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

CARESSANT CARE NURSING AND RETIREMENT HOMES LIMITED

Participant

CARESSANT CARE'S CLOSING SUBMISSIONS

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TORKIN MANES LLP
Barristers & Solicitors
151 Yonge Street, Suite 1500
Toronto, ON M5C 2W7

David M. Golden (24972K)
dgolden@torkinmanes.com
Tel: 416-777-5408
Fax: 1-888-812-2558

Lawyers for Caressant Care Nursing and Retirement Homes Limited

TO: Commissioner
The Inquiry Offices
400 University Avenue
Suite 1800C
Toronto, ON M7A 2R9

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I. OVERVIEW

1. The public inquiry into the safety and security of residents in the long-term care homes system (the "**Commission**") was created as one response to the shocking confessions of nurse Elizabeth Wettlaufer ("**EW**") who, in June, 2017, pled guilty to eight counts of first degree murder and other serious charges. All of the murder victims were part of a vulnerable resident population who, together with their families, had put their trust in Ontario's long-term care system. That system is funded by the Province and delivered by individual licensees with the goal of providing accommodation, care and services focussed on meeting the individual needs of long-term care residents, including their safety and security.

2. The Commission has been tasked with examining what failings might exist in Ontario's long-term care system which allowed EW to kill or harm innocent persons without detection over a nine year period. Concurrently, the Commission will also explore what might be done to prevent similar tragedies from occurring in the future.

3. Caressant Care Woodstock ("**CCW**") is the long-term care facility where, sadly, EW committed many of her crimes. CCW has operated in Woodstock, Ontario since 1982, and in

1999 was expanded to a total of 163 beds. These closing submissions are advanced from the perspective of CCW which, as an institution, and together with its dedicated staff and service providers, was deeply shaken and traumatized by these events.

4. CCW has always attempted to live up to its commitment "Family – Yours and Ours Together".[1] It is submitted that this commitment became clear as the Commission heard evidence from a cross-section of dedicated professionals and staff who were part of the team delivering care and services at CCW over the relevant time period.

5. For obvious reasons, following EW's confession, CCW became the focus of the most significant (and arguably) gruelling inspection in the history of Ontario's long-term care system, which all unfolded under intense political, public and media scrutiny.

6. A burning question for everyone, those who administer the long-term care system, residents across Ontario, families, other long-term care operators, the public and the media was whether EW's criminal actions should have or could have been detected and stopped earlier either by CCW, the Ministry inspection apparatus, the victims' personal physicians, the Coroner's office, the College of Nurses, or for that matter, anyone who had professional interactions with EW.

7. Thousands upon thousands of documents have been summarized and reviewed and thirty-seven days of public hearings have now been completed.

8. By way of overview, it is submitted that we are now in a position to make the following preliminary observations/conclusions:

[1] Transcript Day 5, Vol. 5 – June 11, 2018 – pg. 889 – Helen Crombez

(a) At no time did any of the nurses, health care workers, managers, physicians, residents or families associated with CCW ever suspect that EW was intentionally harming residents or was even capable of intentionally harming residents;

(b) Beyond the CCW work environment, one can also conclude from the evidence that at no time did the Ministry of Health (which inspected CCW), the Union which represented EW, or the College of Nurses ("**OCN**") which regulated her ever suspect that EW was intentionally harming residents or was even capable of intentionally harming residents;

(c) Despite the fact that seven of the eight deaths (involving CCW residents) were reported to the Coroner's Office using the Institutional Patient Death Record Form ("**IPDR**"), and despite the fact that two of the deaths were independently investigated by the Coroner's office, there were no suspicions raised of wrongdoing or foul play;

(d) Even with the benefit of hindsight, there were no clues that EW was a murderer, let alone a serial murderer;

(e) There was no expert or other evidence led indicating that had a particular follow up step or action or investigation been taken or conducted, that acts of intentional wrongdoing would have been uncovered or prevented. In fact, even after months of intensive investigation and review, the only solid evidentiary basis for actually identifying EW's actions in relation to her victims as criminal comes from her confessions;

(f) The totality of the evidence suggests that EW was otherwise a mediocre nurse with some positive attributes whose performance was inconsistent, and that towards the end of her nursing career, she performed at the lower end of a typical range;

(g) Despite the evidence that EW had some mental health issues, there was no compelling evidence whatsoever that her work performance at CCW was actually affected by alcoholism, drug dependency, or any known mental health issues;

(h) In part because of the nine year period over which the crimes were committed, not even sophisticated data analysis/computer modelling was capable of identifying her actions as worthy of further investigation/monitoring;

(i) Fundamentally, it is submitted that despite good intentions, there will be little opportunity for improvement until:

    (i) all of the players commit to working together to make the long-term care sector a more attractive and satisfying career choice for health care workers and professionals. A strong talent pool, whether we are talking about RNs, health care aides, nurse practitioners, physicians, or managers is an essential building block. If manpower shortages continue, there will continue to be opportunities for nurses with EW's profile to quickly and easily find employment.

(ii) a serious exercise is undertaken to assess the actual level of funding required to meet not only the technical requirements of the *Long-Term Care Homes Act,* but also to actually achieve the quality of life objectives for residents which the residents, families and the public expect. This feeds directly into staffing requirements. At least anecdotally, we heard evidence regarding how the nature and quality of resident/staff interactions and overall quality improves when staff are not pressed to their limits just to accomplish routine tasks, but actually have reasonable time to interact with residents and families.

9. It is the view of CCW in making these closing submissions that while there were factors which contributed to allowing EW to continue to work as a registered nurse providing care to residents/patients for too long, there are no obvious institution-specific or systemic factors which can be directly linked to facilitating or concealing her crimes. No expert or other witness made that connection.

10. It is submitted that improving the long-term care system, both from within and in terms of how it functions at part of the broader health care system (i.e. intersections with the Coroner's office, regulatory colleges, trade unions, and the Ministry of Health) might well improve quality of life and even safety for Ontario's long-term care residents. Having said this, from the evidence heard to date, any such changes will not help predict intentional harm. The expert in serial killers in health care hired by the Commission was directly asked whether various "so-called red flags" involving EW such as alcoholism, addiction issues, mental health concerns, poor nursing practice and a lengthy discipline history were predictors of any kind of behaviour of inflicting harm on residents. The expert was clear in answering no, not at all.

11. Having said this, the evidence did suggest opportunities for improving the long-term care system which could, indirectly, make it more difficult for health care workers with criminal intentions remain in the system. Whether this might drive someone with evil intentions into an environment like home care with less oversight and more direct contact with more isolated

vulnerable patients is an open question but it was clear that current long-term care staff are over-burdened, over-worked, under-appreciated, in part as a result of RN shortages, EW had many employment opportunities.

12. Having said the above, the following is a summary of areas which are worthy of review and exploration and which flow directly from the evidence presented:

(a) Difficulties in recruiting and retaining committed staff at all levels in long-term care who will view long-term care as a calling/passion;

(b) Funding – The Province provides approximately $100.91 per resident per day to long-term care licensees to deliver the long-term care program. Of this sum, $75.00 is specifically ear-marked as a direct flow through for nursing and personal care (which includes staffing for the nursing department). This funding appears to be insufficient);

(c) Recruitment practices and available recruitment tools (including access to relevant employment history;

(d) Impact of the unionized work environment both in terms of the progressive discipline system, typical collective agreement provisions (sunset clauses, reference letters), and the impact of the grievance/arbitration process;

(e) The role of the OCN in investigating terminations, managing information (Find a Nurse), and assisting with system improvements both in terms of standards (medication errors), education, and the overall nursing shortages in long-term care;

(f) Role of the Coroner's office in fulfilling its statutory obligations and more generally in their interactions with the long-term care system;

(g) Long-term care legislation, including accountability imbalances, misunderstood and poorly defined reporting obligations, structural failings within the inspection system including the perceived punitive approach;

(h) Specific challenges found within many long-term care homes:

   (i) frequency of medication errors and how best to address them;

   (ii) understanding reporting obligations/education;

   (iii) suitability of staff to meet resident needs.

II. EVIDENCE REGARDING CARESSANT CARE ("CCW")

General Comments

13. As indicated above, CCW, more than any other long-term care home in Ontario, was put under a microscope as result of the fallout from EW's confession. It is submitted that based on the totality of the evidence presented so far, the following observations/conclusions can be made:

(a) Not a single person who worked at CCW or attended there, either as an employee, as an independent physician, or as a representative of the Ministry, the Union, or the Coroner's office, ever suspected that EW was intentionally harming residents;

(b) Although there was some knowledge that EW had personal health issues, they were addressed and her health status was not observed by peers, co-workers, physicians, management personnel, families or residents to have actually negatively affected resident care or interactions. This includes in relation to alcohol or drug use;

(c) CCW followed a typical policy of progressive discipline with EW over a period many years and terminated her when an opinion was formed, following the insulin error in March, 2014, that she was not capable of meaningful or sustained change/improvement;

(d) CCW, through the relevant time period, had a competent and caring compliment of staff who were deeply committed to providing quality resident care;

(e) The sense of betrayal, anger, shock, loss and sadness for victims and their families was profound. Not a single CCW witness was unaffected. Some have not actually recovered, although stayed on doing their best to deliver care despite the chaos of the period following EW's confession;

(f) Despite findings of non-compliance with the *Long-Term Care Homes Act* which were made in response to the EW Inspections, there was no evidence called from residents, families, the local LHIN, the Residents Council, or the Family Council indicating a pattern of complaints from families about the general level of care provided to residents, the professionalism and attitude of the staff, or the commitment to do a good job and meet residents' needs.[2] Obviously, over a nine year period, there will be individual incidents but, remarkably, despite the enormous pressure and suspicion that CCW fell under in the Fall of 2016 and into 2017, its residents, the residents' counsel, families, and staff remained supportive of the Facility. This was confirmed by the Ministry Inspector who had extensive contact with residents over this difficult period;[3]

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[2] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6931 – Rhonda Kukoly
[3] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6931 – Rhonda Kukoly

(g) CCW had a consistent risk rating of 1– the best rating – until that was changed by the Ministry to a 3 but only as a result of EW's confessions having being made known;

(h) Despite the massive inspection which occurred at Caressant Care commencing in October, 2016, the number of orders made in comparison with the volume of orders and non-compliances identified in other long-term care homes during a typical two to three week RQI inspection was not surprising;

(i) Despite thc enormous pressures and the devastation felt by Caressant Care staff and the retirements of both an Administrator and Director of Care, the concerns which were identified by the Ministry in full by August 24, 2017 were addressed and corrected by December, 2017;

(j) Although considerable attention was focused during the evidence on alleged areas of non-compliance involving particular residents (for example CH and DW), at the end of the day, the totality of the evidence demonstrated that CCW did address concerns regarding those residents in a reasonable fashion and that their well-being was not ignored;[4]

(k) While many CCW witnesses described the long-serving Director of Care, Helen Crombez, as strict, the totality of the evidence, both in the written record and as described by witnesses is that Mrs. Crombez was strict with everyone. She routinely met with EW for counselling and discipline when allegations of improper conduct were raised.[5] Although it was not Mrs. Crombez' practice to report back to persons regarding action taken, the general consensus was that when a complaint was made, Mrs. Crombez followed up;[6]

(l) Not a single witness expressed a professional opinion that it was because of the actions (or inaction) of CCW specifically (as opposed to system-wide practices) that EW's criminal intentions/actions were not detected;

(m) Dr. Richard Reddick, who served as CCW's attending physician for forty years, and had many of his own patients living at CCW viewed CCW as having phenomenal caring people who did great work;[7]

(n) Dr. William George who has lived in Woodstock for twenty-five years and had his own patients living at CCW never had any concerns about CCW and in particular, was always pleased with the nursing staff.[8] It is submitted that the observations and opinions of physicians who had their own patients living at CCW were in as good a position to judge the quality of nursing care and resident satisfaction as Ministry Inspectors, who are not directly inspecting for resident care and resident satisfaction, but instead are assessing regulatory compliance.

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[4] Transcript Day 27, Vol. 27 – July 30, 2018 – pgs. 6145-6146, 6151 – Karen Simpson

[5] Affidavit of Helen Crombez sworn June 7, 2018 - paras. 90, 93, 104 and 185

[6] Transcript Day 8, Vol. 8 June 14, 2018 - pg. 18148 – Agatha Krawczyk; Transcript Day 9, Vol. 9 – June 18, 2018 – pg. 1948 – Laura Long; Affidavit of Brenda Black para 35

[7] Transcript Day 13, Vol. 13 – June 22, 2018 – pg. 3128 – Dr. Richard Reddick

[8] Transcript Day 20, Vol. 20 – July 18, 2018 – pg. 4708 – Dr. William George

Given what we now know from EW's confession about her motives, her timing, her use of insulin specifically as a weapon, her choice of victim, it is submitted that the crimes that she

committed at CCW could have been committed in any Ontario's long-term care homes over the same time period.

Comments Regarding Specific Incidents at CCW

14. A considerable amount of hearing time was devoted to reviewing how CCW responded to specific EW incidents involving specific residents. Particular attention was paid to the interactions between EW and two CCW residents, namely CH and DW. Despite the substantial amount of time focussed on these two residents, it should be noted that EW worked at Caressant Care for almost <u>seven</u> years and overall, the evidence suggested that she had a good rapport with both residents and with families and was generally well liked by them.[9] She often went out of her way to make residents feel special and foster a sense of home into an environment that can otherwise feel institutional. She also spoke up to promote her views regarding resident dignity.[10] The best proof of this assertion is the fact that one would be hard pressed to find complaints about EW from residents or families over the entire seven year period during which she provided care at CCW.

15. The Ministry witnesses who gave evidence regarding the underlying goals of the inspection program emphasized that despite all of the technical regulatory requirements which open the door to findings of non-compliance, at the end of the day, the focus still should be on resident care and on whether and how long-term care homes actually respond to resident issues.

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[9] Transcript Day 6, Vol. 6 – p. 1331 – Karen Routledge; Transcript Day 8, Vol. 8 – p. 1845 – Agatha Krawczyk; Transcript Day 8, Vol. 8 – p. 1892 – Brenda Black; Transcript Day 14, Vol 14 – p. 3225 – Robyn Laycock

[10] Transcript Day 2, Vol. 2 – June 6, 2018 – pg. 311 – Brenda Van Quaethem; Transcript Day 4, Vol. 4 – June 8, 2018 – pg. 803 – Helen Crombez; Affidavit of Brenda Van Quaethem sworn June 4, 2018 - paras. 58-59

For this reason, the RQI inspection process now includes a significant component of interacting with and interviewing many residents.

i) Incidents Involving CH

16. With respect to resident CH, despite the criticism levelled against CCW, it is submitted that:

(a) The Director of Care, Helen Crombez, was personally committed to ensuring that not only was CH safe and fairly treated, but that she was on a path intended to work through her challenges and achieve a higher level of independence outside of the long-term care environment.[11] For so many reasons, the long-term care home environment was not appropriate for CH;

(b) Because Mrs. Crombez knew CH so well, she was in a position to exercise her professional judgment in determining that on January 16, 2012, there were not reasonable grounds for believing that CH had been slapped by EW. This was not a case of a resident being disrespected or ignored. The allegation was investigated immediately. There was a context which was investigated. On January 16, 2012 CH apologized;[12]

(c) When there was a subsequent allegation of a slap, CH herself called the Ministry. CCW filed a Critical Incident Report [Document ID 522]. The police were called and they intervened. EW received counselling and a family meeting was

[11] Affidavit of Helen Crombez at para 132
[12] Affidavit of Helen Crombez at paras 121, 124, 125

convened. Goals were set. As a result, CH did not require the Ministry to further investigate;[13]

(d) Shortly thereafter, in March, 2012, Mrs. Crombez personally assisted with transitioning CH to community living including ensuring that she had appropriate accommodation, new dentures, and public health training regarding maintaining nutrition;[14]

(e) The incidents involving CH were investigated by the Ministry as part of the October, 2016 investigation. Ms. Simpson, on behalf of the Ministry, testified that based on the information provided, CCW appeared to have handled the CH incident appropriately. There was no logical need for the Ministry to follow up. Yes, the Ministry does take resident allegations very seriously but this was a unique circumstance which appears to have been handled properly.[15]

ii) Incidents Involving DW

17. Substantial evidence was also led exploring whether CCW appropriately handled incidents that occurred as between EW and resident DW, It is submitted that the evidence disclosed as follows:

(a) The initial incident which was said to occur on April 1, 2013, was a sarcastic comment made by EW to DW regarding whether he needed a psychiatric assessment or a Haldol injection;[16]

[13] Affidavit of Helen Crombez at paras 128, 130
[14] Affidavit of Helen Crombez at para 132
[15] Transcript Day 27, Vol. 27 – July 30, 2018 – pgs. 6147-6148 – Karen Simpson
[16] Affidavit of Helen Crombez at pg. 34

(b) There was no suggestion that DW in fact felt threatened or intimidated.[17]

(c) The context for the incident was investigated and steps were taken.[18] EW's sarcastic comment was made as a response – albeit an inappropriate one – to DW mocking a fellow resident.

(d) A subsequent incident involving DW allegedly slapping EW was reported to the Ministry. In dealing with that situation, CCW looked at the underlying causes, the reason for DW's behaviours, including the fact that he had a urinary tract infection.[19] The Home arranged for extra resources to address DW's responsive behaviours. DW's request that he not receive treatment from EW was respected and accommodated. Changes were made. A memo was sent to staff to this effect.[20] It goes without saying that DW was not given Haldol (which was not being used at CCW) nor was he ever sent out of the Home against his will for any assessment.[21]

18. At the end of the day, it is submitted that CCW addressed the original underlying issues which caused friction between DW, the other resident, and EW. The family was called. A meeting was held and EW and DW got past this. There was no evidence of further issues between them.[22]

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[17] Transcript Day 9 Vol. 9 – June 18. 2018 - pg. 1968-1971 – Laura Long
[18] Transcript Day 27 Vol. 27 – July 30, 2018 – pg. 6147 – Karen Simpson
[19] Affidavit of Helen Crombez at para 161
[20] Transcript Day 27 Vol. 27 – July 30, 2018 – pg. 6149-6150 – Karen Simpson
[21] Transcript Day 9 Vol. 9 – June 18. 2018 - pg. 1981 – Laura Long
[22] Affidavit of Helen Crombez at para 165-166

Medication Errors/Medication Administration

19. Considerable evidence was lead regarding the nature, frequency, causes and severity of medication errors occurring in the long-term care sector, including at CCW. It was a medication error involving insulin which ultimately lead to EW's termination in March, 2014.

20. EW had previously been disciplined for a variety of medication errors. The philosophy of CCW and the philosophy of OCN appear to align in the sense that it is not necessary nor appropriate that every medication error should be treated as a serious breach of professional standards requiring discipline, but rather, there needs to be an attempt to understand the error and provide some opportunity for improvement.[23] Expanding on this general approach, the evidence of pharmacy expert Julie Greenall suggested that the sector needs to go much farther in terms of how medication errors are addressed. The context for understanding, reviewing and addressing medication errors is that it was acknowledged that some residents can be receiving up to fifteen medications in one med pass.[24] The pressure on the RNs doing the med passes is extraordinary, just in terms of getting it done and documenting as required.

21. We heard evidence from a number of witnesses about the "rights" for delivering medication (right patient, right medication, right dosage, right time…). A Ministry inspector, suggested that there are ten "rights" for administering medication.[25]

22. A substantial amount of the criticism was levelled against CCW in relation to its medication administration systems/practices. Yes, there were deficiencies and improvements have since been made, but having said this, in terms of how EW committed her crimes (insulin injections), it is submitted that there was no specific failure on the part of CCW in terms of its

[23] Transcript Day 27, Vol. 27 – July 30, 2018 – pg. 6246 – Karen Simpson
[24] Transcript Day 29, Vol. 29 – August 1, 2018 – pg. 6717-6718 – Rhonda Kukoly
[25] Transcript Day 29, Vol. 29 – August 1, 2018 – pg. 6708 – Rhonda Kukoly

medication administration policies and practices which opened the door for EW's criminal activity. Even the most robust system proposed for insulin inventory management and a two person double check prior to administering insulin would have been easily circumvented by EW.

23. Despite the findings of non-compliance, the following evidence was adduced supporting the fact that CCW did take medication errors seriously and did routinely review those errors and the underlying circumstances surrounding those errors with an interdisciplinary team.

24. CCW's Professional Advisory Committee ("PAC") met quarterly. The PAC consisted of the Administrator, the Director of Care, other department representatives, the Home's advisory physician and the Home's clinical consultant pharmacist. The PAC team specifically discussed medication administration errors made by nurses including how to reduce the number of errors made by the nurses, culminating with formal evaluations of the way medication was managed. The PAC meetings also provided an opportunity for the pharmacist consultant to discuss medication use at CCW in comparison with other facilities, including information regarding how CCW could reduce the amount of medications such as anti-psychotic and anti-anxiety medications. Issues involving insulin were also discussed.[26]

25. In addition, the clinical consultant pharmacist regularly attended at the Home to review charts and resident medications and to make suggestions regarding how to improve medication therapy. This included performing medication audits. During the relevant time period, although medication errors were not always reported individually to the pharmacy, medication incidents were discussed at the PAC.[27] It was the impression of CCW's external clinical consultant pharmacist that the staff at CCW took medication errors seriously. They were reported first to

[26] Transcript Day 13, Vol. 13 – June 22, 2018 - pgs. 3098 – 3102 – Dr. Richard Reddick
[27] Transcript Day 13, Vol. 13 – June 22, 2018 - pgs. 3187 – 3190 – Joanne Polkiewicz

the Director of Care and through the PAC meetings, the pharmacist became informed of all of the errors. It is submitted that the Director of Care, the nursing staff, the advisory physician and the consultant pharmacist took these errors seriously, looked for opportunities to improve and discussed them regularly.[28]

26. It is submitted that the totality of the evidence identified that issues regarding medication incidents (both in terms of number of incidents and identification) and how to manage them is a system-wide issue, not a uniquely CCW issue. A full forty-two percent of homes have medication incidents as described in the Ministry's top ten non-compliance list.[29]

CCW's Unionized Work Environment (Discipline, Grievances and Arbitration)

27. The contractual relationship between EW and CCW was governed by a Collective Agreement.[30] In accordance with the terms of the Collective Agreement, EW's probationary period expired on October 6, 2007.[31] From that point forward, discipline, and if necessary, termination was governed by the Agreement.

28. Caressant Care had (and has) a progressive discipline policy in place for its unionized employees, including RNs.[32] Department managers were expected to follow the progressive discipline process. Generally speaking, before long-term care employees can be disciplined, the Home needs to ensure that they are aware of what is expected of them and given an opportunity to improve and an opportunity to make the employer aware of any barriers to improve work performance or any mitigating circumstances related to specific conduct. If work performance

[28] Affidavit of Joanne Polkiewicz sworn June 21, 2018 - para. 80
[29] Exhibit 131, Document ID 72894
[30] Transcript Day 11, Vol. 11 – June 20, 2018 – pg. 2546 – Wanda Sanginesi
[31] Transcript Day 11, Vol. 11 – June 20, 2018 – pg. 2619 – Wanda Sanginesi
[32] Transcript Day 11, Vol. 11 – June 20, 2018 – pg. 2548 – Wanda Sanginesi

does not improve, or misconduct reoccurs, employees are subject to an escalating series of warnings, then suspensions, and finally termination of employment.[33]

29. Dismissal can only proceed on the basis of "just cause".[34] Disciplinary sanctions, including dismissal, can be challenged through the grievance and arbitration process. The evidence from a former ONA bargaining unit president suggested that five day suspensions and dismissals are almost always grieved.[35] They were in the case of EW.

30. There is an abundance of case law, well known to both employers and unions, supporting this principle. For example, in the case of Humber River Regional Hospital v. ONA (Taylor Grievance), the arbitrator commented as follows:

> "...the theory of progressive discipline provides that dismissal is reserved for the most serious of offences and in situations where after being given an opportunity to correct their behaviour an employee cannot learn from any discipline because they will not alter their behaviour and reinstatement would be futile"... I am of the view that a corrective approach to discipline ought to be applied in most circumstances. Discharges to be reserved for those employees who cannot be rehabilitated and the most serious acts of misconduct, like theft".[36]

31. In another reported decision, also involving ONA (Humber River Regional Hospital v. ONA Cherubino Greivance), the Arbitrator commented as follows:

> "It is not necessary to site authority for the central role that progressive discipline plays in a just cause system of discipline"[37]

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[33] Affidavit of Wanda Sanginesi sworn June 15, 2018 – Exhibit "A" - para. 49
[34] Affidavit of Wanda Sanginesi sworn June 15, 2018 – Exhibit "A" - para. 50
[35] Affidavit of Karen Routledge sworn June 10, 2018 – para. 34
[36] [2012] O.L.A.A. No. 337 at paras. 228 and 232
[37] [2007] CanLII 58708 (O.N.L.A.)

32. The case of Humber River Hospital v. ONA (Cherubino Greivance) is just one example of ONA successfully arguing that a health care employer did not impose progressive discipline or offer mediation/dispute resolution and that in any event, that there was no just cause for discipline. Even if there was just cause for some discipline, it was argued that termination was out of proportion to the misconduct.

33. It is submitted that the discipline system itself, requiring meetings, forms, witnesses and a progression of penalties in and of itself sets off an adversarial dynamic not conducive with the "root cause" approach to medication errors, for example, advocated by Julie Greenall.

34. Arbitration awards are final and binding. Often, as was the case in EW's termination, an order for full reinstatement is demanded.

35. This is the reality of the labour relations environment which helps explain why a decision was made by CCW to settle the grievance filed by EW in response to her 2014 termination which sought, as the primary ground, reinstatement. It was unbeknownst to CCW that EW had already commenced employment at Meadow Park on April 21, 2014.[38] EW, actually signed the termination grievance form and it was submitted in May, 2014.

36. The negotiated reference letter for EW received considerable attention. There was conflicting evidence regarding the extent to which the content of that reference letter [Document ID 16712] was actually negotiated as between CCW and ONA.

37. According to Ms. Sanginesi, Ms. Allingham, from ONA, asked for a reference letter addressing EW's skills. According to Ms. Allingham, the reference letter is generally supposed

[38] Transcript Day 12, Vol. 12 – June 21, 2018 - pg. 2932 – Jillian Allingham

to say something positive about the grievor.[39] The substantive content for the June 11, 2014 letter was actually taken from a prior performance evaluation.[40] It appears as if EW reviewed the draft reference letter and approved it.

38. It is submitted that the exact circumstances surrounding the reference letter are not material. EW had applied for another position and was already working before the reference letter was even signed. It is submitted that both the employer and the Union viewed the provision of some form of reference letter as part of the grievance settlement process. The collective agreement itself requires a basic letter setting out employment details.[41]

39. At the end of the day, CCW made a practical decision to settle the termination grievance. Not only are arbitration awards final and binding, they are expensive and time consuming proceedings which could result in an order for reinstatement, plus damages and costs. It is submitted that under the circumstances, this was a reasonable approach consistent with industry practice.

The 2016/17 Inspection at CCW

40. It was acknowledged by Ministry's Long-Term Care Home Director, Karen Simpson, that there hasn't been a long-term care home in Ontario which has ever had to endure the level scrutiny brought on by this kind of horrific incident. It was clearly traumatizing for the Home.[42]

41. The following is a summary of particularly relevant facts associated with the Inspection:

(a) The inspection at CCW began on the day that the Woodstock Police Department issued its press release regarding the charges against EW;[43]

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[39] Transcript Day 12, Vol. 12 – June 21, 2018 - pg. 2842 – Jillian Allingham
[40] Affidavit of Wanda Sanginesi sworn June 15, 2018 – Exhibit "A" - para. 18
[41] Transcript Day 12, Vol. 12 – June 21, 2018 – pg. 2769 – Wanda Sanginesi
[42] Transcript Day 28, Vol. 28 – July 31, 2018 – pg. 6457 – Karen Simpson

(b) Given the intensity of the inspection, and what was going on, the Inspector was not surprised by the findings;[44]

(c) The inspection included a review of EW's employee discipline file which, for this Inspector, was completely outside of her normal practice;[45]

(d) The Director instructed the Inspector, when inspecting at CCW, to inspect the entire medication IP. It was acknowledged that lots of facilities were having the same challenges as identified at CCW;[46]

(e) The Police training regarding interview techniques was just one part of a two day workshop for long-term care inspectors which covered many things;[47]

(f) CCW staff were being interviewed about events which occurred up to nine years prior. It was acknowledged that it would certainly be difficult to remember events which happened that far in the past;[48]

(g) There was no advice provided to the Inspectors regarding how to handle interviews with persons who were themselves in the state of shock and disbelief, nor was there any advice given regarding how the memories or the judgment of those persons being interviewed might have been affected;[49]

(h) Interviewees were not given an opportunity to prepare in advance for interviews by reviewing relevant documents/records;[50]

(i) Although typed notes of the interviews were prepared, the interviewees were not given an opportunity to obtain a copy of the notes and then later check the notes (or audio tapes) for accuracy and completeness;[51]

(j) There was no interview template for the interviews conducted;[52]

(k) There was a lot of pressure on the Inspectors not to miss anything in gathering evidence;[53]

(l) A significant number of the findings made were classified as "WN" (written notification). The written notification is used when an Inspector finds minimal

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[43] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6829 – Rhonda Kukoly
[44] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6880 – Rhonda Kukoly
[45] Transcript Day 30, Vol. 30 – August 2, 2018 - pg. 6876 – Rhonda Kukoly
[46] Transcript Day 29, Vol. 29 – August 1, 2018 – pgs. 6717 – 6718 – Rhonda Kukoly
[47] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6919 – Rhonda Kukoly
[48] Transcript Day 30 Vol 30 – August 2, 2018 - pg. 6922-6923 – Rhonda Kukoly
[49] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6938-6939 – Rhonda Kukoly
[50] Transcript Day 30 Vol 30 – August 2, 2018 - pg. 6922-6923 – Rhonda Kukoly
[51] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6924-6925 – Rhonda Kukoly
[52] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6940– Rhonda Kukoly
[53] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6953– Rhonda Kukoly

risk, risk that was isolated, and where there wasn't a compliance history that would have impact;[54]

(m) Incidents which occurred at CCW after the police press release of October 5, 2016, up to the end of December, 2016 and which also formed the basis for findings of non-compliance were not viewed with any different or special considerations;[55]

(n) The Management Order made by the Director (Document ID 39100) was dated September 1, 2017. On August 24, 2017 CCW was given a compliance date of September 8, 2017 for achieving compliance with specific requirements. Despite the fact that there were no intervening incidents, crisis, or inspections between August 24th and September 1st, the Director's Order was made on September 1st, without acknowledging that CCW had been given until September 8th to demonstrate compliance;[56]

(o) The September 1st Order itself confirms that many issues had already been brought back into compliance;[57]

(p) It was acknowledged that the last RQI done at CCW in 2016, just before the EW confession became public, did not find significant ongoing problems. It was generally a positive inspection;[58]

(q) The home was in compliance by December, 2017.

42. Interviews are recorded and transcribed but without giving the Interviewee the opportunity to independently verify the completeness and accuracy of the answers provided, Why? Despite the fact that answers provided during an interview might well form the basis for findings of non-compliance and the imposition of penalties against a Licensee (and in relation to Section 24, criminal charges directly against staff), the Ministry takes the position that legal counsel are not allowed to be present during the interviews. It is submitted that this interpretation of the Legislation (specifically Section 147 – excluding counsel) is both intimidating, unnecessary, but more importantly, unlawful.

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[54] Transcript Day 28, Vol. 28 – July 31 – pg. 6455 – Karen Simpson
[55] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6954 – Rhonda Kukoly
[56] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 6959 – Rhonda Kukoly
[57] Document ID 39100
[58] Transcript Day 30, Vol. 30 – August 2, 2018 – pg. 7052 – Carol Hepting

43. In light of the obvious stress created by the media frenzy, the political attention, the general concern for the safety of long-term care residents in Ontario and for the integrity of the Ministry's inspection system, it is submitted that if a team of Inspectors spent the same amount of time in any Home put in a similar awful situation, there would be substantial findings of non-compliance. the data provided by the Ministry on compliance generally – in the absence of those stressors supports this statement.

Comments Regarding the Death of Maureen Pickering

44. It is submitted that the opinion of the local Coroners had a substantial impact on how CCW handled specific cases, specifically, the Maureen Pickering death.

45. It was Nurse Karen Rutledge who had an uneasy feeling about circumstances surrounding Mrs. Pickering's death. It was Nurse Rutledge who filled out the IPDR for Mrs. Pickering but she only did so after speaking to the local Coroner, Dr. George.[59] The fact that Dr. George had decided not to attend at the Home and not to pursue an investigation of Mrs. Pickering's death directly affected Nurse Rutledge's decision to click all of the "no" boxes on the IPDR. (The significance of this will be discussed below)

46. Had Dr. George said that he was interested in investigating this death, the IPDR form might well have been filled out differently.

47. When Coroners such as Dr. George advise nursing staff in long-term care homes that deaths such as the Picking death were not unexpected and do not warrant investigation, it is reasonable to expect that that will inform staff in how to assess and report on future deaths.

[59] Transcript Day 7 Vol 7 – June 13, 2018 - pg. 1386 – 1387 – Karen Routledge

48. Having said the above, it is dangerous to critique professional judgments based on hindsight. There is a reason why EW chose insulin as a weapon. According to Ms. Greenall, even a more robust audit process would not have caught the relatively small doses of insulin given by EW to Mrs. Pickering, and it certainly would have been difficult for an RN to see that those amounts were declining by 80 units and 60 units respectively.

Comments Regarding the Death of Christina Adriano

49. Considerable evidence was led regarding whether the death of Christina Adriano should have raised concerns. In this regard, it is submitted that the most informed evidence, at least from the perspective of CCW, came from Mrs. Adriano's personal physician, Dr. Reddick. He signed the resident's death form. He had no concerns regarding Ms. Adriano's death, including the low blood sugar. He also explained clearly that the use of the term "overdose" on her chart should not be interpreted to mean that a medication error occurred. That term was also used to describe when an administered dose, even the correct prescribed dose, induces a hypoglycemic incident because of other factors.[60]

50. Dr. Reddick was specifically asked, with the benefit of hindsight, knowing that EW was injecting Ms. Adriano with varying amounts of insulin over roughly a six month period between June and December of 2007, to comment on her medical chart. He had no specific concerns. He explained that difficulties regulating her blood sugar pre-dated EW's employment at CCW.[61]

51. The belief by Dr. Reddick, Ms. Adriano's personal physician, that she was not receiving more insulin than had been ordered for her and that he did <u>not</u> suspect a medication error is

[60] Transcript Day 13, Vol. 13– June 22, 2018 – pgs. 3134 – Dr. Richard Reddick
[61] Transcript Day 13, Vol. 13– June 22, 2018 – pgs. 3113 - 3116 – Dr. Richard Reddick
Transcript Day 13, Vol. 13 – June 22, 2018 – pgs. 3114 – Dr. Richard Reddick

significant since CCW's reporting obligation at the time would only have been triggered by a medication error which then required a hospitalization. It is submitted that the most qualified person to identify whether Mrs. Pickering had been intentionally injected with more insulin than had been ordered for her was her own personal physician.

III. ONTARIO COLLEGE OF NURSES

52. CCW's termination report form was submitted on or about April 17, 2014.[62] At least ten separate incidents justifying intervention were described in addition to the culminating error of March, 2014.

53. The first response received by CCW to the termination report was a letter dated July 17, 2014 which indicated that CCW could not and would not be informed of the results of any investigation.[63]

54. The following is a summary of the most relevant evidence presented during the College phase of the Inquiry as it relates to considerations for potential improvements in the areas of recruitment, the reporting and investigation of terminations, and education in relation to areas of need in long-term care:

(a) The Find a Nurse website does not provide information regarding current or prior employers or whether the Member is currently the subject matter of an investigation;

(b) A medication error is viewed as a contravention of a standard and therefore an act of professional misconduct. Having said this, the College view (shared by many others who have considered this issue) is that is not appropriate to use the most forceful regulatory power for every situation.[64] Instead, there needs to be a focus on promoting a culture of safety;

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[62] Document ID 16716/16717
[63] Document ID 16715
[64] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5621-5622 – Anne Coghlan; Document ID. 55063

(c) There is a heavy reliance on the self-reporting of medication errors, in particular, on the night shift when errors are not readily observed by others;[65]

(d) Only in the case of a termination does the governing statute require an employer to report concerns about incompetence in capacity;

(e) RNs are not obliged to self-report health conditions unless asked. It is considered an ethical obligation only;

(f) Up until the termination of EW, CCW had only filed two (perhaps three) termination reports with the College. This lack of experience with the process on the part of CCW would not have been apparent to Ms. Yee, the Investigator;[66]

(g) When a member completes the annual payment form as did EW for example in 2002 (Document ID 36305), and that document contained a lie in terms on how a question is answered, that is considered an administrative form and is not cross-referenced or assessable to an investigator such as Ms. Yee who was responsible for reviewing EW's termination report; [67]

(h) The governing Legislation in Section 2.1 obligates the OCN to assist the Minister as a matter of public interest with advancing the nursing profession. The College views this obligation as being fulfilled through by data collection. There is opportunity here for greater involvement;[68]

(i) The College's Reporting Guide for Employees (Document ID 55074) instructs an employer to include the "reason" for termination. There is no instruction asking an employer to include additional or supporting documentation;[69]

(j) The actual template Report Form (Document ID 36041) also says nothing about attaching additional documentation, it simply asks the employer to describe the termination "event";

(k) The Report Form requires the employer to indicate in a box what the Member response was to an allegation but there is no obvious place for the employer to further comment on the Form whether the Member's response is viewed as sincere or plausible;[70]

(l) The cover letter received by the College from CCW (Document ID 36848) specifically indicated that EW was fired for a medication incident which occurred on March 20, 2014 and which put a resident at risk;[71]

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[65] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5621 – Anne Coghlan
[66] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5982-5983 – Karen Yee
[67] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5635 - 5636 – Anne Coghlan
[68] Legislation Brief Pg. 1874
[69] Transcript Day 25, Vol. 25 – July 26, 2018 pg. 5643 – Anne Coghlan
[70] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5991-5992 – Karen Yee
[71] Transcript Day 25, Vol. 25 – July 26, 2018 pg. 5647 – Anne Coghlan

(m) The initial triage of the level of risk associated with the termination report was made without contacting CCW;

(n) The risk analysis was also made without an understanding of the nature of some of the specific drugs referred to in the termination report, including the unique characteristics behind the specific insulin mistake which led to EWs termination;[72]

(o) The process used for reviewing a termination report is less formal and in contrast with a Section 75 Investigation;[73]

(p) It is not a general practice to contact or interview a Member as part of an investigation when that Member has been terminated;

(q) The medication errors described in the EW termination form were assessed as relatively low risk, consistent with a nurse with substandard practice at the low end of an observed range;[74]

(r) Intentional harm was not considered as a possibility because intentional harm was not raised as a possibility in the Report Form or in the follow up conversation with Helen Crombez;[75]

(s) Ms. Yee had no specific training regarding considering the possibility of intentional wrongdoing for the purpose of reviewing incidents;[76]

(t) The final typed memo prepared by Ms. Yee for review by the Executive Director omitted any reference to EW having been an alcoholic, although this information was in the College's record. This fact was not deemed to be significant given the passage of time;[77]

(u) The contact person for the employer named in the termination report is not advised in advance what the purpose of the call is from the College or what they should review prior to a telephone interview;[78]

(v) The College Form used to create a record of the conversation with Helen Crombez (Document IDs 36833 and 36847) expressly qualifies the contents by indicating that the contents have not yet been approved by the interviewee. It states:[79]

> "The following is a summary of the Investigator's conversation with the contact. It is not a statement of the

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[72] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5651 – Anne Coghlan
[73] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5621-5622 – Anne Coghlan
[74] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5667 – Anne Coghlan
[75] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5906 – Karen Yee
[76] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5928-5928 – Karen Yee
[77] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5633 – Anne Coghlan
[78] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5985-5987 – Karen Yee
[79] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5681 – Anne Coghlan

contact and has not been reviewed or approved as accurate by the contact".

(w) It was suggested that adding a verification step with the contact would slow down the process and interfere with the College's ability to deal quickly with more urgent high-risk matters;[80]

(x) The typed version (Document ID: 36847) of the summary omitted a reference included in the handwritten notes (Document ID: 36845) made of the call with Mrs. Crombez indicating that EW had refused education;[81]

(y) The call with Helen Crombez occurred on July 30, 2014. The Executive Director signed off on the recommended penalty of bank with notice on October 14, 2014. EW was advised that "an investigation was not warranted";

(z) An assumption was made that EW would comply with the Instruction Letter sent from the College dated October 14, 2014 and review applicable standards of practice;

(aa) There was no request made of CCW for a review medical or resident records or nurses notes;[82]

(bb) The employer is not told that the phone call could be the only basis upon which the Executive Director makes a decision;

(cc) There is no specific training for persons assessing Termination Reports regarding unique features of the long-term care setting nor is there any specific training that guides the Investigator in assessing risk differently in the long-term care setting given the profile of the long-term care resident population;[83]

(dd) The employer is not asked whether the RN has grieved the termination or what the status of that grievance is;

(ee) In terms of how health conditions might impact on an RN's ability to practice, it was acknowledged that many nurses have physical or mental health conditions, including bipolar disorder, which are appropriately managed and therefore not a concern to the College;[84]

(ff) In 2014, when the Termination Report was received, the College was dealing with a backlog of investigations and delays were identified as needing attention.[85]

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[80] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5682 – Anne Coghlan
[81] Transcript Day 25, Vol. 25 – July 26, 2018 - pg. 5685 – Anne Coghlan;
[82] Transcript Day 12, Vol. 12 – June 21, 2018 – pg. 2822 – Wanda Sangenisi
[83] Transcript Day 26, Vol. 26 – July 27, 2018 - pg. 5978-5979 - Karen Yee
[84] Transcript Day 25 Vol. 25 – July 26, 2018 – pg. 5680 – Anne Coghlan
[85] Transcript Day 25 Vol. 25 – July 26, 2018 – pg. 5626 – Anne Coghlan

Observations

55. Of all the parties who interacted with EW, it was the College which had the most complete information regarding her work history. The current legislative framework and the current practice prevents the College from being used as a resource by prospective employers in relation to post employment history, but the question needs to be asked to the extent that the College does have relevant information regarding a nurses fitness for a particular job and a employment history, for example, EW's history at the Geraldton Hospital. Should that kind of information be made available to employers, and if so, how should it be made available and how might it be used?

56. The assessment of risk which was performed internally by the College on receipt of the EW termination report, (ie. prior to the July 30th phone call with Helen Crombez), was made without applying the approach to analysing mediation errors suggested by Ms. Greenall in the "Just Culture Guide". That approach starts with an analysis of a medication administration incident by asking whether there was any intent to cause harm and whether there are any indications of substance abuse or physical or mental ill health.

57. The approaches reviewed by Ms. Greenall are thoughtful and would add rigour to the analysis. It is not suggested that applying a more rigorous risk assessment would have uncovered criminal intent in 2014, but as was noted, there are other benefits to applying a more rigorous process which then leads to a more transparent result and potentially, improvements in relation to unintended medication errors and other areas of poor performance.

58. Carol Hepting, who was CCW's Vice-President of Operations at the material time was cross-examined aggressively on why, on October 14, 2016, she sent an additional report to the

College identifying EW as unfit for practice. Clearly, this letter was sent at a time when the parties were in turmoil as a result of EW's confessions. Ms. Hepting had a direct conversation with a College representative who acknowledged that CCW was merely attempting to bring the situation to the attention of the College in light of the new allegations received (specifically, that EW had confessed to horrendous crimes).[86] Until October 14, 2016, EW's status on the College's Find a Nurse site still indicated that she was entitled to practice in Ontario.[87]

59. Despite the suggestion during the hearings that Ms. Hepting had an improper motive for sending in the 2016 letter, at no time following the College's receipt of that letter right through to the commencement of the Inquiry hearings in June, 2018, did the College suggest that the letter was improper, unprofessional, or sent in bad faith.[88] Ms. Hepting is a long-standing member of the College and one can only assume that if she was suspected by the College of improper or unprofessional conduct, it would have contacted her or taken some action.

IV. THE STATUTORY SCHEME (THE LONG-TERM CARE HOMES ACT) – COMMENTS AND OBSERVATIONS

60. It is submitted that the current *Long Term Care Homes Act* contains a major imbalance in terms of the requirements and accountability imposed on licensees, directors of licensee corporations, and all staff, in contrast with the obligation on the Provincial Government to appropriately fund the long-term care program.

61. Beyond the need to address this accountability imbalance in terms of funding, it is submitted that the evidence supports the need for significant clarification in the area of mandatory reporting.

[86] Transcript Day 16, Vol 16 – June 28, 2018 - pg. 3824 – Carol Hepting
[87] Transcript Day 16, Vol 16 – June 28, 2018 - pg. 3690 – Carol Hepting
[88] Transcript Day 16, Vol 16 – June 28, 2018 - pg. 3824 – Carol Hepting

62. The issue of mandatory reporting and the importance of reporting generally was clearly identified during the hearing as an area of concern. The reporting obligation in Section 24 of the *Act* states that:

> "… a person who has reasonable grounds to suspect there has been improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident or unlawful conduct that resulted in harm or risk of harm to a resident shall immediately report the suspicion and the information upon which it is based to the Director." (emphasis mine)

63. It is submitted that in accordance with Section 24, the reporting obligation is only triggered when a person has reasonable grounds to suspect that improper or incompetent treatment or care, abuse, etc., has occurred.

64. The term "reasonable grounds" has not been defined nor has it been explained despite the fact that the Director sent out a detailed memo to the sector on February 12, 2015 reminding Licensees of the obligations to report to the Director.[89] To make matters more difficult in terms of understanding and applying Section 24, the terms "improper or incompetent treatment or care" are also not defined.

65. Even persons with substantial professional expertise and interactions with Long-term care homes, including managers, physicians, Coroners, the College representative did not have a consistent understanding of the reporting obligations.

66. The lack of clear definitions in this area was acknowledged by one of the Ministry's most senior witness, Karen Fairchild, who was the business lead for the compliance

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[89] Transcript pg. 6447-6448 – Karen Simpson; Transcript pg. 6636 – Rhonda Kukoly; Document ID 55639 dated February 12, 2015

transformation project intended to transform the Ministry's compliance and enforcement regime to align with the new *Long-Term Care Homes Act*.

67. According to Ms. Fairchild, the original intent for Section 24 was that as long as there was one report coming from a Home, that would be sufficient. The obvious entity to send the report would be the Licensee. We were told that it was not intended that there would be multiple reports from multiple persons who may have reasonable grounds for notifying the Director. This evidence came directly from a person who was designing the reporting system. In practice, despite the words used in Section 24, we were told that the Ministry does typically accept only one report from the Licensee.[90]

68. This interpretation of the reporting obligation, despite the actual words used in Section 24, seems to have been supported by the fact that the Reporting Tree which was referred to repeatedly in evidence, is specifically directed at the "Licensee".

69. It is submitted that until there is meaningful guidance provided in relation to the definition of "reasonable grounds" and "improper or incompetent treatment or care", it is incumbent upon Inspectors to respect the professional judgment of RNs, RPNs and other regulated health professionals who are trained to make judgment calls, assess risk, and who have personal experience dealing with long-term care residents.[91] In fact, that's why registered staff are hired – because of their clinical/professional judgment.

70. It is submitted that this issue has become even more challenging in the face of the Ministry's decision to move away from compliance advice to a pure inspection model.

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[90] Transcript Day 32, Vol 32 – August 7, 2018 – pgs. 7485 – 7488 – Karin Fairchild
[91] Transcript Day 29, Vol 29 – August 1, 2018 – pg. 6636 – Rhonda Kukoly

71. Ms. Fairchild explained that if a long-term care administrator were to call and ask for a clarification as to whether in accordance with Section 24, reasonable grounds exist for making a report in a particular circumstance, all she can do is walk the Administrator through the words in the legislation and turn the question back to the administrator by asking "what do you think"?[92]

72. CCW was repeatedly criticized for not complying with reporting obligations which, it is submitted, are not well understood across the sector. Not surprisingly, non-compliance with reporting obligations has become one of the top ten areas of non-compliance as set out in the Ministry data regarding the most common findings/orders in long-term care.[93]

73. It is submitted that this is an area which requires greater clarity and immediate attention.

74. One also needs to ask is there a point at which more and more regulations – intended to protect residents – starts to have the opposite effect. A Ministry inspector was asked "so you are in the middle of an inspection and an issue arises that doesn't fall neatly into one of those legislative requirements or regulatory requirement, what do you do?" The answer was: "I'm having a hard time thinking of something that wouldn't fall neatly into an area of legislation".[94] It was suggested in cross-examination that if you try to create a regulation for everything, in fact, the health care professional's ability to exercise their own professional judgment is hindered. The Inspector agreed that this is a broader question for the Commission but wasn't able to express an opinion because this is the system within which she currently works.[95]

75. It is submitted that the stress felt by RNs when they are being observed/inspected within the context of an over-regulated system is unnecessary and distracts from the task at hand. An

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[92] Transcript Day 32, Vol 32 – August 7, 2018 – pg. 7493 – Karen Fairchild
[93] Document ID 72894 – Exhibit 131 – Slide 75
[94] Transcript Day 29, Vol 29 – August 1, 2018 – pg. 6652 – Rhonda Kukoly
[95] Transcript Day 30, Vol 30 – August 2, 2018 – pg. 6961 – Rhonda Kukoly

Inspector gave evidence that when observing a medication pass, she is looking for "ten rights".[96] Various professionals gave evidence over the course of the proceedings regarding the "rights" associated with administering medication, right resident, right dosage, right time…Are there five "rights", six rights, ten rights? Is that how nurses want to be judged? Is this the environment which is going to attract the next generation of nurses into the sector?

V. THE ROLE OF THE OFFICE OF THE CORONER

76. The evidence confirmed the importance of the role of Coroner's office, both locally and centrally in terms of the oversight of death review in the long-term care system and the capacity to provide insights not generally available from within the long-term care system. There was a consensus that going forward, improvements can and should be made. The involvement of the Coroner's system, at the material times, failed to assist in identifying or preventing EW's crimes.

77. In accordance with Section 10(2.1) of the *Coroner's Act*, long-term care facilities are required to notify a Coroner of the death. The onus then shifts to the Coroner to decide whether the death ought to be investigated.

78. Deaths are reported by long-term care facilities using IPDRs, forms which require the ticking of various boxes to answer a standardized list of questions. Unbeknownst to the Long-term care Homes, if all the boxes are ticked "no", then the Coroner's investigation process comes to an end. Again, unbeknownst to the Long-term care Homes, the effect of processing the IPDRs in such a formulaic fashion essentially shifted the gated-keeper function from the Coroner's office to the persons within the long-term care homes filling out the forms. What the evidence demonstrated is that the Coroner's office has provided little or no guidance to the sector for filling out the forms nor has there been specific training in this regard.

[96] Transcript Day 29, Vol. 29 – August 1, 2018 – pg. 6708 – Rhonda Kukoly

79. What also became clear is that there is no agreement or general understanding of what is a "sudden and unexpected" death is in the long-term care context. The Chief Coroner acknowledged that even for Coroners, this is a challenging question to answer and was the subject of conflicting opinions.[97] Admittedly, this issue needs review as it drives the threshold analysis of whether a death or investigation is in order, beyond a formulaic review of the boxes on the IPDR form.

80. It appears form the evidence that seven of the eight murder victims had IPDRs filed (one form was identified as faxed but was not located). The exception was Mr. Horvath. Since he died in hospital, no IPDR was sent (which in and of itself raises an issue for review).

81. Three of the deaths precipitated by EW actually had direct Coroner involvement, specifically, Mr. Silcox, Mr. Hedges and indirectly, Mrs. Pickering. The deaths of Mr. Silcox and Mr. Hedges were investigated at the time, but there were no findings made suggesting intentional harm. In the case of Mrs. Pickering, although there was some involvement from a local Coroner (Dr. George) there was no death investigation.

82. The death of Mrs. Pickering was discussed above. With respect to the Coroner's investigations conducted of the other two deaths, despite the investigations, nothing suspicious was uncovered at the time, and at no subsequent time was CCW ever advised that incorrect or misleading information had been provided to the Coroner's office in an IPDR or in the death registry.

83. One of the issues left for consideration was whether or not the previous policy of investigating "threshold" deaths – every tenth death in a long-term care home was an effective

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[97] Affidavit of Dr. Dirk Huyer – para 118

process. Suffice it to say that opinions seem mixed on this issue with Dr. Huyer characterizing the threshold process as "ineffective".[98] It is submitted that a thoughtful review is needed which would assess whether the benefits of threshold reviews (with or without modifications), justifies the time and associated expense.

84. Last, there was evidence regarding death registries maintained at the long-term care home. These are individual forms prepared by the Homes. Although not directly canvassed, there might well be opportunities for streamlining the death registry process by, for example, making it electronic, potentially adding more information, and thereby allowing the Coroner's office to access it remotely as an alternative to routine threshold investigations.

VI. COMMENTS REGARDING THE EXPERT EVIDENCE

85. Three experts were called at the conclusion of the hearings to address different issues. We heard from Dr. Beatrice Yorker (qualified as an expert in the study of serial killers), Ms. Julie Greenall (qualified as an expert in long-term care pharmacy), and Dr. Michael Hillmer (a clinical epidemiologist with substantial experience in health care data and analytics).

86. I make the following comments/observations regarding their evidence:

Dr. Michael Hillmer

87. In response to the EW confession, the Ministry's Information Management Data and Analytics department was asked to consider whether EW's offences could have been detected and what, if anything, could be done in the future to detect such crimes earlier. Despite the considerable efforts of Dr. Hillmer and his team, he concluded that the model they developed would have been incapable of <u>contemporaneously</u> or <u>retrospectively</u> detecting EW's offences. In

[98] Affidavit of Dr. Dirk Huyer – para. 134

addition, while the model did provide a list of Homes where "observed" deaths were higher than "expected" deaths, CCW was not on that list.

88. Of equal significance was the fact that a Home's ratio of observed deaths versus expected deaths cannot be used in any way to make conclusions about the quality of care delivered in those Homes. Even using Dr. Hillmer's sophisticated modelling, it was simply not possible to determine the cause of the higher numbers of observed deaths.[99]

89. There were also a number of factors which might be used to distinguish homes (and residents) one from another which were not included in the analysis.[100]

90. At the end of the day, Dr. Hillmer was candid in admitting that to understand anything meaningfully about expected deaths vs. observed deaths, you would need to go out and do a lot more investigation to find out why. Perhaps the failure of the tool (albeit at a preliminary stage of development) to assist in detecting EW's crimes explains why no other jurisdictions have created or relied on such a tool. It is submitted that given the conclusion that EW's crimes could not have been detected and would not be detected in future, one must question whether investing further in developing this model is an appropriate use of public resources in a system that itself is under resourced.

Dr. Beatrice Yorker

91. The Commission's mandate includes an investigation of the "contributing factors" which allowed the EW offences to be committed and relevant policies, procedures and accountabilities/oversight mechanisms. Considerable evidence was led regarding the issue of

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[99] Transcript Day 37, Vol. 37 – September 14, 2018 – pgs. 8496, 8498 – Dr. Michael Hillmer; Affidavit of Dr. Michael Hillmer - para. 62

[100] Transcript Day 37, Vol. 37 – September 14, 2018 – pg. 8500 – 8503 – Dr. Michael Hillmer

mandatory reporting of abuse and neglect, the extent to which reporting obligations are not understood, the extent to which poor RN performance (including reckless or abusive behaviour) could or should be more closely monitored, the impact of arguably inadequate staffing levels at different times in long-term care and details regarding medication practice, including the video surveillance of medication rooms.

92. Dr. Yorker was qualified as one of the world's experts in studying serial killers. She has particular expertise in bringing a forensic approach to investigations and has consulted on many of the most egregious cases involving health care serial killers.

93. It is submitted that Dr. Yorker's evidence was particularly significant in addressing many of the suspected "contributing factors" which received considerable focus in the evidence.

94. The following is a summary of her opinions/conclusions that are particularly relevant in assisting with an understanding of the "contributing factors". Her opinions might well help guide where resources should (or shouldn't) be invested in an effort to avoid similar tragedies in the future:

(a) There has been no correlation found between health care environments with enhanced requirements for reporting on abuse and neglect and deterring serial killers;[101]

(b) There is no direct correlation at all between staffing levels in health care institutions and reducing intentional harm to patients;[102]

(c) One cannot conclude that a health care worker who demonstrates reckless or abusive behaviour is more likely to be a serial killer. The serial killer could just as easily be described as a very good nurse. Even if we further invest in preventing reckless or abusive behaviour, Dr. Yorker could not agree that we might also be deterring a health care serial killer;[103]

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[101] Transcript Day 35, Vol. 35 – September 12, 2018 – pg. 169 – Dr. Beatrice Yorker
[102] Transcript Day 35, Vol. 35 – September 12, 2018 – pg. 80 – Dr. Beatrice Yorker
[103] Transcript Day 35, Vol. 35 – September 12, 2018 – pg. 172 - 173 – Dr. Beatrice Yorker

(d) There is no data to suggest that video surveillance of medication rooms would actually assist;[104]

(e) In terms of training student nurses for red flags with a view to potentially identifying health care serial killers, Dr. Yorker suggested that it would be more valuable to equip young nurses with information regarding "what a psychopath looks like" – whether it's a co-worker or whether it's somebody you are dating;[105]

(f) More comprehensive annual inspections would not have contributed to detecting EW's crimes. This opinion was given in response to a suggestion that the Ministry was not consistently conducting RQIs during EW's period of employment at CCW. According to Dr. Yorker, massive compliance units do not seem to deter serial killers.

95. It is submitted that based on Dr. Yorker's expert opinions, while investing in the areas identified above <u>might</u> improve the long-term care system and the lives of Ontario's long-term care residents, it would not materially assist in protecting residents from intentional harm.

Ms. Julie Greenall

96. Ms. Greenall provided thoughtful evidence regarding the benefits of promoting a positive safety culture, a concept which is described in her affidavit and the attached materials. She brought to the Inquiry a perspective of considerable expertise in understanding and reviewing medication systems in long-term care and a root cause analysis of medication incidents. Having said this, again, the primary benefits of pursuing her suggestions would appear to be an attempt to reduce medication errors and improve efficiency in the system.

97. Identifying intentional behaviour is extremely difficult. The Just Culture Guide attached as Appendix 6 to Ms. Greenall's report suggests that it may be useful if the investigation of an incident begins to suggest a concern about an individual action. The first question is characterized as a "deliberate harm test". The question to be asked is "was there any intention to

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[104] Transcript Day 35, Vol. 35 – September 12, 2018 – pg. 85 – Dr. Beatrice Yorker

[105] Transcript Day 35, Vol. 35 – September 12, 2018 – pg. 205 – Dr. Beatrice Yorker

cause harm?". Having said this, there was very little guidance provided regarding how to answer the intentional harm question.

98. Notwithstanding the limitations, promoting a culture of reporting does make sense. When mistakes happen, the appropriate approach should be to understand how and why the mistake happened so that we can reduce the likelihood of future errors. Ms. Greenall was clear that reports regarding errors should be tracked for the purpose of informing the system, not for the purpose of accumulating demerit points against practitioners. The challenge is in how to rationalize this approach with a regulatory environment which deems every medication error to be a breach of a professional standard (for an RN), and an area of non-compliance for a Long-term care Home Licensee.

VII. SUMMARY OF ISSUES FOR REVIEW/CONSIDERATION/ MOVING FORWARD

Make Nursing in the Long-Term Care Sector a Desirable Career Destination

99. It is submitted that all of the parties to the Inquiry will agree that an important goal is to make the long-term care sector a more desirable career destination for health care workers, in particular, for nurses. The current regulatory requirements and environment force homes to keep staff who are otherwise ill-suited for long-term care or are not performing at the highest levels expected. It is submitted that an important role for the Commission will be to craft recommendations which will address this issue. The following are some suggestions:

100. Adequately fund long-term care so that the ratio of RNs to residents is reduced. For nurses in long-term care, the current 32:1 is inadequate to achieve excellence in outcomes and facilitate job satisfaction. A nurse cannot consistently provide quality nursing care to this many residents, supervise the staff , field phone calls from families and respond to emergencies all

during the same shift   Errors are inevitable in this environment. Nurse shortages and regulated requirements also inevitably lead to reliance on double shifts and agency staff. This can be problematic.

101. Fund the long-term care system so that most positions are full-time. An over reliance on part-time employment drives absenteeism, exacerbates staffing problems and makes the sector even less appealing as a serious career choice. The cost of group benefits is also a factor.

102. Consider providing disability coverage through an industry-wide plan. The absence of disability coverage in a physically demanding occupation provides a further disincentive for nurses to work in long-term care. The cost of group benefits is also a factor.

103. Facilitate pension portability from the hospital sector to the long-term care sector and amongst the numerous pension plans within the long-term care sector.

104. Provide supervisory skills training to student nurses as part of their curriculum in RN and RPN programs, with input from the sector as to the nature and challenges of supervision in long-term care homes. New grads are often stepping into charge nurse roles with limited knowledge or skills in relation to supervising people.

105. Create partnerships with post-secondary institutions to develop and provide a standardized management development program for RNs who want to advance into long-term care management roles. There is no need for leadership education to be handled individually within each organization. A recognized generic program could provide a base-line.

106. Include formal education about interpersonal skills and emotional intelligence in PSW programs.

107. Explore existing and emerging technologies with a view to engineering out the more routine and physically demanding tasks currently performed by RNs. Examples include automated medication management systems, robotic lifting devices, and new insulin delivery systems.

108. Review the practice of placing residents into the same facility without regard for their unique care needs or identified behavioral issues. Consideration should be given to funding and staffing facilities or specialized units within facilities for residents with more complex needs (including those with potentially violent behaviors). Enhanced education for staff who work in these environments would also need to be funded.

109. Consideration should be given to developing a province-wide program for directors of care and administrators given the challenges faced by these positions.

Recruitment and Hiring of Nurses

110. Under the current system, applicants are free to omit previous positions from their resumes. Gaps in career histories can be easily explained away (childcare, travel, illness, etc.) and, where this happens, a prospective employer has no way of knowing where the applicant may have worked, why she left, or any issues that she experienced while employed there (much like EW's brief but eventful period at Geraldton Hospital).

111. When considering RNs' applications for employment, employers should have access to a complete employment history. This information helps the prospective employer to understand the nature and breadth of the applicant's experience which, in turn, can predict success in the position for which they've applied, and can identify any anomalies that may warrant exploring during an interview.

112. Consider making available, through the CNO, an RN's complete employment history, showing each employer, job title and employment dates. The CNO already has this information – it is the only organization that does. This would provide a much more consistent, efficient and reliable way for employers in the health care sector to obtain this information and would discourage the practice of hiding relevant job history or, where an applicant does so, allow prospective employers to identify past employers for follow up who have been omitted.

113. All registrants could also have an up-to-date criminal background check and credentialing information listed on the Find a Nurse site so that prospective employers also have easy access to that information when recruiting. Find a Nurse is not currently a reference tool but this merits review.

114. If there is a current (unresolved) College investigation of a registrant trigged by a termination or facility report, a flag of some kind could be raised.

115. As a baseline, provide consistent instruction to long-term care staff who are responsible for hiring about appropriate selection methods with an emphasis on application screening, effective interviewing, and reference checking. This should include alerting hiring managers to the limitations of these methods.

116. Develop a standard reference check form containing information that hiring employers can/should request and that RNs' previous employers should be required to provide. As has been tried in at least two U.S. jurisdictions, consider indemnifying employers from legal challenges where negative information is provided. This could help end job applicants' practice of only providing select referees who will say good things about them, will address employers'

reticence about providing complete yet negative information, and help end the practice and the potential impact of negotiating reference language in grievance settlements.

117. Develop a standard RN orientation, on-boarding, and probationary evaluation process for the long-term care sector.

Addressing Work Performance Issues Discipline

118. The progressive discipline system is not an effective tool for addressing and remedying work performance, behavioural or attendance issues, where the underlying causes of the problems are connected to skill deficits, abilities, cognition, general suitability for the position/occupation, or to the employee's health (including mental health issues or addictions). We need a better approach.

119. Changes should be focused on approaches where attempts to remedy performance issues (as had been identified with EW) are not met with resistance by the employee or their union because of the consequences of the progressive discipline model. There is a normal human reaction to punitive, or potentially punitive, measures. This becomes built into the system. The employee's resistance is usually supported by the union and, where health issues are present, by outside health care providers. The goal needs to be a thoughtful exploration of the causes of the problems and of strategies, methods, tools or supports that may assist the RN in overcoming her challenges. Once disciplinary action is imposed and grievances are filed, the parties become entrenched in their positions and positive outcomes become unlikely.

120. Prior to the initiation of disciplinary action and the grievance procedure, a holistic approach to remediation could be undertaken involving all of the parties who have a role to play in the RN's success: the RN, the employer, the union, the RN's own healthcare provider(s) and

if advisable, the CNO. The parties would share information in a solutions-oriented (without prejudice?) manner intended to provide the RN with meaningful guidance as to how she can overcome whatever is getting in the way of her success.

121. This approach would align well with the concept and benefit of the "Just Culture". Wherc remediation is unsuccessful, the CNO could be involved in making a determination as to the RN's fitness to practice and an assessment of whether imposing restrictions until issues are remedied is necessary.

122. The current grievance/arbitration process is lengthy and expensive. It does not provide the RN with any guidance for improving her practice or overcoming work performance problems. The same can be said of proceedings before the Human Rights Tribunal, where RNs' workplace performance issues sometimes play out.

123. The interests of residents and their families are also not taken into account in any meaningful way in the current grievance/arbitration process. Where the reason for disciplinary action involved harm to a resident, it is generally not feasible for the resident to testify, often leaving the employer unable to produce conclusive evidence of misconduct. This is one of the leading causes of grievance settlements.

124. From the union's perspective, considerations about the length and cost of the proceedings may also be motiving factors. In addition, we heard evidence from EW's union that a failure to aggressively advance an RN's grievance may leave the union open to duty of fair representation complaints, providing a further motivation for aggressive negotiation and deal-making. Again, while compromise-based negotiated settlements in the unionized environment (whether in the collective bargaining or grievance process) have a place, negotiated settlements

do <u>not</u> contribute to remedying work performance issues. Following the grievance/arbitration process, RN's will typically continue to practice elsewhere with the underlying causes of their problems unresolved (as was the case with EW).

Funding

125. From the evidence presented by the Ministry, we know that the allocation of funds to specific homes for the Nursing and Personal Care Envelope, and therefore for staffing for residents in the homes, is made from a fixed sum which is established globally by the Provincial Government. It currently sits provincially at $100.91 per resident per day.[106] Increases in resident acuity and CMI indexes in individual homes will only impact <u>how</u> the total pie is split, but will <u>not</u> increase the total sum available for allocation to homes in Ontario.

126. To the best of our knowledge, there has never been an attempt made to audit resident care plans, either as a pilot project or otherwise, so that the true cost of providing the care as assessed for specific residents is actually calculated.[107] As residents' care needs increase, as they have been doing, long-term care licensees are obligated as a matter of law to meet those needs but the Province is not obliged to actually calculate what those costs are and then fund accordingly to meet resident, family and public expectations.[108]

127. For example if a resident's condition deteriorates such that they need five hours of direct nursing care per day, that care is expected to be provided.[109] In a system of true accountability, not only should the care providers be accountable for meeting the changing needs of the residents, but the Province should be accountable for providing sufficient funds to actually

[106] Side 13 – Affidavit of Karen Simpson
[107] Transcript Day 28, Vol. 28 – July 31, 2018 - pg. 6436-6437 – Karen Simpson
[108] Transcript Day 28, Vol. 28 – July 31, 2018 - pg. 6439 – Karen Simpson
[109] Transcript Day 28, Vol. 28 – July 31, 2018 - pg. 6442 – Karen Simpson

deliver the care needed, not just to meet the many standards for which long-term care homes are inspected.

128. Ultimately, this is a political choice. If we are serious about providing high quality care to an increasingly frail and vulnerable resident population, then serious work needs to be done ensuring that appropriate funds are available for the system. Anecdotal evidence that many or most Homes are meeting regulatory standards, is entirely insufficient.

129. Specific consideration could be given to directing additional RN funding to the evening and night-shifts to increase coverage and the supervisory capacity for staff on those shifts.

130. Additional funding should also be considered for specific educator/quality improvement roles for long-term care homes with over a certain number of beds. Although lip service has been paid to the importance of education and quality improvement activities, additional resources could ensure that all staff across Ontario receive appropriate ongoing education and that they are involved in problem-solving and quality improvement activities which could be directly linked to the mandate of Health Quality Ontario initiatives.

131. One issue could be the extent to which resident abuse/neglect issues or medication error incidents should be reported in a specific way to the CNO when those incidents reach a particular threshold. In appropriate cases, the CNO could trigger clinical competency testing or an independent monitoring visit. The intent here is to create a positive coaching and supportive model which would work in partnership between employers, employees and the College.

Medication Management

132. There appears to be significant opportunities for strengthening the partnership between long-term care operators and pharmacies. Pharmacists certainly have a skill-set which RNs don't

have and which can be capitalized on. Some of the models were specifically addressed in evidence included increased pharmacist availability (up to 24/7) and the use of pharmacy technicians in the area of medication reconciliation when residents are admitted or when new orders are received. This could be made mandatory for all pharmacy providers to long-term care.

133. Pharmacists, including pharmacy technicians may also be able to play a greater role in detecting medication diversion by having direct and immediate input, for example, in incident analysis. They could also assist long-term care homes implementing new technology. This should include a significant commitment to fund appropriate education along the lines recommended by Julie Greenall in how to use the suggested incident analysis framework and decision tree.

The Inspection System for Long-Term Care

134. It is submitted that we also need to take a serious look at the extent to which the regulatory environment in long-term care, and in particular, the inspection process which viewed as punitive and therefore pushes people away from the sector. It is submitted that the distinction made between penalizing licensees as opposed to individual long-term care staff for findings of non-compliance is a distinction without a difference. Long-term care staff are rarely personally charged with offences (nor should they be) but, by way of example, CCW staff were deeply affected by the shaming of the Home when CCW fell under the microscope. They identified with working at a "good home" and are invested, as they should be, in the reputation of the entire organization for providing a safe, caring, professional and homelike environment for residents.

135. It is also suggested that the Ministry re-visit the decision to restrict the ability of its inspectors to provide compliance advice. The current inspection program identifies areas of non-compliance and empowers Inspectors to inspect for compliance but offers no guidance for improvement. It is essentially left up to the licensees to figure it out. If there are already successful programs or approaches in place in other facilities which are improving compliance, there is no reason why the Ministry cannot be more proactive in supporting the understanding, introduction and implementation of those programs across the Province. Opportunities for learning are being lost. There is substantial room for improvement.

136. Last, in broader terms, it is submitted that we investigate to what extent the Annual Resident Quality Inspection (RQI) is in fact a misnomer, in other words, is there really compelling evidence to suggest that this inspection program has improved quality and resident satisfaction, not just regulatory compliance?

137. Consideration could be given to focussing more on inspecting critical incidents (properly defined and screened) and complaints and then utilizing more of the Ministry's scarce resources on meaningful education to address key and recurring areas of non-compliance. By way of example, enormous attention was paid to the fact that there appears to be a lack of understanding regarding mandatory reporting. In response, there was a memo released to the sector in 2015 regarding mandatory reporting, but significantly, there was nothing descriptive in the memo regarding the condition precedent for reporting, namely a determination by the reporter that there are "reasonable grounds" to make a report.[110] Again, there are obvious areas for improvement.

[110] Transcript pg. 6447-6448 – Karen Simpson; Transcript pg. 6636 – Rhonda Kukoly; Document ID 55639 dated February 12, 2015

VIII. CONCLUDING COMMENTS

138. At the opening of the Inquiry, it was submitted on behalf of CCW that from the moment news broke that EW might have committed serious crimes, it has fully cooperated with every investigation undertaken. It will continue to do so.

139. CCW's staff were deeply traumatized by these events. EW's actions were a horrendous breach of trust not only in relation to the victims, residents, families and the long-term care system, but also in relation to the trust that exists (and which must exist) amongst team members in a long-term care home like CCW. Trust is an essential element for meeting the collective goal of providing, as best they can, for the safety, security, and satisfaction of residents in long-term care homes.

140. It is submitted that no long-term care home in the history of Ontario has ever endured such a trauma and such an intense microscopic review of its practices and its personnel. Despite the scrutiny, it is submitted that the fairest conclusion to be drawn from of all of the evidence is that CCW was and remains a decent home, which provides good care to its residents by a caring and committed compliment of staff. There was no obvious opportunity identified, despite the scrutiny to have stopped EW from committing her crimes.

141. CCW will continue to cooperate fully in assisting with identifying factors and making positive suggestions which might improve the long-term care system, enhance the safety, security, and quality of life for residents, and if possible, help avoid similar tragedies in the future.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

David M. Golden

Torkin Manes LLP

Counsel for Caressant Care Nursing and Retirement Homes Limited