Ontario College of Social Workers and Social Service Workers
Ordre des travailleurs sociaux et des techniciens en travail social de l'Ontario
250 Bloor Street E. Suite 1000 Toronto, ON M4W 1E6
Phone: 416-972-9882 Fax: 416-972-1512 www.ocswssw.org

DISCIPLINE COMMITTEE OF THE ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

Indexed as: Ontario College of Social Workers and Social Service Workers v Scally, 2021 ONCSWSSW 5

Decision date: 20210413

BETWEEN:

THE ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

- and -

PATRICK SCALLY

PANEL:	Angele Desormeau	Chair, Professional Member
	Rita Silverthorn	Professional Member
	John Fleming	Public Member

Appearances: Jill Dougherty and Ada Jeffrey, counsel for the College
Member not in attendance
Edward Marrocco, Independent Legal Counsel to the Panel

Heard: January 26 & 28, 2021

DECISION AND REASONS FOR DECISION

[1] This matter came on for an electronic hearing before a panel of the Discipline Committee (the "**Panel**") on January 26 & 28, 2021 at the Ontario College of Social Workers and Social Service Workers (the "**College**").

[2] Patrick Scally (the "**Member**" or "**Mr. Scally**") was neither present nor represented at the hearing. College counsel called evidence to establish that the Member had been served with the Notice of Hearing and advised of the hearing date. The Panel accepted that the Member was properly served with the Notice of Hearing and had adequate notice of the time, date, place and nature of the hearing.

[3] Accordingly, the Panel proceeded with the hearing in the Member's absence on the basis that the Member denied the allegations against him.

The Allegations

[4] In the Notice of Hearing dated November 20, 2018, the Member is alleged to be guilty of professional misconduct pursuant to the *Social Work and Social Service Work Act*, 1998, S.O. 1998, c 31 (the "**Act**") in that he is alleged to have engaged in conduct which contravenes subsections 26(2)(a) and 26(2)(c) of the Act.

[5] The allegations set out in the Notice of Hearing and the particulars of those allegations are as follows:

Particulars

1. At all relevant times, Mr. Scally was registered as a social work member with the Ontario College of Social Workers and Social Service Workers (the "**College**");

2. Between September 2017 and November 2017 Mr. Scally provided social work and counselling services to [Client X] (the "**Client**") for issues related to personality disorder, alcoholism and anxiety.

3. During counselling sessions and/or during the time between September 2017 and November 2017, Mr. Scally:

    a. told the Client that she was "hot" in response to her disclosure to him that she felt ugly;

    b. asked the Client if she masturbated. After telling him that she was uncomfortable discussing this topic, he continued to inquire about it by saying "Are you taking care of things?" during subsequent sessions; and

    c. disclosed intimate and personal details to the Client about his own life and sexual behaviour.

4. While employed as a social worker at [*redacted*] Community Counselling and Addictions Services (**"CCAS")**, Mr. Scally failed to keep records as required by the regulations and standards of the profession of social work, including, but not limited to, one or more clients included in Schedule A.

5. On or about February 1, 2018, Mr. Scally's employment with [*redacted*] Community Counselling and Addictions Services was terminated for his failure to keep records as required by the regulations and Standards of Practice. At the time of his termination, he had approximately 246 patient notes outstanding.

Allegations

It is alleged that by reason of engaging in some or all of the conduct outlined above, Mr. Scally [is] guilty of professional misconduct as set out in section 26(2)(a) and (c) of the *Act*:

(a) In that he violated **Section 2.2 of the Professional Misconduct Regulation** and **Principle I of the Handbook (commented on in Interpretation 1.2, 1.3, 1.5 and**

1.6) by failing to observe, clarify, and inquire about information presented to him by his client; by failing to respect and facilitate his client's self-determination; by failing to be aware of his values, attitudes and needs and how these impacted on his professional relationship with clients; and by failing to distinguish his needs and interests from those of his clients to ensure that, within his professional relationship, clients' needs and interests remained paramount;

(b) he violated **Section 2.2 of the Professional Misconduct Regulation** and **Principle II of the Handbook (commented on in Interpretation 2.2)** by failing to establish and maintain clear and appropriate boundaries in his professional relationship;

(c) In that he violated **Section 2.2 of the Professional Misconduct Regulation and Principle IV of the Handbook (commented on in Interpretation 4.1.1, 4.1.3, and 4.1.6)** by failing to keep records in a format that facilitated the monitoring and evaluation of the effects of the service/intervention; by failing to keep systematic, dated, and legible records for each client or client system served; and by failing to record information when an event occurred, or as soon as possible thereafter.

(d) In that he violated **Section 2.2 of the Professional Misconduct Regulation** and **Principle VIII of the Handbook (commented on in Interpretation 8.2.3)** by engaging in behaviour or making remarks of a sexual nature towards the client other than behaviour or remarks of a clinical nature appropriate to the service provided;

(e) In that he violated **Section 2.20 of the Professional Misconduct Regulation** by failing to keep records as required by the regulations and standards of the profession;

(f) In that he violated **Section 2.28 of the Professional Misconduct Regulation** and **Section 26(2)(a) of the Act** by contravening the Act, regulations, or by-laws; and

(g) In that he violated **Section 2.36 of the Professional Misconduct Regulation** by engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Member's Position

[6] The Member was not present or represented at the hearing. Accordingly, he was deemed by the Panel to deny the allegations.

The Evidence

[7] The Member was employed as a case manager at CCAS from 2013 until his termination for cause on February 1, 2018. At all relevant times the Member was a registered social worker with the College. In his role as a case manager, the Member provided counselling services to the Client and was required to adhere to the documentation practices of both CCAS and the College's Standards of Practice.

[8] College counsel called three witnesses to testify with respect to the allegations in the Notice of Hearing: (1) the Client; (2) [M.S.] (Director at CCAS); and [W.P.] (a Social Worker and previous counsellor to the Client).

[9] The Client testified that the Member made sexually inappropriate comments to her. He told her she was "hot", asked her about masturbation and talked about his own sexuality. All of these topics made the Client feel uncomfortable and unsafe.

[10] [M.S.] testified that, due to the serious nature of the Client's complaint, a third party investigation was conducted by [*redacted*] Regional Hospital - which is the sponsoring organization for CCAS. At the conclusion of that investigation, the Member was dismissal from CCAS.

[11] [W.P.] testified that when the Client reached out to her and disclosed her experience with the Member, [Ms. W.P.]found it necessary to contact the College and make a formal complaint.

[12] College counsel also filed documentary evidence regarding the Member's failure to follow documentation standards as set out in the CCAS Policy and Procedures 5.1 and 5.2 and in contravention of applicable Regulations and the College's Standards of Practice.

[13] The Member first registered with the College as a social worker on April 12, 2012. He has been suspended since May 21, 2019 for non-payment of fees. The conduct at issue nonetheless relates to a time when the Member was registered with the College and the Panel is satisfied that it has jurisdiction to deal with these matters pursuant to subsection 13(5) of the Act.

[14] The Member did not attend or participate in his hearing before the Discipline Committee and did not request an adjournment. Several attempts were made to communicate with the Member regarding the proceedings. These are marked as Exhibits (A) through (L) in Tab 1 of the College's Book of Documents.

Testimony of the Client

[15] The Client testified that she first made contact with CCAS regarding counselling services in the summer of 2017. She recalled providing information both verbally and in writing as part of the intake process with CCAS, and subsequently reviewing this information (including her diagnosis) with the Member during their sessions.

[16] The Client began seeing the Member around September 2017. Their meetings occurred twice a week, primarily at the Client's home. The frequency of their meetings was set by the Member, initially with the Client's agreement. As counselling progressed, the Client came to feel that she did not have autonomy or authority with respect to determining the frequency of the sessions. After the incident described below, the Client wanted to meet less frequently but did not feel this was an option. As above, the Client and the Member met in her home. The Client initially found this convenient until the Member began to make comments that made her feel uncomfortable.

[17] The Client testified that the initial incident occurred in an early session, sometime in the autumn of 2017. The Client recalled that she was discussing self-esteem issues and she began to verbally self-sabotage (by saying she felt ugly, or words to that effect). The Member responded by

saying something along the line of “What are you talking about? You’re hot!” in an expressive manner. This comment made the Client feel uncomfortable and she did not respond to it, as she thought it was an isolated occurrence. At the same session, the Member also said something along the lines of “I don’t understand your husband, I wish I could get into his head” which the client understood related to the issue of her husband not wanting to have sex. The Client felt that sex became a theme for the Member in subsequent sessions, even though it was not one of the presenting issues for which she had sought counselling.

[18] The Client testified that a second incident took place in a session shortly after the first incident. The Client and the Member were sitting at the Client’s kitchen table, doing dialectic behaviour worksheets. The Client made a comment to the Member along the lines that physical intimacy was missing in her marriage. The Member responded by asking her “have you ever masturbated?” The client was taken aback by this question and felt extremely uncomfortable, and unsafe. She responded by shaking her head, indicating no, and putting her head on the table. The Client recalls saying she “didn’t do that” and that she did not want to talk about the subject any further.

[19] The Client testified that at the next session, the Member brought up masturbation again, by saying something along the line of “well did you do it?” The Client was surprised that he had brought up the topic again and felt embarrassed and unsure about how to answer. The Client does not recall saying anything, but rather kept shaking her head. The Member then proceeded to discuss his own sexual life and childhood. He told her how he was not allowed to discuss sex, as it was taboo and that now he was a very sexual person as a result. The Client testified that during this conversation, the Member’s body language made her uncomfortable as he was sitting at the kitchen table with his legs spread apart, pushing forward on the table. The Client perceived his behaviour as indicating arousal due to the nature of the topic he was discussing.

[20] The Client recalls telling the Member that she was not comfortable discussing sex and that she did not want to discuss it anymore. The Client has a history of childhood sexual abuse and PTSD (which the Member was aware of) which was triggered by this experience. The Client testified that the experience with the Member evoked a “disgusting” feeling inside her - one that she associated with her past trauma. In her testimony she stated that the experience “brought her right back” and made her think about “gross things” again.

[21] Shortly after one of the incidents described above, the Client relapsed and started drinking again. This was subsequent to having achieved approximately one year of sobriety before moving to [*redacted*]. The Client recalled that after the second incident with the Member she went across the street to the grocery store and purchased alcohol, which she consumed the following day. After that the Client stopped being in regular contact with the Member. The Client testified that subsequently the Member showed up unannounced at the client’s house while she was in bed. The Client heard noise coming from the living room, and when she went to check, she was surprised and somewhat afraid to find the Member standing there. The Member told her that he was there on a mental health check.

[22] The Client testified that she was primarily seeking treatment for relapse prevention and anxiety support and that the Member’s focus on sexual issues made her very uncomfortable. The Client testified that she brought up the lack of intimacy with her husband only once, in the context of feeling isolated in [*redacted*]. She did not intend for it to become the focus of her therapy.

[23] The Client testified that, after these experiences with the Member, she decided to contact [W.P.], her trusted former counsellor. On the first occasion that the client contacted [Ms. W.P.] she related that therapy was not going well and that she was not doing well integrating into the community. During a later call, the client gave more details to [Ms. W.P.] about the Member and described what the Member had said to her. [Ms. W.P.] made it clear to the Client that the Member's behaviour was not appropriate and she was going to have to report it to the College. The imminent report made the Client feel uncomfortable and scared. She cited how small the community was, and that she did not want to get the Member into trouble. After knowing that [Ms. W.P.] was going to report the matter, the Client contacted CCAS on November 20, 2017, to report the Member's behaviour and ask for a new counsellor.

[24] The Client testified that while she is now in a positive place, having recently moved to Alberta and registered with the College of Social Workers of Alberta, the experience with the Member sent her into a tailspin. She started drinking again and the events set her back for some time following the initial crisis. The Client reported that she found it difficult to trust again and struggled with sobriety for several years afterwards.

Testimony of [Ms. M.S.]

[25] The second witness called to testify was [Ms. M.S.], Director of CCAS. [Ms. M.S.] has been a registered Social Worker since 1997. She has worked for CCAS since 1998, and has been in her current role since 2001. Since 1998, [Ms. M.S.] has maintained a clinical practice in addition to her other responsibilities. [Ms. M.S.'s] educational background includes an undergraduate degree in social development form 1991-1995 at the University of Waterloo, and a Master's of Social Work from Wilfred Laurier University from 1995-1997. She has worked consistently as a social worker since that time, and has a depth of experience in the field of mental health and addictions. In particular, [Ms. M.S.] is familiar with Dialectical Behavioural Therapy and the treatment of individuals with borderline personality disorder and PTSD. [Ms. M.S.'s] current responsibilities include recruitment, clinical supervision, and privacy. [Ms. M.S.] also enforces and maintains standards, including the internal standards of CCAS with respect to documentation.

[26] [Ms. M.S.] testified that she first met the Member during recruitment, when he was applying to work as a mental health case manager at CCAS. He began work on February 4, 2013, and worked until February 1, 2018, when he was dismissed for cause. His responsibilities included providing case management services to individuals with serious mental illness, advocacy, linkage, and counselling. His average caseload was 15-20 active clients. There were times when he had up to 30, but many of those were inactive.

[27] Depending on the client's situation, a case manager might see a client once a week or more. Such decisions were supposed to be made in collaboration with the client, based on an assessment. The Member presented himself as having substantial experience with respect to clients with complex trauma, boundary issues and borderline personality disorder. [Ms. M.S.] recalls that, during his interview, the Member showed her a paper that he wrote on Dialectical Behaviour Therapy and the treatment of borderline personality disorder.

[28] [Ms. M.S.] testified that, as an employee of CCAS, the Member was expected to adhere to certain documentation standards as set out in CCAS Policy and Procedures 5.1 and 5.2. These standards required, for example, that each client contact be documented electronically in the CCAS system within 2 business days of the contact. [Ms. M.S.] testified that the Member was aware of

these standards, was encouraged to read them repeatedly and signed off on them. Client contacts included both scheduled and unscheduled meetings, phone calls, and direct and indirect contact. In addition, employees were to document any contacts with the medical or psychiatric system, and contacts with the client's family member, probation officer or family welfare contact. Other documentation that was required for each file included a psycho-social assessment from which the treatment plan was derived, and discharge summaries.

[29] [Ms. M.S.] testified that the rationale behind the documentation of each client contact was to ensure that the care the clients received was accurately reflected, as each contact could have implications for the care plan. In addition, regular documentation allowed for proper supervision and avoided a risk of boundary slippage. As was clear from [Ms. M.S.'s] documentation in the Member's personnel file, the Member consistently failed to meet the CCAS standards for documentation despite multiple accommodations between 2013-2018.

[30] As noted above, the Client's case was assigned to the Member. The Client's diagnosis was one of borderline personality disorder and PTSD, associated with complex trauma, of which a significant cause can be childhood sexual abuse. The Client's intake note (which the Member would have had access to) indicated that she was seeking therapy for mental health, and substance use issues and had a diagnosis of borderline personality disorder as well as PTSD. In [Ms. M.S.'s] view, the Member's knowledge of borderline personality disorder and Dialectical Behaviour Therapy for clients with that diagnosis was significant. Individuals with this history are known to struggle with boundaries, either over sharing or bring triggered by other's boundary crossing. It is very important for them to avoid any reminders of their trauma, as it will bring up emotional and cognitive distress, and can lead to a wide variety of coping strategies such as cutting or alcohol abuse.

[31] [Ms. M.S.] testified that, on November 20, 2017, she had a telephone meeting with the Client to discuss a transfer - which is the CCAS protocol in situations where a client feels uncomfortable requesting the transfer from their counsellor directly. The Client told [Ms. M.S.] that the Member had made her feel extremely uncomfortable and related the episode where she was talking about low self-esteem and he told her she was hot. She also told [Ms. M.S.] that she didn't feel that she had autonomy in the counseling process, that the Member would direct how often she was seen, and she felt that it was too often. The Client told [Ms. M.S.] that the Member would talk to her about masturbation, and encouraged her to masturbate. He also spoke about his own sexual history, and told her that he grew up being unable to speak about sex, and now was a highly sexual person. The Client indicated that she had told the Member she did not want to talk about sex, but that it had become a focal point for him in their sessions. [Ms. M.S.] described the Client's demeanour during the phone call as highly apologetic stating that the Client was worried about getting the Member into trouble, and was concerned she was being a burden.

[32] [Ms. M.S.] testified that she regarded the concerns raised by the Client as serious ones. She testified that after this meeting with the Client CCAS facilitated an independent investigation and brought in a third party investigator (from [*redacted*] Regional Hospital, which was the CCAS sponsoring organization) who met with the Member and the Client. This investigation occurred in November and December 2017. The final report was given to the hospital and its conclusions, including that the Member lacked insight into his behaviour, formed part of the reason for the Member's dismissal.

[33] [Ms. M.S.] testified that given the Client's history of borderline personality disorder and the identified reasons for seeking therapy (substance use and mental health) it was not appropriate for the Member to be talking about masturbation and his own sexuality. While the Client had some relationship concerns, it would be a leap for the therapist to assume the issues were sexual. Moreover, even if there were concerns around sexuality, if a client expresses discomfort with the topic or - as in this case - actually requests to stop speaking about it, it is not appropriate for the counsellor to continue speaking about it. In particular, where a client has borderline personality disorder, it can be especially difficult for them to connect with others, and to know where they stop and start. To initiate conversation about masturbation would be likely to trigger someone with that history, and could cause them to act out in ways that are not healthy (i.e. cutting, or substance misuse).

[34] [Ms. M.S.] testified that in the counselling relationship, especially with a vulnerable client (like the Client), it is vitally important to be aware of one's impact on others. Consequently, what is important is not whether or not the Member intended for the comment to be taken a certain way, but rather how the client perceived his actions and how she responded. The Client was clear in her communications and body language with him that she was not okay with his line of intervention around sexuality. Consequently, the Member should not have continued to pursue them.

[35] With regards to the issue of documentation and the Client, the Member had approximately 45 direct contacts with the Client documented in her file, and yet the Client's file contains only two progress notes signed by the Member on August 17, 2017 and September 14, 2017. In addition, there was no content in the plan of care. [Ms. M.S.] testified that this level of documentation was not sufficient to meet the standards outlined in the CCAS Policy and Procedure document.

[36] [Ms. M.S.] testified that the concerns about the Member's documentation were longstanding, and ultimately formed a large part of the basis for his dismissal on February 1, 2018. The initial concerns had begun before his probation was over in March 2013 and continued thereafter. There was an initial meeting to raise this concern on March 27, 2014 and there were more formal meetings between 2014 and 2016. The meetings were documented and filed in evidence at Tabs 14-27 of the College's Book of Documents. The Member and [Ms. M.S.] met several times, and created plans for how the Member would rectify the documentation backlog. By June 27, 2016, the Member had gotten his paperwork up to date, but by August 20, 2016 he was behind again by 65 notes. This continued to escalate until 2018 when he was behind by 246 progress notes. Of his 28 clients, 16 did not have a psycho-social assessment, 7 did not have a treatment plan and 14 had not been seen in more than two months.

[37] [Ms. M.S.] testified that the Member had a number of personal circumstances in his life that affected his ability to keep up with the documentation standards. This is why he was provided with latitude over the years, and was encouraged to contact the Employee Assistance Program. CCAS worked with the Member creating progress plans, and also reduced his workload so that he would have more time for documentation. He was given one or more days per week entirely dedicated to getting caught back up on his progress notes, and he was not required to take on new clients.

[38] While the Member raised health issues in the past, including a diagnosis of colitis, and a vitamin D deficiency, he also at times said that he did not require any accommodation for his health issues. Some of his difficulties stemmed from a lack of motivation and the tendency to use work

computers for non-work related internet activity, including job searches and streaming television shows. Consequently, part of his performance management plan including modifying his work station so he would not access non-work related sites. [Ms. M.S.] testified that this level of tardiness with respect to documentation was unique, typically, when other employees were given these same accommodations they improved and were able to complete their notes. In contrast the Member repeatedly set target completion dates, would fail to meet them, and then require additional time. There were multiple occasions in which the Member would take some time off, and then return to CCAS assuring [Ms. M.S.] that he was well and would not require accommodation, but would then continue to be unable to meet the CCAS expectations.

Evidence of [W.P.]

[39] [W.P.] is a registered social worker and has worked in the field of mental health for more than 20 years. [Ms. W.P.] worked with the Client for several years while the Client both in group counselling, as part of the Outpatient Addiction and Gambling Unit at a northern Ontario health unit and in an individual counselling setting. [Ms. W.P.] was in periodic contact with the Client, but was not providing her with regular counselling after the client moved to [*redacted*].

[40] [Ms. W.P.] recalled a few phone conversations with the Client between September and November 2017, in which the Client disclosed to her the details of her experience with the Member. [Ms. W.P.] recalls that in the first phone contact she had with the Client regarding the Member. The Client only told her that she was uncomfortable with the frequency and location of the meetings. [Ms. W.P.] advised the Client at that time to consider having the meetings in the CCAS office.

[41] The second time the Client contacted [Ms. W.P.] in November 2017, she was in crisis about a number of issues in her life. During this conversation, she told [Ms. W.P.] about some of the comments from the Member, including the comment about being hot, the questions regarding her sex life with her husband and the discussion about masturbation. At this point, [Ms. W.P.] encouraged the Member to seek alternative supports such as through the family health team.

[42] Thereafter, [Ms. W.P.] consulted with her own professional team and the College. After these discussions, [Ms. W.P.] decided to report the matter to the College and contacted the Client again to inform her of the imminent report. [Ms. W.P.] testified that the Member's behaviour raised "red flags" for her, and she was concerned about boundary violations with the Member. [Ms. W.P.] felt that it was not clinically appropriate for the Member to be making these sexualized comments, particularly in light of what the Client sought therapy for, her diagnosis and her history of trauma.

Decision of the Panel

[43] The College bears the onus of proving the allegations against the Member on the balance of probabilities, using clear, cogent and convincing evidence.

[44] Having carefully considered the onus and standard of proof, the evidence of the College and the submissions of counsel for the College, the Panel finds that the Member committed professional misconduct as alleged in paragraphs (a) through (g) in Part II of the Notice of Hearing. With respect to all allegations the Member's conduct would reasonably be regarded as unprofessional, dishonorable or disgraceful.

Reasons for Decision

[45] As noted above, the Panel heard evidence from three witnesses, the client, [Ms. M.S.] and [Ms. W.P.]. The Panel has considered the credibility of all of the witnesses prior to making any findings.

The Client

[46] The Panel found the Client to be a credible witness. She testified in a straightforward and detailed manner and was clear about relaying information. She appeared to be honest and forthcoming with information. The Client had no apparent motive to fabricate any of her story. She shared her concerns about her experience with the Member during her initial session that took place sometime in the fall of 2017 and subsequently a second incident that occurred shortly after the first incident. She was consistent in her statements regarding the facts of the incidents and included details regarding comments made to her by the Member with regards to him telling her she was hot, asking her about masturbation and sharing personal information about his sexuality. The Client was not subjected to cross-examination as a result of the Member's decision not to attend the hearing. Nonetheless, the Panel considered the Client's potential interest in the outcome of the matter and did not form any concerns in respect of the veracity of her evidence.

[47] Although the Client expressed feelings of being scared and feeling uncomfortable about the Member being reported to the College for his alleged conduct, she was credible in her description of how the Member's conduct evoked a "disgusting" feeling inside, one that she associated with her past trauma. The Client was explicit in describing her experience as one that "brought her right back" and made her think about "gross things". As a result of her experience with the Member, the Client sought support from her former counsellor, [W.P.] and relayed in the first contact that counselling was not going well and that she was having difficulty integrating into the community. In the second contact with [Ms. W.P.] the client gave [Ms. W.P.] more detail about the Member, including what he said to her in the above noted incidents. The Client testified that although she was uncomfortable and scared about [Ms. W.P.'s] imminent report to the College, she felt the need to contact CCAS on November 20, 2017 to report the Member's behaviour and seek a new counsellor. The Client was able to indicate to the Panel that, while she was now in a positive place, the experience she had with the Member sent her into a tailspin in which she started drinking again and set her back for some time following the initial crisis. She also relayed that she found it difficult to trust again and struggled with sobriety for several years afterwards. After careful consideration the Panel found that the Client's testimony was cohesive, consistent and reliable.

Ms. [M. S].

[48] [Ms. M.S.'s] testimony regarding the Member's conduct followed from the Client's report to her during a conversation on November 20, 2017 in which the Client called to request a transfer. [Ms. M.S.] also testified regarding the Member's failure to adhere to certain documentation standards. Specifically, CCAS Policy and Procedures 5.1 and 5.2 which require that each client contact be documented electronically in the CCAS system within 2 business days of the contact. Due to the Member's failure to attend the hearing, [Ms. M.S.] was not cross-examined. Regarding to the Member's failure to follow CCAS documentation standards, evidence provided in the College Book of Documents, Tabs 14 through 27, demonstrates attempts by CCAS to support the Member in developing plans for how the Member would rectify the documentation backlog. [Ms.

M.S.] relayed that concerns about the Member's documentation practices were longstanding and formed a large part of the basis for his dismissal on February 1, 2018.

[49] The Panel found [Ms. M.S.] to be a credible witness. The Panel is mindful of [Ms. M.S.'s] potential interest in the outcome of the hearing. She testified in a straightforward manner, gave clear and concise answers. Her testimony aligned completely with contemporaneous written documentation contained in the College's Book of Documents.

Ms. [W.P.]

[50] [Ms. W.P.] was a former counsellor of the Client in a different part of the province. As with the other witnesses, the Panel is mindful of an interest [Ms. W.P.] may have in the outcome of the proceeding. Due to the Member's failure to attend the hearing, [Ms. W.P.] was not cross-examined

[51] The Panel found [Ms. W.P.] to be a credible witness. She testified in a straightforward manner, gave clear and concise answers. More critically, her account of her contacts and interactions with the Client regarding the Client's experience with the Member was consistent with the Client's testimony.

Findings

[52] After careful consideration the Panel found that the Member violated Section 2.2 of the Professional Misconduct Regulation and Principle 1 of the Handbook (commented on in Interpretation 1.2, 1.3, 1.5 and 1.6) by failing to observe, clarify and inquire about information presented to him by his client; by failing to respect and facilitate his client's self determination; by failing to be aware of his values, attitudes and needs and how these impacted on his professional relationship with clients; and by failing to distinguish his needs and interests from those of his clients to ensure that, within his professional relationship, clients' needs and interests remain paramount.

[53] The Panel relied on the following evidence in particular:

- The Member failed to be aware of the Client's perception of his actions and her clear communication through body language that she was not okay with the line of intervention used around sexuality.

- The Member failed to recognize the Client's history of borderline personality disorder and the identified reason for seeking therapy (substance use and mental health) and that it was inappropriate to be talking about masturbation and his own sexuality.

- The Member failed to work collaboratively with the Client regarding frequency and location of meetings.

- The Member disclosed intimate and personal details to the Client about his personal life experience and sexual behaviour.

- The Member failed to recognize that when working with vulnerable clients, it is especially important to be aware of potential triggers that could lead to acting out in ways that are not helpful or healthy.

- The Member told the Client that she was "hot" in response to her disclosure about feeling ugly

- The Member asked the Client if she masturbated and after the client expressed that she was uncomfortable discussing the topic, continuing to inquire by saying "are you taking care of things?" in subsequent sessions.

[54] The Panel found that the Member also violated Section 2.2 of the Professional Misconduct Regulation and Principle II of the Handbook (commented on in Interpretation 2.2) by failing to establish and maintain clear and appropriate boundaries in his professional relationship.

[55] The Panel relied on the following evidence in particular:

- The Member disclosed personal information about his personal life including the fact that as a child he was not allowed to discuss sex and how this has impacted his life by becoming a very sexual person.

- The Member pursued the topic of masturbation in more than one session, after the Client expressed their discomfort with the topic and indicated that she did not want to talk about the subject further.

- The Member's conduct resulted in the Client feeling scared and unsafe by showing up in the Client's living room unannounced, claiming the visit was a mental health check.

- The Member continued to pursue the topic of masturbation with the Client and failed to recognize the Client's perception. The Member used body language while sitting at the kitchen table with legs spread apart, pushing forward on the table while discussing his personal life and sexuality and was perceived by the Client as arousal due to the nature of the topic he was discussing.

[56] The Panel found that the Member violated Section 2.2 of the Professional Misconduct Regulation and Principle IV of the Handbook (commented on in Interpretation 4.1.1, 4.1.3 and 4.1.6) by failing to keep records in a format that facilitated the monitoring and evaluation of the effects of the service intervention; by failing to keep systematic, dated, and legible records for each client or client system served; and by failing to record information when an event occurred, or as soon as possible thereafter.

[57] The Panel relied on the following evidence in particular:

- The Member failed to keep records as required by the documentation standards of CCAS in accordance with their Policy and Procedures 5.1 and 5.2.

- The Member failed to recognize the importance of completing electronic documentation in a timely manner, according the CCAS standards, within 2 business days of the contact.

- The Member failed to complete psycho-social assessments that were required in order to create the care plan.

- The Member failed to recognize the importance of the care plan and how recording each contact could have implications on the care plan.

- The Member consistently failed to meet the CCAS standards for documentation despite multiple accommodations between 2013-2018.

[58] The Panel found that the Member violated Section 2.2 of the Professional Misconduct Regulations and Principle VIII of the Handbook (commented on in Interpretation 8.2.3) by engaging in behaviour or making remarks of a sexual nature towards the Client other than behaviour or remarks of a clinical nature appropriate to the service provided.

[59] The Panel relied on the following evidence in particular:

- The Member remarked to the Client while discussing self-esteem issues and engaging in self-sabotaging behaviour by saying that she felt "ugly, by saying something like "What are you talking about? You're hot!" in an expressive manner.

- The Member also commented in reference to the Client's husband, that "I don't understand your husband, I wish I could get inside his head" which the client understood as relating to the issue of her husband not wanting to have sex.

- The Member remarked in a subsequent session and in response to the Client's comment about physical intimacy being missing from her marriage, by asking the Client "have you ever masturbated?"

- The Member brought up masturbation again in a subsequent session by saying words along the lines of, "well did you do it" to which the client was surprised by the remark and the fact that the Member brought up the subject again, even though the client specifically indicated that she did not want to discuss this topic any further.

[60] The Panel found that the Member violated Section 2.20 of the Professional Misconduct Regulation by failing to keep records as required by the regulation and standards of the profession.

[61] The Panel relied on the following evidence in particular:

- The Member failed to keep records as required by the standards of the profession of Social Work while employed at CCAS in respect of not only the Client but many other client files on his caseload. As noted by CCAS Director, the Member had approximately 45 direct client contacts with the client that were documented in her file, however there were only two progress notes signed on August 17, 2017 and September 14, 2017. In addition to this there was no content in the plan of care.

- Although the Member was given multiple opportunities to rectify documentation expectations in June of 2018, there were 246 outstanding progress notes and of 28 clients, 16 did not have a psycho-social assessment, 7 did not have a treatment plan and 14 clients had not been seen in more than 2 months.

[62] The Panel found that the Member violated Section 2.28 of the Professional Misconduct Regulation and Section 26(2)(a) of the Act by contravening the Act, regulations, or by-laws; and Section 2.36 of the Professional Misconduct Regulation by engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonorable or unprofessional.

- Between September, 2017 and November 2017, the Client was seen by the Member at CCAS on a frequent basis. The Member was aware of the Client's mental health diagnosis and her vulnerability. During counselling sessions the Member made inappropriate comments about the client's appearance, and her relationship with her husband which the client perceived to be of a sexual nature.

- The Member also engaged in conversation about masturbation and sexuality and disclosed personal details that were not clinically appropriate. Even though the Client asked that this not be a topic of conversation, the Member continued to bring it up in sessions.

- The Member lacked awareness about the Client's history, and the fact that the sexualized comments would be a trigger for the Client.

- The Member also failed to document adequately and record client contacts, psycho-social assessments and treatment plans for a number of clients. As a result the Member failed to adhere to the documentation standards required by CCAS and by the College regulations and Standards of Practice. The conduct of the Member was significant and caused the client to have a set back in her recovery journey, losing trust and struggling with sobriety for several years following her experience with the Member.

[63] At the end of deliberations, the Panel was satisfied on the totality of the evidence that the Member did make sexually inappropriate comments to the Client and failed to adhere to the required documentation standards of both CCAS and the College. As a result, the Member engaged in all of the forms of professional misconduct alleged in the Notice of Hearing. The Member's conduct falls short of what the public rightfully expects of registered social workers. The Member demonstrated a serious disregard for his professional obligations, and a lack of good judgment and sense of responsibility. The Member's conduct would be regarded as unprofessional, dishonorable or disgraceful.

I, Angele Desormeau, sign this decision as chairperson of the Panel and on behalf of the Panel members listed below.

Date: April 13, 2021

Signed: _____

Angele Desormeau, Chair
Rita Silverthorn
John Fleming