DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Ingrid Wiltshire-Stoby, RN	Chairperson
	Laura Caravaggio, RPN	Member
	Mary MacMillan-Gilkinson	Public Member
	George Rudanycz, RN	Member
	Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	BONNI ELLIS for
	)	College of Nurses of Ontario
- and -	)	
	)	
JOANNE CHRISTO	)	LESLIE DIZGUN for
Reg. No. 0393884	)	Joanne Christo
	)	
	)	
	)	Heard: November 16, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on November 16, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

The Panel ordered a publication ban following a motion brought by College Counsel, pursuant to s.45 (3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*. The Order prohibits the publication and broadcasting of the identity of the client referred to in this hearing or any information that could reasonably disclose the client's identity, including any reference to the client's name in the allegations in the Notice of Hearing or any other documents filed. Counsel for the Member agreed with the publication ban.

The Allegations

Counsel for the College advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 2 (a) and (b) of the Notice of Hearing dated July 24, 2017. The Panel granted this request. The remaining allegations against Joanne Christo (the "Member") are as follows.

IT IS ALLEGED THAT:

1. You have committed an act or acts 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 paragraph 1(1) of Ontario Regulation 799/93 in that, from about March 2015 to May 2016, while working as a Registered Nurse at [Facility A], you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to client [the Client], an inmate to whom you had provided nursing care, when you;

    a) shared personal information about yourself with [the Client], including your address and telephone number;

    b) communicated with [the Client] outside of the therapeutic relationship;

    c) sent money to [the Client] while he was incarcerated at [Facility B];

    d) entered into personal and/or romantic relationship with [the Client] while he was incarcerated at [Facility A]; and/or

    e) continued a personal and/or romantic relationship with [the Client] after he was transferred from [Facility A] to [Facility B].

2. a) {*Withdrawn*}; and/or

    b) {*Withdrawn*}.

3. You have committed an act or acts 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 paragraph 1.37 of Ontario Regulation 799/93 in that, from about March 2015 to May 2016, while working as a Registered Nurse at [Facility A], you engaged in conduct that having regard to all the circumstances would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in relation to client [the Client], an inmate to whom you had provided nursing care at [Facility A], when you:

    a) shared personal information about yourself with [the Client], including your address and telephone number;

    b) communicated with [the Client] outside of the therapeutic relationship;

    c) sent money to [the Client] while he was incarcerated at [Facility B];

    d) entered into personal and/or romantic relationship with [the Client] while he was incarcerated at [Facility A]; and/or

e) continued a personal and/or romantic relationship with [the Client] after he was transferred from [Facility A] to [Facility B].

Member's Plea

The Member admitted the allegations set out in paragraphs 1 (a), (b), (c), (d), (e) and 3 (a), (b), (c), (d) and (e) in the 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 admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College and 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. Joanne Christo (the "Member") obtained a diploma in nursing from Durham College in 2003.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on May 29, 2003.

3. The Member was employed at [Facility A] (the "Facility") from February 16, 2015 to May 26, 2016, when she resigned as a result of the incidents described below.

PRIOR HISTORY

4. The Member has no prior disciplinary findings with the College.

THE FACILITY

5. [Facility A] The Facility is located in Toronto, Ontario.

6. The Member worked as a full-time staff nurse on the Special Needs Unit (the "Unit") with clients with developmental delay and/or major mental illness.

THE CLIENT

7. [the Client] (the "Client") was 31 years old at the time of the incident. He often went by the nickname "[the Client's Nickname]".

8. The Client was the subject of a court-ordered assessment of his mental health to determine whether he was "not criminally responsible" for various offences related to two separate robberies and assaults he committed on May 31, 2014.

9. At the time of the assessment in November 2014, the Client was a repeat offender, with a significant criminal record and a history of violent and antisocial behaviour dating back to his childhood. He was considered a "very high" risk to re-offend and had been diagnosed with antisocial and borderline personality disorders, as well as polysubstance abuse disorder (alcohol, marijuana, cocaine, ecstasy).

10. The psychiatrists who conducted the report from the Centre for Addiction and Mental Health determined that a defence of "not criminally responsible" was not available to the Client from a psychiatric perspective and he was transferred to [Facility A] the Facility on November 12, 2014, where he remained on the Unit until November 26, 2015. At that time, he was transferred to [Facility B] ") to serve the remaining portion of his sentence, until May 31, 2016.

11. The Member provided care to the Client while he was on the Unit. Her signature appears in the Client's record on June 21, September 23 and October 28, 2015. Her signature also appears on the Client's admission/discharge form.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Relationship with the Client

12. The Member entered into a personal and romantic relationship with the Client, which included telephone calls, letters, and the Member depositing money into the Client's [Facility B] account.

13. The relationship between the Client and the Member was reported to [Facility A] the Facility by Staff Sargent [Co-Worker #1] ("[Co-Worker #1]") on May 22, 2016, following a text message exchange she had with the Member, who was a personal friend.

14. During that text exchange, the Member advised [Co-Worker #1] that she had done something that could cause her to lose her job and lose [Co-Worker #1]'s respect. After some probing by [Co-Worker #1], the Member admitted that she "fell for an inmate" who she identified as "[the Client]", indicating that he would be "out next week".

15. When [Co-Worker #1] asked the Member how she communicated with an inmate, the Member stated "He got shipped north and we talk on my ghost line". She went on to explain that "[the Client]" would call the Member at her house and the call would be forwarded to her cell phone.

16. The Member then confided to [Co-Worker #1] that she did not know how things would be when [the Client] was released from custody.

17. In response to hearing the Member's revelations, [Co-Worker #1] asked the Member "You know you could [lose] your job and potentially your licence right? [sic] Is it really worth it? Especially if you don't declare a conflict of interest."

18. In response the Member stated "He has not been a client for over 6 months".

Phone Calls

19. During the course of their relationship, the Member and the Client spoke on the phone on a regular basis.

20. Phone records from [Facility A] the Facility show that the Member's home line was called from a unit phone on 44 occasions the week of October 24-31, 2015. A further 128 calls were placed to the Member's home phone line between November 1-24, 2015. Another 45 calls were placed to the Member's home phone from [Facility B] from November 27, 2015, the day the Client was transferred to [Facility B], until May 2, 2016.

21. Many of the phone calls lasted 20 minutes, the maximum allowed for inmate calls.

22. The Member admits that she provided her telephone number to the Client and that she spoke on the telephone with him during the time he was incarcerated at [Facility A] the Facility and at [Facility B].

Letters

23. The Member and the Client also exchanged letters via regular mail. [Facility B] mail logs indicate that at least 29 letters were mailed to the Client at [Facility B] from the Member's home address between December 4, 2015 and April 29, 2016.

24. The Member admits that she provided her home address to the Client so that he could send her letters from [Facility B].

Sending the Client Money

25. The Member also sent money to the Client while he was at [Facility B].

26. Records from [Facility B] show that the Member mailed money to the Client as follows between December 2015 and April 2016:

- December 16, 2015 - $60
- January 5, 2016 - $120
- January 5, 2016 - $120
- January19, 2016 - $100
- January 26, 2016 - $300
- February 9, 2016 - $400

- March 7, 2016 - $60
- April 18, 2016 - $40

27. There are corresponding deposits in the Client's [Facility B] account for each of the amounts above.

28. The Member admits that she sent the Client at least $1,200.

29. [Facility B]'s ledger for the Client's account shows that the Client "banked" most of the money, with the exception of several cash pay-outs to his girlfriend.

Investigation

30. [Facility A] The Facility conducted an investigation and concluded that the Member had a personal relationship with the Client while he was in custody at both [Facility A] the Facility and [Facility B] and that she failed to submit a conflict of interest declaration. However, [Facility B] did not take any action against the Member as she had already resigned from her position on May 26, 2016, after [Co-Worker #1] reported the relationship to [Facility A] the Facility.

31. The Client, who was interviewed by both [Facility B] and the College denied any relationship with the Member and was not cooperative.

32. If the Member were to testify, she would say that [Facility A] the Facility was a highly stressful environment. She witnessed the death of two inmates during her employment. She would further testify that she was encouraged by [Facility A] Facility staff to date or socialize with higher ranking officers in order to obtain favours. As a result, the environment at [Facility A] the Facility was distressing and traumatizing.

COLLEGE STANDARDS

33. The College's *Therapeutic Nurse-Client Relationship* Standard ("the Standard") places the responsibility for establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationship on the nurse.

34. The Standard states:

> [c]rossing a boundary means that the care provider is misusing the power in the relationship to meet his or her personal needs rather than the needs of the client, or behaving in an unprofessional manner with the client.

35. The Standard further clarifies that a nurse may cross a boundary in a number of different ways, including:

- self-disclosure that does not meet a specified therapeutic client need;

- failing to ensure that the nurse-client relationship promotes the well-being of the client and not the needs of the nurse;

- giving gifts to the client or engaging in other behaviour that suggests a special relationship between the nurse and the client; and

- entering into a personal or romantic relationship with a client.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

36. The Member admits that her relationship with the Client, as described above in paragraphs 13 to 27, breached the College's *Therapeutic Nurse-Client Relationship* standard as alleged in the following paragraphs of the Notice of Hearing:

    - 1(a), (b), (c), (d) and (e)

37. The Member also admits that she committed the acts of professional misconduct as alleged in paragraphs 3 (a), (b), (c), (d) and (e) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 13 to 24 above.

38. With leave of the panel of the Discipline Committee, the College withdraws the following allegations from the Notice of Hearing:

    - 2(a) and (b)

Decision

The Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a),(b),(c),(d) and (e) of the Notice of Hearing. As to allegation 3 (a),(b),(c),(d), and (e) 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 the evidence therein supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1 in the Notice of Hearing is supported by paragraphs 13 to 27 in the Agreed Statement of Facts. The Member engaged in a personal/romantic relationship with a Client who was incarcerated in the Special Needs Unit in which she worked. She failed to maintain her professional boundaries when she shared her phone number and address with the Client. As a result of these disclosures, the Member and the Client spoke many times over the phone and exchanged letters. The Member maintained contact with the Client even after he was transferred to another facility. The Member sent him money totalling at least $1,200. These interactions with the Client

did not serve any therapeutic purpose. They clearly breached the principles enshrined in the College's *Therapeutic Nurse-Client Relationship* standard.

With respect to Allegation # 3, the Panel finds that the Member's conduct would reasonably be regarded by members of the profession as dishonourable and unprofessional. This is supported by paragraphs 13 to 24 in the Notice of Hearing. The Member's conduct was dishonourable. She did not disclose her relationship with the Client to [Facility A] the Facility. She hid it from her employers and her colleagues for several months. She used a "ghost line" as a way for the Client to communicate with her. This showed deceit. The Member's conduct would also be regarded as unprofessional. The Member ought to have known that her behaviour fell below the minimum standards expected of a nurse. The Member showed a serious disregard for her professional obligations. The Member demonstrated a lack of good judgement when she entered into a relationship with a vulnerable Client. He was a repeat offender who had violent and anti-social behaviour since childhood. He also had mental health disorders and a polysubstance abuse disorder. The Member knew the relationship was wrong and persisted with it in any event. She spoke to her colleague and wondered whether she would get in trouble as a result of the relationship. Despite this, she continued on and even considered what the relationship would be like once the Client was released from custody. The Member's willingness to continue on with this relationship in the face of professional obligations shows a persistent disregard for her responsibilities as a nursing professional.

Penalty

Counsel for the College and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission 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 that this Order becomes final 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 Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. 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*,
    2. *Therapeutic Nurse-Client Relationship*,

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 18 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

Submissions were made by College Counsel and the Member's Counsel.

The parties agreed that the mitigating factors in this case included the following:

- The Member cooperated with the College.
- She immediately admitted the allegations thus saving the College time and resources.
- No pre-hearing was required.
- She has no disciplinary history with the College.
- If the Member were to testify, she would speak to the challenges of the working environment.
- The Member's admission is an expression of remorse.
- She wants to learn from her mistakes.
- The Member is a prime candidate for remediation.

The aggravating factor in this case was the vulnerability of the Client. He was a repeat offender who had mental health disorders and a polysubstance disorder. The fact that he was incarcerated added another level of vulnerability. He could not leave the Facility. This non-therapeutic relationship could have produced additional harm to an individual who was already compromised. The Member's conduct demonstrates a significant disregard for her professional obligations. Nurses must ensure that they are extremely careful when dealing with such vulnerable populations.

The proposed penalty provides for general deterrence through a three month suspension. This sends a clear message to the profession that this conduct will not be tolerated. It will also discourage other members from repeating these actions. The terms, conditions and limitations on the Member's certificate indicates to the membership and the public that this type of behaviour is taken very seriously by the College and by this Discipline Committee.

The proposed penalty provides for specific deterrence through the three month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of her actions and how they are perceived by both her profession and the public. The terms, conditions and limitations will provide monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert, the review of the College's publications and the completion of the Reflective Questionnaires and on-line participation forms.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. This will improve her practice. The 18-month employer notification will ensure that the Member's practice is monitored for a significant period when she returns to nursing after the suspension.

Counsel submitted cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

The College submitted the case of *CNO v. Margaret A. Blaney* (Discipline Committee, 2016). The member worked in a correctional facility. She engaged in long telephone conversations with the client and sent him lipstick stained and perfumed scented letters. In her letters to the client, she expressed her love and made references to sex. The member was given a 4 month suspension because, in addition to her boundary violations, she compromised the safety of the other prisoners when she surreptitiously provided the client with a Blackberry and charger.

The College then submitted the case of *CNO v. Sheila Odumeru* (Discipline Committee, 2011). The member worked in a mental health facility and was the client's primary nurse. When the client was on her unit she gave him a birthday card encouraging him in his recovery. Upon the client's discharge, the member and the client exchanged email addresses. The member expressed her romantic feelings to the client in an email. The member contacted the client after he told her to stop all communication and then, once again, after she was terminated from her position. She was given a 2 month suspension and a 12 month employer notification. No reprimand was ordered due to unstated extenuating circumstances.

The College also submitted the case of *CNO v. Ronald Park* (Discipline Committee, 2009). The member worked in a mental health unit. The member and the client engaged in long conversations in the unit which had no therapeutic purpose. They exchanged personal information. They met each other outside of the unit when the client was on a day pass and after she was discharged into a detoxification program. The member visited the client's parent's home. The member and the client exchanged gifts and expressed feelings of affection in cards. The member wrote "Love Ron" on one card. Initially the member denied any relationship with the client and only finally admitted the nontherapeutic relationship during the College's investigation. The member was given a 5 month suspension and a 24 month employer notification.

Both Counsels submit that, upon reviewing and comparing these cases, the three month suspension strikes the appropriate balance. Counsel for the Member asked the Panel to refer to paragraph 44 of the Supreme Court decision of *R.* v. *Anthony-Cook*, 2016. In that paragraph, the Court sets out the rationale for accepting a Joint Submission on Penalty. The Panel does not get to hear all the evidence and the parties who have negotiated the joint submission are in a good position to weigh the public interest. Counsel asked the Panel to accept the joint order if we agree that it is in a reasonable range. Both Counsel agreed that public protection ought to be the Panel's primary concern.

Penalty Decision

The Panel accepts the Joint Submission as to 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 that this Order becomes final 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 Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. 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*,
2. *Therapeutic Nurse-Client Relationship,*

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 18 months from the date the Member returns to the practice of nursing, he 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 Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. Members of the profession will be reminded that the obligation to enforce therapeutic and professional boundaries is always on the nurse.

I, Ingrid Wiltshire-Stoby, RN, sign this decision and reasons for the decision as Chairperson of

this Discipline panel and on behalf of the members of the Discipline panel.

_____ _____

Chairperson Date