Discipline Decision Summary

This summary of the Discipline Committee's Decision and Reason for Decision is published pursuant to the Discipline Committee's penalty order.

By publishing this summary, the College endeavours to:

- illustrate for social workers, social service workers and members of the public, what does or does not constitute professional misconduct;
- provide social workers and social service workers with direction about the College's standards of practice and professional behaviour, to be applied in future, should they find themselves in similar circumstances;
- implement the Discipline Committee's decision; and
- provide social workers, social service workers and members of the public with an understanding to the College's discipline process.

PROFESSIONAL MISCONDUCT
Gail T. Flintoft (Former Member)

Agreed Statement of Fact
The College and Ms. Flintoft submitted a written statement to the Discipline Committee in which the following facts were agreed:

1. Ms. Flintoft was, at all times relevant to the allegations, registered as a social work member of the College. She subsequently resigned her Certificate of Registration as a College member, which resignation became effective on November 30, 2010.
2. From on or about January 1990, until on or about April 2010, Ms. Flintoft was employed as a social worker with a specialty hospital (the "Hospital") that provides health care to people living with HIV/AIDS and offers a residential program, home care and a community outreach program which includes nursing, counselling and complementary therapies.
3. While employed at the Hospital, Ms. Flintoft had a Master of Social Work student under her supervision, for whom she had agreed to act as preceptor. Ms. Flintoft failed to fulfil her responsibilities as a supervisor with respect to this student in that she:
    a) Left the student without any identified supervisor or identified support during Ms. Flintoft's absences;
    b) Failed to sufficiently assist the student to integrate into the inter-professional team with which the student was expected to work at the Hospital;
    c) Allowed the student to perform a difficult funeral planning meeting without appropriate support or supervision and without preparing the student sufficiently;
    d) Allowed the student to engage in unsupervised clinical activity;
    e) Failed to provide appropriate mentorship or scholarly preceptorship by failing to properly analyze discuss and provide feedback on her own activities or those of the student, and to link them to principles of social work research, theory or practice;

f) Failed to properly address the power imbalance in the student/teacher (i.e. student/preceptor) relationship which inhibited the student from raising concerns with Ms. Flintoft directly, even after those issues were raised with Ms. Flintoft by her supervisors at the Hospital;
g) Failed to recognize the need for the student to discuss termination with clients when the student's placement was coming to an end and to provide guidance to the student in that regard.

4. While employed at the Hospital, Ms. Flintoft was the assigned social worker for and was responsible for providing social work services to clients admitted to the Hospital's Residential Program and/or Community Program, including 25 identified clients.
5. One of the identified clients was admitted to the Hospital's Community Program in July 2009, and subsequently to its Residential Program, and then discharged to the Community Program in January of 2010 where the client died in March 2010. With respect to this client, Ms. Flintoft:
    a) Failed to make contact and to follow up with the client on a timely and sufficient basis after the client's discharge from the Hospital's Residential Program to its Community Program;
    b) Disregarded and/or failed to adequately respond to information from other members of the client's treatment team indicating that the client was struggling with physical and mental health and addiction issues, was at high risk for crisis and required prompt and in person contact from Ms. Flintoft;
    c) Failed to adequately document information regarding a critical incident affecting the client (namely the death of the client's friend in the client's home) in a timely fashion;
    d) Failed to convey information about that critical incident to other members of the the Hospital treatment team until a date 17 days after she learned of the incident, and failed to develop a crisis care plan for the client, despite her knowledge that the client was vulnerable and at high risk for crisis;
    e) Failed to arrange for another social worker to follow up with the client while Ms. Flintoft went on holidays for 10 days (commencing in the week following the death of the client's friend); and
    f) Failed to make direct contact with the client for 19 days following the death of the client's friend. On the 19th day, Ms. Flintoft attended at the client's apartment building and discovered, later that day, that the client had been found dead in his apartment and was thought to have been dead for at least 12 hours.
6. Another of the identified clients was admitted to the Hospital's Residential Program in February 2008, for approximately three weeks. With respect to this client, Ms. Flintoft used a translator to communicate with the client, but failed to have the translator execute the Hospital's standard External Consultant Confidentiality Form, and demonstrated a lack of awareness of and familiarity with the Hospital's policies and procedures in that regard.
7. Another identified client was admitted to the Hospital's Residential Program in December 2009 for approximately two months. Ms. Flintoft provided counselling to both the client and the client's partner. In respect to these clients, Ms. Flintoft:

a) Provided counselling to both the client and the client's partner concerning end of life planning and bereavement issues arising from the client's impending death, in circumstances where the client and the client's partner had conflicting issues and needs;
b) Failed to consider the best interests of the client in arranging a meeting with the client's partner to arrange the client's funeral, in anticipation of the client's death, without informing the client of the meeting or inviting the client to attend;
c) Failed to acknowledge or take steps to address the conflict between the needs and interests of the client and the client's partner, although that conflict was repeatedly identified for Ms. Flintoft by her superiors at the Hospital; and
d) Repeatedly ignored her supervisors' recommendations that the client and the client's partner be seen by separate clinicians, before eventually agreeing to that approach.

8. Another identified client was admitted to the Hospital's Residential Program in December 2009, for three months, while awaiting long-term placement. Ms. Flintoft felt the client was having difficulty accessing and managing the client's monthly allowance paid to the client through the Public Guardian and Trustee's Office. In December 2009, Ms. Flintoft arranged to have the client's personal spending money sent to the Hospital in trust, for an approximate two month period, during which period Ms. Flintoft was involved in disbursing the funds directly to the client. Ms. Flintoft failed to appropriately consult with her supervisors at the Hospital (either with respect to the original arrangements or with respect to later evidence that the client was spending the client's money irresponsibly), failed to consider issues of potential personal liability or the liability of the Hospital and failed to consider and develop a plan to deal with the client spending the client's money irresponsibly.
9. In the case of two other identified clients, one client was admitted to the Hospital's Residential Program in December 2008 and remained at the Hospital until the client died approximately seven months later. The second client had previously received services from the Hospital until the client's death in 2008. Ms. Flintoft had money belonging to these clients in her possession, which she failed to return in a timely manner. If called to testify at the Discipline Committee hearing, Ms. Flintoft would have stated that the first client's money was found in a locked medicine cabinet (approximately 17 months after the client's death) and that the second client's monies were given to Ms. Flintoft in March 2010, more than two years after that client's death. Those funds were retained by Ms. Flintoft for approximately one month (until Ms. Flintoft's employment ended in April 2010). Ms. Flintoft acknowledges that she did not document her receipt or retention of the funds and that the money was found in two bags of documents returned to the Hospital by Ms. Flintoft's union representative following Ms. Flintoft's resignation in or about April, 2010.
10. With respect to the 19 remaining identified clients, Ms. Flintoft failed to appropriately document her client contacts and to properly maintain the clinical record, despite repeated chart audits regarding her clients, being required to complete (and completing) a documentation course in 2008 and despite the provision of further training and supervision to Ms. Flintoft by superiors at the Hospital regarding social work documentation. In particular, Ms. Flintoft failed to:

a) Perform and/or record social work assessment(s);
b) Prepare and/or record a treatment plan and/or goals;
c) Consistently document all of her contacts with the clients by means of clinical notes in the clients' files;
d) Prepare documentation of client contacts and/or services at or around the times those services were provided;
e) Appropriately file and maintain documents, notes and records relating to clients in the relevant client files on a timely and consistent basis.

11. Ms. Flintoft acknowledges that by reason of engaging in some or all of the above-described conduct, she is guilty of professional misconduct as set out in subsections 26(2) (a) and (c) of the *Social Work and Social Service Work Act* (the "Act") and of unprofessional conduct as set out paragraph 2.36 of Ontario Regulation 384/00 (Professional Misconduct) made under the Act.

Decision

The Discipline Committee found that the agreed facts support a finding of professional misconduct in regard to all of the allegations in the Notice of Hearing, and in particular, that Ms. Flintoft:

1. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct) made under the Act,, and Principle I of the Standards of Practice (commented on in Interpretations 1.1 and 1.1.1) by failing to participate together with clients in setting and evaluating goals and identifying a purpose for her professional relationship with clients, including the enhancement of clients' functioning and the strengthening of the capacity of clients to adapt and make changes.
2. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle I of the Standards of Practice (commented on in Interpretation 1.2) by failing to observe, clarify and inquire about information presented to her by clients.
3. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle I of the Standards of Practice (commented on in Interpretation 1.7) by failing to maintain an awareness and consideration of the purpose, mandate and function of the organization in which she was employed and how those impacted on and limited her professional relationships with clients.
4. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (commented on in Interpretation 2.1.1) by failing to be aware of the extent and parameters of her competence and professional scope of practice and to limit her practice accordingly.
5. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (commented on in Interpretation 2.1.2) by failing to remain current with emerging social work or social service work knowledge and practice relevant to her areas of professional practice and failing to maintain current knowledge of policies, legislation, programs and issues related to the community, its institutions and services in her areas of practice.
6. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (commented on in

Interpretation 2.1.5) by failing to engage in the process of self-review and evaluation and seek consultation when appropriate as part of maintaining competence and acquiring skills in social work practice. In particular Ms. Flintoft failed to appropriately engage in the process of self-review, evaluation and consultation in order to address issues of concern in her social work practice, despite consultation, supervision and training opportunities provided by her employer.

7. Violated Sections 2.2, 2.10 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (as commented on in Interpretations 2.2 and 2.2.1) by engaging in professional relationships that constituted a conflict of interest or in situations in which she ought reasonably to have known that the client would be at risk and providing a professional service to a client when she was in a conflict of interest.

8. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (commented on in Interpretations 2.2 and 2.2.9) by failing to strive to enhance the capacity of clients to address their own needs; assist clients to access necessary information, services and resources wherever possible and promote and facilitate client participation in decision making.

9. Violated Section 2.2 of Ontario Regulation 384/00 (Professional Misconduct), and Principle II of the Standards of Practice (commented on in Interpretation 2.2.8) by failing to avoid conduct which could reasonably be perceived as reflecting negatively on the profession of social work.

10. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle III of the Standards of Practice (commented on in Interpretation 3.2) by failing to deliver client services and respond to client queries, concerns and/or complaints in a timely and reasonable manner;

11. Violated Sections 2.2 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct), and Principle IV of the Standards of Practice (commented on in Interpretations 4.1.1, 4.1.3 and 4.1.6) by failing to keep systematic, dated and legible records for each client or client system served, failing to record information when the event occurs or as soon as possible thereafter, failing to record information in a manner that conforms with accepted service or intervention standards and protocols and in a format that facilitates the monitoring and evaluation of the effects of the service or intervention and meets the minimum requirements for information to be contained in the social work record with respect to each client.

12. Violated Sections 2.2, 2.20 and 2.28 of Ontario Regulation 384/00 (Professional Misconduct),, and Principle IV and V of the Standards of Practice (commented on in Interpretations 4.2.1, 4.2.2 and 5.2) by failing to maintain records in a manner that reflected a thorough understanding of her employer's policies with regard to the retention, storage, preservation and security of records and appropriately protected the confidentiality and security of the clients' files, and failed to acquire and maintain a thorough understanding of the policies and practices of the organization by which Ms. Flintoft was employed relating to the management of client information.

13. Violated Sections 2.4 and 2.2.8 of Ontario Regulation 384/00 (Professional Misconduct) by failing to supervise adequately a person who was under her professional responsibility and who was providing a social work service.

14. Violated Section 2.36 of Ontario Regulation 384/00 (Professional Misconduct) 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 unprofessional.

Penalty Order

The panel of the Discipline Committee accepted the Joint Submission as to Penalty submitted by the College and by Ms. Flintoft and made an order in accordance with the terms of the Joint Submission as to Penalty. The Discipline Committee ordered that,

1. Ms. Flintoft be reprimanded in person and the fact and nature of the reprimand be recorded on the College Register.
2. The findings and order of the Discipline Committee (or a summary thereof) be published, with identifying information concerning Ms. Flintoft included, in the College's official publication, on the College's website, on the general newswire, and additionally in any other manner necessary to alert regulators in the other provinces, and that the results of the hearing be recorded on the Register.

The Discipline Committee concluded that:

- Although Ms. Flintoft's acts of professional misconduct were not isolated and were pervasive over a two year span, and Ms. Flintoft was a senior practitioner and member of the Hospital's treatment team, there was no dishonesty.
- There were mitigating factors in that Ms. Flintoft admitted to engaging in professional misconduct and agreed to the joint submissions and penalty, thereby sparing the Hospital's clients the emotional turmoil of attending the hearing to testify, and sparing the College the cost and time of extensive investigation.
- Remediation and rehabilitation are not applicable to this case as Ms. Flintoft has resigned from membership in the College.
- College members should know that if they engage in similar misconduct to that of Ms. Flintoft, they will be punished in a similar way.
- Publishing Ms. Flintoft's name and the details of her misconduct is necessary to deter other members of the College from the same type of misconduct and is necessary to protect the public interest and to maintain public confidence in the integrity of the College's discipline process.
- By including every revocation, cancellation and suspension of a College member's certificate of registration on the College Register, as well as other information as directed by Discipline Committee panels, future employers and the public are further protected. In addition, this emphasizes the importance of transparency and public participation in the College's complaints and discipline processes.
- In this case publication of the Discipline Committee's order is necessary to ensure protection of the public. Membership in the College is not a prerequisite for accepting employment in the field of counselling, therapy or in establishing a private practice. There is no assurance that prospective employers or clients will contact the College to inquire about an individual's membership status. Broadly publishing Ms. Flintoft's name and the Discipline Committee's decision may be the only effective way of ensuring that the public or future employers are aware of Ms. Flitnoft's past actions.

- Reprimanding Ms. Flintoft in person serves as a specific deterrent to her in the event she should work in a social work setting in the future. The intent of the reprimand is to impress on Ms. Flintoft the consequences of her actions, not only to herself but also to her clients, her former clients, the College and the public.

At the conclusion of the hearing, Ms. Flintoft waived her right of appeal and the Discipline Committee administered an oral reprimand to her.