College of Speech and
Hearing Health Professionals
of British Columbia

FURTHER AMENDED CITATION TO APPEAR

Section 37 of the *Health Professions Act*, RSBC 1996, ch. 183

To: Wendy A. Young, RSLP (Registration No. 1199)

[Redacted]

TAKE NOTICE that the Inquiry Committee has directed me, the Registrar, to issue this Citation under section 37 of the *Health Professions Act*, R.S.B.C. 1996, chapter 183 (the "Act").

A hearing panel of the Discipline Committee (the "Discipline Committee") of the College of Speech and Hearing Health Professionals of British Columbia (the "College") will conduct a hearing to inquire into your conduct, the circumstances of which are set out in the attached schedule, to determine if your conduct constitutes any matter set out under section 39(1) of the Act.

AND FURTHER TAKE NOTICE that the Hearing will be held as follows:

PLACE: While social distancing remains reasonably necessary with respect to the current COVID-19 pandemic, videoconferencing using the Zoom platform with details to be provided, unless otherwise directed.

DATE: ~~November 4, 5, and 6, 2020~~ March 15-19 & 22-26, 2021

TIME: 9:30 a.m. to 4:30 pm.

If you are unavailable on the date set for hearing, you may apply in writing to request a change in the date or time.

AND FURTHER TAKE NOTICE that section 38(4.1) of the Act entitles you to an outline of the anticipated evidence from each of the witnesses that will be called and an opportunity to inspect any documentary evidence at least 14 days prior to the hearing. Your rights relating to the hearing can be found in the Act and the College Bylaws.

AND FURTHER TAKE NOTICE that at the hearing, legal counsel on behalf of the College will make submissions with respect to the appropriate action to be taken regarding your registration. The action that can be taken includes a reprimand, imposing limits or conditions on your practice, suspension or cancellation of your registration, or imposing a fine, under section 39(2) of the Act.

Non-Appearance by Respondent: If you fail to appear at the date, time and place set for the hearing, the Discipline Committee is entitled to proceed with the hearing in your absence upon proof of receipt of the Citation by you and may take any action, without further notice to you, that it is authorized to take under the Act pursuant to section 38(5) of the Act.

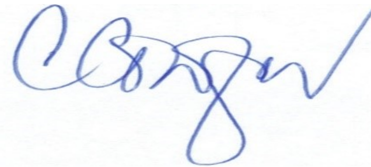
DISCIPLINE COMMITTEE'S CONTACT INFORMATION

The mailing address of the Discipline Committee for delivery is:

College of Speech and Hearing Health Professionals of British Columbia
900 – 200 Granville Street
Vancouver, British Columbia
V6C 1S4

Attention: Discipline Committee

Dated at Vancouver, British Columbia this 18th day of June, 2020.
Dated for reference August 13, 2020 (amendment).
Dated for reference November 03, 2020 (further amendment).



Cameron Cowper
Registrar & Chief Executive Officer

SCHEDULE

1. In this Schedule,

   a. "Bylaws" means the Bylaws of the College;
   b. "Code" means Schedule E of the College's Bylaws (the "Code of Ethics" for registrants);
   c. "College" means the College of Speech and Hearing Health Professionals of British Columbia;
   d. "DSM5" means the Diagnostic and Statistical Manual of Mental Disorders";
   e. "HPA" means the *Health Professions Act*, R.S.B.C. 1996, c. 183;
   f. "Foundations Document" means the document entitled, "Assessing and Certifying Clinical Competency / Foundations of Clinical Practice for Audiology and Speech-Language Pathology (2004)" published by the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA); and

g. "Profile" means the National Speech-Language Pathology Competency Profile (also the "NSLPCP"), published by the Canadian Alliance of Audiology and Speech-Language Pathology Regulators ("CAASPR").

2. In this Schedule, headings are for convenience of reference only.

Nature of the complaint and alleged conduct to be inquired into

3. Ms. Wendy A. Young (the "Respondent") is a Registered speech-language pathologist ("SLP") with the College of Speech and Hearing Health Professionals of British Columbia (the "College").

4. The Respondent was at all material times employed by Northern Health Authority ("Northern Health") as an SLP to provide, among other things, SLP services through the Northern Health Assessment Network ("NHAN" or the "Network"). Through inter-professional assessment teams, the Network provides assessments and diagnoses for children and youth suspected of having an Autism Spectrum Disorder ("ASD") or any other Complex Developmental Behavioural Conditions ("CDBC"), including Fetal Alcohol Spectrum Disorder ("FASD").

5. During a period from October 2017 to April 2018, or thereabouts, the Respondent provided SLP services in a manner that did not meet the standards of practice expected of a reasonably competent SLP, the particulars of which follow.

Case #1 ("SJ")

6. Respecting Case #1, concerning a child born in December 2011 ("SJ") and referred to the Network for suspected ASD and FASD, the Respondent

   a. failed, without justification, to select and administer all required formal measures to assess SJ, including failures to administer

      i. standardized core language measures, including sentence-level receptive and expressive language skills,

      ii. a discourse measure, or

      iii. a clinician-administered social functioning measure;

   b. failed, in lieu of formal measures, to provide adequate informal measures or documentation (e.g., language samples);

   c. failed, specifically in the context of the ASD referral, to administer formal or informal measures and/or to describe social skills as relating to communicative functions, nonverbal communication, reciprocity, conversational skills, and atypical behaviours or utterances;

   d. reported conclusions based on parent ratings without qualification of these as such and failed to adequately distinguish between clinician-administered results versus parent ratings (i.e., "severely delayed skills" and "scores");

   e. failed to completely or accurately specify reasons for referral in the Respondent's SLP report about SJ; and

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f. failed to refer to ASD or FASD as final diagnostic formulations in the Respondent's SLP report about SJ.

Case #2 ("MB")

7. Respecting Case #2, concerning a child born in October 2009 ("MB") and referred to the Network for suspected CDBC, the Respondent

   a. inaccurately scored subtests, resulting in the majority of results, including derived scores, being invalid as presented;

   b. inaccurately scored the parent rating scale (i.e., CCC-2);

   c. failed to recognize inconsistencies in results, and failed to review her administration and scoring, based on errors caught by colleagues during reviews, before sharing and distributing her conclusions;

   d. provided inaccurate conclusions in the Respondent's SLP report about MB, based on inaccurately scored tests and scales, concerning, e.g.,

      i. "average on Following Directions" when the actual score was less than the 1st percentile;

      ii. the re-administered "Understanding Spoken Paragraphs" test (e.g., "[MB] did much better when…" or "average to above average" when less than the 1st percentile on both administrations), or

      iii. the parent's level of concern (e.g., 13th percentile, "mild" level of concern when the actual rating was 1st percentile);

   e. displayed a lack of understanding, and further or alternatively a lack of precision, about the natures or purposes of subtest scores and composite scores;

   f. failed to identify a statistically and clinically significant difference between ~~between~~ MB's Receptive Language Index score and MB's Expressive Language Index score;

   g. provided conclusions about skills which were not measured (e.g., "severe" expository/narrative language and nonliteral language; "moderate" social communication) or unsupported by her measures (e.g., "average" auditory memory) or based on non-compliance (e.g., verbal reasoning);

   h. failed to mention and integrate the inter-professional team finding of "Intellectual Disability", or concerns about ASD, in the Respondent's SLP report about MB; and

   i. diagnosed a condition in terms unaligned with the terminology used by the inter-professional team evaluating the client~~, specifically by using terms not currently used in the field, or within provincial assessment networks~~ (i.e., "Severe Expressive and Receptive Language Delay").~~;~~

   ~~j. given the severity of the delay, failed to definitively recommend a referral (or ongoing services) for MB for Speech-Language Pathology intervention services, and in so doing, failing to adequately advocate for her client; and~~

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~~k. failed to adequately align recommendations to the diagnosis given, e.g., by addressing only adaptation protocols without addressing oral language-related goals.~~

Case #3 (“CS”)

8. Respecting Case #3, concerning a child born in July 2013 (“CS”) and referred to the Network for suspected ASD, the Respondent

   a. failed, in lieu of the possibility of formal measures, to provide informal measures or documentation (e.g., language samples) and observations, e.g., during play-based interactions, about CS’s language and social engagement;

   b. failed to arrange another appointment, or community observation, if no information at all could have been obtained, formally or informally, at the scheduled appointment;

   c. failed, specifically in the context of the ASD referral, to provide formal or informal assessments and/or adequate description of social skills relating to communicative functions, nonverbal communication, reciprocity, conversational skills, and atypical behaviours or utterances;

   d. failed to specify a parent measure report and/or parent description of specific communication difficulties;

   e. failed to completely or accurately specify reasons for referral in the Respondent’s SLP report about CS;

   f. failed to mention and integrate the inter-professional team findings of “Language Disorder” and/or ASD in the Respondent’s SLP report about CS, and made recommendation directing the caregiver to RASP without mentioning ASD anywhere in her report; and

   g. failed to refer to Language Disorder and/or ASD as final diagnostic formulations in the Respondent’s SLP report about CS.

Case #4 (“RO”)

9. Respecting Case #4, concerning a child born in July 2011 (“RO”) and referred to the Network for suspected CDBC, the Respondent

   a. failed, without justification, to select and administer core language measures to assess RO’s receptive and expressive sentence-level skills, such as Clinical Evaluation of Language Fundamentals – Pre-School (“CELF-P”) or the Preschool Language Scales 5th edition (“PLS-5”), or an equivalent measure assessing sentence-level skills, in circumstances where the ~~r~~Respondent was able to administer them, and the child was described as cooperative;

   b. inaccurately scored the tests that were administered (most notably the Renfrew), resulting in the results being invalid as presented;

   c. provided inaccurate reporting, respecting scores and respecting the conclusion that “Expository and narrative language” could not be assessed, despite the Respondent administering the Renfrew; and

d. provided substandard characterizations of RO’s speech in the Respondent’s SLP report about RO, including

    i. that RO’s phonological processes included both “fronting” and “backing”, without clarification; and

    ii. diagnosing a condition in terms unaligned with the terminology used by the inter-professional team evaluating the client, specifically by using terms not used in the field or in the DSM5 (i.e., “Moderate-Severe Phonological processes” instead of Speech Sound Disorder).

Case #5 (“RU”)

10. Respecting Case #5, concerning a child born in June 2012 (“RU”) and referred to the Network for suspected ASD, the Respondent

    a. failed, without justification, to select and administer all required formal measures to assess RU’s core language, such as the CELF-P, the Clinical Evaluation of Language Fundamentals – Fifth Edition (“CELF-5”), the PLS-5, or an equivalent measure;

    b. failed to assess and comment on receptive language (apart from vocabulary);

    c. failed, specifically in the context of the ASD referral, to provide formal or informal measures relating to communicative functions, nonverbal communication, reciprocity, and conversational skills;

    d. inaccurately calculated scores for the parent rating scale (i.e., CCC-2, resulting in “above-average” 94th percentile compared to the 2nd percentile);

    e. failed to score the Renfrew, without any explanation but reported expository and narrative language as “severe” and as greater than “two standard deviations from the mean”;

    f. failed to calculate and report a statistically significant gap between RU’s receptive and expressive vocabulary scores (i.e., Standard Scores of 85 versus 64);

    g. provided conclusions unsupported by measures (e.g., “Semantic skills” described as “Borderline low average”, despite a very low EVT score at the 1st percentile; “Auditory memory” described as “average” and “Verbal Reasoning” described as “Moderate” without either domain assessed; “Social communication” and “Grammar and Syntax” described as “Severe” without supporting information);

    h. failed to refer to the parent report measure in the body of the Respondent’s SLP report about RU;

    i. provided inaccurate reporting, or failed to provide comment about the client’s basic speech sound skills and intelligibility, when describing “Speech” as “uncertain not enough speech spoken to ascertain”, despite the client completing the EVT-2 and providing a language sample;

    j. failed to mention and integrate into her synthesis the inter-professional team findings of global developmental delay (GGD) and ASD in the Respondent’s SLP report about RU; and

k. failed to develop adequate recommendations based on the child's profile, given the severity of his delay and his diagnoses.

Case #6 ("SF")

11. Respecting Case #6, concerning a child born in Dec. 2004 ("SF") and referred to the Network for suspected FASD, the Respondent

a. failed, without justification, to select and administer all required formal measures to assess SF's expressive discourse/narrative skills (e.g., the Test of Narrative Language – Second Edition (or "TNL-2"), or equivalent);

b. provided conclusions unsupported by measures (e.g., "Expository and narrative language" described as "average" when this was not measured; and "Speech" skills described as "average" without description of these skills in the Respondent's SLP report about SF);

c. inaccurately scored subtests relating to the Comprehensive Assessment of Spoken Language ("CASL")~~– Second Edition ("CASL-2")~~ (i.e., Sentence Comprehension, Grammaticality Judgment, Nonliteral Language, Synonyms, Inference, and Ambiguous Sentences), including three errors – respecting Grammatical Judgment, Inference, and Ambiguous Sentences – exceeding 1.5 and 2 Standard deviations from the corrected value;

d. failed to derive any correct composites (in category indexes on this measure);

e. failed to recognize "impossible" values, and failed to review her scoring on those grounds;

f. provided inaccurate conclusions in the Respondent's SLP report about SF, based on inaccurately scored tests

g. provided an uninterpretable table of data (referring to a "Basic Concepts" subtest that does not exist on testing protocols and is only applicable to ages 3-6; calculating a composite score as applicable to ages 3-4, where SF was 12 years 11 months at the time of testing; setting out different values for "Syntax Construction" within the same table); and

h. otherwise producing a draft report with inappropriate content demonstrating a need for supervision, including an assessment of skills or traits, and a resulting recommendation, outside the scope of an SLP (e.g., assessments concerning the client's knowledge of socially acceptable responses to lying; the possibility of the client, as someone adopted, wanting to be perceived as correct, right in her answers and smart; and a possible need for counselling, concerning a fear of being rejected; and a recommendation that the client "receive some counselling around her inability to tell the truth").

Grounds for action by the discipline committee

12. By acting, or failing to act, in the circumstances particularized above, the Respondent

a. committed professional misconduct or unprofessional conduct;

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b. further or alternatively, respecting each instance and in combination, incompetently practiced the profession of speech-language pathology;

c. further or alternatively, failed to comply with s. 150 of the Bylaws, by failing to comply with the ethical standards of the profession, or in accordance with the Code and the Standards of Practice, as approved by the board;

d. further or alternatively, failed to comply with a standard, limit or condition imposed under the HPA.

Relevant professional standards and competencies

13. At all material times prior to May 29, 2018, and subject to standards established by the College, professional standards were reflected by the portion of the Foundations Document pertaining to SLPs, including but not limited to the following provisions:

UNIT TWO: Principles of Clinical Practice & Professional Practice Issues

Section 2.2 EVALUATION

The speech-language pathologist:

i. Uses principles of assessment to generate assessment plans based on available information about the client, the presenting disorder(s), and knowledge of normal and disordered communication; modifies the plan when appropriate.

ii. Obtains a case history that is relevant to the diagnosis and management of each individual's communication disorder.

iii. Demonstrates knowledge of principles underlying clinical assessment including standardized and non-standardized procedures and their advantages, disadvantages, and limitations.

iv. Demonstrates knowledge of test administration and scoring procedures.

v. Interprets assessment data to formulate diagnostic and prognostic statements based on knowledge of normal and disordered communication, the assessment results, and knowledge of treatment efficacy.

vi. Interprets assessment data to make recommendations based on the assessment information and available resources.

vii. Communicates assessment information to the client and/or family when appropriate, and to the referring agency and other professionals in accordance with guidelines for maintaining client confidentiality.

viii. Demonstrates knowledge of the roles of other health professions, when to refer clients, and how to collaborate effectively with them.

Section 2.3 CLIENT MANAGEMENT

The speech-language pathologist:

i. Employs a conceptual framework for client management decisions that is based on accepted philosophies, approaches and/or theories, and which

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considers the needs of the whole client, including communication contexts and partners.

ii. Develops a management plan based on a rationale that considers the results of the assessment, knowledge of the nature of the communication disorder, theories of learning and available resources. The management plan includes selection of a service delivery model (e.g., regular review assessments, home/school program, individual or group therapy, consultation), and development of a specific program of intervention for optimal management of the client's communication disorder.

iii. Formulates appropriate short-term and long-term goals; develops and implements appropriate clinical activities to meet these goals and to facilitate generalization and maintenance; evaluates progress towards goals and modifies them and the discharge criteria accordingly.

iv. Monitors progress during treatment to obtain valid and reliable indicators of change using one or more appropriate methods (e.g., standardized tests, instrumental measures, counting behaviours, probes).

v. Involves families, teachers, caregivers, and other appropriate people in the management process, as appropriate, keeping them informed of progress and current goals.

vi. Provides information to family, caregivers, and team members about communication disorders in general and regarding communicating with specific clients.

…

UNIT THREE: Developmental Articulation/Phonological Disorders

…

Section 3.2 ASSESSMENT

The speech-language pathologist:

i. Develops and implements an assessment plan based on background information about the client, known or suspected concomitant disorders, knowledge of normal and disordered articulation/phonological development, and principles of assessment, and modifies it when appropriate.

ii. Uses appropriate standardized and/or non-standardized procedures for assessing phonemic awareness, articulation, and/or phonology at the sound, syllable, words, sentence, and discourse levels.

iii. Understands issues related to obtaining a representative and diagnostically useful sample of a client's speech.

iv. Conducts an appropriate analysis of a sample of the client's speech (e.g., structural, traditional, and/or phonological approaches) to describe the child's errors.

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v. Applies specific procedures for examination of the speech production mechanism and judges its adequacy for normal speech production.

vi. Assesses the impact of factors in the client's environment on his/her communication needs and effectiveness.

vii. Demonstrates knowledge of specific procedures for assessing auditory/speech perception skills and understands the issues related to an adequate assessment of speech perception ability.

viii. Formulates a diagnostic statement about the client's articulat-ion/phonological skills.

ix. Formulates a prognostic statement about the client's articulat-ion/phonological skills.

Section 3.3 INTERVENTION

The speech-language pathologist:

i. …

iv. Formulates appropriate short-term and long-term goals for treatment of the client's articulation/phonological disorder which takes into account other linguistic, cognitive, or motor deficits.

…

UNIT FIVE: Developmental Language Disorders

Section 5.2 Assessment

The speech-language pathologist:

i. Develops and implements an assessment plan based on information about the client, knowledge of normal monolingual and/or bilingual language development, known or suspected concomitant disorders, and principles of assessment; modifies this plan when appropriate.

ii. Uses standardized and non-standardized procedures appropriately to assess language (phonology, morpho-syntax, semantics, pragmatics, discourse, narrative skills), reading and writing and metalinguistic skills.

iii. Demonstrates ability to obtain, analyse, and interpret a language sample and an understanding of the issues in obtaining a representative and diagnostically useful sample of a child's language.

iv. Assesses the impact of internal (e.g., cognitive, motor, perceptual) and external (e.g., environmental, cultural) factors on the client's communication needs and effectiveness.

v. Assesses the impact of the disorder on the client's daily activities, and his/her educational, vocational, and psychosocial needs.

vi. Formulates a diagnostic statement about the client's language skills.

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vii. Formulates a prognostic statement about the client's language skills.

Section 5.3 Intervention

The speech-language pathologist:

i. …

ii. Chooses appropriate service delivery models (e.g., regular review, home/school program, individual therapy, group therapy, referral to a inter-professional program, consultation/collaboration with parents, teachers and/or other professionals) for treatment of the client's language disorder.

iii. Selects and applies an appropriate approach for treatment of the client's language disorder.

iv. Formulates appropriate short-term and long-term goals in the areas of phonology, morpho-syntax, semantics, pragmatics, metalinguistics skills, literacy, narrative skills, and discourse.

v. Develops and implements appropriate clinical activities for meeting specified language treatment goals and facilitating generalization and maintenance.

14. Further or alternatively, and subject to standards established by the College, professional standards were reflected by standards subsequently reflected by the Profile, including but not limited to the following provisions:

Essential Competencies	Sub-Competencies
1.2 Clinical Expert	
f. Plan, conduct and adjust an assessment.	iii. Plan the assessment, including the appropriate tools, strategies and resources that will address the unique needs of the client. iv. Conduct a valid, accurate and reliable assessment, modifying as necessary. v. Actively listen to and observe all components of communication and/or feeding and swallowing.
g. Analyze and Interpret assessment results.	i. Analyze formal and informal assessment results. ii. Interpret the data accurately. iii. Formulate conclusions regarding the client's diagnosis, abilities, resources and needs.

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Essential Competencies	Sub-Competencies
h. Develop and share recommendations based on assessment results.	i. Develop evidence-informed recommendat-ions, including potential referrals to other professionals, based on the assessment findings. ii. Discuss the assessment results, recommendations and implications with the client and other relevant individuals, as permitted by client.
2. Role of Communicator	
b. Maintain client documentation.	i. Accurately document services provided and their outcomes. ii. Document informed consent. […] iv. Comply with regulatory and legislative requirements related to documentation.

Registrant Code of Ethics

15. At all relevant times prior to September 29, 2018, Schedule E of the College's Bylaws (Code of Ethics) provided as follows:

> Principle Two
>
> A registrant must make the welfare of a client the registrant's primary concern.
>
>> … 4. A registrant must utilize every available resource by initiating appropriate referrals to other professionals whose knowledge may contribute to the diagnosis, assessment and/or treatment of those served.

College standards and guidelines

16. At all relevant times, the College had set professional standards, including the following standards in place in or about October 2017 to April 2018:

a. SOP-PROF-01 ("Interprofessional collaborative practice"), which stated in part as follows:

> "Registrants are responsible for ensuring they are aware of and can utilize the principles and core competencies of ICP." […]
>
> "In the course of Inter-professional Collaborative Practice (ICP), registrants will: […] **Ensure that registrants are** communicating clearly

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and **using common terms with other professionals** (i.e. speaking the same language)…."

"ICP begins with inter-professional education and requires mastery of numerous **core competencies including** but not limited to: […]

- **Use the knowledge of** one's own role and those of **other professions to appropriately address the healthcare needs** of clients and populations served;
- **Communicate** with clients, families, communities and other health professional **in a responsive and responsible manner that supports a team approach** to the maintenance of health and the treatment of disease and disorders;" (emphasis added)

b. SOP-PROF-03 ("Unique & Shared Scope of Practice"), which stated in part as follows:

"Registrants must provide care within their designated scope of practice, unless a formal delegation process is in place with another regulated health professions' regulatory college."

c. SOP-PROF-05 (as currently numbered) ("Professional Accountability & Responsibility"), approved August 9, 2017.

[*End of Schedule*]

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