INVESTIGATION COMMITTEE
of the
COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

-and-

Jessica J. V. McCulloch
Saskatchewan RN #0039641

PENALTY DECISION

of the

DISCIPLINE COMMITTEE

of the

COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

Legal Counsel for the Investigation Committee:	Titli Datta
Legal Counsel for Jessica McCulloch	Scott Hopley
Legal Counsel for the Discipline Committee:	Brittnee Holliday
Chairperson for the Discipline Committee:	Chris Etcheverry

Date of Hearing:	**May 2, 2025**
Location:	*Via Videoconference* College of Registered Nurses of Saskatchewan 1-3710 Eastgate Drive Regina, Saskatchewan S4Z 1A5
Date of Decision:	**August 29, 2025**

I. INTRODUCTION

1. The Discipline Committee of the College of Registered Nurses of Saskatchewan ("CRNS") was reconvened to hear and determine the issue of appropriate penalty, following a partially successful Appeal by Jessica McCulloch, Registered Nurse #0039641, to the Court of King's Bench regarding the Discipline Committee's October 25, 2021 Liability Decision ("Liability Decision") and March 25, 2022 Penalty Decision ("Penalty Decision").

2. As will be discussed below, Justice Layh, of the Court of King's Bench, set aside two findings of guilt from the Liability Decision and, in accordance with section 34(5)(c) of *The Registered Nurses Act, 1988* ("the Act"), remitted the matter back to the Discipline Committee to determine penalty considering the reduced findings of guilt.

II. PROCEDURAL HISTORY

3. In the September 25, 2023 decision, *McCulloch v Investigation Committee of the Saskatchewan Registered Nurses Association*, 2023 SKKB 203 (the "King's Bench Decision"), the Honourable Justice D. H. Layh set out some relevant procedural history at paragraph 4:

> **[4] The discipline proceedings relate to allegations of misconduct beginning in 2015 and include an extensive (and expensive at $537,000.00) procedural history, summarized as follows:**
>
> **(a) a hearing over 14 days, including one in-person session from September 21, 2020 to September 25, 2020 and two video conference sessions, the first from October 19, 2020 to October 23, 2020, and the second from February 8, 2021 to February 11, 2021;**
> **(b) 42 witnesses, 27 called by the Investigation Committee and 15 called by Ms. McCulloch;**
> **(c) extensive documentary evidence filling five three-ringed binders;**
> **(d) lengthy briefs of law filed in support of arguments on April 14, 2021;**
> **(e) a decision of the Discipline Committee on October 25, 2021, with findings of "guilty" and "not guilty" respecting the charges;**
> **(f) a penalty hearing on December 15, 2021;**
> **(g) a Penalty Decision of the Discipline Committee of the College of Registered Nurses of Saskatchewan on March 25, 2022;**
> **(h) a notice of appeal filed April 22, 2022; and**

(i) a hearing before me on June 28, 2023, when I ordered counsel for Ms. McCulloch to file pinpointed references to the transcript.

4. The Discipline Committee's Liability Decision was summarized by Justice Layh, as follows, at paragraph 2:

> **[2] The formal charges against Ms. McCulloch, as found in the "Notice of Hearing of Complaints" served upon her on January 29, 2020, include allegations of misconduct from March 2015 to April 2016 while she was employed at the Regional Psychiatric Centre [RPC] in Saskatoon, Saskatchewan (Charges 1 to 6) and from April 2016 to April 2019 while she was employed at the Saskatchewan Hospital at North Battleford, Saskatchewan [Sask Hospital] (Charges 7 to 10). The charges and the ultimate findings of the Discipline Committee are as follows (Decision of the Discipline Committee of October 25, 2021 [Decision] at pages 2-6):**
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> **Charge Number 1**
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> **…[O]n or about March 13, 2015 …[y]ou completed a medication return form on which there were two entries for acetaminophen with Codeine 30 mg tablets (Tylenol #3). One entry listed five tabs while the other listed 49 tabs for a total of 54 tabs. The 54 tabs of Tylenol #3 were not received by the pharmacy. You could not provide an explanation as to the disappearance of the Tylenol #3. The missing narcotics were never recovered. You failed in your obligation to properly secure and return the narcotics as required by the standards of the SRNA.**
>
> **NOT GUILTY**
>
> **Charge Number 2**
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> **…[O]n October 4 and 5, 2015…[y]ou were the RN on shift when 40 acetaminophen with codeine 30 mg tabs belonging to a Churchill Unit patient went missing. On October 4, 2015 at 2210 hours, you documented on the Narcotic Administration Record "wasted rack fell, meds stepped on" and you proceeded to change the documented count from 40 to 0. You did not sign the Narcotic Administration Record nor did you have another RN co-sign that the narcotics had been wasted. You failed to follow the proper procedure to account for drug wastage. You changed your explanation during the investigation. You failed to honestly account for the missing drugs. There was no evidence that the drugs had been wasted as you stated. you failed in your obligation to properly secure and account for the drugs under your control. You failed to properly account for the drugs and the missing medication card.**
>
> **GUILTY**

Charge Number 3

…[O]n or about January 20, 2016…[y]ou received a card from an inmate stating, "Sorry I pissed you off this morning. I was only joking and didn't realize that you were stressed out. "My bad!" If you aren't getting anything good, just steal a few days worth of mine. (It should make you fell better!) I think you're an awesome nurse and don't want to add to any stressors." You failed to establish and maintain appropriate professional boundaries with patients, including the distinction between social interaction and therapeutic relationship. You shared private and personal details about yourself with inmates. Your conduct put you and your coworkers and patients at risk of harm.

NOT GUILTY

Charge Number 4

…[O]n or about January 21, 2016 … [a]n Autopak roll consisting of nine 150 mg tablets of Wellbutrin prescribed to a patient recently admitted were found in the front foyer of the Bow Unit. You were asked how this medication ended up in the front foyer and you stated, "I have no idea, but those are the medications I just put in the return bin this morning." Later that day, you told your nursing supervisor that "I realize what happened. They must have been stuck to my butt. You know the Velcro on the back of the CPR masks. It must have stuck to that on my belt and fallen off in the foyer when I went for my break." A witness viewed video footage that confirmed that you had been in the foyer where the medications were located, four minutes before the medication had been found. You failed to properly secure and account for drugs as required by the SRNA standards.

NOT GUILTY

Charge Number 5

…[O]n February 26, 2016…[y]ou falsely documented the administration and wastage of narcotics and then wrote the name of a correctional officer as a witness to the wastage. You failed to follow the appropriate standards in relations to the administration of narcotics as well as to account for narcotics and/or wastage. You falsely documented on the Narcotic Administration Record the name of a person who did not witness the alleged wastage of a narcotic. You administered double the dose that had been prescribed. Your actions have potentially contributed to the underground economy of the drug trade among the inmate population at RPG. This can increase the propensity for violence and unrest by creating and sustaining the black market currency in the institution.

GUILTY

Charge Number 6

…[B]etween the dates of March 13, 2015 and April 4, 2016…[y]ou failed to recognize that you were unfit to practice nursing, to remove yourself from working as an RN and, contrary to the Code of Ethics, to advise your employer that you were unfit to practice nursing.

NOT GUILTY

Charge Number 7

..[O]n April 29, 2016…[y]ou failed to advise your potential employer that you were suffering from a longstanding mental health diagnosis that may impact your fitness to practice as an RN.

NOT GUILTY

Charge Number 8

…[B]etween the dates of January 1, 2019 and April 25, 2019…:

(a) You carried on your person and consumed personal medication in front of patients;

NOT GUILTY

(b) You brought contraband items such as Q-tips® and newspapers for specific patients onto the corrections unit;

GUILTY

(c) You brought inappropriate movies rated 18A/R for patients without approval of the health care team and employer;

NOT GUILTY

(d) You consumed patient canteen products contrary to the training provided by our employer;

NOT GUILTY

(e) You completed a patient's puzzle in his absence knowing that it would be upsetting to the patient and stated that you were doing it just to "piss him off";

GUILTY

(f) You would make and leave sticky notes with confidential patient information in an area shared with non-medical staff who did not have the right to know about this confidential patient information;

NOT GUILTY

(g) You failed to maintain a proper therapeutic patient relationship with patients by making inappropriate jokes with patients regarding conducting cavity searches.

NOT GUILTY

Your behavior put you, the patients and other staff at risk by compromising the safety of the unit.

Charge Number 9

[B]etween the dates of April 9 and 10, 2019…[y]ou failed to meet the SRNA Standards and Foundation Competencies and the Standards and Policies and Procedures of your employer, the Saskatchewan Health Authority as follows:

(a) You provided canteen privileges to patients who had lost their privileges;

GUILTY

(b) You provided a patient with his canteen privileges in a cup hidden by a rubber glove and allowed the patient to proceed to his room;

GUILTY

(c) You failed to be truthful with your work colleagues about providing the canteen privileges to two patients;

GUILTY

(d) You untruthfully charted the events surrounding the provision of canteen privileges to these two patients by altering the time stamp on the chart and falsifying the chart; and

NOT GUILTY

(e) Your interaction with these two patients violated your obligation to maintain a therapeutic relationship with patients.

GUILTY

Charge Number 10

[B]etween the dates of January 1, 2019 and April 29, 2019…[y]ou failed to recognize that you were unfit to practice nursing, to remove yourself from working as an RN and, contrary to the Code of Ethics, to advise your employer that you were unfit to practice nursing.

NOT GUILTY

5. Per the above summary, the Discipline Committee found Ms. McCulloch guilty of professional misconduct and professional incompetence respecting eight out of a total of 20 charges, including sub-charges, and imposed the following penalty at paragraph 35 of the Penalty Decision:

35. The Discipline Committee makes the following Order:

1. Pursuant to section 31(1)(b) of the Act, Jessica McCulloch shall be suspended and remain suspended until the following conditions are met:

(a) Ms. McCulloch shall provide a report or reports to the Registrar from her treating psychiatrist (and her treating psychologist) if any which reports shall address the following:

(i) Confirmation that Ms. McCulloch's mental health has been stable for at least twelve consecutive months prior to the date of the report;

(ii) Confirmation that Ms. McCulloch has complied with the treatment recommendations regarding her mental health disorder including regularly attending office visits, participating in recommended programing and taking medication as prescribed for at least twelve months prior to writing the report.

(iii) Whether Ms. McCulloch's mental health is such that she is capable or returning to the practice of nursing safely, competently and without risk of harm to patients.

(b) In addition to a report or reports from her treating psychiatrist and/or treating psychologist if any, Ms. McCulloch shall undergo a neuro-psychological assessment by a qualified psychologist who will conduct a comprehensive evaluation of her cognitive abilities and cognitive functioning. Arising out of the assessment, the psychologist shall produce a report addressing whether Ms. McCulloch has the cognitive abilities and cognitive functioning to safely and competently practice as a nurse. Ms. McCulloch shall bear any and all costs of the assessment and report.

2. Pursuant to section 31(1)(c) of the Act and upon reinstatement and commencement of registered nursing employment:

(a) For the first 480 hours of practice, Ms. McCulloch shall not practice nursing unless she is under the direct supervision of a registered nurse or registered psychiatric nurse.

(b) For the next 500 hours of practice, Ms. McCulloch shall be under the indirect supervision of a registered nurse or registered psychiatric nurse.

(c) For a period of one year, Ms. McCulloch shall be restricted from practicing nursing in the corrections system.

(d) For so long as Ms. McCulloch holds a practicing license, she shall not, at any time have access to nor administer substances listed in the *Controlled Drugs and Substances Act,* the Regulations under that Act and those listed in the Prescription Review Program of the College of Physicians and Surgeons unless she is under the direct supervision of another registered nurse or registered psychiatric nurse.

(e) For a period of one year, Ms. McCulloch shall not assume any overtime hours or serve in a supervisory role in any nursing environment.

3. Ms. McCulloch's nursing employer shall file with the Registrar written performance reviews confirming Ms. McCulloch's professional competence and professional conduct. Any unfavorable reviews shall be reported by the Registrar to the Investigation Committee. Performance reviews shall be provided at the following increments:

(a) After 240 hours of RN practice

(b) After 480 hours of RN practice

(c) After 960 hours of RN practice

(d) After 1500 hours of RN practice

(e) After 2000 hours of practice

4. Pursuant to section 31(1)(c)(ii) of the Act and within 60 days of commencing nursing employment, Ms. McCulloch shall complete the Code of Ethics online learning modules and provide proof of completion to the Registrar. Ms. McCulloch shall bear the costs if any of these online courses.

5. Ms. McCulloch shall provide a copy of this decision to all prospective nursing employers prior to the commencement of her employment and provide written verification to the Registrar that she has done so.

6. Pursuant to section 31(2)(a)(ii) of the Act, Ms. McCulloch shall pay the costs of the investigation and hearing fixed in the amount of $50,000.00. Such costs shall be paid on or before April 1, 2026. Failing payment on April 1, 2026, Ms. McCulloch's license, if any, shall be suspended until payment is made pursuant to section 31(2)(b) of the Act.

6. Ms. McCulloch appealed the Liability and Penalty Decisions to the Court of King's Bench, pursuant to section 34(1)(b) of the Act:

34(1) A nurse who has been found guilty by the discipline committee or who has been expelled pursuant to section 33 may appeal the decision or any order of the discipline committee within 30 days of the decision or order to:

…

(b) a judge of the court by serving the executive director with a copy of the notice of appeal and filing it with a local registrar of the court.

7. Ultimately, Justice Layh quashed two findings of professional misconduct, being sub-charges 8(b) and (e), reducing the findings of guilt from Charges 2, 5, 8(b) and (e), and 9(a), (b), (c), and (e), to Charges 2, 5, and 9(a), (b), (c), and (e):

> **[38] I find that Ms. McCulloch did exercise due diligence, particularly in light of the vagueness of the rules at the Sask Hospital and, specifically, what items might constitute contraband. Although [redacted] apparently told staff that Q-tips were inappropriate to bring to the unit, one must suspect that her direction, which specifically identified the Q-tips, arose after she learned that Ms. McCulloch had brought Q-tips. In my view, Ms. McCulloch's uncontroverted evidence that she gave one Q-tip to one patient, supervised its use, and saw to its return and disposal constitutes "due diligence." In the Discipline Committee's Decision, I find no application of this evidence to the principle of due diligence. Accordingly, the Discipline Committee's finding of guilt respecting charge 8(b) is quashed.**
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> **…**
>
> **[70] A well-known principle of statutory interpretation holds that general words that are followed by specific examples in a list must be construed as referring to the types of things identified by the specific examples, the *ejusdem generis rule*. Placing the conduct alleged in charges 8(b) and 8(e) into the enumerated list of s. 26(2) of the *RN Act* would be glaringly suspect. To permanently mar a nurse's professional reputation for allowing one patient to use one Q-tip (even if it could be considered "contraband") or for potentially upsetting a patient when completing a jigsaw puzzle is not the type of misconduct contemplated by s. 26 of the *RN Act.***
>
> **[71] The Discipline Committee has applied the wrong law, and so has made an error of law. Consequently, aside from other reasons previously explained, the Discipline Committee's finding of "Guilty" for charges 8(b) and (e) must be quashed.**

8. Justice Layh issued the King's Bench Decision on September 25, 2023, quashing two of the findings of professional misconduct and remitting the issue of appropriate penalty to the Discipline Committee, at paragraph 107:

> **[107] Because I have quashed two of the findings of professional misconduct, the issue of appropriate penalty is remitted back to the Discipline Committee. The Discipline Committee will have an opportunity to determine an appropriate penalty in light of the reduced findings of**

professional misconduct. Undoubtedly the Discipline Committee will ask counsel to make further submissions.

9. Ms. McCulloch then appealed to the Saskatchewan Court of Appeal, pursuant to section 35 of the Act, on October 25, 2023. The Discipline Committee understands there were various applications before the Saskatchewan Court of Appeal, and eventually, on May 13, 2024, Ms. McCulloch abandoned her Appeal to the Saskatchewan Court of Appeal.

10. A Penalty Hearing to determine an appropriate penalty in light of the reduced findings of professional misconduct was originally set for August 30, 2024 via Zoom. On August 22, 2024, legal counsel for Ms. McCulloch served an Application for a Remedy for Abuse of Process and Breach of Fiduciary Duty by the Investigation Committee of the CRNS ("Abuse of Process Application"). The Abuse of Process Application was set to be heard by the Discipline Committee on November 22, 2024.

11. On October 18, 2024, legal counsel for the Investigation Committee raised a Preliminary Objection to the Abuse of Process Application on the grounds of lack of jurisdiction ("Preliminary Objection").

12. The Discipline Committee heard the Preliminary Objection on November 22, 2024 and concluded, by way of written decision dated March 7, 2025, that the Application for Abuse of Process was barred due to the principles of *res judicata* and cause of action estoppel.

13. The Discipline Committee has now reconvened to hear submissions on penalty.

III. POSITION OF THE INVESTIGATION COMMITTEE

14. The Investigation Committee's position is that Justice Layh's decision in the Court of King's Bench stands as the final and conclusive decision, upholding liability and penalty except to the limited extent of the reduced findings on liability.

15. The Investigation Committee suggests that there is a direct correlation between the quashed charges and redetermination of penalty and that the only logical and feasible way to reconsider penalty is to reduce the Discipline Committee's costs Order. It was suggested that no other portions of the Penalty Order may be reconsidered because Justice Layh did not direct such review and the quashed charges rank lower in seriousness and gravity and had little or no bearing on the non-costs portions of the Penalty Order.

16. The Investigation Committee suggests that an appropriate penalty would be to reduce the costs Order from $50,000.00 due by April 1, 2026 to $40,000.00 and allow an additional year to April 1, 2027 for payment.

IV. POSITION OF MS. MCCULLOCH

17. Ms. McCulloch's position on penalty reconsideration is that this Discipline Committee is not required to adhere to the prior penalty and may reconsider any aspect of the same.

18. Ms. McCulloch suggests that a reprimand along with the Code of Ethics review previously ordered would be an appropriate sanction, suggesting the practice conditions and requirements to ensure fitness to practice were not important to protect the public or causally connected to Ms. McCulloch's offending behaviour. Ms. McCulloch suggested she surrendered her license and the conditions under that agreement, or applying to practice again, generally, would require her to demonstrate fitness to practice. It was suggested that there is no need to connect a pre-requisite of good mental health to the sentencing and doing so would punish Ms. McCulloch for having mental health problems.

V. DISCUSSION

<u>Sanction</u>

19. Several factors are considered when determining an appropriate sanction for a professional. While the list is not intended to be exhaustive, a frequently cited list of factors established by case law can be found in the decision of *Jaswal v Medical Board (Newfoundland)*, 1996 CanLII 11630 (NL SC), 138 Nfld & PEIR 181 ["*Jaswal*"], at paragraph 35:

1. the nature and gravity of the proven allegations
2. the age and experience of the offending physician
3. the previous character of the physician and in particular the presence or absence of any prior complaints or convictions
4. the age and mental condition of the offended patient
5. the number of times the offence was proven to have occurred
6. the role of the physician in acknowledging what had occurred
7. whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made
8. the impact of the incident on the offended patient
9. the presence or absence of any mitigating circumstances
10. the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine
11. the need to maintain the public's confidence in the integrity of the medical profession
12. the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct
13. the range of sentence in other similar cases

20. In *Camgoz v College of Physicians and Surgeons (Sask.)*, 1993 CanLII 8952, 114 Sask R 161, the Court of Queen's Bench, as it then was, also outlined the *Jaswal* factors as factors to consider when determining penalty. The Court specifically noted that the list is not exhaustive and does not mean that each specified factor will be relevant in every instance. As such, the factors need to be considered in relation to the specific facts of each case.

21. The Discipline Committee completed a thorough analysis of the *Jaswal* factors in the Penalty Decision of March 25, 2022. Since that time, Ms. McCulloch has been successful in having the finding of guilt on two more trivial charges set aside.

22. The Discipline Committee can order any penalty it deems appropriate, as was originally done in its March 25, 2022 Penalty Decision. The Discipline Committee agrees that it could reconsider any portion of such Order, at its discretion.

23. The Discipline Committee has considered the submissions of counsel, the *Jaswal* factors, its previous analysis of the *Jaswal* factors, and the seriousness of the charges that have been upheld and determined that the two trivial findings of guilt overturned by the Court of King's

Bench of Saskatchewan do not convince it that the public will be protected by departing from the non-costs portion of the March 25, 2022 Penalty Order.

24. Charges 2 and 5 are very serious and involve more than sloppy drug management as suggested by Ms. McCulloch. Ms. McCulloch mismanaged narcotics and her explanations were not found to be credible. Similarly, regarding Charges 9(a), (b), (c), and (e), Ms. McCulloch deliberately breached rules that crossed the line into professional misconduct, actively taking steps to cover up her misconduct. The seriousness of the charges Ms. McCulloch has been found guilty of, findings regarding Ms. McCulloch's credibility, and confirmation that the Charges cannot simply be described as sloppy drug management have been addressed in the Liability Decision, the Penalty Decision, as well as by the Court of King's Bench, examples of which include:

Liability Decision of the Discipline Committee:

> **77. Failure to follow appropriate procedure regarding wastage of narcotics and the documentation of wastage is a serious matter. However, there is more to the charge than that as the charge also states "You failed to honestly account for the missing drugs. There was no evidence that the drugs had been wasted as you stated." Ms. McCulloch's version of events is suspect on a number of fronts. When Ms. McCulloch met with [redacted] a few days after the incident, she gave inconsistent explanations for what had occurred and what she had done. [redacted] testified that narcotics would be in the vault and not hanging on a rack as Ms. McCulloch claimed. Further, Ms. McCulloch testified that she stepped on the medication card once and that crushed the bubble card with the result that a number of the narcotics fell out. Many witnesses including the RPC pharmacist ([redacted]) testified that this was quite unlikely. Ms. McCulloch's explanation and version of events simply does not ring true. Further and even if the Discipline Committee accepts Ms. McCulloch's testimony that she was unable to reach [redacted], there were other nurses available on other units to attend and witness the wastage and ensure proper documentation was completed.**
>
> **…**
>
> **94. [redacted] is a corrections officer and he was also working on the Mackenzie Unit that day. Ms. McCulloch testified about an alleged conversation she had with [redacted] shortly after starting her shift. According to Ms. McCulloch, [redacted] advised her about a situation where a patient was found on the top of a dryer so that he could enter the**

ceiling with plans to escape or take a hostage. Ms. McCulloch testified that upon hearing this information, she felt anxious and she wanted to leave. She tried to reach another nurse to take her place but was unsuccessful. She stated "I felt I was stuck there. I couldn't leave so I proceeded the best I could."

95. [redacted] testified for the Investigation Committee. In direct evidence, [redacted] stated he did not recall saying anything to Ms. McCulloch about a patient who had apparent plans to escape or take a hostage. In cross examination, he was not asked any questions about this alleged conversation. The Discipline Committee does not accept Ms. McCulloch's testimony about the alleged discussion with [redacted].

…

99. In her testimony, Ms. McCulloch admitted that she wrote [redacted] name on the Narcotic Administration Record but she did not intend this to be his signature to witnessing wastage. Her purpose in entering [redacted] name on the Narcotic Administration Record was not clear. In cross examination, Ms. McCulloch admitted that she did not reference this incident at shift report, she did not prepare an incident report and she did not advise anyone about the alleged wastage of the Dilaudid. To the extent she had an explanation for her actions, she stated she was "not in a good frame of mind" as she was left alone doing the work of two nurses and she was upset and anxious. She claimed that she called other units to find a witness to the wastage but she could not reach anyone. The Discipline Committee does not accept her explanation that she tried to contact another registered nurse given the evidence about the nurse coverage in the facility.

…

144. The Discipline Committee accepts the evidence presented by the Investigation Committee. The Discipline Committee does not accept Ms. McCulloch's testimony that she was unaware of the suspension of the privileges. If she was unaware, that was a product of her own negligence as the information was there to be seen. Ms. McCulloch's actions in providing a glove to A.F. and her conduct with him illustrates an intention to hide what was going on.

Penalty Decision of the Discipline Committee:

12. …

(a)… The facts underlying charges 2 and 5 are serious. Out of the total of the ten global charges Ms. McCulloch faced, these are likely the most serious. As the findings made by the Discipline Committee illustrate, Ms. McCulloch showed reckless disregard for processes and procedures

regarding narcotics. Adherence to processes and procedures regarding narcotics is fundamental in any health care facility and arguably even more so in a psychiatric facility that houses offenders involved in the criminal justice system.

Court of King's Bench Decision:

[79] As Justice Schwann stated in *MacKay*, what constitutes professional misconduct in any given situation will vary depending on the specifics of the allegation and the context. Proof of moral turpitude is not a necessary element. In this instance, Ms. McCulloch admitted she made "a lot of errors in judgment" and that she did not follow appropriate policies and procedures. In the context of a secure facility with crime-prone patients, some with addictions to narcotics and other substances, the strict control and monitoring of narcotics understandably takes on marked significance. Of all drugs that a nurse might handle, narcotics are particularly prone to misuse.

[80] I find no fault with the Discipline Committee's finding that Ms. McCulloch's handling of the narcotics and her suspect explanation correctly constitutes professional misconduct.

…

[82] When Ms. McCulloch advances this line of argument she fails to appreciate an important distinction between an "error" and the conduct with which she has been charged and found guilty. She admitted that she knew the policies and procedures for drug wastage and documentation and did not follow them. The Discipline Committee found that she then failed to consistently account for the missing drugs. These are not "errors." Understandably, the circumstances would be different if a drug has been mishandled by accident or mistake and where the nurse has been honest and forthright in explaining the situation.

[83] This ground of appeal has no merit and is dismissed.

…

[89] For the same reasons I have found no error in the Discipline Committee's determination of conduct that constitutes professional misconduct under charge 2, the same rationale applies to charge 5.

Other Nurses' Allegedly Similar Conduct:

[90] For reasons I stated previously respecting charge 2, the "errors" that other nurses may have made in handling drugs is not conduct for which Ms. McCulloch has been charged.

…

[95] The Discipline Committee's analysis of the witnesses' testimony is thorough and without palpable error. I accept that Ms. McCulloch's disregard for the suspension of canteen privileges, her comments after her interview with [redacted] and [redacted] (as reported by [redacted]), her unusual written explanation offered later, and the apparent effect of her conduct upon patient A.F. constitutes conduct one would not expect from a registered nurse. The question, though, is whether this conduct meets the mark of professional misconduct.

[96] I accept that in the context of a forensic psychiatric institution there exists a need for consistency in providing and denying privileges to patients. I accept the Discipline Committee's finding that patients with criminal backgrounds or facing criminal proceedings, all having a real or suspected measure of mental health issues, require consistent treatment by all staff. Ms. McCulloch should have been keenly aware that unexpected, sometimes violent behavior can erupt. She was involved in a violent hostage taking at RPC in 2011.

[97] The Discipline Committee explained that the Sask Hospital contains an integrated correctional unit housing persons from the provincial correctional system, meaning patients who have been sentenced to two years less a day or are on remand and have been sent for a psychiatric assessment. The Discipline Committee was aware that patients will manipulate staff. Staff at Sask Hospital received training called "Anatomy of a Set Up" to permit an understanding of how offenders can manipulate and to train staff to minimize their risk of falling victim to a set up.

[98] The Discipline Committee (at para. 34 of their Decision) also explained that part of the program at the hospital allows patients to earn money from jobs. They can spend their money by purchasing items from the canteen, which the nursing staff distributed on Wednesday, Friday and Sunday. Canteen was a privilege that could be suspended by the charge nurse and the team. Such suspensions and the reasons for it were documented in an electronic charge, called the Mental Health Addictions Information System.

[99] Breaching rules that involve the distribution of soft drinks, chips and candy would be trivial in many circumstances. But, in the context of the Sask Hospital, and the evidence that Ms. McCulloch was deliberately defying those rules, I find that the Discipline Committee's decision that Ms.

McCulloch's conduct moved over the line and into professional misconduct cannot be disturbed on appeal.

25. Ms. McCulloch continued to defy rules and failed to properly account for narcotics even after having lost a job as a result. Ms. McCulloch's behaviour was not confined to one incident and this Discipline Committee must be satisfied that Ms. McCulloch is fit to practice and is working under conditions that would not allow for continued behaviour of this sort. It is also worth noting that Ms. McCulloch argued at the initial Penalty Hearing that an independent assessment confirming fitness to practice would be an appropriate Order.

26. The Discipline Committee concludes that for all reasons previously stated in its earlier Penalty Decision and to ensure general and specific deterrence, the practice conditions and requirements to confirm fitness to practice are appropriate and will remain as ordered. Due to the nature of the professional conduct Ms. McCulloch has been found guilty of, the Discipline Committee concludes that Ms. McCulloch should also take an ethics course prior to returning to practice. The Discipline Committee notes that the Code of Ethics modules originally ordered are no longer available, and therefore, the Discipline Committee has identified a suitable course available through PBI Education, but will leave it open to Ms. McCulloch to seek approval from the Registrar should she identify an alternative ethics course.

Costs

27. Turning to the costs portion of the Penalty Order, counsel for Ms. McCulloch pointed to *Jinnah v Alberta Dental Association and College*, 2022 ABCA 336. The Discipline Committee is also aware of the recent Alberta Court of Appeal decision in *Charkhandeh v College of Dental Surgeons of Alberta*, 2025 ABCA 258, which abandoned the *Jinnah* framework and provided new factors to consider regarding costs orders, setting out the types of costs that would be appropriately borne by a member of a regulated profession and removing any link between the seriousness of the charges and the amount of the costs award.

28. This Discipline Committee has concluded that it is not bound by the *Charkhandeh* decision and that this case remains one in which it would be appropriate for Ms. McCulloch to bear a portion of costs. The Alberta Court of Appeal's approach in *Charkhandeh* is inconsistent with the analysis of costs undertaken by most Canadian courts. While the application and ordering of costs in self-regulating professions may now be in a state of flux, it remains to be seen whether the Alberta Court of Appeal's decision in *Charkhandeh* will be applied more widely throughout the rest of Canada or whether the Supreme Court of Canada will offer guidance to professional regulatory bodies on the topic of costs in professional regulatory disciplinary proceedings.

29. Section 31 of the Act sets out the Discipline Committee's "Disciplinary powers". Specifically, section 31(2)(a)(ii) of the Act gives the Discipline Committee discretion to order "the costs of the inquiry and hearing into the nurse's conduct and related costs, including the expenses of the investigation committee and the discipline committee".

30. The Discipline Committee recognizes that costs should not be a sanction, nor a crushing blow to a member, but also is of the view that the profession should not bear of the full costs of the investigation and disciplinary hearing in this matter.

31. Following her appeal to the Court of King's Bench, Ms. McCulloch has been found guilty of six Charges, including sub-charges. The Discipline Committee relies on its reasons set out at paragraphs 21 to 25 and 28 to 33 of its Penalty Decision in determining that Ms. McCulloch should bear a portion of the costs of the investigation and discipline hearing.

32. In determining an appropriate amount of costs to order, the Discipline Committee has considered Ms. McCulloch's financial position, that she has not been working as a nurse for many years, that costs should not be punitive, and that Ms. McCulloch will have additional expenses arising from this Penalty Order, including the expense of the ethics course. The Discipline Committee recognizes that costs are discretionary and should be reasonable when considering all facts and matters before it.

33. The Discipline Committee has concluded that a fair and reasonable allocation of the costs would be for Ms. McCulloch to pay $35,000.00 in costs. In recognizing that much time has passed since its March 2022 Order that such costs be paid by April 1, 2026, the Discipline Committee will extend that deadline to April 1, 2027.

VI. ORDER

34. As outlined above, the Discipline Committee orders that its previous Order shall only be altered with respect to costs and the ethics course. As such, the Discipline Committee makes the following Order:

> 1. Pursuant to section 31(1)(b) of the Act, Jessica McCulloch shall be suspended and remain suspended until the following conditions are met:
>
> (a) Ms. McCulloch shall provide a report or reports to the Registrar from her treating psychiatrist (and her treating psychologist, if any) which reports shall address the following:
>
> (i) Confirmation that Ms. McCulloch's mental health has been stable for at least twelve consecutive months prior to the date of the report;
>
> (ii) Confirmation that Ms. McCulloch has complied with the treatment recommendations regarding her mental health disorder including regularly attending office visits, participating in recommended programing and taking medication as prescribed for at least twelve months prior to writing the report.
>
> (iii) Whether Ms. McCulloch's mental health is such that she is capable of returning to the practice of nursing safely, competently and without risk of harm to patients.
>
> (b) In addition to a report or reports from her treating psychiatrist and/or treating psychologist if any, Ms. McCulloch shall undergo a neuro-psychological assessment by a qualified psychologist who will conduct a comprehensive evaluation of her cognitive abilities and cognitive functioning. Arising out of the assessment, the psychologist shall produce a report addressing whether Ms. McCulloch has the cognitive abilities and cognitive functioning to safely and competently practice as a nurse. Ms. McCulloch shall bear any and all costs of the assessment and report.
>
> 2. Pursuant to section 31(1)(c) of the Act and upon reinstatement and commencement of registered nursing employment:

(a) For the first 480 hours of practice, Ms. McCulloch shall not practice nursing unless she is under the direct supervision of a registered nurse or registered psychiatric nurse.

(b) For the next 500 hours of practice, Ms. McCulloch shall be under the indirect supervision of a registered nurse or registered psychiatric nurse.

(c) For a period of one year, Ms. McCulloch shall be restricted from practicing nursing in the corrections system.

(d) For so long as Ms. McCulloch holds a practicing license, she shall not, at any time have access to nor administer substances listed in the *Controlled Drugs and Substances Act*, the Regulations under that Act and those listed in the Prescription Review Program of the College of Physicians and Surgeons of Saskatchewan unless she is under the direct supervision of another registered nurse or registered psychiatric nurse.

(e) For a period of one year, Ms. McCulloch shall not assume any overtime hours or serve in a supervisory role in any nursing environment.

3. Ms. McCulloch's nursing employer shall file with the Registrar written performance reviews confirming Ms. McCulloch's professional competence and professional conduct. Any unfavorable reviews shall be reported by the Registrar to the Investigation Committee. Performance reviews shall be provided at the following increments:

(a) After 240 hours of RN practice

(b) After 480 hours of RN practice

(c) After 960 hours of RN practice

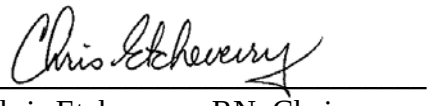
(d) After 1500 hours of RN practice

(e) After 2000 hours of practice

4. Pursuant to section 31(1)(c)(ii) of the Act and within 60 days of commencing nursing employment, Ms. McCulloch shall complete PBI Education's Medical Ethics and Professionalism (ME-15) course, or an alternative ethics course approved by the Registrar. Ms. McCulloch shall bear the costs of any of these online courses.

5. Ms. McCulloch shall provide a copy of this decision to all prospective nursing employers prior to the commencement of her employment and provide written verification to the Registrar that she has done so.

6. Pursuant to section 31(2)(a)(ii) of the Act, Ms. McCulloch shall pay the costs of the investigation and hearing fixed in the amount of $35,000.00. Such costs shall be paid on or before April 1, 2027. Failing payment on April 1, 2027, Ms. McCulloch's license, if any, shall be suspended until payment is made pursuant to section 31(2)(b) of the Act.



August 29, 2025

Chris Etcheverry, RN, Chairperson
On behalf of Members of the Discipline Committee
Stella Swertz, RN(Retired)
Janna Balkwill, RN
Russ Marchuk, Public Representative