DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Mary MacMillan Gilkinson	Chairperson
	Carly Gilchrist, RPN	Member
	Honey Palalon, RN	Member
	George Rudanycz, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	MEGAN SHORTREED for
	)	College of Nurses of Ontario
- and -	)	
	)	
LORLEE GRACE ICBAN	)	CAROL STEPHENSON for
Registration No. 10420010	)	Lorlee Grace Icban
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: December 14, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on December 14, 2018 at the College of Nurses of Ontario (the "College") at Toronto. Lorlee Grace Icban (the "Member") was present and represented by Counsel.

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 the public disclosure of the name of the Client referred to orally or in any documents presented in the Discipline hearing of Lorlee Grace Icban or any information that could disclose the identity of the Client, including a ban on the publication or broadcasting of these matters. The Panel considered the submissions of the parties and made an order as sought in the motion.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated November 8, 2018 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 St. Michael's Hospital in Toronto, Ontario (the "Hospital"), you contravened a standard or practice of the profession or failed to meet the standards of practice of the profession as follows:

    a. between June - August, 2016, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Client]; and/or

    b. in or about August, 2016, you were aware that a fellow nurse had sexual intercourse with [the Client], and you did not report this to the Hospital or the College; 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(19) of *Ontario Regulation 799/93*, in that while working as a Registered Nurse at the Hospital, you contravened a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts, with respect to the following incidents:

    a. in or about August, 2016, you were aware that a fellow nurse had sexual intercourse with [the Client], and you did not report sexual abuse to the College, contrary to s. 85.1 of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended; 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(25) of *Ontario Regulation 799/93*, in that while working as a Registered Nurse at the Hospital, you failed to report an incident of unsafe practice or unethical conduct of a health care provider with respect to the following incidents:

    a. in or about August, 2016, you were aware that a fellow nurse had sexual intercourse with [the Client], and you did not report this to the Hospital or the College; 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 as a Registered Nurse at the Hospital, 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. between June - August, 2016, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Client]; and/or

b. in or about August, 2016, you were aware that a fellow nurse had sexual intercourse with [the Client], and you did not report this to the Hospital or the College.

Member's Plea

The Member admitted to the allegations set out in paragraphs 1(a), 1(b), 2(a), 3(a), 4(a) and 4(b) in the Notice of Hearing. With regard to allegations 4(a) and 4(b), the Member admitted that her conduct would reasonably be regarded by members as dishonourable and unprofessional. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College and the Member advised the Panel that an agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads as follows.

THE MEMBER

1. Lorlee Grace Icban (the "Member") obtained a degree in nursing from Ryerson University in 2010.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on June 11, 2010.

3. The Member was employed at St. Michael's Hospital (the "Hospital") from June 14, 2010 to September 21, 2016, when her employment was terminated as a result of the incident below. This was her first position in nursing.

THE HOSPITAL

4. The Hospital is located in Toronto, Ontario.

5. At the time of the incident, the Member was working full-time on the Respirology Unit, [] (the "Unit").

6. The Unit at the Hospital is located [ ] in Toronto. It has 15 client beds and was almost always filled to capacity. [ ]. The most common diagnosis on the Unit is Cystic Fibrosis, and clients are typically admitted for a minimum of two weeks, though some stays were longer.

7. All nurses on the Unit are RNs who work 12 hour day or night shifts from 0730 to 1930 or from 1930 to 0730. The nurse to client ratio is one nurse to five clients, which means there are always three RNs working each shift, including the Charge Nurse. During the day shift, there is an additional Resource Nurse on shift.

THE CLIENT

8. [ ] (the "Client") was 31-years old at the time of the incident. He was diagnosed with cystic fibrosis.

9. He was admitted to the Hospital as an inpatient on June 29, 2016 and was discharged on October 4, 2016. Between July 13 and August 4, he was temporarily moved to another unit [ ].

10. The Client had previous admissions to the Hospital ([ ]).

11. As a patient with cystic fibrosis, the Client had privileges to leave the unit, and he often did so.

12. The Client was interviewed by the Hospital regarding the incident below. He declined to be interviewed by the College.

13. The Client died in June 2018.

COLLEGE STANDARDS AND MANDATORY REPORTING REQUIREMENTS

14. The College's practice standard, *Professional Standards,* states that:

> Each nurse is accountable to the public and responsible for ensuring that her/his practice and conduct meets legislative requirements and the standards of the profession.

15. It goes on to state that a nurse demonstrates accountability by:

> …reporting sexual abuse of a client by a regulated health professional to the appropriate regulatory college, as legislated in the *Regulated Health Professions Act, 1991*.

16. The College's *Therapeutic Nurse-Client Relationship* (TNCR) Standard states that:

> Nurses protect the client from harm by ensuring that abuse is prevented, or stopped and reported…

The nurse meets the standard by:

> …intervening and reporting a health care provider's behaviours or remarks toward a client that may reasonably be perceived by the nurse and/ or others to be romantic, sexually suggestive, exploitive and/or sexually abusive;

17. The TNCR Standard goes on to state:

> If a nurse witnesses another nurse or a member of the health care team abusing a client, the nurse must take action. College research indicates that when someone intervenes in an incident of abuse, the abuse stops. After intervening, a nurse must report any incident of unsafe practice or unethical conduct by a health care provider to the employer or other authority responsible for the health care provider. ...
>
> Certain legislation requires further reporting of abuse. The *Regulated Health Professions Act, 1991* requires regulated health professionals to report the sexual abuse of a client by a regulated health professional to the appropriate college.

18. The College's *Mandatory Reporting Guide* states that "[a]nurse is required to file a report to the appropriate regulatory college if they believe that another health care professional has sexually abused a client." The *Guide* does not set a time limit for nurses reporting sexual abuse.

19. For facility operators, the *Guide* states: "Once a facility has determined that it has a reporting obligation, the report must be made to the College's Executive Director in writing within 30 days. The report must be filed immediately if there is a concern that the nurse poses a continued risk."

20. Section 85.1 of the *Health Professions Procedural Code* of the *Nursing Act, 1991* (the "*Code*") mandates that a member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient. Section 85.2 imposes the same reporting obligation on facilities.

21. Under s. 85.3(2) of the *Code*, which applies to reports by both members and facilities, "The report must be filed within 30 days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient…".

22. The *Professional Standards* also state that a nurse demonstrates ethical conduct by "creating environments that promote and support safe, effective and ethical practice."

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

23. During the night shift, on August 8-9, 2016, RN M.C. had sex with the Client in his room while on shift. Another RN on duty, [RN #1], walked in on M.C. having sex with the Client. When the Client was later interviewed by the Hospital, he confirmed that the sex was consensual.

24. Three RNs were on shift at the time of this incident: M.C., [RN #1], and G.A.K., who was charge nurse. [RN #1] immediately notified G.A.K., of what she had witnessed. Shortly thereafter M.C., [RN #1], and the Client discussed the incident at the nursing station. The Client also spoke with G.A.K.

25. The Member was not working on this particular night shift, but was scheduled to work the following day shift on August 9, 2016. M.C. was the Member's friend and nursing colleague.

26. Around 0500, before her shift started, the Member received a text message from M.C., which stated something to the effect of, "Oh my god, [RN #1] caught me". The Member asked "caught you what?" and M.C. responded, "Me and [the Client] doing it". The Member understood this message to mean that [RN #1] had caught M.C. having sex with the Client.

27. The Member also received a text message from [RN #1] that morning stating, "I have to talk to you about something." When she arrived at work, [RN #1] told the Member that she had witnessed M.C. and the Client having sex. M.C. also said to the Member at some point that day words to the effect of, "I got caught."

28. Based on her discussions with M.C. and [RN #1], the Member understood M.C. had sex with the Client, which she knew was sexual abuse of a patient. If the Member were to testify, she would say she was shocked by her colleague's actions.

29. M.C., the two other RNs who were on shift when the sex abuse occurred ([RN #1] and G.A.K.) and the Member were all junior nurses at the time.

30. The Member did not report the fact that she had been told that M.C. had sex with the Client to either the Hospital or the College. The Member later explained to her employer that she did not report the incident because she did not witness it first hand and she, M.C., [RN #1] and G.A.K. did not report it because they were all friends, and they hang out outside of work.

31. Neither M.C. nor G.A.K. reported the incident to the Hospital. [RN #1], the RN who directly witnessed M.C. and the Client having sex, reported it to the Resource Nurse, a senior nurse, two weeks later on August 23, 2016 when the Resource Nurse returned from vacation. Before [RN #1] made this report to the Resource Nurse on August 23rd, she discussed "telling someone" with the Member and the Member told her that she should.

32. The Hospital investigated the incident, which included meetings with the Member and the Client. The Hospital first met with the Member on August 23, 2016, during which meeting the Member confirmed that she was aware on August 9, 2016 that M.C. and the Client had been caught having sex. She was asked to keep the investigation confidential and not discuss it with anyone.

33. On August 25, 2016, M.C. called the Member and told her that she had been suspended. The Member drove to the Hospital to pick M.C. up. The Member was supposed to bring a bridesmaid's dress for M.C. to try on. The Member's wedding was scheduled to be held in two weeks' time. M.C. was a substitute bridesmaid for another bridesmaid who was unable to attend the wedding. However, the Member forgot the dress at home. When M.C. got into the Member's car she told the Member that the Client was coming too.

34. Unknown to the Member, M.C. had sent the following text message to the Client:

M.C.: Make sure you say the same story as me. I need to tell you the story. I'm up on Bond just north of Shuter.

35. The Client arrived shortly thereafter. If the Member were to testify, she would say that when she saw the Client, she said to M.C., "Are you crazy? None of us should be talking to him." M.C. said, "Trust me it's ok to have him here". The Client got into the Member's car. The Member drove M.C., the Client and herself to her home. In the car, the Member told M.C., in the Client's presence, that she would probably lose her job.

36. M.C., the Client and the Member went to the Member's home. M.C. tried on the bridesmaid's dress. If the Member were to testify, she would say that she told M.C., in the Client's presence, that the College would see the sex as abuse regardless of consent from both sides, either way M.C. would look bad, and it would not matter. The Member asked the Client and M.C. who had initiated the sex. They both said "it kind of happened". The Member told them they had to figure out what they were going to say, and who came on to who. She said that it did not matter because the College would see it as abuse because M.C. was a nurse. The Member did not tell M.C. or the Client what to say or how to say it. The Client's evidence to the hospital was that his impression was that the Member and M.C. asked him to lie. If the Member were to testify, she would state that she did not tell the Client to lie.

37. If the Client and M.C. were to testify, they would say that the Client was offered alcohol and marijuana at the Member's home. If the Member were to testify, she would state that she did not offer either to the Client. She does acknowledge that M.C. had a beer at her house while the Client was there. If the Member were to testify, she would state that she does not believe that the Client had a beer, however she acknowledged to the Hospital that she did not know if the Client had a beer or other alcohol.

38. The Hospital met with the Client on August 26, 2016. The Member was the Client's assigned nurse on August 29 and 30, 2016.

39. On August 30, 2016, M.C. sent the following messages to the Client via Snapchat:

M.C.: You didn't say you instigated anything, did you?

M.C.: I knew you'd do that fuck. You needed to make it more your instigator, they're not investigating you. [The Member] and I both went over this with you. You should have made it seem more like you instigated.

Client: I had my meeting with patient affairs.
M.C.: how was the meeting

you didn't say you instigated it
Yay, you obviously understand what it feels like to think you are a piece of shit HAHA

Thanks for sorta supporting me…even though you were a part of the big ordeal to begin with :p

40. On August 31, 2016, M.C. sent the following messages to the Client via Snapchat:

M.C.: [The Member] and I both went over this w u. You should have made it seem more like YOU instigated

Now my fucking license is gone forever

I'm fucking going back to fucking waitressing after all my fucking education

41. The Member denies M.C.'s allegations in her texts/snapchats that the Member told the Client to say that he instigated the incident, but acknowledges that she told them they had to figure out what they were going to say and told M.C. she had to be clear who instigated it. The Member had no knowledge that M.C. sent the text messages referred to in paragraphs 39 and 40 above to the Client. The Member did not learn of these messages until the Hospital disclosed them to her in an interview on September 19, 2016.

42. When asked by the Hospital why M.C. included her name in the above-mentioned Snapchat messages, the Member advised that she did not know. The Member speculated that it may be because she had told M.C. that she could not look like a bad person, that the sex was obviously consensual, but regardless of consent it was an abuse of the power imbalance and she had to be clear who instigated it.

43. The Member was further interviewed by the Hospital on September 19 and 21, 2016. In the meeting with the Hospital on September 19, 2016, the Member initially denied speaking to the Client between August 23 and 31, 2016, and denied that he came to her home. She later admitted that she had taken M.C. and the Client to her home on August 25th, and that they discussed the sexual abuse incident as outlined in paragraph 36 above.

44. If the Member were to testify, she would say that the time period in issue was very hectic for her. She was excited about and busy planning her wedding, which was to take place in the Caribbean on September 9, 2016. She was also involved in buying a business at the same time. In hindsight the Member recognizes that as a result of her inexperience, combined with being overwhelmed with her personal issues, she failed to properly reflect on her professional obligations at the time.

45. Prior to the incident on August 8-9, 2016, the Member had occasional contact with the Client during her breaks. The Client frequently exercised his privileges to leave the Unit. The Member often saw him milling about the Hospital grounds when she was on break. The Member played Pokémon with him once or twice during her breaks. Occasionally the Client asked her for a cigarette and she gave him one. On one occasion the Member went to the store to buy cigarettes and the Client followed her to the store.

46. The Hospital filed a report with the College of Nurses regarding the incident of sexual abuse on October 20, 2016, approximately two months after the incident and one month after learning of it.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

47. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a) and (b) of the Notice of Hearing, as described in paragraphs 23 to 46 above, in that she failed to meet the standards of practice of the profession when she failed to maintain the boundaries of therapeutic nurse-client relationship with the Client and because she was aware that a fellow nurse had sex with a Client and she did not report it to the College or the Hospital.

48. The Member admits that she committed an act of professional misconduct as set out in paragraph 2(a) of the Notice of Hearing in that she failed to report sexual abuse to the College and thereby contravened section 85.1 of the *Code.*

49. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3(a) of the Notice of Hearing, as described in paragraphs 23 to 46, in that she failed to report an incident of unsafe practice or unethical conduct of a health care provider when she became aware that M.C. had sex with the Client and she failed to report it to the College or the Hospital.

50. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 4 (a) and (b) of the Notice of Hearing, and in particular that her conduct, as described in paragraphs 23 to 46 above, would reasonably be regarded by members as dishonourable and unprofessional.

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), 2(a), 3(a), 4(a) and 4(b) of the Notice of Hearing. With regard to allegations 4(a) and 4(b), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

Reasons for Decision

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

Allegation 1(a) in the Notice of Hearing is supported by paragraphs 33, 35, 36, 37, 43, 45 and 47 in the Agreed Statement of Facts. On August 25, 2016, the Member drove M.C., the Client and herself to her house. While at her home, the Member admitted to discussing the sexual abuse incident with M.C. and the Client. If the Client and M.C. were to testify, they would say that the Client was offered alcohol and marijuana at the Member's home. Prior to the incident on August 8-9, 2016, occasionally, while the Member was at work and on her break, the Client would ask her for a cigarette and she would give him one. On one occasion, she went to the store to purchase cigarettes and the Client followed her to the store. The Member's actions clearly illustrated to the Panel that she repeatedly breached the therapeutic nurse-client relationship.

Allegation 1(b) in the Notice of Hearing is supported by paragraphs 15, 16, 17, 18, 26, 27, 28, 30, 31, 32 and 47 in the Agreed Statement of Facts. During the Hospital investigation, the Member confirmed that she was aware that her co-worker M.C. and the Client had been caught having sex. The Member admits that she did not report the fact that she had knowledge of this incident either to the Hospital or the College. The Member explained that she did not report the incident because she did not witness it first-hand and she, M.C, [RN #1] and G.A.K. did not report it because they were all friends, and they socialized together outside of work. The Member's failure to report that M.C., a fellow nurse, had sexual intercourse with the Client, is a clear contravention of the College's *Professional Standard, Therapeutic Nurse-Client Relationship Standard* and the mandatory reporting requirements set out in the College's *Mandatory Reporting Guide*.

Allegation 2(a) in the Notice of Hearing is supported by paragraphs 20, 28, 30, 32, 36 and 48 in the Agreed Statement of Facts. Through her discussions with M.C. and [RN #1], the Member understood M.C. had sex with the Client, which she knew was sexual abuse of a client. She told M.C., in the Client's presence, that the College would see the sex as abuse regardless of consent. The Member did not report the fact that she had been told about the incident to the Hospital or the College. By not reporting, the Member ignored the clear mandate set out in Section 85.1 of the *Health Professional Procedural Code of the Nursing Act, 1991* which states:

> "a member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession to believe that another member of the same or different College has sexually abused a patient".

It was only two weeks later, during her first meeting with the Hospital that the Member confirmed that she was aware that her co-worker M.C. and the Client were caught having sex.

Allegation 3(a) in the Notice of Hearing is supported by paragraphs 30 and 49 in the Agreed Statement of Facts. The Member admits that she committed professional misconduct, in that she failed to report an incident of unsafe practice or unethical conduct of a health care provider when she became aware that M.C. had sex with the Client and then when she failed to report it to the College or to the Hospital. With respect to allegations 4(a) and 4(b), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. By breaching, and failing to maintain the boundaries of the therapeutic nurse-client relationship, she ignored a key component of safe, competent care. The Member failed to protect the Client and, by extension, the public. Maintaining public safety is paramount.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through her failure to report her knowledge of M.C. having sex with the Client to the Hospital or the College, even though she recognized that it would be considered sexual abuse. At one point in the Hospital investigation, the Member denied having the Client over to her home. She later admitted that she had taken M.C. and the Client to her home and discussed details of the sexual abuse incident with them.

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 four 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 Regulatory Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,

2. *Therapeutic Nurse-Client Relationship,*

3. *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses;*

iv. Before the first meeting, the Member reviews and completes the College's self-directed learning package, *One is One Too Many*, at her own expense, including the self-directed *Nurses' Workbook*;

v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and Nurses' Workbook;

vi. 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;

vii. 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;

viii. 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 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Submissions were made by both College Counsel and Counsel for the Member.

College Counsel reviewed the mitigating factors in this case which were:

- The Member does not have a prior history with the College.
- The Member has been forthcoming and cooperative with the College.
- The Member has entered into a plea agreement.

There were also aggravating factors in this case according to College Counsel. The Member engaged in professional misconduct which included failure to report the sexual abuse of the Client to her professional governing body and her place of employment, and by breaching the therapeutic nurse-client relationship boundaries with the Client. The Member counselled both M.C. and the Client to figure out what they would say. The Member did not tell them to tell the truth. The Member initially denied the incident that occurred in her home. She lacked insight into her conduct by not reporting the abuse and by citing that she did not personally witness the encounter. The Member valued her friendship with the abuser over the needs of her Client and her professional obligations. The Member also excused her conduct by blaming the demands of her personal life. This further demonstrates that the Member's hectic personal life was taking precedence over her professional obligations. College Counsel also stated that the Member had been practising for six years and, therefore, should have been aware of her professional obligations.

College Counsel stated that the Joint Submission on Order was the product of lengthy negotiations by senior legal counsel. The agreement reached is reasonable, 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 meetings with the Nursing Expert, as well as through the employer notification provision. The College submitted that the penalty as a whole makes it

clear that public protection is paramount and that the conduct at issue is simply not acceptable in the nursing profession.

College Counsel submitted four cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee. She reminded the Panel that they were not perfect parallels.

College of Nurses of Ontario v. Larissa Van De Walle (2017). In this case, the member was found to have failed to report physical abuse of a client that she witnessed. The panel found that the member acted in a dishonourable and unprofessional manner. The penalty was an oral reprimand, two-month suspension, two meetings with a Nursing Expert and employer notification for a period of 12 months.

College of Nurses of Ontario v. Grace Appiah- Kubi (November, 2018). In this case, the member was found to have failed to report that a fellow nurse had sexual intercourse with a client. The panel also found that while in the charge nurse role, the member failed to revise the patient assignment, thus allowing the victim to be assigned to his abuser. The member was found to have acted in a dishonourable and unprofessional manner. The penalty was an oral reprimand, two month suspension and two meetings with a Nursing Expert.

College of Nurses of Ontario v. Farouk Premji (November, 2017). In this case, the member was found to have failed to maintain the therapeutic nurse-client relationship by allowing a minor client to watch an "R" rated movie on his iPad, by showing the Client his personal cell phone, which contained family photos, by exchanging phone numbers with the Client, by initiating personal text messages with the Client, and by repeatedly asking the Client to provide the contact information of his marijuana supplier. The panel found that the member acted in an unprofessional manner. The penalty was an oral reprimand, three month suspension, two meetings with a Nursing Expert and employer notification for a period of 12 months.

College of Nurses of Ontario v. Joseph John Andrew (January, 2016). In this case, the member failed to maintain the professional nurse-client relationship. The member was also found to have failed to properly document his client's condition, treatment, comments and behaviours. The panel found the member acted in an unprofessional manner. The penalty was an oral reprimand, two month suspension, two meetings with a Nursing Expert and employer notification for a period of 12 months.

The Member's Counsel reiterated that the mitigating factors in this case were:

- The Member does not have a prior history with the College.
- The Member has been forthcoming and has shown insight and has cooperated with the College.
- The Member entered into a plea agreement.

The Member's Counsel brought the Panel's attention to her belief that the Member was a junior nurse and the fact that this was her first job. The Member's inexperience was, she stated, the context in which these events occurred. She disagreed with College Counsel and stated that the Member did not rely on her life events as an excuse for her conduct. Member's Counsel stated that the Member now has insight into what she should have done.

ILC advised the Panel that the Joint Submission 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. He also confirmed that the Panel should take comfort in the previous decisions provided which reveal that the proposed penalty falls within a reasonable range.

Penalty Decision

The Panel accepts the Joint Submission as to Order and accordingly orders:

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

2. The Executive Director is directed to suspend the Member's certificate of registration for four 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 Regulatory Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards,*

            2. *Therapeutic Nurse-Client Relationship,*

            3. *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses;*

iv. Before the first meeting, the Member reviews and completes the College's self-directed learning package, *One is One Too Many*, at her own expense, including the self-directed *Nurses' Workbook*;

v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and Nurses' Workbook;

vi. 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;

vii. 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;

viii. 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 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,

4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

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.

In deliberations, 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 penalty provides protection for the public. The four month suspension along with the meetings with the Nursing Expert will help the Member gain insight into her conduct. In this way the public is protected. The public is also protected by the Member's suspension and remediation through the terms, conditions and limitations. The penalty sends a strong message to the nursing profession that nurses must practice according to the College's Standards and that appropriate boundaries in the nurse-client relationship must be maintained at all times. It clearly demonstrates that failure to report sexual abuse of a client, as required by legislation and the College's strict standards and guidelines, will be dealt with severely.

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.

I, Mary MacMillan-Gilkinson, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.

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Chairperson