IN THE MATTER OF	KAREN PETTIT, a member of the College of Paramedics of Manitoba (the "College")
AND IN THE MATTER OF	A hearing of the Inquiry Committee Panel of the College (the "Panel") pursuant to Part 8 of *The Regulated Health Professions Act S.M. 2009, c.15* (the "Act")
Panel	Chris Cauthers (Chair) Michael Foote Cathy Kozminski-Kirby Cory Parrott Dean Scaletta
Counsel	Kelsey L. Schade, for the Complaints Investigation Committee (the "CIC") Anthony Foderaro, for the Member Jeff Hirsch, for the Panel

REASONS FOR DECISION

I. Introduction

1. This case relates to the tragic death of an infant on September 3, 2021 and the care provided by Ms. Pettit on September 2, 2021. The events that occurred have had a terrible impact not only on the infant patient and her family but on Ms. Pettit as well and the Panel wishes to express its deep empathy for all affected parties.

2. Ms. Pettit is a member of the College.

3. She was charged with a variety of offences under a Notice of Inquiry dated September 14, 2022. The Notice of Inquiry is attached to these reasons as Schedule "A".

4. The Notice of Inquiry alleged that Ms. Pettit contravened the College of Paramedics of Manitoba Code of Ethics (the "Code of Ethics"), the College of Paramedics of Manitoba Standards of Practice for the Paramedic Profession (the "Standards"), and is guilty of professional misconduct and has demonstrated an unfitness to practice paramedicine as follows:

On September 2, 2021, when attending on the scene to an infant patient, she:

(a) failed to conduct a thorough and proper assessment of the patient upon arrival in order to:

(i) appreciate the severity of the patient's condition; and

(ii) form a comprehensive treatment plan for transport;

(b) left the patient unattended for a period of time at the scene;

(c) as the highest trained paramedic responding to the September 2, 2021 call, she failed to:

(i) assume primary responsibility for the care of the patient, given the severity of the patient's condition and possible treatment required during transport; and

(ii) failed to provide appropriate oversight and guidance to her partner in order for the patient to be provided with appropriate care and treatment; and

(d) ultimately failed to provide appropriate care and treatment to the patient and was in breach of the standard of care expected of her.

5. The Panel convened an in-person hearing on Thursday, November 2, 2023, at the offices of Thompson Dorfman Sweatman LLP in Winnipeg, Manitoba.

6. With respect to the allegations contained in the Notice of Inquiry, and having heard the parties' agreement and submissions, the Panel has determined that Ms. Pettit has contravened the Code of Ethics and the Standards, is guilty of professional misconduct and has demonstrated an unfitness to practice paramedicine.

7. The parties made a joint recommendation on penalty which was accepted by the Panel.

8. The Reasons of the Panel are set out below.

II. Background and Preliminary Matters

Jurisdiction of the Panel

9. The jurisdiction of the panel is established by subsection 114(1) of the Act:

> The inquiry committee is responsible for holding hearings on matters referred to it by the complaints investigation committee and making disciplinary decisions about the conduct of investigated members.

10. Section 88 defines an "investigated member" as "a member or former member who is the subject of a complaint under [Part 8]".

11. The Practice of Paramedic Regulation R117-71/2018, as amended by Practice of Paramedic Regulation, amendment R117-103/2020, came into force on December 1, 2020. Subsection 12(1) provides that an individual licensed under *The Emergency Medical Response and Stretcher Transportation Act (Manitoba)* (defined in the Regulation as the "former Act) is deemed to be registered as a member of the College, in the appropriate subregister of the full membership class, under the Act, effective December 1, 2020.

12. Ms. Pettit was registered under the former Act on September 18, 2002, and remained so registered as at December 1, 2020. She was therefore a member of the College at the time of the hearing.

13. At the hearing, counsel for the CIC advised the Panel, and Ms. Pettit, through her counsel, admitted that:

(a) the CIC had provided Ms. Pettit and the complainant with copies of the referral decision, and the reasons for the decision, thereby complying with subsections 102(1) and 102(3) of the Act;

(b) on November 15, 2022, Ms. Pettit executed a "Waiver of Time Frames" document acknowledging service of the Notice of Inquiry and waiving the time requirements for the commencement of the hearing set out in section 116 of the Act;

(c) the Notice of Inquiry had been served on Ms. Pettit at least 30 days before the hearing commenced, thereby complying with subsection 116(4) of the Act; and,

(d) Ms. Pettit had been provided with an opportunity to inspect the documents to be put into evidence at least 14 days prior to the commencement of the hearing, thereby complying with subsection 120(1) of the Act.

14. Ms. Pettit admitted that the Panel had jurisdiction to proceed.

15. The Panel was therefore satisfied that it had jurisdiction to hear and adjudicate on the matters before it.

Publication Ban

16. Counsel for the CIC made an application pursuant to subsection 122(2)(b) of the *Act* for an order that the witnesses and other individuals referenced in the materials before the Panel be published by reference to their initials only.

17. It was submitted that personal and other information disclosed in the supporting materials about third parties and the community affected by these events was of such a nature that the desirability of avoiding public disclosure of that information outweighs the desirability of adhering to the principle that meetings be open to the public.

18. The Panel was satisfied that the test set out in subsection 122(3)(b) had been met and granted the following Order:

> The Inquiry Panel of the College of Paramedics of Manitoba duly constituted in accordance with section 114 of *The Regulated Health Professions Act*, S.M. 2009, c. 15, hereby orders that the Inquiry Hearing which would otherwise be fully open to the public be limited to the extent that the names of the witnesses and other individuals referenced in any of the materials is only to be published by reference to their initials. However, the name of the member, Karen

Pettit, who is the subject of the Inquiry may be identified by her full name and this Order is subject to any additional or further Orders of the Inquiry Panel following its deliberations.

A signed copy of the Order is attached as Schedule "B".

III. Guilty Plea, Admissions, and Joint Recommendation

19. Ms. Pettit admitted the facts and allegations set out in the Notice of Inquiry and in a Statement of Agreed Facts (both filed as part of Exhibit 1 to the hearing), and that the witnesses and other evidence available to the College would, if called and otherwise adduced, be substantially in accordance with those facts. A summary of the evidence may be found in Part IV of these Reasons.

20. Ms. Pettit admitted that her conduct constituted a breach of the Code and the Standards and demonstrated professional misconduct and an unfitness to practice paramedicine.

21. Ms. Pettit entered a plea of guilty to all counts set out in the Notice of Inquiry.

22. The parties advised the Panel that they had agreed to resolve the charges by entering into an agreement on penalty on the following basis (the "Joint Recommendation"):

(a) The Panel's Decision will be published and made available to the public;

(b) A suspension of five months, and Ms. Pettit's return to practice is conditional upon:

(i) her completing a course of instruction at her own expense. The course is to be identified and confirmed by the Registrar/College in ethical decision making or leadership; and

(ii) Ms. Pettit providing the Registrar with satisfactory information (and any additional evidence as may be required) that she is in the requisite mental state to practice paramedicine;

(c) Periodic audits of her practice to take place randomly at least four times over the course of her first year of return to practice, and to continue for one year if those reports of performance are satisfactory to the College;

(d) Periodic and random audits of Ms. Pettit's patient care records to be done a minimum of monthly for the first full year in practice and to continue until such time as demonstrating to the College satisfactory performance with the costs, if any, to be borne by Ms. Pettit;

(e) Upon her return to practice, the following conditions be placed on her certificate of practice:

(i) For a period of one year, she may only provide service in a station or community where she can be partnered with a Primary Care Paramedic with a

minimum of five-years' experience, or with other Primary Care Paramedics (Intermediate Care), if her performance is satisfactory to the College;

(ii) Ms. Pettit may apply to remove the above condition after she has completed the courses and supervision described above. The onus will be on Ms. Pettit to demonstrate that the condition is no longer required. The decision to remove the condition will be in the sole discretion of the College; and,

(f) Ms. Pettit will pay costs in the amount of $10,000.00.

IV. The Evidence

23. Ms. Pettit is a Pediatric Advanced Live Support ("PALS") certified Intermediate Care Paramedic ("ICP") with 18 years' experience as a medic and 12 years as an ICP. Her partner was a Primary Care Paramedic ("PCP"), with 14 months' experience.

24. Up to September 2021, Ms. Pettit and her partner had worked together for approximately five months.

25. On September 2, 2021, Ms. Pettit and her partner were dispatched to a Priority 5 call (the lowest priority) for an infant with a rash.

26. Upon arrival, Ms. Pettit and her partner entered the house together. They noted that the infant was lethargic and covered in a purple rash over most of her body. The infant responded to being held and touched.

27. After seeing the infant, Ms. Pettit instructed her partner to prepare the Neo mate seat in the back of the unit. Her partner left the house to do so. Ms. Pettit also left the house to move the ambulance out of a mud puddle, while the infant's mother changed the infant into some other clothes.

28. While Ms. Pettit was moving the unit, the infant's father came out and stated that the infant was turning blue. Ms. Pettit re-entered the house and noted that the infant was crying but did not appear to be blue. She suspected, due to the rash, that the infant had meningitis, but was unsure.

29. Ms. Pettit did not perform an assessment of the infant inside the residence, due to poor lighting, nor did she obtain vital signs on scene.

30. Ms. Pettit brought the infant outside and into the unit, and, upon meeting her partner, she handed the infant to him to place in the Neo mate and asked if he was okay with taking the patient, to which he responded, "I can figure it out".

31. After the infant was loaded into the unit, Ms. Pettit asked her partner if he was okay to be in the back (i.e., attend the call), to which he agreed. Ms. Pettit told her partner to obtain vitals and also indicated that she was in the unit should anything change. Ms. Pettit then drove the unit.

32. This call was the first call of their shift. At the time, Ms. Pettit and her partner had an arrangement whereby he attends the first call of every shift and Ms. Pettit would drive the unit. Ms. Pettit maintains that this arrangement was not set in stone and could be altered if circumstances required.

33. Once the infant was in the unit, both Ms. Pettit and her partner agreed that her partner would be comfortable with the infant in his care and she was very comfortable with his abilities and he never gave her a reason to doubt his skills. She indicated to him that she was in the unit should anything change.

34. The infant was transported to the hospital, with transport taking approximately 58 minutes.

35. Enroute, Ms. Pettit asked for updates from her partner on the infant's status, and the responses she received did not indicate to her that she needed to take over the care of the infant. All the vitals she was being told were, in her view, within normal range for a three-month old infant, except for the infant's temperature.

36. Ms. Pettit recalls receiving reports from her partner that the infant's temperature was high so she advised her partner to "strip her down [to] cool her off". She also recalls telling her partner to give the infant nasal oxygen.

37. Intravenous ("IV") and intraosseous ("IO") treatments were options to treat the infant, but as Ms. Pettit did not believe, based on communications she was receiving from her partner, that these were necessary, she did not propose them to her partner.

38. As a PCP, her partner was certified to insert an IV, but was not certified to initiate IO infusions, and ultimately, the infant did not receive any IV or IO treatments during transport. There was no evidence presented as to why the PCP partner did not initiate an IV which was within his scope of practice.

39. Ms. Pettit's partner says that he recalls asking questions of Ms. Pettit during transport including whether the infant required an IV and if they should do an IO, and whether they should be checking the infant's blood sugars. He recalls Ms. Pettit responding "no" to these questions.

40. During transport, Ms. Pettit maintains that her partner consistently told her that "everything was good" and never said he felt the infant needed an IV. Ms. Pettit says that she does not recall her partner specifically asking her about an IV or an IO.

41. It was not until they arrived at the hospital and Ms. Pettit opened the doors to unload the infant that she became aware that the infant had deteriorated to the point that she was struggling and undergoing agonal respirations. She also learned that her partner had placed ice packs directly on the infant to cool her.

42. On arrival, the hospital emergency room staff undertook resuscitation efforts, but tragically, the infant succumbed to her condition on September 3, 2021. The cause of death was ruled as suspected bacterial meningitis.

43. There was no evidence before the Panel that the infant's death could have been avoided had she received either IV or IO treatments during transport.

44. Unbeknownst to Ms. Pettit, her partner did not have the knowledge to interpret how the infant's vital signs would be indicative of the infant's overall condition and was essentially basing his assessment off of his knowledge about adults' vital signs. Also unbeknownst to Ms. Pettit, during transport, the infant was becoming less responsive, harder to rouse and her partner was having a more difficult time locating a pulse.

45. Following the incident, Ms. Pettit reported herself to her employer which investigated and, in turn, reported it to the College on September 24, 2021.

46. The employer determined, and Ms. Pettit accepted, that:

(a) she failed to recognize the purpuric (purple) rash that the infant was covered in from head to toe as a sign of sepsis; and

(b) an IO would have been an option, but she had never performed one on an infant before, had never performed an IV on an infant before, and the extensiveness of the rash also caused issues with her seeing any IV access.

47. The employer recommended remedial training for Ms. Pettit and she expressed an interest in obtaining remedial training in IV and IO access in infants to increase her comfort level.

48. Ms. Pettit completed her remedial training in September 2021.

49. As part of its investigation, the College retained Ms. Heather Freeland, a peer paramedic, to review and provide an expert opinion on Ms. Pettit's conduct. Ms. Freeland's assessment was that:

(a) Ms. Pettit appeared to have a general knowledge of the severity of the infant's condition upon initial contact as her urgency to get the patient going to the ambulance and to the hospital is clearly documented;

(b) She, by her own account, left a sick patient unattended by allowing the mother to take the patient to another room to get changed and by leaving the home without the patient;

(c) Her entire assessment of the infant prior to transport appears to have been based on the patient's initial appearance;

(d) Her knowledge, skills and judgment due to her years of experience and her PCP-IC training with certification in PALS should have foreseen the potential for this patient to deteriorate during an hour-long transport time;

(e) Ms. Pettit could not only do all the skills her partner could, but she could also attempt an IO, which her partner could not;

(f) Ms. Pettit did not properly assess the patient prior to transport to form a comprehensive treatment plan, including either taking over patient care or coaching her partner on trends to look out for during transport, treatment options to attempt and potential for deterioration during transport;

(g) Ms. Pettit failed to apply critical thinking in this situation, lacked knowledge of her Care Maps, and by her own admission lacked confidence in IV and IO skills; and

(h) Mentoring of her partner was missing in the situation.

50. Ms. Pettit responded to the report, acknowledging full responsibility and stating in writing, that "I could have and should have handled things better" and that "I have learned from this call and have done the remedial training asked of me".

51. On October 19, 2022, the CIC interim suspended Ms. Pettit pursuant to subsection 110(1) of the Act.

52. Ms. Pettit has not worked since being suspended. Since, and as a result of this incident, she has been off work on stress leave.

53. In March 2023, Ms. Pettit provided a letter to the College from her treating psychologist, Dr. Julian Torres, confirming that she has been experiencing mental health issues, including post-traumatic stress disorder, in relation to the events surrounding this Inquiry.

54. Concurrent with providing Dr. Torres' letter, Ms. Pettit provided the College with an Undertaking (signed on February 23, 2023) to not seek to return to practicing paramedicine until she provides evidence satisfactory to the Registrar of the College that her health issues have resolved or have been treated such that her capacity to safely practice paramedicine is no longer an issue.

V. Analysis and Reasons

55. The parties have agreed that Ms. Pettit has contravened the Code of Ethics and the Standards, is guilty of professional misconduct and has demonstrated an unfitness to practice paramedicine.

56. Subsection 124(1) of the Act authorizes the Panel to make any finding permitted under subsection 124(2) which includes that an investigated member: has breached the Code of Ethics or Standards; is guilty of professional misconduct; and has demonstrated an unfitness to practise paramedicine.

The Code of Ethics

57. The Code of Ethics contains the following provisions:

> It is the responsibility of all paramedics in Manitoba to understand and comply with the code of ethics and be accountable, regardless of roles or practice settings.

A paramedic must comply with the Code of Ethics as amended by council from time to time. Any paramedic in contravention of the Act, regulation, by-laws, code of ethics, standards or practice directions is subject to the investigation and complaints process as set out in the Act.

It is important that paramedics recognize that self-regulation of the profession is a privilege.

Responsibility to the Patient and Others

The paramedic must:

- Provide the most effective, efficient, and safe patient care as is reasonably possible within the level of their competencies and seek consultation with other health care professionals when necessary…

- Practice in accordance with the scope of practice, standards of practice, and reserved acts as specified by regulation and the College of Paramedics of Manitoba Standards of Practice

- Provide high quality patient care, including physical comfort and emotional support, to the extent that the paramedic is reasonably able to do

- Once accepting responsibility for a patient or initiating the provision of patient care, continue provision of care until it is no longer required or until another appropriately qualified health care professional accepts responsibility of care…

Responsibility to the Profession

The paramedic must:

Practice in accordance with The Regulated Health Professions Act, College of Paramedics of Manitoba General Regulation, the Practice of Paramedicine Regulation, and other relevant legislation…

The Standards

58. The Standards contain the following provisions:

Compliance with standards of practice is required; these expectations also serve as a legal reference to describe reasonable and prudent paramedic practice.

> It is the responsibility of all paramedics in Manitoba to understand and comply with all standards of practice and be accountable, regardless of roles or practice settings.
>
> A paramedic must comply with the Standards of Practice for the Paramedic Profession as amended by council from time to time. Any paramedic in contravention with the act, regulation, by-laws, code of ethics, standards or practice directions is subject to the investigations and complaints process as set out in the Act.
>
> Professional and Practice Proficiency
>
> Paramedics demonstrate accountability for clinical and technical practice by:
>
> 1. Applying understanding of foundational knowledge within the practice of paramedicine.
>
> 4. Applying and evaluating knowledge developed through experience, clinical analysis and research findings.
>
> 5. Establishing and continuously developing critical and clinical judgment

Behaviour Constituting Professional Misconduct

59. A definition of "professional misconduct" was articulated by the Ontario Court of Appeal in *Re: Davidson and Royal College of Dental Surgeons of Ontario*, 1925 CarswellOnt 254. It reads:

> If it is shewn [shown] that a member of the college, in the pursuit of his profession, has done something with respect to it which would be reasonably regarded as improper by his professional brethren, of good repute and competency, then it is open to the board of directors of the college to decide that he has been guilty of improper conduct in a professional respect.

60. The Panel accepts that Ms. Pettit's conduct as described in Ms. Freeland's report was a marked departure from the conduct expected of a paramedic and constitutes a breach of the Code of Ethics and the Standards, and professional misconduct.

61. In particular, the Panel agreed that leaving the patient unattended, the failure to take vital signs at the outset, the failure to perform a thorough assessment, the failure to recognize the implications of the purpuric (purple) rash as a sign of sepsis, the failure to take on the role of attendant in the back of the unit when she had the superior training, and the failure to take a more active role during transport of the infant all constituted a level of performance that was so deficient as to be professional misconduct.

Unfitness to Practice

62. Subsection 124(2)(e) of the Act empowers an inquiry panel to make a finding that an investigated member "has demonstrated an incapacity or unfitness to practise the regulated health profession".

63. In *Ahluwalia* v. *College of Physicians and Surgeons of Manitoba,* 2017 MBCA 15, an inquiry panel of that College had found the appellant physician guilty of professional misconduct and unfitness to practice medicine. On appeal, the Manitoba Court of Appeal found that the actions of a physician that directly concerned "proper medical practice and patient care" can result in a finding of unfitness to practice. Pursuant to the governing Manitoba legislation, unfitness to practice extends to the fitness to "practice medicine".

64. In addition to the reasoning noted above, the Panel has considered the medical evidence as to Ms. Pettit's current psychological state, her admission that she is suffering from PTSD and is severely traumatized by the incident, the fact she has undertaken not to practice until her health issues have resolved, and her admission she is currently unfit to practice.

65. The Panel is therefore satisfied that she has demonstrated an unfitness to practice paramedicine.

Authority for and Purpose of Sentencing in Professional Discipline Cases

66. The authority of a Panel to make sentencing orders, and orders related to costs are found in sections 126 and 127 of the Act.

67. In reaching its decision, the Panel acknowledges the submissions of counsel to the CIC and counsel for Ms. Pettit and was mindful of the objectives of such orders which have been articulated by various authorities.

68. In *The Regulation of Professions in Canada*, Carswell 2021, James T. Casey describes the purpose of sentencing in professional discipline cases, citing *McKee* v. *College of Psychologists (British Columbia)*, [1994] 9 W.W.R. 374 (at page 376):

> [W]here the legislature has entrusted the disciplinary process to a self-governing professional body, the legislative purpose is regulation of the profession in the public interest. The emphasis must clearly be upon the protection of the public interest...

69. Citing *McKee* and a number of other authorities, Casey goes on to list the factors in determining how the public is protected including:

> … specific deterrence of the member from engaging in further misconduct, general deterrence of other members of the profession, rehabilitation of the member, punishment of the offender, ..., the denunciation by society of the conduct, the need to maintain the public's confidence in the integrity of the profession's ability to properly

supervise the conduct of its members, and ensuring that the penalty imposed is not disparate with penalties in other cases.

Sanctioning Principles in Professional Discipline Cases

70. When determining an appropriate penalty, the following factors should be considered by the Panel:

(a) the nature and gravity of the proven allegations

(b) the age and experience of the offending member

(c) the previous character of the member and in particular the presence or absence of any prior complaints or convictions

(d) the age and mental condition of the offended patient

(e) the number of times the offence was proven to have occurred

(f) the role of the member in acknowledging what had occurred

(g) whether the offending member had already suffered other serious financial or other penalties as a result of the allegations having been made

(h) the impact of the incident on the offended patient

(i) the presence or absence of any mitigating circumstances

(j) the need to promote specific and general deterrence and, thereby, to protect the public

(k) the need to maintain the public's confidence in the integrity of the profession

(l) 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 the range of sentence in other similar cases.

Jaswal v Medical Board (Nfld.), 1996 CanLII 11630 (NLSC)

71. A number of factors may serve to mitigate the severity of an appropriate penalty in a particular case. These include:

(a) the attitude of the member since the offence was committed, with a less severe punishment being justified where the individual genuinely recognizes that their conduct was wrong;

(b) the age and inexperience of the member at the time the offences were committed;

(c) whether the misconduct was a "first offence" for the member;

(d) whether the member pleaded guilty to the charges of professional misconduct, which may be taken as demonstrating the acceptance of responsibility for their actions;

(e) the good character of the member; and,

(f) a long and otherwise unblemished record of professional service by the member.

The Regulation of Professions in Canada, Carswell 2021, James T. Casey

72. In Ms. Pettit's case, the Panel noted the following aggravating factors:

(a) although there is no evidence linking Ms. Pettit's misconduct to the infant's cause of death, the infant did tragically pass away – the most serious possible adverse outcome for the infant and her family;

(b) Ms. Pettit was an experienced PALS-certified ICP, with 18 years' experience as a medic and 12 years as an ICP; and

(c) Ms. Pettit ought to have taken the lead in the patient's care based upon:

(i) Her experience level;

(ii) Her partner's experience level;

(iii) Her partner's designation meant a more limited skill set to be able to respond to a very serious call with a severely ill infant patient;

(iv) The patient's initial presentation; and

(d) Ms. Pettit's failure to do a thorough assessment (including vital signs) prior to transport.

73. The Panel also took into consideration the following mitigating factors, noting that Ms. Pettit:

(a) has no previous discipline/complaints history;

(b) reported herself to her employer and cooperated with the College's investigation;

(c) has taken the remedial training mandated by her employer;

(d) pled guilty to all charges thereby saving the time and expense of a protracted disciplinary hearing;

(e) suffered psychological distress and PTSD as a result of the incident which continues to the present day;

(f) has not practised since the date of the incident;

(g) entered into an undertaking acknowledging her health issues and removing herself from practice until she has healed; and

(h) has acknowledged her mistakes, taken accountability for the incident and is genuinely remorseful.

74. Counsel for the CIC provided the Panel with a number of similar cases involving professional misconduct.

75. In addition, counsel for both parties made oral submissions at the hearing to the effect that the sanction being recommended is consistent with those imposed on health care professionals in other similar cases.

76. The Panel is satisfied that the Joint Recommendation is in line with prior decisions.

77. The Panel is satisfied that the Joint Recommendation properly addresses and protects the public interest and achieves the purpose of:

(a) providing specific deterrence to Ms. Pettit from engaging in the same conduct;

(b) providing general deterrence to all paramedics that this type of conduct will be investigated, reviewed, and punished; and

(c) reassuring the public that the College is working to maintain standards and ensure continued trust in paramedics and the practice of paramedicine.

VI. Decision

78. The Panel has therefore accepted Ms. Pettit's guilty plea and the parties' Joint Recommendation and an Order will issue as follows:

(a) Ms. Pettit has contravened the Code of Ethics and Standards, is guilty of professional misconduct, and has demonstrated an unfitness to practice paramedicine;

(b) Ms. Pettit is hereby suspended for five months and her return to practice is conditional upon:

(i) her completing a course of instruction at her own expense. The course is to be identified and confirmed by the Registrar/College in ethical decision making or leadership; and

(ii) Ms. Pettit providing the Registrar with satisfactory information (and any additional evidence as may be required) that she is in the requisite mental state to practise paramedicine;

(c) There will be periodic audits of her practice to take place randomly at least four times over the course of her first year of return to practice, and to continue for one year if those reports of performance are satisfactory to the College;

(d) There will be periodic and random audits of Ms. Pettit's patient care records to be done a minimum of monthly for the first full year in practice and to continue until such time as demonstrating to the College satisfactory performance. The costs, if any, are to be borne by Ms. Pettit;

(e) Upon her return to practice, the following conditions be placed on her certificate of practice:

(i) For a period of one year, she may only provide service in a station or community where she can be partnered with a Primary Care Paramedic with a minimum of five-years' experience, or with other Primary Care Paramedics (Intermediate Care), if her performance is satisfactory to the College;

(ii) Ms. Pettit may apply to remove the above condition after she has completed the courses and supervision described above. The onus will be on Ms. Pettit to demonstrate that the condition is no longer required. The decision to remove the condition will be in the sole discretion of the College;

(f) Ms. Pettit will pay costs in the amount of $10,000.00; and

(g) The Panel's Decision will be published and made available to the public.

Dated at Winnipeg, Manitoba this 17th day of November, 2023.

Chris Cauthers (Chair/Member)

Michael Foote (Public Representative)

Cathy Kozminski-Kirby (Member)

Cory Parrott (Member)

Dean Scaletta (Public Representative)