DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Renate Davidson	Chairperson
	Carolyn Kargiannakis, RN	Member
	Lina Kiskunas, RN	Member
	Mary MacMillan-Gilkinson	Public Member
	George Rudanycz, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
LEE-ANN NIXEY	)	CAROL STREET for
Registration. No. 10407222	)	Lee-Ann Nixey
	)	
	)	KIMBERLEY ISHMAEL
	)	Independent Legal Counsel
	)	
	)	Heard: April 9, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on April 9, 2019 at the College of Nurses of Ontario (the "College") at Toronto. Counsel for Lee-Ann Nixey (the "Member") advised the Panel that the Member would be arriving late. Accordingly, the hearing recessed for 50 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was in attendance.

The Allegations

At the request of the College, and unopposed by Counsel for the Member, the Panel made an order pursuant to s.40 of the *Health Professional Procedural Code* of the *Nursing Act*, 1991, that allegations 1(c) and 3(c) in the Notice of Hearing dated February 20, 2019 be amended.

The allegations against the Member as stated in the Amended Notice of Hearing, with the amendments underlined, are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, and in particular, while practising as a Registered Nurse at William Osler Health System in Brampton, Ontario:

    a. on or about March 28, 2016, and/or on at least one other occasion, you permitted individuals with no health-care purpose or other authorization into the nursing station and/or other areas of the workplace where they would reasonably be expected to view and/or have access to clients' personal health information;

    b. on or about March 28, 2016, and/or on at least one other occasion, you spent an excessive period of time conducting personal business instead of attending to your nursing duties, when you conducted an information session for your aspiring business;

    c. on or about March 28, 2016, and/or on at least one other occasion, you participated in an informational discussion for your aspiring business without permission or authority, in or around the nursing station and/or other areas of the workplace visible to colleagues and/or clients;

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(17) of *Ontario Regulation 799/93*, in that you used a name other than your name, as set out in the register, in the course of providing or offering to provide services within the scope of practice of the profession except where the use of the other name was necessary for personal safety and provided the employer and the College had been made aware of the pseudonym and the pseudonym was distinctive, and in particular, while practising as a Registered Nurse at William Osler Health System in Brampton, Ontario, you used the following names in the following contexts, while your name as set out in the register was Lee-Ann Nixey:

    a. Lee-Ann Cole and Leigh Cole while employed at William Osler Health System;

    b. Leigh Cole on your LinkedIn profile, in which you identified yourself as a Registered Nurse;

    c. Leigh Cole on the website for Milestone, in which you identified yourself as a Registered Nurse; and

    d. Leigh Cole-Nixey on a resume submitted to the William Osler Health System seeking a nursing position.

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances,

would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, and in particular, while practising as a Registered Nurse at William Osler Health System in Brampton, Ontario:

a. on or about March 28, 2016, and/or on at least one other occasion, you permitted individuals with no health-care purpose or other authorization into the nursing station and/or other areas of the workplace where they would reasonably be expected to view and/or have access to clients' personal health information;

b. on or about March 28, 2016, and/or on at least one other occasion, you spent an excessive period of time conducting personal business instead of attending to your nursing duties, when you conducted an information session for your aspiring business;

c. on or about March 28, 2016, and/or on at least one other occasion, you participated in an informational discussion for your aspiring business without permission or authority, in or around the nursing station and/or other areas of the workplace visible to colleagues and/or clients;

d. you used the following names in the following contexts, while your name as set out in the register was Lee-Ann Nixey:

    i. Lee-Ann Cole and Leigh Cole while employed at William Osler Health System;

    ii. Leigh Cole on your LinkedIn profile, in which you identified yourself as a Registered Nurse;

    iii. Leigh Cole on the website for Milestone, in which you identified yourself as a Registered Nurse; and

    iv. Leigh Cole-Nixey on a resume submitted to the William Osler Health System seeking a nursing position.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b), 1(c), 2(a), 2(b), 2(c), 2(d), 3(a), 3(b), 3(c), 3(d) (i), (ii), (iii) and (iv) in the Amended Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

College Counsel and the Counsel for the Member advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads as follows:

THE MEMBER

1. Lee-Ann Nixey (the "Member") obtained a degree in nursing from York University in 2009.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on January 8, 2010.

3. The Member was employed at William Osler Health System – Brampton Civic Hospital (the "Hospital") – from July 5, 2010 to August 9, 2016, when she resigned her employment as a result of the incidents below, among other things.

THE FACILITY

4. The Hospital is located in Brampton, Ontario.

5. The Member worked as a part-time staff nurse on the Adult Mental Health Unit (the "Unit") on day, evening and night shifts.

6. The nurse/client ratio on the Unit was a maximum of five clients per nurse. The Unit's capacity was 19. There were two RNs and two Registered Practical Nurses on each shift. It was an acute mental health unit.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Business Meeting on March 28, 2016

7. In early 2016, in addition to her employment at the Hospital, the Member was also working on starting a business that would provide coaching to individuals interested in becoming police officers. The Member was developing the business with [Individual A], an acquaintance and friend.

8. The purpose of the business was to provide applicants with coaching and information on the physical, psychological and aptitude testing required to become a police officer. The Member's contribution to the training program related to the physical component, as the Member was trained in martial arts and gymnastics. She was also providing coaching on mathematics, another component of the testing materials.

9. On March 28, 2016, the Member worked the afternoon shift at the Hospital, from 1530 to 2330. During her shift, at about 2000 she let [Individual A]in the back door of the Unit. [Individual A]was at the nursing station with the Member and other staff for approximately two hours. As well, several off-duty Carillion Security Staff (Hospital staff) attended the nursing station to speak with the Member and [Individual A] for significant portions of that two-hour period.

10. The Member had said to [Individual A]that some security guards at the Hospital had questions about the coaching business they were developing. [Individual A]and the Member used this opportunity to discuss with the security guards the business they were developing, and the upcoming training session they intended to hold.

11. The Member acknowledges that she let [Individual A]in the back door of the Unit and that he sat at the nursing station, where he had access to personal health information. The off-duty security staff were also sitting at the nursing station where they had access to personal health information, including paper and electronic files, and the ability to overhear discussions by nursing staff and/or unregistered staff as they went about their work duties. Neither [Individual A]nor the security staff had any care-related or employment-related reason to have access to that information at that point in time. If the Member were to testify, she would say that, to the best of her knowledge, neither [Individual A]nor the security staff actually viewed or overheard any personal health information while in the nursing station, and the College acknowledges that there is no evidence that they did. However, the Member acknowledges that, by allowing these individuals in a staff area, she created a risk of personal health information being viewed and privacy being breached.

12. The Member also acknowledges that it was unprofessional of her to conduct any personal business, for a relatively significant period of time, while on shift, and that when she did so, her primary focus was not on patient care as it should have been.

Practising under a Name not on the Register

13. The Member's birth name is Lee-Ann Nixey. Her first name, Lee-Ann, is frequently shortened by family, friends and colleagues to "Lee." The Member often spells her first name "Leigh" as a matter of preference.

14. The Member's ex-husband's last name is Cole. She used both names (Nixey and Cole) during and after her marriage. The Member's driver's license is under the name "Cole."

15. The Member is registered with the College as Lee-Ann Nixey.

16. The Member used various names, other than Lee-Ann Nixey, as follows:

    - Lee-Ann Cole and Leigh Cole while employed at the Hospital;

    - Leigh Cole on her LinkedIn profile and Milestone website (the website for the training business described above), both of which show the Member listing herself as a Registered Nurse;

    - Leigh Cole-Nixey on her resume submitted to the William Osler Health System seeking a nursing position in July 2017.

17. The Member's use of a name, other than the name on the College's public register, caused actual confusion to the public. The College received an email from a member of the public with concerns about the Member's involvement in a health care workshop. The email stated:

> … One person connected with this workshop is calling herself a registered nurse; however, I am not able to locate her name on the website.
>
> I have provided a link to the website below.
>
> The name is Leigh Cole and she identified herself as an RN with psychiatric training.

18. If the Member were to testify, she would say that, because her marriage ended acrimoniously, she felt less inclined to use the name "Cole" after her divorce. She would further say that she used "Nixey-Cole" on a recent resume in an effort to capture both aspects of her history. The Member would say that she did not intend to cause any confusion, but now recognizes that she was careless in identifying herself professionally.

19. The Member acknowledges that her use of names, other than the name on the College's public register, caused actual confusion to at least one member of the public, and created an opportunity for confusion by the general public.

COLLEGE STANDARDS

20. The College issued a Practice Standard titled *Confidentiality and Privacy – Personal Health Information* ("Practice Standard"). It was first published in 2004 and updated in 2009. It largely addresses the *Personal Health Information Protection Act* ("PHIPA").

21. The Practice Standard begins with a general statement about the purpose of practice standards:

> Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

22. The Practice Standard provides key indicators nurses can use to ensure they are meeting the standard, including:

> The nurse meets the standard by:
>
> - seeking information about issues of privacy and confidentiality of personal health information;
> - **maintaining confidentiality of clients' personal health information with members of the healthcare team, who are also required to maintain confidentiality, including information that is documented or stored electronically**; [emphasis added]
> - maintaining confidentiality after the professional relationship has ended, an obligation that continues indefinitely when the nurse is no longer caring for a client or after a client's death;

- ensuring clients or substitute decision-makers are aware of the general composition of the health care team that has access to confidential information;
- collecting only information that is needed to provide care;
- **not discussing client information with colleagues or the client in public places such as elevators, cafeterias and hallways;** [emphasis added]
- accessing information for her/his clients only and not accessing information for which there is no professional purpose;
  …
- **safeguarding the security of computerized, printed or electronically displayed or stored information against theft, loss, unauthorized access or use, disclosure, copying, modification or disposal;** [emphasis added]
- not sharing computer passwords; …

ADMISSIONS OF PROFESSIONAL MISCONDUCT

23. The Member admits that she committed the acts of professional misconduct as described in paragraphs 7 to 12 above, in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as referenced in the allegations in the Notice of Hearing in paragraphs 1(a), (b), and (c).

24. The Member admits that she committed the acts of professional misconduct as described in paragraphs 13 to 19 above, in that she used a name other than her name on the College's public register, in the course of providing or offering to provide services within the scope of practice of the profession, as referenced in the allegations in the Notice of Hearing in paragraphs 2(a), (b), (c), and (d).

25. The Member admits that she committed the acts of professional misconduct as referenced in the allegations in paragraphs 3 (a), (b), (c) and (d)(i), (ii), (iii) and (iv) of the Notice of Hearing, and in particular that her conduct was dishonourable and unprofessional, as described in paragraphs 7 to 19 above.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence, the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 1(c), 2(a), 2(b), 2(c), 2(d), 3(a), 3(b), 3(c), 3(d) (i), (ii), (iii) and (iv) in the Amended Notice of Hearing. As to allegation 3(a), 3(b), 3(c), 3(d) (i), (ii), (iii) and (iv), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Amended Notice of Hearing.

Allegation #1(a), (b), (c) in the Amended Notice of Hearing is supported by paragraphs 7 - 12 and 23 in the Agreed Statement of Facts. The Panel relied primarily on paragraphs 8 – 12. Paragraph 7 provided context. The Member invited individuals into the nursing station on the Adult Mental Health Unit in which she worked. These individuals were, her friend and colleague, [Individual A]and some off-duty security staff. The purpose was to provide information relating to the business that the Member and [Individual A]were developing. The individuals were present for approximately two hours during which time the Member was responsible for the care of her clients. The Member's clients were not her primary focus during this meeting as she spent a couple of hours promoting, and addressing questions, relating to her new business. The Member participated in these discussions for her aspiring business without permission or authority. The Member acknowledges that, although there is no evidence that privacy breaches occurred, there was the potential for these non-health care individuals to overhear discussions by nursing staff and to view private personal information. This is a breach of the College's Practice Standard titled *Confidentiality and Privacy-Personal Health Information* which emphasizes the importance of maintaining the confidentiality of clients' personal health information.

Allegation #2(a), (b), (c), (d) in the Amended Notice of Hearing is supported by paragraphs 13 – 19 and 24 in the Agreed Statement of Facts. The Member acknowledges that she used different versions of her name at her workplace, on her LinkedIn profile, when conducting a health-care workshop, on her private business website and on the College's public register. The Member did this while describing herself as a Registered Nurse. Although the Member would say that she did not intend to cause any confusion, it did lead to a member of the public seeking clarification from the College regarding an RN who called herself Leigh Cole but who could not be found on the College's register.

With respect to Allegation #3(a), (b), (c) and (d)(i),(ii),(iii) and (iv), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious disregard for her professional obligations when she invited non-health care individuals into the nursing station of the Adult Mental Health Unit in which she worked. There was no therapeutic reason for their presence. This had the potential to cause a breach of private and personal health care information. This conduct was also dishonourable as the Member ought to have known that she was putting the privacy of her clients at risk. It showed an element of deceit when she brought [Individual A]in through the back door of the Unit. The Member's clients were not her primary focus during this meeting as she spent a couple of hours promoting, and addressing questions, relating to her new business. This conduct is unacceptable.

The Member's conduct was also unprofessional and dishonourable when she used different versions of her name while holding herself out as a Registered Nurse. This demonstrates a lack of good judgement and a failure to understand the importance of maintaining a consistent professional profile that prevents any confusion for employers and the public. The Member ought to have known that this conduct fell below the standards of a nursing professional.

Penalty

College Counsel and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for three months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,

        iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;

        v. The subject of the sessions with the Expert will include:

            1. the acts or omissions for which the Member was found to have committed professional misconduct,
            2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,

3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

College Counsel submitted that the mitigating factors in this case were:

- The Member has admitted the allegations and taken responsibility for her actions. This has avoided a lengthy, contested hearing; and
- There is no evidence that there was a breach of personal health information.

No aggravating factors were presented to the Panel.

The proposed penalty provides for general deterrence through the Member's suspension and terms, conditions and limitations. It signals to the membership that this type of conduct is unacceptable.

The proposed penalty provides for specific deterrence through the three month suspension, the reprimand and the remedial activities that the Member will be required to perform.

The proposed penalty provides for remediation and rehabilitation through the reprimand and the terms, conditions and limitations placed on the Member.

Overall, the public is protected because the Member will improve her practice. The Member's employers will be made aware of all aspects of this decision.

College Counsel submitted three cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee. He acknowledged that this particular case is not reflected well in other jurisprudence cases. He stated that the cases presented do show some similar misconduct and show how the Discipline Committee dealt with each of them.

CNO v. Gillian Gamble (Discipline Committee, 2012). In this case, the member practised for an extensive period of time without a valid certificate of registration. This case is similar in that the member used a name other than the name set out in the Register, without notification to the College. The other allegations are not comparable. The member was given a reprimand, a four month suspension and 12 months of employer notification.

CNO v. Elmer Manuel (Discipline Committee, 2016). In this case, the member failed to secure his workstation from an unauthorized access. This case differs in that the member's conduct resulted in a privacy breach rather than the potential for a breach. The member was given a reprimand, a one month suspension and 12 months of employer notification.

CNO v. Jude Nzuonkwelle Nkwelle (Discipline Committee, 2018). In this case, the member failed to complete observational checks and instead chose to complete on-line training at the nursing station. In addition, he falsified documentation. Counsel for the College acknowledged that this case has some distinguishing features that make it outside the realm of what is similar. The member received a reprimand, a three month suspension and 12 months of employer notification.

The Member's Counsel submitted that the Member's judgement was flawed and affected by a work environment that she perceived as stressful. The Member's Counsel also agreed with the mitigating factors set out by College Counsel.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for three months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,

        iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;

        v. The subject of the sessions with the Expert will include:

            1. the acts or omissions for which the Member was found to have committed professional misconduct,

2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Member has avoided the need for a contested hearing.

The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. It sends a strong message to the Member, and the membership as a whole, that actions such as this will not be tolerated. Members must always be vigilant in protecting the privacy of clients. Members will be reminded of the importance of maintaining a consistent professional name that will allow employers and the public to access information regarding their standing with the College.

The penalty is in line with what has been ordered in previous cases.

I, Renate Davidson, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.