DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Michael Hogard, RPN,	Chairperson
	Andrea Arkell	Public Member
	Karen Laforet, RN	Member
	Sandra Larmour	Public Member
	Emilija Stojsavljevic, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE &
	)	DOUGLAS MONTGOMERY for
	)	College of Nurses of Ontario
- and -	)	
	)	
NAOMI CLARK	)	NO REPRESENTATION for
Registration No. AH039141	)	Naomi Clark
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: October 27-28, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") commencing on October 27, 2022, via videoconference.

As Naomi Clark (the "Member") was not present, the hearing was recessed for 15 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was not in attendance.

By way of an affidavit from [ ], Prosecutions Clerk, dated October 14, 2022, College Counsel provided the Panel with evidence that the College had made numerous attempts to notify the Member of the Notice of Hearing via courier, process server and email, without response. In her affidavit, [the Prosecutions Clerk] confirms that the College sent correspondence to the Member, at her last known address on the College Register, on a number of occasions.

The Panel was satisfied that sufficient attempts had been made by the College to notify the Member of the time, place and purpose of the hearing and of the fact that if she did not

participate in the hearing, it may proceed without her participation. Accordingly, the Panel decided to proceed with the hearing in the Member's absence.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, *1991*, for an order preventing public disclosure and banning publication or broadcasting of:

1. the name of the patient, or any information that could disclose the identity of the patient referred to orally or in any documents presented in the Discipline hearing of Naomi Clark and
2. the name(s) and image(s) of any minors referred to orally or in any documents presented in the Discipline hearing of Naomi Clark.

The Panel considered the submissions of College Counsel and decided that there be an order preventing public disclosure and banning publication or broadcasting of:

1. the name of the patient, or any information that could disclose the identity of the patient referred to orally or in any documents presented in the Discipline hearing of Naomi Clark and
2. the name(s) and image(s) of any minors referred to orally or in any documents presented in the Discipline hearing of Naomi Clark.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated August 8, 2022, are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended in that, while registered as a Registered Practical Nurse and/or during your employment at GreeneStone Centre for Recovery in Bala, Ontario, (the "Facility") and/or within one year of such employment, you sexually abused a patient, in that, in or about May 2020 to July 2021:

    (a) you engaged in touching of a sexual nature of Patient [A];

    (b) you engaged in behaviour and/or made remarks of a sexual nature toward Patient [A]; and/or

    (c) you engaged in physical sexual relations with Patient [A]; and/or

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(1) of Ontario Regulation 799/93, in that, while registered as Registered Practical Nurse and/or during your employment at the Facility and/or within one year of such employment, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, in that, in or about May 2020 to July 2021:

(a) you engaged in touching of a sexual nature of Patient [A];

(b) you engaged in behaviour and/or made remarks of a sexual nature toward Patient [A];

(c) you engaged in physical sexual relations with Patient [A]; and/or

(d) you failed to maintain the boundaries of the therapeutic nurse-patient relationship with Patient [A]; and/or

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, while registered as Registered Practical Nurse and/or during your employment at the Facility and/or within one year of such employment, you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that, in or about May 2020 to July 2021:

(a) you engaged in touching of a sexual nature of Patient [A];

(b) you engaged in behaviour and/or made remarks of a sexual nature toward Patient [A];

(c) you engaged in physical sexual relations with Patient [A]; and/or

(d) you failed to maintain the boundaries of the therapeutic nurse-patient relationship with Patient [A].

Member's Plea

Given that the Member was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member is a Registered Practical Nurse ("RPN") and has been registered with the College since May 4, 2018.

The Member was employed at GreeneStone Center for Recovery in Bala, Ontario (the "Facility") in a part-time capacity beginning May 27, 2020. The Member was employed as a nurse for the in-patient unit (the "Unit") until her resignation on July 27, 2020.

The Unit provides 24-hour registered staff care that includes medication administration, patient monitoring, and patient support. The registered staff, including the Member, were required to work 12-hour shifts, including both day and night rotations. The patients residing in the Unit receive individualized care for 30 – 90 days or longer. Patients may request a therapeutic leave once they have been at the Facility for 45 days.

Patient [A] was admitted for inpatient treatment on February 13, 2020. He had been receiving outpatient care through Veterans Affairs Canada ("VAC") and his care team consisted of a VAC Case Manager, a Psychiatrist working with the Operational Stress Injury Clinic ("OSIC"), occupational therapy, physical therapy and other services.

Patient [A] suffered from several aliments: post-traumatic-stress-disorder ("PTSD"), acquired brain injury ("ABI"), substance misuse, depression, paranoia, chronic pain, attention-deficit disorder ("ADHD"), memory loss, anxiety, sleep disorders and impulsive behaviours.

The Member was in a therapeutic nurse-patient relationship with Patient [A] beginning May 29, 2020.

Starting on or around July 21, 2020, the Member and Patient [A] entered into a personal, romantic relationship resulting in the patient signing out against medical advice ("AMA") and moving in with the Member and her son. The Member was secretive about the relationship until Patient [A] left the Facility following his therapeutic leave on July 25, 2020. The Member engaged in deceit and subterfuge with the care team regarding the relationship and enlisted Patient [A] in this deceit. Although the Member resigned from the Facility on July 27, 2020, she continued to present herself to other health care professionals as continuing to provide Patient [A] with care, identifying herself as both his [fiancé] and caretaker.

Having considered the evidence and the onus and standard of proof, the Panel found that the Member committed acts of professional misconduct by sexually abusing Patient [A] as alleged in paragraphs #1(a) and (b) of the Notice of Hearing and by contravening the standards of practice of the profession as alleged in paragraphs #2(a), (b) and (d) of the Notice of Hearing. As to allegations #3(a), (b) and (d) in the Notice of Hearing, the Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable, and unprofessional.

The Panel did not make findings of professional misconduct with regard to allegations #1(c), #2(c) and #3(c). The inference of a physical sexual relationship, without direct evidence, was insufficient to make these findings and these allegations were therefore dismissed.

The Evidence

The Panel received 23 exhibits from the College and heard testimony from six fact witnesses and one expert witness.

The six fact witnesses the Panel heard from included two healthcare professionals working with Patient [A], the Stress Clinic's administrative assistant, the Facility's in-house Psychiatrist, the Vice President of the Canadian Addiction Treatment Centers, including the Facility, and the College's Investigator. The evidence provided by the witnesses was consistent, credible, logical, supported by their actions, and often corroborated by the evidence of other witnesses.

Witness 1 – [ ] ("[Witness 1]")

[Witness 1] is an Occupational Therapist ("OT") working in private practice. [Witness 1] has a PhD and is a university professor and is registered to provide services with VAC. [Witness 1] was referred to see Patient [A] in February 2019 through his existing VAC case manager and continued to provide him with therapeutic support through to September 7, 2020.

[Witness 1] testified that prior to his admission to the Facility, she met with Patient [A] in person once or twice weekly either at his parents' home, at his girlfriend's home or at the VAC base to receive services for chronic pain management, brain injury, addictions, depression, PTSD, paranoia, impulsive behaviours and difficulty focusing.

[Witness 1] confirmed that Patient [A] agreed to be admitted to the Facility's residential program in 2020. While Patient [A] was an inpatient, [Witness 1] attended his monthly team meetings. [Witness 1] stated that Patient [A]'s first few months at the Facility were the best she had ever seen him. This statement was supported by Exhibit #3, the Progress Notes prepared by [Witness 1] in which the July 2, 2020, note stated "Veteran did very well and is much clearer in his actions and thoughts/words than he ever has been…".

The Facility has step-down supportive housing to provide trial living in the outside world. [Witness 1] conducted a kitchen assessment via Zoom to support Patient [A]'s goals to live on his own and to prove to the courts that he was a competent father.

College Counsel asked [Witness 1] to speak to the text received by her from Patient [A] on July 21, 2020. [Witness 1] stated that Patient [A] sent her a text asking for a call back as he had news to share. She spoke to him on July 23, 2020**,** and he shared that he had fallen (in a romantic way) for his nurse who cared for him one night when he was struggling. He stated that he had spent the weekend with her, and her son and they were planning on moving in together on August 1, 2020, and that he would be leaving the Facility. Patient [A] asked [Witness 1] not to tell the rest of the team because the nurse told him she would lose her license to practice if it was made known she had an unprofessional relationship with a patient. [Witness 1] advised him it was mandatory for her to report this situation to the College.

College Counsel asked [Witness 1] what her reaction was to this information. [Witness 1] replied "it was distressing. Patient [A] had a habit of falling for women and they would hurt him mentally". [Witness 1] called the College of Occupational Therapists ("COTO") for advice and then made a mandatory report to the College, as set out at Exhibit #4, Letter of Report #1 dated July 24, 2020, for what sounded like a boundary violation with the nurse and Patient [A]. [Witness 1] also confirmed that on the advice of COTO, she did not disclose the information to Patient [A]'s team.

College Counsel asked [Witness 1] if Patient [A] told her the nurse's name on July 23, 2020. [Witness 1] testified that Patient [A] called her Natasha and confirmed she was sent Exhibit #5, a picture via text, on July 25, 2020, that showed Patient [A], his new girlfriend and her son (whose name was not mentioned).

A telephone call was held on July 30, 2020**,** with Patient [A], [Witness 1], Facility staff, other members of Patient [A]'s care team and his legal counsel.

College Counsel directed [Witness 1] to her Progress Notes of July 31, 2020, regarding the purpose of the July 30, 2020, telephone meeting and inquired whether Patient [A]'s girlfriend was in attendance. [Witness 1] stated that the purpose of the meeting was to better understand Patient [A]'s sudden decision to leave the Facility and to convince him to continue his inpatient treatment plan. He joined the meeting late, and it was initially unclear if his girlfriend was with him on the call, although she did eventually speak without identifying herself. Once only the VAC team remained on the call (case manager, psychiatrist, social worker and [Witness 1]), [Witness 1] asked Patient [A] if he felt comfortable introducing his girlfriend. He called her Natasha and Naomi and indicated that she was an RPN at the Facility and that the plan for them to move in together started about 5 weeks ago, approximately 4 – 5 weeks after the kitchen assessment conducted by [Witness 1].

College Counsel asked [Witness 1] if Patient [A] and the Member indicated where they would live geographically and what impact, if any, this move would have on Patient [A]. [Witness 1] stated that she believed they would live at the Member's house in Oshawa and that the change in location and discharge from rehabilitation would result in losing his team, including his current case manager.

[Witness 1] had no further interactions with Patient [A] after the September 7, 2020, Discharge Report at Exhibit #6.

<u>Witness 2 – [ ] ("[Witness 2]")</u>

[Witness 2] is a psychiatrist, registered with the College of Physicians & Surgeons ("CPSO") since 2017, and works at the outpatient OSIC. The OSIC provides mental health services for VAC and RCMP patients. [Witness 2] was Patient [A]'s attending psychiatrist for medication management from early 2018 until his discharge in August 2020 with varying visit frequency depending on his situation. [Witness 2] was on maternity leave from 2019 to June 2020.

College Counsel asked [Witness 2] to explain the complexity of Patient [A]'s case. [Witness 2] stated that he had PTSD, depression, and ABI, which all stemmed from his deployment in Afghanistan. In addition, there was substance misuse and persistent active symptoms and behaviours resulting from these injuries that included aggression, emotional instability, memory loss, chronic back pain with muscle spasms and headaches, anxiety, low concentration and sleep disorders. [Witness 2]'s role in his care was largely medication management as Patient [A] had a large team and care coordination oversight.

College Counsel asked [Witness 2] if she was involved in the Facility's plan. [Witness 2] confirmed that it was in the works prior to her maternity leave in 2019. [Witness 2] testified that the level of Patient [A]'s wellness upon her return to work had improved. Patient [A] was benefitting from the therapeutic programming, the Facility's location, medication adjustments, sobriety and monthly case conferences.

College Counsel submitted Exhibit #7 and the document was confirmed by [Witness 2] to be her Progress Notes. College Counsel specifically addressed the entry on page 3 dated 2020/07/30 and signed on 2020/08/08. [Witness 2] confirmed that the notes were dictated on the day of the conference call and transcription of the record was delayed, resulting in 2 dates on the document.

[Witness 2] described how housing had been an outstanding concern for Patient [A] as he would not be able to return to his parent's house in Woodstock. The plan was to transition to the Facility's second stage program where he would receive intensive support and living arrangements until he was able to get into Dale Brain Injury housing. They heard about a change in plans on the July 30, 2020, conference call. Patient [A] had decided to move to Oshawa to live with his new girlfriend and her [ ] son.

College Counsel asked [Witness 2] if the girlfriend participated on the July 30, 2020, call. [Witness 2] confirmed someone on the call did acknowledge her presence, although she did not say much. Patient [A] referred to her as Naomi/Natasha. He stated that "she is a nurse with over 10 years of experience in addiction" and that she would be the one to manage/monitor his medications. [Witness 2] also stated that Patient [A]'s demeanor was remarkably different than previous conference calls as he was acting defensive, was irritable, and was making frequent interruptions.

[Witness 2] confirmed there were consequences for Patient [A]'s decision to leave the Facility program, as well as for his decision with respect to where he was planning on moving. While Oshawa was within the OSIC catchment area, he did not qualify for virtual support due to the complexity of his needs. The distance to the Toronto satellite was problematic since he did not have a driver's license. The move to Oshawa would result in an entirely new care team. Patient [A]'s family lawyer also stated that it would not be looked upon favourably for his custody application if he went against his team's treatment recommendations.

College Counsel asked [Witness 2] if Patient [A] introduced his girlfriend once the Facility staff and his lawyers left the call. [Witness 2] confirmed that [Witness 1] prompted him to introduce her. She was introduced as Naomi, she has a [ ] son, and the two met while she was employed at the Facility in the "role as recovery coach". Those present on the call were told she had since given her 2 weeks' notice. [Witness 2] stated that Naomi said during the call that Patient [A] was "doing amazingly well" and that they met "soul to soul".

College Counsel asked [Witness 2] to explain her concerns with this situation. [Witness 2] stated a number of concerns: the boundary violation of Naomi caring for Patient [A]; the limited notice time of his departure from the program; the picture taken with the Member's son; the identification of the relationship as romantic rather than platonic; the involvement of a child; and the rash/impulsiveness on his part to abruptly change his treatment plan.

College Counsel directed [Witness 2] to page 1 of Exhibit #7, the Progress Notes, dated 2020/07/30 and asked her what the purpose of the call was. [Witness 2] confirmed that someone had called the clinic for a prescription renewal. [Witness 2] requested to speak with Patient [A]. While the discharge summary had not yet been received from the Facility, she reviewed the medication list, and provided 30-day prescriptions for all medications, except for the diazepam, which had been stopped by Patient [A]. [Witness 2] confirmed that stopping the diazepam would not have been her advice without clinical oversight and medical support. [Witness 2] also confirmed that Patient [A] had referenced that Naomi was his personal nurse and care provider managing his medications, clinical calls and that she was on the call via speaker phone.

[Witness 2] confirmed that she had filed Exhibit #8, the Letter of Report #2 dated July 31, 2020, with the College following the July 30, 2020, meeting.

<u>Witness 3 - [ ] ("[Witness 3]")</u>

[Witness 3] has been an administrative assistant at the OSIC clinic for almost 15 years. [Witness 3]'s role is intake coordinator, managing referrals and day-to-day interactions with patients. In keeping with the multi-disciplinary nature of OSIC, [Witness 3] works with psychiatrists, nursing, OT, Social Work and other healthcare professionals. Patient [A] was well known to [Witness 3].

[Witness 3] recounted a call to the clinic one morning in August 2020. A woman called and said she was Patient [A]'s nurse caregiver. When asked for clarification, the woman stated, "I'm a nurse and his caregiver for VAC". [Witness 3] did not recognize the person and does not recall her providing a name. [Witness 3] asked if Patient [A] was there and to have him pick up the phone. The woman then asked Patient [A] "What am I supposed to ask her". She then said to [Witness 3], we need "med referrals" and then hung up the phone. [Witness 3] then sent Exhibit #9, an email to Patient [A] dated August 17, 2020, asking for his most current address. The response back from him showed an Oshawa address with a blank email address. [Witness 3] confirmed that there was no further contact with him.

Witness 4 – [ ] (“[Witness 4]”)

[Witness 4] is a psychiatrist and the Medical Director for the Facility. [Witness 4]’s administrative responsibilities include ensuring quality of care and adherence to guidelines and standards for addiction care. Her clinical responsibilities include oversight for all staff, providing psychiatric care, assessments, and staff training.

College Counsel asked [Witness 4] to speak to nursing responsibilities at the Facility. [Witness 4] replied that nurses’ duties included patient assessments, transfers to clinical care when stable and acknowledged that Recovery Coaches were nurses with similar roles. [Witness 4] confirmed that the Member worked at the Facility. However, she did not know the Member’s start date or whether the Member was working when she started as the Medical Director, nor could she recall meeting the Member or any specific interactions.

College Counsel showed [Witness 4] Exhibit #5, a photo and asked [Witness 4] if she could identify the woman in the photo. [Witness 4] confirmed that she now knows the person in the photo as Naomi Clark.

[Witness 4] was vague on the timing of Patient [A]’s admission date in relation to her becoming the Medical Director. [Witness 4] testified that Patient [A] was a complex patient with a multitude of issues: ABI, PTSD, severe chronic pain, substance abuse, ADHD, cluster B personality traits including impulsiveness, secretive and paranoia tendencies.

College Counsel asked [Witness 4] if Exhibit #11, the Medical Log, was accessed by Recovery Coaches. [Witness 4] stated that only healthcare personnel may access the records.

[Witness 4] confirmed that as noted in the Medical Log, Patient [A] had applied for and was approved for a therapeutic leave for July 25, 2020, with an expected return date of July 26, 2020, by 20:00 hours. [Witness 4] was unable to verify if she was notified when Patient [A] did not return. On July 27, 2020, [Witness 4] called Patient [A] and confirmed that he was not planning on returning. [Witness 4] completed an assessment to ascertain if Patient [A] needed hospitalization, how best to support and keep him and others safe. This assessment included speaking with his friend to verify he was safe.

[Witness 4] also confirmed as noted in the Medical Log, that on July 27, 2020, she spoke with Patient [A]’s girlfriend who identified herself as “Natasha” during the telephone meeting. Natasha introduced herself as if they had not met before and at no time referred to herself as Naomi. During the telephone conversation, she corroborated what Patient [A] had said to the team and remained guarded about disclosing her full name and address. She confirmed that she was a nurse and would be Patient [A]’s caregiver, that his name has been added to the lease, and he would be moving in with her and her [ ] son.

On July 27, 2020, [Witness 4] documented on page 7 of the Medical Log, that Patient [A] was reluctant to discuss details of his girlfriend expressing that when he was off property, he would

allow her to talk to staff at GreeneStone including [Witness 4]. [Witness 4] testified that Patient [A] also conveyed that he was trying to protect his girlfriend from gossip at the Facility by not disclosing her identity and not allowing her to have any contact with GreeneStone. During that same telephone conversation, [Witness 4] testified that Patient [A] said he would live near his girlfriend in Oshawa. [Witness 4] also documented on page 8 of the Medical Log that when she spoke with Natasha by telephone later on July 27, 2020, Natasha said that Patient [A] would be moving in with her.

College Counsel referred [Witness 4] to notes on August 2, 2020, regarding Patient [A]'s medication transfer. [Witness 4] confirmed that his medication prescriptions were transferred to an Oshawa pharmacy. However, she was unclear if she recalled his decision to move to Oshawa. The priority was to ensure he had his medications.

College Counsel asked [Witness 4] if the medication changes noted on August 17, 2020, were supported post-discharge. [Witness 4] testified that the medication changes were not physician recommendations and that Patient [A] was doing various things with his meds. [Witness 4] confirmed that she provided input into the Facility's Discharge Summary, set out at Exhibit #12, completed by [ ] ("[Dr. A]"), and that she continued to provide medication support to Patient [A] until his death. [Witness 4] also confirmed that Patient [A] continued his relationship with Naomi, who participated in the meetings following his discharge.

[Witness 4] stated that Patient [A] was receiving psychotherapy with [Dr. A] and was getting better. He started working on a farm that he enjoyed and was stable up until the time surrounding his death, which was due to physical ailments**.**

<u>Witness 5 – [ ] ("[Witness 5]")</u>

[Witness 5] is the Vice President of Inpatient and Virtual Programs for the Canadian Addiction Treatment Centres ("CATC"), including the Facility. [Witness 5] has a Master's in psychotherapy, and Masters in business administration and has worked with the Facility since 2019. At the time of Patient [A]'s discharge she was Executive Director for the Facility.

[Witness 5] provided an overview of the Facility. It houses 26 in-patient beds for stays ranging from 30 days (minimum requirement) to 90 days or longer. Patients receive 24-hour individualized care from registered staff. Patients are encouraged to request leave of absences for therapeutic purposes once they have been on site for 45 days. The full complement of registered staff includes 5 full time RPNs + casual positions, 3 Nurse Practitioners, and physicians. Nursing responsibilities include medication administration, supporting medication detoxification, psychological support and "eyes" for other staff. Nurses work 12-hour shifts days or nights. [Witness 5] confirmed that the Member was employed as a nurse and was hired in the spring of 2020. She did not recall whether the Member was employed full-time or part-time.

College Counsel asked [Witness 5] when Patient [A] was admitted. [Witness 5] recalled that he was admitted in the winter of 2020 and was at the Facility for 6 months and confirmed that he was there prior to the Member starting. [Witness 5] testified that Patient [A] demonstrated manipulative behaviours; including behaviours, that threatened to be divisive for the team such as sharing information from one staff to another. He fixated on women and there was a difference in how he interacted with men versus women. There was an informal directive for female staff to keep doors open and not be alone with him. He was a topic of discussion at the daily team meetings due to his complex behaviours.

College Counsel asked [Witness 5] if the Member provided care for Patient [A]. [Witness 5] stated that she would have since he was on a lot of medications. [Witness 5] was directed to Exhibit #10, the Medication Administration Records and was asked to walk the Panel through how the record would be completed. [Witness 5] stated that while she is a not a healthcare professional, she is familiar with the procedure. Nurses are required to sign out medications and to observe the patient take the medications. [Witness 5] confirmed that the initials "NC" on the record refer to the Member as no one else working at the Facility had those initials at that time.

College Counsel directed [Witness 5] to Exhibit #13, the excerpts from the Medical Log, and asked if this document had been prepared for the College. The witness could not verify but indicated that she had sent in a lot of documents as requested. [Witness 5] confirmed that Naomi Clark in Exhibit #13 was the Member and verified that the length of notes in her records, while not common, could be based on the Patient [A]'s status.

College Counsel asked [Witness 5] if she recalled the events on July 27, 2020. [Witness 5] stated that it was brought to her attention that Patient [A] had not returned from his approved therapeutic leave as scheduled. [Witness 5] called Patient [A] who shared he was close by and was with his girlfriend and her son. [Witness 5] did not speak to the girlfriend at that time. Following the phone call, the witness followed up with the team. Patient [A] did return and shared he was living with his girlfriend; she was a nurse who could provide support and be his caregiver since she worked in the addiction field and that he loved her and her son. He did not want to share her name due to conflict with her work situation.

[Witness 5] shared that the new girlfriend introduced herself as Natasha during the teleconference on July 30, 2020. The focus of the meeting was to convince him to come back to the Facility to build a transition out plan. Once it was clear he did not want to stay, [Witness 5] stepped out of the meeting. At the time of the meeting [Witness 5] confirmed that the Member was still employed.

College Counsel directed [Witness 5] to Exhibit #14, the email resignation from the Member. [Witness 5] confirmed that Human Resources received all resignations. The timing of the resignation was a surprise as it arrived 3 hours before the start of the Member's shift, resulting in a challenge to cover the shift to ensure adequate patient care.

College Counsel inquired if [Witness 5] completed any investigation. [Witness 5] confirmed that she checked on Facebook and recognized the Member. [Witness 5] then checked the Member's address and the address of the pharmacy provided. Following this, [Witness 5] called the Member's number on file and Patient [A] answered. [Witness 5] asked to speak with the Member. He responded that they were sitting down to dinner, and she would call back. The Member did not return the call. [Witness 5] discussed the situation with Human Resources and Quality and filed Exhibit #15, the Letter of Report #3 dated August 4, 2020 with the College.

College Counsel directed [Witness 5] to Exhibit #5, a photo and asked her if she recognized anyone in the photo. [Witness 5] identified the Member and Patient [A].

Witness 6 – [ ] ("[Witness 6]")

[Witness 6] is an investigator for the College whose role and responsibilities include gathering information for investigations and preparing reports. [Witness 6] was the investigator for this case since June 2021 which included investigating the Member's activities on the College website, emails to the College and accessing social media profile pages.

College Counsel asked [Witness 6] to verify Exhibit #16 was a true copy of the Member's registration history. [Witness 6] confirmed that the document was a true copy and that information contained in the document is updated when the College's investigation team receives new information.

College Counsel presented Exhibit #17, 11 photos and asked [Witness 6] how the photos and information were obtained. [Witness 6] confirmed that the photos contained in the document were obtained through the public sources of Facebook and via internet searches. The screenshots were uploaded on October 12, 2022. [Witness 6] testified that she had checked for these pictures in 2021 and the Member's profile had changed along with some pictures. [Witness 6] confirmed that the images were obtained using the "print screen" function and were not altered. The icons from [Witness 6]'s computer were cropped out. The text at the top of each page indicates the URL address and the date the screenshot was taken.

Expert Witness – Dr. Ruth Gallop ("Dr. Gallop")

Dr. Gallop is a Professor Emeritus at the University of Toronto for the Faculty of Nursing and the Department of Psychiatry and has been registered with the College since 1965.

Dr. Gallop's Curriculum Vitae, which was marked as Exhibit #18, outlines a long nursing career starting as a staff nurse on a Psychiatric Unit, then transitioning into an academic career as an Educator, Researcher. Dr. Gallop has published numerous articles focusing on psychiatric nursing and nurse-client relationships. Dr. Gallop reported that she has been asked by the College to testify at over 80 cases, many concerning boundary violations specific to physical, emotional, sexual, and/or financial circumstances. She has a private practice treating persons dealing with sexual abuse and boundary violations.

College Counsel tendered Dr. Gallop as an expert to provide an opinion on whether the Member breached the *Professional Standards*, the *Therapeutic Nurse-Client Relationship* Standard ("*TNCR* Standard") and breached professional boundaries resulting in abuse to Patient [A].

Dr. Gallop confirmed that the opinion she would provide would be non-partisan and objective as indicated in Exhibit #19, the Acknowledgment of Expert's Duty. The Panel qualified Dr. Gallop as an expert in nursing in the areas of the Therapeutic Nurse-Client Relationships and Standard of Care.

Dr. Gallop was asked by College Counsel to explain page 3 of Exhibit #21, the *Professional Standards*. Dr. Gallop stated that the *Professional Standards* are direct guidelines that apply to all nurses, any member who is registered with the College and practicing, regardless of the setting. She stressed that these are not just guidelines, rather they are standards by which one is judged and measured.

Dr. Gallop was asked by College Counsel to explain, in general, Exhibit #22, the *TNCR* Standard. Dr. Gallop highlighted that the nurse needs to maintain boundaries and demonstrate respect, empathy and honesty while working with clients and their families. Dr. Gallop testified that the *TNCR* Standard expands on aspects of nurse-client relationships. Dr. Gallop testified that the *TNCR* Standard specifically works in the best interest of the client, not the needs of the nurse. When the relationship changes to one that is in the interests of the nurse there is a shift from a professional to an unprofessional relationship. The necessity of maintaining professional boundaries protects the patient's interest and maintains the therapeutic role and is critical for the benefit and safety of the client. Dr. Gallop stated that nurses have power over clients and there are many ways nurses can abuse this power. Maintaining professional boundaries protects patients. She walked the Panel through page 11 of the *TNCR* Standard decision tree that supports the basis for clear professional standards and boundaries in order to protect against abuse of power.

Dr. Gallop then directed the Panel to pages 3 and 4 of the *TNCR* Standard. On page 3 it specifically states that the therapeutic nurse-client "relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role." She reinforced that trust is a critical component. Dr. Gallop referred to the definition of "Boundary" page 4 in the Glossary section of the *TNCR* Standard. She testified that crossing a boundary is a misuse of power and the misuse of that power does not need to be intentional to have crossed the line.

College Counsel asked Dr. Gallop if there is a boundary violation if the client wants to change the relationship. Dr. Gallop stated that it does not matter if the client wishes to have a relationship. The absolute responsibility for maintaining boundaries rests with the professional. She stressed that there is no such thing as consensual in these circumstances. Any boundary

violation, even one not intended, can be harmful and compromise the client's capacity to get help.

College Counsel directed Dr. Gallop to page 9(d) and (e) of the *TNCR* Standard where it states that the nurse must not enter into any type of relationship with a client for one year after the nurse-client relationship has been terminated. Dr. Gallop confirmed that this is an overall standard of practice for all healthcare professionals. She testified that in 2018 the *Regulated Health Professions Act* ("*RHPA*") enacted the patient protection act to be a period of one year after patient discharge. She stated it is very meaningful and prescriptive especially for persons with chronic conditions and who may need to return to the same facility. Any relationship may interfere with capacity for care. The *RHPA* also states that any form of sexual relationship is forbidden.

College Counsel directed Dr. Gallop to page 11 of the *TNCR* Standard decision tree and asked her how this tool would determine a boundary violation. Dr. Gallop stated that the third question in the decision tree is critical. Would the nurse document, or tell others the behaviour? It was Dr. Gallop's evidence that if the answer to this question is no, then that is a clear indication the behaviour is a boundary violation.

College Counsel directed the Panel and Dr. Gallop to Exhibit #20, the hypothetical scenario provided in the College's letter to Dr. Gallop of September 26, 2022. Dr. Gallop confirmed that she had read the hypothetical scenario. College Counsel asked Dr. Gallop if assessing the facts to be true, would there have been a breach of the *TNCR* Standard? Dr. Gallop confirmed this would be the case and that all the facts provided show a vulnerable client and therefore there was an absolute necessity to be very clear to protect the client.

College Counsel asked if Dr. Gallop had formed an opinion as to whether the Member had breached the *TNCR* Standard. Dr. Gallop stated yes. Page 6, paragraph 16 of the hypothetical scenario confirms this was a professional relationship. On July 5, 2020, the Member performed a nursing function and documented the interaction.

College Counsel asked Dr. Gallop if there was a patient-nurse perceived romantic relationship, would this be a breach of the *TNCR* Standard? Dr. Gallop stated that if there was a romantic relationship then there would be a breach of the standard.

College Counsel directed Dr. Gallop to paragraphs 26 – 31 in the hypothetical scenario and requested her opinion on a potential breach of standard. Dr. Gallop stated that the Member was in a parallel role as girlfriend and caregiver that was disruptive and interfering with the client's best interest. If the Member was in a caregiver role after discharge and simultaneously in a romantic relationship, this constitutes an abuse of power, specifically the abuse of knowledge and influence regarding his medications. Furthermore, it was against the client's interest to discharge himself against medical advice. All these behaviours are indicative of the Member acting against the best interests of the client.

Dr. Gallop confirmed that, assuming the Panel finds there was a romantic relationship that occurred within a one-year period of the nurse-client relationship, there was a breach of the *Professional Standards* and the *TNCR* Standard. She reiterated that it was clear secrecy was involved all along and this was not in the client's best interest and that the relationship was clearly within the year of discharge. Dr. Gallop testified that she interpreted the photos presented in the hypothetical situation to confirm the parties were involved romantically.

Dr. Gallop then went through the allegations in the Notice of Hearing and confirmed that, in her opinion, the *standards of practice* and the *TNCR* Standard were breached. The Member violated professional boundaries of a vulnerable client who had suffered trauma as a result of his military service and who had a pattern of clinging to anyone, especially to women who showed affection. The member abused her position of power and influence and exploited the client's best interest and vulnerability resulting in loss of opportunity for care.

College Counsel asked Dr. Gallop if her opinion would change if the Panel concluded that the client's health improved in the relationship. Dr. Gallop testified that it would not change her opinion. A boundary violation is not judged based on whether harm was done. The standards are in place to reduce the risk of harm to the client. The patient is in a position of less power; therefore, it is the professional's responsibility and obligation to act in the patient's best interest at all times.

Final Submissions

College Counsel reminded the Panel that the College bears the onus of proving the allegations against the Member on a balance of probabilities based upon clear, cogent and convincing evidence.

College Counsel also acknowledged that, to the extent other witnesses had provided evidence of Patient [A]'s statements or those of the Member, those statements would be considered hearsay. Hearsay, or second-hand information, is not admissible except in limited circumstances. Statements that fall within the limited circumstances are principled exceptions to hearsay and are admissible. College Counsel submitted that in order for hearsay evidence to be accepted, 2 criteria must be met: the evidence must be necessary, and it must be reliable evidence.

College Counsel submitted the case of *CNO v. Trudgen* (Discipline Committee, 2012) that defines, at page 6, the principled exception to the prohibition against hearsay evidence. Under a principled exception the Panel must first examine the necessity of allowing the hearsay evidence. Generally, this is applied when the person is not available to testify: for example, if the witness is ill, dead, or otherwise unable to attend. In this case, Patient [A] is deceased and the Member has not participated in the hearing.

Reliability is based on sufficient circumstantial evidence that can be trustworthy enough. In this case, Patient [A]'s information is inconsistent. The College's position is that this is not an

obstacle to Patient [A]'s statements because there is sufficient corroborating evidence of those statements. After the fact evidence statements made by Patient [A] to the healthcare professionals are consistent, documented in the progress notes as required by their professional obligations and completed contemporaneously. These are indications of reliability. The photos on Facebook further corroborate the evidence. When considered cumulatively, the relationship with the Member is supported by the truth of the evidence provided.

College Counsel submitted that the Member's statements can be accepted based on the rule of thumb that any statement made by an opposing party can be used against their interest and no liability analysis is needed.

College Counsel submitted that both the necessity and reliability criteria to admit hearsay evidence were met.

College Counsel then spoke to the evidence provided by the witnesses and expert witness. College Counsel submitted that, overall, each of the witnesses were clear, cogent, convincing and credible. Their verbal testimony is supported by documentation and each witness provided evidence in a forthright manner.

College Counsel submitted that the Panel ought to consider the following questions:

1. Was there a nurse-client relationship between the Member and Patient [A]?
2. Was Patient [A] vulnerable?
3. Did the Member and Patient [A] form an intimate relationship?

With respect to the first consideration, College Counsel submitted that there was a nurse-client relationship between the Member and Patient [A] as the Member provided care to Patient [A] and therefore was part of the care team. [Witness 4] and [Witness 5] confirmed that nurses provided care anytime during their shifts. The Medication Administration Records and the excerpts from the Medical Log show entries made by the Member proving she was indeed in a nurse-client relationship with Patient [A] while he was an inpatient at the Facility.

College Counsel submitted that Patient [A] was vulnerable. College Counsel referred to the considerable evidence of the complexity of Patient [A]'s case. [Witness 1], [Witness 2], [Witness 4] and [Witness 5] testified that Patient [A] struggled with substance abuse, fixated on women, was impulsive and demonstrated difficulty making decisions. His PTSD, ABI, physical restrictions and chronic pain were directly related to his role in Afghanistan. He suffered huge personal loss for his country. Any behaviours he exhibited do not detract from the responsibility of the Member to ensure the relationship was professional. The expert witness, Dr. Gallop was very clear: it is the nurse and/or other healthcare professional's absolute responsibility to maintain professional boundaries at all times.

Finally, College Counsel submitted that the Member and Patient [A] formed an intimate relationship. Patient [A] summarized their relationship in his email dated August 17, 2020,

where he describes the Member as his nurse/caregiver/fiancé. The start date of the relationship is unclear; however, it did start while she was still employed at the Facility and Patient [A] was an inpatient and had taken a therapeutic leave. The Member, who referred to herself as Natasha, on July 27, 2020, identified herself as caregiver and partner. She stated to [Witness 4] that Patient [A] had spent the weekend with her son and that he would be moving in with her. The Member was still employed until her resignation on July 31, 2020. Patient [A] discharged himself to live with the Member and provided the Member's address. In paragraphs 7, 12, 20, and 24 of Exhibit #2, the Affidavit of [the Prosecutions Clerk] the Member's address is listed and is the same address that Patient [A] provided as his own.

College Counsel referred to Patient [A]'s statement, disclosed to [Witness 1], that he "felt a lightning bolt, a soulmate". On July 30, 2020, he mentioned being a father figure to the Member's son. The term soulmate infers a romantic relationship, and these words were repeated when he spoke with [Witness 2]. Exhibit #17, 11 photos, the Member and Patient [A] kissing and embracing. Exhibit #5 is a photo he sent to [Witness 1] via text. The statements and photos infer an intimate relationship.

Patient [A] discharged himself and the Member resigned within a close time frame. They moved in together and the Member was identified, and identified herself, as caregiver, partner, and/or fiancé.

The inconsistencies in Patient [A]'s statements prior to his discharge do not need to be resolved to make findings of professional misconduct. It is a fact that the Member was employed by the Facility while Patient [A] was an inpatient and she provided direct care to him.

College Counsel acknowledged there is no direct evidence of a sexual relationship since Patient [A] and the Member are the only people who would have been able to testify directly to the sexual relationship but submitted that the Panel might infer a physical sexual relationship based on the evidence of touching, kissing, and failure to maintain professional boundaries.

Allegations #1(a), (b) and (c) assert that the Member committed acts of sexual abuse by touching of a sexual nature, sexual remarks and physical sexual relations which is supported by the *RHPA* definition of sexual abuse. For the purposes of defining sexual abuse, s. 1(6) of the *Health Professions Procedural Code* to the *RHPA 1991*, defines "patient" to include an individual who was a member's patient within one year from the date on which the individual ceased to be the member's patient. Section 1(3) defines "sexual abuse" to include touching, of a sexual nature, of the patient by the member, or behaviour or remarks of a sexual nature by the member towards the patient.

College Counsel provided three cases for consideration in making a finding of sexual abuse.

CPSO v. Porter (Discipline Committee, 2016): This case provides an objective determination for determining if kissing and hugging have a sexual nature. In this decision, the committee

considered the Supreme Court of Canada decision of *R v. Chase* [1987] that describes the test to be applied in determining whether the sexual integrity of the victim is violated:

> "Viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer". The part of the body touched, the nature of the contact, the situation in which it occurred, the words and gestures accompanying the act, and all other circumstances surrounding the conduct… … … Implicit in this view of sexual assault is the notion that the offense is one requiring a general intent only."

CNO v. Hohban (Discipline Committee, 2020): In this case there was a finding of professional misconduct of the member in that they touched and kissed the client. The *Health Professions Procedural Code* (s.1(6) to *RHPA 1991*, section 1(3)) is cited to support findings of sexual abuse.

CPSO v. Yaghini (Discipline Committee, 2016): The Committee found the member's attempted kiss and remarks were of a sexual nature towards the patient and constituted sexual abuse as defined in subsection 1(3) of the *Health Professions Procedural Code*.

Exhibit #17 shows photos posted on Facebook of the Member touching and kissing Patient [A] in a manner that observers would consider the behaviour to be sexual in nature. The individual was a patient and otherwise defenseless and the abuse continued for over 1 year after Patient [A] discharged himself from the Facility.

College Counsel requested that, on the basis of the evidence and case law, the Panel make a finding of sexual abuse for allegations #1(a), (b) and (c) in the Notice of Hearing.

With regards to allegations #2(a), (b), (c), (d), College Counsel submitted that the Member breached the *Professional Standards* and the *TNCR* Standard when she entered into a relationship with Patient [A] while he was still a patient. The Member prioritized her needs over Patient [A]'s and failed to establish and maintain a professional therapeutic relationship as defined in the *Professional Standards* including failure to maintain professional boundaries as defined in the *TNCR* Standard.

With respect to allegations #3(a), (b), (c) and (d), College Counsel submitted that the Member failed to set and maintain boundaries. She failed to recognize the need for increased vigilance in care settings with complex vulnerable populations. Patient [A]'s medical complexities were well known to the Member as was his treatment plan. The *TNCR* Standard specification for nurses to not enter into a personal, sexual or intimate relationship at any time during care and for one year following discharge is to protect the patient from harm. Despite this knowledge and Patient [A]'s vulnerabilities the Member breached the professional boundaries, entered into a personal and intimate relationship and failed to protect Patient [A] from abuse.

Boundary violation is often accompanied by secrecy and deception. The Member used deception when a discussion to move in together took place prior to Patient [A]'s therapeutic

leave. The Member referred to herself as Natasha and placed Patient [A] in the position to not disclose her name and any details for concern "she would lose her license to practice if it was made known she had an unprofessional relationship with a patient". The Member identified herself as caregiver, fiancé and nurse, thereby confusing Patient [A] and increasing the exploitation of a vulnerable patient.

Allegations #3(a), (b), (c) and (d) speaks to the professional misconduct that other members of the profession would view as dishonourable, disgraceful and/or unprofessional. College Counsel reiterated that the terms are disjunctive, and the Panel may determine these separately or together. In this case, College Counsel argued that the Member's conduct is all three in view of the vulnerability of Patient [A] and the Member's abuse of power.

The Member's conduct is unprofessional in that there was a consistent disregard to act with integrity. The Member knew her behaviour was unprofessional, conveyed this to Patient [A] and maintained secrecy while he was an inpatient and she was still employed and active in the nurse-client relationship.

The Member's conduct was dishonourable as the dishonesty demonstrated moral failing in using a different name, stating she had resigned from her job when she had not, and the intentional attempts to keep the relationship a secret while on duty and engaging Patient [A] in the deception.

The charge of disgraceful conduct shows a higher threshold of moral failing to such a degree that brings the reputation of the profession into disrepute. The Member practiced in a clinical setting with patients who were highly vulnerable. The Member disregarded the best interest of Patient [A] and chose to put her own needs first. The abuse of power calls in to question the Member's judgment and suitability to practice and shows a blatant and serious disregard for the profession.

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 and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs #1(a), (b), #2(a), (b), (d) and #3(a), (b), (d) in the Notice of Hearing. With respect to allegations #3(a), (b) and (d), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

As to allegations #1(c), #2(c) and #3(c), the Panel did not make findings of professional misconduct with regard to engaging in physical sexual relations. The inference of a physical sexual relationship, without direct evidence, was insufficient to make these findings and they were therefore dismissed.

Reasons for Decision

With respect to allegations #1(a) and (b) in the Notice of Hearing, the Member breached the *Professional Standards* and the *TNCR* Standard when she touched and kissed Patient [A]. The Member's misconduct is supported by the photographic evidence provided in Exhibit #17 and the definition of sexual abuse in the *Health Professions Procedural Code* to the *RHPA, 1991* section 1(3). The Act defines "sexual abuse" to include touching, of a sexual nature, of the patient by the member, or behaviour or remarks of a sexual nature by the member towards the patient. The allegation that kissing is considered touching of a sexual nature is also supported by the cases provided by College Counsel.

With respect to allegations #2(a) and (b) in the Notice of Hearing, the Member breached the *Professional Standards* and the *TNCR* Standard when she engaged in touching and behaviours of a sexual nature. Photographic evidence in Exhibit #17 supports the finding of professional misconduct.

With respect to allegation #2(d) in the Notice of Hearing, the Member breached the *Health Professions Procedural Code* to the *RHPA, 1991* section 1(6) by engaging in a relationship with an active patient. The Code defines "patient" to include an individual who was a member's patient within one year from the date on which the individual ceased to be the member's patient. The Member was a care provider at the Facility at the time the relationship with Patient [A] was initiated. The Member intentionally entered into a relationship with Patient [A] while he was an inpatient receiving active treatment, had him deceive his care team as to who she was and her qualifications and continued the relationship over one year following his discharge against medical advice.

The Panel accepted Dr. Gallop's evidence. Dr. Gallop stressed that the *TNCR* Standard is there to protect the client and she focused on 3 key actions that demonstrate how a nurse meets the standard to protect a patient from harm:

- not entering a friendship, or a romantic, sexual or other personal relationship with a [patient] when a therapeutic relationship exists;
- ensuring that after the nurse-[patient] relationship has been terminated, the nurse must not engage in a personal friendship, romantic relationship or sexual relationship with the [patient] or the [patient's] significant other for one year following the termination of the therapeutic relationship; and
- not engaging in behaviours with a [patient] or making remarks that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive.

The Member breached the *Professional Standards* and the *TNCR* Standard by failing to respect the requirement that "Nurses protect the client from harm by ensuring that abuse is prevented, or stopped and reported" and failed to maintain professional boundaries.

The *TNCR* Standard defines boundary as: "A boundary in the nurse-client relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal. Crossing a boundary means that the care provider is misusing the power in the relationship to meet her/his personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client. The misuse of power does not have to be intentional to be considered a boundary crossing." Dr. Gallop stressed that trust is a critical component of the nurse-client relationship.

The evidence confirms that the Member was with Patient [A] on his first therapeutic leave while she was still employed by the Facility, and he was in active care. Patient [A] texted [Witness 1] a photo and then spoke to her about his weekend with his new girlfriend—a "soulmate". Patient [A] spoke to staff and [Witness 2] and [Witness 4] regarding his weekend and his intention to move in with the Member. The Member spoke to [Witness 4] on July 27, 2020, called herself Natasha, stated that she would be Patient [A]'s caregiver, added his name "to the rent" and that he would be moving in with her and her son. She confirmed to [Witness 4] that they spent 3 days together and were very happy together.

The Member failed to recognize the breach in the *TNCR* Standard specifically by failing to protect Patient [A] from abuse; failed to identify Patient [A]'s vulnerabilities; exerted her power over Patient [A] to support her deceit by using a different name and requesting him not to divulge details of who she was for fear of losing her registration. In addition, the Member abused her position of power and influence and exploited Patient [A]'s vulnerabilities, resulting in lost opportunity for care. The Member planned and embarked on an intimate relationship while Patient [A] was still in active care while she was still employed at the Facility and part of his care team.

With respect to allegations #3(a), (b) and (d) in the Notice of Hearing, the Member's conduct would be viewed as dishonourable, disgraceful and unprofessional by other members of the profession.

The Member's conduct was clearly relevant to the practice of nursing and she knew her behaviour was unprofessional and proceeded with blatant disregard to act with integrity. Patient [A] shared with [Witness 1] that he would share her name only when he leaves the Facility because "…she will lose her license to practice if it is uncovered that she had an unprofessional relationship with a patient". He also shared that they would be moving in together prior to his therapeutic leave on July 25, 2020, with one of his workers.

The Member's conduct was dishonourable as there were elements of moral failing demonstrated by the intentional use of a different name and stating to a number of Patient [A]'s care team that she had resigned when she had not. The Member knew or ought to have known that her decision to resign 3 hours before the start of her shift would be a hardship for the Facility and risked patient safety.

The Member's conduct was disgraceful in that she acted in her own best interest at the expense of Patient [A]. She worked in a clinical setting where patients were highly vulnerable. Patient [A]'s history demonstrated an increased vulnerability to any form of affection and especially from women. The Member's attempts to keep the relationship a secret by using a different name, restricting Patient [A] from sharing who she is and where he would be living after discharge demonstrated an abuse of power and intentional deceit. The intentionality of her dishonest behaviour removed Patient [A] from access to care. She knew her behaviour was unprofessional and she purposefully disregarded the *Professional Standards* and the *TNCR* Standard.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should make an Order as follows:

1. Requiring Naomi Clark (the "Member") to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. Directing the Executive Director to immediately revoke the Member's certificate of registration.

College Counsel submitted that the penalty provides the only outcome to protect public safety specific to three key factors:

1. Reflecting the aggravating and mitigating factors;
2. Meeting the goal of penalty; and
3. Consistency with prior decisions.

The aggravating factors in this case were:

- The nature of the Member's relationship with Patient [A] overlapped with her professional relationship;
- The seriousness of the Member engaging in the relationship;
- The Member engaged in sexual abuse, defined as touching and kissing of a sexual nature;
- The Panel concluded that the relationship between the Member and Patient [A] was romantic rather than platonic;
- The Member should have been more diligent in her actions and behaviour given the clinical setting;
- Patient [A] was in a vulnerable position with multiple diagnoses that made him more susceptible to a therapeutic power imbalance;
- The Member demonstrated exploitation of that power imbalance;

- The Member commenced a relationship with Patient [A] while in a nurse-client relationship. It was clear the Member was in a professional relationship with Patient [A] on July 25, 2020, and continued in the relationship for over a year;
- The Member's deceitfulness in calling herself Natasha and asking Patient [A] to take part in the charade;
- The Member was instrumental in Patient [A] signing himself out against medical advice and losing his clinical supports; and
- The Member adopted a dual role as caregiver and fiancé blurring the line between therapeutic and non-therapeutic relationships.

The only mitigating factor in this case was that the Member did not have any prior discipline history with the College since her 2018 registration.

College Counsel submitted that the Member has failed to participate in the hearing resulting in increased costs to the College, has shown no remorse nor has she taken any responsibility with the College or the Panel.

The *Health Professions Procedural Code* directs the Panel to reprimand the Member, suspend or revoke registration if found guilty of sexual acts: physical acts or touching of a sexual nature. While there is no evidence that frank sexual acts occurred, the proposed penalty meets the goals of penalty including public safety.

The Member's conduct is quite serious and at the high end of culpability that includes sexual abuse, breach of the *TNCR* Standard and findings of dishonourable, disgraceful and unprofessional conduct.

College Counsel submitted that, in the circumstances of this case, rehabilitation and remediation are not appropriate. The Member has not shown any willingness to be governed by the College. Furthermore, rehabilitation and remediation are not necessary where there is revocation.

Specific deterrence is to assist the Member in not engaging in the behaviour in the future and general deterrence is intended to send a strong message to the profession that this behaviour will not be tolerated.

In this case specific deterrence would be achieved through the reprimand and revocation. The conduct cannot be repeated if the Member is no longer a nurse.

The revocation of registration sends a strong message to the profession that sexual abuse and breach of the standards will not be tolerated.

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

CNO v. Franklin (Discipline Committee, 2020): In this case, the member entered into an Agreed Statement of Facts and a Joint Submission on Order with the College, however, she did not attend the hearing. The allegations were similar to the case before this Panel. The setting was a mental health community treatment team. The member engaged in a personal relationship that including staying overnight in a hotel, staying overnight at the member's home and they kissed. The penalty included an oral reprimand and immediate revocation of the member's certificate of registration.

CNO v. Hubercheck (Discipline Committee, 2018): In this case, the member entered into an Agreed Statement of Facts and a Joint Submission on Order with the College. The member worked at a residential mental health facility in the Acute Stabilization Unit, an inpatient unit housed within the comprehensive psychiatric care unit. During the patient's stay, the member had a romantic relationship, including touching of a sexual nature, including kissing and sexual involvement post discharge. the penalty included an oral reprimand and immediate revocation of the member's certificate of registration.

College Counsel submitted that the Member's deceit, Patient [A]'s vulnerability and the seriousness of the allegations support the proposed penalty. While the Member's certificate of registration has expired, it is voluntary and can be undone by the Member. The Panel has the authority and jurisdiction to revoke the certificate of registration. The College recommends the Panel exercise this jurisdiction for this case.

Penalty Decision

The Panel accepts the College's Submission on Order and accordingly orders:

1. Naomi Clark (the "Member") is required to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. The Executive Director is directed to immediately revoke the Member's certificate of registration.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the College's ability to govern its members. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation.

The Panel concluded that the proposed penalty is reasonable and in the public interest and is appropriate in this case. The Member has not participated in the hearing, has not shown remorse, nor any willingness to be governed by the College. The public is protected with the revocation of the Member's certificate of registration and is therefore no longer a risk to the public. Specific deterrence is met through the oral reprimand and the revocation of the

Member's certificate of registration. General deterrence is met through the revocation of the Member's certificate of registration. This sends a strong message to the Member and to the profession that a sexual and personal relationship between a member and a patient will not be tolerated. As the Member's certificate of registration is revoked, the penalty need not address rehabilitation and remediation.

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

I, Michael Hogard, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.