DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Michael Hogard, RPN	Chairperson
	Tina Colarossi, NP	Member
	Carly Hourigan	Public Member
	Lalitha Poonasamy	Public Member
	Susan Roger, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
SHEREEN JINNAT KHAN	)	NO REPRESENTATION for
Registration No. 9313552	)	Shereen Jinnat Khan
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 26, 2023

AMENDED 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 26, 2023, via videoconference.

As Shereen Jinnat Khan (the "Member") was not present, the hearing recessed for 20 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was still not in attendance.

College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing on December 22, 2022 by way of an affidavit from [ ], Prosecutions Clerk, dated January 5, 2023, confirming that [the Prosecutions Clerk] sent correspondence, which included the Notice of Hearing, on December 22, 2022 to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if she did not participate in the hearing, it may proceed

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

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated December 20, 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(1) of *Ontario Regulation 799/93*, in that, while employed as a Director of Care at Wikwemikong Nursing Home in Wikwemikong, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that in or around September 11, 2020, you:

    (a) prepared Vulnerable Sector Check request letters for yourself and [your sister] using [a colleague]'s name without her consent or authorization and with inaccurate information;

    (b) forged [a colleague]'s signature on the Vulnerable Sector Check request letters; and/or;

    (c) provided the Vulnerable Sector Check request letters to Wikwemikong Tribal Police Service; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while employed as a Director of Care at Wikwemikong Nursing Home in Wikwemikong, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that on or about September 11, 2020, you:

    (a) prepared Vulnerable Sector Check request letters for yourself and [your sister] using [a colleague]'s name without her consent or authorization and with inaccurate information;

    (b) forged [a colleague]'s signature on the Vulnerable Sector Check request letters; and/or;

    (c) provided the Vulnerable Sector Check request letters to Wikwemikong Tribal Police Service.

Member's Plea

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

Overview

The Member was a Registered Nurse and was working as the Director of Care at Wikwemikong Nursing Home (the "Facility") when it was alleged that, on September 11, 2020, she prepared two letters requesting vulnerable sector checks for herself and for her sister. These letters were prepared on the Facility's letterhead, used a colleague's name and forged the colleague's signature and were submitted to the Wikwemikong Police as true and accurate requests.

There were two matters of misconduct for the Panel to consider:

1) did the Member fail to meet the standards of practice by falsifying these letters? and,
2) did the Member commit professional misconduct by engaging in conduct that would be considered by the members of the profession to be disgraceful, dishonourable and/or unprofessional by falsifying these letters, forging a colleague's signature and submitting them to the authorities as a valid request?

The Panel heard evidence from two witnesses and received fourteen exhibits to consider. The Panel made findings that the Member committed professional misconduct by failing to meet the standards of practice of the profession and engaged in conduct that would be regarded by members of the profession to be dishonourable and unprofessional.

The Evidence

The Panel was presented with the Find a Nurse Register Report for the Member dated January 24, 2023. The Member resigned her certificate of registration in December 2021. Despite this fact, the incidents concerning the allegations occurred in September 2020 when the Member held a valid certificate.

The Panel heard from two witnesses.

Witness 1 – [ ] ("[Witness 1]")

[Witness 1] was the Finance Officer at the Facility for seven years and in September 2020 was in charge of corporate functions such as accounts payable/receivable, payroll, writing letters for discipline or requests for vulnerable sector checks. The Member was the Director of Care at the Facility in 2020. [Witness 1] described the reporting hierarchy at the Facility where the Administrator, [ ] was wholly responsible, followed by the Director of Care, Activities Director, Manager of Environmental Services and Food Services. [Witness 1] also reported to the Administrator, [ ], who left in July 2022.

It was [Witness 1]'s testimony that each member of the administrative personnel had their own computer; that computer was password protected; and the password was unique to each individual. Each administrative personnel also had their own computer drives to save their personal electronic files. Only the Administrator had access to each person's computer. Employees did not have access to one another's personal drives. It was [Witness 1]'s testimony that all managers and reception staff had access to company letterheads.

[Witness 1] explained that when an employee is seeking employment at the Facility, a criminal reference check is required for the vulnerable sector and is requested from the police in the prospective employee's home district. As the employer requesting the vulnerable sector (or criminal reference check), [Witness 1] would prepare a standard letter including the new employee's name and the position for which they were being hired. She described it as a standard template that she used and would change the date, name and position. [Witness 1] told the Panel that she then saved the letter on her drive, namely the Finance Drive. She confirmed that access was limited to herself or the Administrator. The Director of Care would not have access to those letters.

[Witness 1] provided a sample letter that she had prepared, which was marked as Exhibit #4. The Panel's attention was drawn to the standard language used in the letter and [Witness 1]'s signature. [Witness 1] told the Panel that letters would be submitted to the employee directly or the Director of Care would send the letter to the new employee. [Witness 1] explained that it was the employee's responsibility to submit it to the police.

It was [Witness 1]'s testimony that in September 2020, she did not receive any request from the Member nor her sister for a vulnerable sector check letter. In September 2020, the Member's sister was not employed by the Facility. The Member was already working at the Facility and would have no need for a vulnerable sector check from the Facility. [Witness 1] told the Panel that the Member had given notice of her resignation, had worked through her notice period and finished work with the Facility on September 24, 2020. She believed the Member left her position for "health reasons" and stated that as far as she was aware, the Member had a new job in Alberta.

Over the days following the Member's departure, the Administrator, [ ], was checking the Director of Care emails received to ensure that nothing was being missed and discovered documents in the Member's email history that required clarification. [Witness 1] testified that [the Administrator] came to her with emails from the Member and asked if she had prepared the vulnerable sector check letters contained therein. [Witness 1] identified several discrepancies between her original example and the letters [the Administrator] presented to her:

1. [Witness 1] signed her name fully on her letters and the signature on the letter presented was initialled only.

2. The letterhead was incorrect, specifically, the letterhead used by the Member was a version that included the Director of Care's old email host name doc@wikynursinghome.com.

3. The second letter identified the nursing home as an assisted living facility.

4. [Witness 1] testified that she always identified herself as the Finance Officer not the Financial Officer.

5. Her first name on the second letter was spelled incorrectly as "[ ]" rather than "[ ]".

[Witness 1] identified a screenshot that had come from a Canon photocopier at the Facility. She told the Panel that while she was unable to identify who had sent the email, the recipient was "Shereen" and if one was to hover over the recipient name, a second screenshot showed the email address shereen.khan@wikwemikongnursinghome.com "comes up" and is the organization's standard naming convention. It is date/time stamped as September 11, 2020 at 5.12 pm. To [Witness 1]'s recollection, this is the date on which the Member submitted her notice.

[Witness 1] told the Panel that she then reported these documents to the police as the Member had forged her signature. [Witness 1] reported that the police already had the letters of vulnerable sector checks on file. It was [Witness 1]'s evidence that the Member is on the wanted list by the police in Wikwemikong and that there is a warrant for her arrest.

Witness 2 – [ ] ("[Witness 2]")

The second witness, [Witness 2], is a Registered Nurse and is employed as an Investigator with the College. [Witness 2] has a BScN (Ryerson, 2004) and a Masters in Health Studies (Athabasca, 2016). She began work with the College in 2010 as a practice consultant and transferred to the investigator role in April 2018. She stated that it is her responsibility to complete such activities as to develop investigation plans, compile information related to the investigation, review witnesses and present her findings to the Inquiries Complaints and Reports Committee ("ICRC").

[Witness 2] identified eight documents for the Panel:

1. Exhibit #5 – screenshot of an email sent from a Canon copier to the Member's email address on September 11, 2020 at 5:12 pm.

2. Exhibit #6 – screenshot of an email that hovers over recipient name and email identified as shereen.khan@wikwemikingnursinghome.com.

3. Exhibit #7 – screenshot for this email that confirms delivery.

4. Exhibit #8 – pdf attachment to the email of both letters.

5. Exhibit #9 – screenshot of the email of the document properties.

6. Exhibit #10 – screenshot of an email dated September 17, 2020 from a Canon copier to the Member's email.

7. Exhibit #11 – pdf attachment of an email dated September 11, 2020 from Christenson Health Services as a letter of offer of employment to Shereen Khan.

8. Exhibit #12 – screenshot of the document properties from the September 17, 2020 email.

College Counsel submitted the College's *Professional Standards* and the *Ethics* Standard which [Witness 2] confirmed were the standards in place in September 2020.

College Final Submissions on Liability

College Counsel asked the Panel to accept the evidence that the Member had failed to meet the standards of practice by preparing letters in [Witness 1]'s name and forging her signature on them. [Witness 1]'s evidence was that the letters had been falsely prepared and were materially different than was her normal practice. These letters came to her attention through the Administrator who had been monitoring emails after the Member had left the organization. [Witness 1] subsequently reported these forged letters to the police.

The second witness, [Witness 2] identified several documents that were screenshots of the Member's work email, copier evidence that the email was sent from the copier to the Member with the letters and correspondence with the Member's future employer as attachments.

College Counsel asked the Panel to consider that the Member had received a new offer of employment and subsequently required a vulnerable sector check. The Member had access and a general sense of the information required and prepared a letter using her colleague's name and signature for the request. A second letter was prepared for the Member's sister in a similar fashion. These letters were signed by the Member and sent to the police.

College Counsel reminded the Panel that expert evidence is not required to accept that the Member's conduct amounted to a breach of the standards. The *Professional Standards* require nurses to act with integrity, honesty and professionalism in all interactions with the team, be aware of how their behaviour affects others and role model professional beliefs and attributes, while maintaining professional relationships based on trust and respect.

The *Ethics* Standard is grounded in nurses' obligations to maintain commitments to colleagues and the team and to ensure that they speak or act without intending to deceive. College Counsel submitted that the Member's actions bring into question her honesty and truthfulness in the way she works with others.

College Counsel submitted that the Member's conduct was relevant to the practice of nursing in that the conduct occurred while she was employed as the Director of Care at the Facility. The Member used her position as Director of Care to gain access to documents for her personal gain. The Panel was asked to make findings that the membership of the profession, acting reasonably, would find the Member's conduct to be dishonourable and unprofessional. It was submitted that

the Member had acted with a serious disregard for her professional obligations. The Panel was asked to find that the Member had also acted with dishonesty and elements of moral failing.

College Counsel submitted to the Panel three cases to support the College's position:

CNO v. Richer (Discipline Committee, 2019): There were some similarities to the case before this Panel in that the member had falsified her credentials and transcripts in seeking employment. There were additional allegations of personal transactions using corporate credit cards. The panel made findings of a breach of the standards and the member's conduct was dishonourable and unprofessional.

CNO v. Olalere (Discipline Committee, 2022): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member provided false information on her employment history. Although there was no patient or care issue, the member was found to have breached the *Professional Standards* and the *Ethics* Practice Standard. The panel found that the member's conduct was unprofessional as it demonstrated a serious disregard for her professional obligations. The member demonstrated deceit and dishonesty and knew or ought to have known that her behaviour would be considered by members of the profession to be dishonourable.

CNO v. Verde-Balayo (Discipline Committee, 2021): This member's conduct was wholly related to her employer relationship. The member failed to conduct herself with honesty and integrity and, as a result, called into question the trust and respect of the public. Findings of dishonourable and unprofessional conduct were made against this member.

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), 2(b) and 2(c) in the Notice of Hearing. With respect to allegations 2(a), 2(b) and 2(c), 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 and accepted the testimony of the witnesses, the documentary evidence and College Counsel's submissions and finds that the evidence supports the findings of professional misconduct as alleged in the Notice of Hearing.

With regard to allegations #1(a), 1(b) and 1(c), the Panel considered the oral evidence from the two witnesses and received exhibits that were compelling descriptors of the events as alleged.

The first witness, [Witness 1] explained the significance of the screenshot Exhibits. She also described her usual practices for writing and requesting vulnerable sector checks as compared to those letters scanned to the Member's email address. [Witness 1] had worked as the Finance Officer at the Facility for 7 years and had completed similar letters over time, using a "template" kept on her personal drive. The Panel found her evidence to be credible as she was clear and consistent in her recollection of events, was forthright, sincere and was convincing in the probability of her testimony.

The second witness, [Witness 2] was also found to be credible as she was straightforward in providing her oral evidence. She answered the questions clearly, concisely and has no personal interest in the outcome of this hearing. She was able to identify and describe her role in providing the documentary evidence in a confident, professional manner.

The Panel found that the evidence established on the balance of probabilities that the Member had prepared vulnerable sector check request letters for herself and her sister without [Witness 1]'s consent, with inaccurate information, forged [Witness 1]'s signature on them and provided them to the Wikwemikong Tribal Police Service. In so doing, the Member breached the standards of the profession, namely the *Professional Standards* and the *Ethics* Standard, specifically in that these standards give direction to all nurses to act with integrity, honesty and professionalism towards all members of the healthcare team. These standards require nurses to conduct themselves in ways that maintain commitments to colleagues and the team, who would not expect a colleague to deceive. The Member's behaviour brought honesty and truthfulness into question in the way she worked with others. The Member's behaviour did not meet the standards as described.

Further, with respect to allegations 2(a), 2(b) and 2(c), the Panel found that the Member's conduct would reasonably be regarded by members of the profession to be unprofessional and dishonourable. It was clearly relevant to the practice of nursing and was unprofessional as it demonstrated a serious disregard for the Member's professional obligations. Her behaviour casts doubt on her moral fitness and in her ability to discharge her professional obligations. It was dishonourable as the Member demonstrated deceit and dishonesty and knew or ought to have known that her conduct was unacceptable and fell well below the standards of the profession.

Penalty

Penalty Submissions

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

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

2. Directing the Executive Director to 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at the Member's own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration in a practicing class. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. 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 and decision tools (where applicable):

            1. *Code of Conduct,* and
            2. *Professional Standards*;

        iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

        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 their report to CNO, 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 the Member's behaviour;

vii. If the Member does not comply with any 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 the Member's 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 the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO 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;

iii. Provide the Member's employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

iv. 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 CNO, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify CNO 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 CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

In making submissions on penalty, College Counsel provided the Panel with details of aggravating and mitigating factors considered in putting together the proposed order.

The aggravating factors in this case were:

- The Member's troubling behaviour in deceiving the Facility, her colleagues and the police; and
- The Member's behaviour was intentional and was committed for her own personal gain.

The mitigating factor in this case was:

- The Member had no prior discipline history with the College.

College Counsel submitted that the goals of penalty were to protect the public, maintain public confidence in the ability of nurses to self-regulate, taking into consideration the Member's personal circumstances. These goals are accomplished by elements of general deterrence, specific deterrence, remediation and rehabilitation. While considering these various goals of discipline, it is the Panel's responsibility to ensure that the Member and the membership understand the consequences of unprofessional conduct.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2 month suspension of the Member's certificate of registration, which will send a message to the Member that this type of behaviour is unacceptable.

The proposed penalty provides for general deterrence through the 2 month suspension of the Member's certificate of registration, which will send a message to the membership that this type of behaviour cannot happen with impunity.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert and the opportunity for the Member to review and reflect upon the standards.

Overall, the public is protected through the 12 months of employer notification, which will provide the Member with support on her return to work as well as further monitoring over that period of time. This monitoring will serve to further protect the public.

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

CNO v. Olalere (Discipline Committee, 2022): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The material difference in the allegations between this case and the case before this Panel is that there were multiple instances of misconduct and several different employers impacted. The penalty included an oral reprimand, a 3 month suspension of the member's certificate of registration, a minimum of 1 meeting with a Regulatory Expert and 18 months of employer notification.

CNO v. Clutario (Discipline Committee, 2008): This case involved a false claim to secure a higher pay grid placement. A letter was falsely created and submitted to the employer for their consideration. The penalty included an oral reprimand and a 30 day suspension of the member's certificate of registration. The Panel was reminded that this was an older case.

Penalty Decision

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

1. The Member is required to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. The Executive Director is directed to 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at the Member's own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration in a practicing class. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

    1. the Panel's Order,
    2. the Notice of Hearing, and
    3. 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 and decision tools (where applicable):

    1. *Code of Conduct,* and
    2. *Professional Standards*;

iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

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 their report to CNO, 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 the Member's behaviour;

vii. If the Member does not comply with any 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 the Member's 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 the Member's employers of the decision. To comply, the Member is required to:

   i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

   ii. Ensure that CNO 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;

   iii. Provide the Member's employer(s) with a copy of:

      1. the Panel's Order,
      2. the Notice of Hearing, and
      3. a copy of the Panel's Decision and Reasons, once available;

   iv. 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 CNO, in which it will confirm:

      1. that they received a copy of the required documents, and
      2. that they agree to notify CNO 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 CNO, 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.

In determining penalty, the Panel considered the College's responsibility to maintain high professional standards. In doing so, the Panel has made an order that meets all these obligations and falls within the range of penalties submitted for its consideration.

The Panel concluded that the proposed penalty is reasonable and in the public interest. Although the Member has not co-operated with the College, the Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The oral reprimand and the 2 month suspension of the Member's certificate of

registration will provide specific deterrence. The 2 month suspension of the Member's certificate of registration will provide general deterrence. A minimum of 2 meetings with a Regulatory Expert will provide for rehabilitation and remediation and the 12 months of employer notification will ensure the public is protected with ongoing monitoring.

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

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