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

The Honourable Eileen E. Gillese, Commissioner

WRITTEN SUBMISSIONS AND RECOMMENDATIONS OF THE ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS (OARC) AT CONCLUSION OF PUBLIC HEARINGS

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Advocacy Centre for the Elderly
2 Carlton Street, Suite 701
Toronto, ON
M5B 1J3

Jane E. Meadus
(LSUC No.: 33997U)

Phone: (416) 598-2656
Toll Free Number: 1-855-598-2656
Fax: (416) 598-7924
E-mail: MeadusJ@lao.on.ca
www.acelaw.ca

Fraser Advocacy
31 Prince Arthur Avenue
Toronto, Ontario
M5R 1B2

Suzan E. Fraser
(LSUC No.: 37098M)

Telephone: (416) 703-9555
Toll Free: 1-877-867-3716
Facsimile: 1-877-704-0348
E-mail: fraser@fraseradvocacy.com

Counsel for OARC

PART I – OVERVIEW

1. Elizabeth Wettlaufer killed eight people, attempted to murder four, and assaulted two other people. These represent her criminal offences. In the course of this inquiry, we have learned much more about her: abusive and neglectful behaviour that went unchecked and unreported, sexual harassment of students and staff, bullying of and discrimination toward staff and residents and host of personal problems that interfered with her ability to care for residents. Her superiors' incompetence made them oblivious to what ought to have been obvious: she was not suitable to care for vulnerable residents. And so, they did not discipline her for abusive or neglectful behaviour. For the most part, they did not report her to the Ministry. We will never know how many other residents suffered at the hands of Ms. Wettlaufer. But the repeated concerns, made across facilities, suggest that there were likely many residents who were neglected and did not get the care they needed or were the subject of her abuse given the free reign she had at Caressant Care Woodstock (CCW). Evident from all of the documentation in evidence in this inquiry about decisions taken in all of the homes, and from all of the professionals whose work touched on the home, is that those with the power to supervise, control and discipline Elizabeth Wettlaufer did not see the issues through the eyes of the residents. They only used their own institutional lens. By failing to use the residents' lens, they missed problems that were in plain sight.

2. While Elizabeth Wettlaufer made it difficult for others to detect her crimes, she left a trail of problematic behaviour that ought to have set off alarm bells. And while the facilities were in no way complicit with her crimes, they are responsible for the

conditions that allowed her to flourish and go undetected. We urge this Commission of Inquiry to so find.

3. Each of the facilities in which Elizabeth Wettlaufer worked demonstrated a lack of understanding of the statutory obligations of management, the protective underpinnings of the statute and their obligation to report abuse and neglect. This deprived the residents of the protections of the statutes governing long-term care.

4. The oversight mechanisms (in the home, through College of Nurses, the Ministry of Health and Long-term Care and the coroners) that might have detected Elizabeth Wettlaufer's crimes were inadequate due to built-in, structural flaws. They provided only superficial accountability. Each gave the veneer of protection for vulnerable residents in long-term care. Yet, each mechanism of accountability is highly dependent on conflicted or implicated parties to report untoward events, critical incidents or occurrences that trigger reporting obligations.

5. For their failure to move beyond superficial accountability and a culture of complacency, OARC states that CCW failed its residents. Those residents include seven people killed by Elizabeth Wettlaufer. Meadow Park and Telfer Place also failed the residents. Each because they failed to appreciate their responsibilities to report abuse and neglect. Each because they failed to take action to report concerning behaviour to the Director. Each because they failed to report her abusive behaviour to the College of Nurses.

6. OARC states that our death investigation system also failed the victims and the residents of long-term care. It did so first when it eliminated the mandatory investigation of deaths in long-term care homes. The coroner's office then sought to save $900,000 by eliminating the one-in-ten death investigation. Last, it made meaningless the mandatory reporting of deaths in long-term care.

7. The CNO also failed when it "banked" the information it received in 2014 with notice despite a prior history that would indicate risk and any meaningful review of her history within the CNO. Its failure to meaningfully examine information in its possession contributed institutional ignorance of the crimes. Yet, the CNO's actions likely would have been different had it been notified of the abusive behaviour witnessed by health professionals over the years.

8. All of these agencies share one thing: they did not put residents first.

9. To ensure that Ontario's residents in long-term care are safe, OARC makes 89 recommendations directed at putting residents first. A residents first strategy means putting the needs and interests of the residents first and above all other interests including government, corporate and professional interests. Putting residents first means targeting stereotypical and ageist beliefs that long-term care is a person's last home where long-term care residents are expected to die. The recommendations, set out below, implore this Honourable Commissioner to make bold recommendations

directed at ending the culture of complacency and creating one which puts residents first and engages meaningful accountability. In order to do this, the Commission will need to examine the issues through the eyes of the residents.

PART II - THE VICTIMS

10. The disturbing facts of how Elizabeth Wettlaufer committed her crimes are well set out in Agreed Statement of Facts on the Guilty Plea. From these facts, we can better understand the lives of her victims. Veterans who served our country. Business people. Parents. Friends. Persons with developmental disabilities. Each moved into long-term care as a necessary step when they could not live at home or where support to live at home was not available. Each trusted in the health professionals to do right by them.

11. They were moving into a new home. They were not coming into care as an end to their lives. They were coming for support. They were entitled to live, and ought to have lived, with dignity and as much independence as possible.

12. They are not here to speak to what would have made a difference. This inquiry, in the spirit of the Coroner's motto, can speak for the dead to protect the living by making finding of fact and robust recommendations.

PART III - POTENTIAL TO INTERVENE BY NON-STATE ACTORS

13. In her confession, Elizabeth Wettlaufer reported having told at least 12 people about her crimes before she was finally believed by her psychiatrist at CAMH. Not one person reported this to the authorities. In some cases, they told her to stop or that she should keep silent. Ms. Wettlaufer was in a position of power over some of the most vulnerable members of our society. With the exception of the confession to her lawyer, each of these confessions presented the information about her crimes, each confession presented an opportunity to intervene, and each confession could have prevented future horrific violence and brought her to justice.

14. If Ms. Wettlaufer is to be believed, some of those people to whom she confessed did not believe her; they certainly did not report her. Others believed her, but chose to do nothing. In our view, it is imperative for those with knowledge about possible violence against residents in long-term care to understand their duty to report. To this end, we believe it is imperative that there be a public campaign by the Ministry of Health and Long-Term Care for people to understand when and how they can report such issues to the Ministry or the police.

PART IV - FAILURES BY THE LONG-TERM CARE HOMES

15. EW murdered eight people and attempted to murder or harm six others, between June 25, 2007 and August 30, 2016. During the period, the *Nursing Homes Ac*t (NHA) was the governing statute for the provision of care at CCW. On July 1, 2010, the long-awaited *Long-Term Care Homes Act, 2007* (LTCHA) came into force and governed the

care provided at CCW, MPL and Telfer Place from July 1, 2010 forward. Both statutes contained mandatory reporting of suspected abuse and neglect.

A. Regime under the *Nursing Homes Act*

16. Prior to July 1, 2010, CCW was governed by *the Nursing Homes Act* (NHA). The NHA and its regulations contained a number of significant protections aimed at ensuring quality and protection of residents. Some of these are discussed below.

(i) The Fundamental Principle

17. The *Nursing Homes Act* (NHA) provided that the fundamental principle was that a nursing home was primarily the home of its residents and was to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents were adequately met and that its residents be given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others. (*Nursing Homes Act*, Final Legislative Brief, FD0000005, p. 1340-1341).

(ii) Residents' Rights

18. The NHA contained a Residents' Bill of Rights dating back to 1993 when all three acts governing long-term care (the *Homes for the Aged and Rest Homes Act, the Charitable Institutions Act and the NHA)* were amended to include a Residents' Bill of Rights. Section 2(2) of the NHA required licensees (homes) to ensure that the 19 rights were fully respected and promoted. (Final Legislative Brief, FD0000005, pp. 1341-1342). Those rights included the right to be treated with courtesy and respect and in a

way that fully recognized the resident's dignity and individuality and to be free from mental and physical abuse. The program manual fully set out the Ministry expectations regarding residents' rights in a detailed program standard 0902-01 (Ex. 14).

19. Residents' councils were not mandatory but section 29 mandated that that if the Administrator received a request to form a residents' council from at least three people, the licensee had an obligation to assist the requestors with establishing a residents' council within 60 days.

(iii) Mandatory Reporting

20. The NHA also required direct reports to the Director when a person (other than a resident) had reasonable grounds to suspect that a resident had suffered or might suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect. They were to report the suspicion to the Director forthwith and the information upon which it was based (Section 25(1), NHA, Final Legislative Brief, FD0000005, p. 1361).

21. Under section 26 of the NHA, licensees were required to forward to the Director complaints received about the care of a resident or the operation of a home. (Final Legislative Brief, FD0000005, p. 1362)

(iv) Medical Director

22. The NHA required each home to have a medical director. The licensee was to appoint a medical director and obtain a written statement signed by the medical director

stating that the medical director would advise the administrator of the home on matters relating to medical care in the home, including the quality of medical care provided in the home.

(v) Administrator

23. Regulation 832 under the NHA defined administrator as a person in charge of a nursing home. (s. 1, Leg. Brief, FD0000005, p. 1400)

(vi) Director of Care

24. The regulations to the NHA (O.Reg. 832, Leg. Brief, p. 1413) required licensees to ensure that the home had a registered nurse who was designated as the director of nurses responsible for the organization, direction and evaluation of nursing care, directing the work of the nursing staff in the nursing home; and the organization and direction of in-service training programs for nursing staff. For the period of time that Elizabeth Wettlaufer worked at CCW, Helen Crombez was the Director of Nursing, later the Director of Care. She bore responsibility for training.

25. The regulations also delineated minimum standards for the administration of drugs within the home (ss. 63-69, Leg. Brief, FD0000005, pp. 24-25)

26. Under the NHA, Ministry standards were set out in the Program Manual including the residents' rights and safeguards. (Van Quaethem testimony, p. 605-606, ex. 14) However, there were issues of compliance and it was not clear that the minimum standards could be enforced (Fairchild Testimony, pp.7565-7566).

B. Regime under *Long-Term Care Homes Act, 2007*

27. The *Long-Term Care Homes Act, 2007* came into force on July 1, 2010. Together with its regulations, and the promise of a new inspection regime, it comprehensively responded to public concerns about the quality of care following many reports and recommendations regarding long term care (the 2006 Caplan report *Choosing Quality, Rewarding Excellence* Ex. 9, Source Document LTCI00044474; the May 2008 Independent Review *People Caring for People* authored by Sharkey, Ex.6, LTCI00046745; the 2004 Smith report *Commitment to Care: A Plan for Long-Term Care in Ontario,* Ex. 154, LTCI00046531). It remains a relevant and comprehensive statute and regulatory framework, the promise of which has not been fully realized. Indeed, there is a wide gap between the promise of the legislation and the lived reality, much of which is evident in this inquiry.

(i) The Fundamental Principle

28. The LTCHA provides that the fundamental principle is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. (LTCHA s. 1). It is obvious that Elizabeth Wettlaufer violated this principle both when she committed her criminal acts and when she failed to meet the needs of the residents for whom she was responsible. Others violated this fundamental principle too, when they took no action in the face of neglect and abuse of the residents.

(ii) Residents' rights

29. The LTCHA expanded and enhanced the statutory and regulatory scheme designed to ensure the safety and security of residents. Numerous government reports called for the creation of a comprehensive regulatory framework because the NHA and the program standards and guidelines had not produced the desired level of service. After an unprecedented consultation with various stakeholders, the statute was proclaimed in force along with its prescribed regulations.

30. Residents rights were expanded: 19 rights under the NHA became 27 rights under the LTCHA. Key rights under the new legislation included:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
9. Every resident has the right to have his or her participation in decision-making respected.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

(iii) Zero tolerance of abuse and neglect

31. The LTCHA required the home to protect its residents from abuse from anyone and neglect from the home (LTCHA s. 19), and to have a policy of zero tolerance of abuse and neglect (LTCHA s. 20). It required that the licensee immediately investigate every allegation of abuse and neglect, take appropriate response and ensure compliance. (LTCHA, section 23) In addition, the LTCHA mandated the reporting of abuse and neglect to the Director, a person at the Ministry appointed pursuant to statute (LTCHA, s. 1, 24). Section 24 required any person who suspected abuse and neglect to report that suspicion to the Director.

(iv) Administrator

32. Every long-term care home must have an administrator who is responsible for the management of the home (LTCHA, section 70). Brenda Van Quaethem filled this role between July 2009 and September 30, 2016. This included ensuring compliance with standards and giving direction (BVQ testimony, Vol. 3, p. 602). She worked under both the NHA and LTCHA regimes.

(v) Medical Director

33. Section 72(1) of the LTCHA requires each home to have medical director who is a licensed physician whose job, according to 72(3)(b) is to advise the licensee on matters relating to medical care in the long-term care home. Section 214 of O.Reg. 79/10 required every licensee to enter into a contract with the medical director and that the responsibilities for the medical director be set out therein. Section 214(3) of the

regulation states that for the purposes of s. 72(3)(b), the responsibilities and duties of the medical director are:

> 1. Development, implementation, monitoring and evaluation of medical services.
> 2. Advising on clinical policies and procedures, where appropriate.
> 3. Communication of expectations to attending physicians and registered nurses in the extended class.
> 4. Addressing issues relating to resident care, after-hours coverage and on-call coverage.
> 5. Participation in interdisciplinary committees and quality improvement activities. (Final Leg. Brief, FD0000005, p. 1157)

(vi) Director of Care

34. Section 71 of the LTCHA requires every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care who is an R.N. and whose responsibilities including the supervision and directions of the nursing and personal care staff of the long-term care home and nursing and personal care provided by them. (Final Leg. Brief, FD0000005, p. 559)

35. The Act also limits the use of agency staff and established clear statutory obligations and standards for the administration of medication.

C. Caressant Care Woodstock

36. CCW failed to meet Ministry expectations for the reporting of suspected abuse and neglect. As set out further below, time and time again, staff and management failed to do what the statute mandated them to do: report abuse and neglect. It also failed to intervene meaningfully at key points when Elizabeth acted in error or behaved in a manner which was clearly inappropriate, risky or reckless. It is difficult to be critical of

apparently well-intended women, which the CCW staff appeared to be, doing hard work in difficult circumstances and who learned of horrific crimes committed on their watch. The process demands it. Residents depended on the administrator, director of care and other staff to uphold their rights, ensure safeguards were met and to care for them, and their roles must be scrutinized. They helped lead a home plagued by a culture of complacency which plagued CCW. Its management appeared woefully ill-equipped to understand the purpose and thrust of their governing legislation. Management did not meaningfully educate staff on the rights of residents and their obligations to them either under the *Nursing Homes Act* or later under the *LTCHA*.

37. We recognize that there were issues with recruitment and retention of nurses in long-term care at CCW and other facilities. Ms. Van Quaethem and Ms. Crombez spoke to these issues. (Testimony, p. 276 p. 506, l.11; p. 509; p. 594, p. 65513). For this reason, we urge the Commissioner to make recommendations directed at improving the recruitment and retention of nurses.

38. Dr. Reddick, despite being CCW's medical director of almost 40 years, appeared ignorant of his responsibilities under the LTCHA. He was neither able to articulate them nor able to acknowledge them when questioned. (Testimony, pp. 3168-3169)

39. Quarterly medication reviews were completed without the involvement of the resident. It was RAI Coordinator and nurse Laura Long who testified that someone would print out the "quarterlies" and she and Dr. Reddick would go through them without

seeing the patient. (Long Testimony, pp. 1966-1967, Reddick, p. 3179)

40. Caressant Care was also unaware of its obligations to report possible abuse and neglect under section 24 of the *LTCHA* (FD0000005 p. 622). While there were multiple possible reports, a Ministry review after the fact found that only there were only two reports made to the Ministry related to Ms. Wettlaufer (Simpson, Transcript Vol. 27, p. 6145). The first involved the resident "CH" who accused Ms. Wettlaufer of assaulting her on January 12, 2012. Instead of reporting the matter immediately to the Director as required, management decided to do their own investigation first. The resident recanted, then made a complaint directly with the Ministry herself on January 23. Caressant Care's management finally submitted a Critical Incident Report in the matter on January 30, 18 days after the incident occurred. Unfortunately, the Ministry also failed to inspect the home on the failure to comply with section 24, justifying their position, incorrectly, that since the resident had recanted the matter was resolved. This is not the case, as the home's failure to immediately report a serious allegation of abuse was the issue, not whether that allegation ended up being verified (Ex. 6, LTCI00000522; LTCI00059485; LTCI00059320; LTCI00059487; LTCI00000389).

41. The second example is related to the resident "DW" who had entered into an altercation with another resident. Ms. Wettlaufer approaches resident DW, threatening him by asking if he needed a "psychiatric evaluation" or a "haldol injection". While this was reported to Helen Crombez, she did not report this to the Director as abuse. Instead, a Critical Incident Report was submitted to the Ministry because of "resident to

staff abuse" when DW came to her office upset with Ms. Wettlaufer, threatening her and demanding that she not be able to give him medication (Ex. 6, LTCI00016810; LTCI00016811, LTCI00000639; LTCI00058989). (Resident threats to staff are not issues that can be reported or inspected by the Ministry,) In October 2016, an inspection was commenced during which time a finding of non-compliance was made against the home in relation to this incident (Simpson, Transcript Vol. 27, p. 6150).

42. The most telling incident related to failure to make a mandatory report relates to the Wettlaufer murders themselves. Upon becoming aware of the murders, Jim Lavelle, the owner of Caressant Care, did not immediately contact the Ministry, instead he contacted a lawyer, hired a PR Firm, and called Candace Chartier, CEO of the Ontario Long-Term Care Association (Ex. 129). It was Ms. Chartier who passed the information on to the Director on October 5 (Simpson, Transcript 27, p. 6261). It is difficult to understand how the owner of a long-term care home chain would fail to realize his duty to report this crime to the Ministry under mandatory reporting sections of the LTCHA.

43. The incompetent management is fully evident in the September 1, 2017 Order of the Director (Ex. 87 LTCI00039074). It is a damning indictment of the state of affairs at CCW. Despite the date of the order, it details numerous failures to comply with regulation in key areas that put residents at risk. These appear to be longstanding problems to which Carole Hepting, the Vice-President Operations was oblivious. These include the issues of medication administration, as well as failing to comply with medication policies, abuse prevention policies, and failing to, immediately investigate

the suspicion of abuse or neglect and take appropriate actions and report the results of the investigation to the Director under the LTCHA. The Order was not appealed and represents legal findings of fact by the Director pursuant to the LTCHA.

44. In addition, the Director's order revealed this shocking fact: despite months of attempts, CCW could NOT achieve compliance and CCW management was found to lack a basic understanding of what was required. (Ex. 87, pp. 1, 2, 8, 9). The Order of the Director stated:

> a. The licensee has demonstrated a continued inability to fully understand the scope and severity of non-compliance and the issues involved, as well as what actions are required and what resources and effort are needed to be in place at the home to comply with Compliance Orders, implement plans and achieve and sustain compliance with the requirements of the LTCHA.

45. Carol Hepting, who continues to occupy the role of Vice-President Operations, did not have an understanding of what was necessary to bring the home into compliance. Why these deficiencies were not discovered in previous inspections is unclear (the suggestion is that they decided post-Wettlaufer confession to do the full medication inspection protocol). That they were uncovered subsequently speaks to the need to do the full protocol. Further, the home, even knowing that it was under intense scrutiny, continued to fail to comply with the legislation, Between August and December, 2017, the Ministry inspectors found 41 medication errors and were not taking appropriate action to investigate and deal with those errors (Simpson, Transcript Vol 27, pp.6258, 6260).

D. Failure to Report Elizabeth Wettlaufer's Neglectful and Abusive Conduct

46. OARC asserts that there were multiple incidents of abuse and neglect that ought to have triggered reports to the Directors. Further, the failure by CCW staff at various places of employment to report abuse and neglect by Ms. Wettlaufer contributed to creating conditions in which she was able to harm residents. We say this because it would have been obvious to her that, with limited exceptions, her behaviour was neither being reported nor triggering an external examination. Almost every single staff member testified as to their devastation at the news that they had worked unknowingly alongside a serial killer. On the one hand, many spoke about her being "good" with residents. However, not only did she commit murders and attempted murders, she also demonstrated at CCW and Telfer Place abusive and neglectful behaviour that was witnessed but often went without report to the Director.

47. Ms. Van Quaethem articulated that the practice in the home was that staff were expected to report suspected abuse and neglect to her or the Director of Nursing, but not directly to the Director. (Testimony, p. 612-613). There were reportable incidents. Included in the events that we know about are:

- not meeting the needs of residents in a timely manner LTCI00016842; (Ms. Slyfield wrote that "this is not the first time that I have complained", Ex. P of Ex. 10);
- disimpacting a resident without pain medication (while the evidence suggested that this was not clinically inappropriate, at the time the complaint was made, there was a suspicion of incompetent treatment thereby requiring a report);

- being sarcastic and mean and threatening a resident with the use of haldol and a psychiatric assessment (Testimony Laura Long, p. 1969-1970, Ex. 42);
- neglected to answer call bells in a timely manner leaving residents in pain;
- shaking her “butt” in front of the face of a resident;
- stabbing a hematoma with unsterilized scissors.

48. Non-reportable but concerning incidents included discriminatory language towards another staff member and that she was a bully (pp. 692-693). Wettlaufer came to the home on Halloween dressed as “the Grim Reaper” and it does not appear that anyone reported this as concerning behaviour. (Laura Long, Transcript, p.1968). She also reported Ms. Wettlaufer “hitting on students” (Transcript, p. 1940).

49. We will never know what truly happened in those evenings where Ms. Wettlaufer was alone with residents. We know that when Laura Long came in early, she would witness a different side to her (Transcript, p.1971). Without management oversight in the evenings, or being visible to professional staff (because they were not on duty), Wettlaufer went unsupervised in the night shifts.

50. Management did not critically examine her problematic error. We understand that people make medication errors but there ought to be a rigor around those errors. Wettlaufer was known to be lazy, sloppy and careless. She was also inappropriate. CCW management did not examine whether the error was born of mistake or sloppiness, or ignorance or recklessness, each which would give rise to a different form

of correction. There was superficial accountability when errors were brought to management's attention, but they did not take steps. Beatrice Crofts Yorker offers a lens through which to examine mistake under the AONE Guiding Principles. These principles are instructive on the kind of analysis that ought to be brought to bear when addressing problematic behaviour: critically thinking being key. Critical thinking and judgement were sorely lacking in CCW's management of Wettlaufer.

51. The inquiry witnessed a strange dichotomy. Witnesses who thought Ms. Wettlaufer to be "nice" would also report very concerning and problematic behaviour. Brenda Black is an example. She described her as nice, referencing her bringing buckets of chicken (Transcript, p.1892). At the same time, she recognized that leaving residents in pain, neglecting them was not nice (Testimony, p. 1904-1905). Ms. Black stated "I never saw anything that would be classified, in my view, as abuse abuse" thereby diminishing the significance of neglectful behaviour which mandated a report to the Director. In addition to Ms. Black, others thought Ms. Wettlaufer was nice: Ms. Crombez (p. 802, 1054, also to the CNO, notes of Karen Yee, testimony p. 870-871,). Incidentally, at MPL, Heather Nicolas also used the word "nice" to describe her first impressions of Ms. Wettlaufer (p. 1920).

E. Meadow Park London

52. Meadowpark London's policy on reporting abuse and neglect did not identify that any person, except a resident, had an obligation to make a report to the Director. It directed staff to report the concern to the most senior administrative personnel on site

with no reference to the Director. (Nicholas testimony, pp. 2324-2326, Ex. 43, p.148, LTCI00021710) The policy further directed the director of care or administrator to conduct an investigation and make a report within 10 days of the investigation to the Director.

53. Most significant is MPL's failure to report the events that lead to Ms. Wettlaufer's resignation from MPL to the College of Nurses of Ontario (CNO), or the issues related to her suicide attempt and drug overdose. While we anticipate that this evidence will be covered in detail by other parties we would like to specifically point out that while termination is required to be reported under the legislation, resigning before one can be terminated is not.

F. Telfer Place

54. Telfer Place had Elizabeth Wettlaufer for 40 shifts. During that period of time, Dr. Macdonald reported to the home feeling very uneasy about an interaction with Ms. Wettlaufer. It was a unique experience in his 42 years as a physician (Testimony, p. 3064-3068). He described how her eyes appeared to glaze over: she was not able to provide details about the patient subject of concern, she could not provide helpful details and had very few words despite his repeated questions.

55. The Ministry also learned of two concerning facts in the course of its 2016 inspection. First, it learned of detail behind vulgar comments made to staff at Telfer place. Second, information that Dr. Williams witnessed what he described verbally abusive behaviour and the behaviour was not reported. No finding of non-compliance

was made. In our view, it matters not that Ms. Vink could not ascertain which nurse or the date of the allegations. She had an admission that a professional witnesses abusive behaviour and did not report it. (Lisa Vink Affidavit, ex.144, para. 72, Testimony, p.7268-7282)

56. Licensees are exempt from ensuring that physicians have the requisite training on abuse and neglect. This does not make sense. Physician's independence should not compromise residents' safety. Presently, section 222 of the regulations to the LTCHA exempts licensees from having to ensure that physicians undergo mandatory training. It is a gap that ought to be closed.

PART V - DEFICIENCIES IN PROFESSIONAL REGULATION BY THE COLLEGE OF NURSES

57. The detail about the underlying referrals to the CNO are well-document in the material in the overview reports. We will address just a few discrete issues.

58. The CNO advised Geraldton Hospital (following the theft of medication and her overdose) that the CNO would not provide the results of the investigation to the Geraldton Hospital (Ex. 6, Source Document, LTCI00037183.) Geraldton Hospital, in turn, requested that the "report" be changed to a "complaint", thereby entitling them to receive information regarding results of the investigation (Ex. 121A, LTCI00037214). Testimony at the Inquiry (Anne Coghlan, Transcript Volume 23, p. 5320) is that institutions can no longer become the "Complainant" to get around this rule (Transcript Volume 23, p.5244-48). Further, when a report is made, the College can use its

discretion and not order an investigation, unlike when a complaint is made and it is mandatory (Anne Coghlan, Transcript Volume 23, p. 5249).

59. OARC can see no principled reason for these to be treated differently in terms of the exchange of information or the investigation process. Institutional reporters ought to be entitled to receive information regarding the outcome of mandatory reports. This will assist them in managing the profession and understanding the expectations of the CNO regarding professional standards. Reports from institutions or employers should always be investigated, as they are more knowledgeable about the provision of healthcare, and the fact that they have reported to the CNO means that there is a serious issue involving one of its members.

60. CNO takes steps to better understand the collective bargaining process when examining mandatory reports and the context in which they are made. It defied belief that the CNO claimed little knowledge of the collective bargaining process and the practice or requirement of progressive discipline. We understand from the evidence that a firing from long-term care will be a significant event. We would have expected the CNO to be aware of the nursing shortage in long-term care, that the facilities will be required to discipline progressively and likely, will attempt to rehabilitate a nurse. These practical realities suggest that a termination is a major event and that, generally speaking, when a nurse is fired in long-term care, it was a very serious event or that the nurse have a lengthy history of problems before they are terminated.

PART VI - EROSION OF THE DEATH INVESTIGATION SYSTEM AND CORONERS' FAILURE TO INVESTIGATE

61. Elizabeth Wettlaufer murdered eight people in Ontario's publicly-funded, long-term care homes. These murders went unnoticed by Ontario's death investigation system. This represents a failure of Ontario's death investigation system, a failure which Dr. Huyer, the Province's Chief Coroner, acknowledged. (Transcript, Vol.19, p.4483). OARC attributes this failure to five factors: the erosion of death investigations in long-term care, bias regarding deaths of residents of long-term care, the inadequacy of the death investigators, failure of coroners to engage with and seek information from families and friends of deceased residents, and the specific failings in the case of Maureen Pickering. We urge you to make recommendations directed at remedying these issues. In addition, we submit that there are lessons to be learned from the development of the Forensic Pathology Service in the post-Goudge Inquiry era.

A. Erosion of Death Investigations in Long-term Care

62. Prior to 1993, deaths in long-term care triggered a mandatory investigation. When the *Coroners Act* was amended in, deaths were reportable but investigations no longer necessary. The coroners were granted absolute discretion to conduct their investigations. The Coroner's office developed a policy to investigate every one in ten deaths.

63. By memo dated September 16, 2013, Dr. Dirk Huyer, then the interim chief Coroner, announced the elimination of the one-in-ten investigation promising a savings

of $900,000 annually. This decision was based on a misunderstanding of the Ministry of Health and Long-Term Care's inspection system as it related to deaths, as well as anecdotal information, and not on data. (Dirk Huyer, Transcript Vol. 18, pp. 4229-4231; Affidavit of Dirk Huyer, Ex. 98, p. 38, para. 113). Further, there was to have been a review by the MOHLTC of all unexpected deaths that occurred between 2001-2005 which would have contributed to the death investigation system; however, it appears never to have been conducted (Ex. 9, LTCI00046530, p.12; Simpson, Transcript Vol. 27, p. 6162).

64. The memo also announced that long-term care homes were no longer required to file an Institutional Patient Death Record (IPDR) with the Office of the Chief Coroner when a long-term care resident died in hospital. It was his interpretation that, in those circumstances, there was no legal requirement for the reporting of deaths. (Transcript, Vol. 18, p. 4220)

65. Respectfully, Dr. Huyer was wrong. The *Coroners Act* requires the reporting of the deaths "where a person dies while resident in a long-term care home to which the *Long-Term Care Homes Act, 2007* applies" (Final Legislation Brief, FD0000005, p.80, 100). Resident is a legal status. Pursuant to s. 138 of O.Reg. 79/10, the LTCHA, a person is still considered a resident when in hospital unless that hospital stay extends beyond 30 days (60 days for a psychiatric admission) (Final Leg. Brief, FD0000005, p. 1128).

66. With these two decisions, combined with a failure of OCCO to look behind the IPDR prepared by an institution, significantly eroded the death investigation process for residents of long-term care.

67. OARC submits that the one-in-ten threshold deaths had the potential to produce meaningful investigations that could afford systemic oversight and contribute to the prevention of deaths in long-term care. For this to occur, coroners would have to believe them meaningful, approach them with a critical mind and good judgment and be willing to seek out information.

68. As for the reporting of deaths in hospital, the death of Arpad Horvath was not reported to the Coroner because he was transported and died in hospital. The coroner's office did not expect notification of the death according to its policy despite the clear language of the *Coroners Act* and the definition of the resident in the LTCHA (Dr. Huyer, Transcript, Vol. 18, p. 4295). An inadequate investigation (or an inadequate consideration of a facility report) may not have prevented further deaths. Unfortunately, we will never know.

B. Implicit Bias in Death Investigation

69. The preliminary report of Dr. Pollanen reflects the bias in the death investigation:

70. In general, when chronically-ill elderly people die, there deaths are routine attributed to the underlying diseases that have caused their poor health. The person's

physician will sign a death certificate indicating the most likely disease that caused the person's death. In the inform elderly, such deaths are not unexpected. As a result, deaths of the elderly are not routinely investigated by coroners or forensic pathologists in Ontario or any other jurisdiction unless there is obvious trauma or *a priori* suspicion of a crime. (LTCI00065278, p. 4)

71. Witness after witness reinforced that this was the bias. In fact, we heard in the evidence that coroners took the position that deaths in long-term care could not be "sudden and unexpected" (William George, Transcript, Vol. 20, p.4672), Such an attitude has created a system in which coroners now very rarely attend in long-term care homes: Dr. George testified that he could not recall having attended at a long-term care home since the threshold death investigations were halted (William George, Transcript Vol. 20, p.4751). Yet, Beatrice Crofts Yorker Schumacher identified that we do not have an understanding of what a good death looks like. Not do we appear to seek to understand through research what this end looks like. This lack of knowledge has translated into an assumption that all deaths in long-term care homes are "good" unless they are homicides, suicides or accidents.

C. Inadequacy of Death Investigations & the Death of Maureen Pickering

72. We anticipate that others will make submissions on the missed opportunity caused by Dr. George's decision not to investigate. The evidence supports Karen Routledge's version regarding her conversation with Dr. George. The reasoned evidence of Dr. Urbantke is compelling. She believed the death needed to be investigated. She saw it as being connected to an overdose of medication.

73. In contrast, Dr. George's evidence was astonishing. It was astonishing that today he stands by his decision making. It is astonishing that he fails today to acknowledge that he was wrong not to investigate or that the death presented an opportunity to reveal Ms. Wettlaufer as a murderer. Sadly, we will never know.

74. His actions stand in contrast to OCCO's written procedures. The Guidelines for Death Investigations required that the Investigative Coroner make appropriate inquiries to obtain sufficient information and to satisfy her/himself that an "investigation is necessary" (Ex. 7, LTCI00069330, p. 6). Dr. George failed to do so and thus failed Ms. Pickering.

75. The manual also required Coroner to make and retain detailed notes of his/her investigation. The notes were to be contained in a proper notebook or the Notes Section of Form 3. Dr. George testified that he would jot notes on a piece of paper but would not keep them for any length of time if he had found the matter not to be a coroner's case (Transcript Vol. 20, pp.4678-4679). There was also a Case Selection Data Form that, if used, would be submitted to the Regional Supervising Coroner for review. However, this document was not mandatory, and neither of the investigating Coroners who gave evidence used them. This results in systemic failure, as there is oversight or review of one of the most important elements of the death investigation system: the decision to investigate.

76. We do believe that there is another issue which is hampering Coroners in making determinations, which is the lack of authority of the Coroner to obtain medical information prior to commencing an investigation under section 15 of the *Coroner's Act* (FD0000005, *Coroner's Act,* p. 126).

77. OARC urges the Commissioner to make recommendations in these areas. A coroner should be required to investigate where there has been an issue or question raised and not simply not refuse out of hand based on a simple phone call (Routledge, Transcript, Vol. 7, p. 1386). There are few autopsies of residents who have died in long term care. (Laura Long, Transcript Vol. 9, p. 1943; Richard Reddick, Transcript Vol. 13, p. 3125). The rates of autopsies in long-term care are 8-9% of deaths compared to 40-45% in the rest of the population (Huyer, Transcript Vol. 18, p. 4220). Dr. George did not remember ever requesting an autopsy of a resident (Transcript, Vol 20, p. 4702).

78. The IPDR as presently drafted does not comply with the actual requirements in the *Coroners Act*. Section 2.1 of the *Coroners Act* provides that where a resident dies in a long-term care home it must be reported to the Coroner's office. If the coroner is of the opinion that the death should be investigated, the coroner shall investigate the circumstances of the death. This section does not set out any specific requirements as to how the coroner is to determine what ought to be investigated.

79. Because of the way the IPDR is used, only those which meet the s. 10(1) criteria are sent along to a coroner, even though 10(2.1) grants coroners an absolute discretion

to investigate. Yet, if a facility decides to fill out the form in a way that does not trigger an investigation, no coroner will be involved (Huyer, Transcript Vol. 18, p. 4215). If no boxes are ticked on the IPDR, then no coroner will be involved (Huyer, Transcript, p.4636). The new proposed form does not improve matters.

80. However, the IPDR sets out eight specific questions, which are answered by someone on behalf of the home. The home submits the form electronically to the coroner's office. If none of the eight boxes are completed, then no coroner ever looks at the document (Dirk Huyer, Transcript Vol. 19, p.p. 4492). It means that the coroner's office applies 10(1) criteria to a 10(2.1) report when that statute does not so require. The result of this approach is a fettering of discretion. The application of this criteria takes the decision out of the Coroner's hands such that investigations into the It means that His means that although investigations of deaths in long-term care homes are discretionary unless they meet the requirements of s. 10(1), this discretion is fettered as it is never put to a coroner to make a decision.

81. There is a lack of oversight over this process and the coroners involved in it (Ex.98, p. 20, para. 64; Transcript, Vol. 18, p. 4219). A coroner's decision not to investigate is not the subject of review or audit. (Transcript, Vol. 18, p. 4252, l.4) The completion of a Case Selection Data Form is not mandatory. There becomes no meaningful way to understand the thought process of a coroner who declines an investigation and provides no reasons and makes no record. (The evidence was that coroners were paid only $30 for the completion of this form ($60 if at night) (Huyer,

Transcript, Vol. 18, p.4258, 4308, 4406, George, Transcript Vol. 20, p.4675) The audit of Form 3 is procedural (i.e. an examination of whether it was completed properly) and not substantive (i.e. did they come to the correct conclusion). (Ex.98, Huyer Affidavit, p. 27, para. 82)

D. Lack of Family Contact

82. The evidence demonstrates that the families had little or no involvement in the death investigation process. Families and friends can be a tremendous source of information. Additionally, as the general public has very little knowledge of what the Coroner's role is, providing as much information to them is vital to ensure that they understand and are satisfied with the process. Coroner's death investigation should always include contacting family or friends as suggested in the Coroner's Death Investigation Manual.

83. While not deeply explored at the inquiry, families and concerned friends seemed to have expressed dissatisfaction with their interactions with the Coroner's office. In the case of Mr. James Silcox, the coroner's records suggest that there was contact with the family. However, the evidence of Dianne Crawford, Mr. Silcox's daughter (Ex. 115, paras. 9 to 11) suggest that there was no contact with the Coroner's office, despite the Coroner's claim that there was. The notes of Rhonda Kukoly (LTCI00043003, pp. 43-44) identify that the family of Wayne Hedges tried to seek answers from the Coroner's office to no avail. The families deserved more.

84. All of this evidence establishes the need for a professionalized coronial service staffed by individuals who are in the role full-time. The fee for service model is broken. The system should permit coroners to make adequate inquiries when receiving a report of a death in long term care to determine whether further investigatory steps are necessary. The all or nothing approach (i.e. investigation/no investigation on the basis of a form) does not work. The death investigation system must build capacity to examine deaths beyond the filing of the IPRD. The KMPG report provides some consideration about improving the service. Dr. Yorker provided other important thoughts on what is needed to better understand a death.

E. Lessons Learned from the Development of the Forensic Pathology Service

85. Dr. Pollanen spoke about the systemic changes that came out of the Goudge Inquiry. At that time, there was no forensic pathology service. Individual pathologists provided pathology services to the Coroner in hospital across the Province and there was a shortage of the forensic pathologists. In the post-Goudge era and with the amendments to the *Coroners Act*, Ontario steadily developed a professionalized and peer reviewed forensic pathology service.

86. The evidence at this inquiry demonstrates that the coronial service needs similar improvements. There is a need to replace part-time fee for service coroners with salaried full-time coroners. There is also a need for the mandatory reports to involve more meaningful consideration of whether there is to be an investigation. At present, it is not clear whether pathologists, acting more like medical examiners and having

primary responsibility for the investigation would perform better. In our view, the best approach would be to professionalize the coronial service with full-time coroners and better consideration of the mandatory reports. It is important from social and preventive perspective to conduct death investigations to understand how long-term care residents come to die in long-term care.

PART VII - FAILURE OF THE MINISTRY INSPECTION PROCESS

87. Under the NHA, there were annual reviews (which inspected against the Long Term Care Home Programs Manual, as well as the Act and Regulations, to identify unmet standards). The reviews were mostly paper based and even when an unmet standard was found, it was up to the compliance advisor to decide whether or not they would issue an unmet standard. The compliance advisor would prepare a report of their findings, but had no authority to make orders. Homes would prepare plans of corrective action and the Ministry would approve those plans. (Karen Simpson, Transcript, Vol 27, pp. 6102-6104). When the transition was made to the LTCHA, the Ministry lost the authority to review and approve the corrective action being tendered by the home (Karin Fairchild, Transcript, Vol. 33, p. 7563).

88. The Government of Ontario promised a rigorous annual inspection system which became known as the Resident Quality Inspection (RQI). The annual inspection is a legislative requirement. An inspection into a complaint does not constitute an annual inspection for the purpose of the LTCHA. While there was a suggestion by Karin Fairchild that the intention was to do the RQI every 3 years, (Fairchild, Transcript Vol.

32, pp. 7502 and 7570), the presentations in evidence document that Ministry promised annual RQI inspections (Ex. 156 (LTCI00055697), Ex. 157 (LTCI00055709).

89. The annual RQI did not come to fruition (Simpson, Transcript Vol. 27, 6203). In the case of CCW, there was no annual inspection between 2010 and December, 2014 (Ex. 134, LTCI00043371, p. 10). At present, although every home will have an RQI annually, this has been modified from the original model. Since 2016,the intensity of the RQI is informed by the home's compliance history and risk level. The full or Intense Risk Focused Inspection is only done every three years for those who are deemed to be a low risk level, while the Risk Focused Inspection is completed in the other two. During the Risk Focused Inspection, only a limited number of protocols or areas of inspection are completed, and, in fact, inspectors are instructed not to look at certain areas, even if concerns are raised (Simpson, Transcript Vol. 28, p. 6482). While inspection reports continue to be public, nowhere on those reports is there any indication that there are two types of RQIs conducted, or which type of RQI was conducted at that time.

90. The Ministry OR report (at p. 84) summarized 2014 and identifies that the first RQI was in the latter part of 2014. In planning for her 2016 inspection, Rhonda Kukoly set out the CCW compliance history in the inspection plan. (Kukoly affidavit, Ex. 134, LTCI00043371). The inspection plan does not list an RQI but it appears that the December 8, 2014 inspection listed therein was the first RQI. From it, the Ministry issued written notices and voluntary plans of correction were the result. In our view, the Commissioner can conclude that there were no full/RQI inspections between July 1,

2010 when the LTCHA came into force and the latter part of 2014, during which time Wettlaufer committed five murders.

91. However, even with the new inspection system, there seems to be gaps in the system, as can be seen in the Inspections that were commenced at Caressant Care Woodstock in October, 2016.

92. Under the current inspection regime, every home will have an Intensive Risk Focused inspection at least once every 3 years. Ministry has a Risk Framework which will assess the performance across the system to determine which homes will have the Intensive Risk Focussed inspection annually. (Ex. 129, p. 37) Under the Intensive Risk Focussed inspection, 40 residents are interviewed, and mandatory protocols must be used. Over time, the protocols appear to have been changed, with fewer questions being asked in respect to the residents' council. Other protocols will be used when triggered.

93. Further, we need to study intentional harm in long-term care. In the Joint Commission Journal on Quality and Patient Safety (LTCI00072896, tab H, p. 188), they noted that we know more about dog bites and shark attacks than we know about intentional harm of patients, let alone murder. We don't study intentional harm and we need to understand the harm caused by health care professionals.

94. For all these reasons, we urge you to make recommendations set out in our recommendations section. OARC is exceedingly grateful for the opportunity to

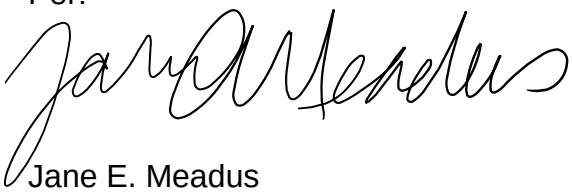
participate in the inquiry, the hard work of Inquiry staff and the Commissioner and look forward to moving to the second phase of the Inquiry.

All of which is respectfully submitted this 20th day of September, 2018.

Fraser Advocacy
Per:

Suzan E. Fraser

Advocacy Centre for the Elderly
Per:



Jane E. Meadus

INQUIRY INTO THE SAFETY AND SECURITY OF LONG-TERM CARE
RECOMMENDATIONS OF OARC

OARC RECOMMENDS:

Recommendations to the Government of Ontario

1. The Government of Ontario impose upon facilities a resident-first approach to the provision of care in long-term care homes which requires every decision to consider the needs of the residents first.

2. The Government of Ontario maintain the requirement for long-term care facilities to have a registered nurse on staff at all times (24/7).

3. The Government of Ontario increase wages for nurses in long-term care homes and increase incentives for nurses to enter long-term care.

Recommendations to the Ministry of Health and Long-Term Care

Inspections

4. Ministry of Health and Long-Term Care (MOHLTC) perform annual inspections of the type presently entitled “Intense Risk Focused RQI”. In the alternative, MOHLTC must specify on the public report which type of RQI has been completed with a detailed description of each type of inspection.

5. MOHLTC must ensure that there are never any years when all homes do not receive full annual inspections.

6. MOHLTC require inspectors to view all shifts during the course of an RQI inspection.

7. MOHLTC send copies of inspection reports directly to third parties (for example, pharmacies) to whom those reports relate so that they may be made aware of the inspector’s findings.

8. MOHLTC perform the full medication protocol at annual inspections as it represents a key area of safety in long-term care.

9. The Government of Ontario prescribe by regulation that an inspector be required to review and discuss findings of non-compliance with the residents’ council to facilitate understanding and awareness.

10. MOHLTC review and revise its residents' council interview inspection protocols to look at the impact of the narrowing of the interview and to improve the information that can be elicited from the residents' council.

11. MOHLTC direct inspectors to approach their inspections neutrally such that they seek to determine whether the home complies with Ministry standards. At present, inspectors look to "find compliance".

12. MOHLTC must direct inspectors that all non-compliance needs to be cited, even if the issue has since been resolved.

13. MOHLTC inspectors upon finding evidence that a professional failed to report witnessing abusive behaviour against a resident be required to make a finding of non-compliance.

14. MOHLTC classify a finding of a failure to report suspected abuse and neglect as a high risk factor when calculating the LRPA/LRA risk factors. A finding of failure to report should necessitate intensive risk focused inspections.

15. Government of Ontario amend section 152(1)2 of the LTCHA to remove the "voluntary" nature of the plan of correction. Plans of correction should be required to be completed and submitted to the Inspector for review and approval within a certain period of time, and inspected upon in the next annual inspection to ensure implementation. This was part of annual review process under the NHA.

Training

16. Government of Ontario eliminate section 222(3) of O.Reg. 79/10 which exempts a licensee from ensuring that physicians and nurse practitioners take mandated training on abuse and neglect and the reporting of it. Physicians working in long term care should be required to undergo mandatory training regarding abuse and neglect and the obligation to report suspected abuse and neglect.

17. MOHLTC ensure that meaningful, accountable education is provided upon initial orientation and ongoing annually to all long-term care home members including staff members from all departments, volunteers, contract staff including physicians, management, and Corporate Leaders) on the following areas:

i. Residents' Councils
    1. What Residents' Councils are;
    2. Importance of Residents' Councils;
    3. Mandatory existence of Residents' Councils;
    4. Scope of influence in the long-term care home;
    5. Powers under the LTCHA;

6. Role in the resolution of issues; and
7. Whole home embracing of Residents' Councils to achieve ultimate effectiveness

ii. Residents' Bill of Rights
1.Education is not simply a "document review"; and
2. Homes must use a holistic program, such as the Ontario Association of Residents' Councils *Through Our Eyes: Bringing the Residents' Bill of Rights Alive* program.

iii. Legislation regarding Abuse and Neglect
1. How to define abuse;
2. Mandatory reporting of witnessed and suspected abuse and neglect to the Director at the MOHLTC;
3. Use of decision tree; and
4. How power imbalance issues between staff members and residents, and between varying levels of staff members affect reporting.

18. MOHLTC must provide educational material to all homes regarding the reporting of medication errors under the LTCHA.

19. The Government of Ontario amend the LTCHA to require that employment agencies be knowledgeable about long-term care homes and their regulation, and require those agencies to ensure that the employees being sent to work in long-term care homes are knowledgeable about the sector, meet all requirements, and have the training required under the LTCHA.

20. Ministry of Health inspectors should be educated on their reporting obligations, including under the *Coroners Act* and the *Health Professions Procedural Code.*

Staffing

21. The MOHLTC commission a comprehensive study to determine appropriate minimum standards to enable homes to meet resident care needs, including the following: (a) accurate minimum hours of hands-on care based on actual acuity of residents, and (b) accurate ratio of staff to resident, including RNs, RPNs and PSWs. Upon completion, long-term care homes should be properly funded so that the hours and ratio can be met.

22. MOHLTC commit substantial resources to enable the hiring of additional staff for holistic resident care (psychosocial, medical, emotional), and registered staff where deemed necessary. Taking care of medical/physical needs and provision for safety is important, but there must be appropriate staffing levels to build authentic relationships so that psychosocial needs are met also.

Other

23. MOHLTC proactively develop an action plan to make available counselors to residents, team/staff members, families, volunteers in the event that a traumatic, tragic event occurs in a long-term care home.

24. MOHLTC create a separate and distinct department of the MOHLTC to provide advice to homes so that those with questions can seek clarification, and those struggling with non-compliance or performance issues can receive the help they need, such as education, referrals, and mentorships, so that homes are able to achieve optimal compliance and performance. This "Advice Department" would be a resource for licensees and long-term care home leadership including but not limited to long-term care corporate leaders, members of management teams, Residents' Councils and Family Councils.

25. MOHLTC clarify from which funding envelope the cost of grievances is to be paid.

CNO and other Colleges

26. The CNO and other Colleges establish clear directions and standards for their investigators related to long-term care homes and compliance with the LTCHA.

27. The CNO and other Colleges train their investigators on the requirements of mandatory reporting under the *LTCHA.* These materials should make clear the legal duty to report to the Director suspected abuse and neglect and identify that i.e. violations to code of conduct or Residents' Bill of Rights must be reported to Colleges.

28. Regulated health professions provide guidelines regarding the reporting of abuse and neglect to ensure all health professional understand their obligation to report suspected abuse and neglect of residents in long-term care homes to the Director.

Regarding the Death Investigation Process

29. The Office of the Chief Coroner (OCCO) must change the system of reporting deaths in long-term care so that a coroner reviews each death to determine whether an investigation is required as mandated by s. 10(2.1). The present electronic system does not forward a case to a coroner unless one of the boxes based on section 10(1) criteria of the *Coroners Act* is completed.

30. OCCO implement a random form of death investigation in long-term care to ensure oversight and continue to have knowledge of issues in long-term care.

31. The Government of Ontario amend section 10(2.1) of the *Coroners Act* to require mandatory reporting, including completion and submission of the Institutional Patient Death Record (IPDR) or other similar document, of the deaths of persons resident (within the meaning of the LTCHA) to the Coroner when a resident dies in hospital.

32. OCCO provide training materials for the staff of long-term care homes and hospitals on reporting of deaths in long-term care and the completion of required documentation.

33. OCCO create information for the public relating to the death of residents in long-term care, the role of the coroner, and how to access the coroner.

34. OCCO hire full-time salaried coroners to perform death investigations.

35. OCCO must have oversight over the entire coronial system including quality control and review of coroners' decisions. The OCCO must have the ability to review decisions made by coroners at every step, including the decision whether or not to investigate.

36. Coroners must be alive to the fact that those completing the IPDR work for the home and therefore be biased in their reporting of the death, for example not checking possible negligence as a contributor to the death.

37. OCCO regularly meet with OARC in order to understand current issues in long-term care from the perspective of the residents.

38. OCCO add persons with lived experience in long-term care to the Geriatric & Long-Term Care Review Committee.

39. The Government of Ontario amend the *Coroners Act* and the *Personal Health Information Protection Act* to provide Coroners with authority to request documents and obtain information in order to make an informed decision as to whether to investigate a death.

40. Coroners investigate a death if an IPDR indicates that it is believed that one of the criteria under s. 10(1) of the *Coroners Act* has been met.

41. OCCO ensure that the electronic system allows the IPDR to be submitted prior to the involvement of the coroner even when one of answers is "yes", and no longer require such contact so that the coroner cannot influence the completion of the document.

42. OCCO ensure that coroners are educated about long-term care homes and their residents, including the facility as the home of the residents and not a place where they go to die. Coroners must be educated that deaths in long-term care homes can be

sudden and unexpected, and autopsies may be helpful, and not simply assume that a death was natural.

43. OCCO mandate the requirements for documenting information and decisions, and how long those documents should be stored.

44. OCCO educate the general public on their role including when and how to contact the coroner, the role of an autopsy, and the rights of the family.

Regarding the College of Nurses and Mandatory Reporting

45. The College of Nurses (CNO) should report the results of its investigation back to institutional reporters.

46. CNO takes steps to better understand the collective bargaining process when examining mandatory reports and the context in which they are made.

47. CNO consider patients and residents as part of its stakeholder process and consult regularly with patient and resident groups, such as the Ontario Association of Residents' Councils.

48. The Government of Ontario amend the *Regulated Health Professions Act*, to include mandatory reporting to the appropriate College where there is harm or alleged harm of a patient by a regulated health professional, similar to s. 85.1 and 85.2 of the *Health Professions Procedural Code* regarding allegations of sexual abuse.

49. The Government of Ontario amend the *Health Professions Procedural Code* to require reporting to the CNO of a suspension of a member from employment.

50. CNO provide comprehensive training to the management of long-term care facilities on reporting requirements under the *Health Professions Procedural Code.*

51. CNO require that the employer provide the entire discipline history of a nurse being reported, so that CNO is able to take it into consideration in the discipline process. The electronic or other reporting system should be modified to allow this to happen.

52. CNO should modify their reporting documentation to include the name of the person completing the form as they may not be the same as the contact person.

53. The Government of Ontario amend s. 85.5(2) of the *Health Professions Procedural Code* to include resigning or otherwise leaving an employment situation.

54. The Government of Ontario amend the reporting requirements in the *Health Professions Procedural Code* to require employers to report members to the CNO when

the member advises that can no longer work as a registered nurse.

55. The Government of Ontario amend the reporting requirements in the *Health Professions Procedural Code* to require mandatory reporting by any person who has a reasonably suspicion that a member of a regulated health profession has stolen medication.

56. The Government of Ontario review the “incapacity” provisions in the RHPA to define what “incapacity” means and when a report should be made of allegations of incapacity.

Long-Term Care Homes

57. Long-term care homes and other health facilities be required to designate a specific person/role as the only person who may give employment references for former employees.

58. Long-term care homes and other health care facilities be prohibited from providing letters of recommendation that they believe to be untruthful.

59. Long-term care homes must supervise all shifts. The Director of Nursing and Personal Care or equivalent to be required to review all shifts on a regular basis.

60. Annual training be provided to management on how to perform investigations with specific emphasis on vulnerable complainants and victims.

61. Long-term care homes and other health care facilities must ensure that progressive discipline or other labour matters do not jeopardize resident safety.

62. Long-term care homes ensure that progressive discipline is cumulative including all types of incidents, not on each class of incident.

63. Long-term care homes must ensure proper note-taking occurs and notes are kept of disciplinary meetings.

64. Long-term care homes must ensure that staff are trained in their personal responsibility to report abuse and neglect to the Director under the LTCHA.

65. Where the long-term care home management is making the report of abuse and or neglect on behalf of a staff member, the long-term care home management must confirm to the staff member that the report has been made.

66. Long-term care homes must report allegations of abuse and neglect immediately and not after they have completed an internal investigation.

67. Long-term care homes must ensure that all staff are trained on the use of the decision-tree regarding reporting of abuse.

68. Long-term care home Administrators must be required to attend annual training programs approved by the MOHLTC for long-term care home administrators.

69. Long-term care home Directors of Nursing and Personal Care must be required to attend annual training programs specifically approved by the MOHLTC for long-term care home Directors of Nursing and Personal Care.

70. Long-term care homes shall be required to fill shifts vacant due to vacation, illness or other temporary issues. If the home cannot do so, this shall be reported to the MOHLTC immediately.

71. Long-term care homes may offer, but shall not require staff to perform, extra shifts to meet staffing shortages.

72. While issues of mental health and addiction do not necessarily make a staff member incapable, where a long-term care home believes that these issues are interfering with the staff members' ability to work and is endangering residents, the home shall be required to take steps to ensure the safety of residents, including reporting concerns about fitness to practice to the appropriate College while also supporting the staff member as required.

73. Long-term care homes administrators be required to understand long-term care home funding and budgets, including the envelope system, even where these matters are managed by a corporate office.

74. Long-term care homes must balance encouraging staff to report medication errors with the requirement to keep residents safe.

75. Long-term care homes should install cameras in medication rooms and doors with at least a portion of clear glass to allow supervision at all times.

76. Management of long-term care homes receiving annual training in all areas of mandatory reporting to third parties including to the Coroner and College of Nurses.

77. Long-term care home management receive annual training and be knowledgeable in the requirements of the *Long-Term Care Homes Act*.

78. Long-term care home staff receive annual training in the requirements of the *Long-Term Care Homes Act* as it relates to their position.

79. Long-term care homes shall ensure that the death registry kept up-to-date and fully completed, including number of deaths per month and average number of deaths.

80. Long-term care home staff must be required to attend mandatory staff meetings unless required to work at the home during that time and be paid for attendance if they are not on shift.
81. Long-term care homes must investigate when they become aware of clusters of complaints about a particular staff member to resolve the issue and ensure the safety of residents is not compromised.

82. Long-term care homes shall ensure that all nursing staff have easy access to the residents' care plans.

83. Long-term care homes shall ensure that when using agency staff, the agency staff meets the required standards, has police checks, and is properly trained as required by the LTCHA prior to commencing work.

84. Long-term care homes must not use agency staff except as a last resort and shall not be the RN fulfilling the 24/7 requirement under the regulations except in an emergency. Where the agency RN is fulfilling this role, it must be reported to the MOHLTC.

85. Pharmacies must provide mandatory training on a regular basis to long-term care home staff.

86. Long-term care homes must ensure that informed consent to treatment is obtained for all treatments from the resident or their substitute decision-maker.

Pharmacies

87. Pharmacies must be required to provide residents or their substitute decision-makers with the same services that they would receive in the community, including information about medication, side effects, and other counselling.

Unions

88. Unions must have a properly trained union representative available on-site to attend discipline meetings with members and where they are not available, an outside union representative must be available to attend discipline meetings on-site or by teleconference.

89. Union representatives in long-term care homes must receive training on the making and keeping of documentation related to employee disciplinary meetings and the Union shall create directives for the proper storage of that documentation.

All of which is respectfully submitted this 20th day of September, 2018.

Fraser Advocacy
Per:

Suzan E. Fraser

Advocacy Centre for the Elderly
Per:

Jane E. Meadus