

**DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO**

PANEL:	Susan Roger, RN	Chairperson
	Mary MacNeil, RN	Member
	Donna May, RPN	Member
	Fidelia Osime	Public Member
	Lalitha Poonasamy	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO)	<u>HAILEY BRUCKNER</u> for
)	College of Nurses of Ontario
- and -)	
)	
SHAHIN FARROKHBAKHT)	<u>LINDA MILLMAN</u> , Paralegal for
Registration No. JJ05405)	Shahin Farrokhbakht
)	
)	<u>PATRICIA HARPER</u>
)	Independent Legal Counsel
)	
)	Heard: January 21, 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”) on January 21, 2022, via videoconference.

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 the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented at the Discipline hearing of Shahin Farrokhbakht.

The Panel considered the submissions of College Counsel and the Member’s Representative and decided that there be an order preventing public disclosure and banning the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented in the Discipline hearing of Shahin Farrokhbakht.

The Allegations

The allegations against Shahin Farrokhbakht (the “Member”) as stated in the Notice of Hearing dated January 4, 2022 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(18) of *Ontario Regulation 799/93*, in that while registered as a Registered Practical Nurse, you contravened a term, condition or limitation on your certificate of registration, as provided in subsections 1.5(1)1.(iv) of *O. Reg. 275/94*, in that you failed to provide the College of Nurses of Ontario (“CNO”) with details of an investigation, inquiry or proceeding for professional misconduct that you were subject to, undertaken by the College of Massage Therapists of Ontario, as follows:
 - a. Between October 2012 and February 2014, for allegedly failing to keep records as required;
 - b. Between December 2017 and February 2019, for alleged inappropriate billing practice(s); and/or
 - c. Between February 2018 and February 2019, for allegedly burning and injuring a patient during laser hair removal in January 2018; 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(15) of *Ontario Regulation 799/93*, in that while registered as a Registered Practical Nurse, you signed or issued, in your professional capacity, a document that you knew or ought to know contains a false or misleading statement, as follows:
 - a. From 2013 to 2019, you provided false and/or misleading information to CNO in your annual membership renewal forms for 2014 to 2020, in that you indicated that you were employed by [Doctor A] when you were not; 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 a Registered Practical Nurse, you engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, as follows:
 - a. You failed to provide CNO with the details of an investigation, inquiry or proceeding for professional misconduct that you were subject to, undertaken by the College of Massage Therapists of Ontario:

- i. Between October 2012 and February 2014, for allegedly failing to keep records as required;
 - ii. Between December 2017 and February 2019, for alleged inappropriate billing practice(s); and/or
 - iii. Between February 2018 and February 2019, for allegedly burning and injuring a patient during laser hair removal in January 2018; and/or
- b. From 2013 to 2019, you provided false and/or misleading information to CNO in your annual membership renewal forms for 2014 to 2020, in that you indicated that you were employed by [Doctor A] when you were not.

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Shahin Farrokhbakht (the "Member") obtained a certificate in nursing from Riverside Technology Centre in Quebec in 1996. The Member obtained a diploma in nursing from George Brown College in 2010.
2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on January 10, 2000.
3. As of December 25, 2020, the Member changed her registration status to "Non-Practicing." She is not currently entitled to practice nursing in Ontario.
4. The Member registered with the College of Massage Therapists of Ontario ("CMTO") on January 30, 2008, after her initial registration with CNO.
5. Massage therapy, like nursing, is a regulated profession under the *Regulated Health Professions Act, 1991*, as amended (the "*RHPA*"). The practice of massage therapy is regulated by CMTO.

6. The Member provided an undertaking to permanently resign her certificate of registration with CMTO effective February 23, 2018.
7. The Member works as an esthetician and hair laser technician. She provides these services at the Clear Skin Clinic and Laser Hair Removal (the "Clear Skin Clinic").

PRIOR HISTORY

8. The Member has no prior disciplinary findings with CNO.

PART I. PARAGRAPHS 1 AND 3(A) OF THE NOTICE OF HEARING

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT – PARAGRAPHS 1 AND 3(a) OF THE NOTICE OF HEARING

Failure to Report CMTO Investigations

9. The Member was subject to several CMTO investigations, inquiries or proceedings for professional misconduct, incompetence or incapacity or any similar investigation from 2013 to 2019.
10. As set out in the "Member's Reporting Obligations" section below, the Member was obligated to provide the details of the CMTO investigations, inquiries or proceedings to CNO.
11. The Member admits that she failed to meet her reporting obligation in respect of each of the investigations, inquiries, or proceedings described below.

1. CMTO Investigation: 2013 – 2014

12. CMTO designs and administers a quality assurance program in accordance with s. 80 of the *Health Professions Procedural Code* (the "Code"), Schedule 2 to the *RHPA*.
13. A quality assurance program prescribed under s. 80 shall include continuing education or professional development designed to promote continuing competence and continuing quality improvement among the members. A quality assurance program must include self and peer practice assessments and a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.
14. As part of CMTO's quality assurance program, the Member participated in a peer assessment on October 2, 2012. The assessor found that the Member's practice in the area of record keeping did not appear to meet CMTO standards of practice. The Member was asked to participate in a record keeping remediation program, but declined to do so.

15. On February 6, 2013, CMTO's Quality Assurance Committee ("QAC") referred the Member to its Inquiries, Complaints and Reports Committee ("ICRC") for allegedly failing to keep records as required (the "2013 QA Referral").
16. The Registrar of CMTO appointed an investigator on April 3, 2013.
17. Once the investigation was completed, the Registrar of CMTO provided a report dated June 25, 2013 to a panel of the ICRC.
18. A panel of CMTO's ICRC reviewed the report of the Registrar and response of the Member. On February 11, 2014, the ICRC disposed of the 2013 QA Referral by ordering the Member to complete a Specified Continuing Education and Remediation Program ("SCERP") and issuing a verbal caution.
19. The Member admits and acknowledges that she did not report the 2013 QA Referral, or the ICRC's disposition on February 11, 2014, to CNO.

2. CMTO Investigations: 2017 – 2019

(i) 2017 QA Referral

20. On December 20, 2017, CMTO's QAC referred concerns about the Member's billing practices to its ICRC (the "2017 QA Referral"). It was alleged that the Member was writing receipts for massage therapy based on the client's insurance coverage, instead of the service provided.
21. The Member was notified that her conduct had been referred to the ICRC on December 7, 2017. The Registrar appointed an investigator on November 15, 2018.
22. The Member admits and acknowledges that she did not report the 2017 QA Referral to CNO.

(ii) The Complaint

23. In or around February 13, 2018, CMTO received a complaint from an individual who had received laser hair removal treatment from the Member in January 2018, and alleged that she had severe burns, injuries, and pain as a result (the "Complaint").
24. The Member responded to the Complaint by letter on February 22, 2018. She stated that the Complaint was frivolous and made in bad faith.
25. A panel of CMTO's ICRC requested an investigation of the Complaint pursuant to subsection 75(1)(c) of the *Code*.
26. The Registrar of CMTO appointed an investigator on May 10, 2018.

27. The Member admits and acknowledges that she did not report the Complaint, or the appointment of an investigator, to CNO.

(iii) The Acknowledgement and Undertaking

28. On February 4, 2019, the Member executed an Acknowledgment and Undertaking with CMTO in which she acknowledged the 2017 QA Referral and the Complaint. The Member further acknowledged that notwithstanding the fact that she had resigned her certificate of registration with CMTO effective February 23, 2018, CMTO retained jurisdiction over the Member for conduct that occurred while she was a member of CMTO.
29. The Member denied the allegations raised in both the 2017 QA Referral and the Complaint, but undertook never to reapply for membership, registration, licensure or similar status with CMTO to resolve the Complaint and 2017 QA Referral.
30. In exchange for the Undertaking, CMTO agreed that the ICRC would take no action against the Member with respect to the allegations in the Complaint and 2017 QA Referral.
31. On February 5, 2019, a panel of CMTO's ICRC disposed of both the 2017 QA Referral and the Complaint (in separate decisions). The ICRC accepted the Member's undertaking and took no further action in respect of either matter.
32. CMTO did not make a finding of professional misconduct against the Member in relation to the 2017 QA Referral or Complaint.
33. The Member admits and acknowledges that she did not report the Acknowledgment and Undertaking with CMTO, to CNO.

THE MEMBER'S REPORTING OBLIGATIONS – TERMS, CONDITIONS AND LIMITATION ON THE MEMBER'S CERTIFICATE OF REGISTRATION

34. In accordance with subsections 1.5(1)1.(iv) of *O. Reg. 275/94*, every certificate of registration with CNO is subject to terms, conditions, and limitations, including but not limited to the following:

The member shall provide to the Executive Director the details of any of the following that relate to the member and occur or arise on or after the day that the member was issued a certificate of registration:

A current investigation, inquiry or proceeding for professional misconduct, incompetence or incapacity or any similar investigation or proceeding in relation to the practice of nursing or another profession in any jurisdiction.

35. The *Health Professions Procedural Code of the Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93*, expressly

establishes that failure to comply with a term, condition, or limitation on a certificate of registration constitutes an act of professional misconduct.

36. The obligation to provide the Executive Director of CNO with details of any current investigation, inquiry or proceeding for professional misconduct, incompetence or incapacity or any similar investigation or proceeding in relation to the practice of nursing or another profession in any jurisdiction, has been in force since 2012, including at the time of the incidents described below.
37. Massage therapy is a regulated profession under the *RHPA*. The Member had an obligation to provide CNO with the details of CMTO's investigations, inquiries, or proceedings concerning her message therapy practice.
38. The Member admits that she did not provide CNO with any information about the 2013 QA Referral, the 2017 QA Referral, or the Complaint, via the Executive Director of CNO (or via any other means).
39. If the Member were to testify, she would say that she was not aware of her obligation to provide CNO with the details of CMTO's investigations, inquiries, or proceedings concerning her massage therapy practice. She would further state that she takes accountability for, and regrets, her failure to report the details of these investigations, inquiries or proceedings to CNO. The Member would testify that she understands that it was her responsibility to familiarize herself with her professional obligations and that she will ensure that she acts in accordance with those obligations going forward.

PART II. PARAGRAPHS 2 AND 3(B) OF THE NOTICE OF HEARING

THE MEMBER'S REPORTING OBLIGATIONS – ANNUAL MEMBERSHIP RENEWAL FORMS

40. Each year, members of CNO must renew their membership with CNO to continue practicing as a nurse in Ontario. The renewal process involves answering questions about employment status, areas of practice, and education, as well as paying an annual fee. The annual membership renewal process helps to ensure that everyone practicing as a nurse in Ontario is registered with CNO, and that their information is accurate and up-to-date.
41. CNO's Bylaw 44.2.02 specifies that each member is to accurately complete and return the annual membership renewal form with the requested information set out therein.
42. Section 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(15) of *Ontario Regulation 799/93*, provides that it is an act of professional misconduct to sign or issue, in a member's professional capacity, a document that the member knew or ought to know contains a false or misleading statement.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT - PARAGRAPHS 2 AND 3(b) OF THE NOTICE OF HEARING

The Member's Annual Membership Renewal Forms: 2014 – 2021

43. The Member admits and acknowledges that she reported the following details about her employment on her Annual Membership Renewal Forms from 2014 to 2021:
- (a) In the Member's Annual Membership Renewal Form for 2014, the Member reported that she had been employed by [Doctor A] since 2011. The Member further reported that she was employed part-time as an office nurse in a physician's office.
 - (b) In the Member's Annual Membership Renewal Form for 2016, the Member described her employment relationship as "self-employed," but also listed [Doctor A] as her employer and stated that she worked as a casual staff nurse in a physician's office.
 - (c) In the Member's Annual Membership Renewal Forms for 2015, 2017, 2018, and 2019, the Member reported that she was employed as a casual staff nurse by [Doctor A].
 - (d) In the Member's Annual Membership Renewal Form for 2020, the Member reported that her employment with [Doctor A] started in December 2011 and ended in April 2017. She reported a casual employment relationship with [Doctor A], in which she was "on call for injections" and her primary area of practice was "Foot Care".
 - (e) In the Member's Annual Membership Renewal Form for 2021, the Member reported that she was self-employed at the Clear Skin Clinic and no longer practicing nursing.
44. If [Doctor A] were to testify, she would state that she never employed the Member in any capacity. Rather, [Doctor A] provided orders to the Member for, and supervised the Member during, the administration of Botox. According to [Doctor A], as of 2019, it had been at least two years since [Doctor A] provided an order to the Member or supervised the Member during the administration of Botox.
45. The Member admits that she provided false and/or misleading information to CNO in her Annual Membership Renewal Forms for 2014 to 2020. She reported to CNO, in her professional capacity, that she was employed by [Doctor A]. The Member admits that this information was false and misleading, as she was never employed by [Doctor A].
46. The Member further admits that [Doctor A] has not supervised her in, or provided her with an order for, the administration of Botox since 2017. The Member admits that she

reported a casual employment relationship with [Doctor A] to CNO, in her professional capacity, on her Annual Membership Renewal Forms for 2018 and 2019. The Member admits that this information was false and misleading in that she was never employed by [Doctor A] and [Doctor A] ceased supervising the Member's administration of Botox in 2017.

PART III. ADMISSIONS OF PROFESSIONAL MISCONDUCT

47. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, in that she contravened a term, condition or limitation on her certificate of registration, as described in paragraphs 9-39 above.
48. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, in that she signed or issued, in her professional capacity, a document that she knew or ought to know contained a false or misleading statement, as described in paragraphs 40-46 above.
49. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a) and 3(b) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 9-39 and 40-46 above.

Decision

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

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

Reasons for Decision

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

Allegations #1(a), 1(b) and 1(c) in the Notice of Hearing are supported by paragraphs 9-39 and 47 in the Agreed Statement of Facts. The Member was subject to several investigations by the College of Massage Therapists of Ontario ("CMTO") from 2013 to 2019. The investigations were related to alleged poor record keeping, alleged inappropriate billing and the alleged burning of a patient during hair removal. In 2014, the Member was ordered by CMTO to complete a Specified Continuing Education and Remediation Program ("SCERP") for her poor record keeping. In 2017, the Member was referred to CMTO's Inquiries, Complaints and Reports Committee ("ICRC") for alleged inappropriate

billing practices. In 2018, CMTO's ICRC appointed an investigator to investigate a complaint against the Member for allegedly burning a patient. The Member admitted that none of these investigations were reported to the College. In the Agreed Statement of Facts, at paragraph 39, the Member indicated she was not aware of her obligation to provide the College with details of the CMTO's investigations, inquiries or proceedings concerning her massage therapy practice. However, the legislation in subsections 1.5(1)1.(iv) of *O. Reg. 275/94* is clear that the investigations such as those conducted by CMTO are reportable to the College. The Member's lack of knowledge of this obligation is not an excuse and does not relieve her from that obligation.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 40-46 and 48 in the Agreed Statement of Facts. From 2013 to 2019 the Member admitted that she reported to the College in her annual membership renewal form that she was employed by a physician. The Member admitted this information was false and misleading. When the Member signed her annual membership renewal form, she knew or ought to have known that she was entering misleading information about her employment status.

With respect to allegations #3(a)(i), (ii), (iii) and 3(b), the Panel finds that the Member's conduct in failing to provide the College with details of the investigation and entering false information in the College's annual membership renewal form as presented in paragraphs 9-39, 40-46 and 49 was unprofessional and dishonorable. The Member's conduct was unprofessional as it showed a serious and persistent disregard for her professional obligations. Submitting accurate information to the College about investigations and/or employment status is an important aspect of the obligation nurses have as members of a self-regulating College. Ignoring professional obligations leads to mistrust by the public and therefore can impact all members.

The Panel also finds that the Member's conduct was dishonorable in that it showed an element of dishonesty and deceit. The Member failed to disclose repeated investigations by the CMTO. For six years the Member deliberately lied on her annual membership renewal form. This is also evidence of a moral failing by the Member. The Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

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

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.
2. Directing the Executive Director to suspend the Member's certificate of registration for 2 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. 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 CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):
 1. *Professional Standards*,
 2. *Code of Conduct*, and
 3. *Self Reporting Form/Reporting Guide*;
 - iv. At least 7 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 patients, colleagues, profession and self,
 3. strategies for preventing the misconduct from recurring,
 4. the publications, questionnaires and modules set out above, and
 5. the development of a learning plan in collaboration with the Expert;
 - vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
 2. that the Expert received the required documents from the Member,
 3. that the Expert reviewed the required documents and subjects with the Member, and
 4. the Expert's assessment of the Member's insight into her behaviour;
- vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;
- b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
- i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
 - ii. Provide her employer(s) with a copy of:
 1. the Panel's Order,
 2. the Notice of Hearing,
 3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. a copy of the Panel's Decision and Reasons, once available;
 - iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
 1. that they received a copy of the required documents, and
 2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession.
4. All documents delivered by the Member to the CNO, the Expert and 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 aggravating factors in this case were the Member's serious and persistent disregard for her professional obligations and her failure to report to the College, over several years, the investigations that were being conducted by CMTO.

The mitigating factors in this case were that the Member took responsibility for her actions and cooperated with the College by entering into an Agreed Statement of Facts and a Joint Submission on Order. The Member also had no discipline history with the College.

The proposed penalty provides for general deterrence through the 2 month suspension of the Member's certificate of registration as it sends a message to other members of the College that conduct of this nature is unacceptable.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2 month suspension of the Member's certificate of registration as it demonstrates the seriousness of the conduct to the Member.

The proposed penalty provides for remediation and rehabilitation through a review of the College's publications and resources as well as the 2 meetings with a Regulatory Expert.

Overall, the public is protected through the 18 months of employer notification as there will be greater vigilance by the employer on the Member's return to practice.

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

CNO v. Smith (Discipline Committee, 2015): While registered with the College, the member was found to have committed acts of professional misconduct by a Board of Nursing in another jurisdiction. The member entered into a Consent Order but failed to comply with the terms and her license was subsequently revoked. The member failed to report that she had been the subject of an investigation to the College. The member also had no prior discipline history with the College. The member was found to have engaged in professional misconduct and the penalty included an oral reprimand, a three month suspension with similar terms, conditions and limitations as the current case before this Panel, including two meetings with a Nursing Expert, 18 months of employer notification and no independent practise in the community for a period of 12 months.

CNO v. Ladipo (Discipline Committee, 2019): The member was registered with the College of Registered Nurses of Manitoba ("CRNM") during a time when he was also registered with the College. In 2016, the member had conditions put on his license by the CRNM but failed to report these to the College. In 2017, the member had additional allegations for professional misconduct with the College and the penalty included an oral reprimand, a five month suspension with similar terms, conditions and limitations as the current case before this Panel, including a minimum of two meetings with a Regulatory Expert, 18 months of employer notification and six random spot audits of the member's practice.

Submissions were made by the Member's Representative.

The Member's Representative agreed with the Joint Submission on Order. She submitted that the Member was not aware of her obligations to report, but that the Member acknowledges that she should have been. The Member's Representative submitted mitigating factors, including that the Member attended the hearing, cooperated with the College and agreed to the terms of the Joint Submission on Order. The Member's Representative submitted that the Member has had no complaints from the medical colleagues with whom she has worked.

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 2 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. 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 CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

1. *Professional Standards,*
 2. *Code of Conduct,* and
 3. *Self Reporting Form/Reporting Guide;*
 - iv. At least 7 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 patients, colleagues, profession and self,
 3. strategies for preventing the misconduct from recurring,
 4. the publications, questionnaires and modules set out above, and
 5. the development of a learning plan in collaboration with the Expert;
 - vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:
 1. the dates the Member attended the sessions,
 2. that the Expert received the required documents from the Member,
 3. that the Expert reviewed the required documents and subjects with the Member, and
 4. the Expert's assessment of the Member's insight into her behaviour;
 - vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;
- b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
- i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
 - ii. Provide her employer(s) with a copy of:
 1. the Panel's Order,

2. the Notice of Hearing,
 3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. a copy of the Panel's Decision and Reasons, once available;
- iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
1. that they received a copy of the required documents, and
 2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession.
4. All documents delivered by the Member to the CNO, the Expert and the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The penalty provides for general deterrence through the 2 month suspension of the Member's certificate of registration and for specific deterrence through the oral reprimand and the 2 month suspension of the Member's certificate of registration. The proposed penalty also provides for remediation and rehabilitation through a review of the College's publications and resources as well as the 2 meetings with a Regulatory Expert. The public is protected through the 18 months of employer notification.

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

I, Susan Roger, 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.