IN THE MATTER OF A HEARING BY
THE DISCIPLINE COMMITTEE OF THE BRITISH COLUMBIA COLLEGE OF NURSES AND MIDWIVES CONVENED PURSUANT TO THE PROVISIONS OF THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183

BETWEEN:

The British Columbia College of Nurses and Midwives

(the "College" or "BCCNM")

AND:

Maryna Byelkova

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

,
Hearing Dates:	By written submissions
Discipline Committee Panel:	Sheila Cessford, Chair Dorothy Jennings, RPN Jackie Murray, RN
Counsel for the College:	Michael Shirreff Greg Cavouras
Counsel for the Respondent:	Shahryar Zandnia

A. INTRODUCTION

1. This panel of the Discipline Committee (the "Panel") of the British Columbia College of Nurses and Midwives (the "College" or "BCCNM") conducted a hearing pursuant to section 38 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), to determine whether Maryna Byelkova (the "Respondent") failed to comply with the College's standards, failed to comply with the Act or the College's Bylaws, or committed professional misconduct or unprofessional conduct.

2. On November 9, 2022, the Panel decided that the allegations set out in the citation (the “Citation”) were proved to the requisite standard and determined that the Respondent committed professional misconduct (the “Conduct Decision”).

3. In the Conduct Decision, the Panel requested written submissions on the appropriate penalty and whether costs should be imposed. The Panel set a schedule for exchange of submissions. The College requested an extension to deliver its submissions and for the parties to communicate regarding same. The Respondent agreed and the Panel directed a revised schedule ending December 23, 2022. In delivering its submissions to the Panel, the College advised that it had first delivered its submissions to the Respondent and that it was the College’s understanding that the Respondent did not intend to oppose the orders sought by the College. The Respondent confirmed that she wishes to resolve the discipline proceeding at this stage, and that she is willing to accept the penalty proposed by the College and the College’s general characterisation of the matter.

4. The College seeks the following orders:

    a. The Respondent be reprimanded;

    b. The Respondent be suspended for a period of three months; and

    c. The Respondent be required to complete three remedial education courses.

5. The College is not seeking an award of costs against the Respondent in this matter.

6. The Panel has decided to grant the orders sought by the College and consented to by the Respondent.

B. LAW and ANALYSIS

7. Having made a determination pursuant to section 39(1) of the Act, the Panel must decide what, if any, penalty is appropriate. Section 39(2) of the Act authorizes the Panel to impose the following penalties:

> 39 (2) If a determination is made under subsection (1), the discipline committee may, by order, do one or more of the following:
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> (a) reprimand the respondent;
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> (b) impose limits or conditions on the respondent's practice of the designated health profession;
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> (c) suspend the respondent's registration;
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> (d) subject to the bylaws, impose limits or conditions on the management of the respondent's practice during the suspension;
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> (e) cancel the respondent's registration;
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> (f) fine the respondent in an amount not exceeding the maximum fine established under section 19 (1) (w).

8. If the Panel orders a suspension or cancellation, the following additional provisions apply:

> 39 (8) If the registration of the respondent is suspended or cancelled under subsection (2), the discipline committee may
> (a) impose conditions on the lifting of the suspension or the eligibility to apply for reinstatement of registration,
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> (b) direct that the lifting of the suspension or the eligibility to apply for reinstatement of registration will occur on
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> > (i) a date specified in the order, or
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> > (ii) the date the discipline committee or the board determines that the respondent has complied with the conditions imposed under paragraph (a), and
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> (c) impose conditions on the respondent's practice of the designated health profession that apply after the lifting of the suspension or the reinstatement of registration.

9. Section 39(5) of the HPA authorizes the Panel to award costs to the College.

Jurisdiction over Former Registrant

10. The Respondent was a registrant at the time of the events set out in the Citation. On March 1, 2018, the Respondent’s registration with the College lapsed and has not been renewed. The Panel retains jurisdiction to impose orders under section 39 against the Respondent as a “former registrant”.

11. Section 26 of the HPA defines “registrant” to include “former registrant” for the purposes of Part 3 of the Act which deals with “Inspections, Inquiries and Discipline”:

> "registrant" includes a former registrant, and a certified non-registrant or former certified non-registrant to whom this Part applies;

12. The Discipline Committee dealt with the jurisdiction of a former registrant in *College of Massage Therapists of British Columbia v. Gill*, 2019 CMTBC 01. Citing *College of Nurses of Ontario v. Dumchin*, 2016 ONSC 626, the panel in *Gill* held:

> 25. The Panel agrees with the rationale above. The interpretation of the HPA should likewise be given a purposive approach having regard to the College's duty to protect the public. Interpretations that limit the College's sanctioning powers and encourage members to resign or allow their registration to lapse in order to avoid consequences are contrary to the purpose of the HPA. This is particularly the case, where the College's registration committee is required to process registration applications and grant registration to individuals who meet the conditions and requirements under section 20(2) of the HPA.
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> 26. The Panel finds, having regard to the words of the statute, their context, and the purpose of the HPA, that the HPA's reference to "registrant" and "respondent" in sections 37 to 39 includes a "former registrant". The Panel finds that it may order any of the penalties listed in section 39(2) against a former registrant, including a suspension.

13. The Panel agrees with and adopts the reasoning set out above.

General Approach

14. The primary purposes for professional sanctions are to protect the public and preserve the public's confidence in the regulation of the profession. Determining an appropriate penalty is a matter of discretion. The Panel may make one or more of the orders set out in section 39(2) of the HPA having regard to the findings it made in the Conduct Decision and all of the circumstances.

15. The relevant factors to consider in determining an appropriate penalty are set out in *Law Society of British Columbia v. Ogilvie*, [1999] LSBC 17:

    a. the nature and gravity of the conduct proven;

    b. the age and experience of the respondent;

    c. the previous character of the respondent, including details of prior discipline;

    d. the impact upon the victim;

    e. the advantage gained, or to be gained, by the respondent;

    f. the number of times the offending conduct occurred;

g. whether the respondent has acknowledged the misconduct and taken steps to disclose and redress the wrong and the presence or absence of other mitigating circumstances;

h. the possibility of remediating or rehabilitating the respondent;

i. the impact on the respondent of criminal or other sanctions or penalties;

j. the impact of the proposed penalty on the respondent;

k. the need for specific and general deterrence;

l. the need to ensure the public's confidence in the integrity of the profession; and

m. the range of penalties imposed in similar cases.

16. Law *Society of BC v. Dent*, 2016 LSBC 05 consolidated the list of relevant factors to consider in determining an appropriate penalty:

    a. nature, gravity and consequences of conduct;

    b. character and professional conduct record of the respondent;

    c. acknowledgement of the misconduct and remedial action; and

    d. public confidence in the legal profession including public confidence in the disciplinary process.

17. Many professional regulation tribunals, including this College's Discipline Committee, have applied the *Ogilvie / Dent* factors. These authorities have been cited with approval by many health profession regulators in British Columbia, including in the recent BCCNM cases of *Whieldon* and *Parniak*. The Panel considers the *Ogilvie / Dent* factors to be the appropriate framework in this case.

Nature, Gravity and Consequences of Conduct

18. The College submits that this is the most important factor in the assessment of an appropriate penalty. The College referred to *Law Society of British Columbia v. Ganapathi*, 2021 LSBC 14 which held that the seriousness of the misconduct is the "prime determinant of the sanction imposed."

19. The College submits that in this case the Respondent provided care to her mother and her father both inside and outside of a hospital setting. In addition, she accessed her father's medical records in circumstances when she knew or ought to have known that she was not to be doing so. The College notes that the Panel found the Respondent's treatment of her family members in avoidable circumstances to be a marked departure from the conduct expected of a registered nurse and that the Respondent's conduct was flagrant and serious. The Panel found the Respondent's conduct contravened the Bylaws, the Boundaries Standard and the Conflict of Interest Standard. The College suggests that these should not be viewed as separate breaches given that the Panel chose to only make a single determination of professional misconduct with respect to each of the allegations. The Panel agrees; it only made a single determination with respect to each of the allegations.

20. The College underlines that the Respondent's colleagues cautioned her about treating her family members and in all cases the Respondent did not seem receptive to the advice and guidance she was given. The College submits that the Respondent may have thought she was doing the right thing by providing care to her parents, however, she was incorrect. It is not open to the Respondent to ignore the College's standards based upon her subjective views of a situation. The College submits that doing so is a fundamental failure to act in her patients' best interests.

21. The College submits that the Respondent did not approach the treatment of her parents to the standard ordinarily expected of a registered nurse. For example, while the Respondent testified that she conducted careful and regular nursing assessments of her father during the evening of July 1, 2018, she testified that those records no longer exist. In the ordinary course, a registrant would carefully chart and retain their observations of a patient. The College submits that the Respondent allowed her personal interests to supersede her professional obligations. This tension is precisely why the relevant professional standards exist.

22. The College acknowledges that there is no evidence in this case of physical harm to the Respondent's father or mother as a result of her misconduct. The College acknowledges that the Respondent's misconduct has already had some

consequences to her as she was terminated from her employment with the Fraser Health Authority ("FHA"). While the Respondent grieved her termination, the College notes that the net result is that she has not practiced as a nurse since late 2017 and her registration lapsed and was not renewed as of March 1, 2018.

23. The Respondent did not make any submissions on the assessment of the penalty factors and as noted above, agreed with the College's characterization of the matter as outlined in the College's submission.

24. The Panel agrees with the College that this factor holds prime importance in the assessment of an appropriate penalty. The Panel finds that the Respondent's misconduct was flagrant and serious. The Respondent took it upon herself to provide nursing care to her mother and father in avoidable circumstances. The Respondent delivered this care in the hospital and at their home. The Respondent was aware of her professional obligations and had been warned by colleagues not to deliver care to her family members. The Respondent accessed her father's medical records.

25. The Panel notes that there is no evidence before it that the Respondent's parents experienced any physical harm as a result of the Respondent's misconduct. The Panel agrees with the College's submission that the Respondent has already experienced some negative consequences in the form of her employment termination. The Panel does not consider there to be sufficient evidence before this Panel to find the Respondent's registration lapse constitutes a negative consequence resulting from her misconduct. There is no evidence before this Panel from either of the parties indicating that the lapse in registration was anything other than voluntary.

26. Overall the Panel considers this factor weighs in favour of imposing a more serious penalty.

Character and Professional Conduct Record of the Respondent

27. The College submits that the Respondent was a junior member of the nursing profession when these events occurred. She obtained her nursing degree in 2015 and began working at the Peace Arch Hospital ("PAH") in February 2016.

Accordingly, the Respondent had been a registrant for approximately one year at the time of the events in question. The College notes that the Respondent does not have a discipline history with the College, however it argues that this would ordinarily not be expected for a registrant of such limited experience and the absence of a discipline history is a less persuasive factor than it might be for an experienced registrant. The College submits that the "Respondent's short tenure as a registrant, and absence of previous discipline history, are slight mitigating factors."

28. The Panel does not agree with the College's submissions that these are slight mitigating factors. The Panel finds that the Respondent's junior membership in the profession and absence of any disciplinary record are mitigating circumstances in this case. The Respondent had been practising nursing for approximately one year at the time of the events set out in the Citation. She has no prior disciplinary record. These factors weigh in favour of the imposition of a less serious penalty.

Acknowledgement of the Misconduct and Remedial Action

29. The College submits that while the Respondent admitted the facts underlying allegations 1(a), 1(b), 1(d) and 2(a) of the Citation, she never accepted responsibility for what occurred and insisted that her conduct did not constitute any type of misconduct. Rather, the Respondent argued that she had permission to treat her mother, that a procedure was routine, that she was in an impossible situation when treating her father, and that access to her father's records was in compliance with FHA's personal information policy. The College points out that the Respondent took the extraordinary step of initiating (herself or in conjunction with her father) regulatory and civil proceedings against a number of the other nurses who were involved with the events outlined in the Citation. The College notes that the Respondent's shop steward testified that the Respondent found it difficult to acknowledge any wrongdoing.

30. The College argues that the combination of these things reveals a significant lack of insight on the Respondent's part. She appears unwilling to acknowledge that she has committed misconduct and that she alone is responsible for her professional

conduct as a registrant. The College notes that the Respondent has not provided any evidence of remedial action.

31. The Panel finds that the Respondent made admissions of fact with respect the matters set out in the Citation, however, she vigorously contested having engaged in any wrongdoing. The Panel agrees with the College that the Respondent displayed a significant lack of insight. The Panel finds that the Respondent has not provided any evidence that she has undertaken any remedial action. The absence of remorse or insight is not an aggravating factor for purposes of the sanctions analysis; however, it may be the absence of a mitigating factor. The Panel finds that in this case, there is an absence of a mitigating factor.

Public Confidence in the Profession Including in the Disciplinary Process

32. This factor involves an assessment of the need for specific deterrence, general deterrence and the need to maintain public confidence in the profession.

33. The College submits that in terms of general deterrence it is very important that College registrants understand that they must not treat family members except in unavoidable circumstances. The rationale and importance of this principle was described in *The College of Physicians and Surgeons of Ontario v. Garcia*, 2017 ONCPSD 6, which was cited at paragraph 46 of the Conduct Decision. This includes that treating family members can create confusion about the role in which the registrant is acting, it may create a serious conflict, and it creates the risk that the family relationship will affect the registrant's ability to provide proper care. The College notes that the Panel already concluded in the Conduct Decision that these principles inform the requirement for nurses to refrain from treating their family members. The College submits that all of this underscores the importance of the prohibition on treating family members except in unavoidable circumstances. Every nurse in the province may encounter circumstances in which there is an opportunity to treat family members and it is therefore very important to communicate a strong message to the profession that this behaviour will not be tolerated. The College argues that general deterrence is also required with respect to viewing family

members' medical records as it engages significant concerns about confidentiality and privacy.

34. The College submits that there is also a particular need for specific deterrence in this case because the Respondent repeatedly treated her family members despite multiple cautions from colleagues, the Respondent effectively asserted that if she wanted to conceal this behaviour she could have, and even in the instances where the Respondent admitted the underlying events, she continued to insist she had done nothing wrong. Accordingly, the College submits the Panel's order must be sufficient to deter the Respondent from repeating this type of misconduct.

35. The College referred to a number of outcomes in similar cases. The College referred to *BCCNP re: Chan* (May 22, 2020). In that case, the registrant was not on shift, took a bottle of nitro-spray and removed it from her workplace to provide it to her father. Her colleagues expressed their concerns when she reported for work, and the registrant reported herself to the facility's management and indicated she was willing to accept any consequences for her actions. The registrant was suspended from her employment for four weeks, and subsequently entered into a consent agreement with the College. She pre-emptively completed remedial education regarding ethics and professionalism. The consent order approved by the Inquiry Committee included an undertaking not to repeat the conduct and a suspension of two weeks (deemed to have been served during the time she was suspended by her employer). The College submits that there are several distinguishing features including that there was not evidence the registrant administered treatment to her father, she self reported the issue, and took remedial action.

36. The College also referred to the following cases:

    a. *BCCNM re: Bader* (July 20, 2022): The registrant accessed the medical records of the complainant on one occasion. The complainant was not a patient of the hospital the registrant worked at, and the registrant had no work-related purpose for accessing the complainant's medical records. The registrant's employer suspended her and required her to take educational coursework. The registrant resolved the matter through a consent

agreement that included a reprimand, an 8-day suspension, and a remedial education course.

b. *BCCNM re Kenwood* (September 7, 2022): The registrant accessed the medical records of 166 patients for no work-related purpose, including accessing her parents' medical records, over a period of several years. The registrant also accessed the medical records of a “VIP" patient and shared a report found therein with her colleagues. The registrant was terminated from her employment, but after an internal process, was instead permitted to resign. The registrant resolved the matter through a consent agreement that included a 60-day suspension, and two remedial education courses.

c. *BCCNM re Hill* (September 8, 2022): The registrant accessed the medical records of 97 patients for no work-related purpose, including accessing two of her family members' medical records, over a period of one and a half years. The registrant was terminated from her employment. She resolved the matter through a consent agreement that included a 60-day suspension and three remedial education courses.

d. *College of Registered Nurses v. Hancock*, CRNM #2015-135095-04: The registrant, an employee at a community health clinic, failed to maintain appropriate professional boundaries by providing nursing care, and becoming involved in a therapeutic relationship with, her mother-in-law when it was avoidable. Considering the registrant’s 25-year history in practice without any disciplinary record, the fact that she had her mother-in-law’s consent to access her records, and the fact that there was no evidence of any harm to her mother-in-law, the panel ordered a two-month suspension from practice and a remedial education course on appropriate boundaries in a medical context. The registrant’s appeal was dismissed in *Hancock v. College of Registered Nurses of Manitoba*, 2021 MBCA 20.

37. The College argues that the Panel should be cautious about according too much weight to consent agreements. The College refers to the Ontario case of *Hanif v. College of Veterinarians of Ontario*, 2021 ONSC 1819 and argues “consent

resolutions before the Inquiry Committee are "not comparable to penalty decisions based on a finding of professional misconduct following a contested hearing"." The Panel agrees but notes that the specific features of provincial regulatory regimes are important to keep in mind. In British Columbia, matters can be resolved under section 36 or section 37.1 of the HPA. As was noted in *CMTBC re: Morgan*, consent orders under section 37.1 of the HPA are reached following the issuance of a citation. A registrant delivering a proposal must admit the nature of the complaint or other matter that is to the subject of the discipline hearing, and consent to an order under section 39(2) or (8) of the HPA. While the proposal is delivered to the Inquiry Committee for acceptance or rejection, if a proposal is accepted, the Inquiry Committee's order is considered to be an order of the Discipline Committee made under section 39 of the HPA.

38. The College argues that what is apparent from the cases cited, is that accessing medical records of a person not under the nurse's care, particularly a family member, ordinarily results in suspension. The College submits that the *Hancock* decision is the most similar to this case, however, the Respondent's case is more serious. In particular, the Respondent provided treatment to her family members on multiple occasions unlike in *Hancock*. The College submits a three-month suspension and remedial action is well aligned with the outcomes of similar cases set out above.

39. The Panel finds that specific deterrence, general deterrence and the need to maintain public confidence in the profession are all engaged in this case.

40. The Panel agrees with the College's arguments with respect to the need for specific deterrence. The Respondent repeatedly treated her family members, she did so despite cautions from colleagues, she stated that if she wanted to conceal her behaviour she could have, and she continued to insist she had done nothing wrong.

41. The Panel also agrees with the College that there is a need for general deterrence in this case given that every member of the profession may be potentially faced with circumstances in which there is an opportunity to treat family members. A message must be sent to the profession about the prohibition on treating family members in avoidable circumstances. It can create confusion about the role in which the

registrant is acting, it may create a serious conflict, and it creates the risk that the family relationship will affect the registrant's ability to provide proper care. It may compromise patient safety and continuity of care. The Panel finds that general deterrence is also required with respect to viewing medical records of a person not within a nurse's care as it compromises basic principles of confidentiality and privacy.

42. The College has statutory duties to at all times serve and protect the public and to exercise its powers and discharge its responsibilities under all enactments in the public interest. The Panel finds that there is a strong need to uphold public confidence in the integrity of the profession and in the College's ability to regulate the profession in the public interest given the important concerns relating to professional boundaries with patients and the importance of maintaining and preserving confidentiality and privacy of in patients' medical records.

43. The Panel has considered the cases referenced by the College and agrees that the *Hancock* decision is the most similar to this case. The following passages from the Manitoba Court of Appeal decision are particularly informative with respect to the penalty analysis:

> [62] In my view, the Panel properly applied the appropriate principles in imposing penalty. It considered the circumstances of the misconduct and the background of the appellant. It also considered whether a lesser sentence, such as a censure or reprimand, was appropriate.
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> [63] Despite admitting that she had improperly accessed H.L.'s medical record, the appellant's position was that she had no other option. This was specifically rejected by the Panel. The Panel concluded that, rather than becoming directly involved in H.L.'s care, the appellant could have spoken to another nurse for assistance, consulted with the College, requested home care services for H.L., and "at the very least, ought to have spoken with [Dawson], her immediate supervisor." Moreover, the Panel concluded that, despite being cautioned about accessing H.L.'s medical records, she continued to involve herself in H.L.'s care.
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> [64] The Panel's determination that the appellant lacked insight is reasonably supported by the record. The appellant's lack of insight and failure to accept responsibility distinguishes this case from other cases involving breaches of professional boundaries. The misconduct was serious. It was intentional and involved repeated intrusions into H.L.'s medical record which continued until the conduct was discovered, rather than being a momentary lapse. While the circumstances here are unique in the sense that they involve a family member's

> medical record accessed with good intentions and after-the-fact consent, the College's policy prohibiting this conduct is clear. The College's policy regarding professional boundaries is intended to prevent conflicts involving a nurse's personal and professional interests in order to ensure client safety.
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> [65] I agree with the submissions of the College that the misconduct in this case involved "a clear violation of a practice expectation that goes to a foundational facet of the nursing relationship with a client".
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> [66] The appellant had a 25-year history of good character and nursing excellence and suffered significant deterioration in her psychological functioning as a result of the discipline hearing process. The order to complete a remedial course provided an appropriate opportunity for rehabilitation.
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> [67] In my view, despite the appellant's background and the mitigating factors, the seriousness of the misconduct and her ongoing lack of insight warranted a suspension as opposed to a censure or a reprimand. Overall, the penalty imposed maintains public confidence and ensures the protection of the public.

44. As in *Hancock*, the Respondent displayed a significant lack of insight and engaged in repeated instances of delivering nursing care to her parents and repeated access of her father's medical records. This is not a case of a momentary lapse of judgment. The Respondent's conduct was a flagrant violation of the applicable practice expectations that go to a foundational facet of the nursing relationship with a patient. As noted by the College, the Respondent's conduct is more serious than the conduct in *Hancock*, as the Respondent provided treatment to her family members on multiple occasions. This factor weighs in favour of the imposition of a more serious penalty.

45. Weighing all of the *Ogilvie / Dent* factors, the Panel finds that the appropriate penalty in this case is the issuance of a reprimand, the imposition of a three-month suspension, and the requirement that the Respondent complete remedial education. The College has not sought remedial education as a pre-requisite to the Respondent's return to practice and notes that the Registration Committee retains complete discretion to consider and determine the Respondent's application for reinstatement, including granting or refusing registration and imposing any terms or conditions it sees fit. The Panel is agreeable to that approach in this case and to the specific courses proposed by the College and consented to by the Respondent.

46. The College takes the position that the Respondent's suspension is deemed to have been served between August 9, 2022 and November 9, 2022 because of the "unique circumstances of this proceeding, in particular the Respondent's termination from her employment and lengthy time out of the profession." The Panel does not agree with the College's characterization of the facts in this case as being unique. Many cases involve registrants who have been terminated from their employment and who have spent time away from the profession. As noted above, the parties' information before this Panel is that the Respondent's change in registration status was due to her registration lapsing. While the Panel disagrees with the College's submissions on this particular point, the Panel is reluctant to depart from the request to consider that the suspension has been served where the parties are in agreement with this point, and as there are no compelling public interest reasons to depart from the terms agreed upon by the parties in this case. The Panel notes that this is particularly the case given that the registrant was a very junior member of the profession when the conduct occurred, she has no prior disciplinary record, she did make admissions of fact during the conduct phase of the proceedings, and she has consented to the penalty portion of these proceedings.

Costs

47. The College is not seeking an order of costs in this case. The College has indicated that it has made this decision given the "unique facts of this case….and also recognizing that the Respondent had to deal with an extended period of time while waiting to receive the Panel's decision." For the reasons set out in paragraph 46, the Panel does not agree with the characterization of this case as being unique. Moreover, the applicable period to consider is not in relation to the issuance of the decision, but from the receipt of a complaint. Under either situation, the length of time is well inside the period contemplated in *Law Society of Saskatchewan v. Abrametz*, 2022 SCC 29. Nevertheless, the Panel reiterates that it is reluctant to depart from the terms agreed upon by the parties absent compelling public interest reasons to do so in this case. This includes the College's decision not to pursue costs in this case. The Panel makes no order as to costs.

C. ORDER

48. The Panel orders that:

    a. The Respondent is reprimanded pursuant to section 39(2)(a) of the HPA;

    b. The Respondent is suspended for a period of three months, pursuant to section 39(2)(c) of the HPA with such suspension deemed to have been served; and

    c. In the event that the Respondent's registration with the College is reinstated, the following conditions are imposed on the Respondent's practice, pursuant to section 39(2)(b) of the HPA:

        i. Within three months of the date of her reinstatement, the Respondent must successfully complete the full module and workbook for *Boundaries* available through the College website;

        ii. Within three months of the date of her reinstatement, the Respondent must successfully complete the full module and workbook for *Privacy and Confidentiality* available through the College website; and

        iii. Within three months of the date of her reinstatement, the Respondent must successfully complete the course titled *Righting a Wrong – Ethics & Professionalism in Nursing*, available through the International Center for Regulatory Scholarship.

49. The Panel reminds the College of the requirements in section 39(3)(c) of the HPA.

50. The Panel directs that the Registrar notify the public of the order made herein pursuant to section 39.3 of the Act.

51. The Respondent is advised that under section 40(1) of the Act, a respondent aggrieved or adversely affected by an order of the Discipline Committee under section 39 of the Act may appeal the decision to the Supreme Court. Under section 40(2) of the Act, an appeal must be commenced within 30 days after the date on which this order is delivered.

Dated: January 30, 2023

Sheila Cessford, Chair

Dorothy Jennings, RPN

Jackie Murray, RN