentioned it again while they were setting up for [redacted] to push and [redacted] refused. [redacted] asked that a vacuum or forceps be tried before going for a C-section.

Ms. Nygaard noted that from Exhibit 4, the maternal pulse can be recorded on the electronic fetal monitoring tracing either by the TOCO or the SpO2 monitor. On the tracing, if there is a question mark and a dash following the SpO2 notation and a "little monitor" after the "Pulse" notation, then the SpO2 monitor is not on. At that time, the TOCO is measuring the maternal heart rate. When the SpO2 is on, then on the tracing, there will be a percentage following the SpO2 notation and the picture beside the "Pulse" will be a waveform.

Ms. Nygaard testified that they are taught to ensure they are monitoring two patients when they see the two lines together. If you are palpating the maternal pulse while you are listening to the fetal heartbeat, then there are two separate heart beats. You know you are then monitoring two different patients, but the monitor is not recording the maternal heart rate properly. This was discussed with Dr. Vetter all throughout the pushing phase as this was happening throughout. Ms. Nygaard palpated the maternal pulse which was different than what they were audibly hearing on the monitor. She told Dr. Vetter it was different and Dr. Vetter stated that "okay, then we have two patients". Dr. DeVos was sitting by the door and could hear the conversation with Dr. Vetter

the entire time that he sat there. He was the anesthetist at that point. A scalp electrode was not used as Dr. Vetter did not feel it was necessary with the anticipation of potentially using a vacuum or forceps.

Ms. Nygaard reviewed the electronic fetal monitoring tracing for her shift. When she came back from her dinner break, Dr. Vetter was at the bedside wanting to reassess [redacted] She checked [redacted] who was fully dilated. They did two trial pushes which coincides with big decelerations on the tracing. Because of the decelerations, Dr. Vetter decided that [redacted] should bet set up for delivery. Ms. Nygaard was palpating for contractions and adjusting the fetal heart rate monitor. If she has time, she would chart, otherwise she would chart at a later time.

Ms. Nygaard reviewed the partogram which noted that [redacted] was actively pushing at 1647h. Dr. Vetter ordered fentanyl for the rectal pressure and Ms. Mailloux went to get that. Ms. Nygaard noted that she palpated mom's heartbeat that was the same as the monitor during contractions and she made Dr. Vetter aware. She continued to adjust the monitor. As the baby moves lower into the birth canal, it can be a bit tricky to obtain a great tracing. The question marks started showing up and Ms. Nygaard knew this was a coincidence alarm and she needed to ensure she had two patients. There is an audible alarm as well as the question marks. She palpated the maternal pulse continuously and ensured by listening to the fetal heart rate monitor that she had two patients. They were different beats. She communicated continuously to Dr. Vetter.

The monitor does not pick up on abdominal pressure and you need to palpate the abdomen. Ms. Nygaard noted that the blips on the bottom of the tracing with jagged peaks are when [redacted] was pushing.

She continuously palpated after every contraction, maternal heart rate versus fetal heart rate and they continued to be different. She discussed this with Dr. Vetter throughout. The fetal heart rate was within the normal range and Dr. Vetter was satisfied that there were two patients.

Ms. Nygaard noted that sometimes during contractions when the mother is pushing there is a loss of contact where the fetal heart rate does not pick up. That was occurring at 1700h. Ms. Nygaard noted that on the electronic fetal monitoring strip, this is occurring and the strip shows that there is a lot of fetal movement. At 1730h, [redacted] was continuing to push and there was still lots of fetal movement. The two lines on the electronic fetal monitoring strip were together and there were question marks on the strip, but Dr. Vetter was aware and Ms. Nygaard was palpating the maternal pulse. Dr. Vetter requested the Syntocin (Synto) to be increased at that time which was done by verbal order, to bring the contractions closer together to have more effective pushing. The charting was done by the LPN as Ms. Nygaard was busy by the bedside. There was almost an hour of pushing with no great movement. Dr. Vetter then discussed a C-section with the patient which was refused and then at 1745h, Dr. Vetter discussed using the vacuum and the patient agreed.

Ms. Nygaard continued to palpate the maternal pulse as there were still two overlapping lines and Dr. Vetter was aware. The patient was still pushing and there was good fetal movement.

There were several vacuum attempts between 1748h and 1828h. Ms. Nygaard voiced each vacuum pop-off, where the suction of the vacuum to the baby's head is lost, to Dr. Vetter so she was aware. Ms. Nygaard requested the LPN to write down the times and Ms. Nygaard then did a late entry since she was at the patient's bedside. While the vacuum attempts were more than the policy suggested, there was descent noted and Dr. Vetter made the decision to continue as the patient had refused a C-section and Dr. Vetter believed that the delivery was going to be imminent.

Ms. Nygaard noted that you would not see the vacuum attempts on the electronic fetal monitoring strip.

Ms. Nygaard was asked if [redacted] was in distress and she noted that everyone in labour is in distress to a certain extent, as it is an exhaustive and hard process. However, it was when [redacted] was having breakthrough contraction pain, which they took action for such as repositioning, epidural bolus button, getting her a top-up and calling Dr. Vetter to get her reassessed.

Ms. Nygaard reviewed the patient record, which noted that, at 1215h, the patient stated the pressure was increasing and Dr. Vetter was called to reassess; at 1230h Dr. Vetter was in to reassess and her plan was to get a top-up and then reassess in two hours and Dr. DeVos was called by Dr. Vetter. At 1231h Dr. DeVos was in for the epidural top-up and then Ms. Mailloux took over for a break. Ms. Nygaard returned at 1340h and patient stated she was having slight cramping in her right lower abdomen with contractions and the bolus button was used for the epidural and Ms. Nygaard continued to monitor. At 1400h the epidural rate was increased according to Dr. DeVos's verbal orders. At 1412h, Ms. Nygaard called Dr. Vetter to come reassess as she was not able to reposition due to the pain. At 1415h, Dr. Vetter was in to reassess and the patient was at 6 centimeters. The plan was to have adequate pain control and reposition the baby. At 1430h Dr. DeVos was called and Ms. Nygaard got orders to give the patient a clinician bolus and to call back in 15 to 20 minutes with an update. Ms. Nygaard then repositioned the patient. At 1500h, Dr. DeVos was called with an update. Patient noted that her pain was no longer in her hip but in her vagina. At 1520h, the patient was resting comfortably and at 1545h she stated there was an increase in rectal pressure. Dr. Vetter was in to reassess. The patient was almost fully dilated. Dr. Vetter was in to reassess in approximately 45 minutes. Ms. Nygaard did an in and out catheter and repositioned her and then Ms. Mailloux took over for the supper break. When Ms. Nygaard returned, the patient was reassessed, was fully dilated, having rectal pain and was given the fentanyl and set up to push.

Ms. Nygaard reviewed the pain numbers provided by the patient, which were between 0 and 5 out of 10. Ms. Nygaard considered this discomfort but not distress in terms of labour and delivery.

In terms of fetal distress, Ms. Nygaard noted that the baby had decelerations with the trial pushes, which would be considered distress, however, Dr. Vetter was aware as she was doing an assessment and she determined that the action to be taken was to set up the patient for delivery.

Ms. Nygaard noted that she was listening to the fetal heart rate on the monitor. [redacted] was not off the monitor, so they did not require a handheld Doppler and did not use the fetal scalp electrode as Dr. Vetter did not view that to be necessary. Ms. Nygaard denied failing to listen to the baby's heart rate. The patient was having contractions throughout Ms. Nygaard's shift. Ms. Nygaard palpated them while she was at the patient's bedside. Her practice is to palpate every contraction while pushing, especially where a deep epidural has been given. Ms. Nygaard testified that she was aware of the question marks on the electronic fetal monitoring strip and she took action by discussing with Dr. Vetter and palpating the maternal heart rate to ensure there were two different patients.

Ms. Nygaard noted that she was not part of the chart review done at the Facility.

In cross-examination, Ms. Nygaard confirmed that her shift started at 0700h and Ms. Kern got there at 1925h. Ms. Nygaard stayed late until Ms. Kern got there. Ms. Nygaard confirmed that during her shift, she was the primary nurse and charted in the partogram. She charted "normal" under fetal health surveillance throughout her shift. She did not use a Doppler to listen to the fetal

heart rate. Ms. Nygaard noted there was no need to as the patient was on a continuous monitor. She did not consider that it would have been prudent to use the Doppler given the question marks and overlapping lines. Ms. Nygaard noted that except for her breaks, she was in the patient room, at bedside or setting up for delivery and did not believe she missed any signs of patient distress. Ms. Nygaard noted that she did not chart longhand her conversations with Dr. Vetter, including advising Dr. Vetter about the question marks on the electronic fetal monitoring strip, as she was busy with patient care, which took priority over charting at that time.

Ms. Nygaard confirmed that the dark line on the tracing is the fetal heart rate and the lighter line is the maternal heart rate. The pulse at the bottom of the screen is the maternal pulse. This is always the case, unless the monitor is not reading accurately. Ms. Nygaard indicated that the question marks do not have anything to do with whether you classify the electronic fetal monitoring strip as normal, abnormal or atypical. She noted that the two lines correlating would be concerning, which is why they make sure they have two patients. However, you have to look at what is happening in the room, you cannot look only at the electronic fetal monitoring strip to say if it is normal or abnormal. The pulse noted on the electronic fetal monitoring strip correlates with the mother's pulse. However, she reiterated that she ensured she had two different patients.

In re-examination, Ms. Nygaard noted that distress is different than normal labour pain. She also indicated that charting is different in the delivery room as the nurse is having continuous discussions at the bedside during delivery. Some things are charted, others are missed or charted at a later time. But it is not always possible to chart in the moment. She noted that the question marks on the electronic fetal monitoring strip alert you to ensure you have two different patients, which she did. The question marks do not mean you only have one patient. In terms of the monitor pulse noting that [redacted] pulse was 169 and Ms. Nygaard was manually palpating the pulse to be 77, Ms. Nygaard noted that it is possible that the monitor was wrong and the technology was faulty. She palpated adequately, as did Ms. Kern who took over the shift following Ms. Nygaard's shift. She was satisfied that she had two different patients, because she was palpating the maternal pulse on the patient's wrist, which was a different beat than the beat she was hearing on the monitor. She noted that palpating a patient's pulse is a basic physical assessment they learn in nursing school and nurses are also educated on it in labour and delivery.

In re-cross-examination, Ms. Nygaard acknowledged that it would be possible for a Registered Nurse to palpate a maternal pulse improperly.

Kelsey Kern

Kelsey Kern is a Registered Nurse with a Bachelor's degree who had been working as a labour and delivery nurse since 2017. She had taken the fetal health surveillance course in May or June 2022. In 2022, she worked on the labour and delivery unit at the Facility. She had been on maternity leave and came back in August 2022. When she returned to work, she reviewed the policies and manuals. She continues to be employed at the Facility on a casual basis.

Ms. Kern noted that Ms. Curran had stated that changes to the Fetal Health Surveillance program occurred in 2020, but it took Alberta some time to make their own practice support document and distribute it. The version of the Fetal Health Surveillance Practice Support Document dated August 2022 in the Agreed Exhibit Book was not the one in the Facility in September 2022.

Ms. Kern reviewed generally what information is provided on the electronic fetal monitoring strip. There is an ultrasound connected to the monitor that sits on the mother's abdomen. They try to connect it to the fetal back, as that will generally give the best fetal heart rate. There is a blood

pressure monitor. The electronic fetal monitoring strip prints the dark line for the fetal heart rate. There is an SpO2 monitor that connects and that provides the blood oxygen saturation and can also give the maternal heart rate, which shows up as the lighter line. There is a TOCO connected, which monitors contractions. It prints contractions at the bottom, showing the frequency and duration, but not the intensity of the contraction, which needs to be manually palpated. In some cases the TOCO can also read a maternal heart rate. On the electronic fetal monitoring strip, the question marks tells them to make sure they have two patients and that they are monitoring two patients and not just one. The electronic fetal monitoring strip also has little black boxes which show fetal movement.

In interpreting the electronic fetal monitoring strip, a nurse would look at the fetal heart rate and how it is responding. They will look for moderate variability which would indicate that the baby is responding well and getting the amount of oxygen needed. They will look for accelerations and decelerations. They take into account the mother's heart rate and contraction patterns, and in general, the whole clinical picture, since the electronic fetal monitoring strip only provides some information. They need to assess what is going in the room to decide if the information in the electronic fetal monitoring strip is accurate. A tracing can have gaps or artifacts, especially with the fetal heart rate which can be caused by the mother's movements or the baby's movements.

On September 21, 2022, Ms. Kern took over care of [redacted] from Ms. Nygaard at 1925h. She attended report at 1900h because after the delivery she would have other patients. She then went to the patient's room and took over [redacted] care at 1925h, at which time she received report from Ms. Nygaard at the patient's bedside. Ms. Nygaard relayed the patient's history, reason for induction, methods of induction, that oxytocin had been started and that during the day, she had discomfort with contractions and Dr. DeVos placed an epidural. Ms. Nygaard told her about the patient's vitals, including blood pressure and maternal heart rate and that there were decelerations throughout the day, but they were watching them and they came back to normal. Ms. Nygaard relayed the vacuum attempts and that the patient really wanted a vaginal birth. Ms. Nygaard mentioned about the coincidence alarms and that the two heart rates looked similar, but that the physician was aware and that they had been manually palpating the maternal pulse to make sure they had two patients. Ms. Kern asked if there was bleeding and testified that this can be a sign of uterine rupture. Dr. Vetter was at the foot of the bed and Ms. Kerns confirmed with her as well. Ms. Kern also reviewed the tracing with Ms. Nygaard. The baby's heart rate was within a normal range with moderate variability. There was fetal movement. Ms. Kerns was comfortable that everything was normal at that time. The patient was still pushing at this time. Dr. DeVos was there as well.

Ms. Kern was responsible for monitoring [redacted] labour progress using an electronic fetal monitor, which was on the patient the entire time. There was also a blood pressure cuff and TOCO. There was a temperature probe used regularly. Later, a handheld ultrasound (Doppler) was used. Ms. Kern stated that the SpO2 was used from time to time, but the patient did not want it on the entire time, as it can be a hindrance during labour. The patient also had an epidural and IV.

The electronic fetal monitoring strip does not, on its own, provide information about everything that is happening. For example, it does not register if the patient is moving, vaginal examinations, vacuum attempts or conversations that are occurring between the nurse and physician.

Ms. Kern explained that at the Facility, a clinician's bolus is where the physician will administer a dose of medication directly into the epidural.

Ms. Kern explained the case review that occurred. She testified that she expected it to be more educational, but it felt somewhat accusatory. There were questions asked but she felt that they did not go through the chart to look at specific times and see what was happening to really understand the electronic fetal monitoring strips.

Ms. Kern also saw the coincidence alarms (question marks) when she took over patient care and also manually palpated the maternal pulse. Ms. Kern also made Dr. Vetter aware that there were coincidence alarms and that she manually palpated the maternal pulse. Dr. Vetter asked her to continue to palpate. Ms. Kern stated that she did this multiple times during her shift. The maternal pulse was between 70 and 90 on palpation. Ms. Kern noted that this is a fairly straightforward skill that they learn in school and that she does often.

Ms. Kern noted that Dr. DeVos was in the patient's room when she started her shift and at one point, he provided a second opinion after the patient asked him. The contractions had started to slow and Ms. Kern let Dr. Vetter know that there had not been a contraction for some time. Dr. Vetter gave an order to increase the oxytocin to try to get the contractions started again. The decision was made to try one more vacuum attempt, which was unsuccessful. Dr. Vetter had a discussion about that her chances of a successful vaginal delivery were decreasing and discussed having a C-section and the patient asked for forceps. They were tried, but could not be applied. The patient then asked Dr. DeVos for a second opinion. At that point, they thought the baby was still healthy and he agreed to do one more vacuum attempt. Dr. DeVos tried the vacuum, which was unsuccessful. Dr. DeVos told the patient that the only option was a C-section.

Ms. Kern noted that there was still fetal movement, which showed as the black boxes on the electronic fetal monitoring strip and which were also confirmed by [redacted] The patient's husband was also in the room and did not voice any concerns. The patient rated her pain as 5 out of, which Ms. Kern considered to be moderate and then a 3 out of 10. The patient rested once the contractions slowed, and she closed her eyes and rested. However, [redacted] always answered Ms. Kern's questions. [redacted] never lost consciousness and was not confused.

Ms. Kern observed the overlapping maternal and fetal heart rate lines on the electronic fetal monitoring strip, but was manually palpating the patient's abdomen and confirmed a separate maternal pulse, leading her to believe they were monitoring two separate patients. She continued to assess the epidural.

Dr. Vetter had been in the room throughout but left around 2045h to change into scrubs to get ready for the operating room. Dr. DeVos had already left to get ready as well.

When she was preparing the patient for the C-section, Ms. Kern noticed that the monitor was only recording the maternal heart rate. She asked the patient if she had moved or the baby had moved and the patient said she had not moved and that she had not felt big movements, but baby was still moving. Ms. Kern tried repositioning the ultrasound transducer. She then called Ms. Mailloux for help. While Ms. Mailloux was trying to find the fetal heart rate, Ms. Kern ran to get Dr. Vetter and they came right back. Dr. Vetter asked for an ultrasound machine and found a fetal heart rate briefly around 154 to 156 beats before it was lost again. The patient was then taken to the operating room for an emergency C-section, which was performed by Dr. DeVos.

Ms. Kern provided a review of the electronic monitoring strip during her testimony, noting that she classified it as normal. Ms. Kern reviewed her charting. Ms. Kern noted that at 2045h the was new paper in the monitor.

Ms. Kern did not view that the patient was in distress although she acknowledged that a patient may feel they are in distress because labour is so exhausting. Ms. Kern stated that she did not see fetal distress until they lost the fetal heart rate. Ms. Kern stated that there was nothing she could have done to stop the question marks on the electronic fetal monitoring strip.

After delivery, Ms. Kern discussed [redacted] right to request an autopsy but did not recommend against it, contrary to [redacted] testimony. Ms. Kern felt [redacted] received preferential treatment as a staff member, with more delivery options explored before the eventual C-section.

Ms. Kern confirmed in cross-examination that she did not use a Doppler to listen to the fetal heart rate. She did not believe it was indicated, given that they were palpating the maternal heart rate and had two different heart rates. Ms. Kern confirmed that she did not chart the conversations with Dr. Vetter about palpating the maternal heart rate or the discussion regarding the report from Ms. Nygaard during handover. Ms. Kern did not think it was possible for a deceased baby to create movement in the womb.

Ms. Kern stated that at some point she thought the electronic fetal monitor machine was malfunctioning since it is not the best technology they have. They get false positives and false negatives. How well the baby is doing is not always reflected by the electronic fetal monitoring strip and they get artifacts. The TOCO often needs to be reset and interventions need to be taken. Ms. Kern has not seen a Doppler often used, except in cases of intermittent auscultation.

Ms. Kern was asked to review the electronic monitoring strip during cross-examination and noted that she could not classify the electronic fetal monitoring strip based only on the information in the strip, since you need to be in the room to be able to categorize what the strips are saying. While Ms. Curran noted there were repetitive uncomplicated variable decelerations, making the electronic fetal monitoring strip atypical, Ms. Kern noted that they were not for more than 50 percent of them and so it is not atypical.

In response to a question from the Hearing Tribunal, Ms. Kern confirmed that she also heard the heart rate when Dr. Vetter found it using the Doppler. She estimated the time the Doppler to be used was 2053h, noting that Dr. Vetter arrived in the room at 2050h.

SUBMISSIONS

Submissions by Conduct Counsel:

Conduct Counsel submitted Allegation 1 against Ms. Kern was factually proven and constitutes unprofessional conduct within the meaning of section 1(1)(pp)(ii) and (xii) of the HPA, including a contravention of the Code of Ethics and Practice Standards. Ms. Kern failed to recognize fetal/maternal distress, read fetal monitoring strips accurately, consult a physician about abnormalities, and palpate the maternal pulse properly on one or more occasion during her shift, based on Ms. Curran's case review.

Conduct Counsel noted Ms. Kern’s failure to document abnormal monitoring results and discussions with physicians. Although Ms. Kern stated the physicians were informed of the coincidence alarms and the fetal and maternal heart rates overlapped, the documentary evidence suggests otherwise as there is no documentation regarding the question marks and overlapping heart rates on the electronic monitoring strips. The saying "if you didn't document it, it didn't happen" was highlighted by Conduct Counsel.

Conduct Counsel submitted the facts underlying the Allegations in the Notices to Attend were proven on a balance of probabilities for Ms. Kern. Conduct Counsel identified Code of Ethics Responsibilities A2, A3, A5, A6, A12, B1, B4, C5, D6, G1 and G3 and Practice Standards: 1.2, 1.4, 2.2, 2.4, 2.7, 3.4, 5.3, and 5.5.

Submissions by the Labour Relations Officer for the Registrants:

The LRO outlined the complainant, [redacted] version of events, stating that she had a previous C-section and was under the care of Ms. Kern during labour. [redacted] alleged that Ms. Kern failed to read the electronic fetal monitoring strip appropriately and ignored her pain.

However, the LRO argued that [redacted] version contradicts the testimonies of other witnesses, including the [redacted] friend Ms. Mailloux, the Registrants, and Dr. Vetter. According to these witnesses, [redacted] had decided against a C-section from the outset and refused it multiple times, despite being offered. Ms. Kern provided appropriate care, accurately read the monitoring strip, and the patient did not exhibit severe pain or request a C-section.

The LRO was critical of the testimony of Angela Curran, the Complaints Director's nurse educator witness, arguing that her testimony should carry no weight as she was not qualified as an expert and made numerous errors in her interpretation of the electronic fetal monitoring strip. The LRO noted the following: Ms. Curran ignored what was really happening in the room at any specific time and the LRO noted this is the most basic element of interpreting a strip; Ms. Curren seemed to limit her interpretation of the electronic fetal monitoring strip to the fetal heart rate and the mother's heart rate, ignoring what was happening on the rest of the printing; Ms. Curran stated that she interpreted the strip every 15 minutes when the documentary evidence shows it was every 10 minutes; Ms. Curran did not know how to read the strip whether the SpO2 was on the patient or not, where it is clearly stated; she noted that the SpO2 was the only way to read the maternal pulse, and that the TOCO cannot provide the maternal pulse, which through documentary evidence was shown to be incorrect; she believed the TOCO provides the intensity of the contractions, and this is incorrect. Further, Ms. Curran relied on the new guideline even though it was not yet in the Facility at the time of the incident.

The LRO addressed the Allegations against Ms. Kern, including failing to recognize maternal and fetal distress, inaccurately reading the monitoring strip, and not consulting the physician. The LRO argued that the evidence does not support these Allegations and submitted that Ms. Kern acted appropriately.

The LRO submitted that the Complaints Director failed to prove any of the Allegations on a balance of probabilities. She argued that the tragic outcome resulted from [redacted] decision not to have a C-section when offered, rather than any failure by Ms. Kern and that the physicians tried to accommodate the patient's wishes.

HEARING TRIBUNAL FINDINGS AND REASONS

The Hearing Tribunal carefully considered the evidence presented by the parties and the closing submissions. The Hearing Tribunal found that Allegation 1(b) is proven on a balance of probabilities. The Hearing Tribunal found that Allegation 1(b) constituted unprofessional conduct under section 1(1)(pp)(i) and (ii) of the HPA.

The Hearing Tribunal found that Allegation 1(a), (c) and (d) were not proven. Therefore, the Hearing Tribunal dismissed Allegation 1(a), (c) and (d).

REASONS FOR ORDER OF THE HEARING TRIBUNAL

Exhibits of Note

While the Hearing Tribunal reviewed all exhibits, it noted some exhibits in particular.

The Hearing Tribunal reviewed and considered the Partogram for September 21, 2022 (Exhibit 1, page 110). The Labour and Birth Record Stage Two (Exhibit 1, page 112) shows the classification of "N" "normal" for the time from 1650h to 2045h and a notation that "new paper in monitor" at 2045h.

The Partogram also notes the patient's pain as reported by [redacted] with the pain between 0 and 5 on the Partogram for Stage One (Exhibit 1, page 110) and between 3 and 5 on the Partogram for Stage Two (Labour and Birth Record) (Exhibit 1, page 112).

The Hearing Tribunal reviewed and considered the electronic fetal monitoring strips, in particular the strip starting at 1700h and onward where the maternal heart rate and fetal heart rate overlap (Exhibit 1, page 378 and onward). The paper was changed in the monitor at 2047h (Exhibit 1, page 415).

The Hearing Tribunal also reviewed and considered the Multidisciplinary Notes for each of Ms. Nygaard and Ms. Kern.

Ms. Nygaard worked on September 21, 2022, from 0700h to 1925h. Exhibit 1, page 126 shows that at 1637h, "Dr. Vetter in to reassess fully dilated". At 1748h, "Dr. Vetter discussing vacuum, patient agrees to same." The vacuum attempts are documented at Exhibit 1, page 127 from 1748h to 1809h; again at 1845h to 1848h; and again from 1959h to 1903h. Ms. Nygaard's Multidisciplinary Notes accord with the testimony of Ms. Nygaard and Dr. Vetter that Dr. Vetter was in the room and attempted multiple vacuum attempts in this timeframe.

The Multidisciplinary Notes show that report was given by Ms. Nygaard to Ms. Kern at 1925h. Ms. Kern entered a late entry note at 0400h (Exhibit 1, page 127 and onward). Ms. Kern also made notes in the moment (Exhibit 1, pages 131 and 133).

The Hearing Tribunal also reviewed and considered the Alberta Classification System as noted in the Practice Support Document (Exhibit 1, page 448).

Witness Testimony

The Hearing Tribunal considered the credibility and reliability of each witness's evidence. Credibility relates to whether the witness is telling the truth. Reliability relates to the witness's ability to perceive and recall.

[redacted]

The Hearing Tribunal found that [redacted] was relaying what she believed to have occurred. [redacted] has more knowledge than a lay person, being a Licensed Practical Nurse on the labour and delivery unit.

[redacted] testified that she felt a band ripping or snapping around 1630h, that she asked for a C-section and that she was in and out of consciousness. Dr. Vetter's evidence was that it was only the next day that [redacted] reported to her that she had felt a band ripping.

None of the Registrants, Dr. Vetter, Dr. DeVos or Ms. Mailloux confirmed the evidence of [redacted] that she was screaming and asking for a C-section. In fact, the evidence of the physicians and Ms. Mailloux was that [redacted] wanted a vaginal delivery, even when the option of a C-section was presented to her.

The Hearing Tribunal also considered that the charting showed that when the patient was asked about her pain level, the charting does not reflect the evidence of [redacted] with the pain as rated by the patient between 0 and 5 on the Partogram for Stage One (Exhibit 1, page 110) and between 3 and 5 on the Partogram for Stage Two (Labour and Birth Record) (Exhibit 1, page 112). The evidence by [redacted] that she was screaming in pain does not reflect the evidence given by other witnesses or the documentary evidence.

[redacted] did not recall anyone taking her pulse, but that is contrary to the testimony of the Registrants and the physicians. [redacted] felt that Ms. Nygaard did not advocate for her, yet Ms. Nygaard was at her bedside for her entire shift. The charting shows that Ms. Nygaard was advocating for pain medication for her, asking Dr. Vetter to reassess and advising Dr. Vetter of the status. Dr. DeVos was in the room to provide pain medication and do "top ups" as necessary.

The Hearing Tribunal found that while [redacted] was trying to tell the truth as she recalled the events that occurred, her testimony did not align with other witnesses or the charting in many respects. While the Hearing Tribunal did not find that [redacted] was trying to mislead them, less weight was placed on her evidence, given that there was not external consistency with other witnesses or the documentary evidence.

Angela Curran

Ms. Curran was asked to do a chart review for the case as part of an educational review at the Facility. She was given the entire chart for [redacted] and the charting for the baby. Ms. Curran used the Alberta classification system in the Fetal Health Surveillance Practice Support Document from the Maternal Newborn and Child Strategic Clinical Network dated August 2022 (Exhibit 1, Tab N), which was not in circulation at the time of the incident.

In addition, Ms. Curran acknowledged a few times in her testimony that you do need to be in the patient room in order to understand the full clinical picture.

The Hearing Tribunal also noted that Ms. Curran was not qualified as an expert. Although she was an educator who teaches the fetal heart surveillance course, she was not asked to provide any opinion regarding the standards expected of the Registrants having regard to what was actually occurring in the patient room. Her review and evidence was much more limited, focusing on the electronic fetal monitoring strips.

Ms. Curran's evidence was that from 1657h onward, there should have been recognition that the electronic fetal monitoring strip was not normal. Although Ms. Curran acknowledged that you need

to know what is occurring in the room in order to fully understand the electronic fetal monitoring strip, her evidence was that where the electronic fetal monitoring strip is showing overlapping lines and coincidence alarms for this length of time, something more should have been done.

The Hearing Tribunal also considered that Ms. Curran was mistaken in noting that the SpO2 was the only way to record the maternal heart rate on the electronic fetal monitoring strip. Exhibit 4 confirms that the TOCO can record the maternal heart rate. She also did not appear to understand the notation on the strip that SpO2 with a question mark and a dash indicates that the SpO2 monitor is not on the mother's finger.

The Hearing Tribunal found Ms. Curran to be a credible witness, but given the qualifications by Ms. Curran that you do need to be in the patient room to understand the full picture when interpreting the electronic fetal monitoring strips and the issue around the SpO2 monitor, as well as her use of a classification system that was not yet in circulation (the Fetal Health Surveillance Practice Support Document dated August 2022), limited weight was placed on her evidence and her case review.

Dr. Vetter

The Hearing Tribunal found Dr. Cheyanne Vetter somewhat cautious in her testimony but found her evidence both credible and reliable.

Dr. Vetter gave evidence that confirmed the demeanour of [redacted] and did not support the evidence of [redacted] regarding maternal distress. Dr. Vetter testified that [redacted] did not scream about a band ripping and only told Dr. Vetter she felt this the following day.

Dr. Vetter also confirmed that the Registrants were palpating manually for a pulse. Dr. Vetter had multiple interactions with Ms. Nygaard and was in and out of the room several times. Dr. Vetter acknowledged progression of labour was slow.

The Hearing Tribunal accepted Dr. Vetter's evidence that she gave [redacted] the option of a C-section a few times. She acknowledged knowing that she did not have a great strip around 1700h and that while [redacted] was actively pushing, she mentioned the C-section again and gave her the choice of attempting a vacuum. After failed vacuum attempts, the patient asked for a second opinion. A decision was made and the operating room was prepared. The Hearing Tribunal noted that Dr. Vetter did not testify directly to hearing the fetal heart rate when she was asked to come back in the room. However, she was not asked directly about this in her testimony. Ms. Kern's evidence was that at a point, she could not find a fetal heart rate and that Dr. Vetter came back to the room and found a heart rate briefly at around 2053h and then lost it again. A decision was made for a "stat" C-section at that point.

The Hearing Tribunal considered that the physician is the most responsible health care practitioner and ultimately it is their call whether or not to proceed by C-section. While Dr. Vetter was asked to interpret the electronic fetal monitoring strips, the Hearing Tribunal placed limited weight on her assessment of the electronic fetal monitoring strips.

The Hearing Tribunal placed significant weight on Dr. Vetter's testimony that the Registrants were palpating the maternal pulse and advising her of the status. Dr. Vetter also confirmed that the Registrants were providing active nursing care to [redacted] throughout their shifts.

Dr. DeVos

Dr. Werner DeVos provided evidence about his role as anesthesiologist involved in [redacted] pain management. The Hearing Tribunal considered that Dr. DeVos did not report that [redacted] pain was "out of the norm" (was not unusual) for a patient in labour and delivery. His role became more active when he was asked for a second opinion.

The Hearing Tribunal found Dr. DeVos to minimize his role in the events. His testimony focussed on his role as anesthesiologist. However, the Operative Report also shows that he was the surgeon who performed the C-section.

However, Dr. DeVos did corroborate the testimony of the Registrants in that he was in the room several times on September 21. As the anesthesiologist, he was the expert in dealing with pain. He did not testify that [redacted] pain was "out of the norm" (was not unusual) for a labour and delivery patient. His evidence aligned with the Registrants' testimony that [redacted] was not in distress and also supported that the Registrants were advocating for [redacted]

[redacted]

The Hearing Tribunal considered the evidence of [redacted] Similar to [redacted] the Hearing Tribunal found that [redacted] was giving testimony to the best of his recollection. However, the testimony was of limited reliability. While [redacted] testified that [redacted] was yelling out in pain, he felt that everything was normal. There was no evidence that in the moment, he thought something was wrong, which contradicts [redacted] evidence that she was screaming about a band ripping and that she wanted a C-section. His evidence was also that his wife was closing her eyes, but did not substantively corroborate that she was losing consciousness.

Dianne Mailloux

The Hearing Tribunal considered the evidence of Dianne Mailloux. Her evidence confirmed that there was someone in the room at all times. The Hearing Tribunal considered that Ms. Mailloux was a friend, but also a Registered Nurse with many years of experience, including being charge nurse on the labour and delivery unit on the day in question and was involved in patient [redacted] care when she was covering breaks. Additionally, after her shift ended, she came in to visit as a friend after her shift ended.

Ms. Mailloux did not recall any screaming. She noted that [redacted] was adamant to have a vaginal delivery. Ms. Mailloux did not testify that [redacted] was in a lot of distress and in fact she testified that they were "visiting" while she was covering Ms. Nygaard's break and that [redacted] was excited.

The Hearing Tribunal placed little weight on the reliability of the clinical information from Ms. Mailloux, noting that she did not know what a coincidence alarm (question mark) was on the electronic fetal monitoring strip. The Hearing Tribunal was concerned that a charge nurse covering breaks in labour and delivery would not be aware of what a coincidence alarm was.

Chantel Nygaard

The Hearing Tribunal generally found Ms. Nygaard to be a credible and reliable witness. She gave her evidence in a direct manner and was not evasive in her answers.

Ms. Nygaard had five years' experience at the time of the incident. She gave evidence that you need to be in the room to understand what the monitors are saying. She recognized the need for

manual palpation of the mother, which was corroborated by the two physicians in the room (Dr. Vetter and Dr. DeVos). Her evidence regarding the manual palpations was credible and supported by the evidence of other witnesses.

Ms. Nygaard's evidence diverged from Ms. Mailloux's regarding whether Ms. Mailloux was present. According to Ms. Nygaard's evidence, after her last break, Ms. Mailloux stayed in the room.

Ms. Nygaard was very confident in her evidence of what occurred during her shift. She understood that decelerations during the trial pushes could be a sign of fetal distress and made Dr. Vetter aware of these with Dr. Vetter taking action and getting [redacted] ready for delivery.

Ms. Nygaard also understood that the electronic fetal monitoring strips were not normal and took steps such as manually palpating the mother's pulse and the mother's abdomen to assess the contractions.

Kelsey Kern

The Hearing Tribunal generally found Ms. Kern to be a credible and reliable witness. She had five years' experience as a nurse in labour and delivery at the time of the events.

Ms. Kern demonstrated during the hearing that she knew how to read the electronic fetal monitoring strips. She had received report at the patient's bedside from Ms. Nygaard who reported there had been decelerations throughout the day and that they had been watching and they came back to normal; that there had been vacuum attempts; that the patient really wanted a successful vaginal birth; that there were coincidence alarms and that the two heart rates looked similar on the strip but that the physician was aware and they had been manually palpating the maternal pulse to make sure they had two patients. Dr. Vetter was at the foot of the bed and Ms. Kern confirmed this with her. Ms. Kern also noted that the coincidence alarms occurred on her shift.

However, the Hearing Tribunal noted that Ms. Kern's evidence was less clear in terms of some of the events during her shift caring for patient [redacted] For example, there was a period of time when the machine ran out of paper and needed to be replaced to capture ongoing electronic readings. This was not thoroughly explained in her testimony. After the paper in the electronic fetal monitor was changed, Ms. Kern noticed the electronic fetal monitoring strip was very different. Ms. Kern did not change the machine to see if it was malfunctioning, just the paper. She wrote on the strip that Dr. Vetter in to assess (Exhibit 1, page 416). Ms. Kern testified that at 2053h, Dr. Vetter found a fetal heart rate but that it was lost again. In addition, Ms. Kern did not give detailed evidence about what occurred between 2053h and 2109h when it was charted that [redacted] went to the operating room.

Allegation 1(a) On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they did one or more of the following: failed to recognize fetal and/or maternal distress on one (1) or more occasion

The Hearing Tribunal found that Allegation 1(a) was not proven.

The Hearing Tribunal considered whether it was proven that there was a failure by Ms. Kern to recognize maternal distress. The Hearing Tribunal recognized that a patient will be in distress

during labour and delivery. However, there was insufficient evidence to support that there was maternal distress experienced by [redacted] which was out of the ordinary.

The Hearing Tribunal considered the evidence of [redacted] and [redacted] regarding [redacted] screaming. However, this evidence appeared more focused to the shift involving Ms. Nygaard.

The patient room was busy when Ms. Kern started her shift. Ms. Kern obtained report from Ms. Nygaard at the bedside with Dr. Vetter present. Ms. Kern charted her observations and care of [redacted] Ms. Kern took the maternal heart rate by palpation and palpated the abdomen for contractions. She charted that [redacted] was requesting a top up and vitals were done in accordance with the policy. [redacted] was given dextrose 5 percent in water for maternal exhaustion. Ms. Kern advised the physician that there were still no contractions on the strip. Ms. Kern had been manually palpating the abdomen for contractions and there were none. Dr. Vetter gave a verbal order for oxytocin to try to get the contractions going. Ms. Kern continued to assess [redacted] epidural.

Dr. Vetter confirmed that Ms. Kern was advising her of the status of the electronic fetal monitoring strip and maternal heart rate by palpation. The Hearing Tribunal found that Ms. Kern took appropriate steps to address maternal discomfort during labour, including distress from the labour. In addition, the evidence did not establish that [redacted] was in maternal distress other than the expected distress of labour.

The evidence showed that Ms. Kern monitored [redacted] throughout her shift and took steps to obtain pain control, address maternal exhaustion and to appropriately manage the patient. The Hearing Tribunal found that based on the evidence of Ms. Kern, Dr. DeVos and Dr. Vetter, Ms. Kern recognized maternal discomfort or distress when it occurred, and took appropriate steps, including getting the patient a “top up”, giving [redacted] dextrose 5 percent in water for maternal exhaustion and monitoring the patient’s vital signs, including the maternal pulse by palpation as per documentation. The testimony and documentary evidence, in particular the Multidisciplinary Notes, confirm that Ms. Kern was involved in active pain management and monitoring of [redacted] during her shift.

Conduct Counsel stated in closing submissions that Ms. Kern failed to recognize that [redacted] was tachycardic based on the electronic fetal monitoring strips on multiple occasions. The Hearing Tribunal found that, while some of the strips could be interpreted as [redacted] being tachycardic, given the evidence from various witnesses that one needs to be in the patient room to know what is happening and given the maternal pulse palpated and documented by Ms. Kern which was not tachycardic (Exhibit 1, page 112), it was not established on a balance of probabilities that [redacted] was tachycardic or that Ms. Kern failed to recognize that [redacted] was tachycardic.

The Hearing Tribunal next considered whether it was proven that Ms. Kern failed to recognize fetal distress. Ms. Kern recognized that there might be fetal distress. She was aware of the overlapping lines on the electronic fetal monitoring strips and advised the physicians, in particular Dr. Vetter of this (as confirmed by Dr. Vetter in her testimony). Ms. Kern palpated for the maternal pulse to confirm there were two different heart rates. In addition, Ms. Kern considered whether there might have been a uterine rupture. Finally, Ms. Kern identified the potential for fetal distress when she could no longer locate the fetal heart rate and immediately went to get Dr. Vetter. The Hearing Tribunal found that the allegation that Ms. Kern failed to recognize fetal distress was not proven.

There is some overlap regarding the issue of fetal distress and the electronic fetal monitoring strip. However, the issue of whether or not Ms. Kern read the electronic fetal monitoring strip accurately is addressed in 1(b).

Allegation 1(b) On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they did one or more of the following: failed to read an electronic fetal monitoring strip accurately on one (1) or more occasion

The Hearing Tribunal found that Allegation 1(b) was proven.

The Hearing Tribunal considered that it would have been helpful to have an expert qualified to provide expert evidence regarding electronic fetal monitoring strips. It would also have been helpful to have a more specific timeline provided. The Hearing Tribunal spent a great deal of time in its deliberations recreating a timeline of events.

In addition, the file review by Ms. Curran, while helpful, did not address the facts of the case, in terms of the medical professionals in the room, what was occurring in the room in addition to the electronic fetal monitoring strip or the standard expected of a registrant given the circumstances occurring in the patient room.

The Hearing Tribunal found that when considering the evidence as a whole, including the Exhibits and witness testimony, it was proven that Ms. Kern failed to read the electronic fetal monitoring strip accurately on one or more occasion. The electronic fetal monitoring strip had overlapping lines and coincidence alarms for a significant period of time. The Hearing Tribunal found that Ms. Kern recognized that there may be fetal distress. She took steps such as palpating [redacted] maternal pulse and advising the physician. However, she recorded in her notes that the electronic fetal monitoring strip was “normal” on several occasions (Exhibit 1, pages 112 and 127).

The Hearing Tribunal found that documenting the electronic fetal monitoring strips as “normal” despite the overlapping lines and coincidence alarms for a lengthy period of time, and the failure to take additional steps to determine if the electronic fetal monitor was working appropriately demonstrate a failure to read the electronic fetal monitoring strip accurately.

Additional steps could have been taken to determine if the electronic fetal monitor was working appropriately. There was testimony that the monitors do not always function properly and that it is not the best technology. For example, the machine could have been changed if it was thought that the machine may not be functioning properly or the fetal heart rate could have been assessed using a handheld Doppler monitor, which occurred when Dr. Vetter was asked to come in to assess. In addition, the electronic fetal monitor had no paper for several minutes. The Hearing Tribunal considered this to be particularly serious, especially given the overlapping lines and coincidence alarms that had been on the electronic fetal monitoring strip for an extended period of time. The failure to ensure the paper was replaced immediately in these circumstances, contribute to the Hearing Tribunal’s finding that Ms. Kern failed to read the electronic fetal monitoring strip accurately as she did not appear to understand the urgency for replacing the paper.

The Hearing Tribunal noted that the medical professionals who provided testimony, including Ms. Curran, noted that one needs to be in the room to fully understand the electronic fetal monitoring strip.

However, Ms. Kern noted on the electronic fetal monitoring strip that it was normal (by noting "N") (Exhibit 1, page 110). The electronic fetal monitoring strip was not normal. Even considering all the factors occurring in the room, including that [redacted] was pushing, that there were vacuum attempts and administration of medication, the Hearing Tribunal found that the electronic fetal monitoring strip was not normal.

During Ms. Kern's shift, the electronic fetal monitoring strip had overlapping lines for the fetal and maternal heart rate and coincidence alarms until the monitor ran out of paper. Ms. Kern was aware that the strip had overlapping lines and coincidence alarms for a significant period of time before her shift started. The paper was not replaced for several minutes.

The Hearing Tribunal found that the Code of Ethics was not engaged for this Allegation.

The Hearing Tribunal noted the following Standards of Practice:

1.4 The nurse practices competently.

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Ms. Kern did not practice competently or apply nursing knowledge and skill in a competent manner in how she classified the electronic fetal monitoring strips as normal ("N") in light of the prolonged overlapping lines and coincidence alarms. The Hearing Tribunal found that the breaches of these Standards were serious and constituted unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

In addition, the Hearing Tribunal found that the conduct demonstrated a lack of skill or judgment in the provision of professional services. Ms. Kern would be expected to have recognized the concerns with the electronic fetal monitoring strip and that it was not a normal strip as documented, even with everything that was happening in the room. Her failure to do so, even with the palpation of the maternal pulse demonstrated a lack of skill or judgment and is unprofessional conduct pursuant to section 1(1)(pp)(i) of the HPA.

Allegation 1(c) On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they did one or more of the following: failed to confirm or consult with a physician on atypical and/or abnormal findings on the electronic fetal monitoring strip on one (1) or more occasion

The Hearing Tribunal found that Allegation 1(c) was not proven.

The evidence of Ms. Kern, Dr. Vetter and Dr. DeVos confirmed that Ms. Kern communicated with the physicians. There was consistently a physician in the patient room when Ms. Kern started her shift and until Dr. Vetter left to get ready for the operating room.

The Hearing Tribunal accepted the evidence of Ms. Kern that she was communicating with Dr. Vetter on a consistent basis regarding the overlapping lines, the coincidence alarms and that she was manually palpating for a pulse. Dr. Vetter's evidence confirmed this. Dr. DeVos also confirmed that Ms. Kern communicated with him about the fetal heart rate. In addition, when Ms.

Kern could not find the fetal heart rate, she went to get Dr. Vetter who had left the patient room to get ready for the operating room. Dr. Vetter came back and reassessed the patient, including using a Doppler ultrasound to attempt to locate the fetal heart rate.

Allegation 1(d) On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgment when they did one or more of the following: failed to palpate the maternal pulse and/or adequately palpate the maternal pulse on one (1) or more occasion

The Hearing Tribunal found that Allegation 1(d) was not proven.

The evidence was clear that Ms. Kern did manually palpate for the maternal pulse during her shift. Ms. Kern testified to this and Dr. Vetter's testimony confirms that Ms. Kern was palpating the maternal pulse. The Patient Chart also reflects this (Exhibit 1, page 113). There was no suggestion that Ms. Kern charted something she did not do and the Hearing Tribunal accepted the evidence regarding Ms. Kern manually palpating the pulse.

The Complaints Director did not demonstrate a failure of Ms. Kern to manually palpate for the pulse. The Hearing Tribunal further noted that no information was provided to assist the Hearing Tribunal in establishing what time it is alleged that the maternal pulse was not palpated or not palpated properly.

In addition, while Conduct Counsel suggested generally that Ms. Kern did not palpate appropriately, suggesting that Ms. Kern was not competent in how she took the maternal radial pulse, there was no evidence to support this argument. It was suggested in closing submissions that [redacted] was tachycardic, but as noted above, this was not proven on a balance of probabilities.

Allegation 1(d) appeared to be based on an assumption that the electronic fetal monitoring strip had to be reflecting the mother's heart rate. However, the Hearing Tribunal noted that taking a patient's radial pulse is a basic skill and there was no evidence provided to show that Ms. Kern did not take the patient pulse correctly. In addition, Ms. Nygaard whose shift preceeded Ms. Kern's, palpated for the maternal pulse and obtained results consistent with Ms. Kern's. The Hearing Tribunal considered that it was very unlikely that two Registered Nurses would fail in the basic skill of palpating the maternal pulse.

CONCLUSION

The Hearing Tribunal finds that Allegation 1(b) is proven and constitutes unprofessional conduct on the basis of section 1(1)(pp)(i) and (ii) of the HPA.

The Hearing Tribunal finds Allegations 1(a), (c) and (d) not proven. Allegation 1(a), (c) and (d) are dismissed.

The Hearing Tribunal will receive submissions from the parties on sanction. The Hearing Tribunal requests that the parties discuss and determine the timing and method of providing submissions on penalty to the Hearing Tribunal. If the parties are unable to agree on a proposed procedure and timing, the Hearing Tribunal will make further directions as required.

Kimberly Boyko, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: September 9, 2025

COLLEGE OF REGISTERED NURSES OF ALBERTA (the "**College**")

DECISION OF THE HEARING TRIBUNAL ON SANCTION

RE: CONDUCT OF **KELSEY KERN,** R.N. REGISTRATION **#106,202**

AS A RESULT OF A SANCTION HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

January 28, 2026

I. INTRODUCTION

A virtual hearing was held on **January 28, 2026,** via videoconference before a Hearing Tribunal of the College to hear submissions on sanction regarding Kelsey Kern, R.N. registration #106,202 **(**the **"Registrant")**.

Those present at the hearing were:

a. Hearing Tribunal Members:

Kimberly Boyko, RN, Chairperson
Bonnie Bazlik, RN,
Andrew Otway, Public Member
Vince Paniak, Public Member

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. College Representative:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Kelsey Kern (sometimes hereinafter referred to as "the **Registrant**")

e. Registrant's Labour Relations Officer ("LRO"):

Silvie Montier

e. CRNA Staff:

Marina Skoreiko, Hearings Facilitator (attending by videoconference)

II. PRELIMINARY MATTERS

The Hearing Tribunal addressed two preliminary matters.

At the outset of the hearing, the Registrant's LRO (Labour Relations Officer) requested that the Complainant be required to keep her camera on during the hearing. Conduct Counsel took no position on the application. The Hearing Tribunal declined the request, noting that witnesses are required to appear on camera when giving evidence, but members of the general public are not. At the time of the request, the Complainant was not appearing as a witness and was attending the hearing as a member of the general public. The hearing was open to the public and no application was brought to close the hearing under section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**").

The second preliminary matter was whether submissions for the two Registrants should be heard together or separately, given that the hearing had been previously joined. Counsel for the

Registrants and Conduct Counsel filed two sets of submissions, one addressing each Registrant. The Hearing Tribunal determined that it would hear submissions from Conduct Counsel on both matters before inviting submissions from the LRO. The Hearing Tribunal was satisfied that this approach was consistent with the procedure followed during the hearing on the Allegations.

III. BACKGROUND

The Hearing Tribunal issued its decision on the Allegations on September 9, 2025 (the "**Merits Decision**").

The Hearing Tribunal found that the following Allegation was proven:

Allegation 1(b):

On or around September 21, 2022, the Registrant demonstrated a lack of knowledge, skill and/or judgement when they did one or more of the following: failed to read an electronic fetal monitoring strip accurately on one (1) or more occasion.

IV. EVIDENCE AND DOCUMENTS PROVIDED:

The following documents were entered as Exhibits in the hearing on sanction:

Exhibit #5 – Appendices to the Registrant's Written Submissions;

Exhibit #6 – Performance Evaluation of Ms. Nygaard;

Exhibit #7 – Performance Evaluation of Ms. Kern;

Exhibit #8 – Certificate of Completion Documentation in Nursing for Ms. Nygaard;

Exhibit #9 – Education Certificates 2024-2026 for Ms. Nygaard; and

Exhibit #10 – Education for Ms. Kern.

In addition, written submissions were provided in advance of the hearing:

a) Submissions on Sanction from Conduct Counsel;

b) Book of Authorities of the College (with Tabs 1-8):

1 Practice Report
2 *Jaswal v. Medical Board (Nfld.), 1996 CanLII 11630 (NL SC)*
3 Decision of the Hearing Tribunal on the Allegations RE: Conduct of Kelsey Kern
4 *College of Nurses of Ontario v Thompson, 2007 CanLII 82762 (ON CNO)*
5 *College of Nurses of Ontario v Hogue, 2021 CanLII 152830 (ON CNO)*
6 *College of Nurses of Ontario v Doak, 2000 CanLII 50735 (ON CNO)*
7 *Course description:* Intro to Health Assessment
8 *Course description:* Responsible Nursing

c) Submissions on Sanction on behalf of Ms. Kern;

d) Appendices (marked as Exhibit #5).

V. SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction to be ordered by the Hearing Tribunal.

Submissions by Conduct Counsel:

Conduct Counsel began his submissions by noting that the primary purpose of sanctioning is to protect the public and maintain confidence in the profession. He submitted that while denunciation and deterrence are legitimate considerations when determining sanction, any sanction imposed must ultimately remain measured, proportionate, and reasonable in the circumstances.

Conduct Counsel submitted that the following sanctions are appropriate:

a. That the Registrant receive a reprimand for unprofessional conduct;

b. That the Registrant complete the following courses by October 20, 2026:

    i. *Intro to Health Assessment* – NURS0163 (MacEwan); and

    ii. *Responsible Nursing* – NURS0170 (MacEwan)

c. That, prior to commencing next employment in Alberta or otherwise performing nursing practice hours in Alberta as a registrant of the College, Nurse Practitioner, Provisional Permit Holder, the Registrant provide a Practice Setting Letter from their prospective employer that confirms in writing:

    i. The anticipated practice setting and workplace;

    ii. The Registrant's role of employment

    iii. The name and contact information of the anticipated Registered Nurse or Nurse Practitioner manager at the Practice Setting (the "**Supervisor**");

    iv. The Supervisor has read the Hearing Order on this matter; and

    v. The Supervisor agrees to provide the College with an Employer Reference;

d. That the Registrant provide the Employer Reference from their Supervisor 180 days after their Practice Setting Letter is approved by the Complaints Director. The Employer Reference must be acceptable to the Complaints Director and confirm the following:

    i. Whether the Registrant has completed at least 330 hours of nursing practice;

ii. That such nursing practice hours occur no earlier than the date of the written hearing order being issued to the Registrant; and

iii. Whether concerns exist about the Registrant's practice and whether they met or exceeded the standards expected of an RN.

Conduct Counsel submitted that the proposed sanctions combine specific deterrence and remediation. He stated they are designed to improve the Registrant's future practice while ensuring the public is protected. More specifically, the *Intro to Health Assessment* course was chosen because the Hearing Tribunal found that the Registrant failed to read an electronic fetal monitoring strip on one or more occasion. Accordingly, the course will ensure that the Registrant applies appropriate assessment tools and maintains patient safety. The *Responsible Nursing* course was proposed to provide the Registrant with a deeper understanding of how professional standards inform and guide nursing practice, thereby reinforcing accountability and commitment to responsible nursing.

In addition, Conduct Counsel submitted that the reprimand, Practice Setting Letter, and Employer Reference serve as specific deterrence measures. These sanctions are intended to support the Registrant's success in future practice, ensure ongoing protection of the public, and guarantee that any future employer is aware of the Hearing Tribunal Order.

Conduct Counsel reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case, noting the following:

1. The nature and gravity of the proven allegations:

   The breach of Allegation 1(b) constitutes a serious breach of the Standards of Practice and consequently, the nature and gravity of the proven Allegation is serious.

2. The age and experience of the member:

   The Registrant was a young and relatively inexperienced nurse at the time of the proven Allegations.

3. The previous character of the member:

   The Registrant does not have a history of discipline with the College.

4. The age and mental condition of the offended patient:

   The patient was a young woman in labour at the time of the proven Allegations.

5. The number of times the offence was proven to have occurred:

   The offence occurred on September 21, 2022.

6. The role of the Registered Nurse in acknowledging what occurred:

   The Registrant has not acknowledged what occurred. Rather, she contested the Allegations and no agreement was reached on sanctions.

7. Whether the member has already suffered other serious financial or other penalties:

   The Registrant has not experienced any apparent financial or other penalties arising from the Allegations.

8. The impact on the offended patient:

   The patient felt her treatment was subpar and consequently submitted a complaint.

9. The presence or absence of any mitigating factors:

   The Registrant was relatively inexperienced at the time of the Allegations and lacks a history of discipline.

10. The need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of nursing:

    General deterrence is an important consideration because it reinforces the obligation to practice competently, use appropriate techniques, and maintain thorough and accurate documentation. Specific deterrence is required to ensure the proven conduct is not repeated. The reprimand and employer reference serve that purpose.

11. The need to maintain the public's confidence in the integrity of the nursing profession:

    Maintaining public confidence in the profession is critical as the College's statutory mandate is to protect and serve the public interest.

12. The degree to which the offensive conduct is outside the range of permitted conduct:

    The Hearing Tribunal found that Allegation 1(b) was proven on the evidence.

13. The range of sentence in other similar cases:

    Hearing Tribunals across Canada treat errors during childbirth as serious. Conduct Counsel referred to several College of Nurses of Ontario Discipline Committee decisions that demonstrate both a punitive and remediation-based approach to sanctioning. In *College of Nurses of Ontario v Thompson, 2007 CanLII 82762 (ON CNO)* ("***Thompson***"), the RN was issued a reprimand, a 30-day suspension and a self-directed learning packet amongst other sanctions. In *College of Nurses of Ontario v Hogue, 2021 CanLII 152830 (ON CNO)* ("***Hogue***"), a variety of sanctions were issued including a reprimand, a 5-month suspension of the RN's practice permit, and course work. Conduct Counsel noted that *Hogue* involved more severe allegations of unprofessional conduct surrounding childbirth than the present case. *College of Nurses of Ontario v Doak, 2000 CanLII 50735 (ON CNO)* ("***Doak***") had similar facts to this case. In that case, the RN was reprimanded, issued a 3-month suspension and ordered to meet with a nursing practice consultant in order to review the standards of practice.

Submissions by the LRO:

The Registrant's LRO began her submissions by disputing Conduct Counsel's characterization of the purpose of sanctioning. Conduct Counsel submitted that the College's regulatory authority is exercised for the purpose of safeguarding the public. By contrast, the LRO argued that this interpretation is too narrow and that the disciplinary process serves a different function, namely, to remedy professional misconduct by a Registrant and to return them to a standard of practice that ensures public safety. The LRO submitted that this approach is consistent with the decision in *Jaswal* v. *Newfoundland Medical Board,* as the factors identified in that case focus on the conduct and circumstances of the offending practitioner.

The LRO noted that the sanctions sought by Conduct Counsel are inappropriate. First, it was argued that the proposed courses would not remedy the Registrant's error and therefore do not serve the purpose of rehabilitating the Registrant to protect the public. In response, the LRO suggested a more suitable course such as *Fetal Health Surveillance*, which the Registrant has already completed.

Second, the LRO submitted that the proposed Practice Setting Letter and Employer Reference are not realistic sanctions as the Registrant is currently employed.

Lastly, the LRO opposed Conduct Counsel's request for a reprimand. The LRO submitted that, within the range of potential errors in these circumstances, the Registrant's conduct was not among the most serious. Furthermore, it was argued that it is unclear whether the outcome would have been different had the error not occurred.

The LRO submitted that the case law relied upon by Conduct Counsel is not applicable to the circumstances of this case. The *Thompson* case is distinguishable because the nurse in that matter failed to perform required tasks, whereas here the Registrant performed the required tasks, but made an error in interpretation. The LRO further submitted that in the *Hogue* case, the nurse failed to seek medical assistance despite identified concerns, while in the present case the Registrant sought guidance from a physician and an anesthesiologist upon identifying irregularities. Finally, the LRO stated that the decision in the *Doak* case is distinguishable as the nurse in that case had a higher level of experience and failed to recognize fetal distress patterns. In contrast, in this case there was no finding of fact that the mother or baby were in distress.

The LRO reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case, noting the following:

1. The nature and gravity of the proven allegations:

   When compared to the seriousness of other offences, the proven Allegations are in the low range of gravity.

2. The age and experience of the member:

   The Hearing Tribunal was asked to strike any mention of the Registrant's specific age and instead, use the term 'young'.

3. The role of the Registered Nurse in acknowledging what occurred:

It was submitted that Conduct Counsel's position regarding the Registrant's acknowledgement of the incident is unfair. A Registrant's decision to proceed to a hearing or to decline proposed sanctions cannot be taken as evidence that the Registrant denied an error occurred. Counsel emphasized that Registrants are entitled to require the College to prove its case and to exercise their right to a full defense.

4. Whether the member has already suffered other serious financial or other penalties:

The Registrant has experienced ongoing negative consequences arising from the Complainant's conduct following the incident. The Complainant has used social media, podcasts, and attendance at a seminar to make commentary regarding the matter and the Registrants that are inconsistent with both the events as they occurred and the findings of the Hearing Tribunal. Consequently, the LRO submitted that the Registrant has been subjected to questions and comments in the workplace and from family members and subject to rumours and odd looks from people in the small community where she resides. The LRO characterized the Complainant's behaviour as bullying and submitted that it has functioned as a form of punishment in itself.

The Registrant has also experienced a significant impact on her health.

5. The presence or absence of any mitigating factors:

Several mitigating factors are present, including, but not limited to, the following:

a. The Registrant does not have a history of discipline and was a young and inexperienced nurse;

b. The incident occurred on the Registrant's first shift back following a one year maternity leave;

c. The Facility did not have staff or resources to properly deal with the incident;

d. The Hearing Tribunal dismissed three of the four Allegations;

e. The incident was a single, isolated error;

f. The incident occurred during the Registrant's first full shift following her maternity leave;

g. The Registrant independently completed several relevant courses after the incident and the Merits Decision;

h. The College published multiple notices to attend on their website with the Registrant's name attached;

i. The Merits Decision and Sanction Decision should have been posted together. Posting them separately will again result in this matter and the Registrant's name being republished on the College's website; and

j. The proceedings in this matter have been excessively delayed. In *Wachtler v College of Physicians and Surgeons*, 2009 ABCA 130 (Alta. C.A.), the Alberta Court of Appeal held that delay is an important mitigating factor and failure to consider it as such is unreasonable. In addition, in *Kherani v Alberta Dental Association and College*, 2025 ABCA 2, the Court of Appeal noted that the time period for delay is from when the event occurred to the time of the order for sanction.

6. The need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine:

   The LRO submitted that a reprimand and employer reference will not serve the purpose of deterrence. An employer evaluation cannot realistically determine whether the Registrant is properly classifying electronic fetal monitoring strips. The LRO further submitted that a reprimand would not serve the purposes of deterrence given the amount of time that has passed since the incident. Accordingly, the LRO suggested a caution instead of a reprimand.

The LRO submitted that the *Jaswal* factors are not exhaustive and asked the Hearing Tribunal to consider the impact that additional sanctions may have on the Registrant. Severe sanctions could undermine the Registrant's confidence in her skills and knowledge, leading to discouragement. The Registrant has already taken steps to remedy the identified errors and to ensure she maintains a safe practice going forward.

The LRO submitted that the following sanction is appropriate:

a. That the Registrant receive a caution for unprofessional conduct.

Reply Submissions by Conduct Counsel:

Conduct Counsel submitted that the proposed assessment course is appropriate because the Registrant failed to use the appropriate tools when assessing electronic fetal monitoring strips. The Hearing Tribunal found that the Registrant demonstrated a lack of understanding when interpreting the strips, which indicates that the patient was inadequately assessed.

In response to the submission that the cited cases are distinguishable, Conduct Counsel noted that it is unlikely to find cases with allegations identical to those in the present matter. Nevertheless, the cited cases remain instructive as they illustrate a range of sanctions that are available to the Hearing Tribunal. Conduct Counsel explained that the proposed sanctions have been tailored to reflect the seriousness of the Allegations and are significantly less onerous than those imposed in *Hogue*.

Conduct Counsel also highlighted that in *Thompson*, the member admitted to the Allegations, a mitigating factor that is absent in the present case. In addition, Conduct Counsel noted that the LRO did not submit case law addressing the treatment of social media posts.

Conduct Counsel denied that there has been a delay in the proceedings and submits that publication bylaws are not at issue in this hearing.

Finally, Conduct Counsel submitted that a mere caution would be insufficient to protect the public or maintain confidence in the profession.

Questions from the Hearing Tribunal:

The Hearing Tribunal asked the following question in relation to the Registrant:

1. Conduct Counsel was asked how the Registrant would be expected to comply with the proposed Practice Setting Letter and Employer Reference sanctions, given that it states, "prior to commencing next employment in Alberta" and she is currently employed.

   Conduct Counsel clarified that the practice setting letter and employment reference would need to be provided within fifteen (15) days of the Hearing Tribunal's order on sanctions.

VI. DECISION OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal reviewed and considered the submissions of the parties with respect to sanction. The Hearing Tribunal found that a reprimand for unprofessional conduct is appropriate in the circumstances.

Additionally, the Hearing Tribunal determined that remedial education is necessary. In particular, the Hearing Tribunal concluded that the Registrant must successfully complete and pass the following course of study:

1. *Fetal Health Surveillance Refresher Workshop (Canadian Fetal Health Surveillance Education);*

Finally, the Hearing Tribunal determined that it is appropriate for the Registrant to provide an Employer Reference Letter from their supervisor confirming whether any concerns exist regarding the Registrant's practice, and whether the Registrant meets or exceeds the standards expected of an RN.

The Hearing Tribunal's reasons and the specific orders of the Hearing Tribunal are set out below.

VII. REASONS

The Hearing Tribunal considered the principles of sentencing and the factors in *Jaswal*, in particular:

i. The nature and gravity of the proven allegation: The Hearing Tribunal found that reviewing and accurately interpreting electronic fetal monitoring strips is a fundamental component of practicing nursing in obstetrics/labour and delivery. Continuous fetal monitoring is relied upon to detect signs of fetal distress/compromise and to guide timely escalation of care. Failing to meet this obligation undermines the safe delivery of care. The Hearing Tribunal concluded that the proven Allegation constitutes a significant departure from the standards expected of a nurse practicing in this area. For these reasons, the Hearing Tribunal considered the proven Allegation to be serious and to warrant a sanction that appropriately reflects that seriousness.

ii. The age and experience of the member: The Hearing Tribunal considered the Registrant's age and experience at the time of the events, including that she was just back from a

maternity leave. While the Hearing Tribunal acknowledges that the Registrant is young and early in her practice, it is well established that nurses are individually accountable for their professional conduct from the outset of their careers. The Hearing Tribunal was not prepared to view the Registrant's conduct as less serious merely because the Registrant was a relatively inexperienced nurse. Accordingly, while the Hearing Tribunal considered the Registrant's age and experience as part of the overall contextual analysis, it concluded that this factor did not significantly mitigate the seriousness of the proven Allegation.

Additionally, the Hearing Tribunal noted the LRO's concern regarding publication of the Registrant's age. The Hearing Tribunal noted it would refer to the Registrants by their level of experience rather than age.

iii. The impact on the offended patient: The Hearing Tribunal carefully considered the impact of the proven conduct on the patient. The events of this case culminated in a profoundly serious outcome, the death of an infant.

iv. The role of the Registered Nurse in acknowledging what occurred: Counsel for the parties took differing positions on this issue. The Hearing Tribunal acknowledges that a Registrant's decision to defend against allegations is not an aggravating factor. Registrants are entitled to require the College to prove its case and to participate fully in the hearing process without fear that doing so will later be viewed as an aggravating factor. In assessing whether the Registrant has acknowledged what occurred, the Hearing Tribunal considered the Registrant's conduct following the events in question. The evidence establishes that the Registrant has taken concrete steps to address the deficiencies identified in the proven Allegations. This included the completion of additional education and a course specifically related to fetal monitoring; the area of practice engaged by the Hearing Tribunal's findings. The Hearing Tribunal found that these remedial efforts demonstrate that the Registrant has reflected on her conduct, recognizes the shortcomings in her practice, and is actively taking steps to prevent recurrence.

v. Whether the member has already suffered other serious financial or other penalties: The Hearing Tribunal considered whether the Registrant has already suffered other serious financial or non-financial consequences. The LRO submitted that the Registrant has been affected both personally and professionally because of the Complainant's public commentary on the hearing. Counsel submitted that these activities have affected the Registrant's experience in the workplace and have caused ongoing stress, health impacts and reputational harm. The Hearing Tribunal accepts that these circumstances have had a real and meaningful impact on the Registrant. However, the Hearing Tribunal also recognized that this has been an extraordinarily difficult and deeply personal situation for the Complainant. Nonetheless, the Hearing Tribunal is required to assess the impact of all relevant circumstances on the Registrant when determining sanction. Accordingly, the Hearing Tribunal found that the public nature of the commentary has resulted in consequences for the Registrant that extend beyond the regulatory process.

The Hearing Tribunal also considered the length of time these proceedings have taken. The Registrant has experienced prolonged stress and uncertainty arising from the unresolved nature of these proceedings and the potential impact of the outcome on her professional future. The Hearing Tribunal found that this extended process has imposed an additional emotional burden on the Registrant. In addition, the passage of time has to some extent addressed the conduct. No further conduct or complaints have arisen in the intervening time

since the events in September 2022. In addition, the Registrant has used the time to take courses to help improve her practice.

vi. The presence or absence of any mitigating factors: The Hearing Tribunal considered the LRO's position that the following are mitigating factors: the Registrant's lack of disciplinary history and the isolated nature of the error, her young age and experience level at the time of the events, the fact that the events occurred during the Registrant's first full shift following her maternity leave, that the facility lacked adequate staffing and resources to appropriately manage the incident, the dismissal of three of the four Allegations, the Registrant's completion of multiple relevant educational courses on her own initiative following the incident, the repeated re-publication of the Registrant's name on the College's website, and the excessive delay in the completion of these proceedings.

The Hearing Tribunal considered the lack of disciplinary record as a mitigating factor. Age and experience of the Registrant are addressed above.

The Hearing Tribunal does not find the repeated re-publications of the Registrant's name to be a mitigating factor. No evidence was provided regarding publication. In any event, the College's publication bylaws are not within the Hearing Tribunal's discretion.

The Hearing Tribunal also notes that the Registrant was found to have engaged in unprofessional conduct on the one Allegation referred to hearing, although some of the particulars in Allegation 1 were found not to be proven.

Further, the Hearing Tribunal did not make findings in its Merits Decision regarding the Facility, its staffing or its resources, so did not consider these factors.

Furthermore, while the Hearing Tribunal recognized the length of these proceedings as noted above, the Hearing Tribunal notes that the delay was attributable in large part to the nature of the case itself. This was a complex and sensitive matter that required careful consideration and deliberation. The Hearing Tribunal met multiple times after the hearing and devoted significant time to a careful review of the evidence and submissions. This, coupled with a joinder application requested by the LRO on behalf of the Registrants and ordinary scheduling conflicts, contributed to delays that were unavoidable in the circumstances.

The Hearing Tribunal considered the authorities submitted when determining the appropriate sanction.

Protection of the public is the paramount consideration in determining an appropriate sanction. Any orders made by the Hearing Tribunal must meaningfully contribute to that objective. The Hearing Tribunal found that the two courses proposed by Conduct Counsel do not address the conduct at issue. The *Intro to Health Assessment* and *Responsible Nursing* courses are introductory level courses and are not sufficiently connected to the proven Allegation. They do not address the specific deficiency identified in this case and would neither remediate the Registrant's conduct nor enhance public safety. By contrast, the Fetal Health Surveillance Refresher Workshop course that the Registrant has completed on her own initiative is directly relevant to the misconduct and is better aligned with the purpose of sanctioning. That course addresses fetal monitoring, the precise area of concern in Allegation 1(b), and therefore more effectively serves the goals of remediation and public protection. The Hearing Tribunal noted that the Registrant has proactively taken and completed the course.

The Hearing Tribunal found that requiring the Registrant to provide an Employer Reference Letter is an appropriate and proportionate sanction that advances the goals of public protection and remediation. An Employer Reference Letter from the Registrant's current supervisor serves to confirm that the Registrant is practicing safely and competently and progressing appropriately in the profession. It provides independent assurance that the Registrant's performance meets professional expectations and that she remains on track in her practice. The Hearing Tribunal is satisfied that the requirement for an Employer Reference Letter is satisfactorily met by the letter provided during the sanction hearing (Exhibit 7). The letter confirms that the Registrant practices in a setting where the patient population includes pre-, ante-, and post-natal patients, that she is practicing in accordance with expectations and that there are no concerns with the Registrant's practice. Accordingly, the Hearing Tribunal will not require the Registrant to submit an additional letter. The Hearing Tribunal considered the requested Practice Setting Letter and found it did not advance the objectives of sanction in the present case. As such, the Hearing Tribunal declines to order a Practice Setting Letter.

Finally, the Hearing Tribunal found that a reprimand is an appropriate sanction in this case. The proven Allegation represented a considerable departure from professional standards. A reprimand appropriately reflects the seriousness of the conduct and affirms the profession's commitment to patient safety and accountability. At the same time, the Hearing Tribunal carefully considered mitigating factors, including the Registrant's demonstrated efforts to remediate her practice and the non-financial consequences she has already experienced as a result of these proceedings. The Hearing Tribunal is satisfied that a sanction of a reprimand, one course and an Employer Reference Letter strikes the correct balance between protecting the public, denunciation and remediation, maintains public confidence in the profession, and is proportionate to the findings without being excessive.

VIII. ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By no later than **October 20, 2026**, the Registrant shall provide a certificate of completion, satisfactory to the Complaints Director, that she has successfully completed and passed the following course of study and learning activity**:**

    a. *Fetal Health Surveillance Refresher Workshop (Canadian Fetal Health Surveillance Education);* ***(completed)***

3. The Registrant shall provide an Employer Reference from her Supervisor. The Employer Reference must confirm the following:

    a. Whether concerns exist about the Registrant's practice and whether she met or exceeded the standards expected of an RN. ***(completed)***

(the "**Condition(s)**").

Given that the courses and Employer Reference Letter have been provided, the Conditions are found to have been completed.

CONDITIONS

4. Notification of the above Conditions arising from this hearing and that they have been completed shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

5. This Order takes effect on the date of this Order and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,

Kimberly Boyko, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: February 27, 2026