DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Ingrid Wiltshire-Stoby, RN	Chairperson
	David Edwards, RPN	Member
	George Rudanycz, RN	Member
	Margaret Tuomi	Public Member
	Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	MEGAN SHORTREED for College of Nurses of Ontario
- and -	)	
DAVID LITTLE Registration # 0412650	)	NO ONE PRESENT for David Little
	)	JUSTIN SAFAYENI Independent Legal Counsel
	)	Heard: AUGUST 23 & 24, 2017

DECISION AND REASONS

This matter came on for hearing before a Panel of the Discipline Committee on August 23, 2017 and August 24, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

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

Counsel for the College provided the Panel with evidence that the Member had been served with the Notice of Hearing on July 17, 2017. The Panel was satisfied that the Member had received adequate notice and therefore proceeded with the hearing in the Member's absence

At the request of the College, the Panel ordered a publication and broadcasting ban prohibiting the publication of the names, addresses or any other identifying information of the clients referred to in the hearing and in any of the documents filed in the hearing. In addition, the Panel ordered a ban on the public disclosure of exhibits #32 and #33 entered in this matter.

The Allegations

Counsel for the College advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 2(d), 3(d), and 4(d) of the Notice of Hearing dated July 5, 2017. The Panel granted this request. The remaining allegations set out in the Notice of Hearing are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(a) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, in that on January 5, 2017, you were found guilty of offences relevant to your suitability to practise nursing, as follows:

    a. on or about the 6th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client A], contrary to Section 266 of the *Criminal Code*; and/or

    b. on or about the 7th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client A], contrary to Section 266 of the *Criminal Code*; and/or

    c. on or about the 8th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client B], contrary to Section 266 of the *Criminal Code*; and/or

    d. on or about the 13th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client B], contrary to Section 266 of the *Criminal Code*; and/or

    e. on or about the 13th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client B], contrary to Section 266 of the *Criminal Code*; and/or

    f. on or about the 20th day of December in the year 2015 in the Town of Kingsville in the Southwest Region, you did commit an assault on [Client A], contrary to Section 266 of the *Criminal Code*; 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 employed by Community Living Essex County in Kingsville, Ontario (the

"Facility"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as follows:

a. on or about December 6, 2015, you punched [Client A] with a closed fist in the face; and/or

b. on or about December 7, 2015, you struck [Client A] twice with a closed fist in her head and face; and/or

c. on or about December 7 or 8, 2015, you pulled [Client B's] pants and adult guard off and threw her soiled adult guard on the ground beside a garbage pail, pointed to the garbage can, and/or struck her on the side of her head with a closed fist; and/or

d. [*Withdrawn*]; and/or

e. on or about December 12 or 13, 2015, you threw [Client B's] adult guard and pants on the ground and then pointed to the client's soiled adult guard to have the client pick it up, stepped on her hand, grabbed her arm roughly, struck her in the head with a closed fist, and/or yanked her from the toilet forcefully; and/or

f. on or about December 20, 2015, you struck [Client A] in the face; and/or

g. on or about December 6, 2015, you grabbed [Client A's] hands to make her tuck her bed sheet into her mattress; and/or

h. on or about December 6, 2015, you stood behind a chair [Client A] was sitting in and aggressively pushed the client's chair two times into a table; and/or

i. on or about December 7, 2015, you urinated in [Client B's] bathroom with the client present and struck her in the head with your fist; and/or

j. on or about December 12, 2015, you entered [Client A's] bathroom while she is in the shower and punched her in the face with your fist; and/or

k. on or about December 15, 2015, you grabbed [Client B's] arm and pulled her towards you, and/or grabbed the back of the client's neck and forced her toward the garbage; and/or

l. on or about December 16, 2015, you struck [Client A] in the head; and/or

m. on or about December 19, 2015, you struck [Client A] in the face with a hairbrush; 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(7) of *Ontario Regulation* 799/93, in that

while employed at the Facility, you abused a client verbally, physically or emotionally, as follows:

a. on or about December 6, 2015, you punched [Client A] with a closed fist in the face; and/or

b. on or about December 7, 2015, you struck [Client A] twice with a closed fist in her head and face; and/or

c. on or about December 7 or 8, 2015, you pulled [Client B's] pants and adult guard off and threw her soiled adult guard on the ground beside a garbage pail, pointed to the garbage can, and/or struck her on the side of her head with a closed fist; and/or

d. [*Withdrawn*]; and/or

e. on or about December 12 or 13, 2015, you threw [Client B's] adult guard and pants on the ground and then pointed to the client's soiled adult guard to have the client pick it up, stepped on her hand, grabbed her arm roughly, struck her in the head with a closed fist, and/or yanked her from the toilet forcefully; and/or

f. on or about December 20, 2015, you struck [Client A] in the face; and/or

g. on or about December 6, 2015, you grabbed [Client A's] hands to make her tuck her bed sheet into her mattress; and/or

h. on or about December 6, 2015, you stood behind a chair [Client A] was sitting in and aggressively pushed the client's chair two times into a table; and/or

i. on or about December 7, 2015, you urinated in [Client B's] bathroom with the client present and struck her in the head with your fist; and/or

j. on or about December 12, 2015, you entered [Client A's] bathroom while she is in the shower and punched her in the face with your fist; and/or

k. on or about December 15, 2015, you grabbed [Client B's] arm and pulled her towards you, and/or grabbed the back of the client's neck and forced her toward the garbage; and/or

l. on or about December 16, 2015, you struck [Client A] in the head; and/or

m. on or about December 19, 2015, you struck [Client A] in the face with a hairbrush; and/or

4. 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 employed at the Facility, 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, as follows:

a. on or about December 6, 2015, you punched [Client A] with a closed fist in the face; and/or

b. on or about December 7, 2015, you struck [Client A] twice with a closed fist in her head and face; and/or

c. on or about December 7 or 8, 2015, you pulled [Client B's] pants and adult guard off and threw her soiled adult guard on the ground beside a garbage pail, pointed to the garbage can, and/or struck her on the side of her head with a closed fist; and/or

d. [*Withdrawn*]; and/or

e. on or about December 12 or 13, 2015, you threw [Client B's] adult guard and pants on the ground and then pointed to the client's soiled adult guard to have the client pick it up, stepped on her hand, grabbed her arm roughly, struck her in the head with a closed fist, and/or yanked her from the toilet forcefully; and/or

f. on or about December 20, 2015, you struck [Client A] in the face; and/or

g. on or about December 6, 2015, you grabbed [Client A's] hands to make her tuck her bed sheet into her mattress; and/or

h. on or about December 6, 2015, you stood behind a chair [Client A] was sitting in and aggressively pushed the client's chair two times into a table; and/or

i. on or about December 7, 2015, you urinated in [Client B's] bathroom with the client present and struck her in the head with your fist; and/or

j. on or about December 12, 2015, you entered [Client A's] bathroom while she is in the shower and punched her in the face with your fist; and/or

k. on or about December 15, 2015, you grabbed [Client B's] arm and pulled her towards you, and/or grabbed the back of the client's neck and forced her toward the garbage; and/or

l. on or about December 16, 2015, you struck [Client A] in the head; and/or

m. on or about December 19, 2015, you struck [Client A] in the face with a hairbrush.

Member's Plea

Given that the Member was neither present nor represented, he 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 was a Registered Practical Nurse ("RPN") with the College since 1997. He resigned his registration as an RPN, and became a Registered Nurse with the College in 2004.

The Member was hired on May 6, 2015 as a Part Time Support Worker at [the Site] with Community Living Essex County. It was noted that while this was not a nursing position, the Member had an active CNO certificate of registration at the time and was still expected to uphold the standards, values and ethics of the profession.

Each of the allegations relate to the Member's treatment of [Client A] and [Client B] during a 14 day period from December 6 to 20, 2015. The Member's assault on these clients took place in each of their respective apartments.

The Member was charged under the Criminal Code. His criminal proceedings were dealt with prior to this discipline hearing. The Member pleaded guilty to 6 counts of criminal assault on January 5, 2017. On February 15, 2017 he was sentenced to 30 days in jail, and 2-years of probation, which included a term that he was "not to be employed or provide professional services to persons that are to receive benefits of a trust relationship through personal care."

To support the allegations in the Notice of Hearing, College Counsel called one witness. The Panel also accepted 37 exhibits into evidence, including certified copies of the Member's criminal proceedings on these matters, four victim impact statements, as well as surveillance videos of the events in question. The primary factual issues the Panel was asked to consider included the following:

1. Did the Member physically abuse a client or clients that were under his care?

2. Did the Member emotionally abuse a client or clients that were under his care?

As discussed below, there was no real factual issue as to the fact of the convictions, and similarly there was no real issue that the conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. As such, the Panel found that all allegations in the Notice of Hearing were proven by the College on the balance of probability, with clear cogent and convincing evidence.

The Evidence

The Facility

Community Living Essex County is a non-profit organization that supports adults with intellectual disabilities. In addition to the locations where the incidents occurred in this case, the facility operates approximately 55 small group living homes in the area. The incidents happened

at [the Site], which is a residential building, comprised of five units. Three of the units on the right side of the building house three men with a secured access kitchen and staff office in the centre of the building and two units on the left side house the clients referred to in this hearing.

The Panel heard from the Facility's Director of Supports, [Witness A]. [Witness A] has been employed with the Facility since 2004. At the time of the occurrences, [Witness A] was in his current role as Director responsible for overseeing support services, crisis intervention training and clinical services.

For the past 6 years, [Witness A] has instructed new employees in the 'Safe Management Group Crisis Intervention Training Program.' This program was developed in 1990 specifically for staff working with adults with developmental disabilities. The training manual filed as an exhibit with the Panel, provides in part that the program was developed to "address the unique needs and challenges posed by individuals with unsafe aggressive/violent behaviour." Orientation information also submitted into evidence supports that the Member had completed this training on June 26, 2015.

[Witness A] also stated that to meet legislative requirements, policy and procedure binders are kept at each location and they are also available electronically. All staff are alerted when they have to do a policy review and quiz. Orientation checklists support that the Member was aware of the Facility's policies and procedures, as this information was part of the mandatory training he underwent at the time he was hired.

[Witness A] described the various professions hired at the facility including Developmental Service Workers and anyone with a human services diploma. When asked if nurses were hired in the Facility [Witness A] acknowledged that nurses are hired, however they are considered direct support professionals and are not expected to be working in a nursing capacity. He also explained that during the day shift [the Site] normally schedules three workers but can have as many as four depending on the specific activities scheduled in a particular day. Overnight there are typically two staff scheduled. [Witness A] testified the staff ratio for [Client A] and [Client B] was one worker for each client.

[Witness A] described the clients housed in the Facility as adults, living with developmental disabilities. In particular, [Witness A] described in detail the two clients addressed in this hearing as having self-injurious behaviour. Both units for [Client A] and [Client B] were specially renovated with abuse-resistant drywall as well as audio and visual monitoring equipment. The video records on a loop and archives footage for two and a half to three weeks before automatically rerecording over the footage.

[Witness A] told the Panel that he had received an e-mail on December 19, 2015 from the site's Manager, [the Manager] informing him of an incident involving a worker [Colleague A] complaining about the Member's conduct toward client [Client A]. The worker expressed to [Witness A] that she was concerned about how the Member was speaking to the Client. She said that the Member seemed very agitated and was talking very crossly to the Client. Subsequently, [Colleague A] filed a serious occurrence report. As a result of the information [Witness A] received from the e-mails, the report and a review of the video surveillance, the Member was put on paid leave until the matters could be investigated.

The Member's employment was ultimately terminated on December 22, 2015 and a local police constable was awaiting him after the meeting to formally press charges.

Findings of guilt relevant to suitability to practise

The Panel considered the uncontested evidence with respect to the Member's convictions for assault on his clients and the relevance of the convictions to his suitability to practise, as set out in allegations 1(a), 1(b), 1(c), 1(d), 1(e), and 1(f).

The Panel reviewed documents from the Ontario Court of Justice (Exhibits 7 through 10). The documents included certified copies of the Member's charges and convictions, as well as certified copies of the transcripts of the proceedings and the probation orders. The evidence confirmed that the Member was charged and convicted of six counts of assault on the two clients in his care.

The Panel also reviewed documents from the College of Nurses of Ontario (Exhibits 35 through 37). These documents included the Professional Standards the Member was obliged to follow as a Registered Nurse. These standards refer to "acting with integrity, honesty and professionalism in all dealings with the client." Further, the Ethics standard provides that "(n)urses are obliged to refrain from abandoning, abusing or neglecting clients and to provide empathic and knowledgeable care."

The Professional Standards filed make no distinction between the conduct expected of a nurse when providing nursing care and when simply providing personal care, as was the case here.

Contravening a standard of practice

The Panel considered the evidence with respect to the Member contravening or failing to meet the standards of practice of the profession as set out in allegations 2(a), 2(b), 2(c), 2(e), 2(f), 2(g), 2(h), 2(i), 2(j), 2(k), 2(l), and 2(m).

[Witness A] testified that during his internal investigation, he reviewed each video recording for the shifts the Member was working and compiled a Summary of Observations of Video Records by Management of Community Living Essex County. That summary was filed with the Panel as exhibit 31.

The Panel reviewed the summary, as well at the video surveillance recordings filed as exhibits 32 and 33. There were 19-key incidents clearly visible in the video surveillance that accorded with the descriptions provided by [Witness A] in his summary. Without setting out in detail each event, the video clearly showed the Member use his hands and fists to engage with these clients on multiple occasions.

The *Ethics* Standard filed with the Panel provides in part that, "Nurses have a commitment to the nursing profession. Being a member of the profession brings with it the respect and trust of the public. To continue to deserve this respect, nurses have a duty to uphold the standards of the profession, conduct themselves in a manner that reflects well on the profession, and to participate in and promote the growth of the profession."

The College of Nurses of Ontario *Therapeutic Nurse-Client Relationship* (rev 2006) practice standard defines abuse as "a misuse of the power imbalance intrinsic in the nurse-client relationship. It can also mean the nurse betraying the client's trust or violating the respect or professional intimacy inherent in the relationship…"

Verbal, Physical or Emotional Abuse of a Client

The Panel considered uncontested evidence with respect to the Member verbally, physically or emotionally abusing a client as set out in allegations 3(a), 3(b), 3(c), 3(e), 3(f), 3(g), 3(h), 3(i), 3(j), 3(k), 3(l), and 3(m).

The Panel reviewed documents from Community Living Essex County which include all of the policies and procedures staff must read and review on a regular basis. These documents are found in Exhibits 23 through 28. College Counsel reviewed the Abuse Prevention and Reporting policy that states the Facility has "zero tolerance for any form of abuse." The policy goes on to define physical abuse as "Acts of assault or threats of assault, such as hitting, slapping and burning that cause or could cause physical injury or fear of physical injury." Emotional abuse is defined by the policy as "The constant criticism, insulting, threatening, degrading, humiliating, intimidation or terrorizing of a person." The Facility's Crisis Intervention policy reads, "The Agency is committed to providing crisis intervention in a safe, respectful and supportive manner for all people we support, employees and others." The Panel also notes the policy states that "safe holds will be used only in exceptional circumstances when a person's or others' safety is at immediate risk…and after the Intrusive Behaviour Intervention has been approved by a psychologist, psychiatrist, physician or other medical professional and included in the person's behaviour support plans."

Further, the Panel notes that the Behaviour Support Plans for [Client A] and [Client B] made no mention of safe holds or other physical interventions. Finally, the Facility's Rules of Conduct state, "Employees who violate these principles in the manner listed below may be subject to disciplinary action up to and including dismissal." Section A (1) reads, "Wilful neglect or abuse of an individual and/or their personal possessions and property."

Allegation 3(a)

The Panel reviewed video evidence of the time and date in question. The video showed the Member assisting client [Client A] in making her bed. [Client A] then began to strike herself in the face. [Client A] walked over to a wall and started hitting her head on it numerous times. The Panel saw the Member walk over to the Client and punch her with a closed fist above her left eye.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observations.

Allegation 3(b)

The Panel reviewed video evidence of the time and date in question. The video showed [Client A] standing in her living room. The Member opened her apartment door and pointed at the

Client. The Member leaves the apartment and then re-enters and shuts the door. The Member is then seen charging toward the Client and punches her two times in the face with a closed fist.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observations.

Allegation 3(c)

The Panel reviewed video evidence of the time and date in question. The video showed the Member assisting [Client B] to undress and toilet. The Client appears to attempt to take off her pants and adult guard. The Member pulled the Client's pants and adult guard off and threw them on the ground beside the garbage. The Member is seen pointing towards the garbage and the Client is seen putting the product on top of a drawer beside the garbage. At this point in the video, the Member punches the left side of the Client's head with a closed fist.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observations.

Allegation 3(e)

The Panel reviewed video evidence of the time and date in question. The video showed the Member in [Client B's] washroom while the Client is undressing. The Member appears to pick up the Client's pants and adult guard, separates them and then throws them both on the ground. The Member is seen pointing at the pants and product. The Client bends down to pick up the product with her right hand and her pants with the left hand. It is at this time the video records the Member stepping on the Client's left hand. The Client is shown picking up the product and walks over to the garbage and places the product on top. The Member walks over to the door and closes it. At this point the Member walks toward the Client as she is sitting on the toilet and grabs her left arm and pulls it around as he is motioning at the product on top of the garbage. The Member is seen on his phone for approximately 10 seconds and then puts his phone away. The Client stands up from the toilet and puts her pants on top of the garbage can. The Member is then seen giving the Client a punch to her head with a closed right fist.

Allegation 3(f)

The Panel reviewed video evidence of the time and date in question. The video shows [Client A] sitting at her table, in her apartment, with a spilled drink in front of her. The Member cleaned up the spill and struck the Client in the face.

Allegation 3(g)

The Panel reviewed video evidence of the time and date in question. The video shows the Member assisting [Client A] to make her bed. The Member is seen walking over to the Client as she is attempting to tuck in a corner of the sheet and he grabs her hands to make her tuck in the corner.

Allegation 3(h)

The Panel reviewed video evidence of the time and date in question. The video shows [Client A] sitting on a chair at her table. The Member enters the apartment bringing her lunch. The Member is then seen forcefully pushing the Client's chair in two times.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observations.

Allegation 3(i)

The Panel reviewed video evidence of the time and date in question. The video shows the Member urinating in [Client B's] personal washroom with the door open. The Client enters the bathroom and sits on the floor behind the Member while the Member continues to urinate. While the Member is seen looking for something the Client turns out the light. The Member quickly turns the light back on and punches the Client's head with a left fist.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observations.

Allegation 3(j)

The Panel reviewed video evidence of the time and date in question. The video shows [Client A] showering. The Member then enters the apartment, forcefully pushes a chair, walks to the washroom, points at the Client and punches her in the face with his right fist.

Allegation 3(k)

The Panel reviewed video evidence of the time and date in question. The video shows the Member assisting [Client B] in her washroom before her shower takes place. The Client undresses and the Member assists the Client to separate her soiled incontinence product from her pants. The Member points to the garbage and the Client walks towards the garbage and places it on top of the garbage can. The Member walks over to the Client and grabs her by the arm and pulls her toward him. The Member is then seen putting his hand on the back on the Client's neck and forcing her to the garbage.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observation.

Allegation 3(l)

The Panel reviewed video evidence of the time and date in question. The video shows [Client A] brushing her teeth in her washroom. The Member is assisting the Client in this task slightly off camera. However, you can see the Member strike the Client and the Client's head jerk back.

Allegation 3(m)

The Panel reviewed video evidence of the time and date in question. The video shows [Client A] standing between her washroom and her bedroom. The Member is assisting the Client by brushing her hair. At this time the Member can be seen striking the Client in the face with the hairbrush, as he continues to brush her hair.

[Witness A] testified that he too had viewed this on the video surveillance and supported this by his summary of observation.

Disgraceful, Dishonourable and Unprofessional Conduct

The Panel considered uncontested evidence with respect to the Member engaging in conduct that would reasonably be regarded as disgraceful, dishonourable and unprofessional as set out in allegations 4(a), 4(b), 4(c), 4(e), 4(f), 4(g), 4(h), 4(i), 4(j), 4(k), 4(l), and 4(m).

The Panel relied on evidence in Exhibits 31 through 33 and 35 through 37.

Final Submissions

Counsel for the College reminded the Panel that the College had the burden of proving on a balance of probabilities that the Member engaged in professional misconduct as described in the allegations set out in the Notice of Hearing. Counsel submitted that the College had discharged its burden as required.

College Counsel summarized the evidence before the Panel and argued that in light of the criminal convictions and the overwhelming video evidence, there should be no difficulty in finding the Member guilty of all the allegations set out in the Notice of Hearing.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities and 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, 2, 3 and 4 of the Notice of Hearing, save for those allegations that were withdrawn. The Member was found guilty of offences relevant to his suitability to practise, he contravened the standards of practice, he abused clients physically and emotionally and his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional by physically and emotionally abusing two Clients under his care.

Reasons for Decision

The Panel received and reviewed all 37 exhibits submitted by College Counsel and accepted the testimony of [Witness A] as credible. [Witness A's] testimony was supported by contemporaneous and relevant documents, as well as the video surveillance. [Witness A] was

very clear and concise, and in particular he provided clear evidence that the Member had received adequate training and supports at the Facility. The Member understood how employees of Community Living were to conduct themselves.

The video surveillance footage showed numerous cases of client abuse of [Client A] and [Client B] which the Panel reviewed carefully. The conduct was egregious and disturbing. It demonstrated a serious moral failing on the part of the Member in his care for his clients.

The Member's conduct described in all of the allegations was a clear contravention of the *Therapeutic Nurse Client Relationship* Standard, *Ethics* Standard and the *Professional Standards*, Revised 2002. Nothing in the standards would support the Member's conduct. He failed in his responsibility as a regulated professional and while he was not providing nursing care at the time, he was still in a position of trust over extremely vulnerable clients. His treatment of the clients falls well outside of the boundaries expected of nurses.

The evidence clearly establishes that the Member committed acts of physical and emotional abuse of clients under his care.

The Panel found the Member's conduct would most certainly be regarded by others in this profession as disgraceful, dishonourable and unprofessional.

Penalty

College counsel submitted that the Panel should make an Order as follows:

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

2. Directing the Executive Director to immediately revoke the Member's Certificate of Registration.

Penalty Submissions

College Counsel reminded the Panel that it made findings of misconduct under four different heads of misconduct:

1. The Member breached standards of practice of the profession;
2. The Member physically and emotionally abused two clients on twelve separate occasions;
3. The Member was found guilty of six counts of assault under the Criminal Code; and
4. The Member was found to have committed acts that other members of the profession would regard as disgraceful, dishonourable and unprofessional.

College Counsel submitted that revocation in this case serves both as general and specific deterrence. The revocation will protect the public in that the Member will no longer be entitled to

practice and it will deter other members of the profession from behaving in such an outrageous manner.

The aggravating factors reviewed by the College included:

1. The Member took advantage of the fact that these clients were highly vulnerable and not in a position to report the abuse.
2. The Member was found guilty in criminal court of six counts of assault.
3. The Member's Director at the facility found incidences on almost every shift in which video recordings were available.
4. The regularity in which the interactions with these clients resulted in assault was significant. In addition, there was serious concern that there may have been even more incidents, not caught on the video surveillance, throughout the time he was employed at the Facility.
5. The Member's lack of insight into these occurrences. The Member did not have much to say when confronted by the Director of the facility and very little to say during sentencing at his criminal trial.
6. The absence of the Member from these discipline proceedings shows he has no insight and provides the Panel with no guidance as to whether he can even be rehabilitated.
7. The Member's absence from the discipline proceedings shows disregard for his accountability to the College.
8. The Member's absence illustrates a lack of ability to be governed.
9. The intentional misuse of power and the breach of trust

The College noted that the only mitigating factor was that the Member had no previous disciplinary action at the College.

The Panel also received and reviewed two previous cases that had come before the Discipline Committee.

CNO vs Gillette (Discipline Committee 2016). This case involved a member physically and emotionally abusing two clients and failing to keep adequate documentation. The Panel ordered revocation of the member's certificate of registration.

CNO vs Hinton (Discipline Committee 2017). This case involved a member physically, emotionally and verbally abusing clients. In this case the Panel ordered a reprimand and revocation of the member's certificate of registration.

Penalty Decision

The Panel makes the following Order as to penalty:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date 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's primary responsibility is to ensure the protection of the public and to preserve the public's confidence in the nursing profession. The Member's conduct and his lack of accountability are in gross contrast to the values of the profession, which holds its standards to the public in the highest regard.

Furthermore, the findings of misconduct and abuse made against the Member involve highly vulnerable individuals, who completely depend on those around them to aid in their activities of daily living. The Member was found to have used violence and physical force to solve problems instead of resolving issues professionally and in a manner that would result in positive outcomes for the clients.

The Panel agreed the Member needs to be held accountable and that any form of abuse is not to be tolerated.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has not taken any action or responsibility at any time during the Facility's investigation or the College's process. In his absence from the process, the Member has shown he is ungovernable and revocation is the only appropriate and necessary option.

I, Ingrid Wiltshire-Stoby, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.

_____ _____

Chairperson Date