DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Spencer Dickson, RN	Chairperson
	Carly Gilchrist, RPN	Member
	Deborah Graystone, NP	Member
	Margaret Tuomi	Public Member
	Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	MEGAN SHORTREED for
	)	College of Nurses of Ontario
- and -	)	
	)	
FAROUK PREMJI	)	ROBERT STEPHENSON for
Reg. No. 0396721	)	Farouk Premji
	)	
	)	
	)	LUISA RITACCA
	)	Independent Legal Counsel
	)	
	)	Heard: NOVEMBER 7, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on November 7, 2017 at the College of Nurses of Ontario ("the College") at Toronto. The Member was present and was represented by counsel. The hearing proceeded at 10:05 a.m.

At the request of the College and on being advised that the Member did not oppose the request, the Discipline panel made an Order banning the publication and broadcasting of the identity of the Client, and any information that could disclose the Client's identity, including any reference to the Client's name contained in the allegations in the Notice of Hearing and in any exhibits filed with the panel, pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991.

The Allegations

The allegations against Farouk Premji (the "Member") as stated in the Notice of Hearing of are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation* 799/93, in that while working as a Registered Nurse at McMaster Children's Hospital, Hamilton Health Sciences, in Hamilton, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, with respect to your inappropriate conduct and communication with the client, [the Client], from September 25 to September 26, 2015; 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(37) of *Ontario Regulation* 799/93, in that while working as a Registered Nurse at McMaster Children's Hospital, Hamilton Health Sciences, in Hamilton, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, with respect to your inappropriate conduct and communication with the client, [the Client], from September 25 to September 26, 2015.

Member's Plea

The Member admitted the allegations set out in paragraphs #1 and #2 of the Notice of Hearing. With respect to the allegations at paragraph #2, the Member admitted that the conduct would reasonably be regarded by members of the profession as unprofessional. The panel received a written plea inquiry, signed by the Member. The panel also conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

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. Farouk Premji (the "Member") obtained a diploma in nursing from Humber College in 2003.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on June 24, 2003.

3. The Member was employed at McMaster Children's Hospital, Hamilton Health Sciences (the "Hospital") from September 2012 to October 26, 2015, when his employment was terminated as a result of the incident described below. The Member grieved the termination of his employment and it was converted to a resignation.

PRIOR HISTORY

4. The Member has no prior disciplinary or fitness to practise findings with the College.

THE HOSPITAL

5. The Hospital is located in Hamilton, Ontario.

6. The Member worked as a part-time staff nurse in the Pediatric Emergency Department (the "Unit").

THE CLIENT

7. [the Client] (the "Client") was 16 years old at the time of the incident.

8. The Client arrived at the Unit at approximately 12:00 on September 25, 2015. He was suffering from abdominal pain, vomiting and weight loss.

9. The Client was accompanied by his mother, [the Client's Mother]

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

10. The Member worked the night shift on September 25, 2015 and was assigned to the Client's care.

11. After the Client had an MRI at approximately 22:30, [the Client's Mother] went to the washroom and the Client went for a walk to wait for the results.

12. When [the Client's Mother] returned to the Unit, the Client was sitting behind the nursing station with the Member looking at the Member's cell phone, which contained photos of the Member and his family. The Member was talking to the Client about Jailbreak, an application used to unlock older iPhones in order for the user to download free content.

13. If the Member were to testify, he would say that the only picture on his phone, which was used as wallpaper, was of his two children and that he never showed the Client pictures of his family. However, he acknowledges that the Client may have seen that personal photo on his phone when he was showing the Client the Jailbreak application.

14. The Member offered the Client his personal iPad to watch a movie. The Client watched "Straight Outta Compton," which is an "R" rated movie. If the Client were to testify, he would state that the Member selected this movie from his iPhone and downloaded it onto the iPad for the Client to watch. If the Member were to testify, he would say that he did not select or otherwise assist the Client with any downloads or choice of movies. The Member would further say that he only provided his iPad to the Client and offered his assistance with the Jailbreak application, all of which was done in the presence of the Client's mother.

15. The Client's MRI results were obtained and he was discharged around 01:00 on September 26, 2015. It was determined that the Client was experiencing abdominal pain and vomiting as a result of smoking marijuana.

16. Prior to the Client's discharge, the Member asked for the Client's cell phone number so he could send instructions on how to use Jailbreak on his iPhone. The Member and the Client exchanged cell phone numbers.

17. The following morning, the Client checked his cell phone and noticed text messages from the Member. He engaged in the following exchange with the Member via text message:

Member:	Hi [First name] its Farouk. Text me when you're up I have a question for you.
Client:	Hey and I haven't slept yet
Member:	Really? How come? How are you feeling?
Client:	Yea idk my stomachs been hurting a lot
Member:	oh no Like bad enough that you're going to go back to the hospital?
Client:	Well if I start throwing up again violently we might come back
Member:	Oh man. I'm sorry to hear that! Well I'm at home now. But if you do go back I'll be there again after 8 tonight What did the doc say was the reason for your pain? All the tests we did were normal
Client:	She said she doesn't know what's causing the pain or nausea
Member:	Hmmm not helpful Did you smoke any since you got home?
Client:	Nope I haven't had any its almost been 2 days
Member:	That's interesting. There is some evidence that shows weed can cause vomiting in teenagers. But you're having the pain without weed and when you do smoke it goes away right?
Client:	Yeaa
Member:	What quality is the weed you get?

I'm actually trying to find medical grade for a family member

Client: Good

Member: Do you think you could put me in touch with your guy? Let him know I'm ok? (Not a cop, not gonna bust him!)

Client: My guy doesn't serve medical marijuana, if you want the stuff for actual medical treatment go to a doctor or dispensary but I'm just not comfortable doing that

Member: I understand. That's fair. Would you ask if I can get in touch with him anyway. Not for medical grade. Just recreational? I'm finding it tough to find good stuff anywhere in Milton!

Client: Try even Hamilton or Toronto, I know Toronto has 2

Doc I wish I could help you out but I can't

Member: I understand. Could you ask your guy if I could get in touch with him? I just want a little for myself. Doesn't have to be medical grade. Just good.

Client: I wish I could help you out but I can't

…

Client: Thankss [sic]

Member: [First name] please also think about what I asked. You know I'm a nurse and a good guy. I'm just really looking for a reliable source for myself.

You needn't feel uncomfortable.

Client: Look I know I'm 16 but can't you get fired for this? And shouldn't a nurse or doctor know where to get dope? Why do you want it so bad from me?

Member: To be honest it's been literally years since I smoked and it's so hard to find someone if you don't already know them.

You're seriously the first person I've trusted to ask.

I just get a good vibe from you.

And I'm a nurse. And I have no idea where to get dope!

Lol

Guess I'm out of the loop

I'm sorry to have made you feel uncomfortable

Client: Yeah I guess you are but I just don't want anything to do with this cause it's heat idk you much

Member: What you mean heat?

Like I'll get you in trouble?

Client: I mean your [sic] an adult asking a 16 year old to hook him up with dope it's just making me really uncomfortable.

Member: I understand

I'm sorry

18. On October 6, 2015, [the Client's Mother] complained to the Hospital about the Member's conduct.

19. The Member would further testify that, although he provided the Client with his personal iPad to watch a movie, it was the Client who chose the movie, also in the presence of his mother.

20. The Member would further testify he turned to marijuana to help him cope with some relationship issues, which he now realizes was a foolish decision.

21. In any case, the Member admits that his interactions with the Client were a breach of the therapeutic nurse-client relationship and unprofessional conduct.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

22. The Member admits that he breached the *Therapeutic Nurse-Client Relationship* standard when he allowed the minor Client to watch an "R" rated movie on his iPad, showed the Client his personal cell phone, which contained family photos, exchanged phone numbers with the Client, initiated personal text messages with the Client, and repeatedly asked the Client to provide the contact information for his marijuana supplier.

23. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, by engaging in inappropriate conduct and communication with the Client from September 25-26, 2015 as described in paragraphs 9 to 22 above.

24. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, by engaging in conduct relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, with respect to his inappropriate conduct and communication with the Client from September 25-26, 2015 as described in paragraphs 9 to 22 above.

Decision

The panel finds that the Member committed acts of professional misconduct as alleged in paragraphs #1 and #2 of the Notice of Hearing. As to allegation #2, the panel finds that the Member engaged in conduct that would reasonably be considered by members of the profession to be unprofessional.

Reasons for Decision

The panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing. The panel also considered the advice of Independent Legal Counsel, that the allegations should be supported by the Agreed Statement of Facts and as such the Notice of Hearing was reviewed carefully.

Allegation #1 in the Notice of Hearing is supported by paragraphs 12, 13, 14, 16, 17, 19, 21, 22 and 23 in the Agreed Statement of Facts.

Allegation #2 in the Notice of Hearing is supported by paragraphs 12, 13, 14, 16, 17, 19, 21 and 24 in the Agreed Statement of Facts.

With respect to Allegation # 2, the panel finds that the Member's conduct was unprofessional. The Member crossed the therapeutic nurse-client boundaries as set out in the standards and as expected of nurses. It demonstrated a serious and repeated disregard for his professional obligations. The Member admits to engaging with the Client in a non-therapeutic interaction by allowing the minor to watch an "R" rated movie on his iPad and by showing the Client his personal cellphone which contained family photos. The Member exchanged phone numbers with the Client, initiated and continued to engage in personal text messages that repeatedly asked the Client to provide contact information for a marijuana supplier. The behaviour revealed a complete disregard for the Member's obligations.

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 his 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 his 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 his certificate of registration;

b) For a period of 12 months from the date the Member's suspension ends, the Member will notify his 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 his 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. The Member's Counsel indicated that he agreed with those submissions.

The parties agreed that the mitigating factors in this case were as follows: the Member does not have a prior history with the College; he was forthcoming, and cooperative; and, as Member's Counsel reminded the panel, the Member is very remorseful believing his behaviour was inappropriate, as he was coping with personal circumstances at this time. The Member waived the right to appeal the decision within 30 days. The Member was prepared to accept the Joint Submission on Order.

There were also aggravating factors in this case. The Client was a minor who presented in Pediatric Emergency Room. The Member initiated the non-therapeutic contact by allowing the minor Client to watch an "R" rated movie on his iPad, showed the Client his personal cellphone which contained family photos, exchanged phone numbers with the Client and ultimately initiated personal text messages with the Client. On those text messages the Member repeatedly asked the Client to provide contact information for his marijuana supplier.

College Counsel stated that the Joint Submission on Order was the product of lengthy negotiations. The agreement reached is reasonable and in the public interest and meets the goals of penalty by striking a balance. The suspension and oral reprimand act as both specific and general deterrents. The penalty sends a strong message to the profession that these actions will not be tolerated. Remediation and rehabilitation are attained through the meeting with the Nursing Expert, as well as through the employer notification provision. The College submitted that the penalty as a whole makes clear that public protection is paramount and that the conduct at issue is simply not acceptable for the profession as a whole.

College Counsel stated that the Joint Submission on Order is consistent with other decisions from other panels of the Discipline Committee, but reminded this panel that they are not perfect parallels.

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

College of *Nurses of Ontario v. Ruel Hufano* (June 22, 2010). In this case the Member became roommates with the Client, he failed to disclose this relationship when the Client was readmitted into hospital. The penalty was an oral reprimand, 2-month suspension, 3 meetings with a Nursing expert and employer notification for a period of 12-months.

College of *Nurses of Ontario v. Annette Aubut* (February 9, 2009). In this case the Member had a relationship with the Client outside the clinical setting. The Client would stay at the Member's home and would use her mailing address to receive mail. The Member and the Client would exchange emails. There was minor physical contact. The panel found the Member acted in an unprofessional manner. The penalty was an oral reprimand, 3-month suspension, 3 meetings with a Nursing expert and employer notification for a period of 24-months.

College of *Nurses of Ontario v. Joseph John Andrew* (January 12, 2016). In this case the Member failed to maintain appropriate documentation as well as crossed professional boundaries. The panel found the Member acted in an unprofessional manner. The penalty was an oral reprimand, 2-month suspension, 2 meetings with a Nursing expert and employer notification for a period of 12-months s.

College of *Nurses of Ontario v. Betty- Lou Homer* (October 24, 2013). In this case the Member's conduct was more serious in nature. The Member worked with a vulnerable population and would stay over at the home of her Clients and failed to maintain appropriate therapeutic boundaries. The panel found the Member acted in a disgraceful and unprofessional in nature. The penalty was an oral reprimand, 4-month suspension, 2 meetings with a Nursing expert and employer notification for a period of 12-months.

Independent legal counsel's advice to the panel was that Joint Submissions on Order should be accepted unless to do so would bring the administration of this process into disrepute or would otherwise be contrary to the public interest. Counsel also confirmed that the panel should take comfort in the previous decisions provided and which reveal the proposed penalty falls within a reasonable range.

Penalty Decision

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

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

2. The Executive Director is directed to suspend the Member's certificate of registration for three months. This suspension shall take effect from the date 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 his 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 his 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 his certificate of registration;

b) For a period of 12 months from the date the Member's suspension ends, the Member will notify his 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 his 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 nurses to self-regulate. 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. The penalty is in line with what has been ordered in previous cases

The penalty provides protection for the public. It provides a strong message to the profession that nurses must practice according to standards regardless of their practice setting and that at all times appropriate boundaries in the nurse/client relationship must be maintained. The public is protected when nurses practice according to standards and are mindful that their relationship with clients is a professional relationship for therapeutic purposes rather than a personal relationship for friendship.

I, Spencer Dickson, 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