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

CLOSING SUBMISSIONS OF JARLETTE HEALTH SERVICES AND MEADOW PARK (LONDON) INC. O/A MEADOW PARK LONDON LONG-TERM CARE

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TORKIN MANES LLP
151 Yonge Street, Ste. 1500
Toronto, Ontario M5C 2W7

Lisa Corrente (44959I)
Tel: (416) 643-8800
Fax: 1-888-554-6180

Lawyers for Jarlette Health Services and Meadow Park (London) Inc. o/a Meadow Park London Long-Term Care

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

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The Honourable Eileen E. Gillese,
Commissioner

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O/A MEADOW PARK LONDON LONG-TERM CARE**

I. OVERVIEW

1. The staff at Meadow Park (London) Long-Term Care ("MPL")[1] were shocked and devastated to learn that one of their residents, Arpad Horvath ("Mr. Horvath"), had been murdered by their co-worker, Registered Nurse Elizabeth Wettlaufer ("Wettlaufer").[2] There was nothing whatsoever in the events leading to Mr. Horvath's death that caused them to suspect any wrongdoing.[3]

2. Wettlaufer is Canada's first and only convicted health care serial killer.[4] To our knowledge, never before in Canadian history has a resident ever been murdered by a health care professional in a long-term care home.[5] Tragically, between 2007 and 2016, while practicing as a Registered Nurse, Wettlaufer murdered eight individuals under her care, including Mr. Horvath, and attempted to

[1] In these closing submissions, reference to Meadow Park London includes its owner and operator, Jarlette Health Services ("Jarlette").
[2] Affidavit of Heather Nicholas, Exhibit 43, para.85; Affidavit of Robert VanderHeyden, Exhibit 60, p.11, para.38; Affidavit of Melanie Smith, Exhibit 48, p.23, para.80; Affidavit of Felina Cabrera, Exhibit 70, pp.13-14, para.67; Affidavit of Cassidy Pizarro, Exhibit 71, pp.17-18, para.83.
[3] Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2191, lines 14-25; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2446, lines 26-31; Cross-examination of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3019, lines 28-32; Cross-Examination of Tanya Adams, Transcript taken on June 25, 2018, p.3473, lines 16-21.
[4] Report of Professor Yorker (#72896), Exhibit 163, Tab F:SMHP Spreadsheet Convictions.
[5] Cross-Examination of Professor Yorker, Transcript taken September 12, 2018, p.131, line 19 – p.132, line 15.

murder several others. These offences took place in three Ontario long-term care homes, including MPL, and in a home care setting.[6]

3. During the public hearings of the Long-Term Care Homes Public Inquiry (the "Inquiry"), Professor Beatrice Crofts Yorker Schumacher ("Professor Yorker") – an expert in health care serial killers – testified that Wettlaufer's crimes would have been "very difficult" to detect.[7] Indeed, the evidence of witnesses testifying at the Inquiry hearings has demonstrated that no one – not nursing, medical or care staff at the homes; union representatives; the victims' families; local coroners; the College of Nurses of Ontario ("CNO") or Ministry of Health and Long-Term Care inspectors – ever suspected that Wettlaufer was injecting residents with fatal amounts of insulin with the intent to cause their death.

4. MPL submits that it had no reason at all to suspect that Wettlaufer was a serial killer or that she had murdered Mr. Horvath. Wettlaufer was employed with MPL for only five months in 2014.[8] During that time, she presented as a polite, competent and caring nurse.[9] Mr. Horvath was Wettlaufer's only victim at MPL – there was no cluster of deaths. He was an elderly resident with several comorbidities, including diabetes and previous episodes of hypoglycemia. Staff at MPL did not find his death unusual or suspicious in these circumstances.[10]

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[6] Sentence Decision of Thomas J. dated June 26, 2017, Exhibit 2, FD0003, pp.11-13.

[7] Examination-in-chief of Professor Yorker, Transcript taken September 12, 2018, p.69, line 20 – p.70, line 9; p.74, line 15 to p.75, line 31.

[8] Overview Report: The Facilities and Agencies, Exhibit 6, p.146.

[9] Cross-Examination of Tanya Adams, Transcript taken on June 25, 2018, p.3472, lines 5-21; Cross-examination of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3028, lines 8-17; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2402, lines 19-25, p.2403, lines 11-32; Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2151, line 5 to p.2152, line 3.

[10] Cross-Examination of Tanya Adams, Transcript taken on June 25, 2018, p.3472, line 22 to p.3473, line 15; Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2479, line 13 to p.2480, line 7; Affidavit of Dr. Dirk Huyer, Exhibit 98, Coroner's Investigation Statement (Form 3) (#65183), p.2.

5. Wettlaufer carried out her crimes in a manner which made detection virtually impossible. In September 2016, her offences became known because she confessed them to a social worker and psychiatrist after voluntarily admitting herself into the Centre for Addiction and Mental Health (CAMH)[11]. Wettlaufer subsequently confessed her crimes to police.[12]

6. As a result of Wettlaufer's detailed confessions, the resulting investigations (e.g. by police and the Coroner's office) and the inquires made by Commission Counsel in these proceedings, the Inquiry participants now have greater insight into the circumstances surrounding Wettlaufer's crimes. MPL submits that it is only in hindsight, and with the benefit of this information, that it has been able to identify possible contributing factors which may have allowed these events to occur.

7. The submissions which follow have been organized into three main parts: (i) the events and contributing factors during the period up to and including the death of Mr. Horvath; (ii) the events and contributing factors surrounding Wettlaufer's resignation from MPL; and (iii) the events and contributing factors during the period after Wettlaufer's confession to police. Within each of these parts, MPL has proposed recommendations in the hopes that a similar tragedy can be avoided in the future.

8. MPL respectfully submits that it is important to keep in mind the comments of Professor Yorker that the public should not be alarmed by the "phenomenon" of health care serial killers.[13] In Canada, this phenomenon is not prevalent and has a very low incidence rate with less than half a percent of cases having occurred here.[14] With that said, innocent lives of vulnerable residents were taken by an individual entrusted by long-term care homes, families and friends to care for our

[11] CAMH Discharge Data (#57687), Agreed Statement of Facts on Guilty Plea, Exhibit 1(D), p.2.
[12] Transcript of Wettlaufer's Police Statement dated October 5, 2016 (#57686), Agreed Statement of Facts on Guilty Plea, Exhibit 1(C).
[13] Cross-Examination of Professor Yorker, Transcript taken September 12, 2018, p.190, lines 15 to 23.
[14] Cross-Examination of Professor Yorker, Transcript taken September 12, 2018, p.132, lines 14 to 29.

elderly. Thus, MPL fully supports the efforts of this Inquiry to identify contributing factors and recommend improvements to resident safety in order to contribute to the deterrence and possible early detection of health care serial killings.

II. THE EVENTS AND CONTRIBUTING FACTORS

A. The Period Up To and Including the Death of Mr. Horvath

(i) Meadow Park London

9. MPL is an accredited long-term care home located in London, Ontario[15]. In 2014, it was (and still is) licensed to operate 126 beds. At all material times, the residents at MPL lived in rooms on the main floor of the building in four separate home areas (or units): Oxford, Elgin, Kent and Lambton. Mr. Horvath resided in the Kent unit (where Wettlaufer was eventually assigned).[16] The home had three locked medication rooms next to a nursing station: one medication room in Kent, one medication room in Lambton and a shared medication room for Oxford and Elgin.[17] Only those registered nurses ("RN") or registered practical nurses ("RPN") on shift had a key to the medication room in their respective home areas. Each medication room had its own distinct key.[18]

10. Staffing levels in long-term care homes are not prescribed by the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8 (the "*LTCHA*"). The only requirement is that a long-term care home must have at least one RN who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times.[19] In 2014, the staffing levels at MPL were as follows: 2 RNs, 3 RPNs and 16 personal support workers ("PSWs) on day shift (6:30 a.m. to

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[15] CARF Accreditation Letter dated October 13, 2016, Exhibit 149.
[16] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2092, lines 4-7; Affidavit of Melanie Smith, Exhibit 48, p.2, para.6.
[17] 2014 Floor Plan for MPL (#72516), Affidavit of Heather Nicholas, Exhibit 43, p.23; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2387, lines 29-31.
[18] Affidavit of Heather Nicholas, Exhibit 43, p.9, para.35; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2089, line 26 to p.2090, line 10.
[19] Legislation Brief, Exhibit 4, s.8(3), p.846.

2:30 p.m.); 2 RNs, 2 RPNs and 12 PSWs on evening shift (2:30 p.m. to 10:30 p.m.) and 1 RN, 1 RPN and 4 PSWs on night shift (10:30 p.m. to 6:30 a.m.).[20] In addition to this complement of staff, four managers were on duty during part of the day and evening shifts and available on-call otherwise.[21]

11. During the Inquiry hearings, the medication management system at MPL was described in detail by several witnesses.[22] MPL's medication management system, including its handling of insulin, was consistent with the medication management systems in long-term care homes generally as described by the expert witness from Canada's Institute of Safe Medication Practices ("ISMP"), Julie Grenall ("Ms. Grenall").[23] Ms. Grenall's evidence was that there is a high level of consistency in medication management systems across long-term care homes, all of which must comply with the minimum requirements of the *LTCHA*.[24] MPL participates annually in the ISMP's Medication Safety Self-Assessment to meet its legislative obligations[25].

12. The former Co-Director of Care ("Co-DOC") at MPL, Melanie Smith ("Ms. Smith"), was a witness at the Inquiry. In 2014, as part of her role as Co-DOC, Ms. Smith oversaw the frontline staff. Ms. Smith was often working on the floor, knew all of the residents and knew the registered staff quite well.[26] Ms. Smith testified that the quality of resident care at MPL was "good" and staff "worked hard to try and provide the needs of the residents".[27] In his testimony at the Inquiry, the

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[20] MPL Nursing Staff Levels from April to August 2014 (#72511), Affidavit of Heather Nicholas, Exhibit 43, p.131; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2091, line 17 to p.2092, line 20.
[21] Cross-Examination of Heather Nicholas, Transcript dated June 19, 2018, p.2289, line 4 to p.2290, line 14.
[22] Affidavit of Heather Nicholas, Exhibit 43, paras.31-44; Affidavit of Melanie Smith, Exhibit 48, pp.6-11, paras.26-44; Affidavit of Felina Cabrera, Exhibit 70, pp.7-8, paras.23-33; Affidavit of Cassidy Pizarro, Exhibit 71, pp.8-11, paras.28-41.
[23] Report of Julie Grenall (#72897), Exhibit 166, pp.5-16.
[24] Report of Julie Grenall (#72897), Exhibit 166, p.16.
[25] Cross-Examination of Julie Grenall, Transcript taken on September 13, 2018, p.8384, lines 5-22.
[26] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2086, lines 8-16.
[27] Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2458, line 28 to p.2459, line 3.

home's then Administrator, Robert VanderHeyden ("Mr. VanderHeyden"), confirmed that staff at MPL were "very dedicated".[28]

13. During the Inquiry hearings, the issue of management turnover at MPL was raised by certain participants. In her examination, Ms. Smith was asked if she believed that resident care suffered at all as a result of management turnover at MPL. She testified that resident care did not suffer.[29] In any event, it is important to note that during Wettlaufer's employment at MPL, there was no turnover in the roles of Administrator, DOC or Co-DOC. Changes in management happened after Wettlaufer's resignation.[30]

14. As required by the *LTCHA*, MPL had a zero tolerance policy for resident abuse and neglect, and it enforced that policy.[31] Training with respect to the policy of zero tolerance of resident abuse and neglect was provided to all new staff during orientation, and mandatory training was provided annually thereafter. Staff knew how to report concerns of abuse and neglect, and would go to management with concerns.[32] MPL also displayed a poster at the main entrance of the home advising staff, residents and family members on how to report concerns to the Ministry of Health and Long-Term Care (the "Ministry").[33]

15. MPL offered a week-long orientation to all new registered staff. The first two days of the orientation process at the home consisted of in-class education offered by the Staff Educator or another member of nursing management. Registered staff received training in areas such as

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[28] Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3033, lines 11-15.
[29] Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2461, lines 1-5.
[30] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2081, lines 10-32.
[31] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2107, line 28 to p.2108, line 7.
[32] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2111, line 26 to p.2112, line 6; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2404, lines 1-7, p.2405, lines 7-11; Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3003, line 27 to p.3005, line 13; Affidavit of Felina Cabrera, Exhibit 70, p.3, para.13; Affidavit of Cassidy Pizarro, Exhibit 71, p.7, para.23.
[33] Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2457, line 20 to p.2458, line 10.

dementia care (including responsive behaviours), zero tolerance for abuse, restraint minimization, falls prevention, amongst various other topics. After the in-class orientation, registered staff received orientation on the floor of the home. Each new hire was partnered with a nurse (e.g. a new RN was partnered with an existing RN) over the course of two day shifts, two evening shifts and one night shift. Newly hired nurses would observe the administration of medication and also complete medication passes under supervision. They were also educated on the EMAR (electronic medication administration record), mandatory reporting and risk occurrence reporting. Wettlaufer received this orientation during her first week at MPL.[34]

16. The nursing staff at MPL, like those in other long-term care homes, work very hard to care for residents. Their hard work has intensified as resident acuity levels have increased, without a corresponding increase in Ministry funding which is sufficient enough to increase staffing levels.[35]

17. MPL submits that it is a typical long-term care home – staff work hard to care for residents and to meet the many regulatory demands under legislation. Residents are well cared for – but nurses need more time to focus on providing care to complex and frail residents especially as acuity increases. There was nothing specific to the work environment at MPL that contributed to Wettlaufer's crimes. The offences could have happened and gone undetected in any health care setting.

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[34] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2140, line 25 to p.2143, line 30, p.2147, line 20 to p.2149, line 17, p.2159, lines 12-16, p.2214, line 22 to p.2215, line 20; General Orientation Plan – Days 1 and 2 – for Wettlaufer (#17532 and #17549), Affidavit of Heather Nicholas, Exhibit 43, pp.122-123; Affidavit of Melanie Smith, Exhibit 48, p.5, paras.18-23; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2372, line 14 to p.2374, line 14.

[35] Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2367, line 29 to p.2368, line 8; Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3000, line 15 to p.3001, line 32; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2085, lines 11-23.

18. MPL agrees with Professor Yorker's observations that better nurse to resident staffing ratios can improve resident safety (e.g. more eyes to detect potential intentional harm), satisfaction and outcomes.[36] Therefore, it recommends the following measures to improve resident safety overall:

- **Increased Ministry funding for all envelopes, including the Nursing and Personal Care ("NPC") Envelope, to enable homes to attract and retain qualified staff, drive quality outccomes and maintain better nurse to resident ratios.**

- **Increased flexibility with respect to how homes can utilize funding within the NPC envelope to permit recruitment of an appropriate mix of staff beyond RNs, RPNs and PSWs (e.g. aides, porters, nursing attendants, pharmacy).**

- **An evaluation by appropriate stakeholders with respect to the 24-hour RN requirement versus an increased presence of RPNs. Consideration as to whether the care needs of residents can be met by having an RN available on-call.**

(ii) <u>Elizabeth Wettlaufer</u>

19. Prior to joining MPL in April 2014, Wettlaufer had a history of mental health issues, a substance abuse problem and other difficulties which followed her to the home. MPL was entirely unaware of Wettlaufer's troubled personal history throughout her employment.[37] Wettlaufer's personal issues included, without limitation, the following:

- mental health diagnoses which included major depression[38], obsessive compulsive behaviour[39] and borderline personality disorder, requiring treatment in a psychiatric hospital;[40]
- use of antipsychotics, antidepressants and anti-obsessional medications;[41]
- alcoholism, which began while she was a nursing student;[42]

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[36] Report of Professor Yorker (#72896), Exhibit 163, p.15.

[37] Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.3019, lines 25-27; Examination/Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2411, lines 25-27, p.2480, lines 24-28; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2161, lines 6-9.

[38] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.24, lines 22-26.

[39] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.35, lines 17-29.

[40] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.36, lines 10-30.

[41] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.37, lines 23-30.

[42] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.12, line 30 to p.13, line 1; p.24, line 31 to p.25, line 4.

- a substance abuse problem which included drug diversion from her previous employers, including Ativan, Valium and Morphine;[43]
- multiple suicide attempts;[44]
- financial pressure associated with supporting her partner and her partner's children;[45] and
- failed relationships with her husband and same-sex partner.[46]

20. MPL submits that Wettlaufer's combined significant personal issues, in particular her serious mental illness, were contributing factors to her crimes. In fact, in her interview with Commission Counsel and police, Wettlaufer described having considerable anger and thoughts of killing caused by her mental health issues.[47] When she confessed to police, Wettlaufer described hearing voices which influenced her to kill people and a laughter in her tummy after she murdered her victims.[48]

21. In view of the above, MPL makes the following recommendations:

- **Continued development and prompt implementation of a Nurse Help Program through the CNO to provide support for nurses with mental health and substance abuse issues**.

- **A requirement that the CNO offer nurses an employee assistance program (EAP).**

- **Consideration to whether the CNO should complete psychological assessments for nurses as a requisite for registration, having regard for the need to balance privacy and human rights interests.**

[43] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.18, lines 5-20.
[44] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.40, lines 24-28; p.41, line 30 to p.12, lines 1-8; p.42, line 7.
[45] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.50, lines 20-29; p.53, lines 5-11.
[46] Transcript of Wettlaufer's Police Statement dated October 5, 2016 (#57686), Agreed Statement of Facts on Guilty Plea, Exhibit 1(C), pp.17 and 31.
[47] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.52, lines 15-19, p.57, lines 12-19; Transcript of Wettlaufer's Police Statement dated October 5, 2016 (#57686), Agreed Statement of Facts on Guilty Plea, Exhibit 1(C), p.93.
[48] Transcript of Wettlaufer's Police Statement dated October 5, 2016 (#57686), Agreed Statement of Facts on Guilty Plea, Exhibit 1(C), p.19.

(iii) Hiring of Wettlaufer by MPL

22. Wettlaufer commenced her employment as a RN with MPL on April 22, 2014.[49] She was hired to work the evening shift (2:30 p.m. to 10:30 p.m.) on the Kent unit.[50]

23. During the Inquiry hearings, Ms. Nicholas described the circumstances surrounding her hiring of Wettlaufer. According to Ms. Nicholas, Wettlaufer applied for employment at MPL on April 13, 2014 when she submitted her resume[51]. Wettlaufer's resume indicated that she had been a RN since 1995 with 18 years of experience in long-term care and assisted living care. It made no mention of her employment with Geraldton Hospital. Caressant Care Woodstock ("CCW") was listed as Wettlaufer's most recent employer where she had been employed for almost seven years.[52] Ms. Nicholas had received a resume from an RN documenting several years of experience in long-term care.[53] Wettlaufer was offered an interview.

24. On April 14, 2014, Wettlaufer was interviewed at MPL as part of a group, and then individually.[54] That is, MPL followed a job interview guidebook created by Jarlette known as "Hiring the Jarlette Way".[55] This required all candidates to participate in a group interview with several members of management and other candidates with nursing and PSW backgrounds. The purpose of the group interview was to assess a candidate's ability to interact with others, their compatibility with work, their critical thinking, their leadership qualities and how they worked within

[49] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2114, line 32 to p.2115, line 6; Time Card for Wettlaufer at MPL (April 30-May 3, 2014) (#72620), Exhibit 44.
[50] Affidavit of Felina Cabrera, Exhibit 70, p.9, paras.36-37;
[51] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2113, lines 1-5, p.2115, lines 29-32.
[52] Resume for Wettlaufer (#17513), Affidavit of Heather Nicholas, Exhibit 43, p.169.
[53] Cross-Examination of Heather Nicholas, Transcript dated June 19, 2018, p.2230, lines 17-23.
[54] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2113, lines 17-20, p.2122, lines 8-16.
[55] "Hiring the Jarlette Way" (#72015), Affidavit of Heather Nicholas, Exhibit 43, pp.30-120.

a team. Wettlaufer was pleasant and professional during the group interview and moved forward to an individual interview with Ms. Nicholas that same day.[56]

25. During the individual interview with Ms. Nicholas, Wettlaufer presented as "very knowledgeable and very professional".[57] She advised Ms. Nicholas that she had left CCW as a result of a medication error involving insulin that got noticed. Ms. Nicholas recorded this information in her notes of Wettlaufer's interview.[58]

26. Following her interviews with Wettlaufer, Ms. Nicholas conducted various background checks of Wettlaufer. On April 21, 2018, she checked the CNO's "Find the Nurse" database to confirm that Wettlaufer was registered and in good standing with her regulatory body. Ms. Nicholas confirmed that Wettlaufer was "entitled to practice without restrictions". The "Find a Nurse" database does not indicate whether a nurse is under investigation or if mandatory reports have been filed in relation to a nurse. Further, findings of incapacity are listed on the database for a limited time. "Find a Nurse" does not list the employment history of a nurse. Therefore, when Wettlaufer was hired and throughout her employ, MPL was unaware that Wettlaufer had worked at Geraldton Hospital, had previously been found to be incapacitated by the Fitness to Practice Committee of the CNO, and that Wettlaufer had been reported to the CNO by CCW.[59] Ms. Nicholas testified that had she known about the incident at Geraldton, it would have affected her decision to hire Wettlaufer.[60]

27. That same day, Ms. Nicholas called the employment references provided by Wettlaufer. She spoke to Wettlaufer's former supervisor at Christian Horizons, Mr. David Petkau ("Mr. Petkau"),

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[56] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2119, line 7 to p.2121, line 31.
[57] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2122, lines 17-25.
[58] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2122, line 32 to p.2123, line 21.
[59] Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2137, line 17 to p.2138, line 10, p.2123, lines 22-30, p.2138, lines 7-10; "Find a Nurse" Check (#17528), Affidavit of Heather Nicholas, Exhibit 43, p.181.
[60] Examination of Heather Nicholas, Transcript dated June 19, 2018, p.2117, lines 5-14, p.2237, line 5 to p.2238, line 6.

whom had supervised Wettlaufer for six years. Mr. Petkau described Wettlaufer as "very good" and someone he would re-hire. Ms. Nicholas also spoke separately to two representatives at CCW, namely Wettlaufer's former supervisor, Sandra Fluttert ("Ms. Fluttert"), and a former co-worker, Jennifer Hague (Ms. Hague"). The CCW representatives provided positive references for Wettlaufer indicating that they would re-hire her. When asked about the circumstances surrounding Wettlaufer's departure from CCW, Ms. Fluttert and Ms. Hague both advised Ms. Nicholas that it was due to a medication error that also involved other nurses. None of Wettlaufer's employment references expressed negative comments about her although they were specifically asked for negative feedback.[61]

28. Thereafter, on April 22, 2014, Ms. Nicholas conducted a vulnerable sector screen of Wettlaufer with the Woodstock Police Service. Wettlaufer had no criminal record.[62]

29. Also that day, in view of the medication error made at CCW, Ms. Nicholas asked Wettlaufer to take the Medication Safety Test developed by the CNO. Wettlaufer got a perfect score.[63]

30. Ms. Nicholas had considerable experience with hiring numerous nursing staff in her previous position at another long-term care home. Nothing about Wettlaufer presented differently from other nurses that she had previously hired.[64] Wettlaufer seemed intelligent, professional and experienced.[65] Although Ms. Nicholas knew that Wettlaufer had made a medication error at CCW,

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[61] Applicant Reference Check Form (#17516), Affidavit of Heather Nicholas, Exhibit 43, pp.177-179; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2129, line 15 to p.2136, line 19.
[62]Vulnerable Sector Check (#17523), Affidavit of Heather Nicholas, Exhibit 43, p.183; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2138, lines 16-32.
[63]CNO Medication Safety Test (#17562), Affidavit of Heather Nicholas, Exhibit 43, p.185; Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2139, line 1 to p.2140, line 4.
[64]Cross-Examination of Heather Nicholas, Transcript dated June 19, 2018, p.2205, line 10 to p.2206, line 2.
[65]Examination-in-chief of Heather Nicholas, Transcript dated June 19, 2018, p.2122, lines 22-25.

it was not unusual for competent nurses to make such errors.[66] MPL submits that there was no reason for Ms. Nicholas to second guess hiring Wettlaufer.

31. MPL submits that its hiring of Wettlaufer, including the process followed, was in no way a contributing factor to her crimes. However, MPL would not have hired Wettlaufer if it was provided complete information about her employment history. Accordingly, the following recommendations are proposed:

- **CNO to maintain a public registry (e.g. "Find a Nurse") containing the qualifications and complete employment history of nurses to prevent possible falsification of credentials. The public registry should also advise employers and prospective employers regarding the status and outcomes of CNO investigations into a nurse's practice. It must be a real-time registry in order to enable users to receive current information.**

- **Consideration to implementing immunity legislation for employers which provide honest information to prospective employers about adverse incidents and reasons for termination of employment of a nurse.**[67]

- **Consideration to developing a standard Applicant Reference Form that includes a waiver for information to be provided by employers, including formal disciplinary actions for incidents involving abuse, neglect or violence toward residents, and reasons for separation from employment.**[68]

- **Development of best practice hiring guidelines for the long-term care sector.**

(iv) Resident Care During Wettlaufer's Employment

32. Despite Wettlaufer's mental health issues and ongoing substance abuse issues, there were no reported concerns from residents, families or staff with respect to her care of residents at MPL. MPL was never advised of any medication errors made by Wettlaufer while in its employ, she had no performance issues or discipline, no inappropriate comments made by her were brought to the

[66] Cross-Examination of Heather Nicholas, Transcript dated June 19, 2018, p.2312, lines 21-32.
[67] Report of Professor Yorker (#72896), Exhibit 163, p.20.
[68] Report of Professor Yorker (#72896), Exhibit 163, p.20.

attention of management, she never appeared to be under the influence of alcohol or drugs while at work, and there were no reported concerns of her practicing unsafely in the home.[69]

33. At one point, Ms. Nicholas was concerned about Wettlaufer's attendance and wrote her a letter in this regard. There was no indication that Wettlaufer's absences were related to substance abuse and the absences never reached the point of requiring an attendance plan or discipline.[70]

34. The only complaint received by a staff member regarding Wettlaufer was from a fellow RN, Felina Cabrera ("Ms. Cabrera"), on September 16, 2014.[71] Ms. Cabrera provided a note to Wettlaufer (copied to Ms. Nicholas) citing concerns about her leaving her shift without completing a narcotic count with Ms. Cabrera (who was taking over the medication cart for the night shift). This complaint was made after Mr. Horvath's death and no narcotics were reported missing by Ms. Cabrera.[72]

35. It is submitted that there were absolutely no "red flags" in Wettlaufer's actions while at MPL leading to the death of Mr. Horvath. Nevertheless, MPL is of the view that educating and training staff, residents and families on recognizing and reporting usual behaviours could help prevent intentional harm of a resident by a health care professional. In that regard, MPL proposes the following recommendation:

- **Heath care organizations and regulatory bodies to increase awareness of health care serial killings amongst long-term care physicians, nursing staff, residents and families.**

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[69] Please refer to footnotes 9 and 32, above. See also Examination of Robert VanderHeyden, Transcript taken on June 22, 2018, p.2985, lines 14-27, p.3019, lines 12-32; Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2404, line 30 to p.2405, line 2, p.2480, lines 12-31, p.2482, lines 16-27; Cross-Examination of Tanya Adams, Transcript taken on June 25, 2018, p.3458, lines 1-11; Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2159, lines 18-31.

[70] Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2159, line 32 to p.2161, line 9; Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.2986, lines 17-20.

[71] Affidavit of Heather Nicholas, Exhibit 43, p.193.

[72] Cross-Examination of Heather Nicholas, Transcript taken on June 19, 2018, p.2216, line 25 to p.2217, line 3.

(v) Arpad Horvath's Death

36. Mr. Horvath was Wettlaufer's last murder victim. On August 23, 2014, Wettlaufer fatally injected Mr. Horvath with nontherapeutic insulin. The lethal dose of insulin sent Mr. Horvath into hypoglycemic shock and he passed away in hospital one week later – on August 31, 2014.[73]

37. As previously mentioned, Mr. Horvath had various medical conditions while he lived at MPL. He suffered from dementia, diabetes, coronary artery disease, hypertension, past stroke, and chronic kidney disease. He had previous episodes of hypoglycemia and was medicated with oral hypoglycemic medication (not insulin). Due to his dementia, he also had a history of responsive behaviours toward staff at MPL.[74]

38. MPL submits that, unfortunately, Mr. Horvath's comorbidities made him particularly vulnerable to Wettlaufer and were a contributing factor in her crimes. During Wettlaufer's interview with Commission Counsel, she confirmed that she deliberately selected residents with dementia as her victims because they could not report her, or would not be believed if they did report her.[75]

39. Furthermore, Mr. Horvath's medical conditions made his death difficult to determine as sudden, unexpected or unusual. For instance, given that Mr. Horvath was diabetic, had experienced previous episodes of hypoglycemia and it was difficult to control his blood sugar levels, his transfer to hospital and subsequent death were not suspicious to the staff at MPL.[76] Mr. Horvath's medical fragility led MPL's consultant pharmacist (who was familiar with his medical conditions) to believe that his death possibly resulted from complications such as a cardiovascular event.[77]

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[73] Agreed Statement of Facts on Guilty Plea (#57683), Exhibit 1, pp.34-35.
[74] Affidavit of Dr. Dirk Huyer, Exhibit 98, Coroner's Investigation Statement (Form 3), #65183, p.2.
[75] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.53, lines 17-29, p. 73, lines 21-25.
[76] Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2479, line 13 to p.2480, line 7.
[77] Cross-Examination of Tanya Adams, Transcript taken on June 25, 2018, p.3472, line 30 to p.3473, line 15.

40. Notably, when Mr. Horvath was transferred to hospital from MPL, he was presenting with hypoglycemia. Mr. Horvath was hospitalized for one week prior to his death. Attending hospital staff were able to perform various tests on Mr. Horvath while he was alive, including a CAT scan and MRI. Pursuant to s.10(1) of the *Coroner's Act*, R.S.O. 1990, C.37, the hospital was required to make a mandatory report to the Coroner's office if it had reason to believe that Mr. Horvath died of violence, misconduct, unfair means, suddenly and unexpectedly, or under other unusual circumstances that may require investigation. The hospital did not report Mr. Horvath's death to the Coroner's office because it did not view it as suspicious. Rather, the hospital determined that Mr. Horvath had passed away naturally from a stroke.[78]

41. During the Inquiry hearing, Ontario's Chief Coroner, Dr. Dirk Huyer, was asked about the circumstances surrounding Mr. Horvath's death. Dr. Huyer was involved in the death investigations of Wettlaufer's murder victims, including Mr. Horvath. Dr. Huyer testified that he could see why someone would interpret Mr. Horvath's death as a natural death.[79]

42. In summary, MPL submits that Mr. Horvath's vulnerability as a resident with dementia and his comorbidities which made his death appear to be expected and natural were contributing factors which allowed Wettlaufer to conceal her offences. The evidence proffered by Professor Yorker confirms that residents who are critically ill, elderly, mentally compromised or frail are over-represented victim populations in cases of health care serial killings.[80] In the circumstances, MPL proposes the following recommendations:

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[78] Legislation Brief, Exhibit 4, s.8(3), p.122; Cross-Examination of Dr. Dirk Huyer, Transcripts taken on July 17, 2018, p.4448, line 23 to p.4449, line 24; Affidavit of Dr. Dirk Huyer, Exhibit 98, Coroner's Investigation Statement (Form 3) (#65183), p.530.

[79] Cross-Examination of Dr. Dirk Huyer, Transcripts taken on July 17, 2018, p.4449, line 25 to p.4450, line 15.

[80] Report of Professor Yorker (#72896), Exhibit 163, p.7.

- **The Coroner's office to provide training and support for long-term care physicians and nursing staff with respect to recognizing when a death is sudden, unexpected or otherwise unusual.**

- **The Coroner's office to update the Institutional Patient Death Records ("IPDR") for residents who pass away in the home, and provide training and support to long-term care nursing staff with respect to completing the form in order to allow for accurate reporting.**

- **Reinstatement of the automatic threshold death investigation by the Coroner's office with consideration to ways in which to improve effectiveness of the process.**

- **Consideration to utilizing existing and new data from IPDR and death investigations to identify patterns and trends in long-term care deaths (e.g. data analytics).**

- **Training for hospital and long-term care nursing staff with respect to considering medication error as a differential diagnosis in cases of unexpected or severe hypoglycemia (e.g. situations in which individuals fail to recover after glucagon is administered).** [81]

- **Establish a clear set of intervention responses (e.g. checking vital signs and blood sugar levels) to assist staff in responding to and evaluating sudden and unexpected changes in a resident's condition.**

- **Building capacity amongst long-term care leadership in systemic incident analysis using the Canadian Incident Analysis Framework (or similar methodology), along with sufficient resources, in order to assist in detecting intentional harm.**[82]

- **Development by long-term care stakeholders of "Consensus Guidelines" for managing suspicious situations.**[83]

- **Increased Ministry funding for behavioural supports training and more dedicated BSO staff in long-term care homes.**

(vi) Insulin

43. In Wettlaufer's interview with Commission Counsel, she revealed why she used insulin to harm and murder her victims – she knew it was a drug that could kill people, she knew it was not counted and as an RN, she had easy access to it.[84]

[81] ISMP Canada Safety Bulletin, Report of Julie Grenall (#72897), Exhibit 166, p.50.
[82] Report of Julie Grenall (#72897), Exhibit 166, p.33.
[83] Report of Professor Yorker (#72896), Exhibit 163, p.19.

44. MPL submits that the use of insulin specifically was a contributing factor to Wettlaufer's crimes for several reasons. Firstly, insulin can cause significant harm or death if used incorrectly. Expert witness, Ms. Grenall, gave evidence at the Inquiry hearings that insulin is a high alert medication. As with any high alert medication, the administration of an incorrect dose of insulin, or administration to the incorrect resident, has a high likelihood of causing harm.[85]

45. Furthermore, insulin is easily accessible to the general public – not just nurses. Insulin is available without a prescription from any community pharmacy in Ontario - it is stored "behind the counter" but no identification or documentation is required to access it.[86]

46. In addition, the use of insulin is very difficult to track which makes diversion exceedingly challenging to detect. Insulin is a non-controlled substance. Unlike controlled substances, there is no tracking (or recording) when an insulin cartridge is removed from the active medication supply. The only tracking of usage is what is recorded to have been administered to a resident in the EMAR.[87] Also, wastage of insulin is not tracked. When insulin pens are primed prior to injecting a resident, a small amount is wasted with each injection. Sometimes, an insulin cartridge may not have enough units left in it to administer to the resident, in which case the amount remaining in that cartridge is discarded to avoid injecting the resident twice. When a resident is discharged from the home or insulin is expired, insulin is disposed of without tracking the amount being destroyed.[88]

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[84] Interview with Wettlaufer by Commission Counsel (#71420), Exhibit 5, p.60, lines 1-8, p.61, line 28 to p.62, line 23.
[85] Report of Julie Grenall (#72897), Exhibit 166, p.10.
[86] Report of Julie Grenall (#72897), Exhibit 166, p.12.
[87] Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2390, lines 6-24.
[88] Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2398, line 16 to p.2399, line 15; Affidavit of Melanie Smith, Exhibit 48, pp.13-15; Examination-in-chief of Jonathan Lu, Transcript taken June 25, 2018, p.3290, lines 18-23, p.3291, lines 8-17, p.3296, lines 2-25; Affidavit of Tanya Adams, Exhibit 78, p.8, para.44.

47. Also, a nurse would need to divert a significant amount of insulin from the home before a pharmacy service provider could flag an issue. In Mr. Horvath's case, Wettlaufer administered both short and long acting insulin to him. The diversion of insulin from more than one cartridge would be less likely to trigger an "early refill" error at the pharmacy.[89]

48. According to the research of Professor Yorker, insulin is the most used injectable medication by convicted health care serial killers – it was used in 40% of cases since 2006. The use of insulin by health care serial killers is increasing likely in part because insulin injection poses unique challenges to detection. Professor Yorker has found that there is a significant correlation between the diversion of injectable medications, such as insulin, and health care serial killings.[90]

49. The expert evidence of Ms. Grenall cited examples of how long-term care homes and hospitals could enhance oversight with respect to insulin and insulin supplies in order to mitigate against the risk of intentional harm from insulin misuse. However, she noted that the non-prescription status of insulin means that any enhanced oversight in health care settings (e.g. double checks, automated dispensing cabinets) may be circumvented through access elsewhere.[91] Nevertheless, MPL supports recommendations, including several made by Ms. Grenall, which explore measures to prevent diversion and misuse of insulin including the following:

- **Review of the ongoing need for non-prescription public access to insulin and consideration of whether insulin should only be available through prescription or some other documentation.**

- **Review the use of automated dispensing cabinets, bar coding and disposable insulin pens as mechanisms to minimize risk of harm. Provision of start-up and sustainability funding for this type of technology and innovation.**

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[89] Examination-in-chief of Jonathan Lu, Transcript taken June 25, 2018, p.3289, lines 14-32; Affidavit of Tanya Adams, Exhibit 78, p.9, para.48.
[90] Report of Professor Yorker (#72896), Exhibit 163, pp.11-13.
[91] Report of Julie Grenall (#72897), Exhibit 166, pp.26-27.

- **Limit the supply of insulin pens for diabetic residents to current pen(s), with limited spare pens available in the home.**

- **Consideration to increased pharmacy technician support (including on-site support) within long-term care homes to assist with medication management activities and providing sustainability funding of same.**

- **Labelling of insulin and hypoglycemic agents on packaging and cartridges as a high alert medication.**

- **Implement a systemic review by pharmacy of each long-term care home's use of rescue and symptom management medications from the emergency drug supply (e.g. glucagon).**

B. Events Relating to Wettlaufer's Resignation from MPL

(i) Resignation and Missing Narcotics

50. On September 25, 2014, Wettlaufer provided a letter of resignation to MPL effective October 15, 2014. The letter of resignation was addressed to Ms. Nicholas. It stated: "Unfortunately, I must tender my resignation. I have an illness which will require long-term treatment. I will be unable to work during this treatment and also unable to work as an RN following treatment."[92] At the time, MPL was entirely unaware that Wettlaufer had a substance abuse issue and a history of diverting medications.[93]

51. As it turned out, Wettlaufer's last shift with MPL was the evening shift on Friday, September 26, 2014.[94] The reason being was that over the weekend on September 27th and 28th,

[92] Resignation Letter dated September 25, 2014 (#17578), Affidavit of Heather Nicholas, Exhibit 43, p.196.
[93] See footnote 37 above.
[94] Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2170, lines 11-15.

Wettlaufer was hospitalized due to a drug overdose. On or about Tuesday, September 30, 2014, she informed Ms. Nicholas of this fact.[95]

52. On Wednesday, October 1, 2014, Wettlaufer attended at MPL and provided Ms. Nicholas with a note from her physician advising that she would be off work until further notice. Wettlaufer requested to rescind her resignation but Ms. Nicholas refused her request.[96]

53. After Wettlaufer had resigned from her employment at MPL, on October 2, 2014, narcotics were discovered missing from the home. Specifically, it was brought to the attention of Ms. Smith by nursing staff that a 1 mg card of Hydromorphone had been ordered for a resident on the Kent unit on September 26, 2014. The pharmacy service provider at the time had confirmed that the medication had been delivered to the home that evening. However, the narcotics could not be located.[97]

54. MPL commenced an immediate investigation into the missing narcotics. The pharmacy was contacted, the home was searched, relevant documentation was reviewed, a critical incident report was filed with the Ministry and the incident was reported to police.[98]

55. Ultimately, MPL could not conclusively determine who had taken the narcotics. It was clear from the investigation that an RPN had received four bags of medication from the pharmacy driver. It was confirmed that three bags were delivered to other units in the home. However, it could not be confirmed that the bag containing the Hydromorphone was delivered by the RPN to the Kent unit. Wettlaufer (who was the RN on the Kent unit that evening) claimed that the RPN had left

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[95] Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2173, line 28 to p.2174, p.2.
[96] Physician's Note dated October 1, 2014 (#17579), Affidavit of Heather Nicholas, Exhibit 43, p.203; Examination-in-chief of Heather Nicholas, Transcript taken on June 19, 2018, p.2179, line 27 to p.2181, p.4.
[97] Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2414, line 23 to p.2415, line 2;
[98] Critical Incident Report (#17595), Affidavit of Melanie Smith, Exhibit 48, pp.34-36, p.20, para.66-68, p.21, para.73.

other medication at the nursing station (i.e. outside of the locked medication room) but the bag containing the narcotics was not there. The RPN claimed that she had locked the narcotics in the Kent medication room. However, Wettlaufer had not signed the shipping report acknowledging receipt of the narcotics from the RPN.[99]

56. Given Wettlaufer's recent disclosure to Ms. Nicholas that she had overdosed in hospital the weekend after the narcotics went missing, MPL suspected that Wettlaufer had stolen the drugs. However, MPL could not prove it based on the evidence gathered during the investigation.[100]

57. Like MPL, police were not able to prove that Wettlaufer had stolen the narcotics and no charges were laid.[101]

58. The Ministry inspected the critical incident report filed by MPL with respect to the missing narcotics. No findings of non-compliance were made against MPL.[102]

59. Wettlaufer never admitted to MPL that she diverted the Hydromorphone.[103]

60. In the opinion of Professor Yorker, in the vast majority of cases, diversion of medication by a health care provider is not used to cause intentional harm to others – it is for personal use.[104] In the case of the missing Hydromorphone, if it was diverted by Wettlaufer it was for her personal use. MPL submits that a single incident of diversion by Wettlaufer at MPL is not a contributing factor, or

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[99] Investigation File (#72011), Affidavit of Melanie Smith, Exhibit 48, pp.37-56; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2424, line 7 to p.2425, line 28.

[100] Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2443, lines 15-21; Cross-Examination of Tanya Adams, Transcript taken June 25, 2018, p.3458, line 12 to p.3459, line 32; Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.2995, lines 8-23.

[101] Affidavit of Heather Nicholas, Exhibit 43, p.19, para.78.

[102] Cross-Examination of Melanie Smith, Transcript taken on June 20, 2018, p.2443, lines 6-18; Inspection Order dated November 5, 2014 (#39395), Affidavit of Rhonda Kokoly, Exhibit 134, p.252.

[103] Cross-Examination of Heather Nicholas, Transcript taken on June 19, 2018, p.2328, lines 7-17.

[104] Report of Professor Yorker (#72896), Exhibit 163, p.12.

otherwise correlated, to her crimes. However, given that diversion of injectable medications is linked to health care serial killers, MPL proposes the following recommendations:

- **Review by appropriate stakeholders of medication management systems in long-term care homes to suggest improvements to minimize the risk of diversion.**
- **Provide long-term care homes with additional government funding for the purpose of installing cameras in medication rooms and common areas, as well as the installation of windows into the doors of medication rooms.**
- **Consideration of measures proven effective in early detection of drug diversion (e.g. Anomalous Usage Reports).**[105]
- **The Ministry to conduct a survey of long-term care stakeholders, on a periodic basis, of any new technologies which can be utilized to improve medication management systems.**

(ii) Mandatory Reporting

61. Pursuant to the Procedural Code under the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the "Procedural Code"), employers and facility operators have an obligation to report professional misconduct, incompetence and incapacity of a nurse to the CNO in specified circumstances. During the course of the Inquiry hearings, it has been suggested by certain participants that MPL should have reported Wettlaufer to the CNO when it suspected her of diverting narcotics. However, in 2014, the mandatory reporting obligations in place at the time did not require MPL to make a report to the CNO regarding Wettlaufer. Furthermore, there was no evidence in the Inquiry proceedings that reporting Wettlaufer to the CNO by MPL would have resulted in the detection or prevention of her crimes.

[105] Report of Professor Yorker (#72896), Exhibit 163, p.21.

Reporting by Facility Operators

62. Long-term care homes are facility operators for the purposes of the mandatory reporting requirements under the Procedural Code. In 2014, s.85.2 of the Procedural Code[106] required reporting by facility operators to the CNO if there was reasonable grounds to believe that a nurse who practiced at the facility was incompetent, incapacitated, or had sexually abused a patient.

63. At the time, under s.1(1) of the Procedural Code, "incapacitated" was defined to mean: (i) that the member was suffering from a physical or mental condition or disorder; and (ii) the condition or disorder made it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practice.

64. The CNO has a Mandatory Reporting Guide (the "Guide") (which was available in 2014) that is a tool to assist facility operators, employers and nurses understand the mandatory reporting process and when to file a report under the Procedural Code. With respect to incapacity, the Guide provides that "the College expects a facility operator to make a report only when a current health condition is accompanied about concerns of unsafe practice or there is a need for ongoing monitoring". The Guide further states that "a nurse may decide to take time off from work to deal with personal issues, and there is no concern about client safety. In such a situation, the College does not expect the facility operator to file a report".[107]

65. In the case of Wettlaufer, staff at MPL had no basis to believe that she was "incapacitated". Although Wettlaufer had disclosed to Ms. Nicholas that she had overdosed in late September 2014,

[106] Please refer to the historical version of the Procedural Code under the RHPA (November 6, 2014 to December 10, 2014). This version of the RHPA appears to have been omitted from the Legislative Brief and was not otherwise entered as an exhibit.

[107] Mandatory Reporting Guide (#60161), Exhibit 25, pp.5-6; Cross-Examination of Anne Coghlan, Transcript taken on July 26, 2018, p.5591, lines 11-18.

she never appeared to be under the influence while at work and there were never any reported concerns regarding unsafe practice.[108] Additionally, Wettlaufer's letter of resignation advised MPL that she was removing herself from practice in order to seek treatment.[109] In the circumstances, there was no concern about resident safety.

66. With respect to incompetence, the Guide states that it includes the following three key components: (i) it must relate to the nurse's professional care of a client; (ii) the nurse must display a lack of knowledge, skill or judgment; and (iii) any deficiencies must demonstrate that the nurse is unfit to continue to practice, or that her practice should be restricted.[110] Wettlaufer's care of residents was not incompetent while she worked at MPL. The evidence of MPL's then DOC, Co-DOC and Administrator was that there were never any reported medication errors made by Wettlaufer or any other concerns regarding her knowledge, skill or judgment – there were no reported deficiencies.[111]

67. In the circumstances, MPL submits that as a facility operator, it had no obligation (and no basis) to make a report to the CNO with respect to incompetence or incapacity regarding Wettlaufer.

Reporting by Employers

68. Section 85.5 of the Procedural Code contains the mandatory reporting requirements for employers. In 2014, that section required employers to mandatorily report to the CNO if the

[108] Examination of Heather Nicholas, Transcript taken on June 19, 2018, p.2159, lines 18-31, p.2320, lines 20-26, p.2351, line 24 to p.2352, line 20; Examination-in-chief of Melanie Smith, Transcript taken on June 20, 2018, p.2480, lines 17-31; Examination-in-chief of Robert VanderHeyden, Transcript taken on June 22, 2018, p.2995, lines 14-27.
[109] Resignation Letter dated September 25, 2014 (#17578), Affidavit of Heather Nicholas, Exhibit 43, p.196.
[110] Mandatory Reporting Guide (#60161), Exhibit 25, p.5.
[111] See footnote 108, above.

employer terminated the employment of a nurse for reasons of professional misconduct, incompetence or incapacity.

69. With respect to these reporting obligations, the Guide explains that an employer must also file a report if the employer intended to terminate the nurse's employment but the nurse resigned first.[112]

70. For the reasons outlined above, Wettlaufer did not demonstrate incompetence or incapacity as a nurse while she was employed at MPL. Further, the uncontroverted evidence in this case is that Wettlaufer resigned from her employment and stopped working at MPL prior to it having discovered the missing narcotics. MPL never terminated Wettlaufer's employment, and never intended to terminate her employment.[113] Thus, it had no obligation to report her to the CNO as her employer.

71. Anne Coghlan ("Ms. Coghlan"), the Registrar of the CNO, gave evidence at the Inquiry hearings with respect to MPL's mandatory reporting obligations. In cross-examination, Ms. Coghlan conceded that MPL had no obligation as a facility operator or as an employer to make a mandatory report concerning Wettlaufer for incompetence, incapacity or professional misconduct:

> Q. Okay. So I just want to be very clear on this. You were suggested that in 2014, there was no mandatory reporting obligation on Meadow Park to file a report with the College as an employer; is that correct?
>
> A. That's correct.
>
> Q. Or as a facility operator?
>
> A. That's correct.

[112] Mandatory Reporting Guide (#60161), Exhibit 25, p.4.
[113] Cross-Examination of Heather Nicholas, Transcript taken on June 19, 2018, p.2318, line 32 to p.2319, line 2.

> Q. In relation to incompetence, in relation to incapacity, and in relation to professional misconduct?
>
> A. That's right.[114]

72. Ms. Coghlan corrected the testimony which she provided the previous day – MPL was not required to file a mandatory report regarding Wettlaufer, but the College would have wanted MPL to make a "voluntary report".[115] However, Ms. Coghlan was not able to identify any specific professional standard or other resource for employers or facility operators which communicated to them the CNO's wish that they file voluntary reports. Indeed, the Guide makes no mention whatsoever of voluntary reporting. To the contrary, the Guide advises that the CNO does not expect a facility operator to report a nurse with a medical condition if that condition does not result in unsafe practice or the nurse takes time off from work to deal with these personal issues.[116]

73. Ms. Coghlan also testified that if MPL had reported Wettlaufer to the CNO, she would have been prompted to initiate a health inquiry which would have led the Inquires, Complaints and Reports Committee of the CNO to *consider* an interim suspension.[117] This evidence was speculative at best. Indeed, Ms. Coghlan conceded that her testimony was premised on the assumption that MPL knew of the CNO's wish to receive voluntary reports (of which there was no evidence).[118] In any event, there was no evidence that an interim suspension order would have been made by the CNO regarding Wettlaufer, or that such an order would have prevented her future crimes.

74. Put simply, in 2014, the legislation which governed mandatory reporting of nurses by facility operators and employers did not require MPL to file a report with the CNO regarding Wettlaufer. There was no evidence to suggest that MPL was aware, or should have been aware, of any voluntary

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[114] Cross-Examination of Anne Coghlan, Transcript taken on July 26, 2018, p.5596, line 32 to p.5597, line 11.
[115] Cross-Examination of Anne Coghlan, Transcript taken on July 26, 2018, p.5597, lines 12-15.
[116] Mandatory Reporting Guide (#60161), Exhibit 25, p.6.
[117] Cross-Examination of Anne Coghlan, Transcript taken on July 26, 2018, p.5567, line 25 to p.5568, line 9.
[118] Cross-Examination of Anne Coghlan, Transcript taken on July 26, 2018, p.5598, line 25 to p.5599, line 23.

reporting requirements. To the extent that there were any contributing factors relating to Wettlaufer's offences arising from the circumstances surrounding her resignation and suspected theft of narcotics from MPL, it was the absence of mandatory reporting requirements and the lack of clarity and communication from the CNO regarding its expectations with respect to voluntarily reporting information. Therefore, MPL proposes the following recommendations:

- **A review of mandatory reporting obligations under the Procedural Code to determine if additional requirements are needed to protect against intentional harm of residents resulting from drug diversion or otherwise (including self-reporting obligations for nurses with substance abuse issues).**

- **An update to the Mandatory Reporting Guide to reflect current mandatory reporting requirements and the CNO's expectations regarding voluntary reports.**

C. The Period After Wettlaufer's Confession to Police

(i) Ministry Inspection

75. On October 5, 2016, Wettlaufer confessed her crimes to Woodstock police. She subsequently pleaded guilty to the offences and was sentenced to life imprisonment for eight counts of first degree murder, four counts of attempted murder and two counts of aggravated assault. The news of Wettlaufer's confessions stunned and left distraught the entire long-term care community.

76. In response to Wettlaufer's confession, the Ministry immediately commenced inspections at CCW, MPL and Telfer Place (another long-term care home at which Wettlaufer had been placed by an agency and where she attempted to murder a resident). On October 6, 2016, the Ministry commenced its inspection at MPL.[119] Natalie Moroney ("Ms. Moroney") and Neil Kikuta were assigned as the inspectors.

[119] Affidavit of Natalie Moroney, Exhibit 142, p.5, para.16.

77. The Ministry inspections into the Wettlaufer murders were like none ever experienced before by the long-term care homes, their staff and the Ministry inspectors. It was the first time that the Ministry was ever tasked with inspecting murders of residents by a staff member in long-term care. At the Inquiry hearings, Karen Simpson ("Ms. Simpson") – the Director of the Long-Term Care Inspections Branch at the Ministry – testified that the Ministry wanted to be certain that it did not miss anything during the inspections. [120] It was acknowledged by Ms. Simpson that there had never been a long-term care home in Ontario which had to endure the level of scrutiny brought on by this kind of horrific incident. She stated that the events deeply impacted everybody in all levels in all of the homes where Wettlaufer committed her offences. [121]

78. There were many aspects of the Ministry inspections at MPL which were unfamiliar to staff in the wake of Wettlaufer. For instance:

- The inspectors would not typically request and review an employee's personnel file or a resident's health care records prior to their on-site inspection of the home;
- It was unusual for inspectors to be under the direction to speak only to the Administrator of the home and no one else at the outset of the inspection;
- It was not the usual practice for inspectors to make observations around the home without also being able to speak to staff during a critical incident inspection;
- For the first time ever, inspectors audio-recorded their interviews of the home's staff. Inspectors did not permit staff to audio-record the interviews;
- Never before had inspectors been directed to complete the Medication Inspection Protocol (the "Medication IP") in its entirety; and

[120] Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7144, lines 20-25, p.7158, lines 28-31; Affidavit of Karen Simpson, Exhibit 129, p.44, para.140.
[121] Cross-Examination of Karen Simpson, Transcript taken on July 31, 2018, p.6457, lines 15-32.

- The inspection at MPL was the most lengthy inspection that the home and the inspectors had ever experienced.[122]

79. The Ministry inspection at MPL spanned five months from October 2016 to February 2017. During this time, the inspectors conducted a thorough and comprehensive inspection of concerns relating to Wettlaufer, as well as 14 other complaints and critical incident reports. Inspectors attended at MPL on 47 separate dates. They made observations of resident care and various aspects of medication management; reviewed extensive documentation including resident health records, documentation relating to medication ordering, receiving and administration (EMAR), and policies and procedures of the home and the pharmacy service provider; and interviewed 51 current and former employees of MPL, as well as residents and family members, sometimes more than once.[123] During her testimony, Ms. Moroney agreed that the Ministry inspection at MPL was a stressful and overwhelming process for staff and inspectors.[124]

80. Despite the intensity of the Ministry inspections regarding Wettlaufer, there was no guidance 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.[125] No support person was offered by the Ministry to staff members being interviewed by inspectors and, in fact, support persons were not permitted to be present during interviews. In the absence of being permitted to

[122] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7148, line 14 to p.7151, line 11, p.7160, lines 18-24; Affidavit of Natalie Moroney, Exhibit 142, pp.5-6, para.18; Affidavit of Karen Simpson, Exhibit 129, p.46, para.147.
[123] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7152, lines 12-22, p.7150, lines 15-22, p.7154, line 2 to p.7155, line 6, p.7155, line 7 to p.7158, line 14.
[124] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7161, lines 23-27.
[125] Cross-Examination of Rhonda Kokoly, Transcript taken on August 2, 2018, p.6938, lines 12-21.

access a support person, many frontline staff at the home opted to bring legal counsel into their interviews.[126]

81. As mentioned above, for the first time ever, Ministry inspectors reviewed the entire Medication IP at MPL in the course of inspecting the Wettlaufer matter to ensure complete compliance with the legislation. In her testimony, Ms. Simpson acknowledged that long-term care homes are heavily regulated and the *LTCHA* contains a "detailed" and "prescriptive" framework of requirements with which homes must comply, including requirements for medication management.[127] In 2016, the Medication IP covered 69 areas of a long-term care home's medication management system in order to determine compliance.[128]

82. As a result of its intense inspection, Ministry inspectors found 10 areas of non-compliance at MPL with respect to its mediation management system.[129] In their testimony, Ms. Simpson and Ms. Moroney described these findings as "small failures" in the medication management system that were not high risk and which, individually, would not justify a compliance order.[130] Furthermore, Ms. Moroney confirmed that MPL was 85% compliant with the Medication IP.[131] In the circumstances, the Ministry issued one compliance order with respect to MPL's medication management system which has since been removed by the Ministry.[132]

83. Notably, it was acknowledged by Ms. Simpson during the Inquiry hearings that a significant percentage of long-term care homes are experiencing challenges with respect to compliance with the

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[126] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7162, lines 15-22, p.7173, p.14-18.
[127] Cross-Examination of Karen Simpson, Transcript taken on July 31, 2018, p.6395, lines 8-14, p.6398, lines 21-31.
[128] Medication Inspection Protocol (#31806), Affidavit of Rhonda Kokoly, Exhibit 134, pp.170-189.
[129] Inspection Order dated February 6, 2017 (#40984), Affidavit of Natalie Moroney, Exhibit 142, pp.40-41.
[130] Examination-in-chief of Karen Simpson, Transcript taken on July 30, 2018, p.6263, lines 14-27; Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7179, line 28 to p.7180, line 4.
[131] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7178, lines 1-5.
[132] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7180, lines 16-19.

LTCHA's requirements for medication management. Recently, after a meeting with the CNO, the Ministry circulated a memorandum to all long-term care homes to provide guidance with respect to medication management issues.[133]

84. In addition to the compliance order issued by the Ministry to MPL regarding medication management, inspectors made findings of non-compliance with respect to the critical incident reports and complaints that were inspected together with the Wettlaufer matter. Specifically, the Ministry issued 7 written notifications ("WN") and voluntary plans of correction ("VPN") in this regard. In her testimony, Ms. Moroney confirmed that some of these incidents dated back to 2014 and were no longer issues in the home. Further, all of these findings represented minimum risk, or minimum harm or potential for actual harm to residents.[134]

85. Additionally, there were no findings made by Ministry inspectors in relation to Wettlaufer's crimes. Inspectors reviewed Wettlaufer's personnel file at MPL, as well as the home's compliance history. They looked into whether there was any previous compliance history in relation to Wettlaufer and nothing stood out to inspectors.[135]

86. As a result of having experienced the Ministry inspection in relation to Wettlaufer, MPL makes the following recommendations:

- **The development of guidelines and ongoing training for Ministry inspectors with respect to conducting trauma-informed inspections.**
- **The development of clear guidelines by the CNO for Ministry inspectors with respect to reporting concerns about a nurse discovered during the inspection process, and ongoing training with respect to reporting requirements.**

[133] Cross-Examination of Karen Simpson, Transcript taken on July 31, 2018, p.6432, line 6 to p.6433, line 27.
[134] Cross-Examination of Natalie Moroney, Transcript taken on August 3, 2018, p.7180, line 27 to p.7181, line30.
[135] Affidavit of Natalie Moroney, Exhibit 142, p.6, paras.19-20.

- **Clear protocols to permit staff at long-term care homes to access an appropriate support person during Ministry inspections.**

- **A clear direction from the Ministry that inspectors are not permitted to utilize their inspection powers under the *LTCHA* to deny any person being interviewed as part of an inspection their lawful right to legal representation.**

- **Development (or updating) of guidelines for Ministry inspectors which provide direction with respect to the interview process including audio-recording, opportunities for staff to review relevant documentation (e.g. care plans, resident charts, etc.) prior to the interview, etc. Input is to be sought from long-term care operators, staff and residents.**

- **Creation of an office/positions within the Ministry to allow for the return of compliance advisors, separate and apart from Ministry inspectors.**

- **Increased guidance and support for long-term care homes from the Ministry (e.g. compliance advisors, bulletins, etc.) with respect to achieving compliance with medication management requirements and other requirements under the *LTCHA*.**

- **Development of a system by the Ministry to track nursing staff that are the subject of critical incident reports and complaints for the purpose of identifying concerning patterns and trends, with reporting to the CNO as necessary.**

(ii) LQIP Risk and Priority Assessment Framework

87. MPL submits that despite extremely devastating circumstances which were consuming and overwhelming its staff, and in spite of being under the microscope for many months during a very comprehensive and intense Ministry inspection, the Ministry's overall findings against the home were not considerable. MPL made efforts to correct deficiencies cited by inspectors and the compliance order was eventually removed. Nevertheless, apart from the personal impact of Wettlaufer's crimes on its residents and staff, MPL continues to be adversely and unfairly impacted by Ministry processes resulting from Wettlaufer. In particular, this unfair treatment has been experienced through the LQIP Risk and Priority Assessment Framework ("LPA").

88. The LPA is a risk assessment framework or methodology developed by the Ministry for assessing risk in Ontario long-term care homes. It is a ranking of each long-term care home's performance relative to other homes in the province.[136]

89. The LPA uses four sets of data for assessing risk: (i) compliance and inspection data; (ii) RAI-MDS data; (iii) LSAA Compliance Reports; and (iv) qualitative data. Based on these data sets, the LPA generates a report which assigns a home one of the following levels: (i) Level 1: "in good standing"; (ii) Level 2: "improvement required"; (iii) Level 3: "significant improvement required"; and (iv) Level 4: "licence revoked".[137] Since April 2018, the risk levels assigned to a particular home have been made public on the Ministry's website. If a home is not assigned a Level 1 or 2, they lose the Quality Attainment Premium, which is funding provided through the Other Accommodation envelope.[138] They are also subject to Intensive Risk Focussed RQIs. There is no formal process for a home to challenge the risk levels.[139]

90. Philip Moorman is an Appeals Specialist and Program Consultant with the Ministry. Although he had no previous experience with developing risk management frameworks specific to long-term care, he was tasked with leading the creation of the LPA[140]. He testified at the Inquiry hearings with respect to the development and implementation of this framework. In cross-examination, Mr. Moorman conceded that the LPA has numerous limitations with respect to assessing risk in long-term care homes, including the following:

- External stakeholders were not consulted with respect to the development of the LPA. It was developed entirely by the Ministry;[141]

[136] Slide deck of Karen Simpson's Evidence (#72869), Affidavit of Karen Simpson, Exhibit 129, p.107.
[137] Affidavit of Philip Moorman, Exhibit 148, pp.1-12.
[138] Affidavit of Karen Simpson, Exhibit 129, p.14, para.40.
[139] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7429, lines 3-25.
[140] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7402, lines 3-10.
[141] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7402, line 11 to p.7403, line 18.

- Since 2013, the LPA has gone through five different versions and is still being updated for improvement;[142]

- When new versions of the LPA were implemented, the Ministry did not retroactively apply the new version to adjust previous assigned risk levels;[143]

- All findings of non-compliance are weighed equally when assessing risk under the LPA. A finding with respect to not posting a dinner menu is ranked equally with resident abuse;[144]

- There is duplication when assessing data that increases risk levels. For instance, the model considers both the number of findings of non-compliance and the number of orders;[145]

- The framework considers only 3 of 23 clinical indicators of RAI-MDS data. The LPA does not consider other relevant indicators such as use of antipsychotics, use of restraints, worsening physical functioning, falls, etc., which Mr. Moorman agreed are all valid and reliable data from CIHI. CIHI has never been consulted by the Ministry with respect to the use of clinical indicators to assess risk;[146]

- The RAI-MDS data received by the Ministry from CIHI is already 4 to 5 months old when it is used by the LPA;[147]

- The performance measure received from the LHIN is not specific to how a home is performing compared to other homes in the province;[148]

- Management turnover within a home is weighed as an indicator of risk without consideration given to potential positive improvements resulting from a change in leadership or turnover resulting from recruitment by the Ministry;[149] and

- With respect to qualitative data, no weight is given to indicators of positive performance (e.g. absence of fire safety orders, results of resident and family satisfaction surveys, accreditation, feedback from Residents Council and Family Council, etc.)[150]

91. Although the LPA was initiated in 2012, it was launched publically in April 2018. At that time, long-term care homes learned for the first time their assigned level of risk for each quarter since 2013. MPL learned that it had been consistently ranked at Level 3 since September 2016.[151]

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[142] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7404, lines 21-28.
[143] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7405, lines 3-10.
[144]Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7408, line 32 to p.7409, line 13.
[145] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7408, lines 14-31.
[146] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7411, line 9 to p.7412, line 7.
[147] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7412, lines 4-20.
[148] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7413, lines 12-26.
[149]Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7414, line 4 to p.7415, line 2.
[150] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7415, line 20 to p.7419, line 23.
[151] Slide deck of Karen Simpson's Evidence (#72869), Affidavit of Karen Simpson, Exhibit 129, pp.107 and 110.

However, during his testimony, Mr. Moorman revealed that MPL would have been ranked as a Level 1 home for each quarter since September 2016 but for Wettlaufer's crimes.[152]

92. MPL respectfully submits that the evidence in these proceedings suggests that the LPA is an inherently flawed, subjective and imprecise methodology for assessing risk level in long-term care homes. MPL has been prejudiced through loss of the Quality Attainment Premium and annual Intensive Risk Focussed RQIs by having been unfairly ranked as a Level 3 home as a result of Wettlaufer's crimes. MPL is of the view that its assigned risk level is especially unfair in view of the expert evidence in this Inquiry that Wettlaufer's crimes were very difficult to detect.[153] Indeed, Dr. Michael Hillmer (the Executive Director of Information Management, Data and Analytics with the Ministry) confirmed his conclusion that based on the Ministry's data-driven project (the "Project") to determine if Wettlaufer's offences could be detected, it would have been "virtually impossible to contemporaneously or retrospectively detect the Offences from a data perspective".[154]

93. In regard to the foregoing, MPL proposes the following recommendations:

- **Suspending the use of the LPA until an audit of the LPA by appropriate stakeholders, including long-term care homes, has been completed and improvements to minimize the framework's considerable limitations have been implemented to ensure its accuracy.**
- **Limiting the use of the LPA to its original purpose of allocating Ministry inspection resources. Cessation of public reporting of assigned risk levels.**
- **Alternatively, implementation of a formal process which will permit homes to appeal assigned risk levels under the LPA to the Director and HSARB prior to their publication on the Ministry's website.**

[152] Cross-Examination of Philip Moorman, Transcript taken August 7, 2018, p.7422, line 29 to p.7423, line 3.
[153] Examination-in-chief of Professor Yorker, Transcript taken September 12, 2018, p.69, line 20 – p.70, line 9; p.74, line 15 to p.75, line 31.
[154] Affidavit of Dr. Michael Hillmer, Exhibit 168, p.24, para.62.

- **No longer linking receipt of the Quality Attainment Premium or Intensive Risk Focussed RQIs to the LPA. The Quality Attainment Premium would be based solely upon accreditation.**

- **Changing the annual RQI (including risk-focussed) requirement for all Level 1 homes to once every three years. This will reduce demands placed on staff during the RQI process and permit more time to focus on resident care.**

- **Consultation with appropriate stakeholders with respect to the ongoing development, implementation and use of the Project, including whether investing further in the Project is an appropriate use of public funds.**

(iii) Information Known by Others

94. The investigations, inspections and inquiries made into Wettlaufer's offences have revealed that several entities had information relevant to Wettlaufer's crimes during the time that she was murdering and intentionally harming residents. MPL does not intend to suggest that based on the information held by these entities that they were in a position to detect any wrongdoing. However, in some instances, there were practices which contributed to a lack of transparency which may have been contributing factors that allowed these events to occur.

95. For instance, both the Ontario Nurses' Association ("ONA") and the CNO were aware of Wettlaufer's termination of employment from Geraldton Hospital as a result of diverting Ativan and overdosing while at work. ONA grieved the termination and negotiated a resignation on behalf of Wettlaufer. The CNO commenced Fitness to Practice proceedings as a result of the Geraldton incident and ultimately placed conditions on Wettlaufer's practice, including mandatory treatment by an addiction specialist. Both ONA and the CNO were aware that Wettlaufer had mental health issues, was an alcoholic, had abused drugs and had attempted suicide.[155]

[155] Overview Report: The Facilities and Agencies, Volume 1, Exhibit 6; Report of the Board of Inquiry (#37317), Overview Report: CNO, Exhibit 8; Memorandum of Agreement between Wettlaufer and the CNO (#36838), Overview Report: CNO, Exhibit 8.

96. The CNO and ONA had additional information with respect to Wettlaufer as a result of her employment at CCW and dismissal from that employment. These entities were aware that Wettlaufer had a history of progressive discipline for medication errors and other mistakes, including incorrect treatment of a hypoglycemic episode and improper administration of insulin.

97. When Wettlaufer's employment was terminated by CCW after the insulin error, ONA grieved the termination, and negotiated a resignation and letter of reference. Jill Allingham ("Ms. Allingham") was the Labour Relations Officer ("LRO") representing Wettlaufer in her grievance negotiations with CCW. Ms. Allingham was also the LRO at MPL during this period. However, she did not share any information about Wettlaufer's discipline history at CCW with MPL.[156]

98. The CNO received a mandatory report from CCW with respect to Wettlaufer's termination and it was "banked with notice".[157] CCW was not advised of the outcome of its mandatory report by the CNO – in a letter to CCW, the CNO stated that this information was confidential.[158] While Wettlaufer was employed at MPL, the home had no idea that a mandatory report concerning her had been made to the CNO by CCW.

99. MPL submits that the facts described above suggest practices which promote a lack of transparency between and amongst organizations that play an important role in overseeing a nurse's practice. In her expert report, Professor Yorker noted certain measures to improve patient safety in response to health law serial killers. Firstly, she noted that sharing meaningful information regarding a previous employee (including providing honest work histories) with a prospective employer is one

[156] Affidavit of Jill Allingham, Exhibit 58; Cross-Examination of Jill Allingham, Transcript taken June 21, 2018, p.2938, line 29 to p.2939, line 13, p.2940, lines 13-24.
[157] Report Form for Facility Operators and Employers (#36841), Exhibit 55; Memo to File dated July 24, 2014 (#34993), Overview Report: CNO, Exhibit 8.
[158] Letter from the CNO to CCW dated July 17, 2014 (#36846), Overview Report: CNO, Exhibit 8.

strategy to prevent health care serial murders.[159] If former employers are to be transparent about a nurse's performance, including reasons for termination, a better model to resolve workplace disputes between employers, employees and unions is required.

100. Another measure recommended by Professor Yorker to improve resident safety in response to health law serial killings is stronger collaboration between regulators and employers in the discipline monitoring process.[160] MPL proposes that this collaboration should include prospective employers such that if there is an ongoing investigation of a member taking place, a flag of some kind could be raised by the CNO through the Find a Nurse site.

101. MPL proposed recommendations, therefore, include:

- **A better model to resolve workplace disputes between employers, employees and unions in order to ensure honest communication about a nurse's performance, including reasons for termination, to prospective employers.**
- **Stronger collaboration between regulators and employers in the discipline monitoring process.**
- **Provision of additional government funding to long-term care homes to subsidize legal and other costs associated with responding to grievances, both prior to and at arbitration proceedings.**

102. In terms of information known by others, MPL is most concerned by the fact that on various occasions, Wettlaufer confessed her murders to others and they failed to report her to police. We know from Wettlaufer's criminal proceedings that her confessions included the following:

- Between 2009 and 2011, Wettlaufer told a teenaged nurse's aide at CCW that she had harmed residents by overdosing them with insulin. The nurse's aide wanted to report Wettlaufer to police or staff. However, Wettlaufer told the nurse's aide that she would deny it and no one would believe her. The confession went unreported;

[159] Report of Professor Yorker (#72896), Exhibit 163, p.19.
[160] Report of Professor Yorker (#72896), Exhibit 163, p.20.

- In October 2013, Wettlaufer confessed to her pastor and his wife that she had murdered some of her patients through the use of a drug. The pastor was unsure about whether to believe Wettlaufer and his wife did not believe her. The confession went unreported;

- In the Fall of 2014, Wettlaufer told her roommate/girlfriend that sometimes she felt like she wanted to kill somebody in the nursing homes. At the time, the roommate did not tell anyone about this conversation;

- In or around 2014, Wettlaufer insinuated to her Narcotics Anonymous sponsor that she had murdered 8 people. The sponsor thought Wettlaufer was lying and the confession was not reported;

- In 2015, Wettlaufer told an ex-boyfriend that she had murdered two residents using insulin and had attempted to murder another. The boyfriend thought that the confession could be attributed to a psychiatric event. He did not report the admission to police;

- In September 2016, Wettlaufer confided in her cousin that she was responsible for the deaths of some residents at work and felt that she had given them too much insulin. Her cousin did not report the admission;[161] and

- Years before confessing to police, Wettlaufer consulted a lawyer who advised her that it would be in her best interest to remain silent. The lawyer urged her to seek assistance from a mental health professional.

103. Wettlaufer's confessions were not taken seriously enough by several individuals. Had her admissions been reported to police at the time that she made them, some of her crimes would likely have been prevented. Therefore, increasing awareness of the potential for health care serial killing is imperative. MPL recommends:

- **Development and implementation of strategies by licensing and regulatory bodies to increase public awareness of health care serial killings and the importance of reporting admissions or concerns to the authorities.**

[161] Agreed Statement of Facts on Guilty Plea, Exhibit 1(D), Doc #57687, pp.45-48, 51.

III. CONCLUSION

104. Jarlette and MPL appreciate the opportunity to propose recommendations to help improve the safety and security of residents in our long-term care system. They look forward to participating in the next phase of the Inquiry to further discuss the recommendations made by all participants.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

LIST OF PROPOSED RECOMMENDATIONS

1. Increased Ministry funding for all envelopes, including the Nursing and Personal Care ("NPC") Envelope, to enable homes to attract and retain qualified staff, drive quality outcomes and maintain better nurse to resident ratios.

2. Increased flexibility with respect to how homes can utilize funding within the NPC envelope to permit recruitment of an appropriate mix of staff beyond RNs, RPNs and PSWs (e.g. aides, porters, nursing attendants, pharmacy).

3. An evaluation by appropriate stakeholders with respect to the 24-hour RN requirement versus an increased presence of RPNs. Consideration as to whether the care needs of residents can be met by having an RN available on-call.

4. Continued development and prompt implementation of a Nurse Help Program through the CNO to provide support for nurses with mental health and substance abuse issues.

5. A requirement that the CNO offer nurses an employee assistance program (EAP).

6. Consideration to whether the CNO should complete psychological assessments for nurses as a requisite for registration, having regard for the need to balance privacy and human rights interests.

7. CNO to maintain a public registry (e.g. "Find a Nurse") containing the qualifications and complete employment history of nurses to prevent possible falsification of credentials. The public registry should also advise employers and prospective employers regarding the status and outcomes of CNO investigations into a nurses practice. It must be a real-time registry in order to enable users to receive current information.

8. Consideration to implementing immunity legislation for employers which provide honest information to prospective employers about adverse incidents and reasons for termination of employment of a nurse.

9. Consideration to developing a standard Applicant Reference Form that includes a waiver for information to be provided by employers, including formal disciplinary actions for incidents involving abuse, neglect or violence toward residents, and reasons for separation from employment.

10. Development of best practice hiring guidelines for the long-term care sector.

11. Heath care organizations and regulatory bodies to increase awareness of health care serial killings amongst long-term care physicians, nursing staff, residents and families.

12. The Coroner's office to provide training and support for long-term care physicians and nursing staff with respect to recognizing when a death is sudden, unexpected or otherwise unusual.

13. The Coroner's office to update the Institutional Patient Death Records ("IPDR") for residents who pass away in the home, and provide training and support to long-term care nursing staff with respect to completing the form in order to allow for accurate reporting.

14. Reinstatement of the automatic threshold death investigation by the Coroner's office with consideration to ways in which to improve effectiveness of the process.

15. Consideration to utilizing existing and new data from IPDR and death investigations to identify patterns and trends in long-term care deaths (e.g. data analytics).

16. Training for hospital and long-term care nursing staff with respect to considering medication error as a differential diagnosis in cases of unexpected or severe hypoglycemia (e.g. situations in which individuals fail to recover after glucagon is administered).

17. Establish a clear set of intervention responses (e.g. checking vital signs and blood sugar levels) to assist staff in responding to and evaluating sudden and unexpected changes in a resident's condition.

18. Building capacity amongst long-term care leadership in systemic incident analysis using the Canadian Incident Analysis Framework (or similar methodology), along with sufficient resources, in order to assist in detecting intentional harm.

19. Development by long-term care stakeholders of "Consensus Guidelines" for managing suspicious situations.

20. Increased Ministry funding for behavioural supports training and more dedicated BSO staff in long-term care homes.

21. Review of the ongoing need for non-prescription public access to insulin and consideration of whether insulin should only be available through prescription or some other documentation.

22. Review the use of automated dispensing cabinets, bar coding and disposable insulin pens as mechanisms to minimize risk of harm. Provision of start-up and sustainability funding for this type of technology and innovation.

23. Limit the supply of insulin pens for diabetic residents to current pen(s), with limited spare pens available in the home.

24. Consideration to increased pharmacy technician support (including on-site support) within long-term care homes to assist with medication management activities and providing sustainability funding of same.

25. Labelling of insulin and hypoglycemic agents on packaging and cartridges as a high alert medication.

26. Implement a systemic review by pharmacy of each long-term care homes use of rescue and symptom management medications from the emergency drug supply (e.g. glucagon).

27. Review by appropriate stakeholders of medication management systems in long-term care homes to suggest improvements to minimize the risk of diversion.

28. Provide long-term care homes with additional government funding for the purpose of installing cameras in medication rooms and common areas, as well as the installation of windows into the doors of medication rooms.

29. Consideration of measures proven effective in early detection of drug diversion (e.g. Anomalous Usage Reports).

30. The Ministry to conduct a survey of long-term care stakeholders, on a periodic basis, of any new technologies which can be utilized to improve medication management systems.

31. A review of mandatory reporting obligations under the Procedural Code to determine if additional requirements are needed to protect against intentional harm of residents resulting from drug diversion or otherwise (including self-reporting obligations for nurses with substance abuse issues).

32. An update to the Mandatory Reporting Guide to reflect current mandatory reporting requirements and the CNO's expectations regarding voluntary reports.

33. The development of guidelines and ongoing training for Ministry inspectors with respect to conducting trauma-informed inspections.

34. The development of clear guidelines by the CNO for Ministry inspectors with respect to reporting concerns about a nurse discovered during the inspection process, and ongoing training with respect to reporting requirements.

35. Clear protocols to permit staff at long-term care homes to access an appropriate support person during Ministry inspections.

36. A clear direction from the Ministry that inspectors are not permitted to utilize their inspection powers under the *LTCHA* to deny any person being interviewed as part of an inspection their lawful right to legal representation.

37. Development (or updating) of guidelines for Ministry inspectors which provide direction with respect to the interview process including audio-recording, opportunities for staff to review relevant documentation (e.g. care plans, resident charts, etc.) prior to the interview, etc. Input is to be sought from long-term care operators, staff and residents.

38. Creation of an office/positions within the Ministry to allow for the return of compliance advisors, separate and apart from Ministry inspectors.

39. Increased guidance and support for long-term care homes from the Ministry (e.g. compliance advisors, bulletins, etc.) with respect to achieving compliance with medication management requirements and other requirements under the *LTCHA*.

40. Development of a system by the Ministry to track nursing staff that are the subject of critical incident reports and complaints for the purpose of identifying concerning patterns and trends, with reporting to the CNO as necessary.

41. Suspending the use of the LPA until an audit of the LPA by appropriate stakeholders, including long-term care homes, has been completed and improvements to minimize the framework's considerable limitations have been implemented to ensure its accuracy.

42. Limiting the use of the LPA to its original purpose of allocating Ministry inspection resources. Cessation of public reporting of assigned risk levels.

43. Alternatively, implementation of a formal process which will permit homes to appeal assigned risk levels under the LPA to the Director and HSARB prior to their publication on the Ministry's website.

44. No longer linking receipt of the Quality Attainment Premium or Intensive Risk Focussed RQIs to the LPA. The Quality Attainment Premium would be based solely upon accreditation.

45. Changing the annual RQI (including risk-focussed) requirement for all Level 1 homes to once every three years. This will reduce demands placed on staff during the RQI process and permit more time to focus on resident care.

46. Consultation with appropriate stakeholders with respect to the ongoing development, implementation and use of the Project, including whether investing further in the Project is an appropriate use of public funds.

47. A better model to resolve workplace disputes between employers, employees and unions in order to ensure honest communication about a nurses performance, including reasons for termination, to prospective employers.

48. Stronger collaboration between regulators and employers in the discipline monitoring process.

49. Provision of additional government funding to long-term care homes to subsidize legal and other costs associated with responding to grievances, both prior to and at arbitration proceedings.

50. Development and implementation of strategies by licensing and regulatory bodies to increase public awareness of health care serial killings and the importance of reporting admissions or concerns to the authorities.