ONTARIO
COMMISSION OF INQUIRY

IN THE MATTER OF THE PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS IN THE LONG-TERM CARE HOMES SYSTEM

CLOSING SUBMISSIONS
(as presented by counsel for the Victims' Groups)

VAN KRALINGEN & KEENBERG LLP
43 Front Street East
Suite 400
Toronto, ON M5E 1B3

Alex Van Kralingen
Mark Repath
Katherine Chau

Lawyers for the Participants, Andrea Silcox, Adam Silcox-Vanwyk, Arpad Horvath Jr., Laura Jackson, Don Martin, Shannon Lee Emmerton, Jeffrey Millard, Judy Millard, Sandra Lee Millard, Stanley Henry Millard & Susie Horvath

HARRISON PENSA LLP
450 Talbot Street
London, ON
N6A 4K3

Paul H. Scott
Annie Legate-Wolfe

Lawyers for the Participants, Jon Matheson, Pat Houde & Beverly Bertram

Introduction

> ***"Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."***
>
> -Justice Louis Brandeis, U.S. Supreme Court

1. It would be easy to say – as some have tried – that Elizabeth Wettlaufer's crimes are such an aberration, the circumstances being so unique, that they may not be worthy of the sort of systemic review conducted through the public hearings of the Long-Term Care Inquiry (the "**Inquiry**") and its subsequent policy phase. Put simply, if Ms. Wettlaufer's crimes were an awful, onetime experience, then perhaps nothing useful can be learned from a review of their underlying circumstances.

2. Those people would be wrong.

3. The simple fact is that although Ms. Wettlaufer's crimes are hers to own (and nothing in these submissions should be read as an attempt to shift the burden of blame away from her), they occurred in a very specific context. We have heard for many weeks that Ms. Wettlaufer's crimes occurred in a system where those who provide care and those who regulate the system are all chronically under-resourced. Ms. Wettlaufer's crimes occurred in arguably the most highly regulated sector in the province – aimed at protecting the most vulnerable in our society – but where many in positions of authority disregarded their obligations (for whatever reason) pursuant to those very regulations. Ms. Wettlaufer's murders also occurred in a context of a local coroner's system which appears, in some important ways, to be wanting. All of this led to repeated missed opportunities to uncover her wrongdoings. No one can guarantee that Ms.

Wettlaufer's crimes would have been uncovered earlier if everyone had been more diligent in their approach, but in the same vein, the Victims' Groups are convinced that we would have been in a much better position to find out.

4. Each of those systemic failures are independent of Ms. Wettlaufer's crimes, but they were undoubtedly aggravating factors, allowing Ms. Wettlaufer's crimes to go undetected for far too long.

5. Coupled with these challenges is what appears to be a pervasive cultural attitude in long-term care, that this is how it will always be. From listening to the testimony at the public hearings, all of this under-resourcing and failure to abide by the mandatory regulations of the *Long-Term Care Homes Act, 2007* ("**LTCHA**") seems to be casually accepted by those who provide front-line care, those who manage long-term care facilities, and those who regulate the providers and the nurses who work in them.

6. Put bluntly, our seniors deserve better. As a society, we have made the important decision that we will house and take care of seniors in their final years with long-term care and home care programs. We do this through publicly-funded institutions, because we have collectively recognized that all of our seniors are valued and contributing members of our society, and we have decided that it is only appropriate to ensure their older years are handled with care and dignity. To a certain extent, it is a social contract with our seniors. It is inherent in that social contract that we take all appropriate steps to keep them safe.

7. After hearing the evidence at the public hearings of the Inquiry, the victims and their loved ones who were granted participation rights (collectively, the "**Victims' Groups**") are

deeply concerned that those who were involved in providing and regulating for each of the victims' care collectively failed them. In short, there are many ways in which our society could have done much better. Much of what we heard at the Inquiry involved systemic failures compounding upon other systemic failures, which the Victims' Groups believe provided Ms. Wettlaufer the space and time to surreptitiously commit her crimes.

8. It is often said that history does not repeat itself, but it does rhyme. So, while we may never encounter another case involving the identical fact pattern as the one at hand, the Victims' Groups hope that the lessons learned from this Inquiry can prevent another healthcare worker with nefarious intent from committing comparable crimes against vulnerable members of our community.

9. Accordingly, the quote which starts these submissions should loom large. The "*sunlight*" which Justice Brandeis talked about is incredibly important to the Inquiry's mandate – the only way our province can learn from our collective failures is to first provide the public with the unvarnished truth about what happened. Doing so brings comfort to the victims and their loved ones that there has been a fulsome accounting of what went wrong, and that their respective losses and pain will be used for some better purpose; it also provides a constant reminder of what could happen again if nothing is done and the *status quo* remains.

10. Accordingly, counsel for the Victims' Groups present these joint closing submissions with an eye to being true to the underlying facts uncovered during the 37 days of public hearings, including a number of troubling revelations that the public would not have known about absent the Inquiry being called. Although it is undoubted that the role of the Inquiry is not to apportion

liability, that does not mean that individual players should be immune from criticism for their conduct. The Victims' Groups have every right to share their criticisms.

11. That said, these submissions will not only be retrospective, but will also present a forward-looking approach with constructive suggestions in an effort to try and achieve an important goal of all of the victims who have chosen to participate in the Inquiry's public hearings: to ensure that no family member or loved one ever has to feel the loss they have felt.

12. The focus of these submissions will be to first underscore the relative vulnerability of the population who live in long-term care homes or who are serviced through home care services. These submissions will then outline the evidence heard at the public hearings – organized thematically – which the Victims' Groups believe is most relevant to the Inquiry's mandate. During the discussion of those themes, various recommendations will be proffered which the Victims' Groups believe will not only keep long-term care residents and home care patients safe, but will also improve the quality of outcomes in the system generally.

The Vulnerable Population of Long-Term Care Homes

> ***Every patient I ever picked had some dementia and that was part of what became my criteria. If they had dementia so they couldn't report it or if they reported they wouldn't be believed***.
>
> -Elizabeth Wettlaufer[1]

13. The Victims' Groups believe that properly addressing the systemic issues which provided Ms. Wettlaufer the space to commit her crimes is an urgent matter, for no other reason than the

[1]Wettlaufer Interview with Commission Counsel (Feb 14, 2018), p. 74, Line 21-25; Exhibit 5

population at long-term care homes is amongst the most vulnerable in our society, and that trend is not changing. Ms. Wettlaufer made the depraved decision to target those who had no ability to understand what was happening, to fight back, or to report. Aside from being a heinous crime, it was also the greatest betrayal that a health care worker could engage in: taking advantage of the very vulnerabilities that brought the victims to Ms. Wettlaufer in the first place.

14. The Inquiry has heard the significant statistics relating to the living circumstances of older Ontarians:

(a) for those older than 85 years old, as many as thirty percent (30%) live in some form of long-term care, seniors residence, or assisted living facility;[2]

(b) close to 79,000 long-term care beds are found in the Province of Ontario;[3] and

(c) over two-thirds of long-term care residents suffer from dementia or Alzheimer's, and over ninety percent (90%) suffer from some form of cognitive impairment.[4]

15. Those statistics lead to an inevitable conclusion. There are tens of thousands of Ontarians who are no different than Ms. Wettlaufer's victims, and arguably, with the increasing acuity of residents in long-term care, there are more people who are more vulnerable in long-term care now than there were at the time Ms. Wettlaufer was committing her offences.

---

[2] Opening Statement of Commission Counsel, LTCI Transcript, Vol. 1 at p. 93, Line 21-25
[3] Opening Statement of Commission Counsel, LTCI Transcript, Vol. 1 at p. 94, Line 5-10; LTCI00071969, Exhibit 129
[4] Opening Statement of Commission Counsel, LTCI Transcript, Vol. 1 at p. 94, Line 24-30

16. There might be some comfort to the larger population if the victims who Ms. Wettlaufer chose shared medical conditions which were, in some way, unique to them.

17. They did not. Separate and apart from the above-referenced prevalence of dementia and other cognitive disorders, we have learned about the number of patients across Ontario who have their blood sugars managed through the use of injectable insulin or oral medications. We have learned how common the use of these medications is in all health environments, but particularly, a long-term care facility.

18. With the greatest respect to all those who have tried to fashion systemic solutions since Ms. Wettlaufer's crimes have come to light, the relative safety of these vulnerable populations who have medical conditions similar to Ms. Wettlaufer's victims is no different than it was as of the day she confessed.

19. All the above is to say that because of the size of this vulnerable population – a population that Ms. Wettlaufer deliberately targeted – there is an importance and urgency to this matter which needs to inform the policy process for any government that tackles the issue. They need our help. The Victim's Groups hope that the Commissioner's final report – and the Province of Ontario's response – will reflect this urgency.

The Circumstances & Contributing Factors which Allowed Ms. Wettlaufer's Crimes to Occur

20. One of the challenges associated with identifying the systemic factors which may have allowed Ms. Wettlaufer's crimes to continue unabated for many years, is that many existing systemic failures interacted with others, meaning that it can become difficult to adequately assess

the impact of any one of those given failures. Accordingly, the Victims' Groups have listed a number of contributing factors, in no particular order, which they believe contributed to Ms. Wettlaufer's crimes going undetected for so long. Each of the below factors should be understood to have a heightened impact because of its interaction with the other factors – the cumulative impact is greater than the sum of them individually.

(A) Deficiencies in the Labour Relations and Human Resources Practices at Caressant Care Woodstock & Meadow Park

21. Both Caressant Care Woodstock and Meadow Park engaged in a series of practices, at the time of Ms. Wettlaufer's hiring, during the course of her employment, and upon her departure from both facilities, that were deficient, at best.

22. These challenges were compounded by Ms. Wettlaufer's relationship with her union, the Ontario Nurses Association ("**ONA**"), which the Victims' Groups believes protected her in two important ways: (i) ensuring that her termination for cause would be treated as a "*resignation*" for the purposes of subsequent employers, which the Victims' Groups believes made it easier for Ms. Wettlaufer to obtain subsequent employment; and (ii) fostering a culture whereby Caressant Care Woodstock was nervous to engage (what it perceived to be) the ire of ONA. The consequence was that Ms. Wettlaufer worked at Caressant Care Woodstock for far longer than she otherwise would have, and most concerningly, for almost eighteen (18) months after both Helen Crombez and Brenda Van Quaethem – Caressant Care Woodstock's Director of Nursing and Administrator, respectively – first believed that Ms. Wettlaufer posed a risk to residents.

(i) The Hiring Process

23. The Victims' Groups believe that, either consciously or unconsciously, the sector-wide shortages for RN's impacted good decision making at the homes in question. Given the sector-wide shortages of RN's and the short-staffing at Caressant Care Woodstock, Ms. Crombez indicated that she felt "*blessed*" to have Ms. Wettlaufer walk through the door in 2007.[5] Heather Nicholas candidly admitted that hiring at Meadow Park was an urgent concern given the staff turnover in 2014[6], and that this urgency lasted for her entire time working at Meadow Park.[7]

24. With respect to the hiring process at Caressant Care Woodstock, questions were not asked about why a RN, with years of qualification to work as a nurse, did not do so in her previous job (Ms. Wettlaufer worked as a support worker).[8] Ms. Crombez could not explain why Ms. Wettlaufer had told her she had just moved from the east coast when her job history showed time at working at Christian Horizons only shortly before she applied.[9] Of course, Ms. Crombez did not know about Ms. Wettlaufer's time at Geraldton Hospital, and at that time, had no ability to learn about it.

25. All of this becomes incredibly important when we consider the work of Professor Crofts-Yorker, who highlights that health care serial killers are not only prone to falsifying their credentials, but also other things relating to their work history.[10] It is suggested that asking reasonable and critical questions of those who are applying for jobs allows employers to identify

---

[5] LTCI Transcript, July 26, 2018, Vol. 5 at p.928, Line 22-24 [Crombez]
[6] LTCI Transcript, June 19, 2018, Vol. 10 at p.2234-2235, Line 30-32; Line 1[Nicholas]
[7] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2234, Line 20-22 [Nicholas]
[8] LTCI Transcript, July 26, 2018, Vol. 5 at p. 928, Line 1-10 [Crombez]
[9] LTCI Transcript, July 26, 2018, Vol. 5 at p. 928, Line 7-10 [Crombez]
[10] LTCI Transcript, September 12, 2018, Vol. 35 at p. 8067, Line 1-5 [Yorker]

candidates who are being dishonest with their credentials or other elements of their work history and avoid hiring them.

26. The process at Meadow Park was even more disappointing than that at Caressant Care Woodstock. Ms. Wettlaufer did not initially reveal that she had been terminated from Caressant Care Woodstock in her first interview, and in fact, only did so during a second interview with Ms. Nicholas on the day before she went through orientation.[11] That alone is deceptive, and would have struck any employer, in any context, as concerning. However, in the context of a health care facility looking after our most frail citizens, it bears examination and interest from a hiring manager of any sort. That said, Ms. Nicholas, in a blunt and honest answer, indicated that the reasons for Ms. Wettlaufer's termination were not, in any way, a concern for her:

> *Q. Did Meadow Park have any incentives to find out the true reasons why Ms. Wettlaufer was fired from Caressant Care Woodstock?*
>
> *A. No.*
>
> *Q. They had no incentives?*
>
> *A. What are you -- can you please explain what "incentives" means?*
>
> *Q. That's fair. Are there any reasons why Meadow Park would want to know about the underlying circumstances of Ms. Wettlaufer's termination?*
>
> *A. No.*[12]

27. It is a stunning statement for someone who was primarily responsible for hiring nurses at Meadow Park. The notion that a Director of Nursing at a long-term care facility would

---

[11] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2145, Line 9-12 [Nicholas]
[12] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2243, Line 13-31 [Nicholas]

understand that a nurse had been fired from her previous nursing role, and take absolutely no interest in the reasons for the termination, is beyond disappointing.

28. One wonders whether the shortages in the labour market for RN's made Ms. Wettlaufer a more attractive candidate than she otherwise would have been. It made it easier for Ms. Wettlaufer to be hired at both Caressant Care Woodstock and Meadow Park, without prompting the detailed questions one would expect an employer to ask. Separately, the prospect of replacing her (someone who worked the night shift, a difficult one to fill as Ms. Van Quaethem admitted[13]) likely affected the timing of Caressant Care's termination of Ms. Wettlaufer.

<u>Recommendation #1</u>: every Local Health Integration Network ("LHIN") contract with individual long-term care homes should mandate that the homes are obliged to:

> ***(i) engage in substantive reference checks for all front-line staff, including requesting full particulars from former managers about circumstances where they have been advised the candidate had been terminated; and***
>
> ***(ii) provide full and frank disclosure in employee references about the circumstances of the termination of front-line staff, to any employer who requests such information.***

<u>Recommendation #2</u>: the Province of Ontario should enact legislation which protects health care institutions from civil actions should they provide an honest reference or evaluation of an employee or former employee.

29. In normal circumstances, we should be loathe to interfere in the hiring procedures associated with any private business. However, in the circumstances of long-term care, where the businesses are publicly funded and the vulnerable residents often have few to no options about

[13] LTCI Transcript, June 7, 2018, Vol. 3 at p. 458, Line 12-21 [Van Quaethem]

where they are placed, it is reasonable to use the power of the government purse to try and enforce the most basic of human resources practices.

30. Separately, Professor Crofts-Yorker seems to indicate that the fear of litigation – likely more present in the United States but still possible in Canada – precludes a reference of any substance, for fear of liability for defamation or other causes of action. The above-referenced suggestion regarding legislative change, in line with what Professor Crofts-Yorker has told the Inquiry exists in Pennsylvania and New Jersey, would be prudent and can only help. That said, it bears noting that the Ontario Superior Court has clearly stated that a job reference constitutes a circumstance of qualified privilege for the purposes of defamation law:

> The defendant pleads that qualified privilege applies because his remarks were made as part of an employment reference. The employment reference has been described as "a classic occasion of qualified privilege": see Roger D. McConchie & David Potts, *Canadian Libel and Slander Actions*...
>
> The social policy underpinning the protection of employment references in this manner is clear: an employer must be able to give a job reference with candour as to the strengths and weaknesses of an employee, without fear of being sued in defamation for doing so. Without this protection, references would either not be given, or would be given with such edited content as to render them at best unhelpful or at worst misleading to a prospective employer.[14]

31. Accordingly, there should be nothing precluding any employer – including a health care facility – from providing an honest reference about an employee or former employee.

32. In response, Wanda Sanginesi, Vice President Human Resources at Caressant Care, stated that the federal *Personal Information Protection and Electronic Documents Act*[15] ("**PIPEDA**") would have prohibited her from providing a substantive reference for Ms. Wettlaufer in any event, because it would result in a disclosure of "*personal information*" under PIPEDA. That is

---

[14] *Kanak v Riggin*, 2017 ONSC 2837 (S.C.) at paras 26 & 27; aff'd, *Kanak v. Riggin*, 2018 ONCA 345
[15] *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5

inaccurate, for a number of reasons, including that section 4(1)(b) of PIPEDA clearly states that it only applies to personal information of employees of, and applicants for employment with, federal works, undertakings or businesses – which is not applicable to long-term care homes.

33. In any event, in a practical sense, if Meadow Park had engaged in a reference check with management at Caressant Care Woodstock and been provided accurate information, it is very possible that Ms. Wettlaufer would not have been hired.

(ii) Discipline in the Workplace & Union Matters

34. One of the themes that we consistently heard during the course of the Inquiry is that Caressant Care Woodstock's administrators – rightly or not – were made more nervous in their role as employee managers because of the spectre of prompting a grievance from the ONA, and perhaps affecting the home's nursing budget. This was because of a policy – mandated by Caressant Care itself – that any damages relating to a successful grievance would be taken from the home's nursing budget[16]. The painful irony of this policy – as was acknowledged by Ms. Van Quaethem – is that any good faith attempt to discipline a nurse for something that prompts a successful grievance will lessen monies to be spent on nursing care for residents.[17]

35. The possibility of difficult dealings with the ONA affected how Caressant Care Woodstock dealt with Ms. Wettlaufer's various discipline issues. Ms. Van Quaethem clearly said that if you took the ONA out of the equation, she would have fired Ms. Wettlaufer earlier.[18]

---

[16] LTCI Transcript, June 7, 2018, Vol. 3 at p. 456, Line 1-6 [Van Quaethem]
[17] LTCI Transcript, June 7, 2018, Vol. 3 at p. 453, Line 5-14 [Van Quaethem]
[18] LTCI Transcript, June 7, 2018, Vol. 3 at p. 453, Line 15-18 [Van Quaethem]

36. That timidity surrounding dealing with the ONA was aggravated because it became clear that Ms. Van Quaethem, Caressant Care Woodstock's Administrator for the majority of Ms. Wettlaufer's employment there, did not have a good familiarity with the Collective Agreement for her nurses[19], nor did she have a working knowledge of Caressant Care's own Progressive Discipline Policy.[20] She had little training in human resources matters, including but not limited to, how to discipline employees or request information regarding their ongoing medical conditions in a manner which complied with Ontario's *Human Rights Code.*

37. A series of important consequences followed. First, because Ms. Van Quaethem believed that the period for removal of discipline from an employee's record was twelve (12) months instead of eighteen (18) months, the way in which she managed Ms. Wettlaufer's discipline changed; Ms. Wettlaufer could have been subject to steeper discipline consequences, including the possibility of termination, at an earlier point. Separately, Ms. Van Quaethem did not appear to have facility with Caressant Care's own Progressive Discipline Policy, including the ability to escalate beyond the usual step-by-step basis for issues of serious concern.[21]

38. Combined, the above led to patterns of discipline that did not follow Caressant Care's own progressive discipline model, or alternatively, a lessening of discipline that Ms. Wettlaufer otherwise could have received.

---

[19] LTCI Transcript, June 6, 2018, Vol. 2 at p. 287-288, Line 10-32; 1-22 [Van Quaethem]
[20] LTCI Transcript, June 7, 2018, Vol. 3 at p. 453, Line 15-22 [Van Quaethem]
[21] LTCI Transcript, June 7, 2018, Vol. 3 at p. 520, Line 4-19 [Van Quaethem]

39. Further, neither Ms. Van Quaethem nor Ms. Crombez took any steps to follow up with Ms. Wettlaufer regarding the medical conditions discussed in August 2012[22], despite the fact that the *Human Rights Code* is clear that both employers and employees have to be active parts of the accommodation process, including asking for reasonable information to facilitate that process.

40. The dealings between the ONA and Caressant Care Woodstock also bear some commentary. It is clear that Caressant Care Woodstock was not adequately communicating with ONA with respect to at least some of Ms. Wettlaufer's discipline issues, such as the complaint from Mr. Bhat regarding Ms. Wettlaufer's failure to participate in narcotic counts[23] or the various PSW complaints about her conduct[24]. For some of Ms. Wettlaufer's discipline meetings, a local union representative was not present, and Caressant Care Woodstock did not request the ONA send a representative. Outcomes of meetings would sometimes not be shared with ONA[25]. There appeared to be no system for union representatives within the home to learn about previous discipline histories, leading Karen Routledge to admit that she only learned about some of Ms. Wettlaufer's discipline issues through the newspaper over the course of the Inquiry.[26]

41. However, ONA should not be immune from criticism in these proceedings. Despite what is alleged, it does not appear that ONA took steps to fully appreciate Ms. Wettlaufer's entire discipline history before grieving her termination. Specifically, ONA took no steps to try and

---

[22] LTCI Transcript, June 7, 2018, Vol. 3 at p. 548, Line 11-19 [Van Quaethem]; LTCI Transcript, June 11, 2018, Vol. 5 at p. 1062, Line 28-31 [Crombez]
[23] Overview Report – The Facilities and Agencies, Source Document LTCI00016841, Exhibit 6; LTCI Transcript, June 7, 2018, Vol. 3 at p. 532, Line 8-16 [Van Quaethem]
[24] LTCI Transcript, June 7, 2018, Vol. 3 at p. 534, Line 22-31 [Van Quaethem]
[25] LTCI Transcript, June 7, 2018, Vol. 3 at p. 539-540, Line 12-32; 1-17 [Van Quaethem]
[26] LTCI Transcript, June 13, 2018, Vol. 7 at p. 1464, Line 3-8 [Routledge]

obtain the discipline file from Caressant Care Woodstock before initiating the grievance[27], nor did they appear to contact Ms. Routledge – their own representative for many discipline meetings – to obtain an understanding of the entire context.

42. It should be noted that a union's duty of fair representation pursuant to Ontario's *Labour Relations Act* does not mean blindly grieving any discipline a member receives. At some point, this Inquiry will have to grapple between the competing interests of robust but fair representation of union members versus ensuring that vulnerable patients are not exposed to unsafe nurses. The Victims' Groups strongly believe that the interests of vulnerable patients should always be given priority, and accordingly, that such concerns should inform ONA's duty of fair representation to its members.

(iii) Policies Surrounding Termination

43. It is respectfully submitted that at the time of Ms. Wettlaufer's termination from Caressant Care Woodstock, a decision was made to pursue a path of least resistance.

44. Despite the various issues they had with Ms. Wettlaufer including:

(a) concerns about resident safety associated with her practice since at least August 2012;

[27] LTCI Transcript, June 7, 2018, Vol. 3 at p. 633, Line 7-24 [Van Quaethem]

(b) that in its termination letter, Caressant Care stated that Ms. Wettlaufer had an extensive disciplinary record and that the medication error involving H.D. was part of a pattern of behaviours that were putting residents at risk[28]; and

(c) that at the time of termination, Carole Hepting, Vice President, Operations at Caressant Care, believed Ms. Wettlaufer would have been a danger to anyone she subsequently would have worked with[29] and that Ms. Wettlaufer was "*unfit to safely practice nursing*"[30];

a decision was made to provide Ms. Wettlaufer a reference letter, falsely stating that she left the employ of Caressant Care to pursue other opportunities – which Ms. Crombez acknowledged was not true[31] – and that the organization was "*pleased*" to provide Ms. Wettlaufer with a reference.

45. On its face, Caressant Care's settlement of Ms. Wettlaufer's grievance – including terms that would treat the termination as a resignation and giving the reference letter – provided Caressant Care with various benefits: (i) not having to spend time and cost fighting a grievance[32]; (ii) certainty that Ms. Wettlaufer would never return[33]; and (iii) avoiding the possibility of reinstatement and backpay after an arbitration[34]. The terms of settlement were part of a risk

[28] Overview Report – The Facilities and Agencies, Source Document LTCI00016755, Exhibit 6.
[29] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3682-3683, Line 31-32; 1-27 [Hepting]
[30] Overview Report – The Facilities and Agencies, Source Document LTCI00072096, Exhibit 6
[31] LTCI Transcript, June 11, 2018, Vol. 5 at p. 1000-1001, Line 28-32; 1-5 [Crombez]
[32] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2701-2702, Line 31-32; 1-8 [Sanginesi]
[33] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2702, Line 9-13 [Sanginesi]
[34] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2702, Line 14-17 [Sanginesi]

mitigation strategy, or as Ms. Sanginesi put it: "*the best possible outcome that could be achieved through the arbitration process*" [35].

46. The decision to settle Ms. Wettlaufer's grievance in this way was the equivalent of Caressant Care preferring its own interests over those of others. Coupled with the deficiencies in their reporting to the College of Nurses of Ontario ("**CNO**"), Caressant Care's conduct constituted placing someone who they thought was unfit back into another health care environment, without warning of any sort.

47. During her cross-examination, Ms. Sanginesi's response was tone deaf to the larger implications of Caressant Care's decision, particularly regarding the choice to provide a reference letter. Despite Ms. Sanginesi's best efforts to defend Caressant Care's conduct, the reference letter was not "*boilerplate language*"[36]. When pressed on why she chose to write the reference letter, Ms. Sanginesi said that it was a calculated risk:

> *That was not the context or the thinking behind that language at all. I had no expectation at all that any employer would treat -- assuming any employer actually saw that letter. Because a lot of grievors who receive these type of letters through negotiated settlements don't actually use them for job searches.*[37]

48. It is clear from Ms. Sanginesi's testimony that Caressant Care made a calculated but baseless assumption that the positive reference letter they gave to a nurse they thought was dangerous would never be used.

---

[35] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2702, Line 6-8 [Sanginesi]
[36] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2699-2700, Line 13-32; 1-5 [Sanginesi]
[37] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2700, Line 12-19 [Sanginesi]

49. But unfortunately it was. Ms. Nicholas indicated that Ms. Wettlaufer provided her the reference letter during her probation period at Meadow Park and said that "*everything's cleared at Caressant*"[38]. In short, Ms. Wettlaufer used the letter to help buttress a fabricated story about the circumstances of her departure from Caressant Care Woodstock, the sort of fabrication that Professor Crofts-Yorker has warned about.

(B) The Failure to Keep Pace with Increasing Resident Needs

50. Ontarians are living longer than ever before. That increase in longevity creates corresponding pressures on long-term-care homes, home-care services and nursing staff.

51. There can be no real question that the acuity level of long-term care residents has been increasing.[39] When asked about the changes she has observed over her time at Caressant Care Woodstock, Ms. Van Quaethem stated residents in long-term care facilities are "*definitely more frail*" than they were before, and there are "*not that many independent people*".[40] That opinion was reiterated by a long line of witnesses at the Inquiry with experience in long-term care homes.[41]

---

[38] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2247, Line 14-16 [Nicholas]
[39] LTCI Transcript, June 6, 2018, Vol. 2 at p. 273, Line 23-27 [Van Quaethem]
[40] LTCI Transcript, June 6, 2018, Vol. 2 at p. 274, Line 8-11 [Van Quaethem]
[41] LTCI Transcript, June 8, 2018, Vol. 4 at p. 768, Line 15-17 [Crombez]; LTCI Transcript, June 12, 2018, Vol. 6 at p. 1315, Line 12-18 [Routledge]; LTCI Transcript, June 18, 2018, Vol. 9 at p. 1920, Line 7-13 [Long]; LTCI Transcript, June 19, 2018, Vol. 10 at p. 2085, Line 15-23 [Nicholas]; LTCI Transcript, June 20, 2018, Vol. 11 at p. 2367-2368, Line 29-31; 1 [Smith]; LTCI Transcript, June 22, 2018, Vol. 13 at p. 3000, Line 15-32 [Vanderheyden]; LTCI Transcript, June 25, 2018, Vol. 14 at p. 3333, Line 4-8 [Beauregard]; LTCI Transcript, June 25, 2018, Vol. 14 at p. 3375, Line 22-26 [Raney]; LTCI Transcript, June 26, 2018, Vol. 15 at p. 3521, Line 6-9 [Shannon]; LTCI Transcript, June 26, 2018, Vol. 15 at p. 3691, Line 3-7 [Cornelissen]

52. This issue of increased acuity is not limited to long-term care homes. Tamara Condy of St. Elizabeth's Health Care ("**St. Elizabeth**") testified that acuity levels have been increasing in the context of home care as well.[42]

53. These witnesses all agree: the level of care required to treat our aging population has dramatically increased.

54. Increasing resident acuity brings with it increased responsibilities and workload for nursing staff. Ms. Crombez defined acuity as the measurement of the intensity of nursing care required by the resident.[43] Higher levels of nursing staff are required for certain types of care, which increases with the acuity of the resident.[44] Residents with behaviour and mobility issues, and who otherwise need a higher level of care, trigger a greater "*vigilance*" from nurses, as Ms. Routledge stated.[45]

55. It was evident throughout the Inquiry that this requirement for increased vigilance due to these changes in acuity was not being met by the long-term care homes. Front line staff and managers alike complained about inadequate staffing levels, and the associated failure to meet the residents' needs. Perhaps they could not be met due to a lack of funding, amongst other issues. The Victims' Groups believe the question of adequate funding of long-term care homes is an issue which should bear important examination during Phase 2 of the Inquiry.

---

[42] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3936, Line 4 - 10 [Condy]
[43] LTCI Transcript, June 11, 2018, Vol. 5 at p. 978, Line 23-27 [Crombez]
[44] LTCI Transcript, June 12, 2018, Vol. 6 at p. 1192, Line 17-23 [Crombez]
[45] LTCI Transcript, June 12, 2018, Vol. 6 at p. 1315, Line 12-18 [Routledge]

56. We know that with increased acuity in a long-term care home's resident population, the greater the funding received from the Ministry of Health and Long-Term Care (the "**Ministry**"). The question then remains: is the current funding model adequate to meet residents' needs, particularly given the context of increasing acuity? When asked this question, the Administrator of Meadow Park, Robert Vanderhayden's response was clear: No.[46]

(ii) Funding

57. In their testimony before the Inquiry, managers and executives associated with Caressant Care Woodstock, Meadow Park and Telfer Place testified that they completely exhausted their Nursing and Personal Care funding "envelope" every year.[47] We also know that the funding for RNs, RPNs, and PSWs working in the long-term care facilities is taken from the nursing and personal care envelope.[48] All managers gave evidence that staffing levels are limited by funding. There are three other funding envelopes provided by the Ministry,[49] but no funds may be taken from nursing or personal care to pay for items under any of the other three categories.[50] This led Ms. Sanginesi to testify that funding for staff is simply "*out of [their] hands*".[51]

---

[46] LTCI Transcript, June 22, 2018, Vol. 13 at p. 3001, Line 27 [Vanderheyden]
[47] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2086, Line 4-7 [Nicholas]; LTCI Transcript, June 12, 2018, Vol. 6 at p. 1216, Line 4-9 [Crombez]; LTCI Transcript, June 27, 2018, Vol. 16 at p. 3726, Line 3-7 [Hepting]; LTCI Transcript, June 26, 2018, Vol. 15 at p. 3523, Line 27-28 [Shannon]
[48] LTCI Transcript, June 26, 2018, Vol. 15 at p. 3595, Line 5-11 [Shannon]
[49] Other Accommodations, Program and Services, and Raw Food envelopes.
[50] LTCI Transcript, June 22, 2018, Vol. 13 at p. 3012, Line 1-9 [Vanderheyden]
[51] LTCI Transcript, June 21, 2018, Vol. 12 at p. 2728, Line 19-27 [Sanginesi]

58. Of course, the funding model is more complicated than that. Homes are permitted to use their "Other Accommodation" ("**O/A**") envelope of funding for whatever they want, including investing in additional nursing care resources, or taking any residue as profit[52].

59. Additionally, we have learned that residents provide "co-payments" to the long-term care homes, which as of 2014/2015 was a minimum of $56.95 per resident, per day[53]. Long-term care homes collect the co-payment[54]; the Ministry tops up revenue not collected, and provides subsidies for some residents who cannot afford the co-payment[55]. The co-payment can go into the O/A envelope[56].

60. One gets the impression that the sector is chronically underfunded, and that this seems to be accepted by those who are involved, but this Inquiry does not appear to have made that issue a particular focus of the public hearings. It is respectfully suggested that Phase 2 of the Inquiry take steps to investigate the question of the amount of funding received by long-term care homes, including but not limited to the above-referenced co-payments, and how (if at all) that money is used and directed for the purposes of quality care of our seniors.

61. Each of the long-term care homes which the Inquiry focused on were for-profit enterprises. No one denies that they should have a right to make some profit, but if that profit is being earned primarily through the expenditure of public resources, the Victims' Groups believe that there should be corresponding obligations of transparency on those who are facility operators. To that end, we have not been provided with the financial statements for any long-term

[52] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6091-6092, Line 32; 1-7 [Simpson]
[53] LTCI00071733, p. 7, Exhibit 169
[54] LTCI00072869, p. 12, Exhibit 129
[55] LTCI00072869, p. 12, Exhibit 129
[56] LTCI00072869, p. 12, Exhibit 129

care homes, and no testimony on the topic was given from an appropriately senior representative or owner of the facilities involved. Accordingly, aside from questions specific to industry players which can be asked at Phase 2 of the Inquiry, the Victims' Groups believe that the financial statements for publicly-funded long-term care homes should be made public.

> ***<u>Recommendation #3</u>: All long-term care facilities should be required to provide full disclosure of their year-end financial statements. Those statements should be made available to the public for review. In the alternative, the Ministry of Health and Long-Term Care should receive copies of the year-end financial statements from all long-term care facilities receiving public funding.***

62. The Victims' Groups believe that additional financial documentation should be provided by the facilities participating in the Inquiry, specifically, detailed Financial Statements for the years 2007 to 2014, inclusive. This will provide the Commissioner with a clear and comprehensive understanding of how for-profit facilities make their profit while consistently claiming to be underfunded on their nursing and personal care envelope. It is respectfully submitted that in the interest of public accountability and transparency, such information needs to be made available to the Commissioner during Phase 2 of the Inquiry.

(iii) <u>Understaffing of Long-Term Care Homes</u>

63. The implications of chronic understaffing at long-term care homes are significant, and directly related to the mandate of the Inquiry. It is undoubted that one of the aggravating factors which led Ms. Wettlaufer to both abuse alcohol and drugs, as well as commit the crimes themselves, was the pressures she felt in the workplace.

64. Almost without exception, Caressant Care staff provided evidence confirming there was an ongoing shortage of care providers in the home. With respect to staffing at Caressant Care

Woodstock, Ms. Hepting was asked directly whether she was ever told by site administrators that they needed more staff. She replied "no."[57] But the home Administrator, Ms. Van Quaethem, along with other Caressant Care Woodstock staff, had expressed for some time that they felt constantly short-staffed, prompted by complaints from front-line staff, such as Robyn Laycock. Those front-line staff were often told that it was simply not in the budget.[58]

65. When the home was staffed to the legislative minimums, there was only one RN working the night shift for a group of ninety (90) to ninety-nine (99) residents.[59] It is respectfully suggested that the average Ontarian would be shocked by that ratio, and would question whether that could ever constitute good – or even adequate – care for residents.

66. During the course of Ms. Routledge's examination, one counsel put to her that this night shift ratio equates to four-and-a-half (4.5) minutes of time with each resident, assuming there are no interruptions, for an entire shift.[60] Based on the increased daytime staffing ratio, this number increased to approximately ten (10) minutes per resident.[61]

67. The Victims' Groups believe that neither one of these numbers demonstrates a sufficiently long period of time for staff to appropriately assess, treat, and administer medications to residents of long-term care homes. Furthermore, it creates a culture where it is not unusual for residents to be without a caregiver for extended periods of time, which may provide the space and time for a nefarious actor like Ms. Wettlaufer to hurt residents.

---

[57] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3726, Line 25 [Hepting]
[58] *See*, for example, LTCI Transcript, June 25, 2018, Vol. 14 at p. 3223, Line 5-18 [Laycock]
[59] LTCI Transcript, June 8, 2018, Vol. 4 at p. 765, Line 25-28 [Crombez]
[60] LTCI Transcript, June 13, 2018, Vol. 7 at p. 1434, Line 5-10 [Routledge]
[61] LTCI Transcript, June 12, 2018, Vol. 6 at p. 1433, Line 5-9 [Routledge]

68. But certainly this is not the only reason why increasing staffing ratios is desirable. In fact, this issue, like many others, aligns better care outcomes for long-term care residents with a safer environment for them. Nowhere could this be better found than the testimony of Brenda Black, a PSW who worked at Caressant Care Woodstock. Ms. Black spoke of the time that Caressant Care Woodstock was on a cease admissions order, meaning that no new residents could be housed, and the home's numbers would naturally dwindle as people passed away in the normal course. Some would think that it would have been a point of low morale at the home, but Ms. Black's comments challenged that assumption:

> *Q. And just in terms of that period of time that Mr. Scott raised with you, the ten-month period where you were receiving no residents and you were able to provide the residents with care, was there a corresponding improvement in the residents' behaviours in the sense that some people who maybe had some responsive behaviours, that actually they were easier to care for, in addition to you being able to care for them, because you were providing that extra care?*
>
> *A. Yes, we could get to residents' needs a lot quicker. There was less of them, so we were able to get to them quicker and catch them and get them on the toilet before they had their -- like had an accident. And you know, we were just able to spend more quality time with them and at least even just sit town and talk. Like usually it is in and out, gotta go, gotta go. We can't sit and spend five minutes. And they would talk and we would kind of keep walking and they would still keep talking because we have ten other things we had to do. But with less residents, we had more time to spend with them. So it was nice.*[62]

69. The positive, but unexpected effect of the cease admissions order from the Ministry was that the additional one-on-one care of residents at Caressant Care Woodstock improved everyone's quality of life and the dignity of their experience. One wonders if there was a corresponding decrease in that quality once the cease admissions Order was removed and the number of residents returned to 'normal'.

---

[62] LTCI Transcript, June 14, 2018, Vol. 8 at p. 1906, Line 2-27 [Black]

70. During her cross-examination Ms. Hepting confirmed that funding for RNs, RPNs, and PSWs at Caressant Care Woodstock was an issue.[63]

71. This was not an uncommon experience. Mr. Vanderhayden, testified that Jarlette Health Services did not increase its budget yearly to accommodate increased acuity, resident needs, or staffing requests. Rather, they "*would know the amounts that were set out, and then we would have to work within those from head office*."[64] Likewise, Dian Shannon, Executive Director at Telfer Place, confirmed that their home "*didn't have the extra funds*" to change the ratio of nursing staff to residents despite looking into it in 2015-2016.[65] This may be even more of an issue in smaller long-term care homes, that have fewer residents, and therefore less funding available to support increases in staff.[66]

72. When given an option for an increase in the level of funding, many witnesses opined on what level of staffing they thought would be required in order to bring the levels of RNs in line with the acuity levels of the residents. Ms. Van Quaethem suggested a ratio of one RN to every ten residents, and at least four RPNs with one RN assisting during nights.[67] Ms. Crombez suggested a ratio of one RN to every twenty residents during the day.[68] Others suggested increasing the minimum levels of RNs in the building at any given time.[69] It appears that they all would agree that the current minimum of one RN on duty at all times provides insufficient care for resident.

---

[63] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3729-3730, Line 13-32; 1-16 [Hepting]
[64] LTCI Transcript, June 22, 2018, Vol. 13 at p. 3036, Line 11-14 [Vanderheyden]
[65] LTCI Transcript, June 26, 2018, Vol. 15 at p. 3603, Line 24-26 [Shannon]
[66] LTCI Transcript, June 13, 2018, Vol. 7 at p. 1581, Line 9-13 [Wilmot-Smith]
[67] LTCI Transcript, June 7, 2018, Vol. 3 at p. 454, Line 14-17 [Van Quaethem]
[68]LTCI Transcript, June 12, 2018, Vol. 6 at p. 1147, Line 23-24 [Crombez]
[69] LTCI Transcript, June 22, 2018, Vol. 13 at p. 3046, Line 1-4 [Vanderheyden]

73. We respectfully submit that there is a clear staffing shortage in the long-term care system, especially with respect to registered staff. On the evidence provided at the Inquiry, no consensus emerged that would clarify what level of staffing would meet the needs of the residents of long-term care homes.

> ***<u>Recommendation #4</u>: The Ministry of Health and Long-Term Care should assemble a group of experts to identify the appropriate level of staffing to provide high quality care to residents of long-term care homes. Those findings should not include budgetary or funding considerations.***

(C) The Ministry's Accountability and Oversight Mechanisms Failed to Detect Ms. Wettlaufer's Crimes

74. The Victims' Groups believe that the accountability and oversight mechanisms employed by the Ministry were ineffective at detecting Ms. Wettlaufer's crimes or identifying the compliance issues which allowed them to occur. Through the course of this Inquiry, the following themes have emerged with respect to the Ministry's oversight of long-term care homes:

<u>(i) Lack of Resources</u>

75. During the past decade, the Ministry's compliance and enforcement regime has gone through significant changes which have resulted in increased demands on the resources of Service Area Offices ("**SAO**"). These changes include:

(a) the legislative and regulatory oversight of long-term care homes in Ontario changed fundamentally when the LTCHA and its regulations (the "**Regulation**") came

into force on July 1, 2010[70] which has given rise to heightened obligations on the Director and on inspectors[71];

(b) the Ministry undertook a compliance transformation process which resulted in the development of a new inspection regime, including the introduction of the Resident Quality Inspection ("**RQI**") methodology in all homes[72];

(c) the government has committed to conducting an annual RQI in every home[73]; and

(d) the number of complaints received by the Ministry continues to increase.[74]

76. In the face of these changes, the Inspections Branch has adopted a number of strategies to increase efficiency and cope with the lack of resources, including: bundling complaints[75]; streamlining the RQI process[76]; rolling out risk-focused RQIs[77]; triaging intakes for inquiries instead of inspections[78]; "*clearing the path*" to clear backlogs of Complaints, Critical Incident and Follow-Up ("**CCF**") inspections[79]; and opening two new SAOs[80].

77. Notwithstanding these strategies, we have heard repeatedly from witnesses during the weeks of the public hearings dedicated to the Ministry – from people who both worked on the front line of long-term care inspections and those involved in historical policy development for

---

[70] Affidavit of Karen Simpson at para. 55, Exhibit 129
[71] Affidavit of Karen Simpson at paras. 51 and 60, Exhibit 129
[72] Affidavit of Karen Simpson at paras. 51 and 60, Exhibit 129
[73] Affidavit of Karen Simpson at para. 106, Exhibit 129
[74] Overview Report – Ministry of Health and Long-Term Care at p. 391, Exhibit 9
[75] Affidavit of Rhonda Kukoly at para. 29, Exhibit 134
[76] Affidavit of Karen Simpson at para. 108, Exhibit 129
[77] Affidavit of Karen Simpson at para. 114, Exhibit 129
[78] Affidavit of Karen Simpson at para. 120, Exhibit 129
[79] Affidavit of Rhonda Kukoly at para. 30, Exhibit 132
[80] Affidavit of Rhonda Kukoly at para. 5, Exhibit 132

the Ministry – that the SAOs are not properly resourced[81]. This should be troubling to the public, as presumably when the LTCHA was passed, Ontarians were given comfort that the move from a compliance-based regime to an inspection-based regime would be coupled with appropriate resources to conduct those inspections. The Ministry cannot provide effective oversight of long-term care homes if it does not have adequate resources to conduct inspections in a timely manner.

> ***Recommendation #5: The Ministry of Health and Long-Term Care should immediately conduct an audit of its SAO's to determine whether they require more resources to meet their statutory obligations under the LTCHA. If so, the Province of Ontario must allocate appropriate funding to meet these needs.***
>
> ***Recommendation #6: The Ministry of Health and Long-Term Care should ensure that SAOs are appropriately staffed with inspectors to ensure that inspections are conducted on a timely basis.***

78. It is imperative that SAOs have sufficient staffing to ensure that Inspectors are able to devote the necessary time and resources for their inspections. As such, the Ministry should conduct a review of current staffing levels at SAOs and determine if additional hiring is necessary. As part of this review, the Ministry should consider whether new inspectors should be hired to carry out any of the Commissioner's recommendations from this Inquiry.

79. Separate and apart from properly resourcing the SAOs, in an effort to address the above-referenced problems, the Victims' Groups believe specialization may assist.

---

[81] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6871, Line 20-26 [Kukoly]; LTCI Transcript, August 7, 2018, Vol. 32 at p. 7504, Line 1-7 [Fairchild]

<u>Recommendation #7</u>: The Ministry of Health and Long-Term Care should create a pilot project to examine the use of two separate inspection teams – one with a focus on RQI inspections and the other to focus on CCF inspections.

80. During the Inquiry, we learned that RQI inspections are incredibly resource intensive – a risk-focused RQI takes ten (10) inspector days while an intensive risk focused RQI takes thirty (30) inspector days.[82] Consequently, SAOs are experiencing a backlog of CCF intakes and are having difficulty completing all CCF intakes in the appropriate timeframe.[83] As is noted above, in order to maximize their time in the home efficiently, Ministry inspectors have started bundling CCF intakes[84] or sending a team to "*clear the path*".[85] However, as Rhonda Kukoly, a Ministry Inspector in the London SAO, noted in her affidavit, sometimes inspecting CCF intakes along with RQIs can result in findings of non-compliance becoming mixed together.[86]

81. In Karin Fairchild's affidavit, who is the Manager of Compliance Inspection at the Hamilton SAO, she suggests that the Ministry create two (2) separate inspection teams – one with a focus on the RQI methodology and the other with a focus on CCF inspections. [87] The Victims' Groups believe this approach may be a more efficient use of the Ministry resources, and is more likely to ensure that there is not a backlog of CCF inspections. We would encourage the Ministry to create a pilot project at the Hamilton SAO to determine if Ms. Fairchild's suggestion creates greater efficiencies with the inspection process. In the circumstances that the pilot project is successful, the Ministry should introduce this change province-wide.

---

[82] Affidavit of Karen Simpson at paras. 109 and 116-117, Exhibit 129
[83] Affidavit of Rhonda Kukoly at para. 29, Exhibit 134
[84] Affidavit of Rhonda Kukoly at para. 29, Exhibit 134
[85] Affidavit of Rhonda Kukoly at para. 30, Exhibit 134
[86] Affidavit of Rhonda Kukoly at para. 32, Exhibit 134
[87] Affidavit of Karin Fairchild at para. 63, Exhibit 154

82. Both the above-noted questions of resources, as well as specialization, are aimed at ensuring better quality and more timely inspections. The Victims' Groups believe that these goals align with the goals of overall resident safety.

(ii) The Scope and Conduct of Ministry Inspections is Too Rigid

83. Throughout the Ministry phase, we heard from witnesses that the role of Ministry inspections was to look for compliance and nothing else.[88] After listening to the evidence at the public hearings, one gets the impression that Ministry inspectors felt they had to '*stay in their own lane'* of compliance, as opposed to taking a more holistic and practical approach which focuses on the well-being and safety of residents and the public-at large. Ms. Kukoly's inspection of the missing narcotics at Meadow Park in fall 2014 is illustrative.[89] At paras. 77-79 of Ms. Kukoly's affidavit, she states:

> *I did a missing narcotics Inspection at Meadow Park London in the fall of 2014 that involved EW … The CI for this inspection indicated that a 1mg card of Hydromorphone was missing, and that the police were investigating. During the inspection, the DOC and the Administrator told me that they suspected that EW took the missing narcotics because she had been working the day that the narcotics went missing, and that EW gave them a doctor's note that said she had an illness that required treatment, and then resigned. The Administrator and DOC also told me that EW had revealed that she had overdosed on drugs after the narcotics went missing.*
>
> *In the Inspection of the missing narcotics, I did not make a finding of non-compliance. It is not the Inspector's role to determine whether a person committed a criminal act. The Inspector's role is to determine whether the home is compliant with the LTCHA and the Regulation…*
>
> *…*
>
> *For this inspection, I reviewed the home's policies related to ordering, receiving, and storing controlled substances to ensure that they complied with the requirements in the*

[88] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6999, Line 9-30 [Kukoly]; LTCI Transcript, August 8, 2018, Vol. 33 at p. 7613, Line 10-30 [Fairchild]
[89] Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00039395, Exhibit 9

> *regulation, and that they had been followed… With respect to the suspected theft, the home had contacted the police. The suspected staff member had resigned and had indicated that she was no longer going to be working as a nurse. In retrospect, I should have also asked the home if they had contacted the CNO about this suspected theft of narcotics by a nurse.*[90]

84. During the Meadow Park inspection in 2014, Ms. Kukoly was advised that Ms. Wettlaufer had a drug and alcohol problem.[91] Yet, Ms. Kukoly did not review the quality of care provided by Ms. Wettlaufer[92], review Ms. Wettlaufer's employee file[93], ask whether Meadow Park had reported Ms. Wettlaufer to the CNO[94], inquire about whether Ms. Wettlaufer would be working as a nurse elsewhere[95], or follow up with Meadow Park about the status of the police investigation.[96]

85. Rather, the focus of Ms. Kukoly's inspection was solely on the questions contained in the Medication Inspection Protocol. The Victims' Groups are concerned that this reflects an underlying culture at the Ministry, whereby inspectors are trained to only look at an issue if it could be reportable under the LTCHA and the Regulation, or could lead to possible non-compliance. Simply put, such an approach is very different than one which is animated primarily by the best interests of residents and the public.

> ***<u>Recommendation #8</u>: The Ministry of Health and Long-Term Care should provide training and resources to its Inspectors, to shift the focus of inspections from strict compliance to one of promoting resident dignity, security, safety and comfort.***

---

[90] Affidavit of Rhonda Kukoly at paras. 77-79, Exhibit 134
[91] Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00039398, Exhibit 9
[92] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6861, Line 10-17 [Kukoly]
[93] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6860-6861, Line 20-32; 1-3 [Kukoly]
[94] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6858-6859, Line 31-32; 1-3 [Kukoly]
[95] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6863, Line 19-26 [Kukoly]
[96] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6866, Line 1-7 [Kukoly]

86. In our view, this approach takes a narrow view of section 142 of the LTCHA which states that "*an inspector may conduct inspections for the purposes of ensuring compliance with requirements under this Act*."[97] The Victims' Groups note that section 1 of the LTCHA guides how the entire act should be interpreted:

> ***Home: the fundamental principle***
>
> *The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.* [98]

87. As such, the Victims' Groups respectfully submit that the purpose of an inspection should be interpreted broadly and with regard to the legislated fundamental principles of promoting resident dignity, security, safety, comfort and needs.

88. To that end, the Victims' Groups recommend that the Ministry take steps to shift the focus from the rigid process set out in the Inspection Protocols to a more proactive and flexible approach to inspections. While Inspection Protocols are useful guides, Ministry inspectors should not be relying entirely on the questions in the Inspection Protocols. Rather, if an inspector becomes aware of a serious issue that does not fall squarely within the legislative framework, they should be encouraged to examine this issue further or direct it to another authority if necessary.

89. To assist, the Ministry should develop training and best practices which will provide guidance to inspectors on how to approach inspections when they become aware of issues that

---

[97] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8, section 142, Exhibit 4
[98] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8, section 1, Exhibit 4

may not relate to any specific compliance requirements. For example, there may be value in best practices which suggest that, amongst other things:

(a) inspectors who have reasonable grounds to believe that a nurse may lack capacity or be incompetent should:

(i) voluntarily contact the CNO[99];

(ii) review the quality of care provided by the nurse in question; and/or

(iii) review the nurse's employment file[100]; and

(b) in the circumstances where there are multiple instances of narcotics theft in a long-term care home, Inspectors should review staff schedules to identify trends and to monitor the situation by following up with the home and the police.

90. The Victims' Groups believe that these kinds of best practices will help Ministry inspectors address issues that do not necessarily give rise to findings of non-compliance and to ensure that there is an additional, common-sense level of oversight with respect to issues that may prevent future harm to residents.

---

[99] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6364, Line 8-28 [Simpson]
[100] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6986-6987, Line 5-32; 1-13 [Kukoly]

(iii) Improving the Mandatory Home Tasks

91. During the RQI process, there are a number of mandatory home tasks that must be completed during the inspection (i.e. resident interview, dining observation, family council interview, etc.).[101] We recommend that the Ministry add the following tasks:

(a) a pre-inspection review of employee files for all staff who have been subject to discipline since the last RQI inspection; and

(b) resident observations during a night shift.

92. When these suggestions were proffered to Ministry witnesses, they agreed that such changes would be worthwhile to consider.[102] From the Victims' Groups perspective, there are no downsides to adding such tasks.

(A) Reviewing Employee Files during the Inspection Process

93. The evidence heard during these public hearings revealed that Ms. Wettlaufer was a troubled nurse who had a lengthy discipline history at Caressant Care Woodstock and was subject to numerous complaints. Yet, the Ministry was completely unaware of these incidents, as most of this information was not reported to the Ministry (often, as was required), and inspectors did not have any reason to review Ms. Wettlaufer's employee file during their inspections of that home.

---

[101] Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00047525 at p. 7, Exhibit 9
[102] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6874-6876, Line 30-32; 1-32; 1-9 [Kukoly]

94. We have heard from Karen Simpson, the former Director of the Ministry's Long-Term Care Inspections Branch, and Ms. Kukoly, that it is not the Ministry's practice to review an employee file unless something specific in the inspection requires them to.[103] For example, during an inspection concerning a medication error, the inspector may potentially review an employee file to see if there is a history of medication errors committed by the staff member who was involved in the error they were investigating.[104]

95. In our submission, there is great value to reviewing employee files during an inspection to identify non-compliance in a home that otherwise would not be identified through CCF or RQI inspections.

96. The circumstances of Ms. Wettlaufer's case are illustrative of the value of such an approach. In this case, Ms. Wettlaufer's employee file was a trove of information related to non-compliance at Caressant Care Woodstock.[105] Notably, Ms. Kukoly found the following information in Ms. Wettlaufer's employee file – that the Ministry had not previously known about – which resulted in findings of non-compliance during the Ministry's inspections of Ms. Wettlaufer's offences (the "**2016 Wettlaufer Inspections**"):

(a) multiple staff members had concerns about Ms. Wettlaufer's neglect or suspected abuse dating back to early December 2011 but failed to report to the Director[106];

---

[103] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6380-6381, Line 9-32; 5-8 [Simpson]; LTCI Transcript, August 2, 2018, Vol. 30 at p. 6874-6875, Line 30-32; 1-13 [Kukoly]
[104] LTCI Transcript, August 1, 2018, Vol. 29 at p. 6725-6726, Line 20-32; 1-7 [Kukoly]
[105] Affidavit of Rhonda Kukoly at para. 89, Exhibit 132
[106] Affidavit of Rhonda Kukoly at para. 108(g), Exhibit 132

(b) the January 2012 incident where a PSW complained about improper/incompetent treatment of a resident's hematoma[107];

(c) the January 2012 incident where a PSW complained about improper/incompetent treatment of a resident with a suspected hip fracture[108];

(d) the April 2013 incident where Ms. Wettlaufer was alleged to have spoken inappropriately to D.W. by asking him if he needed a Haldol® injection or a psychiatric assessment[109];

(e) the January 2014 incident where Ms. Wettlaufer was alleged to have spoken inappropriately to Maureen Pickering when she had wandered into another resident's room and was showing responsive behaviours[110];

(f) the March 2014 incident where Ms. Wettlaufer administered the wrong insulin to HD which Caressant Care Woodstock failed to analyze or take any corrective action[111]; and

(g) thirteen (13) medication errors documented in Ms. Wettlaufer's employee file[112].

---

[107] Affidavit of Rhonda Kukoly at para. 108(i), Exhibit 132
[108] Affidavit of Rhonda Kukoly at para. 108(i), Exhibit 132
[109] Affidavit of Rhonda Kukoly at para. 108(h) and (i), Exhibit 132
[110] Affidavit of Rhonda Kukoly at para. 108(i), Exhibit 132
[111] Affidavit of Rhonda Kukoly at para. 108(m), Exhibit 132
[112] Affidavit of Rhonda Kukoly at para. 108(l), Exhibit 132

97. Given the widespread findings of non-compliance at Caressant Care Woodstock during the 2016 Wettlaufer Inspections, we query whether the Ministry would have discovered these compliance issues sooner if it were a practice to review employee files.

98. With respect to the proposed review of employee files, we recognize that it would not be practical to require the Ministry to conduct an annual review of all employee files in a home. As such, the Victims' Groups recommendation is that the Ministry simply conduct a review of employee files for any staff which have been subject to discipline since the last RQI. The rationale is that conduct which is disciplinable by the home is more likely to be conduct which would result in non-compliance and/or a risk of harm to residents. For this reason, we believe that there is significant value in conducting a review of these particular employee files; it will allow inspectors to determine whether the home dealt with the issues appropriately and is compliant with the LTCHA and Regulation.

Recommendation #9: The Ministry of Health and Long-Term Care should revise the Mandatory Home Tasks to be completed during the RQI process to add a pre-review of employee files for any staff who have received discipline since the last RQI was conducted.

(B) Limited Ministry Oversight of Care Provided During Night Shifts

99. As discussed above, staffing levels are very low during night shifts.[113] As the only RN on duty during the night shift, Ms. Wettlaufer had ease of access to the medication room and was subject to minimal supervision.[114] This was a significant contributing factor which allowed Ms. Wettlaufer's crimes to go undetected, as there was no management or other RNs present to

[113] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6521, Line 1-9 [Simpson]
[114] LTCI Transcript, June 6, 2018, Vol. 2 at p. 502-503, Line 16-32; 1-6 [Van Quaetham]

observe Ms. Wettlaufer's actions or to provide treatment for the insulin overdoses.[115] Given the lack of supervision, it is alarming that the Ministry does not regularly conduct inspections during the night shift.[116] This means that there are currently very few checks and balances in place to ensure that sufficient care is provided during nights shifts. The Victims' Groups believe we need more Ministry oversight during night shifts to protect residents from potential abuse and neglect.

Recommendation #10: The Ministry of Health and Long-Term Care should revise the Mandatory Home Tasks to be completed during the RQI process to add resident observations during the night shift.

(iv) Limitations in the LPA Model

100. Given the lack of resources at the Ministry, the Long-Term Care Quality Inspection Program Assessment ("**LPA**") is an important risk management tool which allows the Ministry to determine how to best allocate its resources with respect to RQI inspections.

101. Alarmingly, the LPA consistently assessed Caressant Care Woodstock as a Level 1 home[117] which is entirely inconsistent with the 2016 Wettlaufer Inspections which uncovered widespread non-compliance at Caressant Care Woodstock[118] and ultimately led the Ministry to issue a mandatory management order ("**MMO**") at the home.[119] As such, it is clear that the LPA – at least in this particular instance – was not an accurate predictor of a long-term care home's risk of non-compliance.

---

[115] LTCI Transcript, June 7, 2018, Vol. 3 at p. 279-280, Line 9-32; 1-31 [Van Quaetham]
[116] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6388-6389, Line 8-32; 1-11 [Simpson]
[117] Affidavit of Karen Simpson at para. 132, Exhibit 129
[118] Affidavit of Rhonda Kukoly at para. 108, Exhibit 134
[119] Affidavit of Karen Simpson at paras. 152-153, Exhibit 129

102. On cross examination, Mr. Moorman admitted that a limitation of the LPA model is that it is dependent on staff to properly input RAI-MDS data and to fulfil their reporting obligations.[120] Yet, Mr. Moorman stated that he was not overly concerned about long-term care homes receiving a risk-focused RQIs instead of an intensive RQIs due to failure to report.[121]

103. On this issue, the Victims' Groups strongly disagree. With the greatest of respect to Mr. Moorman, we have heard throughout this Inquiry that the failure to report is a high-risk area, and in fact, was a top area of non-compliance in 2017.[122] As such, the Victims' Groups query whether the Ministry's LPA process is underestimating non-reporting in the sector and the associated risk that this may shift a home's risk level from a non-compliant status (Level 2 or 3) to a compliant status (Level 1).

104. While the Ministry has attempted to mitigate this risk by putting in place the policy where every long-term care home will have an intensive risk-focused RQI every three years[123], we believe the LPA model must be improved to ensure that it is a more accurate predictor of a long-term care home's risk of non-compliance.

<u>Recommendation #11</u>: The Ministry of Health and Long-Term Care should create a sixth iteration of the LPA model with improvements to the data elements used.

---

[120] LTCI Transcript, August 7, 2018, Vol. 32 at p. 7445-7446, Line 1-28 [Moorman]
[121] LTCI Transcript, August 7, 2018, Vol. 32 at p. 7350, Line 3-9 [Moorman]
[122] LTCI00072894 at p. 5, Exhibit 131
[123] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6221-6222, Line 24-32; 1-3 [Simpson]

105. The Victims' Groups believe that in order to avoid similar tragedies in the future, the LPA model needs to be improved so that the Ministry can effectively discharge its oversight function. In his affidavit, Mr. Moorman suggested that the next version of the LPA should: (i) allow for differentiation between high-risk versus low-risk areas of non-compliance; (ii) add certain RAI-MDS data; (iii) add more financial data; and (iv) automate the LPA report which would allow for more sophisticated trend analysis.[124]

106. We would support all of Mr. Moorman's suggestions as we believe that utilizing a broader data set, incorporating weighing of compliance data and automating the LPA report will enhance the Ministry's ability to accurately determine risk levels. In particular, we believe that it would be valuable for the LPA model to weigh compliance data by attributing greater significance to findings of non-compliance in high risk areas compared to those in low risk areas. For example, on cross examination, Ms. Simpson strongly agreed with the proposition posed by counsel for the Victims' Groups that a long-term care home's history of non-reporting should be attributed more significance in the LPA Model.[125]

(D) Inadequate Medication Management System Processes

(i) Widespread Non-Compliance Related to Medication Management

107. It is clear that Caressant Care Woodstock, Meadow Park and Telfer Place all had issues with respect to their medication management practices and in particular, had significant gaps in their processes with respect to the recording, tracking, and investigating of medication incidents

---

[124] Affidavit of Philip Moorman at para. 35, Exhibit 148
[125] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6359, Line 2-10 [Simpson]

and adverse drug reactions.[126] Given the nature of Ms. Wettlaufer's offences and her personal history of addiction, this is deeply concerning.

108. As explained by Ms. Fairchild, the Regulation concerning medication management was drafted with the intention of setting minimum standards and reflecting best practices which would allow for developments over time.[127] In particular, sections 114, 115 and 135 of the Regulation establish comprehensive requirements with respect to the medication management system and addressing medication incidents and adverse drug reactions.[128] This reflects the philosophy that medication errors will occur in the long-term care sector, but that it is important for licensees to review each of these incidents and take corrective action to reduce the risk of a similar incident occurring in the future.

109. As a result of the 2016 Wettlaufer Inspections, it was revealed that Caressant Care Woodstock, Meadow Park and Telfer Place were all in breach of sections 114, 115 and/or 135 of the Regulation by failing to implement appropriate medication management systems at their respective locations.[129] We note that the medication management problems were particularly egregious at Caressant Care Woodstock and that ongoing issues with compliance with section 135, among other issues, led to a cease of admissions and the MMO.[130]

110. In hindsight, Ms. Wettlaufer's crimes occurred, in part, because the facilities were not stringently reviewing, analyzing or investigating medication incidents and adverse drug

---

[126] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6139, Line 14-19 [Simpson]
[127] Affidavit of Karin Fairchild at paras. 36-37, Exhibit 129
[128] O. Reg. 79/10, sections 114, 115 and 135, Exhibit 4
[129] Affidavit of Rhonda Kukoly at para. 108(m), Exhibit 134; Affidavit of Natalie Moroney at para. 41(h), Exhibit 142; Affidavit of Lisa Vink at para. 73(e), Exhibit 144
[130] Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00039100 at p. 9, Exhibit 9

reactions. In addition, there was also no quarterly review of the medication management system at Caressant Care Woodstock; shockingly, Ms. Kukoly testified that Dr. Richard Reddick had *never conducted a medication management system evaluation* in his over forty (40) years of service as Medical Director at Caressant Care Woodstock.[131] In our submission, the lack of due diligence surrounding medication at Caressant Care Woodstock and the other facilities created an environment whereby Ms. Wettlaufer felt comfortable committing her offences.

111. Caressant Care Woodstock's failings in response to Ms. Adriano's insulin overdose illustrates the medication management issues at the home. In Ms. Adriano's case, Caressant Care Woodstock – despite completing an internal incident report which Ms. Crombez, the then home Administrator and Dr. Reddick each signed[132] – failed to report the medication error and adverse drug reaction to the prescriber and pharmacist or take specific follow up action as required by the Program Manual.[133] Furthermore, there was no evidence that anyone at Caressant Care Woodstock took steps to investigate who administered the insulin or who called the on-call doctor about an insulin overdose.[134] This is significant: had there had been a meaningful investigation or corrective action taken in response to Ms. Adriano's October 2007 hospitalization, which was Ms. Wettlaufer's first offence, Ms. Wettlaufer's crimes could have been uncovered, or at least, this could have deterred Ms. Wettlaufer from committing any subsequent offences.

---

[131] LTCI Transcript, August 2, 2018, Vol. 30 at p. 6999, Line 9-30 [Kukoly]
[132] Overview Report – The Facilities & Agencies, Source Document LTCI00012113, Exhibit 6
[133] Affidavit of Rhonda Kukoly at para. 107(c), Exhibit 134
[134] LTCI Transcript, June 11, 2018, Vol. 5 at p. 935, Line 8-22 [Crombez]

<u>Recommendation #12</u>: The Ministry of Health and Long-Term Care should provide clear direction to inspectors regarding the protocol for reviewing section 135 during RQI Inspections.

112. In January 2017, as a result of the findings in the 2016 Wettlaufer Inspections, the Ministry made it mandatory to conduct a review of section 135 of the Regulation during all RQI inspections to ensure that homes have those processes in place.[135] Ms. Simpson explained in her affidavit that the new practice involves determining whether the licensee has implemented the appropriate systems to address medication errors and adverse drug reactions.[136] However, once the inspector knows that there is a system in place, they would not look further to review how the home is addressing specific medication errors or incidents unless there is a complaint or critical incident that triggers them to do so.[137]

113. During the public hearings, Ms. Kukoly further explained that the Ministry's new practice involves reviewing the most recent medication incident and making sure they have met all of the requirements under section 135 of the Regulation. [138] Ms. Kukoly noted that the specific practice is in flux as the inspectors were previously directed to look at the three highest-risk medication incidents and to inspect on those.[139] As a result of the change in practice, inspectors identified non-compliance in connection with section 135 in forty-two percent (42%) of homes in 2017.[140] This shows how prevalent the issue is across the long-term care sector. Accordingly, while the

---

[135] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6139, Line 25-31 [Simpson]; LTCI Transcript, July 31, 2018, Vol. 28 at p. 6320, Line 23-31 [Kukoly]
[136] Affidavit of Karen Simpson at para. 126, Exhibit 129
[137] Affidavit of Karen Simpson at para. 126, Exhibit 129
[138] LTCI Transcript, August 1, 2018, Vol. 29 at p. 6713, Line 24-30 [Kukoly]
[139] LTCI Transcript, August 1, 2018, Vol. 29 at p. 6713, Line 3-30 [Kukoly]
[140] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6320, Line 19-22 [Kukoly]

Ministry's new practice is a step in the right direction, the Victims' Groups feel that the Ministry needs to clarify and establish best practices with respect to how inspectors are reviewing section 135 during the RQI process.

(ii) Lack of Insulin Controls

114. Insulin is not a controlled substance; therefore, long-term care homes are not required to track the use of insulin through daily counts or monthly audits.[141] In this case, Ms. Wettlaufer made a very deliberate decision to use insulin as her weapon of choice. In her own words, Ms. Wettlaufer chose insulin "*because it wasn't counted, and because I knew that it was something that could kill people.*"[142] This accords with Professor Crofts-Yorker's report – insulin is a frequent choice of health care serial killers due to its ease of access and relative inability to trace its use, and its use is on the rise. [143] As such, the lack of insulin tracking in long-term care homes is troubling given the grave risk of resident harm if it is used inappropriately.

115. Ms. Wettlaufer also explained that she chose to harm residents with insulin because it was easily accessible. With respect to security, long-term care homes must ensure that insulin is kept in an area or medication cart which is secure and locked. [144] Nevertheless, Ms. Wettlaufer had a key to the medication room and as such, insulin was readily available to her:

> *So when I take the insulin that I would do my crimes with I would go into the treatment room, take insulin cartridges out of the fridge and just put them in my pocket. And then I could go into the med room, and we always had at least one insulin pen that wasn't*

---

[141] O. Reg. 79/10, section 130, Exhibit 4; Affidavit of Jonathan Lu at para. 86, Exhibit 73
[142] Wettlaufer Interview with Commission Counsel (Feb 14, 2018) at p. 61, Line 6-8, Exhibit 5
[143] Expert Report of B. Crofts-Yorker, p. 11-12, Exhibit 163
[144] O. Reg. 79/10, section 129, Exhibit 4; Affidavit of Karin Fairchild at para. 40, Exhibit 154

> *in use, like it was an extra. So I could just put the cartridge in that and use it without having to use anybody's insulin.*[145]

116. Finally, Ms. Wettlaufer noted that "*if the treatment room and med room were completely made of glass … there's no way I could have done what I did without somebody seeing me*."[146] In particular, the treatment and medication rooms were locked and did not have windows which made it easier for Ms. Wettlaufer to avoid detection. We note that, at one point, Caressant Care Woodstock had approved the installation of video surveillance in the medication room; however, for reasons that remain entirely unclear after the testimony of Ms. Van Quaethem and Ms. Crombez, such video surveillance was never installed.[147] The lack of visibility and monitoring of the treatment room and medication room gave Ms. Wettlaufer free rein to take insulin from the facilities.

117. Given the lack of insulin controls in long-term care homes, it is very difficult to detect when residents have been injected with insulin beyond the medically prescribed amount; and in this case, allowed Ms. Wettlaufer to commit her offences without detection.

118. Currently, the LTCHA and Regulation only distinguish between controlled and non-controlled substances. Controlled substances must be kept in a separate, double-locked stationary cupboard in a locked area or in a separate locked area within the medication cart.[148] Those that are required to be refrigerated are kept in a locked portion of the fridge.[149] In contrast, non-controlled substances, including insulin, must only be kept in an area or medication cart that is

---

[145] Wettlaufer Interview with Commission Counsel (Feb 14, 2018) at p. 62-63, Line 28-32; 1-5, Exhibit 5
[146] Wettlaufer Interview with Commission Counsel (Feb 14, 2018) at p. 68, Line 6-12, Exhibit 5
[147] LTCI Transcript, June 7, 2018, Vol. 3 at p. 590-591, Line 30-32; 1-4 [Van Quaethem]; LTCI Transcript, June 11, 2018, Vol. 5 at p. 926, Line 10-29 [Crombez]
[148] Affidavit of Karin Fairchild at para. 40, Exhibit 154
[149] Affidavit of Jonathan Lu at para. 84, Exhibit 73

secure and locked—insulin pens are in the locked medication cart,[150] while insulin is stored in an unlocked fridge in the medication room.[151]

> ***<u>Recommendation #13</u>: The Province of Ontario should adopt ISMP's "high-alert medication" terminology in to the LTCHA and Regulation and create minimum standards to ensure safe access and use of these drugs in long-term care homes.***

119. The Victims' Groups believe that the government should adopt ISMP's "*high-alert medication*" terminology to properly distinguish practices for non-controlled substances which pose a serious health risk if it is inappropriately used. [152] By doing so, the government can create minimum standards with respect to the ordering, storage, preparation and administration of these medications and minimize the risk of harm to residents in long-term care homes.

120. It should be noted that Professor Crofts-Yorker's report highlighted a successful instance in a hospital based in Georgia, whereby the hospital treated another high-alert medication, Potassium Chloride, in a manner comparable to how they treated controlled substances, including stricter controls on access and testing patients for the substance immediately after a cardiac event. The relative success in that circumstance – although not totally comparable to the use of insulin – could be instructive.[153]

---

[150] Affidavit of Jonathan Lu at para. 80, Exhibit 73
[151] Affidavit of Jonathan Lu at para. 79, Exhibit 73
[152] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8218, Line 6-16 [Greenall]
[153] Expert Report of B. Crofts-Yorker, p. 44, Exhibit 163

<u>Recommendation #14</u>: The Ministry of Health and Long-Term Care should assemble a group of subject matter experts to identify the appropriate accountability and oversight mechanisms that can be introduced to ensure that insulin is not used to intentionally harm residents.

121. Ms. Wettlaufer admitted during her interview with Commission Counsel that "*if there was a way that the insulin was counted, I would not have been able to do what I did without getting caught*."[154] As we heard during the public hearings, there are many practical difficulties with tracking insulin.

122. There has been much discussion about using a barcoding system or a human double-check to ensure that insulin is administered in accordance with the prescribed amount. The goal of a double-check is to provide a verification immediately prior to administering a medication to make sure that it is, in fact, ordered for that person, that it is the right drug and the right dose.[155] While this is not a foolproof practice, Julie Greenall, Director of Projects and Education, ISMP Canada, indicated that this was one method of ensuring tighter control of insulin.[156]

123. During Ms. Greenall's testimony, she explained that one would not be able to verify the dosage of insulin administered using a barcoding system as somebody could change the dose after the verification is completed.[157] Similarly, numerous witnesses were asked whether they believed a human double check would be useful and they all felt that it was not practical given the staffing levels and the fact that somebody could change the dosage dialed up on the insulin

---

[154] Wettlaufer Interview with Commission Counsel (Feb 14, 2018) at p. 69, Line 18-20, Exhibit 5
[155] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8226, Line 22-27 [Greenall]
[156] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8227, Line 10-31 [Greenall]
[157] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8227, Line 10-31 [Greenall]

pen after the double check was conducted.[158] Ms. Wettlaufer also agreed that this would not be an effective oversight mechanism.[159]

124. Aside from the use of some specific technologies (discussed below), the Inquiry has not heard evidence of a more practical method of tracking insulin. As such, the Victims' Groups believe that a meeting of subject matter experts should be convened to further investigate potential accountability and oversight mechanisms that can be used in long-term care homes to effectively track and safeguard insulin.

> ***<u>Recommendation #15</u>: The Province of Ontario should provide capital funding and other incentives for long-term care homes to invest in technology which will allow for more automation, electronic record keeping, and surveillance with respect to medication administration in long-term care homes.***

125. As new technology emerges over time, long-term care homes should be making capital investments to improve their medication management systems. The Victims' Groups would strongly advocate for increased funding from the Province of Ontario, or other sorts of incentives to support greater automation, electronic record keeping and surveillance in medication management systems in long-term care homes. Specifically, the Inquiry has heard expert evidence about the various benefits of automated dispensing of medication[160], barcoding systems[161], and surveillance in medication rooms[162] (including, without limitation, deterrence, better tracking of medications used and more accurate recordkeeping). As such, there is a

---

[158] Affidavit of Agatha Krawczyk at para. 39-41, Exhibit 40; Affidavit of Robyn Laycock at para. 43, Exhibit 72; Affidavit of Jonathan Lu at para. 23, Exhibit 73
[159] Wettlaufer Interview with Commission Counsel (Feb 14, 2018) at p. 66, Exhibit 5
[160] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8246-8247, Line 18-32; 19 [Greenall]
[161] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8341-8342, Line 21-32; 1-7 [Greenall]
[162] LTCI Transcript, September 13, 2018, Vol. 36 at p. 8330, Line 4-25 [Greenall]

compelling argument for long-term care homes to invest in new technologies which will reduce the risk of medication errors as well as intentional harm through the administration of medication.

(E) The Failure to Report Ms. Wettlaufer's Dangerous Practices

126. The long-term care sector is subject to a number of mandatory reporting obligations to various agencies and regulatory bodies; it is an important function of being a highly-regulated sector who takes care of our most vulnerable. The failure to report means that we cannot collectively intervene to ensure a resident's quality of life is being promoted in a way consistent with the fundamental principle of the LTCHA[163], and more importantly, how we as a society want our seniors to be treated.

127. It was dispiriting for the Victims' Groups to learn that there is a fundamental lack of understanding – at all levels of the system – about what those reporting obligations are.

128. To be clear, in this case, we have not seen evidence that anyone who engaged Ms. Wettlaufer had direct knowledge or suspicions about Ms. Wettlaufer's crimes or intentions to harm her residents. However, what we have learned over the course of this Inquiry is that co-workers and management at the facilities all possessed important information about Ms. Wettlaufer's abuse, neglect, incompetence and incapacity, and other dangerous practices that were not reported to the Ministry and/or CNO. In our submission, the cumulative effect of their failure to report is significant; each of those moments provided important missed opportunities to place Ms. Wettlaufer's conduct under scrutiny.

---

[163] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8, section 1, Exhibit 4

(i) The Licensees' Duty to Report to the Ministry

129. The LTCHA and Regulation imposes a number of critical incident and mandatory reporting obligations on licensees.[164] As a result of the 2016 Wettlaufer Inspections, both Caressant Care Woodstock and Meadow Park had findings of non-compliance related to various and repeated failures to report to the Ministry.[165] With respect to Telfer Place, there were allegations that the licensee failed to report Dr. Williams' allegations of abuse in accordance with section 24 of the LTCHA. However, given Dr. Williams' limited recollection of what he had seen, and the fact there was no record of any such event, Lisa Vink, Ministry Inspector, Hamilton SAO, did not think it would be appropriate to make any findings of non-compliance.[166]

130. Regardless, it appears that this is a sector-wide issue. During the course of the Inquiry, we have learned that the failure to report is one of the top areas of non-compliance in long-term care homes.[167] To our mind, it strikes us that there is a substantial lack of understanding amongst licensees with respect to their reporting obligations, or a significant neglect with respect to those obligations. Either way, the outcome is the same: the Ministry is not getting the information it needs to fulfil its mandate.

---

[164] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8, sections 23 and 24(1), Exhibit 4; O. Reg. 79/10, section 107, Exhibit 4; Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00055639, Exhibit 9
[165] Affidavit of Rhonda Kukoly at para. 108(m), Exhibit 134; Affidavit of Natalie Moroney, at para. 31(b), Exhibit 142
[166] Affidavit of Lisa Vink at para. 73(e), Exhibit 144
[167] LTCI00072894 at p. 5, Exhibit 131

131. By far, the failure to report found at Caressant Care Woodstock was the most significant. To begin, there were two (2) findings of unmet standards under the *Nursing Homes Act* ("**NHA**")[168] – one involving Mr. Silcox and the other involving Ms. Adriano.[169]

132. On cross-examinations, Ms. Crombez displayed startlingly little knowledge about her obligations to report an unexpected death or a medication error which led to a transfer to hospital to the Ministry and merely answered "*I do not recall*" repeatedly to questions on these issues.[170] It is disheartening to assume that a Director of Nursing, with her purported experience, would be so poorly placed to answer basic questions about reporting obligations to the Ministry.

133. Such criticisms are important, because they underscore the fact that reporting from licensees is crucial for the Ministry to get the information they need to effect their statutory mandate to oversee long-term care homes and keep residents safe.[171] Had Caressant Care Woodstock reported Ms. Adriano's insulin overdose, the Ministry would have been able to inspect the circumstances surrounding the medication incident (namely, the identity of the nurse who administered the medication) and this may have enabled Caressant Care Woodstock to have taken appropriate corrective action.[172]

134. As discussed above, as part of the 2016 Wettlaufer Inspections, the Ministry discovered numerous incidents in Ms. Wettlaufer's employee file that should have been reported to the Ministry pursuant to sections 23 and 24 of the LTCHA. Specifically, there were complaints of

---

[168] *Nursing Homes Act*, R.S.O. 1990, c. N.7
[169] Affidavit of Rhonda Kukoly at paras. 107(a) and (b), Exhibit 132
[170] LTCI Transcript, June 11, 2018, Vol. 5 at p. 944-945, Line 27-32; 1-12 [Crombez]
[171] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6358, Line 16-27 [Simpson]
[172] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6357, Line 1-6 [Simpson]

improper/incompetent treatment of a resident's hematoma[173] and a resident with a suspected hip fracture.[174] Further, there were complaints of verbal abuse of DW[175] and Ms. Pickering[176].

135. Finally, after Caressant Care Woodstock became aware of Ms. Wettlaufer's crimes, the licensee failed to file a critical incident report immediately as required by section 107 of the Regulation. Instead, Ms. Simpson testified that the Ministry only became aware of Ms. Wettlaufer's crimes as a result of an email by Candace Chartier from the Ontario Long-Term Care Association informing her that a nurse had killed residents in a long-term care home.[177] It is absurd that the Ministry would have to obtain this crucial information from a third party, and not Caressant Care itself. The above shows a shocking disregard for the importance of the reporting structure required by the LTCHA, and one wonders whether it reflects a broader cultural issue.

(ii) Individual's Duty to Report to the Ministry

136. There is also mandatory reporting to the Director by any person (except a resident) in certain circumstances if it resulted in either harm or a risk of harm to a resident.[178] Despite the fact that all of the facilities had written procedures about initiating complaints, it was evident during the public hearings that there was a lack of appreciation amongst staff members about their reporting obligations to the Ministry.

---

[173] Affidavit of Rhonda Kukoly at paras. 107(a),(b), 108(a),(h) and(i), Exhibit 132
[174] Affidavit of Rhonda Kukoly at para. 108(i), Exhibit 132
[175] Affidavit of Rhonda Kukoly at para. 108(h) and (i), Exhibit 132
[176] Affidavit of Rhonda Kukoly at para. 108(i), Exhibit 132
[177] Affidavit of Karen Simpson at para. 137, Exhibit 129; Overview Report – Ministry of Health and Long-Term Care, Source Document LTCI00062126, Exhibit 9
[178] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8, section 24, Exhibit 4

137. We repeatedly heard from staff that they believed that reporting their concerns about Ms. Wettlaufer to the charge nurse or management was sufficient.[179] As result of this misunderstanding, many complaints by Ms. Wettlaufer's co-workers about her incompetence, improper treatment, abuse and/or neglect went unreported to the Ministry.[180] This lack of understanding was not limited to staff. At Telfer Place, we heard that Dr. Williams had a recollection about seeing a nurse one night swearing and being verbally abusive towards some residents.[181] Yet, he did not report to the Ministry.[182] It appears that there is much more work to be done to ensure that people working in long-term care have a clear understanding about what should be reported to the Ministry and by whom.

<u>Recommendation #16:</u> The Ministry of Health and Long-Term Care should provide clarifications regarding the definitions of "reasonable grounds" and "incompetent or improper treatment" for the purposes of subsection 24(1) of the LTCHA and "unexpected or sudden death" for the purposes of subsection 107(1) of the Regulation.

138. We propose that the Ministry update the memorandum dated February 12, 2015 from Nancy Lyttle[183] and the memorandum dated August 4, 2010 from Tim Burns[184] to clarify the reporting of critical incidents under section 107 of the Regulation and mandatory reporting under subsection 24(1) of the LTCHA.

---

[179] *See, for example* LTCI Transcript, June 13, 2018, Vol. 14 at p. 3227, Line 13-25 [Laycock]; LTCI Transcript, June 13, 2018, Vol. 7 at p. 1536, Line 10-19 [MacKnott]
[180] Affidavit of Robyn Laycock at para. 73, Exhibit 72; Overview Report – The Facilities and Agencies, Source Documents LTCI00016843, LTCI00016910, LTCI00016811 and LTCI00041461, Exhibit 6
[181] Affidavit of Lisa Vink at para. 79-80, Exhibit 144
[182] Affidavit of Lisa Vink at para. 79-80, Exhibit 144
[183] Overview Report – The Ministry of Health and Long-Term Care, Source Document LTCI00055639, Exhibit 9
[184] Overview Report – The Ministry of Health and Long-Term Care, Source Document LTCI00044970, Exhibit 9

(iii) The Facilities' Duty to Report to CNO

139. Separate from the reporting obligations found in the LTCHA, the Inquiry heard how employers and facility operators in the long-term care sector have mandatory reporting obligations pursuant to the *Nursing Act, 1991*[185] and the *Regulated Health Professions Act, 1991*[186] (more specifically, the *Health Professions Procedural Code* therein).

140. Most relevant for the purposes of the Inquiry was the mandatory report that employers and facility operators must make to the CNO when, for reasons of professional misconduct, incompetence or incapacity:

(a) a member's employment is terminated;

(b) the employer/facility operator intended, or had reasonable grounds to terminate the employment of a member, but the member resigned beforehand; or

(c) a facility operator had an nurse resign in a situation where there was a concern about his/her incapacity.

141. When Ms. Wettlaufer's employment was terminated by Caressant Care Woodstock on March 31, 2014 following a string of incidents, the CNO had the opportunity to review her competence/capacity through the report submitted by Caressant Care Woodstock. The CNO witnesses testified that this report was received by the CNO on May 1, 2014, reviewed and considered starting July 23, 2014 and ultimately determined by the Executive Director and CEO

---

[185] *Nursing Act, 1991*, S.O. 1991, c. 32
[186] *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

on October 14, 2014. Based on the information available, the CNO decided to "bank" the Caressant Care Woodstock report with notice to Ms. Wettlaufer, as it considered her to be "sloppy", but still practicing within the range of acceptable nursing – albeit at the low end.[187]

142. Although it was not known by the CNO at the time, the Inquiry heard how less than a month after her employment was terminated from Caressant Care Woodstock, Ms. Wettlaufer commenced new employment in the London area, this time with Meadow Park.[188] More importantly, the Inquiry heard how events transpired at Meadow Park that ought to have been reported to the CNO, while it was still in the process of assessing the Caressant Care Woodstock report. Anne Coghlan, the Executive Director and CEO of the CNO, confirmed frankly that had this information been reported, a health inquiry into Ms. Wettlaufer would have been commenced – in the fall 2014[189] – in advance of some of Ms. Wettlaufer hurting some of her most recent victims.

143. In the Fall of 2014, the relevant portions of the *Code* involving mandatory reports to the CNO were as follows:

> **Reporting by facilities**
>
> **85.2** (1) A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated, or has sexually abused a patient. 1993, c. 37, s. 23; 2007, c. 10, Sched. M, s. 61.
>
> …

---

[187] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5446, Line 8-28 [Coghlan]; LTCI Transcript, July 27, 2018, Vol. 26 at p. 5882-5883, Line 32; 1-11 [Yee]
[188] Foundational Document – Timeline of Major Events, Exhibit 3.
[189] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5567, Line 11-24 [Coghlan]; Overview Report – The College of Nurses of Ontario, Source Document LTCI00036840, Exhibit 8

Reporting by employers, etc.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons. 1993, c. 37, s. 23; 2000, c. 42, Sched., s. 36.

Same

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act. 1993, c. 37, s. 23.[190]

144. On August 1, 2016, s. 85.5(2) of the *Code* was amended as follows:

Same

(2) Where a member resigns, or voluntarily relinquishes or restricts his or her privileges or practice, and the circumstances set out in paragraph 1 or 2 apply, a person referred to in subsection (3) shall act in accordance with those paragraphs:

1. Where a person referred to in subsection (3) has reasonable grounds to believe that the resignation, relinquishment or restriction, as the case may be, is related to the member's professional misconduct, incompetence or incapacity, the person shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting out the grounds upon which the person's belief is based.

2. Where the resignation, relinquishment or restriction, as the case may be, takes place during the course of, or as a result of, an investigation conducted by or on behalf of a person referred to in subsection (3) into allegations related to professional misconduct, incompetence or incapacity on the part of the member, the person referred to in subsection (3) shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting

[190] *Regulated Health Professions Act, 1991,* SO 1991, Chapter 18, Schedule 2, Health Professions Procedural Code, sections 85.2 & 85.5 (in force for the period November 6, 2013 to December 10, 2014).

> out the nature of the allegations being investigated. 2014, c. 14, Sched. 2, s. 12.[191]

145. With this legislative context in mind, the sequence of events relating to Ms. Wettlaufer's departure from Meadow Park was as follows:

(a) Ms. Wettlaufer provided a letter of resignation dated September 25, 2014, providing a period of working notice to October 15th, but also importantly, reads that she will not be able to work during her treatment, nor as a nurse again after her treatment[192];

(b) a card of hydromorphone is stolen from Meadow Park on September 26, 2014, but not discovered by Meadow Park until October 2, 2014;[193]

(c) September 26, 2014 is Ms. Wettlaufer's last day of active employment at Meadow Park[194];

(d) On either September 30 or October 1, 2014, Ms. Wettlaufer came to Ms. Nicholas, and indicated that she had overdosed the weekend prior, and had spent time in hospital. During the course of this conversation, Ms. Wettlaufer disclosed an alcohol and drug addition, but that she would like to return to Meadow Park after her treatment was

---

[191] *Regulated Health Professions Act, 1991,* SO 1991, Chapter 18, Schedule 2, Health Professions Procedural Code, section 85.5, Exhibit 4
[192] Overview Report – The Facilities & Agencies, Source Document LTCI00017578, Exhibit 6
[193] Overview Report – The Facilities & Agencies, Source Document LTCI00017595, Exhibit 6
[194] Overview Report – The Facilities & Agencies, Source Documents LTCI00017580; LTCI00017581, Exhibit 6

completed. Ms. Nicholas declined the request[195]. Ms. Nicholas thought that Ms. Wettlaufer may have attempted suicide[196];

(e) On October 1, 2014, Ms. Wettlaufer obtains a note from her doctor, indicating that she should be off work until further notice[197];

146. In light of this evidence, much time was spent by counsel for Meadow Park in cross-examining Ms. Coghlan with respect to what her expectations of Meadow Park would have been in 2014, *as an employer*. Although at one point Ms. Coghlan indicated (without the benefit of being taken to the legislation) that she would have expected Meadow Park to file a voluntary report to the CNO[198] – as opposed to a mandatory report – on the whole, her evidence and the evidence of representatives from Meadow Park make clear that Meadow Park had a mandatory obligation to report Ms. Wettlaufer in October 2014, as either an employer or alternatively, a facility operator, but failed to do so.

147. There was much time spent determining what Meadow Park's reporting obligations to the CNO were – as Ms. Wettlaufer's employer – as of 2014. But it is a moot point, because Meadow Park's obligations as a facility operator were clear: they had to report, and given what Ms. Nicholas knew, they had to report immediately.

---

[195] Overview Report – The Facilities & Agencies, Source Document LTCI00017626, Exhibit 6; LTCI Transcript, June 19, 2018, Vol. 10 at p. 2179-2181, Line 27-32; 1-32; 1-4 [Nicholas]
[196] LTCI Transcript, June 19, 2018, Vol. 10 at p. 2269, Line 2-4 [Nicholas]
[197] Overview Report – The Facilities & Agencies, Source Document LTCI00017579, Exhibit 6; LTCI Transcript, June 19, 2018, Vol. 10 at p. 2179-2181, Line 27-32; 1-32; 1-4 [Nicholas]
[198] LTCI Transcript, July 26, 2018, Vol. 25 at p. 5596-5597, Line 1-32; 1-15 [Coghlan]

148. With respect to Meadow Park's obligations as a facility operator, a mandatory report is based on an objective standard of whether the facility had "*reasonable grounds*" to believe that a member is incapacitated.[199] Despite the quizzical and unrepentant nature of Ms. Nicholas, the Victims' Groups submissions is that Ms. Wettlaufer's resignation letter, easily meets the low threshold of "*reasonable grounds*" mandating a report to the CNO.

149. The CNO's Mandatory Reporting Guide in effect at the time provides further confirmation of this position. It stated (as does the current version[200]) that:

> *The reporting obligation is not based on the employment relationship. Rather, it's based on the facility operator's direct knowledge of the concern… Once a facility has determined that it has a reporting obligation, the report must be made to the College's Executive Director in writing within 30 days. The report must be filed immediately if there is a concern that the nurse poses a continued risk.*[201]

150. As should be the case for any report to the CNO, the obligation is grounded on a concern about the broader public interest; it needs to be said that this was completely misunderstood by Meadow Park, and in particular Ms. Nicholas. This is even more explicit in the case of mandatory reports from facility operators where the reporting obligation isn't based on the employment relationship, but simply knowledge of the concern.

<u>Recommendation #17:</u> The Ministry of Health and Long-Term Care and the College of Nurses of Ontario should provide broad-based education and training to management, staff and physicians in long-term care homes on their reporting requirements.

---

[199] *Regulated Health Professions Act, 1991,* SO 1991, Chapter 18, Schedule 2, Health Professions Procedural Code, section 85.2
[200] Overview Report – The College of Nurses of Ontario, Source Document LTCI00060147, p. 4, Exhibit 8
[201] Overview Report – The College of Nurses of Ontario, Source Document LTCI00060161, p. 4, Exhibit 8

151. Given the confusion surrounding reporting, the Ministry and CNO need to invest in broad-based education and training for all individuals working in long-term care. It is the Victims' Groups position that effective regulation can only be achieved if the long-term care sector, as a collective, fully understands their reporting obligations and individuals are diligent about their responsibilities. We believe this begins with promoting a culture of resident-centered care: education and training initiatives must ensure that the importance of reporting is engrained in each and every individual and that there is clear and unequivocal understanding by facilities and staff as to what needs to be reported and by whom.

<u>Recommendation #18:</u> The Ministry of Health and Long-Term Care and the College of Nurses of Ontario should strictly enforce violations of reporting obligation against individuals and licensees/facility operators.

152. The Ministry and CNO's reporting obligations are not strictly enforced. While the Ministry may initiate a prosecution against any regulated person for a failure to report under subsection 24(5) of the LTCHA – Ms. Fairchild has indicated that, since the LTCHA came in force, there have been no successful prosecutions of this offence.[202]

(F) Need for Clarity Surrounding "Sudden and Unexpected" Deaths in LTC Homes

153. Where a resident dies in a long-term care home, notice of the death is to be immediately given to a coroner.[203] The process by which this should be done is through the submission of an

---

[202] LTCI Transcript, August 7, 2018, Vol. 32 at p. 7562, Line 1-25 [Fairchild]

[203] *Coroners Act*, RSO 1990, c C.37, section 10(2.1), Exhibit 4

Institutional Patient Death Record ("**IPDR**") form[204] electronically through a Service Ontario® online portal[205], although there are some straggling homes that use facsimile submissions.

154. The *Coroners Act* states that the person in charge of the long-term care home is responsible for providing the notice.[206] However, the practice appears to be that it is the RN or RPN on shift who fills out the IPDR form.[207] The Office of the Chief Coroner has not mandated anything to the contrary.[208]

155. In addition to the notification function of the IPDR form (for data collection purposes), it also serves as a questionnaire to assist the reporter with whether or not they ought to call a local coroner, via provincial dispatch, to commence a death investigation.

156. One of the questions on the IPDR form, which if answered in the affirmative mandates a call to a local coroner, is whether or not the death was "*sudden and unexpected*".

157. We heard from coroner witnesses how RNs and RPNs at long-term care homes are often confused by what the phrase "*sudden and unexpected*" means.[209] The Chief Coroner for Ontario, Dr. Dirk Huyer, commented that it needs to be explored whether this question ought to be

---

[204] Affidavit of Dr. Dirk Huyer, at para. 93(b) & Exhibit "Z" LTCI00065223, p. 7, Exhibit 98
[205] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4186, Line 18-31 [Huyer]
[206] *Coroners Act,* RSO 1990, c C.37, section 10(2.1), Exhibit 4
[207] *Coroners Act,* RSO 1990, c C.37, section 10(2.1), Exhibit 4; Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00065236, p. 284, Exhibit 7; Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00003479, p. 4, Exhibit 7
[208] Affidavit of Dr. Dirk Huyer at para. 95, Exhibit 98
[209] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4597, Line 13-20 [Mann]; LTCI Transcript, July 17, 2018, Vol. 19 at p. 4368, Line 16-31 [Huyer]

removed from the IPDR form.[210] Professor Crofts-Yorker went out of her way to discuss why it was very important to come to a common understanding of a "*normal"* or *"typical"* death.[211]

158. We heard from Dr. Richard Mann, the Regional Senior Coroner ("**RSC**") for the London Office, how this phrase is interpreted inconsistently even amongst local coroners themselves.[212] Nowhere was this clearer than in the testimony of Dr. William George, who was contacted in connection with the death of two (2) of Ms. Wettlaufer's victims, when he stated that it was his belief that it was "*highly unlikely*" for a death in a long-term care home to be unexpected, and that he believes it is not an appropriate term in a long-term care home because typically residents have comorbidities.[213]

> ***<u>Recommendation #19</u>: The Office of the Chief Coroner should design an IPDR form that is more practical for front-line healthcare providers and institute a standard practice for the submission of these forms.***

159. In hindsight, the confusion by nurses and coroners over whether a death is "*sudden and unexpected*" likely proved to be a contributing factor in Ms. Wettlaufer's murder of Ms. Pickering going undetected.

160. One cannot help but think that had there been greater clarity over whether Ms. Pickering's death was "*sudden and unexpected*", or whether a different standard had been used to prompt a coroner to commence a death investigation, that may have led to such an investigation

---

[210] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4316-4317, Line 31-32; 1-15 [Huyer]
[211] Expert Report of B. Crofts-Yorker at p. 13, Exhibit 163
[212] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4630, Line 15-28 [Mann]
[213] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4672-4673, Line 23-32; 1-9 [George]

into the circumstances of Ms. Pickering's death. Dr. Pollanen characterized this as an important missed opportunity.[214]

(G) Threshold Death Investigations in Long-Term Care Homes

161. Prior to the introduction of the LTCHA, the OCC had a policy with respect to long-term care homes (then called nursing homes) that, for every tenth death in a particular facility – regardless of whether there was reason to believe that particular death met the criteria for coronial jurisdiction pursuant to s. 10(1) of the *Coroners Act* – a local coroner had jurisdiction pursuant to subsection 10(2.1) and was required to investigate the circumstances of that death.[215]

162. The purpose of the threshold death policy was, as part of the OCC's public safety mandate, to be a random spotcheck to identify significant concerns within long-term care homes.[216]

> ***<u>Recommendation #20</u>: The Office of the Chief Coroner should re-introduce a threshold death investigation policy, or random death investigation policy, that includes a review of long-term care homes' death registers.***

163. When the LTCHA was enacted, the OCC understood that the Ministry's increased safeguards and oversight would render the oversight function of the threshold death policy

---

[214] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5109, Line 3-19 [Pollanen]
[215] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4225, Line 3-29 [Huyer]
[216] Affidavit of Dr. Dirk Huyer at para. 113, Exhibit 98

moot.[217] More specifically, based on an understanding by the OCC that the new regulatory regime of the LTCHA involved a proactive review of all deaths in long-term care homes, the threshold death policy was removed.[218]

164. The Inquiry heard from the Chief Coroner for Ontario how the OCC's understanding of the LTCHA was incorrect.[219] Ms. Simpson testified she had no idea where this information came from that led to the OCC's misunderstanding, but made it clear that it has never been the case that there is a review of all deaths in long-term care by the Ministry.[220]

165. Nevertheless, there were conflicting opinions on the value of threshold death investigations. The Chief Coroner for Ontario stated that he did not believe threshold death investigations were finding any concerns in long-term care homes, and he didn't think that random death investigations were the way to answer the questions raised by Ms. Wettlaufer's offences going forward.[221]

166. On the other hand, the Inquiry heard from the RSC for the London Office who stated that he saw value in having threshold death investigations[222] and was uncomfortable with the removal of the policy in 2013 because it meant there were fewer coroners visiting long-term care homes and fewer eyes on these homes' death registries to see if there were any irregularities.[223] This concern appears to have been borne out as Dr. George had trouble recalling the last time he had

---

[217] Affidavit of Dr. Dirk Huyer at para. 113, Exhibit 98; LTCI Transcript, July 16, 2018, Vol. 18 at p. 4229-4230, Line 28-32; 1-14 [Huyer]
[218] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4230, Line 21-32 [Huyer]
[219] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4231, Line 11-18 [Huyer]
[220] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6475, Line 2-25 [Simpson]
[221] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4236-4237, Line 23-32 & 1-22 [Huyer]
[222] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4633, Line 3-23 [Mann]
[223] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4591, Line 6-30 [Mann]

visited a long-term care home for the purpose of a death investigation.[224] It seems he had not visited a long-term care home since the removal of the threshold death investigation policy. One wonders if the removal of the threshold death policy reinforced beliefs of some local coroners that deaths in long-term care homes rarely warrant an investigation.

167. Previously, when a local coroner attended at a long-term care home during a threshold death investigation, their mandate was to review not only the threshold death itself, but the previous nine (9) deaths recorded in the home's death registry as well.[225] The coroner was to look for any pattern in the previous ten (10) deaths that might signal a larger issue in the home, and for any failures to report a particular death to a coroner previously. If it was discovered a death occurred in circumstances that ought to have been reported, but was not, an investigation at that point could commence.[226] This provided an opportunity to double-check each death in a long-term care home and consider why a coroner had not been called previously.

168. As will be discussed in further detail below, unfortunately, Dr. George decided not to investigate the circumstances of Ms. Pickering's death. It is respectfully submitted that there were strong indicia that pointed towards it being an appropriate case for a death investigation.

169. We will never know if a subsequent coroner in the course of a threshold death investigation would have come across Ms. Pickering's case and determined that an investigation ought to have occurred. Further still, considering Ms. Pickering's body was cremated, we do not know what the results of this investigation would have been without a post-mortem examination

---

[224] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4682-4683, Line 32 & 1-20 [George]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4751, Line 5-15 [George]
[225] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4329-4330, Line 28-32 & 1-13 [Huyer]; LTCI Transcript, July 19, 2018, Volume 21 at p. 4839-4840, Line 30-32; 1-11 [Urbantke]
[226] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4840, Line 12-30 [Urbantke]

(particularly of the brain). However, this subsequent review by a coroner would have occurred relatively contemporaneously to Ms. Pickering's death (as Caressant Care Woodstock was averaging approximately five (5) deaths per month), as opposed to the review that occurred in the wake of Ms. Wettlaufer's confession. It is important to remember that an investigating coroner has powers separate and apart from an autopsy that could have revealed the true nature of Ms. Pickering's death[227], and prompted a conversation to identify its cause.

170. Considering how little oversight there is in a coroner's decision not to investigate a death and considering the OCC's belief that there is considerable confusion among long-term care health professionals as to when deaths are reportable, the threshold death investigation does serve an important double-check function.[228]

(H) Implement and Enforce Mandatory Practices at the OCC & OFPS

171. During the testimony of the five (5) witnesses in the section of the Inquiry dedicated to the Coroner's office, it was apparent that the OCC & OFPS tend to use *"guidelines"*, rather than use "*rules*" or "*protocols*". This was expressly discussed in Dr. Pollanen's cross-examination:

> *Q: You know what I don't understand, Dr. Pollanen, is that I don't understand why doctors tend to use guidelines and not rules. Why wouldn't you just have a – I think I said "rules" or a "protocol" that they must follow, and you said "guidelines", and why can't you just say that this is the way you are supposed to do it?*
>
> *A: Well, very – there is one very obvious reason, and that is doctors value their professional autonomy.*
>
> *Q: I see.*

[227] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4790, Line 2-18 [George]
[228] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4633, Line 3-23 [Mann]

> *A: And they don't respond well to being told about rules. They value professional autonomy and therefore guidelines are usually what we use.*[229]

172. A number of examples were identified at the public hearings:

(a) where a local coroner is contacted by provincial dispatch and needs to make a determination about whether or not to initiate an investigation in a suspected natural death, the OCC does not mandate the information the coroner must review, or people that the coroner must speak to, in order to make that determination;[230]

(b) submission of the Case Selection Data Form ("**CSDF**") was "*not required*" but believed by the Chief Coroner for Ontario to be a "*best practice*"[231], nevertheless, neither of the local investigating coroners stated they submitted CSDFs on a regular basis and it was one coroner's impression that based on conversations with other coroners that they didn't think it was necessary;[232]

(c) similarly, there was no legal requirement for local coroners to review memorandums distributed by the OCC, or to attend relevant continuing education courses, but it was considered an "*expectation*" or "*best practice*", to do so;[233]

(d) it was only an "*expectation*" that local coroners maintain notes of their investigations as well as notes of their decisions not to accept death investigations as it

---

[229] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5144, Line 11-26 [Pollanen]
[230] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4248, Line 1-10 [Huyer]
[231] Affidavit of Dr. Dirk Huyer at para. 62, Exhibit 98
[232] LTCI Transcript July 19, 2018, Vol. 21 at p. 4823-4824, Line 19-32; 1-11 [Urbantke]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4675-4676, Line 2-11, 29-32; 1-6 [George]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4747, Line 10-28 [George]
[233] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4349-4350, Line 29-32; 1-13 [Huyer]

was a "*best practice*".[234] Unfortunately, Dr. Huyer, the Chief Coroner for Ontario candidly admitted that he believes most coroners do not follow these instructions;[235]

(e) it was only "*recommended*" that local coroners provide family members with the information pamphlet about the OCC;[236] and

(f) it appears it was only an "*expectation*" that a local investigating coroner make efforts to contact the family or next of kin of the deceased during a death investigation, as detailed below.

173. Despite Dr. Huyer being shown a document created by the OCC which says:

> *It is MANDATORY to speak to the next-of-kin, legal representative, or substitute decision maker regarding the death, including communicating the autopsy findings, and this should be recorded [in the Form 3].* (bold in original has been removed)[237]

and despite the admission of a local investigating coroner that one can glean much information from the family that is often overlooked in the medical documentation by the coroner[238], the following exchanges occurred with the Chief Coroner for Ontario during cross-examination:

> *Q: Yeah, it's very helpful. Let's assume a scenario where a death investigation has commenced. If a local coroner failed to make efforts to speak with available family members during that death investigation, would you consider that to be a failure?*
>
> *A: So it is an expectation that they would be – would be reaching to the family and making reasonable efforts to do that. And so you've suggested to me that they're*

---

[234] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4513, Line 22-27 [Huyer]; LTCI Transcript, July 17, 2018, Vol. 19 at p. 4379, Line 11-24 [Huyer]; Affidavit of Dr. Dirk Huyer at para. 63, Exhibit 98
[235] Affidavit of Dr. Dirk Huyer at para. 63, Exhibit 98
[236] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4650-4651, Line 27-32; 1-31 [Mann]
[237] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4389-4390, Line 16-32; 1-24 [Huyer]; Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00071446, p. 3, Exhibit 7
[238] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4698, Line 2-18 [George]

> *reasonably available. I would have expected that they spoke to the family (emphasis added).*[239]

And further:

> *Q: If a local coroner failed to speak with a family member after completing their Form 3 or during the course of their death investigation, would you consider that to be a failure of the local coroner?*
>
> *A: It would really depend on the overall circumstances, and I would – it would be certainly something that I'd be interested to explore.*
>
> *Q: If family was available to have a conversation, would that change your analysis?*
>
> *A: Expectation that the family is spoken to.*[240]

174. It appears that even when directives are issued from the OCC, they are not always followed and/or enforced. The evidence of Dianne Crawford, daughter to James Silcox, Ms. Wettlaufer's first murder victim, was that neither she, nor any members of her family, spoke to the coroner who investigated her father's death, despite the Form 3 implying that he had. Considering Ms. Crawford had concerns with the circumstances surrounding her father's death, it is entirely unacceptable that she was not contacted.[241] Instead, it appears that Ms. Wettlaufer acted as a conduit between the Silcox family and the coroner and provided incorrect information to the coroner that the family had no concerns.[242] The Chief Coroner for Ontario testified that local coroners are not authorized to delegate communication with the family to another person.[243]

175. The Chief Coroner for Ontario testified that one method to implement commitments by local coroners to some rules or standard protocols would be to leverage the recent transition away

---

[239] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4365-4366, Line 25-32; 1-5 [Huyer]
[240] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4390-4391, Line 25-32; 1-6 [Huyer]
[241] Affidavit of Dianne Crawford at para. 7, Exhibit 115
[242] Affidavit of Dianne Crawford at paras. 7-10, Exhibit 115; Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00065227, p. 1-2, Exhibit 7
[243] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4773, Line 15-26 [George]

from Order-in-Council appointments of coroners to set re-appointment timeframes and link re-appointment with performance.[244] Pathologists listed on the OFPS Register are subject to such a review before the Credentials Committee.[245] A similar process would be helpful with local investigating coroners. It is respectfully submitted that if a particular coroner, upon review, is found not to be following rules, he/she ought not be re-appointed.

***Recommendation #21*: The Office of the Chief Coroner should depart from the use of "guidelines" or "expectations" for local investigating coroners where possible and implement rules or standard protocols of procedure.**

***Recommendation #22*: The Office of the Chief Coroner should require investigating coroners to have substantive conversations with families/next-of-kin – where those parties are reasonably available – regarding the death of their loved one, and create service standards to enforce this requirement.**

***Recommendation #23*: The Office of the Chief Coroner should use a cyclical review and re-appointment process of local coroners to enforce rules or standard protocols of procedure.**

(I) Consult with Families when Determining to Investigate a Death or Not

176. As discussed above, the OCC agrees that speaking to families in the course of a death investigation is useful, because they can learn things which may be missed by the coroner alone when reviewing the deceased's medical history.[246]

177. It is therefore confusing why the OCC does not require a coroner, in the context of assessing whether an investigation is required in the first place, to make best efforts to speak to

---

[244] Affidavit of Dr. Dirk Huyer at para. 17, Exhibit 98; LTCI Transcript, July 17, 2018, Vol. 19 at p. 4358-4359, Line 14-32; 1-24 [Huyer]
[245] LTCI Transcript, July 23, 2018, Vol. 22 at p. 4980-4981, Line 10-32; 1-9 [Pollanen]
[246] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4698, Line 2-18 [George]

the next-of-kin. The RSC for the London Office testified that a coroner only needs to contact persons other than the reporter if they feel it is appropriate.[247] In practice, the evidence from the Chief Coroner for Ontario was that it was "*typical*" in such a scenario for the coroner not to speak to the family, unless it was the family who reported the death to the coroner in the first place.[248] The result is that families are typically not even alerted to the fact that a coroner has made a decision not to investigate their loved-one's death, despite the fact there was a concern from a third party (the person who initially reported the death).[249]

178. Presumably, the same information a family may hold and the coroner may want in the formal investigation stage may also held by the family before an investigation has been commenced. If there is a concern from a third party that prompted a call to the coroner, the family may have evidence that augments or alleviates the concern from the third party – but it is information that may assist the coroner, either way. At the very least, the family ought to know that someone has a concern about the death of their loved one (and to perhaps explore that concern), considering other oversight mechanisms in long-term care that are designed to alert them to such a possibility are arguably ineffective.

Recommendation #24: The Office of the Chief Coroner should mandate that local coroners consult with the family of the deceased when making a determination as to whether to investigate a reported death or not.

(J) Case Selection Data Forms

---

[247] Affidavit of Dr. Richard Mann at para. 15, Exhibit 104
[248] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4363, Line 14-32 [Huyer]
[249] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4388, Line 16-26 [Huyer]

179. Much time was spent with the four (4) witnesses from the OCC regarding the history of the CSDF.[250] The CSDF was introduced after an audit in 2009 by the OCC into natural death investigations across the province. The Chief Coroner for Ontario stated that the audit found that twenty-four percent (24%) of investigations in these scenarios were not required, while statistics on the inverse scenario – where an investigation was required but was not performed – were not available.[251] Although this missing data is a problem in and of itself, it was clear from the audit that there was great variability between coroners as to when to accept an apparently natural death for investigation, or not.

180. The CSDF was therefore created to be a framework to establish a consistent approach across coroners in the province to natural death investigations.[252]

181. It was recognized that an additional benefit of the CSDF would be to allow an opportunity for oversight of the decisions of local coroners by the RSCs.[253] If a CSDF is not submitted, both the Chief Coroner for Ontario and the RSC for the London Office acknowledged that there would be no oversight of the decision not to accept a death investigation.[254] In fact, the RSC may have no information, or notice at all, that a particular death had been brought to the attention of the coroner system in his/her region.[255]

---

[250] Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00071435 & LTCI00071436, Exhibit 7
[251] Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00071435, p. 1, Exhibit 7; LTCI Transcript, July 16, 2018, Vol. 18 at p. 4262-4263, Line 6-32; 1-13 [Huyer]
[252] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4254-4255, Line 30-32; 1-11 [Huyer]; Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00071435, p. 3, Exhibit 7
[253] Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00071435, p. 3, Exhibit 7
[254] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4251, Line 7-16 [Huyer]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4617, Line 25-31 [Mann]
[255] Affidavit of Dr. Richard Mann at paras. 17-19, Exhibit 104

182. When Dr. George was contacted in connection with Ms. Pickering's apparently natural death, he did not submit a CSDF. He made the decision not to investigate the death and his decision was not reviewed by the RSC, because the RSC had no information such a decision had been made. It is respectfully submitted that had Dr. George used the CSDF, he would have likely concluded that he ought to investigate the circumstances of Ms. Pickering's death. As stated by the Chief Forensic Pathologist, it was a *"missed opportunity"*[256] and from a medical/scientific perspective, it was likely the best chance at detecting Ms. Wettlaufer's crimes.[257] At the Inquiry, all four (4) OCC witnesses stated they now see value in the CSDFs.[258]

183. If Dr. George had turned to the CSDF, one of the questions asked is: *"Is the case free of significant care related concerns from either family or care providers?"* We know that Dr. Urbantke called Caressant Care Woodstock nursing staff to say that Ms. Pickering's *"blood sugar was extremely low when she arrived at the hospital and the cause is unknown"* and that *"it might be a good idea to call the coroner on this one"*.[259] Considering that Ms. Routledge conveyed this information to Dr. George, it is respectfully suggested that he ought to have answered "*no*" to this question. If any of the questions in the CSDF are answered "*no*", the coroner should investigate the death. This did not occur.

---

[256] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5108, Line 19-21, [Pollanen]
[257] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5106-5110, Line 15-32; 1-32; 1-21; 2-32; 1-5 [Pollanen]
[258] LTCI Transcript, July 16, 2018, Vol. 18 at p. 4266, Line 12-31 [Huyer]; LTCI Transcript, July 17, 2018, Vol. 19 at p. 4580-4581, Line 23-32 & 1-16 [Mann]; LTCI Transcript, July 18, 2016, Vol. 20 at p. 4678, Line 17-27 [George]; LTCI Transcript, July 19, 2018, Vol. 17 at p. 4824, Line 12-26 [Urbantke]
[259] Overview Report – Office of the Chief Coroner & Ontario Forensic Pathology Service, Source Document LTCI00065222, p. 2, Exhibit 7

184. Dr. Mann, testified that he reviews CSDFs submitted to his office *"probably every day"*.[260] Although he would like more information in the CSDFs in order for him to better fulfill his oversight function, if he has any concerns with the information provided by the local coroner in the CSDF, he can follow up with the coroner for more information, or direct them to commence an investigation.[261] Obviously, Dr. Mann did not have an opportunity to review the CSDF in relation to Ms. Pickering, because the form was never completed. It was a rare opportunity for oversight in the death investigation system that was missed and was a contributing factor in Ms. Wettlaufer's crimes going undetected.

***Recommendation #25*: The Office of the Chief Coroner should mandate that coroners document information and their decisions from their case selection process through submission of the Case Selection Data Form and enforce this requirement.**

***Recommendation #26*: The Office of the Chief Coroner should augment the Case Selection Data Form to request further information from the local coroner, in an effort to assist Regional Senior Coroners with their oversight function.**

(K) Continuing Education / Training Specific for Coroners

185. The way in which Ms. Wettlaufer killed her victims was, by design, extremely difficult for the death investigation system to detect. She took deliberate actions to avoid raising

[260] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4578, Line 21-32 [Mann]
[261] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4581, Line 2-16 [Mann]

suspicion.[262] Nevertheless, suspicions should have been aroused at certain points by the death investigation system.

186. By comparing the evidence of the two (2) local coroners who testified at the Inquiry, it will be seen that greater emphasis needs to be placed on the value of continuing medical education ("**CME**") for coroners in the death investigation system. It is respectfully submitted that this could have led to detection of Ms. Wettlaufer's crimes in 2014 – at the time of Ms. Pickering's death.

187. First, there was the evidence of Dr. George that he did not consider even the possibility that a caregiver might be intentionally harming a resident.[263] As one counsel suggested, he had a closed mind to the possibility,[264] even though courses taught by the OCC recognize that caregivers may conceal evidence of abuse/neglect.[265]

188. Dr. George also testified that it had been many years since he had been in a long-term care home to do an investigation and that going through exercises at long-term care homes would be *"very, very helpful for a lot of people… to maintain your competency as a coroner"* if for nothing else than as an educational tool.[266]

189. Most importantly, was the fact that Dr. George appeared to have little concern[267] with getting to the bottom of the *"severe hypoglycemia"* that Ms. Pickering presented with when she

---

[262] Foundational Document – Agreed Statement of Facts at para. 15, Exhibit 1
[263] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4708-4709, Line 22-32; 1-15 [George]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4784, Line 18-23 [George]
[264] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4791, Line 6-14 [George]
[265] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4415-4416, Line 15-32; 1-12 [Huyer]
[266] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4684, Line 2-15 [George]
[267] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4737-4739, Line 20-32, 1-32; 1-24 [George]

was assessed at the local hospital – even though Ms. Pickering was not diabetic and the emergency room doctor stated the cause was unknown and it would be a good idea to call the coroner.

190. Although Dr. George flagged the possibility of a medication error, an investigation (and autopsy) should have followed to test his hypothesis of stroke as the cause of death, against the competing possibility of hypoglycemia (or complications therefrom) as the cause of death. This is particularly so where the hypoglycemia may have been caused by a medication error. Of note, Dr. George's explanation that Ms. Pickering's death was not worthy of investigation because he believed her hypoglycemia to be a solitary event was not accepted by the Chief Pathologist for Ontario.[268]

191. If we contrast this evidence to that of Dr. Urbantke, it illustrates the value of CME. Dr. Urbantke's evidence was that first, *"you always have to keep an open mind"* when conducting an investigation in a long-term care home.[269] Although she may not be thinking of intentional harm, she would keep an open mind to physical harm and neglect.[270]

192. Further, it was Dr. Urbantke's evidence that her comment to Caressant Care Woodstock's nursing staff that the coroner should be called when Ms. Pickering dies was because Dr. Urbantke was concerned with the possibility of a medication error and that it was important to get to the bottom of the unexplained hypoglycemia.[271] She even went a step further – showing the extent of her concern – by informing the coroners' provincial dispatch that she would speak

---

[268] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5102, Line 4-24 [Pollanen]
[269] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4846-4847, Line 31-32; 1-13 [Urbantke]
[270] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4846-4847, Line 31-32; 1-13 [Urbantke]
[271] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4879, Line 15-22 [Urbantke]

to the coroner who is called to give more information.[272] She was not taken up on that offer.[273] In an exchange with counsel on cross-examination, Dr. Urbantke explained that it was her memory of a CME course dealing with the scenario of a death caused by a possible medication error involving insulin, that prompted her concerns and comments.[274]

193. As it stands, there is no requirement for local coroners to take CME courses specific to death investigations, although the Chief Coroner for Ontario has expressed a desire to have a re-appointment process include an analysis of the coroner's participation in CME.[275]

194. Had Dr. George been properly trained to recognize the importance of a possible medication error involving insulin – perhaps by attending the same CME course that Dr. Urbantke did – important revelations may have followed.

<u>Recommendation #27</u>: The Office of the Chief Coroner should mandate continuing medical education specific to the death investigation system for local coroners.

<u>Recommendation #28</u>: The Office of the Chief Coroner should consider practical training sessions for coroners in long-term care settings.

(L) Making Information Available to "Intake" Decision Makers

<u>(i) The OCC & OFPS</u>

[272] Affidavit of Noelle Kelly at para. 5(c) & Exhibit "A" LTCI00071986, Exhibit 97
[273] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4866-4867, Line 32; 1-3 [Urbantke]
[274] LTCI Transcript, July 19, 2018, Vol. 21 at p. 4878-4879, Line 5-32; 1-22 [Urbantke]
[275] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4350 & 4352, Line 5-13; 18-26 [Huyer]

195. When a local coroner is contacted by provincial dispatch and must make an assessment about whether he/she ought to accept the case pursuant to sections 10 and 15 of the *Coroners Act*, the Chief Coroner for Ontario testified that they do not have the authority to review medical records.[276] Coroners only have authority once a formal investigation is commenced, thus giving them powers to issue warrants under the *Coroners Act*.

196. However, in practice, it appears that local coroners are reviewing certain medical records that they have access to, such as hospital records, in making the decision to accept a case.[277] Presumably, the purpose of reviewing these records is to make an informed decision on an important threshold question, or as one local coroner put it: *"I access them to help me make a good decision"*.[278]

197. It seems counter-intuitive for the decision makers – who as medical professionals would be well-versed on issues of privacy and confidentiality – to not have the authority to review these records. This is particularly so in the context of a death of a long-term care resident, where there would be a large number of medical records easily available from the facility.

198. Without access to these documents, coroners must rely on the relevant information to be identified and conveyed accurately by the reporter. Surely local coroners deserve better information.

---

[276] LTCI Transcript, July 17, 2018, Vol. 19 at p. 4375-4376, Line 24-32; 1-30 [Huyer]
[277] LTCI Transcript, July 18, 2018, Vol. 20 at p. 4669, Line 22-29 [George]; LTCI Transcript, July 19, 2018, Vol. 21 at p. 4907-4908, Line 10-25; 18-26 [George]
[278] LTCI Transcript, July 19, 2018, Volume 21 at p. 4908-4909, Line 29-32; 1-8 [Urbantke]

199. The Chief Coroner for Ontario and two (2) local coroners who testified at the Inquiry stated that it would be helpful to have the legal authority to review medical records, including long-term care home records, at the assessment stage of a death investigation.[279]

<u>Recommendation #29</u>: The Province of Ontario (through legislative amendments, if required) should authorize local coroners and Regional Senior Coroners to review medical records at the assessment stage of a death investigation (i.e. before the commencement of a formal death investigation).

<u>Recommendation #30</u>: The Office of the Chief Coroner should work with long term care homes to create technological tools for local coroners to electronically access medical records in long-term care homes.

<u>(ii) CNO</u>

200. The CNO relies on its Intake Investigators to assess whether a report (as opposed to a complaint) gives rise to a level of risk that requires further investigation and/or discipline. This is not a statutory process – it is a voluntary process chosen by the CNO in order to manage the volume of mandatory reports it receives.

201. Unfortunately, Intake Investigators have no formal powers of investigation.[280] Nevertheless, they are tasked with assessing risk and providing a recommendation to the Executive Director of the CNO of the appropriate regulatory intervention for a reported member at this early stage.

---

[279] LTCI Transcript July 17, 2018, Vol. 19 at p. 4376-4377, Line 31-32; 1-9 [Huyer]; LTCI Transcript, July 18, 2018, Vol. 20 at p. 4669-4670, Line 30-32; 1 [George]; LTCI Transcript July 19, 2018, Vol. 21 at p. 4908-4909, Line 29-32; 1-8 [Urbantke]

[280] Affidavit of Anne Coghlan at para. 86, Exhibit 121

202. Typically, Intake Investigators will be performing their function based on an analysis of the member's previous history, a *Report Form for Facility Operators and Employers*[281] (the "**Report Form**") and a follow-up conversation with the author of the Report Form.[282] As the Intake Investigator has no formal powers of investigation, they cannot compel a response from others who may have relevant information, including a new employer or facility operator.[283] Ms. Coghlan acknowledged that it would be helpful for Intake Investigators if new employers/facility operators were required to be forthcoming with information requested by the CNO.[284]

203. Frankly, considering the CNO's public interest mandate, the public should be disappointed to learn that employers/facility operators (who would themselves have separate reporting obligations to the CNO with respect to their own employees) are not forthcoming to the CNO *"nine times out of ten"*.[285] Indeed, certain employers/facilities simply say they are not able to comment.[286] It is respectfully submitted that this posture may be a function of the lack of available nursing and also fear of labour union practices, discussed above. Therefore, removing any discretion of the employer/facility operator in such a scenario, and protecting good faith reporting, will likely go a long way in ensuring the CNO's Intake Investigators can get better information.

204. We also heard from the CNO that Intake Investigators do not have the power to compel evidence.[287] Ms. Coghlan's opinion at the Inquiry was that Intake Investigators should not have

---

[281] Overview Report – The College of Nurses of Ontario, Source Document LTCI00036841, Exhibit 8
[282] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5370-5371, Line 14-32; 1-14 [Coghlan]
[283] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5516-5518, Line 15-32; 1-32; 1-21 [Coghlan]
[284] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5517-5518, Line 10-27; 14-21 [Coghlan]
[285] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5516-5517, Line 31-32; 1-5 [Coghlan]
[286] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5515, 5517-5518, Line 14-21; 28-32; 1-13 [Coghlan]
[287] Affidavit of Anne Coghlan at para. 83, Exhibit 121

this ability because they perform a triage function that needs to be done quickly.[288] That of course is predicated upon the important assumption that the CNO is receiving accurate information from employers/facility operators, allowing those Intake Investigators to properly perform that triage function. If Ms. Wettlaufer's case can be cited for any proposition, it is that regulators of all sorts, be they the Ministry or a professional regulatory body like the CNO, have to look at all information delivered by employers and facility operators with a critical eye, and take active steps to get comfort that said information is accurate.

205. In reality, the evidence from the CNO witnesses was that mandatory reports of low to moderate risk take six (6) months, on average, to move through the reporting process.[289]

206. Separately, from the evidence of Ms. Van Quaethem[290], it is possible employers are unaware of what information they need to report to the CNO. It is respectfully submitted that, aside from providing additional education to health care facilities on what items need to be reported, the CNO must not simply rely on the employer to provide the information it needs; in order to effect its statutory mandate, the CNO may need to probe for documents. Certainly, in this case, there were many documents that might have led the CNO's Intake Investigator to a different conclusion, and accordingly, a different regulatory response.

---

[288] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5530, Line 3-26 [Coghlan]
[289] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5462, Line 1-24 [Coghlan]
[290] LTCI Transcript, June 6, 2018, Vol. 2 at p.419, Line 15-23 [Van Quaethem]

<u>Recommendation #31</u>: The College of Nurses of Ontario should mandate that subsequent employers/facility operators co-operate with its Intake Investigators.

<u>Recommendation #32</u>: The College of Nurses of Ontario's Intake Investigators should be given the authority to compel documents from employers/facility operators at the intake stage and enforce non-compliance.

(M) 2014 CNO Mandatory Report & Intake Investigation

207. The report provided by Caressant Care Woodstock to the CNO in 2014 was deficient in many ways. It did not accurately outline all of Ms. Wettlaufer's discipline history, particularly with respect to medication errors, nor that Caressant Care Woodstock had concerns about resident safety associated with Ms. Wettlaufer's practice as far back as August 2012. With respect to the August 2012 discipline indicating a concern for "*safety of the residents*", an explicit note to this effect should have been included on the employer report form, and discussed by Ms. Crombez in her conversation with the CNO's Intake Investigator.[291]

208. Perhaps though, more importantly, Caressant Care Woodstock's employer report did not convey any urgency about Ms. Wettlaufer's ability to safely practice, and certainly did not convey what Ms. Hepting felt on the morning right before Ms. Wettlaufer was terminated, namely that Ms. Wettlaufer was a danger to residents' welfare[292]. Neither did Caressant Care Woodstock's employer report to the CNO convey Ms. Hepting's concern about Ms. Wettlaufer

---

[291] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5449, Line 23-28 [Coghlan]
[292] Overview Report – The Facilities & Agencies Source Document LTCI00072096, Exhibit 6

working with other patients, namely that Ms. Wettlaufer would be a danger to any resident she subsequently would have worked with, anywhere.[293]

209. This is fundamental, and absolutely would have changed how the CNO would have responded. Ms. Coghlan clearly indicated that it was worthy of an immediate report.[294]

210. In any event, for whatever reason, this sort of urgency was not, in any way, conveyed by Caressant Care to the CNO. There is no good explanation provided by Caressant Care for that failure.

(N) The CNO Register Offers Little Assistance to Employers

211. Pursuant to section 23 of the *Health Professions Procedural Code* (hereinafter the "***Code***"), the CNO is required to maintain a public register of all RNs and RPNs.[295]

212. Certain information about a nurse, including their current business address and telephone number, is legislated to be disclosed, although the *Code* provides the CNO with discretion to include in its by-laws further requirements to be included in the public register.[296]

213. An issue that was canvassed at the Inquiry was the reliability of resumés and employment references that Ms. Wettlaufer had provided to prospective employers. For example, the reference letter negotiated by ONA on behalf of Ms. Wettlaufer following her termination from

---

[293] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3736, Line 1-16 [Hepting]
[294] LTCI Transcript, July 25, 2018, Vol. 24 at p. 5553, Line 1-4 [Coghlan]
[295] *Regulated Health Professions Act, 1991*, SO 1991, c. 18, Schedule 2, *Health Professions Procedural Code*, section 23, Exhibit 4
[296] LTCI Transcript, July 26, 2018, Vol. 25 at p. 5767-5768, Line 26-32; 1-20 [Coghlan]

Caressant Care Woodstock in 2014 that was subsequently provided to Meadow Park, which, as is noted earlier in these submissions, Ms. Van Quaethem agreed included untrue statements.

214. A potential deterrent to this practice was canvassed at the Inquiry with Ms. Coghlan, namely, giving employers access to CNO information relating to a member's employment history.[297] As nurses can be found to have committed professional misconduct if they do not provide the CNO with current employment information, by storing and maintaining previous information, the CNO has data that can assist an employer in ensuring they are getting a complete picture of a member's employment history.

215. The Executive Director of the CNO testified that it is not the intention to have the CNO's public register be a substitution for employers following up on employment references or asking probing questions in an application process.[298] Ms. Coghlan testified that it was her belief that employees are the best source of information relating to their employment history.[299] With respect, that position ignores the reality that, as occurred with Ms. Wettlaufer, employees may tell half-truths and provide a distorted picture of their past to prospective employers because that information is difficult to verify. This becomes all the more important when considering the expert evidence regarding serial killers in the health care environment, namely, that they are much more likely to falsify their credentials.[300]

---

[297] LTCI Transcript, July 24, 2018, Vol. 23 at p. 5300-5301, Line 22-32; 1-11 [Coghlan]
[298] LTCI Transcript, July 26, 2018, Vol. 25 at p. 5719-5720, Line 28-32; 1-12 [Coghlan]
[299] LTCI Transcript, July 26, 2018, Vol. 25 at p. 5773, Line 14-20 [Coghlan]
[300] LTCI Transcript, September 12, 2018, Vol. 35 at p.8066-8067, Line 24-32; 1-5 [Yorker]

<u>Recommendation #33</u>: The College of Nurses of Ontario should create a new Register, or modify the existing Register, to include a nurse's employment history, or at least to provide registered health care facilities the opportunity to access this information.

(O) Issues with Homecare Services

(i) Background

216. Homecare services, such as those offered by St. Elizabeth, are governed by the *Homecare and Community Services Act, 1994* ("**HCCSA**")[301]. Among other things, the purpose of the HCCSA is to ensure that community services are available to people in their own homes and in their own community settings. The services are to be delivered by an "*approved agency*" as set out under subsection 5(1) of the HCCSA[302].

217. Under the current regulatory structure, the Minster can approve an agency, in this case the LHIN, to provide certain types of community based services. The LHIN can then provide those services directly to the client or, they can contract with community based Service Provider Organizations ("**SPO**") such as St. Elizabeth to provide them.[303]

218. SPOs enter into contractual agreements with the LHIN using a Service Accountability Agreement ("**SAA**") under which the LHIN pays the SPOs to provide services on its behalf. [304] The SAA are contractual in nature and are, for the most part, of boilerplate construction produced

---

[301] *Homecare and Community Services Act,* 1994, S.O. 1994, c. 26, Exhibit 4
[302] *Homecare and Community Services Act,* 1994, S.O. 1994, c. 26, section 5(1) Exhibit 4
[303] Affidavit of Donna Ladouceur at para. 22, Exhibit 160
[304] Affidavit of Donna Ladouceur at para. 17, Exhibit 160

by the Ministry. It is the SAA that sets out the duties and responsibilities of the parties.[305] Importantly, unlike the LTCHA, there are relatively minor reporting requirements for SPO's and no inspection or oversight provisions. [306]

219. The Inquiry heard from Donna Ladouceur, the Vice-President of Home and Community Care with the LHIN, that the number of patients in homecare as well as the acuity of those patients has dramatically increased over the past ten (10) years. She estimated that the Southwest LHIN ("**SW LHIN**") has between 18,000 and 20,000 patients on its roster on any given time.[307] With respect to increasing acuity, the statistics are startling: in 2007/08, approximately 34.7% of adult long-stay home care patients were classified as having high care needs. In 2015/16, 73.5% of adult long-stay home care patients had high care needs.[308]

220. Anyone can apply to the LHINs for services. Once an application has been made and an initial assessment of the patient is conducted. A plan of care is developed, and that individual is assigned a Care Coordinator in the community. Once the patient has been accepted by the LHIN, their services are provided by an SPO. At that point, the patient becomes the SPOs responsibility in almost every way. While the Care Coordinator may do periodic re-assessments and is deemed to be the "*point of contact*" for the patient, the truth of the matter is it is the SPO staff members who has most of contact with the patient. [309]

---

[305] Affidavit of Donna Ladouceur at para. 21, Exhibit 160
[306] LTCI Transcript, August 8, 2018, Vol. 33 at p. 7644, Line 2-9 [Ladouceur]
[307] Affidavit of Donna Ladouceur at para. 32, Exhibit 160
[308] Affidavit of Donna Ladouceur at para. 34, Exhibit 160
[309] Affidavit of Donna Ladouceur at paras. 37-38, Exhibit 160

(ii) Deficient Human Resources Practices in Homecare Sector

221. The importance of the LHIN staff and their training was clearly articulated by Ms. Ladouceur in her affidavit:

> *Having a well-staffed and supported home and community care sector is a critical underpinning to a well-functioning healthcare system. The ability to attract and retain staff in the home and community care sector is crucial. In my experience in the SW CCAC (now LHIN) if there is not sufficient staff, it creates blockages in the healthcare system. Hospitals are unable to discharge patients if there is not the capacity to provide them with the necessary services in their homes.*[310]

222. At the time of the attempted murder of Beverly Bertram in August of 2016, Ms. Condy was the Health Services Supervisor and clinical practice coach with the St. Elizabeth. One of her duties was the recruitment and retention of RNs. Prior to starting her position as Health Services Supervisor, Ms. Condy received no formal training in hiring practices or human resources. [311]

223. In this role, Ms. Condy was in charge of 40 RNs and RPNs who would conduct 1000 to 1200 client visits in an average week.[312] She was able to observe their work in the field approximately once a year for a half-day.[313] Despite being a senior staff member, Ms. Condy was unaware of the relevant Act governing the actions of her agency.[314]

224. Similar to the issues faced by long-term care homes, St. Elizabeth had great difficulties with recruiting and retaining nurses.[315] Community nursing is a particularly hard profession requiring the nurse to travel sometimes long distances and work in uncontrolled and sometimes

---

[310] Affidavit of Donna Ladouceur at para. 71, Exhibit 160
[311] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3946-3947, Lines 14-32; 1 -19 [Condy]
[312] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3952, Lines 1-25 [Condy]
[313] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3951, Line 14-19 [Condy]
[314] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3947, Line 20-23 [Condy]
[315] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3971, Line 1-5 [Condy]

unsavory conditions.[316] It is both a physically and mentally demanding job that does not pay as well as other types of nursing.[317] The starting rate for a fully qualified nurse at St. Elizabeth in 2016 was only $27.20 per hour.[318]

225. In 2014, Ms. Wettlaufer first applied for a position with St. Elizabeth. While reviewing her application, Ms. Condy received information that there had been issues with Ms. Wettlaufer at Caressant Care Woodstock and Christian Horizons[319]. Based on this information, Ms. Condy declined to hire Ms. Wettlaufer at the time.[320]

226. Subsequently, in June of 2016, when Ms. Wettlaufer once again applied to St. Elizabeth, they were still in need of nurses and despite the earlier warnings, Ms. Condy gave Ms. Wettlaufer an interview. This speaks to the chronic and unrelenting shortage of nurses in the homecare setting.[321] Alarmingly, despite 27 years of experience of a RN and a Nursing Administrator, Ms. Condy never thought to inquire further into why Ms. Wettlaufer had been fired by Caressant Care Woodstock for a medication error. In fact, she found Ms. Wettlaufer's admission surrounding her termination by Caressant Care Woodstock to be "brave".

<u>Recommendation #34</u>: The LHINs should amend their Service Accountability Agreements to include a mandatory requirement that SPOs conduct fulsome reference checks during the hiring process of all nurse candidates.

---

[316] LTCI Transcript, August 8, 2018, Vol. 33 at p. 7697, Line 16-20 [Ladouceur]
[317] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3841, Line 17-32 [Condy]
[318] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3960, Lines 9-17 [Condy]
[319] LTCI Transcript, June 27, 2018, Vol. 16 at p. 3839, Lines 13-18 [Condy]
[320] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3938-3839, Line 31-32; 1-29 [Condy]
[321] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3959, Line 11-13 [Condy]

227. St. Elizabeth's policy is to not call any of the references given by a potential candidate. When Ms. Condy was pressed on this issue during her cross-examination she was very clear that she had never called a reference as it was "*not part of our onboarding process*".[322] In fact Ms. Condy was adamant that in the time following the tragic events coming to light, she continued on with the same human resources process.[323] To this day, St. Elizabeth does not call the references that are given by applicants.[324]

Recommendation #35: The LHINs should strictly enforce obligations with respect to a SPO's verification and screening practices and education and training requirements of staff members to under the Service Accountability Agreements.

228. The SAA contains a number of obligations of both the SPO and LHINs with respect to patient care, including a number of verification and screening measures that the SPOs must perform with respect to each nurse that is hired.[325] However, the LHINs do not require the SPO to provide it with confirmation that those requirements have been satisfied. Furthermore, the SAA imposes obligations on the SPO with respect to orientation, education and the training of staff. Again, the SPO is not required to provide the LHINs with that documentation.

229. Separately, we heard during the Inquiry that Ms. Condy was aware that Ms. Wettlaufer was not performing particularly well in the field. Despite training and re-training, Ms. Wettlaufer continued to have difficulty with PIC line administration. Notwithstanding clear problems with Ms. Wettlaufer's skill level, Ms. Condy testified that she did not have concerns

---

[322] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3964, Line 7-8 [Condy]
[323] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3964, Line 29-32 [Condy]
[324] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3964, Line 29-32 [Condy]
[325] Affidavit of Donna Ladouceur at para. 43, Exhibit 160

with having hired Ms. Wettlaufer at the time.[326] Eventually Ms. Condy went out into the field to observe and instruct her personally. Even after witnessing the errors and acknowledging that Ms. Wettlaufer failed to complete the procedure twice in a row as required under their own policy, Ms. Wettlaufer was recertified to perform PICC line duties.[327]

(iii) Lack of Accountability and Oversight of Homecare Services

230. The management and administration of medications in the homecare setting is almost completely unregulated. Homecare patients manage and often administer their own medications, making them responsible for the storage and safekeeping of those medications. Unlike hospitals and long-term care homes, there is no protocol for the storage and safety of narcotics, or for that matter, insulin. It is left up to the patient and the patient's family to secure the drugs in any way that they see fit.

Recommendation #36: The Ministry of Health and Long-Term Care should convene a group of subject matter experts to identify accountability and oversight mechanisms for medication administration and drug security in the home care setting.

231. The SPO is responsible for the administration of medications to their patients where it is part of the service. Ms. Condy candidly states, "*the most significant difference between homecare and other healthcare settings is that usually there is only one healthcare worker going into the home at a time in the homecare setting*."[328] The acknowledgement of that fact makes it all the more important that the nurses being used in homecare settings are highly skilled and

[326] LTCI Transcript, June 28, 2018, Vol. 17 at p. 3990, Line 1-4 [Condy]
[327] LTCI Transcript, June 28, 2018, Vol. 17 at p. 4001, Line 26-32 [Condy]
[328] Affidavit of Donna Ladouceur at para. 51, Exhibit 160

accountable. Unlike a hospital, there are no colleagues to turn to for a second opinion or a second set of hands in difficult situations. While there are some advancements being made in the field of virtual nursing which can provide a second opinion, that fails to provide oversight or in the moment assistance.

232. While the LHINs have some reporting mechanisms for their own staff, they rely almost entirely on SPO workers to report most issues. Those issues can include abuse, neglect and medication errors. Since SPO staff members usually work alone with the client, if an SPO staff member fails to report an issue, the SPO's failure to report the issue may go unnoticed unless it is brought to their attention by the patient or by the patient's family member, friends, informal caregiver, physician or other healthcare worker. In short, the LHINs have no inspection protocol in place to independently monitor the care being provided to their clients by the staff of an SPO.

233. The usual complaint process for clients of St. Elizabeth is to tell their next visiting nurse of any problems or dislikes that they had during their last attendance by the homecare nurse. It was expected that the second nurse would make a supervisor aware of the issue. The supervisor would then instruct the nurse to instruct the client to come to her directly with any concerns.

234. As such, the LHIN receives limited direct feedback and interaction with the clients of SPOs. They would however have regular meetings on a monthly basis involving senior leadership teams from the CCAC and the LHINs. It appears that the LHIN and the Ministry become involved in only the most serious of incidents. As Ms. Condy said:

> *Although I do not personally deal with these contracts on a regular basis, the CCAC (now the LHIN) has a Contracts team that oversees these agreements and their specific requirements. Members of the Contracts and Quality Teams work with the SPOs to resolve issues related to the provision of home care services. When the CCAC*

> *existed, the LHIN and the MHLTC would generally not be brought into this process, although the CCAC would report very serious issues that arose to the LHIN. One example was EW's confessions: the CCAC reported this issue to the LHIN when it learned of it.*[329]

It is indeed disturbing if the triggering event for reporting to the Ministry from a homecare setting is the confession of a serial killer.

235. An individual with nefarious intent such as Ms. Wettlaufer would quickly become aware that other than some initial monitoring for training purposes, they would interact independently with patients in the homecare setting. They would also know that there is almost no chance of random spot checks being conducted by either the LHIN or their employer. Given the high acuity level of the patients now being cared for at home, we could be creating a similarly fertile ground for the abuse of our at-risk citizens. The most vulnerable and incapacitated of our society are no longer concentrated in facilities. Many are remaining in their homes with few family and friends to watch over them.[330]

> ***Recommendation #37: The LHINs and SPOs should clarify what SPO reporting obligations are in the Service Accountability Agreements and create policies on how SPOs should input adverse risk events into the Event Tracking Management System.***
>
> ***Recommendation #38: The Ministry of Health and Long-Term Care should engage in random spot checks of homecare services and SPOs.***

236. One method for reporting complaints by SPOs to the SW LHINs is through an Event Tracking Management System ("**ETMS**"). It is a requirement that all reportable complaints and

---

[329] Affidavit of Donna Ladouceur at para. 29, Exhibit 160
[330] Affidavit of Donna Ladouceur at para. 61, Exhibit 160

risk events must be entered into ETMS.[331] Oddly, there is no specific field in the ETMS in which to put the SPO staff member's name. In any event, the LHINs has no ability to discipline or dismiss an SPO staff member despite being aware of an issue. They can however request that the SPO not send that staff person to a patient's home.

237. The LHINs do not capture, track, or trend complaints or risk events related to the individual SPO staff members. It is the responsibility of SPO leadership to monitor their performance, knowledge, skills, and abilities of each staff member within their organization. While the LHIN may become aware that an individual SPO staff member, was the cause of previous complaints or risk events, is working for another SPO, the LHIN does not have a form or mechanism to track and trend issues related to individual SPO staff members, including if they move between SPOs. In short, even if a particular staff member were known to have had complaints or difficulties with a specific SPO, if that employee moves employers, there is no mechanism to track them. [332]

238. Much if not all of the data collected by the LHINs is used to determine overall quality of care by SPOs and track other statistical data. There is no mechanism for monitoring service providers at the grassroots level. In fact, the SAAs are drafted to place that burden on the SPOs. We are again left with a system where the individual is asked to self-report and self-monitor their own activities, including medication errors. The LHINs believes that it is the responsibility of the employer to report a nurse to the CNO if appropriate. [333]

---

[331] Affidavit of Steven Carswell at para. 24, Exhibit 161
[332] Affidavit of Steven Carswell at para. 48, Exhibit 161
[333] LTCI Transcript, August 9, 2018, Vol. 34 at p. 7823, Line 1-10 [Carswell]

239. It was revealed that, in August 2016, Ms. Wettlaufer had been caught in a client's home without their knowledge or permission.[334] We now know the purpose of her entry was to steal insulin to kill Ms. Bertram and to divert narcotics for her own use. Despite being advised by two (2) other nurses that the incident had taken place, it was never reported or recorded in the ETMS system as required – and therefore, the LHIN was unaware that Ms. Wettlaufer entered a home without authorization and stole insulin until the public hearings began[335]. Ms. Condy confirmed that it is unusual for a nurse to enter a client's home unannounced and without permission and in fact she had never known a nurse to do so. It should be noted that Ms. Wettlaufer was still on probation at the time. When pressed, Ms. Condy could not say whether this was a firing offence because she did not investigate it.[336] This is shocking and demonstrates the serious consequences associated with the lack of accountability and oversight of homecare services in Ontario.

(P) Failure to Collaborate Between Stakeholders

240. Throughout the Inquiry process, the Victims' Groups were disappointed by the lack of collaboration amongst stakeholders. Given the shared goals of protecting the public interest, we believe that there were clear opportunities for the Ministry, the OCC & OFPS and the CNO to collaborate and share information that were not seized upon.

(i) The Ministry and the CNO

---

[334] LTCI Transcript, June 28, 2018, Vol. 17 at p. 4002, Line 15-18 [Condy]
[335] LTCI Transcript, August 9, 2019, Vol. 34 at p. 7893, Line 18-30 [Carswell]
[336] LTCI Transcript, June 28, 2018, Vol. 17 at p. 4005, Line 30-31[Condy]

241. As discussed further above, Ms. Kukoly received information about Ms. Wettlaufer's drug and alcohol problem during the 2014 inspection at Meadow Park but did not share this information with the CNO. We recognize that Ms. Kukoly did not have a mandatory reporting obligation to the CNO[337]; however, Ms. Coghlan stated that it *"absolutely"* would have been helpful for the CNO if it had this information.[338] Likewise, if the CNO had concerns about non-compliance with the LTCHA and Regulation, they should voice their concerns with the Ministry.[339] Arguably, the CNO had a legal obligation pursuant to section 24 of the LTCHA to immediately report to the Director[340] – an obligation the Inquiry has heard is frequently ignored.

<u>Recommendation #39</u>: The Ministry of Health and Long-Term Care and the College of Nurses of Ontario should create best practices to foster greater collaboration between their respective organizations.

242. We need a cultural change, to reinforce the notion that the Ministry and the CNO both operate in the public interest and therefore, need to collaborate. We know that the Ministry and the CNO have previously worked together on the issue of medication errors. The Ministry and the CNO should continue to have an open dialogue and work together to identify the kinds of information that would be useful for each of their respective organizations, to flag for the other.[341] Once potential opportunities to collaborate have been identified, the Ministry and the CNO should clearly communicate this to staff so that they may turn their minds to these issues going forward.

---

[337] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6287-6289, Line 2-17; 24-32; 1-7 [Simpson]
[338] LTCI Transcript, July 25, 2018, Vol. 23 at p. 5533, Line 6-23 [Coghlan]
[339] LTCI Transcript, July 31, 2018, Vol. 28 at p. 6366-6368, Line 1-2; 9-11 [Simpson]
[340] *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 section 24, Exhibit 4
[341] LTCI Transcript, July 30, 2018, Vol. 27 at p. 6289, Line 17-27 [Simpson]

(ii) The Ministry and the OCC & OFPS

243. Another opportunity for collaboration, between the Ministry and the OCC & OFPS, was highlighted in the testimony of the Chief Forensic Pathologist for Ontario, Dr. Pollanen.

244. Dr. Pollanen provided evidence about a current practice at the OCC & OFPS involving another vulnerable sector – neglected and/or abused children. Dr. Pollanen testified that whenever the OCC & OFPS gets involved in a case where they suspect neglect, abuse, maltreatment of a child under five (5) years of age, they always *"positively"* follow up with the police, who have protocols of information sharing with children's aid societies.[342] This practice has been included in the OCC & OFPS Death Investigation Manual, including a reference to the mandatory obligation to report this abuse.[343]

245. Unfortunately, there is no comparable section in the Death Investigation Manual as it relates to deaths of elderly persons or persons residing in long-term care homes.[344] The policy reasons for stressing such a reporting obligation are the same as it relates to this vulnerable group and it is important to ensure our local coroners are aware of their reporting obligations – including, again, section 24 of the LTCHA – which we heard are so frequently misunderstood or ignored.

---

[342] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5125, Line 15-21
[343] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5125-5126, Line 22-32; 1
[344] LTCI Transcript, July 23, 2018, Vol. 22 at p. 5126, Line 2-13

<u>Recommendation #40</u>: The Office of the Chief Coroner and Ontario Forensic Pathology Service should revise the Death Investigation Manual to include protocols for sharing information with the Ministry of Health and Long-Term Care.

<u>Looking Forward: The Important Work to Be Done</u>

246. The public has learned much during Part 1 of the Inquiry about Ms. Wettlaufer's crimes and the circumstances and contributing factors which may have allowed those crimes to go undetected for so long. We have had the difficult conversations – in the public eye – identifying a series of systemic failures in the long-term care sector.

247. Those conversations cannot be in vain. Our work is not done yet. There is much to be canvassed during the policy phase in Part 2 of the Inquiry so that the Commissioner may make recommendations on how to prevent similar tragedies from occurring again.

248. The Victims' Groups hope that once the Commissioner releases her final report and recommendations, the Province of Ontario and all other stakeholders will collaborate and take on the difficult work of improving the long-term care system. If those efforts are not made, it will be a disrespect not only to this process, but also to the lives of those whose deaths prompted the entire exercise in the first place.

249. Accordingly, the Victims' Groups hope that all stakeholders will meet the challenge, and ensure that the recommendations flowing from this Inquiry are taken to heart so that positive and enduring changes to our long-term care system will follow. By doing so, we will be meeting the

primary objective of each member of the Victims' Groups: to ensure no one will ever again have to endure the pain of losing a loved one under such circumstances.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 20th day of September, 2018.

VAN KRALINGEN & KEENBERG LLP

Alex Van Kralingen
Mark Repath
Katherine Chau

Lawyers for the Participants,
Andrea Silcox, Adam Silcox-Vanwyk,
Arpad Horvath Jr., Laura Jackson, Don
Martin, Shannon Lee Emmerton, Jeffrey
Millard, Judy Millard, Sandra Lee Millard,
Stanley Henry Millard & Susie Horvath

HARRISON PENSA LLP

Paul H. Scott
Annie Legate-Wolfe

Lawyers for the Participants,
Jon Matheson, Pat Houde &
Beverly Bertram

ONTARIO
COMMISSION OF INQUIRY

THE PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS IN THE LONG-TERM CARE HOMES SYSTEM

CLOSING SUBMISSIONS OF THE VICTIMS' GROUPS

VAN KRALINGEN & KEENBERG LLP
43 Front Street East
Suite 400
Toronto, ON M5E 1B3

Alex Van Kralingen
Tel: (647) 348-7445 / Fax: (416) 364-9705
avankralingen@vklaw.ca
Mark Repath
Tel: (416) 703-5353 / Fax: (416) 364-9705
mrepath@vklaw.ca
Katherine Chau
Tel: (416) 703-7523 / Fax: (416) 364-9705
kchau@vklaw.ca

HARRISON PENSA LLP
450 Talbot Street
London, ON
N6A 4K3

Paul H. Scott
Annie Legate-Wolfe
Tel: (519) 850-5585 / Fax: (416) 667-3362
pscott@harrisonpensa.com

Lawyers for the Victims Groups