College of Pharmacists of Manitoba

# NEWSLETTER

SUMMER 2024

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## Safety IQ Feature

MedError.ca is an online platform designed to collect medication error reports from the public across Canada. Developed by ISMP Canada and supported byHealth Canada.

## Medical Examiner Review

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***Our mission is to protect the health and well-being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice in collaboration with other health-care providers.***



**The mandate of the College is to serve and protect the public interest**


This Newsletter is published four times per year by the College of Pharmacists of Manitoba (CPhM) and is forwarded to every licenced pharmacist and pharmacy owner in the Province of Manitoba. Decisions of the CPhM regarding all matters such as regulations, drug-related incidents, etc. are published in the newsletter. The CPhM therefore expects that all pharmacists and pharmacy owners are aware of these matters.



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# Safety Feature: Enhancing Medication Safety with MedError.ca

MedError.ca is an online platform designed to collect medication error reports from the public across Canada. Developed by ISMP Canada and supported by Health Canada, the platform features an easy-to-use reporting tool co-created with input from patients and healthcare providers. Patients and caregivers can submit reports of medication errors to ensure that issues are properly documented. Each submission is reviewed by a multi-disciplinary team, and follow-up is provided if the reporter leaves contact information. Every report contributes valuable data to identify patterns and prevent future errors. Additionally, the platform offers guidance and support options for patients who have experienced medication errors.

In addition to the educational material found on MedError.ca, patients can find more valuable resources, including newsletters, at safemedicationuse.ca. This information is designed to keep patients and caregivers informed about potential medication safety risks and how to mitigate them.

The greatest benefit of MedError.ca is the empowerment it offers patients. With the tools and information available on the platform, patients can actively contribute to reducing medication errors and enhancing healthcare safety. Every report can make a difference.

## Types of Medication Errors:

- Mistakes with medications, including close calls
- Wrong dose
- Wrong person
- Missing known allergies
- Wrong medications or confusing labels, including but not limited to:
  - » Prescription and non-prescription medications
  - » Natural health products
  - » Devices or equipment used for medications

## Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. Here is the latest posts:

- Strategies for Enhancing Medication Safety Culture Through Incident Reporting

  Explore strategies for enhancing medication safety culture through incident reporting in community pharmacies. Discover how to craft effective incident reports, prioritize system-based solutions, and foster a culture of continuous improvement. Learn from ISMP Canada's analysis of medication incidents and gain insights to prevent future errors. Empower your pharmacy team with actionable tips and resources for promoting patient safety.

- Pharmacy Workflow Improvements: Insights from the Community Pharmacy Survey on Patient Safety Culture

  Discover practical strategies to enhance pharmacy workflow and promote patient safety and staff satisfaction. Based on insights from the 2023 College of Pharmacists of Manitoba (CPhM) survey, learn how optimizing workflow processes can streamline operations, reduce errors, and improve overall pharmacy efficiency.

# Safety Measure

## Data Reports from the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies highlight the common types of incidents and near-miss events in Manitoba, guiding the improvement efforts of pharmacy professionals and the College of Pharmacists of Manitoba (CPhM).

**2023 Year in Review: Medication Incidents and Near-Miss Events**

Here is a summary of the data reported by Manitoba's pharmacy professionals for 2023:

- Pharmacy professionals have submitted 2317 reports to the NIDR in 2023
- Pharmacy professionals have reported 1333 medication incidents (medication dispensed and reached the patient) and 193 caused patient harm
- Pharmacy professionals reported 984 near-miss events in 2023

**The top three incident types were:**

- Incorrect dose
- Frequency
- Incorrect drug and Incorrect strength/concentration

Please view the Safety IQ: 2023 Year in Review graphic for more details.

Thank you for your commitment to continuous quality improvement. Every report you submit to the NIDR contributes to provincial, national, and international learning about medication incidents and near-miss events. Your efforts are part of a broader movement to enhance pharmacy practice and reduce the risk of patient harm.

# Resources for Professional Development

## ISMP Canada Safety Bulletins

- Central Fill Services for Community Pharmacies: A Multi-Incident Analysis (March 6, 2024)
- A New Canadian Approach to High-Alert Medications (February 14, 2024)
- Pre-pouring Medications: A Risky Approach (December 19, 2023)

## ISMP Canada Learning Opportunities

The following learning opportunities are available at https://ismpcanada.ca/education/:

- Keeping Pediatric Patients Safe: Pediatric Safety Considerations for Community Pharmacists
- Application of TALLman Lettering for Selected High Alert Drugs in Canada
- Incident Analysis and Proactive Risk Assessment
- Multi-Incident Analysis and Medication Safety Culture Assessment
- Safe Label and Package Design
- Medication Reconciliation and Best Possible Medication History
- Medication Safety Considerations for Compliance Packaging

**Safety. Improvement. Quality.**

# Feature: Time-Delayed Safes

Pharmacy security is critical and innovative solutions are crucial to safeguard medications and establish a safe environment for the public, pharmacy professionals, and staff. On January 31, 2024, new regulations mandating the use of time-delayed safes for storing narcotics and controlled drugs in community pharmacies came into effect. This measure, which includes the requirement for prominent signage, aims to enhance the security of community pharmacies.

Mandatory use of time-delayed safes extends beyond Manitoba, as provinces such as Ontario, Saskatchewan, Alberta, and British Columbia require pharmacies to secure their narcotics inside time-delayed safes. British Columbia was the first in 2015 to implement mandatory time-delayed safes and since 2022 the other western provinces and Ontario have followed. British Columbia, Alberta, and Ontario all have reported a lower number in pharmacy robberies since their mandates went into effect. Just recently Toronto Police announced a significant decrease in pharmacy robberies since Ontario required their nearly 5,000 pharmacies to use time-delayed safes.

Time-delayed safes serve as a preventive measure for the safety and health of the public. By increasing the time to access narcotics, the safes discourage potential thieves and increase the likelihood of detection by authorities with the College of Pharmacists of British Columbia reporting in 2015, prior to the use of time-delayed safes, the average pharmacy robbery took less than two minutes.

The new requirements are a proactive step toward enhancing public health and pharmacy security. By deterring theft, ensuring regulatory compliance, and providing peace of mind to pharmacy staff, these safety measures play a crucial role in protecting both the public and medications.

**Benefits of Time-delayed Safes:**

- **Deterrence of Robberies:**
  - Potential thieves are less likely to target pharmacies equipped with these safes and prominent signage. The waiting period disrupts the quick in-and-out nature of most robberies, which makes pharmacies less appealing targets for criminals.

- **Protection of Pharmacy Staff and Patients:**
  - Robbery prevention reduces the risk of physical and emotional harm to pharmacy staff and the public. Since there is a province-wide mandate, thieves cannot target community pharmacies where time-delayed safes are not used.[1]

- **Protection of our Communities:**
  - The opioid epidemic continues to affect communities in Manitoba and Canada at large. In 2023 there were an average of 22 apparent opioid related deaths a day across Canada, representing a 7% increase from 2022.[2] Preventing pharmacy robberies helps prevent opioids from being diverted to the illicit market.

- **Compliance with Regulations:**
  - The implementation of time-delayed safes is part of CPhM's comprehensive approach to public protection. By adopting such measures, pharmacies not only enhance their security but also align with regulatory expectations, fostering trust and accountability within the community.

### Implementation and Best Practices:

- **Effective Communication:**
  - Clearly communicate the purpose of the time-delayed safe system to all patients and clients, especially those waiting for narcotics or other controlled substances. Proactively manage their expectations by explaining the necessity of the delay, which enhances the safety of customers and the public. Use clear signage and direct verbal explanations to educate customers about how the system works and why it is in place. Pharmacy professionals can also direct patients to the resources and educational material on the CPhM website.

- **Clear Signage:**
  - Pharmacies that have a time-delayed safe on site must display clear signage indicating its presence. This transparency can function as a deterrent to would-be thieves and communicate the pharmacy's commitment to safety. Additionally, pharmacies who do not carry narcotics or controlled substances can also display signage indicating they do not carry narcotics to deter would-be thieves.

- **Proper Use:**
  - To effectively deter robberies the time-delayed safe must be kept closed and locked when not in use. Once pharmacy staff have removed the required drugs to fill a prescription, or finished restocking the safe it should be promptly closed.

Additional information for pharmacy professionals, including suggestions for implementing time-delayed safes into your pharmacy's workflow can be found on the CPhM website.


1. https://pharmacyconnection.ca/3-ways-time-delayed-safes-make-pharmacies-and-communities-safer/
2. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

# Message from the Chair

## Dear Colleagues,

I am thrilled to begin my one-year term as Chair of the College of Pharmacists of Manitoba (CPhM).

I would like to extend my gratitude to the past Chair, Jane Lamont, for her dedicated service over the past two years. Her leadership and commitment have been instrumental in advancing pharmacy care and protecting the public interest in Manitoba. It was a privilege to collaborate with her, and I am honored to step into this role, building upon the strong foundation that those before me have established.

I also want to extend my thanks to the past council members — Tory Crawford, Kristine Petrasko, and Sonal Purohit — whose hard work and contributions have been invaluable. Your efforts will always be remembered and built upon. I wish you all the best in your future endeavors.

The Annual General Meeting on May 14, 2024, brought forward key changes regarding the future selection of CPhM Council. These changes align with best practices adopted by regulators in Manitoba and across Canada. CPhM has integrated valuable lessons into our selection process by learning from early adopters of these practices.  Key changes include:  Key changes include:

- Full registered pharmacists and listed pharmacy technicians can serve on council.
- Competency-based selection ensuring selected candidates are based on merit and relevance.
- Objective review process, focusing on how candidates meet the established competencies and criteria.
- Selection process considers background factors, including practice experience, work environments, and perspectives.
- Emphasis on candidates' commitment to public service
- Staggered terms of service consistently introduce new perspectives while maintaining experienced vision and diverse representation

These changes enhance public interest, encourage diversity of perspectives, and enhance CPhM's governance framework.

A notable regulatory initiative from this past year was the implementation of time-delayed safes in all community pharmacies. This decision was made following extensive research and consultation with other jurisdictions and law enforcement, aiming to enhance the safety for patients and pharmacy staff. Most recently, CPhM launched a public awareness campaign to promote the use of time-delayed safes and to ensure transparent communication with the public about the new signage and its results.

In addition, as part of our ongoing commitment to safety and continuous learning, I encourage you to read the latest blog post from Safety IQ. The post features practical strategies to enhance pharmacy workflow and promote patient safety and staff satisfaction. It outlines how optimizing workflow processes can streamline operations, reduce errors, and improve overall pharmacy efficiency.

I look forward to collaborating with CPhM Council members and committee volunteers in the coming year. Together, we will work to advance the regulatory constructs for pharmacy professionals in Manitoba, and strive to expand pharmacy scope of practice, allowing pharmacy professionals to contribute more fully to the health care system and better serve patients and the public.

Sincerely,

Ryan Buffie
Chair, College of Pharmacists of Manitoba

# Education from the Adult Inquest Review Committee Meetings of the Office of the Chief Medical Examiner

The College of Pharmacists of Manitoba (CPhM) attends the Office of the Chief Medical Examiner (OCME) to review deaths which may have involved prescription drugs, focusing on opioids and other psychoactive medications. A de-identified case study based on information obtained from the OCME is presented in each Newsletter to provide an opportunity for education and self-refection for all pharmacy professionals.

## Introduction

DJ is a 40-year-old female who was found dead on her bathroom floor on December 7, 2020, surrounded by drug paraphernalia including used syringes. DJ had a history of intravenous drug use and had been injecting morphine tablets and sometimes mixing them with fentanyl. Her medical history included cardiomyopathy, pulmonary edema, and hepatomegaly. An autopsy was performed, and the immediate cause of death was determined to be an accidental mixed drug toxicity involving fentanyl, cocaine, morphine, citalopram, and gabapentin.

## Results

The following chart represents the results of the toxicology report. Drugs that were above the therapeutic range are indicated by an asterisk (*):

| Drug | Level in blood | Therapeutic Range (if applicable) |
|---|---|---|
| Fentanyl* | 37 ng/mL | Within 24 hours of the application of a 100ug/ hr transdermal patch, the expected serum concentration is 1.9-3.8 ng/mL. |
| Morphine (free) | 34 ng/mL | 10 - 80 ng/mL |
| Citalopram*^ | 670 ng/mL | 30 - 200 ng/mL |
| Cocaine<br>Benzoylecgonine (inactive metabolite) | 0 ng/mL<br>295 ng/mL | --<br>-- |
| Gabapentin | 12 ug/mL | 2 - 20 ug/mL |
| Ethanol | 10 mg/mL | 0 mg/dL |
| Diphenhydramine, diazepam, alprazolam, brompheniramine | Detected but not quantified | Various |

^ *tricyclic antidepressants and selective serotonin and norepinephrine reuptake inhibitors undergo post-mortem redistribution and therefore levels can be significantly elevated in the toxicology report. This, in addition to the length of the post-mortem interval, affect the interpretation of the post-mortem toxicology.*

DJ's DPIN history below only includes a summary of medications relevant to her toxicology report:

| Generic Name | Dates Dispensed | Strength | Quantity | Days' Supply | Prescriber & Pharmacy |
|---|---|---|---|---|---|
| Alprazolam | Dec 7, 2020<br>Nov 31, 2020<br>Nov 24, 2020<br>Nov 18, 2020<br>Nov 11, 2020<br>Nov 4, 2020<br>Oct 27, 2020<br>Oct 20, 2020<br>Oct 13, 2020 | 1 mg | 21 | 7 | Dr. A<br><br>ABC Pharmacy |
| Citalopram | | 40 mg | 7 | 7 | |
| Gabapentin | | 600 mg | 28 | 7 | |
| Morphine | | 10 mg<br>30 mg SR | 28<br>14 | 7<br>7 | |

## Discussion

DJ passed away from a multidrug overdose involving opioids. The greater availability of prescription opioids has contributed in part to the rise in opioid-related harms.[1] While unregulated fentanyl has been a primary contributor to opioid-related deaths in recent years, previous research has found that as many as 29% of individuals with substance use disorder were initially introduced to opioids through a prescription for pain.[2] Pharmacists can play a crucial role in enhancing opioid stewardship, mitigating the risk of opioid-related harms and the development of opioid use disorders among patients. The risk of long-term opioid use increases when opioids are initiated early after an injury[3], are prescribed for longer than a week[4], and when patients receive their second opioid prescription[4].

In this case, DJ had been prescribed 100 mg of morphine per day, which is greater than the recommended maximum dose of 90 MME per day.[5-8]. Moreover, ethanol was found in DJ's blood serum. The concomitant use of opioids with CNS depressants, including ethanol, alprazolam, and gabapentin in this patient, is not recommended due to the risk of additive CNS effects such as sedation, respiratory depression, coma, and possibly death.[6] Prioritizing an opioid taper and exploring other non-sedating alternatives to gabapentin or alprazolam could be considered to reduce the risk of opioid-related toxicity.[7]

High levels of illicit substances, including fentanyl and cocaine, were found in DJ's toxicology report. According to a study by Gomes et al. in Ontario, 37.8% of participants with active opioid prescriptions at the time of death had evidence of a non-prescribed opioid based on their post-mortem toxicology report.[9] Non-prescribed opioids refer to diverted or illicitly obtained opioids. Fentanyl was the most commonly identified non-prescribed opioid after death as it was found in 41% of cases.[9]

Pharmacists play a pivotal role in the opioid crisis by guiding conversations with patients, prescribers, and other healthcare professionals for the prevention and management of opioid use disorder. It is the pharmacist's responsibility to monitor for signs of diversion or aberrant behavior in patients and communicate this to their prescribers and other involved healthcare professionals.[10] Further, recognizing these signs can be an opportunity to connect patients to evidence-based and potentially life-saving treatment for opioid use disorder. Rapid Access to Addictions Medicine (RAAM) Clinic is an accessible walk-in clinic for those seeking help with substance use and addictions.[11]

Patient counselling is another key role of pharmacists in the prevention of opioid use disorder. According to NAPRA's Pharmacist's Virtual Communication Toolkit, there are 3 steps to engage in effective conversations about opioids.[12] First, pharmacists should stop and listen to patients' concerns regarding opioids.[12] Pharmacists are encouraged to ask open-ended questions, such as "Where is the pain?" and "How well is your medication controlling your pain?". It is also important to implement active listening and acknowledge the patient's experiences.[10,12] The next step is to drop the stigma by avoiding assumptions about the patient's situation and sharing accurate information about opioids.[12] Lastly, pharmacists

should utilize motivational interviewing strategies when educating patients about the benefits and risks of opioid therapy.[12] The fundamental principles for motivational interviewing include rolling with resistance, expressing empathy, avoiding argument, developing discrepancies, and supporting self-efficacy.[12] The following article on Tapering Opioids Using Motivational Interviewing by the Canadian Family Physician describes excellent examples on how motivational interviewing techniques can be used in practice.

It is a pharmacist's primary responsibility to ensure patient safety when dispensing a prescription medication. All pharmacists are reminded of their professional obligation to ensure that each prescription is reviewed thoroughly, and all potential issues are addressed, even if this entails difficult patient and prescriber encounters. According to the Ensuring Patient Safety Practice Direction, measures must be taken to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists are not obligated to dispense medications they believe may have the potential to cause patient harm, but they have the professional responsibility to collaborate with the prescriber and the patient to develop an appropriate and acceptable therapeutic plan.

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# Feature: Combating Forgeries

Prescription forgery remains a significant concern, posing risks to patient safety and public health. With the rising number of forgery reports received by the College of Pharmacists of Manitoba, it is crucial for pharmacy professionals to stay informed and vigilant.

## Evolving Forgery Trends

In recent years, certain trends have appeared in the methods of prescription forgeries. The most forged prescription involves, [N]TEVA-COTRIDIN and [N]PERCOCET®, often in large quantities such as 120 tablets of [N]PERCOCET® and/or 210 ml of [N]TEVA-COTRIDIN. Pharmacy professionals must assess suspicious prescriptions with the M3P program guidelines and CPSM's opioid prescribing standards in mind. Suspicious prescriptions often signify forgery attempts.

Another notable trend is the increasing use of faxed prescriptions to perpetrate forgeries. These often originate from out-of-province area codes, enabling rapid distribution to multiple pharmacies. This method of transmission has affected pharmacies across Manitoba. It is essential to inspect the origin of faxed prescriptions, as sender information can be easily falsified using technology.

In addition to out-of-province prescription faxes, trends involving patient demographics are evolving. Forged prescriptions often pertain to out-of-province patients, sometimes listing a Manitoba address but lacking a valid Manitoban PHIN. In such cases, pharmacy professionals must verify patient information diligently, requesting photo identification for new patients receiving controlled narcotics or substances. If no ID is available, additional steps to confirm patient identification should occur.

Forgeries have also affected prescriber demographics. Both Manitoban and out-of-province prescribers are targets, with forged prescriptions often having false clinic contact information. Furthermore, pharmacies report receiving follow-up phone calls from individuals impersonating prescribers or patients to verify prescription availability. Verifying prescriber's contact information against reliable sources and confirming the identity of callers is crucial in these scenarios.

## Strategies for Detection and Prevention

Pharmacy professionals must remain vigilant and adopt procedures to detect and prevent prescription forgeries. Indicators of forged prescriptions include missing or incorrect clinic information, discrepancies in fax numbers, inconsistencies in prescriber details, and unusual quantities or tampering signs.

In suspected prescription forgery cases, pharmacy professionals should keep the original prescription or take a photocopy if it needs to be returned. If a forgery is confirmed, notifying the police, and documenting the refusal to fill prescription on the DPIN system, including non-M3P drugs, is necessary.

### Key Tips for Pharmacy Professionals:

- **Inspect faxed prescriptions** for missing clinic details and inconsistencies in fax numbers.
- **Exercise caution** with verbal prescriptions if the caller cannot provide specific details about the clinic or prescriber.
- **Check** in-person prescriptions for tampering signs, unusual quantities, and discrepancies in signatures.
- **Be attentive** to spelling errors, abnormal quantities, and multiple presentations at different pharmacies.

## Conclusion

Prescription forgery remains a significant concern, posing risks to patient safety and public health. By staying informed about current trends and implementing thorough verification procedures, pharmacy professions can effectively combat this issue. CPhM appreciates the continued diligence of all pharmacy professions and encourages ongoing reporting and adherence to best practices. For comprehensive guidelines on identifying and responding to prescription forgeries please visit: https://cphm.ca/uncategorized/6108/

# DISCIPLINE DECISIONS/SUSPENSIONS

## Pharmacy and Pharmacist License Decisions

1. Effective November 27, 2023, the Registrar imposed an interim suspension of the practicing license of Mr. Nicholis St. Goddard (College License No. 41151), pending review of the matter by the Complaints Committee in accordance with subsection 24(1) and 24(2) of *The Pharmaceutical Act* (the Act).

   Effective July 19, 2024, the Complaints Committee has directed the Registrar to maintain the interim suspension of the practicing license of Mr. Nicholis St. Goddard (College License No. 41151) pending the outcome of the proceedings of the matter, in accordance with section 40(1) of *The Pharmaceutical Act.*

   The profession was previously advised of the interim suspension by the Registrar on November 27, 2023, and the interim suspension by the Complaints Committee on July 23, 2024.

   This notice is pursuant to section 132(2) of the Pharmaceutical Regulation.

2. Effective June 18, 2024, the Registrar has issued an interim suspension of 10019160 Manitoba LTD, the pharmacy license holder of Panet Pharmacy (College Licence No. 35693) under section 24(1) of *The Pharmaceutical Act*, pending review of the matter by the Complaints Committee. Consequently, the pharmacy license of Panet Pharmacy is interim suspended.

   Effective June 19, 2024, the Complaints Committee has directed the Registrar to maintain the interim suspension of 10019160 Manitoba LTD the pharmacy license holder of Panet Pharmacy (College Licence No. 35693) pending the outcome of the proceedings of the matter, in accordance with section 40(1) of *The Pharmaceutical Act.*

   The profession was previously advised of the interim suspension by the Registrar on June 18, 2024, and the interim suspension by the Complaints Committee on July 23, 2024.

   This notice is pursuant to section 132(2) of the Pharmaceutical Regulation.

# DISCIPLINE DECISIONS/SUSPENSIONS

## Decision and Order of the Discipline Committee: Lance Breland

Pursuant to a Notice of Hearing dated December 7, 2022 (the "Notice"), a hearing was originally convened on February 22, 2023 by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the offices of Thompson Dorfman Sweatman LLP, 242 Hargrave Street, Suite #17, Winnipeg, Manitoba, R3C 0Vl, but adjourned to March 14, 2024, with respect to charges formulated by the College alleging that Lance Breland ("Mr. Breland"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c. P60 (the "Act") and a former registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, or has displayed a lack of skill or judgment in the practice or operation of a pharmacy, or any of the above, as described in section 54 of the Act, in that, between approximately November 13, 2020 and March 8, 2021, Mr. Breland:

1. failed to maintain professional liability insurance required to maintain licensure in 2020 and 2021, or either of them, in contravention of sections 15(l)(d) of the Act, section 123 of the *Pharmaceutical Regulation,* Man. Reg. 185/2013 (the "Regulation"), and/or Statements VII, VIII and X of the *Code of Ethics* (the "Code"), or any of them;

2. failed to disclose to the registrar that his liability insurance for his 2020 practising pharmacist licence had lapsed, in contravention of section 20 of the Regulation;

3. failed to disclose to the registrar that his liability insurance for his 2021 practising pharmacist licence had lapsed, in contravention of section 20 of the Regulation; and

4. failed to produce to the College investigator records, documents or things in his possession or under his control pertaining to his professional liability insurance, in contravention of subsection 33(10) of the Act and/or Statement VIII of the Code.

On March 14, 2024, Mr. Jeffrey Hirsch ("Mr. Hirsch") and Ms. Sharyne Hamm ("Ms. Hamm") appeared as counsel on behalf of the Complaints Committee. Mr. Breland did not attend the hearing and no one appeared on his behalf, despite having received notice of the hearing. Ms. Gabrielle Lisi ("Ms. Lisi") appeared as counsel to the Discipline Committee (the "Panel").

Ms. Hamm advised the Panel that Mr. Breland had indicated that neither he nor his agent intended to attend the hearing or appear before the Panel.

After hearing from Ms. Hamm, the Panel agreed to adjourn the hearing for fifteen minutes to permit Mr. Breland additional time to arrive and attend the hearing. Neither Mr. Breland nor his agent appeared during that time. After the 15-minute adjournment, the Panel then elected to proceed with the hearing in Mr. Breland's absence pursuant to section 53 of the Act.

As Mr. Breland did not attend the hearing and no one appeared on his behalf, the Panel entered a plea of not

guilty to all counts on behalf of Mr. Breland.

Ms. Hamm on behalf of the Complaints Committee advised the Panel at the outset of the hearing that it was not seeking suspension or cancellation of Mr. Breland's pharmacist licence should the Panel find Mr. Breland guilty on the charges, and that accordingly, it intended to proceed with the hearing on affidavit evidence alone. As the Complaints Committee was not seeking a suspension of Mr. Breland's registration or licence, the Panel agreed to proceed with the hearing on affidavit evidence alone pursuant to section 48(6) of the Act.

Ms. Hamm submitted before the Panel the affidavit of Dr. Brent Booker, affirmed March 11, 2024, and the affidavit of Janice Nesbitt, affirmed March 7, 2024, and the affidavit of Trista Feniuk, affirmed March 12, 2024, which indicated that:

1. Mr. Breland was a member of the College at all times material to this proceeding;

2. Mr. Breland was validly served with the Notice of Hearing dated December 7, 2022;

3. Mr. Breland had provided his written consent to commence the hearing on a date beyond the 120-day period referenced in subsection 46(2) of the Act;

4. the College complied with the jurisdictional requirements of subsection 46(3) of the Act; and

5. so far as the Complaints Committee was aware, Mr. Breland did not raise any objection to the composition of the Panel or the legal counsel of the Panel on the basis of bias, reasonable apprehension of bias or a conflict of interest.

The Panel heard submissions from Ms. Hamm that confirmed the allegations of all counts contained in the Notice of Hearing dated December 7, 2022.

After reviewing the authorities and the affidavit evidence provided to the Panel and hearing the submissions of counsel for the Complaints Committee, the Panel retreated to deliberate and reconvened the hearing to inform the Complaints Committee of the decision of the Panel.

The Panel found that pursuant to section 54 of the Act, Mr. Breland is guilty of professional misconduct, conduct unbecoming a member and has displayed a lack of knowledge, skill and judgment in the practice or operation of a pharmacy on all counts. The Panel advised that written reasons would follow.
CPhM - Discipline Decision and Order - Lance Breland

In arriving at that decision, the Panel considered the affidavit evidence and concluded that:

1. during an investigation into a complaint made against Mr. Breland in November 2019, the College determined that Mr. Breland's professional liability insurance had lapsed;

2. the lapse in Mr. Breland's professional liability insurance occurred in late 2020 and was not rectified by the time Mr. Breland requested that that his pharmacist licence be cancelled in March 2021;

3. during the investigation into the lapse of his professional liability insurance, Mr. Breland not only did not cooperate with the College but actively attempted to obstruct the College in its investigation efforts. In particular, Mr. Breland:

a. refused to produce to the College investigator copies of records identifying his insurance coverage during the relevant period; and

b. directed his insurance broker not to produce to the College investigator his insurance information; and

4. as a result of Mr. Breland's conduct, the College was required to obtain a court order directing the production of records from his insurance broker, incurring significant costs to do so.

**Submissions on Penalty**

Having been informed of the finding of the Panel, counsel for the Complaints Committee made submissions on penalty, and submitted to the Panel the affidavit of Dr. Brent Booker, affirmed March 14, 2024.

Ms. Hamm recommended to the Panel that the following penalty be imposed on Mr. Breland:

1. That the reasons for decision of the Panel be published and made available to the public;

2. That Mr. Breland pay a fine of $2,000;

3. That Mr. Breland, upon resumption of practice, be prohibited from being a pharmacy manager or preceptor for a period of five years; and

4. That Mr. Breland pay a contribution of the costs of the investigation and hearing in the amount of $10,000.

After reviewing the authorities provided to the Panel regarding disposition and hearing the submissions of counsel for the Complaints Committee, the Panel accepted the recommended disposition of legal counsel for the Complaints Committee and ordered that:

1. the reasons for decision of the Panel be published and made available to the public;

2. Mr. Breland is to be fined $2,000;

3. Mr. Breland is, upon resumption of practice, to be prohibited from being a pharmacy manager or preceptor for a period of five years; and

4. Mr. Breland is to pay a contribution of the costs of the investigation and hearing in the amount of $10,000.

In arriving at its decision, the Panel considered:

1. that Mr. Breland had only received one previous complaint despite his having been licensed as a pharmacist almost continuously since 2010;

2. that Mr. Breland repeatedly ignored or failed to respond to communications from the College and indeed, actively attempted to obstruct the College's investigations into the matter by instructing his insurance representative not to communicate with the College;

3. that a portion of the costs associated with the discipline process should be recovered from the member who is guilty of the professional misconduct; and

4. the costs ordered in this decision are less than 20% of the total costs incurred or to be incurred by the College in respect of this matter, which costs exceeded $50,000.

Based on the foregoing, the Panel is satisfied that this disposition should serve to act as a deterrent, both general and specific, while at the same time ensuring that the public's interest will be protected and the public's confidence maintained.

DATED at Winnipeg, Manitoba this 30th day of April, 2024.

Martha Mikulak
Chair, Discipline Panel

# DISCIPLINE DECISIONS/SUSPENSIONS

## Decision and Order of the Discipline Committee: Jeffrey Coldwell

Pursuant to the Notice of Hearing (the "Notice") dated December 14, 2022, a hearing was conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on November 15, 2023, with respect to charges formulated by the College alleging that Jeffrey Coldwell ("Mr. Coldwell"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c.P60 (the "Act") and a registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, or has displayed a lack of knowledge, skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above, as described in section 54 of the Act, in that, at Co-op Pharmacy, 605 Park Avenue, Beausejour, Manitoba, (the "Pharmacy"), in the capacity of a pharmacist and/or pharmacy manager, Mr. Coldwell:

1. Diverted, for personal use, on multiple occasions between February 19, 2019 and April 29, 2021, Tramadol tablets and/or tablets containing Tramadol in contravention of his undertaking to and agreements with the College dated February 28, 2020 and October 2, 2020, and/or alternatively, Statements VIII and X of the *Code of Ethics*, or any of them;

2. On two occasions between February and October 2020, failed to conduct monthly narcotic verification counts, including investigation and reporting of discrepancies, in contravention of his undertaking to and agreements with the College dated February 28, 2020, and October 2, 2020, and/or alternatively, Statements VIII and X of the *Code of Ethics*, or any of them;

3. Failed to secure narcotics and controlled substances in contravention of: section 43 of the Narcotic Control Regulations, C.R.C., c. 1041; subsection 72(1)(a) of the Benzodiazepine and Other Targeted Substances Regulations, SOR/2000-217, (the "BOTSRs"); section 2.3.1 of the Practice Direction – Drug Distribution and Storage (the "PD – DDS"), and, the Narcotic and Controlled Drug Accountability Guidelines, or any of them, in that you:

    a) failed to establish, implement, ensure compliance with, and maintain policies and procedures to protect narcotics and controlled and targeted substances in contravention of: subsections 56(1)13 and 65(1) of the *Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"), or either of them;

    b) on multiple occasions between July 2019 and March 2021, failed to submit Loss or Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada, in contravention of subsection 72(2) of the BOTSRs; and,

    c) failed to maintain clear and readily retrievable records in contravention of: subsection 56(1)12 of the Regulation; section 3.1 of the PD-DDS; and, sections 2.1.1, 2.1.2 and 2.1.3 of the Practice Direction – Records and Information, or any of them.

The hearing into the charges convened on November 15, 2023. Mr. Jeffrey Hirsch ("Mr. Hirsch") and

Ms. Sharyne Hamm appeared as counsel on behalf of the Complaints Committee. Mr. Coldwell was self represented and Mr. David Marr ("Mr. Marr") appeared as counsel to the Discipline Committee (the "Panel").

A Statement of Agreed Facts (the "Statement") was filed in which Mr. Coldwell admitted:

- his membership in the College;
- that a Notice of Hearing was issued on December 14, 2022;
- valid service of the Notice and that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act;
- he had no objection to any of the Panel Members nor to legal counsel to the Panel on the basis of bias, a reasonable apprehension of bias, or a conflict of interest;
- he graduated with his pharmacy degree from the University of Manitoba in 1992;
- at all times material to this proceeding, he was a Member of the College as a practicing pharmacist in Manitoba;
- beginning in January 1993 he was employed by Safeway Pharmacy at numerous Manitoba locations;
- beginning on January 17, 2017, he voluntarily surrendered his practicing license and was approved to return to practice on May 15, 2017;
- beginning in October 2017 he was employed as a Pharmacy Manager at Rexall Pharmacy, in Stonewall, Manitoba;
- beginning in February 2019 he was employed as the Pharmacy Manager of Beausejour Co-op Pharmacy, in Beausejour, Manitoba;
- the College issued written cautions to Mr. Coldwell on January 26, 1998 and February 15, 2000;
- his license to practice was suspended on April 15, 2021; and
- he had reviewed the Notice as well as the Statement and admitted the truth and accuracy of the facts in the Statement and that the witnesses and other evidence available to the College would, if called and otherwise tendered, be substantially within these facts.

Mr. Coldwell entered a plea of guilty to counts 1, 2, 3(a)-(c), as set out in the Notice and admitted that the misconduct demonstrated professional misconduct as described in section 54 of the Act.

**Facts and Background:**

1. In or around January 2017, Mr. Coldwell advised the College that he had been misusing drugs and alcohol and was undergoing medical care for the treatment of benzodiazepine withdrawal. Mr. Coldwell voluntarily withdrew from practice on January 17, 2017.

2. On May 15, 2017, Mr. Coldwell was approved for relicensure by the Complaints Committee of the College (the "Committee") and was permitted to return to practice with no conditions on his

practicing license.

3. On February 20, 2018, Ms. Rani Chatterjee-Mehta, then-Assistant Registrar, Quality Assurance, conducted an unannounced inspection at Rexall Pharma Plus #7409 in Stonewall, Manitoba, where Mr. Coldwell was pharmacy manager. The inspection identified several issues and deficiencies with respect to narcotic and controlled substances accountability practices. By letter dated February 26, 2018, Mr. Coldwell was directed to correct the significant issues by March 28, 2018.

4. On March 15, 2018, the then-Registrar, Ms. Susan Lessard-Friesen, made a referral to the Committee with respect to the issues identified at the February 20, 2018, inspection.

5. On or about March 15, 2018, the Committee ordered an investigation.

6. On March 27, 2018, Mr. Coldwell met with the Committee and agreed to sign an undertaking and submit to random drug testing.

7. On or about April 6, 2018, Mr. Coldwell entered into an undertaking with the College, pursuant to which he undertook not to ingest narcotics or benzodiazepines unless prescribed for medical reasons, and to comply with a program of random drug test monitoring (the "April 2018 Undertaking").

8. On May 1, 2018, Ms. Chatterjee-Mehta conducted an onsite visit to Rexall Pharma Plus #7409.

9. Ms. Chatterjee-Mehta submitted her Investigation Report to the Committee on May 18, 2018.

10. On September 21, 2018, Ms. Chatterjee-Mehta submitted an Updated Investigation Report to the Committee.

11. In February 2019, Ms. Kathy Hunter, Assistant Registrar - Field Operations, conducted a pre-opening inspection at the Beausejour Co-op Pharmacy in Beausejour Manitoba (the "Pharmacy"), at which Mr. Coldwell was to be the pharmacy manager.

12. The Committee and the College continued to monitor Mr. Coldwell through 2019 by random drug testing, completing unannounced inspections at the Pharmacy, and having Mr. Coldwell attend meetings of the Committee to discuss his health status.

13. On or about February 28, 2020, Mr. Coldwell entered into a further undertaking with the College (the "February 2020 Undertaking"), pursuant to which Mr. Coldwell, among other things:

    a) Agreed not to ingest any controlled drugs or substances unless approved in writing in advance by the College;

    [redacted]

    c) Engaged Dr. Brent Booker as a mentor;

    d) Agreed to submit to random drug and alcohol testing;

e) Agreed to comply with a program of random drug test monitoring;

f) Agreed to continue attending sessions with a treating psychologist; and

g) Agreed that the undertaking would remain in place until April 30, 2023.

14. In August 2020, Dr. Brent Booker became the Assistant Registrar- Review and Resolution of the College. Accordingly, on October 2, 2020, Mr. Coldwell entered into a new undertaking on the same terms as the February 2020 Undertaking, but which appointed [redacted] as Mr. Coldwell's mentor with respect to narcotic and controlled substances accountability practices (the "October 2020 Undertaking").

15. 15. On March 24, 2021, Mr. Coldwell's random drug screening sample tested positive for benzodiazepines, in particular, oxazepam and lorazepam. The College received notification of these results on April 8, 2021.

16. On April 9, 2021, the College wrote to Mr. Coldwell to advise him of the positive drug screening and request a written explanation, pursuant to the October 2020 Undertaking.

17. On or about April 12, 2021, a staff pharmacist, on behalf of the Pharmacy, submitted a Loss or Theft Report to Health Canada and the College indicating that an unexplained loss of 35 tablets of Apo-Lorazepam 1mg was identified in the course of a narcotic and controlled substances inventory count that took place on March 21, 2021.

18. On April 12, 2021, Mr. Coldwell replied in writing to the April 9, 2021, letter.

19. On or about April 13, 2021, a staff pharmacist, on behalf of the Pharmacy, notified the College that an unexplained loss of 20 tablets of Apo-Lorazepam 1 mg was identified in the course of a narcotic and controlled substances inventory count that took place on January 31, 2021.

20. Mr. Coldwell attended before the Committee on April 15, 2021.

21. On April 15, 2021, the Registrar of the College wrote to Mr. Coldwell to inform him of the Committee's decision to suspend Mr. Coldwell's pharmacist license on an interim basis.

22. On April 15, 2021, the Committee directed that the matter of inventory discrepancies at the Pharmacy be investigated and the Registrar ultimately appointed Mr. Ken Zink a College Investigator (the "Investigator"), to conduct the investigation.

23. On May 19, 2021, Mr. Coldwell wrote to the Committee to provide a further explanation for the positive drug screening result.

24. On August 2, 2022 and August 17, 2022, Mr. Zink conducted on-site visits at the Pharmacy. Mr. Zink subsequently had a telephone interview with staff at the Pharmacy on August 24, 2022, and a telephone interview with Mr. Coldwell on September 14, 2022.

25. Mr. Zink submitted his Investigation Report to the Committee on September 19, 2022.

26. On November 1, 2022, the Committee directed that the matter be referred to the College's Discipline Committee.

27. Mr. Coldwell was informed of the decision of the Committee to refer the matter to the Discipline Committee on November 22, 2022 by email and registered mail.

28. The Notice was issued on December 14, 2022.

**In the Statement, pertaining to Count 1, the parties agreed that:**

1. Count 1 alleges that Mr. Coldwell, on multiple occasions between February 19, 2019 and April 29, 2021, diverted for personal use Tramadol tablets and/or tablets containing Tramadol in contravention of his undertaking to and agreements with the College dated February 28, 2020 and October 2, 2020, and/or alternatively Statements VIII and X of the *Code of Ethics* (the "Code") or any of them.

2. The Investigator conducted a review of the Pharmacy's controlled substances accountability processes. In particular, he reviewed the Drug Inventory History Reports for manual adjustments. These reports are helpful tools which can be used to determine instances of pharmacy staff adding or removing quantities of controlled substances from the perpetual inventory system. A drug removed from the perpetual inventory without an acceptable reason and proper documentation is vulnerable to diversion.

3. The drug tramadol is a synthetic opioid that became listed under the Controlled Drug and Substances Act ("CDSA") and the NCR since March 31, 2022. As an opioid drug, the chronic use of tramadol can lead to the development of tolerance and physiological dependence. Long-term tramadol use is also associated with a risk of developing serious complications such as opioid use disorder, respiratory depression, and death.

4. Tramadol as an opioid drug produces similar physiological and psychological effects as related substances such as opium and morphine, and thus fits the medical definition of a narcotic drug.

5. Prior to March 31, 2022, tramadol was regulated under the Food and Drug Act ("FDA") prescription drug list and would have required a prescription from a licensed prescriber for its use.

6. As a drug not included in a CDSA schedule prior to March 31, 2022, tramadol containing products would not normally have appeared on perpetual inventory narcotic, controlled or targeted drug reports generated prior to this date.

7. During the course of the investigation, the Investigator conducted a search of seven pharmaceutical products containing tramadol as the active ingredient. The Drug Inventory History Report with respect to these seven products identified a multitude of inventory adjustments. These adjustments are summarized in the following table:

| Drug Name | # Adjustment (Decrease) | # Tabs | # Adjustment (Increase) | # Tabs |
|---|---|---|---|---|
| Mint-Tramadol / Acetaminophen 37.5/325 | 32 | 169 | 1 | 5 |

| | | | | |
|---|---|---|---|---|
| Taro-Tramadol / Acetaminophen 37.5/325 | 117 | 1310 | 7 | 209 |
| Tramacet 325/37.5 | 2 | 25 | 1 | 10 |
| Tramadol 50 mg | 10 | 210 | 1 | 10 |
| Tridural 100 mg | 78 | 211 | 7 | 52 |
| Tridural 200 mg | 0 | 0 | 0 | 0 |
| Tridural 300 mg | 79 | 168 | 4 | 12 |
| Total | 318 | 2093 | 21 | 298 |
| Net | | 1795 | | |

8. The Investigator determined that on 318 separate occasions between February 19, 2019 (the date on which the Pharmacy opened) and April 29, 2021 (following Mr. Coldwell's suspension from practice) pharmaceutical products containing tramadol were removed from the Pharmacy's perpetual inventory without a documented explanation. These 318 occasions resulted in a total of 2,093 tablets being removed from the perpetual inventory. There were also 21 occasions, for a total of 298 tablets, where the perpetual inventory was positively adjusted for these tramadol-containing products.

9. The first adjustment to inventory was made on June 1, 2019, for two tablets. Between the date of the first adjustment and April 20, 2021, an average of more than three tablets per day were adjusted for, seven days per week.

10. In the interviews conducted by the Investigator with [redacted] stated that [redacted] could think of no other explanation for the adjustments other than pilferage. During the interviews, Pharmacy staff stated that manual adjustments made using their initials were not made by them.

11. In an interview with Mr. Coldwell on September 14, 2022, Mr. Coldwell admitted to the pilferage of tramadol from the Pharmacy. Mr. Coldwell stated that the tramadol was taken for his personal use, without having received a prescription from a licensed prescriber to use this medication.

12. Mr. Coldwell was required by the April 2018 Undertaking, the February 2020 Undertaking and the October 2020 Undertaking to refrain from ingesting narcotic medications unless they were prescribed to him and he obtained approval from the College. Mr. Coldwell did not seek permission from the College for his use of tramadol. Mr. Coldwell's personal misuse of tramadol constituted a breach of these undertakings.

13. On December 16, 2022, the Pharmacy reported to Health Canada and to the College that between June 2019 and April 2021, tramadol and tramadol containing products were pilfered from the Pharmacy.

**In the Statement, pertaining to Count 2, the parties agreed that:**

1. Count 2 alleges that Mr. Coldwell, on two occasions between February and October 2020, failed to

conduct monthly narcotic verification counts, including investigation and reporting of discrepancies, in contravention of his undertaking to and agreements with the College dated February 28, 2020 and October 2, 2020, and/or alternatively Statements VIII and X of the Code, or any of them.

2. Federal and provincial legislation requires all pharmacies to conduct quarterly physical counts of narcotic and controlled drugs. The reconciliation of expected and on hand quantities is important to the protection of controlled drugs from loss, and the early detection and deterrence of drug pilferage.

3. Mr. Coldwell was required, pursuant to the February 2020 Undertaking, to conduct monthly narcotic verification counts. Mr. Coldwell confirmed to the Investigator in an interview that he was aware of the requirement to conduct monthly narcotic and controlled drug counts.

4. The Investigator reviewed all documented controlled substance counts on file at the Pharmacy between May of 2019 and March of 2021. In doing so, he identified that physical counts of the narcotic and controlled drug inventory had not been completed on time in May of 2020 or at all in September of 2020.

5. No counts of the physical inventory of benzodiazepines at the Pharmacy were completed in April 2020, July 2020, August 2020, September 2020 or October 2020.

6. In addition, Mr. Coldwell was not involved in any physical counts of benzodiazepines between March and December of 2020, despite his role as pharmacy manager throughout this period.

**In the Statement, pertaining to Count 3(a)**

1. Count 3(a) alleges that Mr. Coldwell failed to secure narcotics and controlled substances in contravention of section 43 of the Narcotic Control Regulations, C.R.C. c. 1041 (the "NCR"), subsection 72(1)(a) of the Benzodiazepine and Other Targeted Substances Regulations, SOR/2000-217 (the "BOTSRs", section 2.3.1 of the Practice Direction — Drug Distribution and Storage (the "PD-DDS"), and the Narcotic and Controlled Drug Accountability Guidelines, or any of them, in that he failed to establish, implement, ensure compliance with and maintain policies and procedures to protect narcotics and controlled and targeted substances in contravention of subsections 56(1)13 and 65(1) of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation"), or either of them.

2. Subsection 56(1)13 of the Regulation requires that pharmacy managers establish, implement and maintain written policies and procedures to ensure safe and effective pharmacy practice.

3. During the course of the investigation, the Investigator reviewed the policies and procedures manual (the "P&P Manual") maintained by the Pharmacy to assess whether the guidance it provided regarding controlled drug inventory counts, investigation and loss reporting was consistent with regulations, and whether Mr. Coldwell was compliant with these written policies.

4. Part 16 of the P&P Manual, titled Pharmacy Manager Responsibilities, required the pharmacy manager to conduct periodic inventory counts and complete all documentation. Mr. Coldwell did not complete all required controlled substances counts, appropriately document his investigation into discrepancies, or report all unexplained losses.

5. The P&P Manual required the pharmacy manager to document the reason for all discrepancies and

the actions taken to correct. For the unexplained shortages listed at paragraph 73 herein, as well as for two additional shortages of Tylenol #3 identified by the Investigator, there was no documentation to show that Mr. Coldwell was compliant with this policy.

6. The P&P Manual stated that all unexplained shortages greater than one tablet be reported to Health Canada and to the College. This is offside of federal and provincial legislation and College practice directions, which require that all unexplained shortages (including a single tablet) be reported. As outlined herein, Mr. Coldwell also failed to notify Health Canada of unexplained shortages on multiple occasions.

7. The P&P Manual required that all changes to narcotic on-hand values in the perpetual inventory system required the pharmacist's initials and password, and required the pharmacist to enter a clear and concise reason for the change. Of the unexplained shortages listed at paragraph 73 herein, there was no documentation of the reason for the change. The Investigator also discovered 13 occasions on which there were unexplained overages of controlled substances without documentation of investigation. The Investigator identified 22 occasions where a pharmacy assistant's password and initials were used to change the inventory value of a controlled substance, contrary to the policy outlined in the P&P Manual.

8. Mr. Coldwell's personal misuse of tramadol was also a violation of the Pharmacy's Policies and Procedures Manual, which stipulated that all employees were prohibited from the intentional misuse of medications, from being under the influence of medications which affect an employee's ability to safely perform their duties, and from possessing prescription medications without a legal medically obtained prescription.

**In the Statement, pertaining to Count 3(b)**

1. Count 3(b) alleges that Mr. Coldwell failed to secure narcotics and controlled substances in contravention of section 43 of the NCR, subsection 72(1)(a) of the BOTSR, section 2.3.1 of the PD-DDS, and the Narcotic and Controlled Drug Accountability Guidelines, or any of them, in that he, on multiple occasions between July 2019 and March 2021, failed to submit Loss or Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada, in contravention of subsection 72(2) of the BOTSRs.

2. Subsection 72(2) of the BOTSR requires that unexplained shortages of benzodiazepines and other targeted substances must be reported to Health Canada within 10 days of discovery.

3. Pursuant to the P&P Manual, when discrepancies in the narcotic and controlled substances inventory was discovered, the reason for the discrepancy and the action taken to correct the discrepancy were to be detailed on the Drug Inventory History Report. All shortages were to be reported to Health Canada using the Loss or Theft Report Form.

4. The Investigator reviewed the computerized perpetual inventory at the Pharmacy. He reviewed the Drug Inventory History Report for all manual adjustments to assess and identify if and when inventory discrepancies were discovered and adjusted for.

5. The Investigator discovered 14 occasions on which benzodiazepine shortages were identified by the Pharmacy without an explanation in the Drug Inventory History Report and without a Loss or Theft

Report being provided to Health Canada. These shortages are outlined in the following table:

| Drug | Date | # of Shortage |
|---|---|---|
| PMS-Clonazepam 0.5 mg | 2019-07-31 | 1 |
| Teva-Alprazolam 0.5 mg | 2019-10-30 | 3 |
| Teva-Alprazolam 0.5 mg | 2019-11-16 | 1 |
| Restoril 15 mg | 2019-12-23 | 1 |
| PMS-Clonazepam 0.25 mg | 2020-02-04 | 2 |
| Apo-Lorazepam 1 mg | 2020-05-03 | 1 |
| Apo-Alpraz 0.5 mg | 2020-05-03 | 1.5 |
| Lorazepam SL 0.5 mg | 2020-06-21 | 2 |
| Apo-Lorazepam 1 mg | 2020-06-21 | 10 |
| Apo-Alpraz 0.5 mg | 2020-11-16 | 1 |
| PMS-Clonazepam 0.5 mg | 2020-11-16 | 1 |
| Lorazepam SL 0.5 mg | 2020-12-24 | 1 |
| Apo-Lorazepam 1 mg | 2021-01-31 | 20 |
| Apo-Lorazepam 1 mg | 2021-03-21 | 35 |

6. The above-noted 14 drug shortages remain unexplained.

**In the Statement, pertaining to Count 3(c)**

1. Count 3(c) alleges that Mr. Coldwell failed to secure narcotics and controlled substances in contravention of section 43 of the NCR, subsection 72(1)(a) of the BOTSRs, section 2.3.1 of the PD-DDS, and the Narcotic and Controlled Drug Accountability Guidelines, or any of them, in that he failed to maintain clear and readily retrievable records in contravention of subsection 56(1)12 of the Regulation, section 3.1 of the PD-DDS, and sections 2.1.1, 2.1.2 and 2.1.3 of the Practice Direction — Records and Information, or any of them.

2. The PD-DDS requires that all documentation is to be recorded in a readily retrievable manner, either electronically or in written form.

3. The Practice Direction — Records and Information requires that documentation be in a clear, concise and easy to read format that facilitates sharing, ease of use and retrieval of information.

4. These requirements allow for essential records maintained within the Pharmacy to be easily interpreted and reviewed by pharmacy staff and available for regulatory review. This allows for effective practice and ensures patient safety as information can be quickly retrieved and interpreted.

5. Documentation reviewed by the Investigator during the course of the investigation, including notations made in the Drug Inventory History Reports and the Expired Narcotic and Controlled Drug Perpetual Inventory Log were extremely messy and difficult to interpret. The documentation at the Pharmacy created difficulties in the review process and did not facilitate a simple examination of important records maintained by the Pharmacy.

Although there was an Agreed Statement of Facts as set out above, the parties made separate submissions regarding the Orders the Panel may make in accordance with sections 54, 55 and 56 of the Act.

After considering the submissions made by the parties, the Panel orders that:

a) Mr. Coldwell will be suspended from practice for two (2) months, with credit for the time during which he has been interim suspended since April 15, 2021;

b) Restrictions be placed on Mr. Coldwell's practicing license for five (5) years, to be effective from the date of his return to practice, or the date of the Panel's Decision and Order, whichever is later, that:

   i. he cannot be a Pharmacy Manager or Preceptor;

   ii. he cannot have ordering or receiving authority for drugs covered under the ***Controlled Drugs and Substances Act;*** and

   iii. he is not permitted to engage in the sole practice of pharmacy and cannot work in a pharmacy without another person present in the dispensary;

   iv. upon his return to practice, or the date of the Panel's written decision, whichever is later, Mr. Coldwell shall enter into an undertaking with the College which will include terms that:

      - he will continue to participate in counselling;
      - he will continue to submit, at his cost, to random drug and alcohol screening, to the satisfaction of the College;
      - he will be required to advise that the Pharmacy Manager in all pharmacies who employ him in some capacity, that monthly reconciliation counts of narcotics, controlled and targeted drugs must occur; and
      - he will be required to advise the Pharmacy Manager in all pharmacies who employ him in some capacity that he has restrictions placed on his license as set out above.

c) He will pay a contribution towards costs of the investigation and hearing in the amount of $10,000.00 pursuant to s. 56(1)(a) of the Act.

d) Mr. Coldwell is also levied a fine of $7,500.00 pursuant to s.56(1)(b) of the Act.

e) The costs and fine are to be paid within 3 years from the date of the Decision and Order.

f) The decision of the Panel will be published and made available to the public pursuant to s.58 of the Act.

In arriving at its decision, the Panel considered Mr. Coldwell's admissions of guilt, and the cooperative discussions between him and counsel for the Complaints Committee. Based upon the foregoing, the Panel is satisfied that this decision adequately provides for a specific deterrence to Mr. Coldwell, as well as general deterrence to dissuade members of the profession from partaking in similar conduct. Additionally, it serves as a denunciation of Mr. Coldwell's misconduct and as punishment to him while, at the same time recognizing and providing for his potential rehabilitation. Overall, the Panel is satisfied that this decision will serve to ensure that the public's interest is protected and will maintain the public's confidence in the profession's ability to properly supervise the conduct of its members.

DATED at Winnipeg, Manitoba this 26th day of January, 2024

Per:
Glenda Marsh
Chair, Discipline Panel

# In Memorium

*In loving memory...*

| | |
|---|---|
| Colin Briggs | 3/31/2024 |
| Matthew Glass | 6/28/2024 |