



Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System

REPORT

The Honourable Eileen E. Gillese
Commissioner

Volume 1 – Executive Summary and Consolidated Recommendations

Volume 2 – A Systemic Inquiry into the Offences

Volume 3 – A Strategy for Safety

Volume 4 – The Inquiry Process

**Public Inquiry into the Safety
and Security of Residents in the
Long-Term Care Homes System**

The Honourable Eileen E. Gillese
Commissioner



**Commission d'enquête publique
sur la sécurité des résidents des
foyers de soins de longue durée**

L'honorable Eileen E. Gillese
Commissaire

July 31, 2019

The Honourable Douglas Downey
Attorney General of Ontario
Ministry of the Attorney General
720 Bay Street, 11th Floor
Toronto, ON
M5G 2K1

Dear Mr. Attorney:

I am pleased to deliver to you the Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, in both its English and French versions, as required by the Order in Council creating the Inquiry.

I hope the Report will serve to enhance the safety and security of residents living in long-term care homes, as well as those accessing home care services.

It has been an honour and a privilege to serve as Commissioner to this important Inquiry.

Yours very truly,

A handwritten signature in blue ink that reads "Eileen E. Gillese".

Eileen E. Gillese
Commissioner

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This Report consists of four volumes:

1. Executive Summary and Consolidated Recommendations
2. A Systemic Inquiry into the Offences
3. A Strategy for Safety
4. The Inquiry Process

ISBN 978-1-4868-3585-0 (PDF)

ISBN 978-1-4868-3581-2 (Print)

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Disponible en français

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VOLUME 3: A Strategy for Safety

VOLUME 4: The Inquiry Process



Dedication

This Report is dedicated to the victims and their loved ones. Your pain, loss, and grief are not in vain. They serve as the catalyst for real and lasting improvements to the care and safety of all those in Ontario's long-term care system.

Acknowledgments

I owe an enormous debt of gratitude to the many people who worked tirelessly to ensure that this Inquiry discharged its mandate. Thank you, all.

I begin with the Commission legal team. I am privileged to have had the assistance of first-class legal counsel: Mark Zigler, Will McDowell, Liz Hewitt, Megan Stephens, Rebecca Jones, Lara Kinkartz, Ida Bianchi, and Nicolas Rouleau. Commission counsel were ably supported by staff lawyers Lindsay Merrifield, Alexandra Campbell, Kat Owens, and Laura Robinson. I thank law graduates Étienne Lacombe, Greg Furmaniuk, and Sean Pierce, who stepped in during the 2017 winter to dig us out of a deluge of documents.

The legal team was indisputably critical to the work of the Commission, but so, too, was the Commission's administrative staff, led by executive director Andrea Barton. Andrea, together with Carla Novakovic and Nazma Dusruth, made sure that every aspect of the Commission's operations ran smoothly. Here I must also thank Lauren Moran, the coordinator of public inquiries for the Ministry of the Attorney General, who was very helpful in launching the Inquiry. Dominatum managed the Inquiry's website, Peter Rehak lent his expertise in media relations and communications, and Al Gayed made sure that counselling and support were available for the victim and for the victims' families and their loved ones. Each person's professionalism and commitment to the Inquiry was vital to the fulfillment of its mandate.

I also want to recognize the contributions of the Participants and their counsel, who played an important role in both parts of the Inquiry process. At the Participation hearings, I expressed my hope that all those who were given the opportunity to participate would co-operate with one another and with Commission counsel – and they fully fulfilled that hope.

It was important that the Inquiry's public hearings take place in southwestern Ontario, close to the most directly affected communities. The beautiful St. Thomas courthouse immediately came to mind – its facilities are second to none in the province for running proceedings such as these hearings. When asked, Regional Senior Justice Bruce Thomas readily agreed to our using this historic building. He was supportive throughout, as were Justice Kelly Gorman, the local administrative judge at the courthouse at the time the Inquiry was established, and her successor, Justice Scott Campbell. The St. Thomas courthouse staff worked long days and evenings, without complaint, to keep the public hearings running smoothly – in addition to their regular duties.

A big thanks to all for their professionalism, their many kindnesses, and their commitment to the work of the Inquiry.

I wish, too, to thank the witnesses at the public hearings. It took enormous courage to stand before the people of Ontario and testify. The testimony they gave played an important role in our understanding of what happened – one that I appreciate very much. I am also grateful to the witnesses who provided expert and technical evidence at the public hearings: Professor Beatrice Crofts Yorker, Ms. Julie Greenall, and Dr. Michael Hillmer.

For the Inquiry to fulfill its mandate, it was vital that its public hearings were available to all Ontarians. It took one dedicated person and three dedicated organizations to make that possible. Christina Shiels-Singh, law clerk at Lenczner Slaght, was instrumental in establishing and providing ongoing support for the Inquiry's document management system, which housed tens of thousands of documents. Christina worked closely with Commonwealth Legal, a Division of Ricoh Canada Inc., which was on site daily at the public hearings, ensuring that exhibits were available in real-time. Neesons produced a transcript of every word that was said every day of the hearings, and the daily transcripts were always on the Inquiry website by the following morning. Sight N Sound Design Inc. was responsible for webcasting the hearings. Together, the transcripts and the webcast ensured that the Inquiry was accessible to all, not just those who attended the hearings in person in St. Thomas.

The creation of a report such as this one requires exceptional talents in editing, translation, and design. I am fortunate to have had the outstanding assistance of the editing team Shipton, McDougall Maude Associates – Dan Liebman, Mary McDougall Maude, and Rosemary Shipton – a trio with considerable experience on past inquiry reports and a commitment to excellence. Larrass Translations Inc. and H3Creative Inc. rose to the respective challenges of translating and designing this Report so that it is accessible and approachable. Thanks also to Webcom, a Division of Marquis Book Printing Inc., the Report's printer, for a job well done.

I am also indebted to those who, in addition to the Participants, assisted in the consultation process, giving freely of their time and expertise: Advisory Group for Regulatory Excellence, Alzheimer Society of Ontario, College of Physicians and Surgeons of Ontario, Elder Abuse Ontario, Family Councils Ontario, Institute for Safe Medication Practices Canada, Ontario College of Pharmacists, Dr. Samir K. Sinha, Saint Elizabeth Health Care, and staff at the Veterans Centre at Sunnybrook Hospital.

In addition, I am very grateful to the members of the public who shared their experiences of the long-term care system with us, as well as their thoughts on how to improve it.

My colleagues and friends – Justices Denise Bellamy, Stephen Goudge, Susan Lang, Dennis O'Connor, and Michael Tulloch – were trusted advisors throughout the Inquiry. I am grateful for their first-hand accounts about the work of commissioners.

I close by recognizing the victim and the victims' family members and loved ones – in particular their willingness to support and help the Inquiry. I hope they find solace in the fact that, as a result of this Inquiry, many changes have already been implemented in long-term care in Ontario. Your loss and grief have not been in vain.

Finally, to my family and most especially my ever-patient husband, Rob Badun, my heartfelt thanks for their unwavering support over the past two years. You are the best.

The Honourable Eileen E. Gillese
Commissioner

Acronyms and Abbreviations

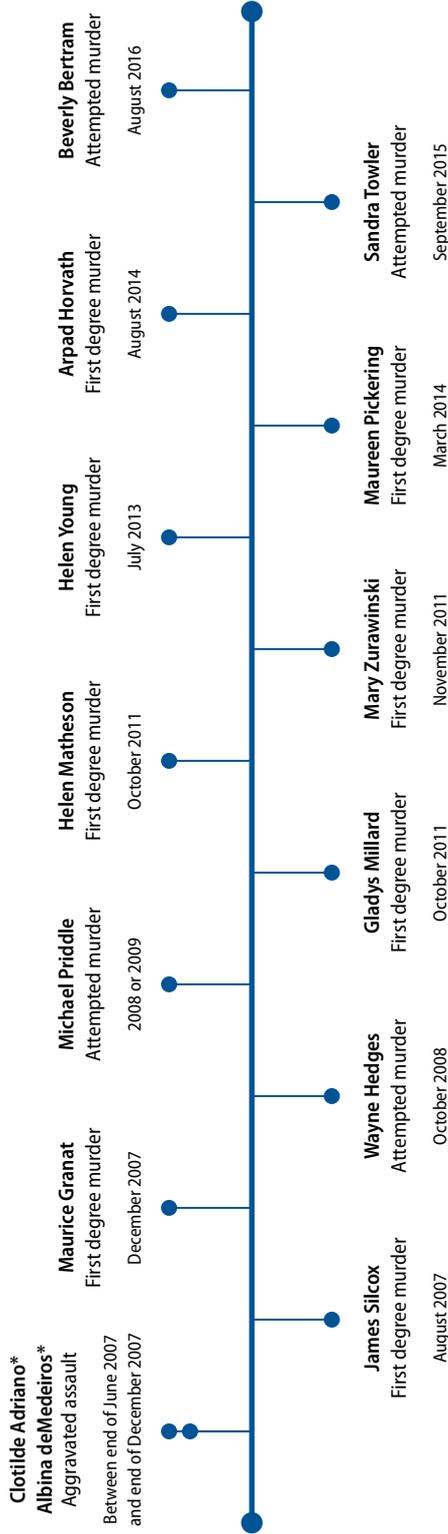
ADC	automated dispensing cabinets
ADR	alternative dispute resolution
APR	automated provider reports
BCMA	barcode-assisted medication administration
BPMH	best possible medication history
CAMH	Centre for Addiction and Mental Health
CCAC	Community Care Access Centre
CCF	complaint, critical incident and follow-up
CFS	Centre of Forensic Sciences
CIAF	Canadian Incident Analysis Framework
CIATT	Centralized Intake, Assessment and Triage Team
CIHI	Canadian Institute for Health Information
CIS	Critical Incident System
CLRIs	Centres for Learning, Research and Innovation
cMAR	computer-generated medication administration record
CMI	Case Mix Index
CNO	College of Nurses of Ontario
COPD	chronic obstructive pulmonary disease
CVA	cardiovascular accident
CVH	cardiovascular heart disease
DIOC	Death Investigation Oversight Council
DNR	do not resuscitate
DOC	director of care
DON	director of nursing
EDB	emergency drug box
eMAR	electronic medication administration record
ESPA	External Service Provider Agencies Policy
ETMS	events tracking management system

FPU	Forensic Pathology Unit
FTE	full-time-equivalent (employee)
HCCSA	<i>Home Care and Community Services Act, 1994</i>
HCSK	healthcare serial killer
HESP	Health, Education and Social Policy (Committee of Cabinet)
HNHB	Haldimand Niagara Haldimand Brant
HQO	Health Quality Ontario
HSARB	Health Services Appeal and Review Board
HSIM	Health System Information Management (Division)
HSMR	hospital standardized mortality ratio
HSP	health service provider
HSSP	Health and Social Services Policy (Committee of Cabinet)
IALP	Inter-Agency Leadership Partnership
I/CAD	Intergraph Computer Aided Dispatch
ICRC	Inquiry, Complaints and Reports Committee
IPDR	Institutional Patient Death Record
IQS	Inspector's Quality Solution
ISMP	Institute for Safe Medication Practices
LHIN	Local Health Integration Network
LHSIA	<i>Local Health System Integration Act, 2006</i>
LQIP	Long-Term Care Home Quality Inspection Program
LRPA	Long-Term Care Home Quality Inspection Program Risk Performance Assessment
LSAA	Long-Term Care Home Service Accountability Agreement
LTC	long-term care
LTCH	Long-Term Care Home (Division)
LTCHA	<i>Long-Term Care Homes Act, 2007</i>
LTCI	Long-Term Care Homes Public Inquiry
MAPLe	Method for Assigning Priority Levels
MAR	medication administration record
MAR/TAR	medication administration record / treatment administration record

MDS	Minimum Data Set
MOU	memorandum of understanding
MPP	Member of Provincial Parliament
NHA	<i>Nursing Homes Act</i>
NHP	Nurses' Health Program
NP	nurse practitioner
NPC	nursing and personal care
OARC	Ontario Association of Residents' Councils
OCC	Office of the Chief Coroner
OCD	obsessive compulsive disorder
OFPS	Ontario Forensic Pathology Service
OHIP	Ontario Health Insurance Plan
OIC	Order in Council
OLTCA	Ontario Long Term Care Association
ONA	Ontario Nurses' Association
OPA	Ontario Pharmacists Association
PAC	Professional Advisory Committee
PFPU	Provincial Forensic Pathology Unit
PIA	<i>Public Inquiries Act, 2009</i>
PICB	Performance Improvement and Compliance Branch
PICC	peripherally inserted central catheter
PLP	Preceptee Learning / Developmental Plan
PME	Post Mortem Examination
POM	provider operations meeting
PRN	pro re nata ("as needed")
PSW	personal support worker
RAI	Resident Assessment Instrument
RAI-CA	Resident Assessment Instrument – Contact Assessment
RAI-HC	Resident Assessment Instrument – Home Care
RAI-MDS	Resident Assessment Instrument–Minimum Data Set
RCPSC	Royal College of Physicians and Surgeons of Canada

RHPA	<i>Regulated Health Professions Act, 1991</i>
RL6 system	electronic complaint / incident reporting system (Saint Elizabeth Health Care)
RN	registered nurse
RPN	registered practical nurse
RPNAO	Registered Practical Nurses Association of Ontario
RQI	resident quality inspection
RSC	regional supervising coroner
SAO	Service Area Office
SCAN	Suspected Child Abuse and Neglect (Program)
SDM	substitute decision-maker
SIU	Special Investigations Unit
SW CCAC	South West Community Care Access Centre
SW LHIN	South West Local Health Integration Network
TAR	treatment administration record
WHMIS	Workplace Hazardous Materials Information System
WSIB	Workplace Safety and Insurance Board

Victims: The Chronology



*There were various spellings of Ms. Adriano's first name and Ms. deMedeiros's last name in documents the Commission received. In this Report, I have used the spelling from their obituaries.
 Source: From Exhibit 3.

SECTION I

SECTION II

SECTION III

APPENDICES

The Inquiry Is Established



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I. Background

Elizabeth Wettlaufer is Canada's first known healthcare serial killer (HCSK).¹ In June 2017, she was convicted of eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault (the Offences). She committed the Offences between 2007 and 2016 in the course of her work as a registered nurse. In every case, Wettlaufer intentionally injected her victims with overdoses of insulin.

Wettlaufer committed all but the last Offence in licensed, regulated, long-term care (LTC) homes in southwestern Ontario. She committed the last Offence in a private home where she was providing publicly funded nursing care under the auspices of the *Home Care and Community Services Act, 1994*.² Although the last Offence was committed in a private home and not an LTC home, for ease of reference, I refer to the Offences throughout this Report as having been committed in the long-term care system.

Until the Offences came to light, Wettlaufer appeared unremarkable in any way. She was born on June 10, 1967, and raised in a town in southwestern Ontario. After graduating from high school, she tried a few different college programs before settling on nursing as a career. She became a registered nurse and member of the College of Nurses of Ontario in 1995. She worked as a nurse for 22 years, during which time there were “ups and downs” in her personal life and in her work life. In her personal life, she faced issues common enough today – failed relationships, a search for her sexual identity and acceptance of it, mental health challenges, and substance addiction. In her work life, at times she enjoyed success and at other times she was viewed as sloppy, lazy, and prone to making insensitive and inappropriate comments to her colleagues.

In September 2016, the veneer of an apparently normal life was stripped off by Wettlaufer herself. She abruptly resigned from her nursing job and checked herself into the Centre for Addiction and Mental Health in Toronto. There she announced to her treating psychiatrist that, over the previous nine years,

¹ I use the word “known” because, as I discuss in Chapter 16, it appears that an unidentified serial killer – almost certainly a healthcare provider – was responsible for as many as 36 deaths of babies and children between June 1980 and March 1981 at the Hospital for Sick Children in Toronto, Ontario. Justice Samuel Grange chaired the public inquiry tasked with examining the victims' causes of death and the police investigation into the deaths. He found that the deaths caused by digoxin toxicity were not the result of accident or medication error.

² SO 1994, c 26, as amended.

she had harmed and killed a number of people in the course of her nursing practice by injecting them with insulin overdoses. Without the benefit of notes or documentation of any kind, Wettlaufer then handwrote a four-page confession in which she set out the details of the Offences. Shortly thereafter, she voluntarily met with police, gave them her handwritten confession, and answered their questions. After the police investigated her claims, she was charged.

On June 1, 2017, in a courtroom in Woodstock, Ontario, Wettlaufer pled guilty to the charges against her arising from the Offences. Justice Bruce Thomas of the Superior Court of Justice of Ontario accepted her guilty pleas and convicted her of all 14 Offences. On June 26, 2017, Justice Thomas sentenced Wettlaufer to life in prison with no chance of parole for 25 years.

Public outrage followed. The Offences are tragedies that triggered alarm across the province about the safety of the long-term care system. The media reports showed widespread feelings of anger, insecurity, and vulnerability about the safety of the care provided for our loved ones as they age and require more assistance. Important questions arose immediately. How could a registered nurse commit so many serious crimes in licensed and regulated LTC homes, over such a long period, without detection? Could the Offences have been prevented? And, most important, how do we make sure that similar tragedies are not repeated in the future?

The Government of Ontario responded by calling this public inquiry.

II. The Inquiry

A. Mandate, Function, and Purpose

This Inquiry was established on August 1, 2017, pursuant to the *Public Inquiries Act, 2009*,³ and Order in Council 1549/2017 (OIC). The OIC appears as Appendix A to this volume.

³ SO 2009, c 33, Schedule 6.

The Commission mandate is set out in paragraph 2 of the OIC:

2. Having regard to section 5 of the *Public Inquiries Act, 2009*, the Commission shall inquire into:

- a. the events which led to the Offences;
- b. the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices, and accountability and oversight mechanisms; and
- c. other relevant matters that the Commissioner considers necessary to avoid similar tragedies.

In short, the Commission mandate was to inquire into the events of the Offences and to uncover the truth of what happened.

The Commission mandate is not the same thing as the Inquiry mandate. The Inquiry mandate includes both the Commission's obligations and those that the OIC places on me, as Commissioner. The most significant of those obligations are two in number. First, the OIC requires me to make recommendations on how to avoid similar tragedies in the future. Second, it obliges me to deliver a final report to the Attorney General on the Inquiry activities, including the recommendations, by July 31, 2019. The final report must be in both English and French, and in electronic and printed versions.

Like most public inquiries, in addition to its mandate, this Inquiry served an important social function. In *Phillips v Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*,⁴ Justice Cory explains:

Inquiries can and do fulfil an important function in Canadian society. In times of public questioning, stress and concern they provide the means for Canadians to be apprised of the conditions pertaining to a worrisome community problem and to be a part of the recommendations that are aimed at resolving the problem.

In my view, this Inquiry was also established to accomplish a purpose: to help restore the public's shattered trust in the long-term care system.

⁴ [1995] 2 SCR 97, at para 62.

B. Process

I divided the work of the Inquiry into two parts. Part 1 was directed at fulfilling the Commission mandate, set out in paragraph 2 of the OIC, to inquire into the Offences and the circumstances that allowed them to occur. Part 2 was directed at developing recommendations and writing this Report.

I began part 1 of the Inquiry by meeting with those most directly affected by the Offences. Over a two-week period in September 2017, in hotels in Woodstock, London, St. Thomas, and Brantford, Ontario, I held 16 private meetings with groups of victims' families and loved ones. In mid-October, the Commission team and I held three community meetings, two in Woodstock and one in London.

Commission counsel then conducted investigations into five areas:

- the police investigation into the Offences and the subsequent criminal proceedings;
- the homes and home care agencies that employed Wettlaufer when she committed the Offences;
- the College of Nurses of Ontario, the regulatory body governing all registered nurses in Ontario, including Wettlaufer;
- the Office of the Chief Coroner for Ontario and the Ontario Forensic Pathology Service, which is responsible for death investigations in Ontario; and
- the Ministry of Health and Long-Term Care and the Local Health Integration Networks, both of which play a role in overseeing long-term care homes and the provision of publicly funded home care services.

The investigations resulted in the production of over 42,000 documents, comprising approximately 400,000 pages.

Part 1 culminated in the public hearings in which Commission counsel presented the results of their investigations through both documentary evidence (primarily through overview reports) and the testimony of some 50 witnesses. The hearings ran for 39 days between June and the end of September 2018. In the hearings, Commission counsel led the evidence, and the 16 Participants,⁵ most of whom had their own counsel, tested and supplemented it.

⁵ The right to participate in the public hearings and those given that right (Participants) are discussed in Chapter 20.

All but three days of the public hearings – those devoted to expert and technical evidence – were held in the Elgin County courthouse in St. Thomas, Ontario. I chose that location because it was close to the communities in which the Offences had been committed, making it easier for those most directly affected by the Offences to attend in person. The three days of expert and technical evidence were heard in Toronto, Ontario.

A live webcast of the public hearings was accessible through the Inquiry website, making it possible for people to watch the hearings without having to attend in person. The recordings remained on the website until January 2019. Transcripts of the public hearings were also posted on the Inquiry website.

Part 1 of the Inquiry laid the factual foundation on which part 2 rested. In part 2, Inquiry researchers looked to other parts of Canada and the world to learn about healthcare serial killers, different approaches to long-term care, and the complexities of medication management in LTC homes. Based on that research, the evidence in the public hearings, and the key themes I saw emerging from both, I prepared a consultation brief that set out a framework for the discussion of potential recommendations. Using the consultation brief – which I circulated in advance – I held 19 consultations in October and November 2018 with the Participants and other stakeholders in the LTC system. The consultations were generally a day in length, although some ran over two days. The consultation process continued on an informal basis through to a plenary session in January 2019, which brought together all those who had participated in the consultations.

C. My Approach to the Recommendations

The recommendations in this Report are designed to fulfill the Inquiry mandate, as they must be. Thus, they address the threat to resident and client safety posed by a healthcare serial killer such as Wettlaufer. They are intended to prevent, deter, and detect intentional wrongdoing by healthcare providers.

However, wherever possible, the recommendations are also designed to improve resident care and quality of life. Human and financial resources are stretched thin in the long-term care system. It makes sense that we use these resources wisely and make changes that will not only improve the safety and security of those in the LTC system but also improve the quality of their daily lives.

III. The Suffering Caused by the Offences

The suffering caused by the Offences is greater than can be imagined. The following descriptions are inadequate to capture the depth and breadth of that suffering.

A. The Victims

I begin by acknowledging the suffering of the 14 people whom Wettlaufer harmed or killed. Their names are listed below in the chronological order of the Offences. These fine people had spent their lives working, raising families, and contributing to their communities and country. They were much loved spouses, parents, grandparents, siblings, and friends.

Clotilde Adriano⁶

Albina deMedeiros⁷

James Silcox

Maurice Granat

Wayne Hedges

Michael Priddle

Gladys Millard

Helen Matheson

Mary Zurawinski

Helen Young

Maureen Pickering

Arpad Horvath

Sandra Towler

Beverly Bertram

⁶ There were various spellings of Ms. Adriano's first name in documents the Commission received. In this Report, I have used the spelling from her obituary.

⁷ There were various spellings of Ms. deMedeiros's last name in documents the Commission received. In this Report, I have used the spelling from her obituary.

B. The Victim and the Victims' Families and Loved Ones

The only surviving victim who can communicate has been profoundly affected by the attack on her. Her description of the physical and psychological effects of the insulin overdose is horrifying: she was doubled over and moaning in pain and thought she was dying. In the aftermath of the attempt on her life, she became afraid to go to bed at night and afraid to have visitors. Her husband had to take care of all the household tasks because she could not “seem to do anything,” and her relationships with other family members were damaged as a result of this experience.

The victims' family members and loved ones struggle with feelings of sadness, anger, guilt, grief, anxiety, fear, depression, and betrayal. Some have lost trust in healthcare professionals, people in positions of authority, and the government. Others have withdrawn from family and friends, and most have difficulty eating, sleeping, and focusing. Many of the victims' children feel guilty for not protecting their parents the way their parents had protected them when they were small. In some cases, families have been torn apart by the Offences. Many knew and liked Wettlaufer – some had even praised and hugged her for providing good care to their loved ones. They are now haunted by those memories.

The aftermath of these Offences for the surviving victim and the victims' families may take years of therapy to manage. I arranged for counselling services for them during the Inquiry and, as you will see from the recommendation at the end of this chapter, I recommend that counselling continue to be made available to them, at no cost, for two years following the Inquiry's conclusion.

A number of the victims' family groups actively participated in the work of the Inquiry, at great personal cost. It is my sincere hope that each one found some healing through the Inquiry process itself and that they take comfort in the Report and its recommendations, knowing that their suffering has been the catalyst for improvements to long-term care in Ontario.

C. The Immediate Communities

The shock and horror caused by the Offences radiated in waves outward from the victims and their families. Many of the residents in the LTC homes in which the Offences were committed were fearful, as were their families. Those who worked with Wettlaufer in those homes were, and remain, shattered. They feel

shame over what happened, and guilt at not preventing it. Those in the Ministry of Health and Long-Term Care responsible for LTC homes, and the inspectors tasked with conducting inspections in them, were sickened.

The Offences were committed in small Ontario communities in which many community members knew Wettlaufer, the victims, and the victims' families. The Offences shocked and horrified them. They continue to grieve.

The Offences also cast an undeserved stain on the many fine people who work in long-term care and provide excellent care for residents and clients. These people bring a passion and commitment to work that is physically and emotionally challenging. They deserve our thanks and recognition, rather than feeling tarnished because of Wettlaufer's reprehensible actions.

D. The Toll on the Broader Community

It has been widely reported that the Offences have shaken public confidence in the Ontario LTC system. The Inquiry process bore that out: the public sense of betrayal was palpable throughout. People are now worried about the long-term care system and whether it can be relied on to safely care for their loved ones and for them, when their care needs reach a level that precludes them from living in their own homes.

E. The Offences Were Not Mercy Killings

During the Inquiry, I heard it suggested that the Offences were "mercy killings" designed to end the victims' suffering. Nothing could be further from the truth. When Wettlaufer committed the Offences, the victims were still enjoying their lives, and their loved ones were still enjoying time with them. It was not "mercy" to harm or kill these people.

Indeed, Wettlaufer herself has not suggested that she killed out of a sense of mercy. By her own admission, she committed the Offences because she felt angry about her career, her responsibilities, and her life in general. There was no mention of feelings of pity or concern for the victims. She felt euphoric after killing.⁸ Wettlaufer committed these crimes for her gratification alone, and not out of some misguided sense of mercy.

⁸ Reasons for Sentence, p 3. The Reasons for Sentence are at Appendix B to this volume.

IV. The Context for the Inquiry: Ontario's Aging Population

A. A Changing Demographic

Canada's population is aging, and Ontario's population reflects this trend. The primary reason is that the first of the baby-boom generation (those born between 1946 and 1965) turned 65 in 2011. The 2016 census was the first to record more individuals aged 65 years and older than children aged 14 years and younger.

On its own, the aging of the baby-boomers would be a self-limiting resource problem. However, Ontario's population redistribution is due to more than the baby-boom phenomenon. It is also due to increasing life expectancy and low birth rates dating back to the 1970s. This trend of older Canadians making up a significant proportion of the overall population is likely to continue on well after the influence of this post-war generation.

The aging of its population is a phenomenon that Canada shares with other G7 nations. In 2016, Canada's proportion of seniors was lower than in any G7 country except for the United States, which has a higher birth rate than Canada at present.⁹ Canada's population has aged more slowly because of its relatively high level of immigration and the lower average age of immigrants compared to that of the general population.¹⁰ However, if Canada's population continues to age as expected, the proportion of seniors in this country could reach Japan's current levels by 2031 – a level where one in four people is aged 65 years and older.¹¹

⁹ Statistics Canada, Age and Sex, and Type of Dwelling Data: Key Results from the 2016 Census, *The Daily*, May 3, 2017, <https://www150.statcan.gc.ca/n1/daily-quotidien/170503/dq170503a-eng.htm>.

¹⁰ John Ibbitson and Darrell Bricker, "The Vanishing," *Globe and Mail* (Toronto), January 26, 2019.

¹¹ Statistics Canada, Age and Sex, and Type of Dwelling Data: Key Results from the 2016 Census, *The Daily*, May 3, 2017, <https://www150.statcan.gc.ca/n1/daily-quotidien/170503/dq170503a-eng.htm>.

B. Care Options for Older Ontarians

As we grow older, our health and personal care needs tend to increase. For many older Ontarians, a key question is whether their care needs can be met while living in their own homes – with the assistance of family members, friends, and home care providers – or whether they will find it necessary to move into a collective dwelling where higher levels of support are provided.¹²

The care options for older Ontarians can be seen as a spectrum. At one end of the spectrum is “aging in place” – that is, continuing to live independently at home, with minimal support. Long-term care homes, which provide residents with around-the-clock monitoring and nursing care, are at the other end of the spectrum. As care needs increase and personal circumstances change, older Ontarians move along the care continuum: remaining at home but with increased support; moving into accommodation that offers assisted living; and, when constant monitoring and care are required, moving into a long-term care home.

C. Aging at Home

Most older Ontarians live in private, as opposed to collective, dwellings. *Aging with Confidence: Ontario’s Action Plan for Seniors* (2017) indicates that 93% of Ontarians aged 65 and older live in private households, a statistic that accords closely with the 2016 census data. Most of those in private households live with a partner or spouse (63%), slightly fewer than a quarter (23.5%) live alone, 11% live with other relatives, and 1.9% live with non-relatives.¹³

Caregiving that allows people to continue living in their homes, despite health challenges, comes from a combination of family help and home and community care. *Bringing Care Home: Report of the Expert Group on Home and Community Care* (2015) shows that, in Ontario, 1.8 million individuals living at home were assisted by a staggering 3.3 million family caregivers.¹⁴

¹² Statistics Canada categorizes dwellings as either private or collective and defines a collective dwelling as “a dwelling of a commercial, institutional or communal nature” (<https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/dwelling-logements002-eng.cfm>). As such, collective dwellings include long-term care homes and seniors’ residences.

¹³ Ontario, Ministry for Seniors and Accessibility, *Aging with Confidence: Ontario’s Action Plan for Seniors*, November 2017, 9, https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf

¹⁴ Ontario, Ministry of Health and Long-Term Care, *Bringing Care Home: Report of the Expert Group on Home & Community Care, March 2015*, 7, http://health.gov.on.ca/en/public/programs/lhin/docs/hcc_report.pdf

The *Home Care and Community Services Act, 1994*, governs the provision of a wide array of publicly funded services, including community support service agencies (which provide, among other things, meals, transportation, and caregiver support services); homemaking services (including housecleaning, laundry, and shopping); personal support services (including personal hygiene services); and professional services (including nursing, occupational therapy, physiotherapy, and social work services).

Many Ontarians receive home care through the Local Health Integration Networks (LHINs).¹⁵ (Until 2017, Community Care Access Centres provided this service.) LHINs are Crown agencies funded by the Ministry of Health and Long-Term Care. In the 2016/2017 fiscal year, roughly 760,000 individuals were served through the LHINs, of whom approximately 561,000 received home care. More than half of LHIN clients are older Ontarians.¹⁶

LHINs' staff directly provide some home care but, more commonly, the LHINs contract with service provider organizations to provide clients with home care such as nursing and personal support worker services. A large proportion of clients receive home care for short periods. The majority of "short-stay" home care clients receive services for only a few months. "Chronic" home care clients, in contrast, often have multiple co-morbidities that are managed over a period of years. Nursing services are provided to the largest number of clients, followed by personal support and homemaking services.

The acuity¹⁷ of home care clients is rising. Three factors have contributed to this increase: people are living longer, and the later years are often accompanied by cognitive and physical impairment; patients are released from hospital into the community earlier in their recovery; and many who would have previously been cared for in hospitals or LTC homes are living at home.¹⁸ Today, some home care clients are on ventilators 24 hours a day and have multiple care needs. In addition, the medical complexity of palliative clients has changed.¹⁹

¹⁵ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received royal assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the LHINs. All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC system, including Ontario Health.

¹⁶ Affidavit of Donna Ladouceur, at paras 31–33.

¹⁷ Acuity refers to the intensity of care that a person needs.

¹⁸ Testimony of Donna Ladouceur, Transcript, Aug. 8, 2018, pp 7741–42.

¹⁹ Testimony of Donna Ladouceur, Transcript, p 7713.

D. Living in Long-Term Care Homes

Despite the supports that facilitate aging at home, some older Ontarians require more care than can be provided in the home. Those requiring constant care or monitoring may become residents of long-term care homes.

In 2019, Ontario's 626 long-term care homes provided 78,667 beds for residents.²⁰ Most long-term care home beds are of two types: long-stay and short-stay beds. Residents with long-stay beds typically stay until they pass away. Short-stay beds include convalescent care beds, interim beds, and respite beds. These beds allow individuals in the community to stay in an LTC home for a short period of time before returning home.

The Canadian Institute for Health Information (CIHI)²¹ statistics for 2016–17 help to paint a general picture of the resident population of long-term care homes in Ontario. According to these data, the average age of a long-term care home resident is 83 years. While a small majority (54.6%) of the long-term care home population is aged 85 years and older, 6.7% are younger than 65. Residents in long-term care homes are predominantly female: approximately two-thirds (67.1%) of LTC home residents are women.

The LTC home resident population is undeniably one of high needs. The vast majority of residents have some form of cognitive impairment and physical frailty, along with chronic health conditions that have compromised their well-being. In *This Is Long Term Care 2019*, the Ontario Long Term Care Association sets out a profile of residents in LTC homes in 2017–18. The profile shows, among other things, that 90% of residents have some form of cognitive impairment, and 86% need extensive help with activities such as eating or using the washroom.²² (The profile is set out in full in Chapter 4.) The number of residents with cognitive impairments and those who require extensive or complete support with everyday activities is steadily increasing.²³

²⁰ Ministry of Health and Long-Term Care, Health Data Branch, HSIM Division, *Long-Term Care Home System Report from New CPRO*, February 2019.

²¹ CIHI is an independent, not-for-profit organization that provides information on Canadian health systems and the health of Canadians. It collects information from various healthcare sectors in Ontario (including LTC homes), all the other provinces, and the territories.

²² Ontario Long Term Care Association, *This Is Long-Term Care, 2019* (Toronto, April 2019), 3.

²³ Ontario Long Term Care Association, *This Is Long-Term Care, 2018* (Toronto, April 2018), 2.

V. Principal Findings

A. Introduction

Based on the evidence presented in the Inquiry's public hearings, I make three principal findings that are foundational to the recommendations in this Report:

- if Wettlaufer had not confessed, the Offences would not have been discovered;
- no findings of misconduct are warranted; and
- the long-term care system is not broken.

The significance of these findings cannot be overstated.

The fact that the Offences were discovered only because Wettlaufer confessed to them tells us that, to prevent similar tragedies in the future, we cannot continue to do the same things in the same ways in the long-term care system. Some fundamental changes must be made: changes directed at preventing, deterring, and detecting intentional wrongdoing by healthcare providers.

I make no findings of misconduct because the Offences were the result of systemic failures in the long-term care system, not the failures of any individual or organization within it. In saying this, I do not mean to suggest that there is nothing the stakeholders can do individually to improve the safety and security of residents. Of course there is – and I make specific stakeholder recommendations on those matters. What this finding highlights, however, is that there is no simple “fix.” We cannot point our fingers at any given individual or organization, identify their shortcomings, and end the threat posed by wrongdoers such as Wettlaufer by remedying those shortcomings. Rather, it will take all those in the long-term care system working together to achieve the common goal of safety and security for the residents and clients in it. Collaboration, co-operation, and communication must become the watchwords for the system.

There is also real significance to my conclusion that the LTC system is not broken. Ontario has no need to jettison the existing regulatory system and start over. Instead, we need to identify and acknowledge the strengths of the existing system and build on them. Celebrating the existing areas of excellence in the long-term care system should inspire others to follow suit. But we must also step up and acknowledge the gaps in the long-term care

system that the Offences and this Inquiry have exposed. As well, the delivery of this Report forces us, as a society, to decide if we are willing to make the financial investments necessary to improve not only the safety and security of older Ontarians but also the quality of their lives.

I will summarize now the basis for these three findings.

B. No Knowledge of the Offences Without Wettlaufer's Confession

I have no hesitation in finding that the Offences would not have been discovered had Wettlaufer not confessed and turned herself in to the police. I rely on the following three areas of evidence for this finding.

First, Justice Thomas made this finding when he sentenced Wettlaufer to life in prison, stating, "Without her confessions, I am convinced this offender would never have been brought to justice."²⁴ He explains how she was able to continue to commit the Offences, without detection, saying:

She was the RN in charge of the shifts. She controlled the medication, she controlled the staff and the paperwork. It seemed she had a free run. Most of her victims were residents at Caressant Care (Woodstock). They were there exhibiting different conditions and different levels of awareness of their surroundings and their circumstances. They all, however, were exceedingly vulnerable to the abuse of Elizabeth Wettlaufer. One of the victim impact statements describes her as a "predator stalking the weak and easily overwhelmed."²⁵

Second, no one suspected that Wettlaufer was intentionally harming residents. The evidence from witnesses in the various homes and organizations for which Wettlaufer worked shows that no one suspected she was intentionally harming residents under her care – not the residents or their families, not those who worked alongside Wettlaufer, and not those who managed and supervised her. None of the reports or complaints that the Ministry of Health and Long-Term Care received from or about the homes where Wettlaufer was working suggested that she might be intentionally harming residents. Nothing raised the suspicion of the many Ministry inspectors who regularly attended at the homes in the period in which Wettlaufer committed the Offences. Nothing sounded alarm bells for the coroners who conducted death investigations on some of the victims. Although the College of Nurses

²⁴ Reasons for Sentence, p 10. The Reasons for Sentence are at Appendix B to this volume.

²⁵ Reasons for Sentence, p 2. The Reasons for Sentence are at Appendix B to this volume.

of Ontario (College) received the termination report that Caressant Care (Woodstock) filed with it when it fired Wettlaufer, the College saw nothing that raised concerns about Wettlaufer's treatment of residents. Its decision to take no action beyond "banking with notice" the termination report²⁶ shows that it had no serious concerns about the care that Wettlaufer provided to residents.

Third, Dr. Michael Pollanen, Ontario's chief forensic pathologist, gave evidence at both the criminal proceedings against Wettlaufer and this Inquiry that, even if full death investigations (including autopsies) had been conducted on all the murder victims, it is unlikely they would have produced evidence that Wettlaufer had intentionally injected them with overdoses of insulin. Dr. Pollanen explained a number of difficulties in identifying insulin overdose after death: no mechanism currently exists to diagnose hypoglycemia (too much insulin in the body) by using samples from a dead body; hypoglycemia leads to non-specific symptoms associated with other medical conditions; there are serious practical challenges to identifying hypoglycemia caused by insulin administration; deaths from insulin overdoses often occur days after the insulin was administered, and the passage of time makes detecting insulin overdoses virtually impossible; and changes that occur after death make it difficult to distinguish between natural insulin produced by the body and synthetic insulin introduced into it. A fuller explanation of Dr. Pollanen's evidence is found in Chapter 14.

C. No Findings of Misconduct

In this case, systemic failings – not individual ones – created the circumstances allowing the Offences to be committed. It would, therefore, be unfair of me to embark on a personal attribution of responsibility.

Given the societal interest in the tragedies that lead to public inquiries, it is not surprising that the issues which public inquiries uncover are frequently systemic in nature and call for a system-wide response. As Justice Archie Campbell observed in the Bernardo Investigation Review:

It is often the case that systemic failures, as opposed to individual mistakes, are the real cause of public disasters and the most appropriate focus of public inquiries. The public identification of individual mistakes or wrongdoing, while important, does not necessarily address the underlying problem. And unless the underlying problem is addressed,

²⁶ "Banking with notice" refers to giving the nurse member notice that a copy of the report will be kept on file with the College, to be reviewed should further concerns come to the College's attention. This decision is addressed in detail in Chapter 13.

the same mistakes or wrongdoing will likely occur again if the system that permitted it is not fixed.

It is a mistake for a Royal Commission or public inquiry to focus exclusively on the search for scapegoats when the failure is really an institutional failure in the sense of a lack of appropriate systems, a lack of reasonable resources, a flawed institutional culture, or a breakdown in the machinery of accountability.

... These problems do not go away simply because individuals have been implicated. These problems only go away when people change their systems, their attitudes and the way they do business.²⁷

D. The Long-Term Care System Is Not Broken

In Chapter 15, I explain why the long-term care system is not broken. Here, a summary of the strengths of the existing system is sufficient to justify this finding.

- First, the *Long-Term Care Homes Act, 2007*, establishes clear, consistent standards that every long-term care home in Ontario must meet and a compliance regime to enforce those standards. It provides a strong foundation on which to introduce changes that will supplement compliance efforts with strategies to build capacity and excellence in resident care.
- Second, throughout the Inquiry process, I have been impressed by the passion and dedication of those working in the long-term care system, despite the challenges they face. Nowhere is this more evident than in the fact that many stakeholders have already implemented recommendations that I discussed with them in consultations. They did not wait for this Report before taking action. Instead, on learning of things that they could do better or differently, they took immediate steps to address them. In Chapter 15, you will find a list of the many matters on which stakeholders acted in advance of this Report.
- Third, Ontario has a strong death investigation system with excellent leadership. What is needed now is to build on those strengths by tailoring the death investigation system as it applies to resident deaths and the possibility of intentional wrongdoing. This topic is discussed in Chapters 14 and 18.

²⁷ “The Bernardo Investigation Review,” in Allan Manson and David Mullan, eds., *Commissions of Inquiry, Praise or Reappraise?* (Toronto: Irwin Law, 2003), quotation reproduced in Ed Ratushny, *The Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009), 385–86.

- Long-term care homes have a solid medication management system on which to build. With the injection of modest sums of money, this system can be improved in ways that will not only address the safety concerns revealed by the Offences but also lead to overall quality improvements for residents and improved working conditions for those providing direct resident care. This subject is addressed in Chapter 17.

VI. A Roadmap for the Report

This Report consists of four volumes, each of which has a different focus and purpose.

Volume 1: Executive Summary and Consolidated Recommendations briefly summarizes the key components of the Report and includes a consolidated list of all the recommendations in it. This list comprises the recommendations that I make in several, but not all, of the chapters. Unlike the recommendations at the end of chapters, however, the consolidated list in Volume 1 does not include the rationales for the recommendations.

Volume 2: A Systemic Inquiry into the Offences summarizes the results of the Commission's inquiries into the Offences and the circumstances in which they were committed. It consists of three sections. Section I has background on the Offences and the Inquiry. Section II covers the role of LTC homes and home care service providers. Section III describes the oversight and regulatory bodies in the LTC system.

Chapter 2 gives an overview of Wettlaufer's nursing career, the Offences she committed, and how she ended up in jail. It describes the victims so that, in a small way, readers will come to know their stories. It also gives an expanded explanation of the scope of the Inquiry mandate and how we approached our duties in fulfilling that mandate.

Chapter 3 describes the first 12 years of Wettlaufer's nursing career. Apart from a disastrous start in the profession, for over a decade Wettlaufer exhibited nothing unusual about either herself or the work she performed. This chapter also underscores the expert evidence, discussed in Chapter 16, which shows that profiling is of little or no use in attempting to identify healthcare serial killers.

Chapter 4 sets out, in general terms, the role of long-term care homes. The majority of recommendations that are specifically targeted at licensees and LTC homes appear at the end of this chapter. However, licensees and homes

are directed also to look at the systemic recommendations in Volume 3 because most of these recommendations have direct implications for them.

Chapters 5 through 8 explore the settings in which Wettlaufer committed the Offences: as an employee of Caressant Care (Woodstock) and Meadow Park (London); as an agency nurse at Telfer Place; and as a nurse for a service provider, Saint Elizabeth Health Care, working in the home care setting.

Chapters 9 through 12 describe the regulatory role that the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs) play in the oversight of the LTC system. They describe the steps that the Ministry took when it learned of the Offences, including extensive inspections in every home in which an Offence was committed. Most of the recommendations specific to the Ministry, which appear at the end of Chapter 9, can be implemented quickly, with immediate positive benefits for the LTC homes. The systemic issue and its associated recommendations, which call for change to be led by the Ministry, are explored in Chapter 15. The recommendations directed at the LHINs (or successor organization) appear at the end of Chapter 12. The Ministry and the LHINs are directed also to review all the systemic recommendations in Volume 3, many of which directly affect their work in the LTC system.

Chapter 13 addresses Wettlaufer's crimes in relation to her work as a registered nurse and as a member of the College of Nurses of Ontario (College). Nursing is a self-governing profession and, to practise nursing in Ontario, nurses must be members of the College. As the regulatory body, the College's role is to regulate, in the public interest, its 175,000 nurse members. In Chapter 13, I first explore the College's role generally in governing nurses in Ontario, and then I examine Wettlaufer's interactions with the College, from the time of her initial registration in 1995 until 2017, when the College revoked her registration. This chapter concludes with recommendations specific to the work of the College. I also direct the College to the systemic recommendations in Volume 3, particularly those relating to training on the healthcare serial killer phenomenon (Chapter 16) and medication management (Chapter 17).

Chapter 14 describes the death investigation system in Ontario, led by the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS). It focuses on how deaths in LTC homes are reported to the OCC/OFPS and the steps taken when a resident's death is investigated. I also describe the OCC/OFPS involvement with the Wettlaufer murder victims both before and after the Offences came to light. I conclude by recommending a two-pronged approach to reform the death investigation process for residents

in LTC homes. This chapter addresses the first prong: a redesigned death report to flow from the long-term care homes to the OCC/OFPS. The second prong calls for changes to the death investigation process as it relates to residents in LTC homes. This second prong depends on a systemic response, to be led by the OCC/OFPS, and is considered in Chapter 18.

Volume 3: A Strategy for Safety sets out the results of the Inquiry's work on the systemic issues and its recommendations for addressing the systemic vulnerabilities in Ontario's long-term care system. These chapters and recommendations are directed at all stakeholders in the LTC system.

Chapter 15 describes what is meant by systemic issues, and why they call for systemic responses. It also makes clear that Ontario's long-term care system is not broken; its regulatory framework is strong and effective at ensuring that all LTC homes meet rigorous care standards. However, as I explain in Chapter 15, a culture shift is needed, with the Ministry of Health and Long-Term Care providing the leadership necessary to build capacity and excellence in LTC homes. The recommendations are a blueprint for the Ministry to take this brave step into the future, working closely with other stakeholders in long-term care.

Chapter 16 sets out the results of the Inquiry's expert evidence and research on the healthcare serial killer (HCSK) phenomenon. Although rare, the phenomenon is longstanding and universal in its reach. After setting out where, when, and how HCSKs have operated, and the large numbers of people they have killed, I compare the features common to healthcare serial killings with Wettlaufer's Offences: it is clear that she is a healthcare serial killer. Importantly, this chapter proves that the essential first step in combatting HCSKs is to build awareness, throughout the healthcare system, of the possibility that healthcare providers may intentionally harm those in their care. I also explain why the Office of the Chief Coroner and the Ontario Forensic Pathology Service is ideally situated to lead the process of building that awareness. As a systemic issue, however, it will take the work of many to achieve the goal of creating the requisite awareness.

Chapter 17 describes a three-pronged approach for deterring wrongdoers from intentionally harming residents in long-term care homes through the use of medications. First, I suggest strategies for strengthening the medication management system in the homes and recommend that the Ministry inject funds to make it possible for homes to implement these strategies. Some of

these strategies are simple and straightforward – put windows in the doors and walls of medication rooms, so what happens inside them is readily visible, and install cameras in common areas in the home so that incidents are more easily and effectively investigated. Other strategies call for the use of technology, such as automated dispensing cabinets, to assist in tracking and auditing medications. Yet others call for a strengthening of the medication management functions through the greater involvement of pharmacists and pharmacy technicians.

Second, I recommend that homes improve their medication incident analysis through, among other things, the use of a framework for analysis that includes screening for the potential of intentional harm. Third, to avoid tragedies such as the Offences, it is clear that the number of registered staff in long-term care homes must be increased. The third prong calls for the Ministry of Health and Long-Term Care to conduct a study to determine adequate levels of staffing on each of the day, evening, and night shifts and, once determined, to provide adequate funding to LTC homes so they can reach those levels.

Chapter 18 is about the death investigation system in Ontario and how it operates in relation to the deaths of residents in long-term care homes. I explain the challenges in detecting intentionally caused resident deaths and why existing methods are inadequate to meet the threat that HCSKs pose. I then set out two key strategies for increasing the number of resident deaths that are investigated: a redesigned Institutional Patient Death Record and the use of data analytics, in the form of the Ministry's project to detect elevated death rates in long-term care homes.

Chapter 19 discusses suggestions that were made to the Inquiry on how to prevent similar tragedies in the future but which did not ultimately become recommendations. As I explain, some of the suggestions fell outside the Inquiry mandate. The Inquiry is obliged to honour the limits of its mandate, so it could not pursue these suggestions. I found other suggestions to be unworkable. A weighing of the associated costs and benefits of yet other suggestions augured against pursuing them. Although the suggestions set out in Chapter 19 did not become recommendations, the very act of exploring them caused my team and me to reflect, consult, and research the problems they identified. In so doing, they helped guide this Report and the recommendations in it.

Volume 4: The Inquiry Process explains the process followed in each of parts 1 and 2 of the Inquiry.

Chapter 20 describes establishing the Inquiry team, setting up the Commission offices, and initiating communication with the public. It then explains each step in part 1 of the Inquiry process, beginning with the meetings I held with victims' families and concluding with the public hearings. In this chapter, I also address the right of participation, who was given that right, and how I made funding recommendations for certain of the Participants.

Chapter 21 describes part 2 of the Inquiry process, beginning with the stakeholder consultations and ending with the production of this Report. In Chapter 21, I also describe a development that arose late in the Inquiry process and how I handled that matter.

RECOMMENDATIONS

Recommendation 1: The Ministry of Health and Long-Term Care must issue a public report on the first anniversary of the release of this Report describing the steps it has taken to implement the recommendations in this Report. The Minister of Health and Long-Term Care should table the public report in the legislature.

Recommendation 2: The Ministry of the Attorney General should make counselling services available for a period of two years following the Inquiry's conclusion on July 31, 2019, to the victim, and the victims' families and loved ones, at no cost to them.

The Offences, the Victims, and the Establishment of the Inquiry

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I. Introduction

Between 2007 and 2016, Elizabeth Wettlaufer – a registered nurse – harmed or killed more than a dozen of her patients while working in southwestern Ontario (the Offences). All the Offences, except the last, were committed in licensed, regulated long-term care (LTC) homes. The last offence was committed in a private home where Wettlaufer was providing nursing care under the auspices of the *Home Care Community Services Act, 1994*.¹ Although the last offence was committed in a private home and not a long-term care home, for ease of reference, throughout the Report, I will refer to the Offences as having been committed in the long-term care system.

The Offences shattered public trust in Ontario's LTC system. The ensuing public outrage was widespread and vocal. The victims were some of the most vulnerable in our society, and at a stage in their lives where they warranted our collective respect, care, and affection.

Nothing short of an independent inquiry could rebuild public trust in the LTC system and answer this question: How could so many serious crimes be committed, over such a lengthy period of time and in so many different locations, without detection? This public inquiry was established to find answers to that question and to make recommendations on how to avoid such tragedies in the future.

This chapter begins with some brief background information on Wettlaufer. Because she committed the Offences by injecting the victims with insulin, I next set out some basic information about insulin and hypoglycemia, the body's reaction to an overdose of insulin. The Offences are set out in the section that follows, including when Wettlaufer committed them and where she was working at the time.

I will then briefly describe the victims. As you will see, they were fine people who spent their lives working, raising families, and contributing to their communities. They were much loved spouses, parents, grandparents, siblings, and friends. I pause to make an important point. Over the course of the Inquiry, many people suggested that perhaps the Offences were "mercy killings." Nothing could be further from the truth. The victims were still enjoying their lives when they were harmed, and their loved ones were still enjoying time with them. It was not "mercy" to harm or kill these people.

¹ SO 1994, c 26, as amended.

The last sections in this chapter describe Wettlaufer's confession, the ensuing criminal proceedings, the establishment of the Inquiry, and its mandate.

II. Elizabeth Wettlaufer's Background

Elizabeth Tracy Mae (Parker) Wettlaufer² was born on June 10, 1967. She was raised in the Woodstock area in southwestern Ontario, grew up in a religious family, and attended church regularly when she lived at home.

After high school, Wettlaufer studied journalism for a year and then attended the London Baptist Bible College in London, Ontario, for four years. She graduated with a Bachelor of Religious Education. When she decided that she wanted to be a nurse, she upgraded her high school sciences and math courses. She then completed a three-year nursing program at Conestoga College in Stratford, Ontario, and obtained her nursing diploma in June 1995. Her nursing education included medication administration and training in palliative and seniors' care.

Wettlaufer became a registered nurse and member of the College of Nurses of Ontario (College) in 1995.

Before becoming a registered nurse, Wettlaufer moved to Geraldton, Ontario, in northern Ontario. In April 1995, she began working for the Geraldton and District Association for Community Living as a support worker. She continued to work there until February or March 1996.

After becoming a registered nurse, Wettlaufer worked for:³

- Geraldton District Hospital (Geraldton, Ont.), June to October 1995;
- Victoria Rest Home (Woodstock, Ont.), March or April to October or November 1996;
- Christian Horizons (Woodstock, Ont.), June 1996 to June 2007;
- Caessant Care Nursing Home (Woodstock, Ont.), June 2007 to March 2014;
- Meadow Park Nursing Home (London, Ont.), April to October 2014;

² Wettlaufer's birth name was Parker. Some of the documents in evidence before the Inquiry refer to her by her birth name of Parker.

³ Much of the following information – particularly the dates and spelling of names of Wettlaufer's employers – has been taken from the Agreed Statement of Facts filed in the criminal proceedings against Wettlaufer. Other dates and spelling of names appear in various documents in evidence before the Inquiry.

- Life Guard Homecare (Brantford, Ont.), including at Telfer Place Long-Term Care Facility (Paris, Ont.), January 2015 to August 2016⁴; and
- Saint Elizabeth Health Care (Oxford County, Ont.), July to August 2016.⁵

On September 16, 2016, Wettlaufer checked herself into the Centre for Addiction and Mental Health (CAMH) in Toronto. While at CAMH, she confessed to killing residents by injecting them with insulin in the homes in which she had worked.

In June 2017, Wettlaufer pleaded guilty to, and was convicted of, the 14 Offences: eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault.

In July 2017, the College revoked Wettlaufer's certificate of registration, describing her actions as the "most egregious example of abuse and disgraceful conduct."⁶

III. Insulin and Hypoglycemic Reactions

Wettlaufer committed all the Offences by injecting the victims with insulin.⁷ For that reason, it is helpful to understand why people can need synthetic insulin and what happens when they get too much of it, which results in a state called hypoglycemia.

Glucose, sometimes called blood sugar, is a simple sugar which the human body uses as fuel. Normally, glucose comes from the food we eat and some fluids we drink.

The human body naturally produces two substances that stabilize glucose levels – insulin and glucagon. When a person's blood sugar level gets too high, the body produces insulin to lower blood sugar levels. When a person's blood

⁴ Wettlaufer worked at Telfer Place for a shorter period than she was employed by Life Guard. These dates reflect her employment with Life Guard. She worked at Telfer Place between February 2015 and April 2016.

⁵ Wettlaufer was offered employment by Saint Elizabeth in June 2016 but did not begin working there until July 2016.

⁶ *College of Nurses of Ontario v Elizabeth Tracy Mae Wettlaufer Registration #9581737*, 2017 CanLII 77173 (Ont. CNOD), *CanLII-2017 CanLII 77173 (ON CNO)*, accessed on 2018-12-01.

⁷ The material in this section draws heavily from the report that Dr. Michael Pollanen, chief forensic pathologist for Ontario, prepared for the criminal proceedings against Wettlaufer and the Agreed Statement of Facts filed in those proceedings.

sugar level gets too low, the body produces glucagon to elevate the blood sugar level. A low blood sugar level is known as hypoglycemia. A high blood sugar level is known as hyperglycemia.

People with diabetes are unable to stabilize their blood sugar levels naturally. Thus, they must take measures to ensure that their blood sugar levels remain within the normal range. Some do so by taking synthetic insulin by injection. Others are able to control blood sugar levels through medication in a pill form.

Many older people have diabetes to varying degrees, so synthetic insulin is commonly administered in homes providing long-term care.

Two broad classes of insulin are relevant to this matter – “short-acting” and “long-acting” insulin. As their names imply, the former is designed to lower blood sugar levels more immediately while the latter does so more slowly over a longer period. Both forms are commonly available in LTC homes.

The use of synthetic insulin – its form, timing, and quantity – is individualized to a person’s needs. During the period in which Wettlaufer committed the Offences, synthetic insulin was administered through a device known as an insulin pen, which has a needle at one end and a button for dispensing the medication at the other. A cartridge of insulin was inserted in the insulin pen. The person administering the insulin would then turn a dial (“dial it up”) to set the desired amount of insulin to be injected from the cartridge into the person who needed it.

Injecting insulin into a person who does not need it can cause the person’s blood sugar to drop below the normal range and cause hypoglycemia. So, too, can injecting an overdose of insulin.

Hypoglycemia can be mild or serious. It leads to a wide spectrum of non-specific symptoms, including confusion, pallor, diaphoresis (sweating), shakiness, irritability, hunger, anxiety, tachycardia (abnormally rapid heart rate), dizziness, headache, and weakness. When hypoglycemia becomes severe enough, a person may experience a reduced level of consciousness, coma, or death. The full impact of an overdose of injected insulin often takes hours – it does not kill instantly.

Stocks of insulin pens and cartridges in LTC homes are kept in medication rooms. Although medication rooms are typically locked, with limited numbers of keys held only by registered staff members, those with keys can remove insulin without detection. Typically, insulin use is not tracked. When a resident’s supply is low, the insulin is reordered.

Hypoglycemia is fairly common in older people, even those without diabetes. For this reason, when a hypoglycemic event is detected in an older person, it may not arouse suspicion. Further, because many of the symptoms of hypoglycemia can result from other medical conditions, it can be difficult to identify. This may explain why insulin has been used by a number of serial killers in the healthcare sector.⁸

IV. The Offences

Apart from approximately one year in which Wettlaufer worked in northern Ontario, she spent her career in a small part of southwestern Ontario. It was there that she committed the Offences.

Wettlaufer's career was marked by performance issues and difficulties with colleagues. The latter part of her career was marked also by numerous changes of employment. It is worthy of note that Wettlaufer was able to continue her nursing career in small communities that were in close geographical proximity, despite her performance issues.

Figure 2.1 provides a sense of the geographical proximity of the homes in which Wettlaufer committed the Offences.



Figure 2.1: Locations of the Offences: Ingersoll, London, Paris, and Woodstock, Ontario

Source: Compiled by the Commission.

⁸ Chapter 16 in Volume 3 examines the healthcare serial killer phenomenon and the use of insulin by nurses to murder those in their care.

A. Wettlaufer's Employment Before the Offences

Wettlaufer committed the Offences while working at Caressant Care Nursing Home (Woodstock), Meadow Park Nursing Home (London), Telfer Place Long-Term Care Facility, and in a private home. None of the Offences were committed before she began working at Caressant Care (Woodstock), in 2007. A brief description of her employment before 2007 nonetheless provides useful background information.

Geraldton and District Association for Community Living (April 1995–March 1996)

Wettlaufer was employed as a support worker (not a nurse) at Geraldton and District Association for Community Living while she lived in northern Ontario. For part of the time that Wettlaufer worked for this association, she also worked at the Geraldton District Hospital.

Geraldton District Hospital (June–October 1995)

Wettlaufer's first nursing job was as a student nurse at Geraldton District Hospital. She began work at the hospital as a registered nurse in June 1995, under a temporary registration with the College, and received her general registration with the College in August.

Wettlaufer's employment with the hospital was short-lived. In September 1995, she collapsed at work. She had stolen Lorazepam (a controlled substance) from the hospital supply and ingested it while at work. Two other registered nurses reported that she appeared dazed, was unsteady, and had difficulty communicating. The hospital fired her and reported the matter to the College, the governing body for nurses in Ontario, as required by the *Regulated Health Professions Act, 1991*.⁹

Details of the College's investigation can be found in Chapter 13. It is sufficient at this point to note that the College took steps to determine whether Wettlaufer was incapacitated. It ordered her to undergo an examination by an addiction medicine physician. She was also seen by a psychiatrist.

Ultimately, the College imposed terms, conditions, and limitations on Wettlaufer's nursing licence. The conditions required her to, among other things, abstain from abusing substances, remain alcohol free, comply with

⁹ SO 1991, c 18.

a treatment program, advise the College if she obtained employment in nursing and of any subsequent changes in her nursing employment, and advise her employers of the conditions on her licence.

The College monitored Wettlaufer through communications with her employer and her treatment providers. It lifted the conditions in May 1998.

Victoria Rest Home (March–October 1996)

Wettlaufer briefly worked at Victoria Rest Home in Woodstock as a nurse.¹⁰

Christian Horizons (June 1996–June 2007)

In June 1996, Wettlaufer began working at Christian Horizons, an organization in Woodstock, Ontario, that provided residential support services for people with disabilities. She worked there for more than a decade – not as a nurse, but as a support worker.

In the early summer of 2006, Wettlaufer took a brief leave of absence and was hospitalized for mental health reasons, including depression. She returned to work at the end of July 2006.

In early 2007, Wettlaufer's marriage ended. That spring, she resigned from Christian Horizons, planning to move to New Brunswick with a new partner. However, that relationship ended shortly after her resignation, and Wettlaufer stayed in Woodstock.

B. Caressant Care Nursing Home (Woodstock) (June 2007–March 2014)

1. Overview

Wettlaufer began work at Caressant Care (Woodstock), as a registered nurse, in June 2007. As a registered nurse in an LTC home, she was responsible for resident assessments, care planning, medication administration, scheduling, carrying out nursing interventions such as skin and wound care, and charting. Her duties included supervising registered practical nurses and personal support workers.

¹⁰ Little is known about her work at Victoria Rest Home. In one resumé, Wettlaufer described her position there as “Charge Nurse.” In another, she said she worked there as a “Staff Nurse.” The College's memo of a conversation with the home says that she worked there as a registered practical nurse.

As a registered nurse, Wettlaufer had ready access to medications and medical supplies. She knew that the insulin stored in the homes in which she worked was not strictly accounted for. She often worked evenings and nights with minimal supervision and ready access to insulin.

Wettlaufer committed the majority of her Offences while working at Caressant Care (Woodstock), beginning soon after she arrived.

On March 20, 2014, Wettlaufer made another error in a long series of medication errors committed during her employment at Caressant Care (Woodstock). It was a serious error relating to her administration of insulin but did not involve one of her victims. Caressant Care (Woodstock) terminated her employment.

In a report to the College dated April 17, 2014, Caressant Care (Woodstock) reported Wettlaufer's termination of employment. The report included a summary of many of her performance issues and medication errors committed in the approximately two-year period leading up to her termination. The report also referred the College to Wettlaufer's personnel file, indicating that it included other reprimands and issues concerning attendance and professional behaviour.

The College determined that an investigation was not needed and placed no restrictions on Wettlaufer's licence. A description of the College's handling of this matter can be found in Chapter 13.

2. The Offences

The Offences that Wettlaufer committed while working at Caressant Care (Woodstock) are set out below, in chronological order.

Clotilde Adriano¹¹ – aggravated assault Wettlaufer intentionally injected Ms. Adriano with unnecessary doses of long-acting insulin on more than one occasion between June and December 2007. Other healthcare providers, including nurses, successfully treated Ms. Adriano for hypoglycemia on those occasions.

¹¹ In some documents before the Commission, Ms. Adriano's first name is spelled as Clotilda, rather than Clotilde. The Commission has used the spelling used in her obituary.

Albina deMedeiros¹² – aggravated assault Wettlaufer intentionally injected Ms. deMedeiros with unnecessary doses of insulin on more than one occasion between June and December 2007. Again, nurses and other healthcare providers successfully treated Ms. deMedeiros for hypoglycemia on those occasions.

James Silcox – first-degree murder On August 11, 2007, Wettlaufer intentionally injected Mr. Silcox with an overdose of short-acting insulin. He passed away the following day.

Maurice Granat – first-degree murder On the night of December 22–23, 2007, Wettlaufer injected Mr. Granat with short-acting insulin in order to end his life. He was not diabetic and had no need for synthetic insulin. She told Mr. Granat that the injection was a vitamin shot. He passed away on December 23, 2007.

Wayne Hedges – attempted murder In October 2008, Wettlaufer injected Mr. Hedges with a large amount of insulin, intending to end his life. Records show that Mr. Hedges had a hypoglycemic event in October 2008 and that Wettlaufer administered medication to restore his blood sugar levels. She told police she had no recollection of giving him that medication.

Michael Priddle – attempted murder In 2008 or 2009, Wettlaufer injected Mr. Priddle with a large amount of insulin, intending to end his life. Medical records confirm that in July 2008, Wettlaufer was attending to Mr. Priddle and he experienced an incident that appeared to be hypoglycemic in nature. He survived the overdose, apparently without medical intervention.

Gladys Millard – first-degree murder In the early hours of October 14, 2011, Wettlaufer injected Ms. Millard with both short-acting and long-acting insulin. When staff on the day shift noticed that Ms. Millard was red and incoherent, with low vital signs, they moved her into a palliative care room. Despite staff attempts to assist Ms. Millard, she passed away the following day.

¹² The Commission has used the spelling of Albina deMedeiros that was used in her obituary. It was spelled in different ways in different documents in evidence before the Inquiry.

Helen Matheson – first-degree murder On the evening of October 25, 2011, Wettlaufer injected Ms. Matheson with short-acting insulin, intending to end her life. Over the course of that evening and the following day, Ms. Matheson's condition deteriorated and she was moved into a palliative care room. She passed away on October 27, 2011.

Mary Zurawinski – first-degree murder On November 6, 2011, Ms. Zurawinski was moved into a palliative care room. Wettlaufer injected her with short-acting and long-acting insulin, telling her that the needles were for pain. Ms. Zurawinski passed away early the following day.

Helen Young – first-degree murder On July 13, 2013, Wettlaufer injected Ms. Young with short-acting insulin and later with long-acting insulin, telling her that the needles were to help with pain. Ms. Young passed away the following morning.

Maureen Pickering – first-degree murder On March 22, 2014, Wettlaufer gave Ms. Pickering a sedative, telling her it was a vitamin injection. She then gave Ms. Pickering two insulin injections, about two-and-a-half hours apart – the first was long-acting insulin, and the second was short-acting insulin. The following day, Ms. Pickering was found unresponsive, cold, and clammy and was taken to hospital. Hypoglycemia was noted; she had also suffered a stroke. She returned to Caressant Care (Woodstock) for palliative care and passed away on March 28, 2014.

C. Meadow Park Nursing Home (London) (April–October 2014)

1. Overview

On April 22, 2014, Wettlaufer began work at Meadow Park (London) in London, Ontario, as a registered nurse.

On September 25, 2014, Wettlaufer resigned from Meadow Park (London), effective October 15, 2014, to get help with “an illness” that required long-term treatment. She later admitted to the director of care¹³ at Meadow Park (London) that she had an alcohol and drug dependency. Her last day of work at Meadow Park (London) was September 26, 2014.

¹³ In other homes, this position is called the director of nursing (DON).

2. The Offence

Arpad Horvath – first-degree murder On August 23, 2014, Wettlaufer injected Mr. Horvath with short-acting and long-acting insulin. Later that night, Mr. Horvath was found unresponsive, cold, and clammy. He was taken to hospital and determined to be hypoglycemic. He was treated but remained in hospital because he was in a coma and having seizures. Mr. Horvath passed away on August 31, 2014, while in hospital.

D. Life Guard Homecare (January 2015–August 2016)

1. Overview

In January 2015, Wettlaufer began working as a registered nurse for Life Guard Homecare of Brantford, Ontario. Life Guard is an assisted living company that offers nursing assistance and personal support services in clients' homes. It also contracts out registered nurses, registered practical nurses, and personal support workers to LTC homes in the Brant, Oxford, and Haldimand-Norfolk areas.

Through her employment with Life Guard, Wettlaufer was placed in a number of LTC homes, including Telfer Place Long-Term Care Facility in Paris, Ontario. She was placed at Telfer Place on various shifts between February 2015 and April 2016.

On September 7, 2016, Wettlaufer resigned from Life Guard.

2. The Offence

Sandra Towler – attempted murder On September 6, 2015, Wettlaufer was working at Telfer Place as an agency nurse through Life Guard. She injected Sandra Towler with long-acting and short-acting insulin. Ms. Towler became hypoglycemic but was successfully treated. At the time of writing this Report, Ms. Towler is alive.

E. Saint Elizabeth Health Care (July–August 2016)

1. Overview

In July 2016, Wettlaufer began working for Saint Elizabeth, the largest healthcare service provider in Ontario, with more than 8,000 staff delivering approximately five million healthcare visits annually. Across Canada, Saint Elizabeth makes approximately 20,000 visits each day. It provides registered nurses, registered practical nurses, and other staff to attend to clients' needs in their homes.

Through her employment with Saint Elizabeth, Wettlaufer provided nursing care to clients in their homes in Oxford County. One of her clients was Beverly Bertram.

On August 29, 2016, Wettlaufer resigned from Saint Elizabeth after being told she would be working with diabetic children in a school. She later told police that she had resigned because she did not trust herself not to harm the children.

2. The Offence

Beverly Bertram – attempted murder Ms. Bertram has a number of health issues including diabetes, which is controlled through injected insulin. She does not have dementia. She had surgery on her left leg in the summer of 2016, and on August 19 of that year, returned home from hospital. Saint Elizabeth nurses attended at her home periodically to assist with an infection. Part of their help was to administer intravenous antibiotics through a PICC line (a peripherally inserted central catheter), which is a tube inserted into a vein.

On August 20, 2016, Wettlaufer attended at Ms. Bertram's home and administered antibiotics intravenously through the PICC line.

Later that day, after deciding that Ms. Bertram would be her next victim, Wettlaufer went to the home of a different Saint Elizabeth client to steal insulin from her. She entered the home, uninvited and unannounced, while the client was in the shower. The client heard something and called out, but there was no response. When the client finished showering, she came out of the bathroom to find Wettlaufer going through her medications, which included insulin and morphine. Wettlaufer told her she was looking for an oxygen meter she had forgotten there on a previous visit. She had, in fact,

stolen some of the client's insulin. Wettlaufer later admitted that she also stole some of the client's "hydromorph" medication for herself.

Although Ms. Bertram is diabetic and had her own insulin, Wettlaufer stole the other client's insulin so that if Ms. Bertram died, as Wettlaufer intended, an examination of Ms. Bertram's own insulin supply would not appear unusually depleted.

On August 21, 2016, Wettlaufer attended at Ms. Bertram's home and gave her a "huge amount" of the other client's insulin through her PICC line. After receiving what she thought were merely antibiotics, Ms. Bertram described herself as feeling unusually nauseous and dizzy. Concerned, she decided not to inject herself with insulin that day.

Ms. Bertram survived the attack without medical intervention. She is alive today.

V. The Victims

The following information is taken from the Agreed Statement of Facts in Wettlaufer's criminal proceedings. The Agreed Statement of Facts can be found in Appendix C to this volume in the Report.

Clotilde Adriano

Clotilde Adriano was born on October 25, 1920. She lived in Woodstock with her husband (deceased 1997) and two children.

In March 2007, Ms. Adriano became a resident of Caressant Care (Woodstock), where her sister-in-law, Albina deMedeiros, was living. Their rooms were next to one another.

Ms. Adriano had dementia and was an insulin-dependent diabetic.

She passed away in 2008, at the age of 87.

Albina deMedeiros

Albina deMedeiros was born in Portugal on February 25, 1919, and later moved to Canada to join her brothers and family. She and her husband worked together growing tobacco in the Woodstock area. They did not have children, but her husband had children from a previous marriage.

After Ms. deMedeiros's cognition declined, she became a resident of Caressant Care (Woodstock) on December 4, 2006.¹⁴ She lived in a room beside her sister-in-law, Clotilde Adriano. Ms. deMedeiros's diabetes required insulin injections.

She passed away in 2010, on her 91st birthday.

James Silcox

James Silcox was born on February 17, 1923, and lived in Woodstock for most of his life. He worked at Standard Tube Inc. for more than 30 years and served in World War II. He was married for 63 years to his wife, Agnes, with whom he had six children. He was a grandfather and great-grandfather.

Mr. Silcox had a stroke in the spring of 2007 and was hospitalized for four-and-a-half months. He was admitted to Caressant Care (Woodstock) on July 25, 2007, with a number of medical conditions including Alzheimer's disease and diabetes controlled through insulin injection. On August 4, 2007, Mr. Silcox had surgery on his right hip at Woodstock General Hospital. He returned to Caressant Care (Woodstock) on August 10, 2007.

He passed away on August 12, 2007, at the age of 84.

Maurice Granat

Maurice Granat was born on February 7, 1923, and lived in Tillsonburg, Ontario, for most of his life. He was a tinsmith and ran a small shop in Tillsonburg where he would fix devices. He had extensive family and friends in the Tillsonburg area.

Mr. Granat was admitted to Caressant Care (Woodstock) in December 2006. He had cancer and a number of other physical ailments. He was not diabetic but had become frail. Although at times he was noted as being confused, he was not diagnosed as having dementia or a similar illness.

He passed away on December 23, 2007, at the age of 84.

¹⁴ The Agreed Statement of Fact says that Ms. deMedeiros entered Caressant Care (Woodstock) in April 2006 but the home's admission document shows her admission as Dec. 4, 2006.

Wayne Hedges

Wayne Hedges was born on April 23, 1951. Most of his family was based in western Ontario.

Mr. Hedges was admitted to Caressant Care (Woodstock) in 2000 at the age of 49. He took insulin injections for his diabetes. He also had schizophrenia and developmental disabilities.

He passed away in January 2009 at the age of 57.

Michael Priddle

Michael Priddle was born June 1, 1949, and grew up in Ingersoll, Ontario, where he met his wife. He married in 1971 and had one son. Mr. Priddle was a butcher by trade and an ardent hockey fan.

Mr. Priddle developed Huntington's disease. As the illness progressed, he needed 24-hour care. His condition left him unable to voice the presence of pain, and he was at significant risk of injuries, falls, and choking. He was not diabetic and had no need for synthetic insulin. He was admitted to Caressant Care (Woodstock) on October 20, 2006.

He passed away in 2012, at the age of 63.

Gladys Millard

Gladys Millard was born October 11, 1924, in New Glasgow, Nova Scotia. She and her husband (deceased in 1997) settled in Woodstock, Ontario. They had two children. Ms. Millard was active in her church and in various charities and service clubs.

She was admitted to Caressant Care (Woodstock) on September 11, 2006. She had Alzheimer's disease and other medical conditions, but she did not have diabetes and had no need for synthetic insulin.

She passed away on October 14, 2011, shortly after celebrating her 87th birthday with family and friends.

Helen Matheson

Helen Matheson was born on June 4, 1916, and settled in the village of Innerkip, Ontario. She and her husband (deceased in 1998) had two sons, and grandchildren and great-grandchildren. She was active in her church for many years.

Ms. Matheson moved into Caressant Care (Woodstock) on January 20, 2010, when she was 93 years old. She had dementia and other medical conditions but did not have diabetes. She had no need for synthetic insulin.

She passed away in the early hours of October 27, 2011, at the age of 95.

Mary Zurawinski

Mary Zurawinski was born on April 7, 1915, and grew up in Sudbury, Ontario. She was married, worked as a waitress, and had four sons. Her husband and three of her sons predeceased her. She was a very independent woman before her admission to Caressant Care (Woodstock) on May 6, 2011, at the age of 96.

Ms. Zurawinski had a number of medical conditions, including dementia, but she did not have diabetes. She had no need for synthetic insulin.

She passed away early on November 7, 2011. She was 96 years old.

Helen Young

Helen Whitelaw Marshall Young was born in Edinburgh, Scotland, on June 29, 1923. She served in World War II, which is how she met her husband (deceased in 1988). After they married in 1948, she came to Canada, and they settled in Woodstock in 1971. The couple, who had no children, loved animals and travelling.

After a bad fall, Ms. Young could not continue living on her own, and she became a resident of Caressant Care (Woodstock) on December 16, 2009.¹⁵ She had a number of medical conditions, including dementia, but she did not have diabetes and had no need for synthetic insulin.

She passed away on July 14, 2013. She was 90 years old.

Maureen Pickering

Maureen Pickering was born on June 9, 1935, and lived in the town of Tillsonburg, Ontario. She and her husband (deceased in 2009) lived in the greater Toronto area before moving to Tillsonburg. They did not have children. After her husband passed away, she regularly spent time in Florida before her health declined.

¹⁵ The Commission has used the date of Dec. 16, 2009, which was the date in records produced to the Inquiry. The date Dec. 12, 2009, is found in other documents in evidence before the Inquiry.

Ms. Pickering went into the Tillsonburg Hospital on August 21, 2013. On September 9, 2013, she became a resident of Caressant Care (Woodstock). Her medical conditions included dementia and Alzheimer's disease. She did not have diabetes, and she had no need for synthetic insulin.

She passed away on March 28, 2014. She was 78 years old.

Arpad Horvath

Arpad Horvath was born on November 14, 1938, and lived most of his life in Straffordville, Ontario. He and his wife had two children.

Mr. Horvath ran his own tool and die business for 50 years. He was an avid hunter and proud of his Hungarian heritage.

He was admitted to Meadow Park (London) on August 29, 2013. He had a number of medical conditions including dementia and diabetes. His diabetes was treated with an oral hypoglycemic medication, not with injections of insulin.

He passed away on August 31, 2014. He was 75 years old.

Sandra Towler

Sandra Towler was born on April 6, 1939. She resided in Brant County, where she raised her daughter and son.

Ms. Towler was admitted to Telfer Place on February 12, 2014. She had dementia and diabetes. Her diabetes was controlled through an oral hypoglycemic medication, and she had no need for injectable insulin.

Although Ms. Towler is alive today, having survived Wettlaufer's attempt to murder her, she cannot communicate because of her illness.

Beverly Bertram

Beverly Bertram has diabetes, among other medical conditions. She does not have dementia.

Ms. Bertram is alive today, but, having survived Wettlaufer's attempt to murder her, she suffers from lasting psychological trauma.

VI. The Confession and Criminal Proceedings

A. The Confession

On September 16, 2016, approximately two weeks after resigning from Saint Elizabeth, Wettlaufer voluntarily went to the Centre for Addiction and Mental Health (CAMH) in Toronto. She remained there until October 5, 2016. Although she went to CAMH of her own accord, she was admitted and held there by law as an involuntary patient¹⁶ under the *Mental Health Act*.

At the time of her admission to CAMH, there was no ongoing criminal or other type of investigation relating to Wettlaufer or any of her victims.

While at CAMH, Wettlaufer disclosed to her psychiatrist that she had intentionally overdosed a number of her patients with insulin, causing them to die. She chose to speak about her actions in detail, despite her awareness that there were limits to patient-physician confidentiality. She was advised of her legal rights, including the right to speak to a lawyer, and that CAMH might have a legal obligation to report what she was saying to both the police and the College of Nurses. Wettlaufer refused the assistance of a lawyer and continued to confess over the course of 20 days, even after CAMH told her that the police and the College had been contacted. She consistently stated that she went to CAMH to talk openly about her actions and to prepare herself to report them to the police and the College.

The psychiatrist who was treating Wettlaufer suggested that, for therapeutic purposes, she should organize her thoughts and admissions on paper. On September 24 and 25, 2016, Wettlaufer hand wrote a four-page statement in which she set out detailed notes about murdering eight patients in her care and administering insulin non-fatally to six others.¹⁷ She wrote it from memory, without any records available to her. With her consent, the handwritten document was later given to the police.

¹⁶ Wettlaufer was admitted to CAMH for assessment on a Form 1 under section 13 of the *General Regulation*, RRO 1990, Reg 741, to the *Mental Health Act*, RSO 1990, c M.7. A Form 3 (involuntary admission certificate) was also executed to ensure that she remained at CAMH. This certificate was later renewed.

¹⁷ The dates Sept. 24 and 25, 2016, are those appearing in the Agreed Statement of Facts filed in the criminal proceedings against Wettlaufer.

B. The Police Investigation

Because a majority of the Offences were committed in Woodstock, on September 29, 2016, Woodstock police were notified of the reported Offences. It was agreed that detectives with the Toronto Police Service would conduct an initial interview with Wettlaufer. With her consent, the Toronto police interviewed Wettlaufer that day. She was temporarily released from CAMH for that purpose. She declined an opportunity to speak with counsel and spoke voluntarily for about 40 minutes before becoming tired and asking to return to CAMH. Woodstock police were advised of the contents of the interview.

On October 3, 2016, Woodstock police began their own investigation. Because the Offences involved multiple Ontario jurisdictions, the investigation was conducted jointly by the Woodstock Police Service, the Ontario Provincial Police, and the London Police Service.

On October 5, 2016, Wettlaufer was discharged from CAMH and voluntarily transported by Woodstock police back to Woodstock, where she gave a second police interview. This interview lasted for about three hours and took place at the Woodstock police station. She was again cautioned that anything she said could be used against her, and again advised of her right to counsel. She provided a detailed confession during this interview.

On October 6, 2016, Wettlaufer appeared before a judge and voluntarily entered into a recognizance under the *Criminal Code*, which is a form of undertaking.¹⁸ Under the recognizance, Wettlaufer was subject to strict conditions while police conducted a more in-depth investigation.

On October 24, 2016, Wettlaufer turned herself in, and police arrested her. She was formally charged with eight counts of first-degree murder.

The police seized and searched Wettlaufer's computer. The search revealed that, in the days before her admission to CAMH, Wettlaufer had performed Google searches on the names of five victims and reviewed the obituaries of three others. The search also revealed that Wettlaufer had looked at online articles about nurses who kill and that she had searched for information on the length and pain involved in death from insulin overdoses.

¹⁸ RSC 1985, c C-46, s 810.2. A judge can order this kind of undertaking if satisfied that there are reasonable grounds to fear that the person will commit a serious offence causing personal injury. The undertaking requires that the person keep the peace and be of good behaviour, and may also include other conditions to secure the person's good conduct. Breaching any of the conditions is a criminal offence.

The police also obtained Wettlaufer's psychiatric records, from CAMH and elsewhere. There was no evidence that she had told any other mental health professionals about harming patients. The most detailed and meaningful records are from CAMH. The CAMH discharge summary is appended to the Agreed Statement of Facts located at Appendix C to this volume. It shows the psychiatrists' determinations that Wettlaufer showed no evidence of psychosis, did not suffer from hallucinations, had full insight into her own actions, and was aware of the consequences of her actions. Her diagnoses included adult antisocial behaviour, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

None of Wettlaufer's mental health diagnoses amount to a defence that she was not criminally responsible on account of mental disorder.

Although Wettlaufer admitted to using prescription drugs on occasion while working, she did not claim to have been intoxicated by drugs or alcohol when she committed the Offences.

The police exhumed the bodies of two of the murder victims so that the chief forensic pathologist of Ontario could conduct autopsies on them. Because all of the other murder victims had been cremated, it was possible to conduct autopsies on only those two victims.

On January 13, 2017, Wettlaufer was rearrested and charged with two new counts of aggravated assault and four new counts of attempted murder.

C. The Guilty Pleas and Sentence

Wettlaufer has been in custody since she turned herself in on October 24, 2016, and police arrested her.

On June 1, 2017, Wettlaufer pled guilty in a Woodstock courtroom to all 14 charges against her. She was represented by a lawyer at that time. Her counsel and counsel for the Crown jointly submitted the Agreed Statement of Facts, which set out the critical facts of the Offences. In it, Wettlaufer acknowledges that she intentionally applied force to each of her victims by injecting them with insulin, knew she was doing it for no medical purpose, and did so without the victims' consent. She also acknowledges that she had the requisite legal intention for each Offence for each victim.

Justice Bruce Thomas of the Superior Court of Justice of Ontario accepted her guilty pleas and convicted her of all 14 Offences. On June 26, 2017,

Justice Thomas sentenced Wettlaufer to life imprisonment with no chance of parole for 25 years.

Wettlaufer received sentences of life imprisonment on all eight counts of first-degree murder (Mr. Silcox, Mr. Granat, Ms. Millard, Ms. Matheson, Ms. Zurawinski, Ms. Young, Ms. Pickering, and Mr. Horvath), with all sentences to run concurrently and no eligibility for parole for 25 years.

She received sentences of 10 years in prison on each of the four counts of attempted murder (Mr. Hedges, Mr. Priddle, Ms. Towler, and Ms. Bertram), with all sentences to run concurrently to each other and to all other sentences.

On the two counts of aggravated assault (Ms. Adriano and Ms. deMedeiros), Wettlaufer was sentenced to seven years on each count, to run concurrently to each other and to all others.

The reasons for sentence are contained in Appendix B to this volume. In those reasons, Justice Thomas observes that the victims were all “exceedingly vulnerable.” He uses Wettlaufer’s own description of the effects of the insulin overdoses on the victims, saying: “It was a painful and contorting experience on the mind and body of all the victims, both the deceased and those who survived.”

He also notes the evidence of Beverly Bertram. Ms. Bertram was the sole survivor able to assist with the circumstances of the Offences. Justice Thomas recounted Ms. Bertram’s description of the pain, suffering, and hallucinations she endured as a result of the insulin overdose.

Justice Thomas made this chilling observation:

One thing seems certain, had Elizabeth Wettlaufer not chosen to walk into CAMH on September the 16th, 2016, none of us would be here today. The families of those victimized would be none the wiser regarding the abuse of their loved ones and perhaps the offender would still be in business.

Justice Thomas said this to the victims and their loved ones:

A civilized society protects its most vulnerable, its young, its infirm, its aged; those who can no longer care for themselves. As families of the sick and elderly, you must at some point pass off the task of the day to day care to those who are trained and better able to provide a safe and secure environment. That is especially true as an increasing percentage of our population ages and lives are extended by modern medicine.

It is a complete betrayal of your trust when a caregiver does not prolong life but rather terminates it. But you simply cannot blame yourselves. The value of the lives of your loved ones is not diminished by their age or condition, nor does the law recognize a sliding scale of penalties for murders of this nature. Your losses are just as unbearable.

Wettlaufer was then returned to prison, where she remains, serving her life sentences.

VII. The Inquiry

A. The Establishment of the Commission

On June 1, 2017, Wettlaufer pled guilty to eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault. The court accepted her guilty pleas and registered convictions on all 14 counts. On June 26, 2017, Wettlaufer was sentenced to life in prison with no chance of parole for 25 years.

That same day, the Ontario government released a public statement declaring that it would establish an independent public inquiry and appoint a commissioner to lead it. The statement concluded:

It is our hope that through the inquiry process, we will get the answers we need to help ensure that a tragedy such as this does not happen again.¹⁹

On August 1, 2017, this Public Inquiry was launched, with me as its Commissioner. It was established pursuant to the *Public Inquiries Act, 2009*²⁰ and Order in Council 1549/2017 (OIC). The OIC sets out the Inquiry's terms of reference. It is reproduced as Appendix A.

¹⁹ Ontario, Ministry of Attorney General, *Statement from Attorney General and Minister of Health and Long-Term Care on a Public Inquiry into the Circumstances of the Elizabeth Wettlaufer Case* (June 26, 2017), <https://news.ontario.ca/mag/en/2017/06/statement-from-attorney-general-and-minister-of-health-and-long-term-care-on-a-public-inquiry-into-t.html>, accessed on 2018-12-05.

²⁰ SO 2009, c 33, Schedule 6.

B. The Mandate of the Commission

The Commission mandate, established by the OIC, requires the Commission to inquire into the events that led to the Offences, and to the circumstances and contributing factors allowing them to occur, and to other relevant matters, as determined by me. As Commissioner, I am to make recommendations on how to avoid similar tragedies in the future.

Paragraph 14 of the OIC requires me, as Commissioner, to deliver a final report to the Attorney General by July 31, 2019, summarizing my activities and including any recommendations. Paragraph 16 of the OIC makes me responsible for translating and printing the Report and ensuring that it is delivered in English and French, at the same time, and in both electronic and printed versions.

C. The Scope of the Inquiry

What is the scope of this Inquiry? What falls outside its scope? Given the size and complexity of the long-term care system, it was vital that these questions be answered early in the process if the Commission were to fulfill its purpose and meet the deadline imposed for the delivery of its final Report.

A determination of the Inquiry's scope begins with a consideration of the OIC, of which paragraph 2 is critically relevant. It reads as follows:

2. Having regard to section 5 of the *Public Inquiries Act, 2009*, the Commission shall inquire into:
 - a. the events which led to the Offences;
 - b. the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices and accountability and oversight mechanisms; and
 - c. other relevant matters that the Commissioner considers necessary to avoid similar tragedies.

It is important to note that paragraph 2 of the OIC does *not* task the Commission with reviewing the long-term care system and making recommendations on how it might be improved. Rather, paragraph 2 states the Commission mandate in clear and focused terms: inquire into

the events and circumstances surrounding the Offences and other relevant matters necessary to avoid similar tragedies in the future. It is my task, as the Commissioner, to make recommendations on how to avoid such tragedies in the future.

This understanding of the mandate is reinforced by the following preamble to the OIC:

AND WHEREAS it is considered desirable and in the public interest for the Ontario Government to *appoint a person to identify and make recommendations to address systemic failings in Ontario's long-term care homes system that may have occurred in connection with the Offences;* [emphasis added]

Next, it is necessary to carefully articulate the nature of the Offences. The Offences were the intentional infliction of harm by a registered nurse, acting in the scope of her employment, on residents in LTC homes and on a client receiving publicly funded home care, through the injection of insulin overdoses.

Although critical, the foregoing considerations are not exhaustive. In determining the scope of the Inquiry, it is also necessary to consider the purposes for which it was called.

Like most public inquiries, this Inquiry was called in response to tragic events of substantial public interest. Because the Commission was an independent third party, the Inquiry could best meet the need for public accountability – the public's legitimate "right to know" – through answers to these two questions:

1. What failings in our long-term care system could allow Elizabeth Wettlaufer to seriously harm or kill 13 residents in LTC homes and attempt to kill a home care client in her own home, without detection, while working as a registered nurse?
2. What can be done to prevent similar tragedies from happening again?

In my view, the Inquiry was also established to achieve another important purpose: to restore the public's shattered trust in the LTC system. When we or our loved ones need continuous care, there must be a safe place for us. After the Offences, how could we be confident that those who live in Ontario's LTC system are safe?

After weighing all these considerations, I concluded that the scope of the Inquiry was to inquire into the events and circumstances surrounding the Offences and to make recommendations to prevent and deter healthcare providers from intentionally harming those in the LTC system through the improper administration of medication and to detect those who commit such offences.

Although my recommendations are driven by the scope of the Inquiry, they have broader implications, as you will see. If implemented, the recommendations in this Report should lead to overall improvements to the LTC system and for those who live within it.

D. The Commission's Duties and Guiding Principles

This Inquiry was established pursuant to the *Public Inquiries Act, 2009*. Accordingly, it is governed by its terms.

Section 5 of the *Public Inquiries Act* places the following duties on the Commission:

5. A commission shall,
 - (a) conduct its public inquiry faithfully, honestly and impartially in accordance with its terms of reference;
 - (b) ensure that its public inquiry is conducted effectively, expeditiously, and in accordance with the principle of proportionality; and
 - (c) ensure that it is financially responsible and operates within its budget.

These duties create the framework within which the Commission had to operate.

Although such a framework is useful, I felt that the work of the Commission would be enhanced if we committed to a set of shared values that would inform all aspects of our work. I took guidance on this matter from the reports of previous public inquiries and established the following four guiding principles:

- **Thoroughness** We commit to examining all relevant issues with care so there can be no doubt that the questions raised by the Inquiry mandate were explored and answered.

- **Timeliness** We commit to conducting our work in a timely fashion, to engender public confidence, remain relevant, and meet our deadline.
- **Transparency** We commit to ensuring that the Inquiry proceedings and processes are as open and available to the public as reasonably possible.
- **Fairness** We commit to ensuring that the interests of the public in finding out what happened are properly balanced with the rights of those involved to be treated fairly.

As in all matters of substance, these guiding principles were soundly debated by the Commission team before we adopted them. And do not think for a moment that the guiding principles were mere window-dressing. As we struggled to complete an overwhelming amount of work in a short period of time, these principles were regularly invoked and used for guidance.

Wettlaufer’s Early Years as a Nurse

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I. Introduction

This chapter examines two periods in Wettlaufer's early employment history. Although both precede the Offences, lessons can be learned from them, as you will see in recommendations made in later chapters.

The first period is in 1995, when Wettlaufer began her nursing career at the Geraldton District Hospital. Her job at the hospital lasted only a few months, ending when she collapsed at work after consuming narcotics she had stolen from the hospital. The second period runs for over a decade (June 1996–June 2007) when Wettlaufer worked at Christian Horizons as a support worker. A different picture of Wettlaufer emerges in this period, one that shows her making progress in her professional behaviour.

II. Geraldton District Hospital

A. Wettlaufer's First Nursing Job

In January 1995, Wettlaufer – known by her birth name of “Parker” at the time – took a placement as a student nurse with the hospital. On March 31, she applied for a position there as a registered nurse. On April 11, the hospital offered her a position as a casual, part-time graduate nurse, a unionized position with the Ontario Nurses' Association (ONA), Local 228. Wettlaufer accepted the job on April 13. At that time, she was not yet a registered nurse with the College of Nurses of Ontario (College). In May 1995, Wettlaufer and the hospital completed a College form entitled “Offer of Employment for Temporary Registration,” which enabled her to get a temporary certificate of registration with the College. In June 1995, Wettlaufer passed her comprehensive nursing examinations, and the College issued her a certificate of registration on August 11.

B. Events of September 12–14, 1995

On September 12, 1995, at 19:30, Wettlaufer began a 12-hour shift at the hospital. She went on shift after having already worked that day for the Geraldton and District Association for Community Living where she was a direct care worker. During her shift at the hospital, she stole Ativan¹ from the hospital's medication room and consumed it.

¹ In some documentation, the stolen drugs are referred to as Lorazepam.

As part of the Inquiry investigations, Commission counsel interviewed Wettlaufer.² In describing this episode, Wettlaufer said that she felt isolated and depressed at the time and took the Ativan in an attempt to end her life. In that same interview, she told Commission counsel that she had previously stolen Ativan and Valium from the hospital and that she had also taken a patient's morphine for herself when the patient refused it.

Wettlaufer, however, has given a number of different descriptions of the events in question. She told Commission counsel that she stole and ingested 30 pills that night. But, immediately following the incident, Wettlaufer gave a number of different versions, in which she said she had consumed anywhere between two and 27 pills. Whatever the actual number of pills she took and consumed, there is no dispute that toward the end of her shift on September 13, 1995, a colleague found Wettlaufer emerging from a washroom stumbling and looking dazed. She was taken to a patient room and examined by the staff health nurse. On examination, Wettlaufer's pupils were found to be small and sluggish, and it was reported to the staff health nurse that Wettlaufer had been "slow and sleepy all night."

Dr. Gomide, a physician with the hospital, was called to assess Wettlaufer. Dr. Gomide reported to the director of nursing, Marlene Pavletic, that he had found Wettlaufer "drowsy but easily arousable." His admission note³ contains Wettlaufer's initial recounting of what had happened that night:

Initially she denied having taken any medications but soon after when the Nursing Supervisor, Marlene, arrived she did state that she took 2 Ativan out of the medicine cabinet. When asked why she stated that she took the Ativan 1 mg. each just to take the edge off "because she was very nervous since she had not worked here very often."

Wettlaufer was admitted to the hospital. When Dr. Gomide and Ms. Pavletic visited Wettlaufer later that morning, she consented to a blood test. She told Ms. Pavletic that she had never taken Ativan from the hospital before and had never sold it on the street. She also told Ms. Pavletic that taking the Ativan was not a suicide attempt.

At approximately 16:00 that same day, Ms. Pavletic spoke to Wettlaufer again. This time, Wettlaufer said that she had no recollection of her earlier conversations with Ms. Pavletic. Ms. Pavletic told Wettlaufer that she had

² The interview took place the morning of Feb. 14, 2018, at the Grand Valley Institution for Women located in Kitchener, Ontario.

³ Ms. Pavletic was present during Dr. Gomide's examination of Wettlaufer. The notes that she took during the examination are consistent with the admission note.

said that she had taken 2 mg of Ativan at 22:00 on September 12, 1995, and had become unwell at the end of her shift. According to Ms. Pavletic's notes, Wettlaufer responded saying she did not know why she had said that because she had actually taken 0.5 mg of Ativan soon after her shift began at 19:30 and then another 2 mg at approximately 07:15. Ms. Pavletic told Wettlaufer that she would be in contact with the College to determine the hospital's obligations, given the circumstances.

In the early morning of September 14, 2015, Wettlaufer's account of the events changed dramatically. Dr. Gomide's discharge summary of that same date describes the change in her story as follows:

On admission she stated that she took 2 1 mg tablets of Ativan and later on in the day she told Marlene, the Nursing Supervisor, that she took .5 mg before she started her shift and 2 mg. in the morning. After Dr. Shiu left, later on in the night at 2:15 a.m., I went to reassess her and she was fully alert and oriented and she stated that she was waiting to go home early in the morning. A few hours later, when I went to see her during my morning rounds, her history had changed again. She stated that she had lied to me and that she actually took 25 Ativan as a suicide attempt. She also stated that she had been treated for depression in the past. At that time I contacted Mental Health even though she denied being suicidal at this time. The patient was waiting to go home and on the same day I discussed her case with Brenda Abraham, a Mental Health Worker, and we decided to discharge her. She is to have a follow up as an outpatient.⁴

Dr. Gomide told Ms. Pavletic of this latest discussion with Wettlaufer.

Ms. Pavletic spoke with Wettlaufer again on September 14. Wettlaufer told Ms. Pavletic that she could not remember the events of the previous day, and that she had been hallucinating. This time Wettlaufer told Ms. Pavletic that she had taken 0.5 mg of Ativan shortly after coming on shift on September 12 and that she had taken 25 tablets of Ativan at approximately 07:00 on September 13. She expressed concern about how the events might impact her job and her career. Ms. Pavletic told her that she would be consulting with the College and attempting to investigate the matter internally.

⁴ The blood tests were inconclusive on the quantity of Ativan ingested. Dr. Gomide noted in his discharge summary that Wettlaufer's Ativan level was within the normal range and not compatible with 25 tablets of Ativan but added, "On the other hand the patient did state that she vomited after taking the pills."

Notes from the mental health consultant give this description of Wettlaufer on September 14, 1995:

Worker met with Elizabeth, she presented with good eye contact, willingness to talk, laughed & cried when appropriate.

Elizabeth gives the impression that she is extremely lonely, she related she must hide a lot of things from her family.

Elizabeth has gotten caught up in a caretaker role and has not identified or met her own needs. Elizabeth indicates that she does not want to take her life. This worker feels she should be monitored to see if she eats, if so when Dr. feels ready, she may be discharged.

Elizabeth stated she would call for followup.

Wettlaufer was discharged from the hospital on September 14. At that time, Ms. Pavletic told Wettlaufer that she would be in touch within a week and, in the interim, Wettlaufer would be given no shifts at the hospital.

On September 20, 1995, Ms. Pavletic met with Wettlaufer and her ONA representative and told them that the matter would be reported to the College and an internal investigation would be completed. Wettlaufer was told that she would not be given any further shifts at the hospital pending the results of the investigation. Wettlaufer reported that she had returned to work with her other employer (Geraldton and District Association for Community Living) on September 16, 1995.

C. Wettlaufer's Employment Terminated

In investigating the incident, Ms. Pavletic interviewed staff members on shift on the evening that Wettlaufer stole and consumed Ativan, those coming on shift the next morning, and the nurses who treated her when she was admitted to the hospital. The interviews disclose that:

- Wettlaufer appeared tired during her shift, and at one point could not be found for an hour.
- During a patient assessment, another nurse had to assist Wettlaufer in applying a nasal cannula.
- Wettlaufer's medication tray was found at a patient's bedside at approximately 07:20 on September 13, 1995.

On October 12, 1995, Ms. Pavletic again met with Wettlaufer, who was accompanied by an ONA representative. Wettlaufer said that earlier in the day of the incident, she had worked at Geraldton and District Association for Community Living and was stressed. She told Ms. Pavletic that she took 0.5 mg Ativan at approximately 22:00 hours and, toward the end of her shift, she took another 25 mg. When asked again at what time she had initially taken the Ativan, Wettlaufer said that it could have been when she came on duty at the hospital.

In the meeting, Ms. Pavletic described the results of her investigation, including that Wettlaufer was reported to have been missing for an hour during her shift and appeared sleepy. Wettlaufer said that she had no recollection of the missing hour and insisted that she only took a small amount of Ativan at the beginning of her shift and the rest toward the end of her shift. Ms. Pavletic identified that there were inconsistencies in Wettlaufer's account of the events.

During this meeting, Wettlaufer acknowledged the inappropriateness of her conduct. Ms. Pavletic's notes of the meeting say: "Beth added here that she is seeking help, that she accepts that what she did was wrong and that she feels that this would never happen again." As readers will see in later chapters of this Report, Wettlaufer's willingness to acknowledge and apologize for her mistakes is a pattern throughout her career.

On October 13, 1995, Wettlaufer was told that her employment with the hospital was terminated and that the hospital would file a mandatory termination report with the College within 30 days.

D. Wettlaufer Grieves Termination

On October 19, 1995, Wettlaufer filed a grievance of her termination.

E. The Hospital's Report to the College

On September 14, 1995, Ms. Pavletic contacted the College to advise that Wettlaufer had collapsed at work and had admitted to taking drugs from the hospital stock. Ms. Pavletic indicated that at that time she was not sure whether Wettlaufer's employment would be terminated. She was reminded of the hospital's mandatory reporting obligations if Wettlaufer's employment was terminated. Given the seriousness of the situation, Ms. Pavletic was encouraged to report the matter in any event.

The College explained to Ms. Pavletic that, in reporting the matter, the hospital had two options; file a letter of report or letter of complaint. The *Health Professions Procedural Code*⁵ (Code) requires the College to investigate "complaints" but it is discretionary whether the College investigates "reports," including those filed when a nurse's employment is terminated. If classified as a report, the College cannot provide the reporting person or organization with information because of the privacy provisions contained in section 36 of the Code.

Ms. Pavletic advised the College that the hospital would be reporting the matter.

On October 25, 1995, the hospital verbally advised the College of Wettlaufer's termination of employment and advised that she had grieved the termination. In its report, the hospital described Wettlaufer's conduct as follows:

Member was completing a 12 hour night tour at 0730 hours. Two oncoming RNs reported that the member, who was coming out of the staff bathroom, appeared dazed, was grossly unsteady on her feet and had difficulty communicating verbally. Subsequently it was ascertained from the member that she had removed Lorazepam (2 mg) from the ward medication stock without authorization and had ingested them during her working hours. The history given by the member changed several times over the 24-hour period September 13 to September 14/95.

Along with its report, the hospital gave the College Wettlaufer's work schedule for September. The schedule shows that September 12, 1995, was only Wettlaufer's second shift at the hospital that month.

In a letter dated November 7, 1995, the College acknowledged receipt of the termination report and informed the hospital:

Since all of the information pertaining to this matter is confidential, we are unable to inform you of the proceedings or outcome in relation to any investigation which may ensue. If further information is required, an investigator of the College may contact you at a later date.

We request that all documentation relevant to this matter be retained for a period of up to two years pending investigation.

⁵ Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18.

On November 24, 1995, a telephone interview took place between Ms. Pavletic and an investigator with the College. During that discussion, Ms. Pavletic told the investigator that she would like the letter reporting Wettlaufer's termination of employment to be considered a letter of complaint. Ms. Pavletic formalized that request in a letter dated November 27, 1995.

The College then told the hospital that it had appointed an investigator pursuant to section 75 of the Code. At the request of the College investigator, the hospital produced Wettlaufer's health records related to her admission to the hospital on September 13, 1995; all documents relating to the incident; all documentation gathered in the internal investigation; and the names, addresses, and telephone numbers of the staff identified as witnesses.

By the end of December 1995, the College's investigation into Wettlaufer's conduct was under way and her grievance was outstanding. Wettlaufer continued to work at the Geraldton and District Association for Community Living. Her registration with the College was unrestricted, and no information was made available to the public to indicate that Wettlaufer had been reported to the College or that she was the subject of an investigation.

F. Decision of the College's Complaints Committee

On March 22, 1996, the College's Complaints Committee told the hospital that it had decided to refer the complaint to its Executive Committee to be dealt with as an "incapacity proceeding." At that time, the Code defined "incapacitated" as follows:

"incapacitated" means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member no longer be permitted to practise or that the member's practice be restricted.

By letter dated April 3, the hospital received a copy of the Complaints Committee's decision. The decision, dated March 20, set out the allegations that had been made against Wettlaufer and continued as follows:

Health Information concerning Ms. Parker⁶

Ms. Parker has not provided the College with signed forms for the release of health information.

⁶ Wettlaufer's birth name was Parker.

In the discharge summary signed by Dr. J.G., it is stated that Ms. Parker indicated that she took 25 tablets of Ativan in a suicide attempt. She also indicated that she had been treated for depression in the past.

In a report provided by Ms. Parker's legal counsel, Ms. B.A., a mental health worker, states that Ms. Parker felt isolated and lonely while in Geraldton. Ms. B.A.'s report goes on to say that Ms. Parker experienced considerable emotional instability, but that she was making progress in dealing with her problems.

In a separate report provided by Ms. Parker's legal counsel, J.R., a substance abuse worker, states that Ms. Parker does not have a drug problem, other than the recent suicide attempt. J.R. states that Ms. Parker had had problems with alcohol consumption, but that she is attempting to bring her drinking under control.

Member's response

In her response submitted through legal counsel, Ms. Parker states that she always acknowledged taking the medication, but that her actions were due to the depression she was experiencing at the time of the incident.

Given that Ms. Parker believes her actions relate to a health problem, she requests that the committee refer the matter to the Executive Committee for the purpose of incapacity proceedings.

CONCLUSION

The committee considers that the allegations concerning Ms. Parker, and the information obtained during the College investigation, point to the member suffering from health-related problems that may be affecting her capacity to practise safely and effectively. The committee therefore refers this matter to the Executive Committee for the purpose of incapacity proceedings.

The letter also advised that the Executive Committee's role was to "identify a potentially incapacitated member and take steps to ensure the protection of the public" and that as a result of the matter being referred to the Executive Committee, the College had "no continuing authority to keep you advised of any further decisions which may be made in relation to this matter."

This letter of April 3, was the College's final communication to the hospital about the complaint.

G. Wettlaufer's Grievance Settled

On November 15, 1996, the hospital and the ONA settled Wettlaufer's grievance and executed minutes of settlement, set out below, in their entirety:

The undersigned parties agree to the following final and binding settlement of the said grievance of Beth Parker dated October 19, 1995:

1. It is expressly agreed that this settlement is without prejudice and without admission of liability on the part of the Hospital (which liability is in fact expressly denied by the Hospital) relative to any of the issues in the grievance of Beth Parker dated October 19, 1995;
2. The Hospital agrees to amend Beth Parker's personnel file to indicate that Ms. Parker resigned her employment with the Hospital for health reasons;
3. The Hospital agrees that any persons contacting the Hospital for employment references for Beth Parker will be directed to the Human Resources Department of the Hospital, and will be advised by the Human Resources Department that Beth Parker resigned her employment for health reasons;
4. The Hospital, in agreeing to the terms of this settlement, is relying upon the assurance of Beth Parker that she did, at the time of termination of her employment, suffer from a medical condition for which she has since sought professional attention;
5. The Union and the grievor agree to withdraw the above-noted grievance, and that the subject matter of the above-noted grievance will not form the basis for any other grievance.

This ended the hospital's involvement with Wettlaufer.

III. Christian Horizons

A. Introduction

In June 1996, Wettlaufer began working as a support worker for Christian Horizons, an organization in Woodstock, Ontario, that provided residential support services for people with disabilities. When she applied to work there, she did not disclose that she had worked as a nurse at the Geraldton District Hospital or was under investigation at the College. She referred only to her experience working with people with developmental challenges: her work as a residential support staff with Woodstock and District Developmental Services (1991–92); and, her work with the Geraldton and District Association for Community Living, which she gave as being from May 1995 to February 1996.

B. Wettlaufer Disciplined for Medication Errors

In December 1996, Wettlaufer made three medication errors, described as follows:

- December 9, 1996 – did not sign
- December 25, 1996 – did not sign
- December 27, 1996 – did not sign

Wettlaufer was given a verbal warning for the first two errors but, after the third, she was suspended from administering medications for three days and advised that she was required to meet and discuss Christian Horizon's expectations of her. She was told that a further error in the following three months would result in another suspension and her having to meet the regional manager to discuss the nature of and reasons for the recurring errors.

No other suspensions are noted in Wettlaufer's employment records with Christian Horizons.⁷

C. Christian Horizons Notified of the Incapacity Decision

The result of Wettlaufer's incapacity proceeding before the College was a decision (Incapacity Decision), dated May 9, 1997, issued by the Fitness to Practise Committee, on consent of the parties. In the Incapacity Decision, the Fitness to Practise Committee found that Wettlaufer was incapacitated, as that word is defined in section 1(1) of the *Health Professions Procedural Code of the Nursing Act, 1991*,⁸ and that alcohol dependency was the disorder giving rise to the finding.

The Incapacity Decision imposed terms, conditions, and limitations (Conditions) on Wettlaufer's nursing certificate that required Wettlaufer to, among other things:

- remain alcohol- and drug-free, apart from drugs prescribed by her family doctor and her addictions physician specialist;

⁷ Christian Horizons produced to the Inquiry a list of medication incidents that involved Wettlaufer beyond December 1996. It was unclear from that list, however, whether Wettlaufer was responsible for the errors or had found and reported them.

⁸ SO 1991, c 32.

- advise her employer, Christian Horizons, that her nursing certificate was subject to the Conditions and that Christian Horizons, through its representative, David Petkau, had to file a letter with the College confirming that it had received a copy of the Incapacity Decision and would advise the College if Wettlaufer's chemical dependency was affecting her ability to practise nursing or if she failed to comply with any of the Conditions;
- advise the College immediately, in writing, if she obtained other nursing employment or made other change in her nursing employment;
- before obtaining any other employment in nursing, advise a prospective employer that her nursing certificate was subject to the Conditions;
- supply urine samples if the College or her treating addictions physician so requested;
- continue to obtain treatment and monitoring from her addictions physician specialist and to take such counselling as he considered appropriate, including monthly individual counselling with him and weekly attendance at the health professional group⁹; and
- attend Bible study meetings and/or Narcotics Anonymous or Alcoholics Anonymous meetings at least twice per week.

The Incapacity Decision also stated that the Conditions were to remain in force for one year and, if fully complied with, the Conditions would end, unless otherwise ordered by a panel of the Fitness to Practise Committee. The Incapacity Decision also stated that the Conditions could be extended beyond the one-year period, if the College learned that Wettlaufer had "relapsed to the use of alcohol."

Wettlaufer gave Mr. Petkau a copy of the Incapacity Decision, as required.

On June 19, 1997, Mr. Petkau wrote to acknowledge receiving the Incapacity Decision and, on behalf of Christian Horizons, agreed to co-operate with the College and notify it if Wettlaufer's "chemical dependency" was affecting her ability to practise nursing or if she failed to comply with any other Condition. There was no evidence that any reportable incident occurred during Wettlaufer's time at Christian Horizons.

⁹ A support group specifically for health professionals with substance use disorders, similar to Narcotics Anonymous or Alcoholics Anonymous (as per testimony of Anne Coghlan, Transcript, July 24, 2018, p 5351).

By letter dated July 2, the College confirmed receipt of Mr. Petkau's acknowledgement and told him that, during the one-year monitoring period, the College's incapacity coordinator would contact him by phone approximately four times. The records indicate that the College had one telephone conversation with Mr. Petkau on December 2, 1997. In that call, Mr. Petkau indicated, among other things, that Wettlaufer was doing well, there had been no problems with her fulfilling her duties, and he had no concerns about a relapse.

By May 29, 1998, Wettlaufer was found to have met the Conditions, and they were lifted. The steps taken by the College in this matter are outlined in Chapter 13.

D. Information Available to the Public

The Geraldton Hospital reported to the College in November 1995 that it had terminated Wettlaufer's employment. Until the Incapacity Decision of May 1997, the public – including prospective employers – would not have known that there were any issues respecting Wettlaufer's licence to practise nursing. After the Incapacity Decision was released, the public would have been entitled to learn, from the College, both that Wettlaufer had been found to have been intoxicated at work and the Conditions that had been imposed on her nursing licence. After the Conditions were lifted in May 1998, the finding of incapacity – but not the resulting Conditions – was information available to the public for six years.

Thus, by the time that Caressant Care (Woodstock) considered hiring Wettlaufer in 2007, information from the College would not have shown that Wettlaufer's practice had ever been restricted or that Wettlaufer had, at one time, been found to have been incapacitated.

E. Performance at Christian Horizons

Wettlaufer worked at Christian Horizons for 11 years. Until her resignation in June 2007, she had numerous performance reviews, including peer reviews. Three themes emerge from those reviews. First, apart from her first review, her relationship and interactions with those whom she supported were described as very good. Second, she was not seen by her peers as particularly motivated. Third, at least at the beginning, she struggled to build relationships with her colleagues. These themes would remain constant during her nursing career.

Christian Horizons' performance review system included performance planning and development, an appraisal of core competencies, and a peer evaluation. In February 1997, Wettlaufer received her evaluation for the period June 1996 to February 1997. In that performance review, Wettlaufer set these goals for the following year:

To make only comments to clients in a way and in a place that I would want to make myself.

To operate as a team member assigning value to those I work with in the following ways: Keep humour appropriate. Respectful of others' feelings. Listen to concerns brought to me.

Mr. Petkau assessed Wettlaufer's core competencies at the time and noted that the following areas needed improvement:

Promote Well-being

- Be alert to and aware of signs / symptoms of abuse
- Respect privacy and dignity of clients, including the area of sexuality

Display Professional Behaviour

- Conduct reflects professional ethics
- Model expected behaviours

Teamwork

- Effectively manage conflict and confrontation
- Respect viewpoints / decisions of others

Mr. Petkau's comments suggest that he was concerned about Wettlaufer's professional behaviour and teamwork. Wettlaufer acknowledged his assessment, commenting: "I believe this is, for the most part, an accurate assessment of my performance & the areas needing improvement."

In her 1998 performance evaluation, the goals that Wettlaufer had set the year before were reviewed. Her goals to operate as a team member and to keep her humour appropriate were thought to have been partially met. Her manager notes:

Improvement has been made in this area with Beth working hard at appropriate responses, use of humour and dealing more professionally with conflicts within the team. However peer input still reflects need for growth with such comments as needing to be more tactful, rude, enjoying the mistakes of others. This will remain a goal in next period.

As for Wettlaufer's goal to be mindful of the comments she made to those whom she supported at Christian Horizons, her manager notes:

Great improvement has been made in the support of individuals we serve. I believe that this area is one to be aware of in the future and needs to be constantly guarded against. Personality type and humor preferences are never an acceptable reason for disrespect to individuals we serve.

In her self-appraisal in 1998, Wettlaufer identifies that she had reached some of her goals, including:

One objective was to become more team oriented in my approach. I feel I am accomplishing this. I attend some staff meetings & when I don't I make sure I read the records so I know of decisions made reached by the team.

I have become more focused on the guys needs & less focused on my own agenda for caring for them.

I have become more approachable. I know this because several staff members have approached me when there have been problems.

I have two major obstacles. One is the fact that every staff meeting is on my day off. I therefore did not meet my objective of attending every staff meeting.

My other obstacle is my own habit of procrastination. I did not get things entered in the computer as promptly as I want to.

Wettlaufer's relationship with her peers seems to have improved in 1999, as captured in her manager's comments:

This past year it seems as though you have accomplished what you set out to do. It is wonderful to see how you have grown in the areas outlined in your last appraisal.

"Professional Behaviour" You have gained much by putting some effort into this area. Your team has seen you grow in the wise and mature use of your tongue and humor. In return the team have given you respect in the duties and tasks you have taken on.

"Self Management" Again you have grown in this area, putting first things first and being able to take on more responsibilities. It is encouraging to see your teammates describe you as a hard worker, a good advocate, open to praise and criticism etc.

“Team Work” This area as with those above have seen growth due to your respect of your teammates, despite personality differences, experiences and education. You have grown in a more objective expectation of your teammate.

Certainly, you know that this is not the end of growth, I believe, as I know you do, that the three areas listed above need constant attention and growth. Continue to work together with the team valuing people and opinions, continue to trust and be trusted, and review often the common goals you have with everyone around you.

By 2001, Wettlaufer had taken on responsibility for overseeing medication training at Christian Horizons. Her reviewing manager notes of her performance:

Beth you have demonstrated a keen desire to carry out your responsibilities with a very high degree of professionalism and integrity. You have consistently expressed your desire to grow both personally and professionally. From my observation and periodic discussions with you over the course of the past year, I am confident that you have exceeded in all of these areas. You have proven yourself to be very professional and sensitive in your interactions with teammates, family members and the people you support. Your teammates have described you as being kind, caring, compassionate and as possessing a good sense of humor.

Beth, your skills in nursing and your attention to details regarding the overseeing of the med procedures and training are appreciated – I would simply ask that you continue to strive for the level of excellence that comes through in your work. It would appear that you have addressed the areas of self-motivation and completion of duties in a timely fashion.

Wettlaufer’s 2002 peer performance review was the last one that Christian Horizons could find and produce for the Inquiry. In it, her peers describe her as having strength in such areas as monitoring medication procedures, teaching, communication, honesty, humour, and relationship with supported individuals. Areas noted for improvement included “jumping in and taking over situations,” being “authoritarian,” and sometimes making staff feel like they should not be working there because of lack of knowledge.

F. Leave of Absence, 2006

In July 2006, Wettlaufer took a leave of absence from Christian Horizons. In the communication book at the location at which she worked, it was noted that Wettlaufer was “struggling with some emotional issues” and had been hospitalized.

In her interview with Commission counsel in 2018, Wettlaufer said that she was depressed at this time and that she ended up spending two weeks in a psychiatric hospital in Woodstock, Ontario. She said that she was having obsessive thoughts with religious themes and that, if she had a thought that she didn't want, she would “have a bible verse that countered that thought” and would have to say or sing the verse aloud. Wettlaufer further stated that she was diagnosed at that time with borderline personality disorder and placed on medication.

Following her stay in hospital, Wettlaufer returned to work at Christian Horizons.

G. Resignation from Christian Horizons, 2007

Wettlaufer resigned from Christian Horizons in June 2007 so that she could move east with her new partner. On June 2, she wrote in the communications book:

Hey everyone, I just wanted to thank everyone for their prayers & concern. I wanted to let you know that I will be moving to Fredericton, New Brunswick on June 27th. My last day of work here will be Tuesday June 26th. I have thoroughly enjoyed my time working here & hope we can keep in touch.

On June 11, 2007, Mark Lambley, program manager for Christian Horizons, wrote Wettlaufer the following reference letter.¹⁰

Beth Wettlaufer has worked for Christian Horizons in Woodstock Ontario since June 28, 1996. Christian Horizons is a non-profit organization supporting individuals with developmental disabilities across Ontario, Canada.

¹⁰ Caessant Care (Woodstock) had a copy of this letter when considering whether to hire Wettlaufer.

During this time Beth has demonstrated a solid concern for and dedication to the individuals for whom she has provided service. This dedication has been demonstrated not only in the day to day supports of the individuals in areas such as daily hygiene care and routines, but also in making days both meaningful and interesting for them. Beth has remained focused on a person-centered approach to knowing the hopes and dreams of those she serves and working toward achieving these goals and has maintained the role of a primary support worker at various times during her employment.

Beth has also functioned in the roles of the house health and safety representative, ensuring that regular inspections are done, areas requiring attention were identified and followed up on, and updated WHMIS [Workplace Hazardous Materials Information System] documentation was present. Beth also functioned as the medication trainer and co-coordinator for the home, and was also able to provide training for staff at times during her employment around special medical needs, drawing on her nursing background to do this. Beth was also able to utilize this knowledge at one time in order to provide some intensive supports to an individual with complex care needs.

We would like to take this opportunity to wish Beth all the very best in her future endeavors.

Wettlaufer did not end up leaving Ontario. In her interview with Commission counsel, she said that, shortly after she resigned from Christian Horizons, her new relationship ended. She felt that she could not return to Christian Horizons because her relationship had been a same-sex one. Instead, she applied to work at Caressant Care (Woodstock). Caressant Care (Woodstock) hired her the same month that she left Christian Horizons.

Shortly after starting work at Caressant Care (Woodstock), Wettlaufer began to commit the Offences.

SECTION I

SECTION II

SECTION III

APPENDICES

Long-Term Care Homes and Home Care Service Providers



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I. Introduction

The Offences that Elizabeth Wettlaufer committed were spread across almost a decade, in three separate long-term care (LTC) homes and one private home in southwestern Ontario. As I explain in Chapter 1, had Wettlaufer not confessed to the Offences, they would never have been detected. In my view, based on the evidence in this Inquiry, Wettlaufer could have committed the Offences in any LTC home in Ontario without detection. This chilling observation explains why it is important that we do not focus solely on the three homes in which she committed the Offences. If we are to find solutions to this threat to the safety and security of residents in long-term care, we need a system-wide approach. To achieve that, it is necessary to understand, in general terms, how LTC homes in Ontario operate. That is the subject of this chapter. In later chapters, I will examine each of the three homes and the Offences committed within them.

In the first section of this chapter, I consider three matters: the rights of residents in LTC homes; the roles played by key personnel in the homes and the responsibilities associated with those roles; and the LTC homes' reporting obligations. Because the Offences were committed between 2007 and 2016 – a period in which two different regulatory regimes governed the three for-profit LTC homes in which Wettlaufer committed the Offences – each of these three matters is considered under both regimes. Until July 1, 2010, for-profit homes were governed by the *Nursing Homes Act* (NHA)¹ and its regulations² (Regulation 832).³ During this period, the homes also had to comply with the standards and criteria set out in the *Long-Term Care Homes Program Manual* (Program Manual). Since July 1, 2010, all LTC homes – whether for-profit, not-for-profit, or municipal – have been governed by the *Long-Term Care Homes Act, 2007* (LTCHA),⁴ and its regulations⁵ (Regulation).

¹ RSO 1990, c N.7.

² RRO 1990, Reg 832.

³ Until July 1, 2010, three different statutes governed LTC homes in Ontario: the NHA, which governed most for-profit homes; the *Charitable Institutions Act*, RSO 1990, c C.9, which governed not-for-profit homes; and the *Homes for the Aged and Rest Homes Act*, RSO 1990, c H.13, which applied to municipal homes. The *Long-Term Care Homes Act, 2007*, repealed and replaced all three of these Acts.

⁴ SO 2007, c 8.

⁵ O Reg 79/10.

In the second section, I discuss the challenges that LTC homes face, including the rising acuity of residents in LTC, the shortage of staff – particularly nurses – to care for them, and ways to provide staff in the homes with effective training, given the intensity of their workloads.

Wettlaufer committed the Offences by injecting her victims with overdoses of insulin. Consequently, it is important to understand the medication management system in LTC homes, the subject of the section that follows. There are two main parts to this section. First, I explore the roles of the nursing staff, the medical director, and the pharmacy service provider in the medication management system. Second, I look at the trajectory that medications follow in LTC homes, from the time they are ordered to their receipt, storage, and administration.

The last three sections in this chapter explore how LTC homes manage injectable insulin, narcotics, and medication errors. I address the way in which insulin is handled in LTC homes because insulin was the medication that Wettlaufer used to commit the Offences. The handling of narcotics is discussed because Wettlaufer diverted narcotics in the homes for her personal use. Deterrence and detection are linked to how medication errors are addressed in LTC homes. Thus, I end this chapter with a discussion of how LTC homes deal with medication errors, and the philosophy which animates their approach to such errors – the just or positive safety culture.

II. Key Rights, Roles, and Responsibilities in LTC Homes

A. The Rights of Residents

The fundamental principle underlying both the NHA and the LTCHA is that an LTC home is to be the residents' *home*:⁶ a home in which the residents' physical needs are met, as well as their social, psychological, and spiritual needs; a home in which residents are – and feel – safe and secure; and a home in which residents are treated with respect and are able to maintain their sense of dignity. A full description of residents' rights can be found in Chapter 9.

⁶ NHA, s 2(1); LTCHA, s 1.

B. Key Roles and Responsibilities in LTC Homes

The regulatory regimes of both the NHA and the LTCHA place significant obligations on LTC homes, their licensees, and the administrators of the homes.⁷ In addition to having to promote and respect residents' rights, key obligations include:

- ensuring that the home's staff receive appropriate training and education;⁸
- having a system of medication management;⁹
- adhering to reporting obligations to the Ministry;¹⁰ and
- having a quality management system in place.¹¹

The key personnel in an LTC home responsible for the discharge of these obligations include:

- the administrator, who is in charge of the home;
- the director of nurses (now called the director of nursing and personal care);
- the medical director;

⁷ A significant change made by the LTCHA was to impose most obligations on the licensee of the home. The few limited exceptions include the section 24 reporting obligation, which is placed on all persons except residents. Under the NHA, the obligations were sometimes imposed on licensees but could also be imposed on the homes directly or administrators.

⁸ Reg 832, s 61.2; LTCHA, s 76; O Reg 79/10, ss 216–22. This obligation fell to the licensee under both regimes.

⁹ Reg 832, ss 63–69. Reg 832, s 63, required the administrator to be “responsible for the administration and enforcement in the nursing home of the provisions of this Regulation relating to drugs.” There was no similar obligation imposed on homes governed by the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act* or the regulations to those Acts. The Program Manual also imposed a number of standards and criteria relating to medication management and administration, which did apply to *all* LTC homes in the province. Under the LTCHA and the Regulation, the obligation was imposed directly on the licensee: O Reg 79/10, ss 114–36.

¹⁰ NHA, s 25, required any person (other than a resident) to report suspected harm to a resident to the Director under the NHA. NHA, s 26, required the licensee to forward written complaints to the Director. Reg 832, s 96, required the licensee to report certain specific occurrences to the Director under the NHA. Finally, the Program Manual required the administrator (or designate) to report “unusual occurrences” to the Director. LTCHA, ss 22–24; O Reg 79/10, ss 103–7. Under the LTCHA, all reporting obligations were imposed on the licensee, with the exception of the s 24 reports, which were required of anyone, other than a resident, who had reasonable grounds to suspect there had been improper or incompetent treatment or care or abuse or neglect of a resident (among other things).

¹¹ NHA, s 20.11; LTCHA, s 84. This obligation fell/falls to the licensee under both regimes.

- the nursing staff;
- the pharmacy service provider; and
- personal support workers.

Personal support workers (PSWs) play an important role in the daily care of residents. They are responsible for assisting residents with all activities of daily living and personal hygiene, such as bathing, dressing, and toileting; transporting residents to and/or assisting residents in getting to and from the dining room and other places within the home; assisting residents with their meals; and charting all non-nursing and non-medical aspects of the residents' activities of daily living. Because the legislation does not focus on the specific duties and responsibilities of the PSW, I do not discuss them further in this section.

1. Key Roles Under the NHA and the LTCHA Regulatory Regimes

a) The Administrator

The NHA regulatory regime required LTC homes to have an administrator and so does the LTCHA regulatory regime. The LTCHA specifies how many hours a week the administrator must work in the position, based on the number of licensed beds in the home.¹² The required qualifications for an administrator have changed. Under Regulation 832 to the NHA, the administrator of an LTC home had to be enrolled in (and complete within three years of the enrolment) the Long Term Care Organization and Management Course given by the Canadian Hospital Association.¹³ Under the Regulation to the LTCHA, administrators are now required to have:

- a post-secondary degree from a program at least three years in duration, or a post-secondary diploma in health or social services from a program at least two years in duration;
- three years' work experience in a managerial or supervisory role in a health or social services sector, or in another managerial capacity if the person has completed a program in long-term care home administration that is at least 100 hours long;

¹² Reg 832, s 79; LTCHA, s 70.

¹³ Reg 832, s 80. The exception to this requirement was if, in the opinion of the Minister of Health, the administrator had equivalent qualifications.

- demonstrated leadership and communication skills; and
- successfully completed a program in long-term care home administration or management that includes a minimum of 100 hours of instruction time (or be enrolled in such a program).¹⁴

The regulations to the NHA imposed significant obligations on administrators, including responsibility for the administration and enforcement of the regulations relating to drugs and drug storage;¹⁵ the creation and maintenance of detailed written records and files for each resident in the home (including detailed medical records); general records for the home (including records relating to inspections); and personnel records for each person employed in the home.¹⁶

The LTCHA places most of these obligations on the licensee. Instead of specific obligations being placed on the administrator, under section 70(2) of the LTCHA the administrator is “in charge of the home and responsible for its management.”¹⁷ During the Inquiry’s public hearings, I heard that administrators are often responsible for relationships with external stakeholders, including liaising with the Ministry and the Community Care Access Centres (CCACs) (when they existed) and then the Local Health Integration Networks (LHINs).¹⁸ Administrators remain responsible for the daily operations of most homes, including dealing with complaints and staffing and personnel issues. The home’s administrator is also one of the required members of the interdisciplinary team assigned to evaluate the effectiveness of the home’s medication management system.¹⁹

b) The Director of Nurses / Nursing and Personal Care

Under Regulation 832 to the NHA, the licensee was required to ensure the home had a registered nurse (RN) who was designated as the director of nurses. The director of nurses was responsible for the organization, direction,

¹⁴ O Reg 79/10, s 212(1)–(4). The Regulation provides some exceptions to these requirements for administrators who were working as administrators at the time the LTCHA came into force.

¹⁵ Reg 832, s 63(1).

¹⁶ Reg 832, ss 88–95.

¹⁷ LTCHA, s 70(2)(a).

¹⁸ On April 18, 2019, *The People’s Health Care Act, 2019*, SO 2019, c 5, received royal assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC system, including Ontario Health.

¹⁹ O Reg 79/10, s 115(1).

and evaluation of nursing care, which included both directing the work of the nursing staff and coordinating the in-service staff training programs.²⁰ Regulation 832 specified the number of hours the director of nurses had to be in the home, which was based on the number of beds.²¹

The LTCHA requires every licensee to ensure the LTC home has a director of nursing and personal care who must be an RN. The director of nursing and personal care is often known as the director of nursing (DON). The Regulation imposes more significant qualification requirements for the DON than the NHA did for the director of nurses. Licensees must ensure that DONs have at least one year of experience working as an RN in the long-term care sector; have at least three years' experience working as an RN in a managerial or supervisory capacity in a healthcare setting; and have demonstrated leadership and communication skills.²² The LTCHA specifies whether the position must be filled on a full- or part-time basis, depending on the number of beds in the home.²³

DONs are responsible for supervising and directing the home's nursing and personal care staff and the care they provide. Typically, DONs have a wide range of responsibilities within the home, including hiring nursing staff and PSWs; scheduling; responding to nursing-related complaints; and reporting and investigating critical incidents. They must also be a member of the interdisciplinary team responsible for reviewing the effectiveness of the home's medication management system,²⁴ described later in this chapter.

c) The Medical Director

The NHA regulatory regime required licensees to appoint a physician as the home's medical director. The licensee was obliged to obtain a written statement from the medical director stating that he or she agreed to advise the administrator "on matters relating to medical care in the home including the quality of medical care provided to the home."²⁵

²⁰ Reg 832, s 60(1).

²¹ Reg 832, s 60(3).

²² O Reg 79/10, s 213(4). The Regulation provides some exceptions to these requirements for directors of nursing who were working as directors of nursing at the time the LTCHA came into force.

²³ LTCHA, s 71; O Reg 79/10, s 213(1)–(3).

²⁴ O Reg 79/10, s 115.

²⁵ Reg 832, s 50(1). Although a licensee was also authorized to appoint one or more registered nurses in the Extended Class (nurse practitioners are nurses in the Extended Class) for the nursing home, that appointee was not known as the medical director of the home: see Reg 832, s 50(5)–(7).

A resident (or substitute decision-maker) was able to retain a personal physician to provide medical care.²⁶ If this was not done, the administrator was required to retain a physician – typically, the home’s medical director – to provide medical care to the resident.²⁷ The administrator was also responsible for arranging for a physician to be on call to respond to emergencies when a resident’s physician or substitute physician was not available.²⁸

Each physician or registered nurse in the Extended Class (nurse practitioner) retained to care for a resident was required to visit the resident and review his or her medication and diet at least once every three months; conduct an annual physical examination of the resident and file a written report of the examination and findings with the administrator; and attend additionally as required by the resident’s condition.²⁹

Under the LTCHA, the licensee must still ensure that the LTC home has a medical director, who is a physician.³⁰ The licensee must have a written agreement with the home’s medical director, which specifies, at a minimum, the term of the agreement, the responsibilities of the licensee, and the responsibilities and duties of the medical director.³¹ The LTCHA specifies that the medical director’s role is to advise the licensee on “matters relating to medical care” in the home and perform other duties as provided for in the Regulation.³² The Regulation stipulates that the medical director must develop, implement, monitor, and evaluate medical services; advise on clinical policies and procedures, where appropriate; communicate expectations to attending physicians and nurse practitioners; address issues relating to resident care, after-hours coverage, and on-call coverage; and participate in interdisciplinary committees (including the committee relating to medication management in the home) and quality improvement activities.³³ When performing their duties, medical directors must consult with the DON, as well as other health professionals working in the home.³⁴

²⁶ Reg 832, s 51(1).

²⁷ Reg 832, s 51(1).

²⁸ Reg 832, s 53(1). A registered nurse in the Extended Class could be part of the on-call team providing emergency services: Reg 832, s 53(2).

²⁹ Reg 832, s 51(4).

³⁰ LTCHA, s 72(1)–(2).

³¹ O Reg 79/10, s 214(1).

³² LTCHA, s 72(3).

³³ O Reg 79/10, s 214(3).

³⁴ LTCHA, s 72(4).

The LTCHA regulatory regime requires licensees to ensure that residents have access to medical services in the home 24 hours a day. Section 82 of the Regulation further requires that licensees ensure that either a physician or a nurse practitioner conducts a physical examination of each resident upon admission (and annually thereafter); attends the home regularly to provide services, including assessments; and participates in the provision of after-hours coverage or on-call coverage. Residents (or their substitute decision-makers) may retain a physician or nurse practitioner to provide this medical care. If that does not occur, the licensee must appoint a physician or nurse practitioner for this purpose, in consultation with the medical director, the resident, and the resident's substitute decision-maker (if there is one).³⁵ Again, the home's medical director is often appointed in those circumstances to be the resident's physician. If a nurse practitioner is appointed, then that nurse must specify the doctor with whom he or she will consult.³⁶ The role of the medical director in a home's medication management system is more fully explored below.

Before they begin to work in an LTC home, all staff – except medical directors, and attending physicians and nurse practitioners appointed by the home to care for a resident – must undergo screening measures that include criminal record checks and vulnerable sector screens.³⁷

d) Nursing Staff

Under the NHA regulatory regime, the licensee of a nursing home was obliged to ensure that 24-hour nursing service was available in the home. Section 59(1.1) of Regulation 832 required the licensee to ensure there was “at least one registered nurse who is a member of the regular nursing staff on duty and present in the home at all times.”³⁸ The director of nurses, while working in that capacity at the home, could not satisfy this requirement.³⁹ The number of staff required to provide care to residents was left to a licensee's discretion, provided “a sufficient number of registered nurses, registered practical nurses and health care aides” were available to “provide the nursing care required by the residents in the home.”⁴⁰

³⁵ O Reg 79/10, s 82(3).

³⁶ O Reg 79/10, s 84(c).

³⁷ LTCHA, s 75; O Reg 79/10, s 215.

³⁸ There was no similar requirement under the regulations to the *Homes for the Aged and Rest Homes Act*. Although this requirement did exist under the regulations to the *Charitable Institutions Act*, there was an exception for smaller homes, at least until 2005.

³⁹ Reg 832, s 60(4). This section did not apply to licensees of nursing homes with 80 beds or fewer until Aug. 1, 2005: Reg 832, s 60(5).

⁴⁰ Reg 832, s 60(6).

The LTCHA requires that licensees ensure there is an organized program of nursing services in the home to meet the assessed needs of its residents.⁴¹ Licensees must ensure that at least one RN who is both an employee of the licensee and a member of the regular nursing staff be on duty and present in the home at all times, except as provided for in the Regulation.⁴² This is colloquially known as the “24/7” RN requirement. Neither the administrator nor the DON can be considered the RN on duty when acting in those capacities.⁴³ To improve continuity of care for residents, the LTCHA restricts the ability of licensees to use temporary, casual, or agency staff.⁴⁴ Although the LTCHA regulatory regime does not prescribe specific staffing levels, section 31 of the Regulation requires that the licensee ensure there is a written staffing plan that provides for a staffing mix consistent with the residents’ assessed care and safety needs; promotes continuity of care; includes a back-up plan to ensure nursing coverage when staff cannot come to work; and is evaluated and updated at least annually.⁴⁵

Some LTC homes struggle to meet the 24/7 RN requirement and, as a result, rely on nurses from employment agencies or other third parties (agency nurses). Agency nurses can be called upon only in limited circumstances, a matter addressed in Chapter 7 of this Report.

e) The Pharmacy Service Provider

The NHA and Regulation 832 were silent on the role of pharmacy service providers. However, the Program Manual imposed a number of standards and criteria relating to pharmacy services in LTC homes. For example, the Program Manual required that a pharmacist provide clinical pharmacy services to the home and that there be a pharmacy to provide drugs and drug products to the home. The pharmacist providing the medications to the home and the one providing clinical services could be different. The Program Manual also specified that there had to be an “organized program for the provision of pharmacy service to meet the residents’ needs” including:

- an organized, interdisciplinary review process for directing the pharmacy’s programs and services;
- the safe provision of medications to residents;

⁴¹ LTCHA, s 8(1). Licensees must also ensure the home has an organized program of personal support services to assist with the activities of daily living.

⁴² LTCHA, s 8(3).

⁴³ LTCHA, s 8(4).

⁴⁴ LTCHA, s 74.

⁴⁵ O Reg 79/10, s 31(3).

- accurate record-keeping to ensure the safe receipt, disposition, tracking, reconciliation, and auditing of medications;
- accurate and safe dispensing, proper storage, and disposal of medications; and
- a system for immediate reporting of medication errors and adverse drug reactions (with specific follow-up action).

The Program Manual required a written contract between the home and those responsible for providing pharmacy services. This contract specified “expectations” from the pharmaceutical service, among them:

- the established method of communication between the pharmacist and the home;
- quality management expectations, including for drug storage, prescribing, and distribution systems;
- participation in an interdisciplinary review process;
- accurate and safe acquisition and dispensing of medications;
- reporting of any irregularities or concerns about medication ordering or administration to the administrator, physician, or director of nursing;
- preparation and review of the residents’ drug regimes for the home’s quarterly review;
- maintaining of complete medication profiles for each resident;
- implementation of programs designed to improve residents’ pharmacotherapy (e.g., drug utilization);
- provision of education seminars; and
- drug destruction.⁴⁶

The Program Manual also specified that access to a pharmacy service had to be available 24 hours a day, seven days a week.

⁴⁶ Program Manual, s 1016-01, pp 1–4.

Under the Regulation to the LTCHA, a licensee must retain a pharmacy service provider that holds a valid certificate of accreditation to operate a pharmacy.⁴⁷ The Regulation mandates that there be a written agreement between them requiring the pharmacy service provider to provide drugs to the home on a 24/7 basis (or arrange for their provision by another accredited pharmacy) and perform all its responsibilities under the Regulation.⁴⁸

Many of the pharmacy service provider's responsibilities relate to the medication management system in the home, which I explore more fully later in this chapter.

C. Reporting Obligations

The NHA, Regulation 832, and the Program Manual imposed different reporting requirements on licensees and other individuals in a variety of circumstances. Most of these requirements continue to exist – with slight variations – under the LTCHA. Both the NHA and the LTCHA impose a broad duty on all persons, except residents, to report suspected harm of residents (or potentially harmful conduct) to the Director under the NHA (and now LTCHA).⁴⁹ Both regulatory regimes also require the reporting of unusual occurrences or critical incidents that happened in the home.⁵⁰ The reporting obligations imposed under the NHA and then under the LTCHA and its Regulation are reviewed in detail in Chapter 9 (see section III for a review of the NHA-related reporting obligations and section V for those obligations under the LTCHA).

In addition to these reporting obligations, when a resident dies in an LTC home, the *Coroners Act* requires that the “person in charge” of the home immediately notify the coroner of the death.⁵¹ This obligation is fulfilled by the home completing an Institutional Patient Death Record (IPDR) and sending it to the Office of the Chief Coroner (OCC). The process undertaken by the OCC on being notified of the death of a resident is explained in Chapter 14 of this Report.

⁴⁷ O Reg 79/10, s 119 (1)–(2).

⁴⁸ O Reg 79/10, s 119(3)–(4).

⁴⁹ NHA, s 25(1); LTCHA, s 24(1).

⁵⁰ Reg 832, s 96; O Reg 79/10, s 107.

⁵¹ RSO 1990, c C 37, s 10(2.1).

III. Challenges That LTC Homes Face

During the public hearings, many witnesses gave evidence about working in LTC homes in Ontario. These witnesses – who included administrators, DONs, a medical director, attending physicians, and pharmacy consultants – spoke about the environment in LTC homes and the challenges that the homes face. I discuss those now.

A. The Increasing Acuity Level of Residents

In the healthcare sector, acuity refers to the intensity of care that a person requires: a high level of acuity means the person has high care needs. At the public hearings, all witnesses questioned about acuity had the same thing to say: LTC homes have always cared for residents needing a level of support beyond what is possible at home, but there has been a sharp increase in the proportion of residents with high acuity in recent years.

Three factors have contributed to the rising acuity of residents in LTC homes. First, starting in 2010, the Ontario government began to focus more on “aging at home.” Second, since 2010, stricter criteria for admission into long-term care have been in effect so that only those with high or very high needs (based on MAPLe (Method for Assigning Priority Levels) scores) are eligible for admission.⁵² Third, many residents who would previously have been cared for in hospitals now live in LTC homes. As a result, residents enter LTC homes at a later stage of their cognitive and physical impairment, when their health is likely to be unstable, they are more physically frail, and their care needs are higher.

Today, the vast majority of people living in LTC homes have some form of cognitive impairment and physical frailty, along with chronic health conditions that have compromised their well-being. The following profile, drawn from the Ontario Long Term Care Association’s 2019 report, gives a current snapshot of the care needs of Ontario’s long-term care residents.

⁵² Final Report of the Registered Practical Nurses Association of Ontario (RPNAO), March 2018, *Changing An Unacceptable Reality: Enabling Nursing Knowledge for Quality Resident Outcomes in Ontario’s Long Term Care Homes*, p 2. This report is based on a study funded by the RPNAO and the Ministry of Health and Long-Term Care.

Profile of Residents in LTC Homes, 2017–18⁵³

- 90% have some form of cognitive impairment
- 86% need extensive help with activities such as eating or using the washroom
- 80% have neurological diseases
- 76% have heart / circulation diseases
- 64% have a diagnosis of dementia
- 62% have musculoskeletal diseases such as arthritis and osteoporosis
- 40% need monitoring for an acute medical condition
- 21% have experienced a stroke
- 61% take 10 or more prescription medications

Note: Data relating to prescription medication use are from 2012.

With more residents needing higher levels of care, staff in LTC homes face ever-increasing demands and responsibilities, particularly those providing residents with direct care. One nurse who testified at the public hearings shared that she went into LTC thinking it would be “a nice precursor to retirement” but found that she had “never worked harder in [her] life.”

B. The Shortage of Nurses in LTC

The vulnerability of residents in LTC homes is not only a function of their physical and mental states. It also stems from the shortage of staff – particularly nurses – in the home. The core reason for the low levels of staff is the limited government funding provided to LTC homes for nursing and personal care staff. However, it is also attributable to the difficulty that LTC homes have in recruiting and retaining nursing staff.

The hospital sector is the homes’ biggest competitor for nursing staff. Witnesses at the public hearings gave many reasons for why it is more attractive to work in a hospital setting than in an LTC home. Better pay, better benefits, and better working conditions top the list. As well, in a hospital

⁵³ Ontario Long Term Care Association, *This Is Long-Term Care 2019* (Toronto, Ont., April 2019), p 3. The association’s report shows that, in creating this profile, it relied on information from the Canadian Institute for Health Information (2018), including Continuing Care Reporting System: Profile of Residents in Continuing Care Facilities 2017–18 and *Drug Use Among Seniors on Public Drug Programs in Canada, 2012* (2014).

setting, an RN has other healthcare professionals with whom to immediately consult when an emergency arises – physicians, nurse practitioners, pharmacists, respiratory therapists, and other RNs. In contrast, at an LTC home, especially in small rural homes, often only one RN is on duty. That nurse is solely responsible for the immediate care and assessment of the residents' medical needs, including in emergencies. There is also a significant disparity in the number of patients or residents for whom the nurse is responsible, with nurses in LTC homes typically having responsibility for much higher numbers of individuals.

When the heavy workload in LTC is considered in combination with these other matters, it is easy to understand why homes have difficulty recruiting and retaining nurses. These challenges are compounded by the fact that work in LTC appears to be undervalued, from a societal point of view, and undesirable, from the perspective of many healthcare professionals. These challenges are explored in Chapters 13 and 15, where I also set out recommendations on how they might be addressed.

C. Increasing Documentation Responsibilities

In recent years, nursing staff (as well as personal support workers) in LTC homes have been tasked with increasing documentation responsibilities, owing in part to the implementation of the LTCHA regime. Most of the information gathering and documenting is designed to ensure that the residents receive the level of care necessary for their mental and physical status; there is continuity in resident care; appropriate medications are administered to the residents; and changes to residents' conditions are noticed and responded to quickly. Although the rationale for the increased documentation is compelling, these extra responsibilities have increased the workload of nurses in LTC homes. Many of the nurses who testified said that, to get their charting done, they routinely have to stay after their shifts end (for which they are not paid).

The following list – by no means exhaustive – provides examples of the documents that nurses in LTC must prepare and review:

- admission assessments, including head-to-toe assessments, a medication reconciliation, and a 24-hour care plan;
- resident care plans;
- daily progress notes;
- medication administration records;

- treatment administration records;
- quarterly medication reviews;
- quarterly Resident Assessment Instrument–Minimum Data Set (RAI-MDS) assessments (explained below); and
- incident reports for things such as falls, medication errors, suspected abuse, and suspected neglect.

1. Documentation Required on Admission

On admission to an LTC home, a resident's health and physical status must be assessed. Registered nursing staff play a major role in this process, which begins with a reconciliation of the resident's medications.

A nurse prepares a "best possible medication history," which contains information on the medications the resident is taking, directions on how they are to be taken, prescriber information, and allergies to medication (if any). Because the medical director does not typically see the resident within 24 hours of admission, nursing staff also must arrange for the resident's medications to be reviewed by the resident's doctor (usually over the phone) and then obtained from the home's pharmacy service provider as soon as possible.

Multiple assessments must be conducted to develop as complete a picture as possible of the resident's health status, preferences, and activities. For example, licensees are required to ensure that a 24-hour admission care plan is developed and communicated to direct care staff within 24 hours of a resident's admission to the home.⁵⁴ Some of the issues that must be addressed in the care plan include:

- any risks the resident may pose to himself or herself, or to others, including the risk of falling, and interventions to mitigate those risks;
- the type and level of assistance required for activities of daily living;
- regular routines and comfort measures;
- required medications and treatments;
- information on known health and skin conditions; and
- dietary considerations.⁵⁵

⁵⁴ O Reg 79/10, s 24(1).

⁵⁵ O Reg 79/10, s 24(2).

2. Resident Care Plans

Although a 24-hour care plan is prepared on admission, the licensee must also ensure that a more comprehensive care plan is completed within 21 days.⁵⁶ Section 26 of the Regulation specifies a broad range of issues that the plan of care must address beyond those included in the 24-hour care plan, including cognition ability, communication abilities, mood and behaviour patterns, sleep patterns and preferences, psychological well-being, physical functioning, and safety risks.⁵⁷ I heard that both a head-to-toe and a bedside assessment are conducted to complete the care plan, along with other assessments such as a physician's assessment or examination. Together, these assessments and the resulting care plan are meant to cover every aspect of the resident's care needs and preferences.

If the resident meets a goal in the plan, his or her care needs change, an aspect of care is no longer necessary, or the care set out in the plan is not effective, the resident must be reassessed and the care plan reviewed and revised.⁵⁸ Even in the absence of such changes, the licensee must ensure that the resident is reassessed and the care plan is reviewed at least every six months.⁵⁹ The resident, his or her substitute decision-maker (if there is one), and anyone designated by them are entitled to be given an explanation of the plan of care.⁶⁰

3. Progress Notes

Progress notes are kept for each resident. Registered nursing staff, the director of nursing, the resident care coordinator, dietitians, and physiotherapists are among those able to access and make entries in the progress notes. It mainly falls to the nurses, however, to chart a resident's progress.

Typically, nurses do not chart each day for each resident. To do so would be too onerous. The charting that does take place was described as "by exception." One RN explained that she would chart anything significant that had occurred. A review of a resident's progress notes may show notes on behaviours, falls, pain, incidents, PRN (as needed) medications, infections, lab results, family notes, and doctors' visits. Progress notes are not intended to

⁵⁶ O Reg 79/10, s 25(1).

⁵⁷ O Reg 79/10, s 26(3).

⁵⁸ LTCHA, s 6(10); O Reg 79/10, s 24(9).

⁵⁹ LTCHA, s 6(10).

⁶⁰ LTCHA, s 6(12).

reflect the amount of interaction a nurse has with the resident; rather, they capture the significant and/or important points relating to the resident's care.

4. Quarterly RAI-MDS Assessments

On admission to the home, and at regular intervals afterward, each resident has an interdisciplinary assessment based on an electronic tool called a Resident Assessment Instrument–Minimum Data Set (RAI-MDS). The RAI-MDS is an international, standardized, interdisciplinary assessment and care planning tool. It was implemented in all LTC homes across Ontario in 2009, before the LTCHA regime came into effect.

The RAI-MDS must be completed by either an RN or a registered practical nurse. The nurse will assess – and then input – details of the resident's health and medical conditions; algorithms will then draw on this information to create an individualized care plan for the resident. The RAI-MDS is the most comprehensive assessment of a resident's health status. Essentially, all of a resident's health- and medical-related information is a part of it, including the resident's mood, behaviour, diet, vision, elimination patterns, diagnoses, mobility, and activities. The RAI-MDS data are submitted to the Canadian Institute for Health Information (CIHI), where they are processed so they can be used by the Ministry to assist in care planning, tracking things such as the residents' acuity and the performance of the home relative to others in the province, and supporting oversight generally of the LTC homes sector.

Nurses are not alone in charting for the RAI-MDS. PSWs must chart all non-nursing and non-medical aspects of the resident's activities of daily living, including all fluid and food intake, incontinence / continence, dressing, mood, behaviour, and washing and bathing.

As I explain in Chapter 9, the Ministry provides funding to the LHINs, which in turn administer that funding to the homes through four funding envelopes.⁶¹ One of the envelopes is for nursing and personal care (NPC). The amount of funding a home will receive in the NPC envelope varies according to the acuity of the home's residents. The home's acuity is based on its RAI-MDS reporting for each resident.⁶² A home with residents who have more acute or complex health problems, as compared with other homes in the province, will receive more of the funds in its NPC envelope.

⁶¹ As I explain in that chapter, the Ministry also provides some funding directly to LTC homes.

⁶² The home must do a RAI-MDS assessment on the admission of a new resident and when a resident has a significant change in health status. Assessments must also be updated quarterly for each resident.

The RAI-MDS is detailed and labour-intensive and has increased the amount of recording and charting that nurses and PSWs must do. To assist, the Ministry funds a coordinator position in the homes, devoted to the RAI-MDS assessments. The RAI coordinator takes the RAI-MDS information from the nurses and PSWs, reviews it, and codes it into the CIHI system. The coordinator is also responsible for scheduling subsequent RAI-MDS assessments for all residents. Although the RAI-MDS eliminated some nursing assessments, many others must still be conducted, including those required to prepare a resident's plan of care.

D. Challenges Relating to Staff Training and Orientation

The LTCHA and its Regulation impose a number of training and orientation responsibilities on licensees of LTC homes for both staff and volunteers.⁶³ The licensee must ensure that a training and orientation program is in place, that the program is assessed and evaluated at least annually, and that a written record is kept of that assessment.⁶⁴ Staff must receive training before assuming responsibilities in the home, but annual retraining is also required.⁶⁵ Every volunteer in the home must also receive specified orientation.⁶⁶

All direct care staff, with the exception of medical directors and attending physicians or nurse practitioners, must receive annual training in a number of areas, including abuse recognition and prevention; mental health issues (including the care of those with dementia); behaviour management; restraint minimization; palliative care; falls prevention and management; skin and wound care; continence care and bowel management; and pain management.⁶⁷

Homes deliver training in various ways, including through computer modules, education fairs, presentations, policy reviews, and quizzes. Some homes devote one day yearly to the training, while others have monthly educational requirements. Yet others provide ongoing training in staff meetings.

⁶³ LTCHA, ss 76–77.

⁶⁴ O Reg 79/10, s 216.

⁶⁵ LTCHA, s 76; O Reg 79/10, ss 219 and 220.

⁶⁶ LTCHA, s 77; O Reg 79/10, s 223.

⁶⁷ LTCHA, s 76(7); O Reg 79/10, ss 221 and 222(3).

In addition to developing and delivering the required training and orientation to staff and volunteers, a licensee must ensure the home has all policies, procedures, and programs required by the LTCHA regime. Licensees that operate multiple homes may be able to draw on standardized practices, but must still tailor policies and procedures to the individual location. Licensees that operate a single home must produce their own sets of policies, procedures, and programs. Since much of the training pertains to these policies, procedures, and programs, a licensee devotes significant resources to complying with its training and orientation obligations under the legislation.

Ensuring that staff complete required training and that the training is effective is challenging, in part because of scheduling issues that shift work creates. Staff often do not have the time to complete training while at work because there is usually no one to cover for them. Some staff complete their training at home, despite not being paid for it. The former staff educator at Meadow Park (London) explained the difficulties she encountered:

I followed the schedule [of education topics] that was prepared by Jarlette [Health Services] each month. I had to track everyone down, catch them while they were in between residents, and get them to do this training. When the registered staff did the training, it would take time away from the floor.

Licensees must also ensure that the pharmacy service provider delivers educational support to staff in relation to medications in the home.⁶⁸ This training covers such topics as the ordering, receiving, handling, storage, administration, and destruction of medication.

Further, licensees are required to provide staff training on the home's policy to promote zero tolerance of abuse and neglect, as well as training on abuse recognition and prevention. The evidence at the public hearings shows that there has been no education about the potential for a healthcare provider to intentionally harm a resident. In light of the Offences, in my view it is essential that the possibility of intentionally caused harm leading to medication incidents or deaths must now be factored into a home's training and risk management processes. In Chapter 16, I address the healthcare serial killer phenomenon and make recommendations on how it should be addressed.

⁶⁸ O Reg 79/10, s 120.

IV. Medication Management in LTC Homes

A. Introduction

Medication management in an LTC home is challenging. On admission to an LTC home, residents relinquish responsibility for their medication and its management. As a result, depending on the home's size, registered staff may be responsible for meeting the medication needs of well over a hundred people. Because residents have more complex medical issues than ever before, most are on multiple medications that are to be given at various times of the day, and in various dosages. There are tablet-form medications and injectable medications. There are controlled drugs, such as narcotics, and non-controlled drugs, such as blood pressure medications and insulin. It is clear that medication management is a serious responsibility and fraught with danger. Consequently, it is heavily regulated under the LTCHA and the Regulation.

Below, I examine the obligations relating to the medication management system in the Regulation, which seek to ensure that each resident receives his or her proper medication at the right time. Then I review how medications are handled within an LTC home: how they are packaged, ordered, delivered, and stored, and then administered to residents through what is commonly known as the medication pass.

B. Medication Management: Roles and Responsibilities

Many people are involved in the medication management system in an LTC home. The licensee has the overall responsibility for developing an interdisciplinary medication management system, and the home's nursing staff, director of nursing, medical director, and pharmacy service provider each plays a role in ensuring that system is functioning effectively. After describing the roles that each one plays in the medication management system, I address how these professionals are required to work together to review and assess the effectiveness of the system within the home and look for improvements to it.

1. Nursing Staff and the Director of Nursing

A nurse's responsibilities begin with conducting the required medication reconciliation for every resident admitted to the home, as discussed above. Thereafter, nurses are responsible for all aspects of the handling of medication

within the home. They order the medications; reconcile the medications received against what was ordered; ensure that medications are properly stored; and administer them to the residents.

Section 134 of the Regulation requires licensees to ensure that residents taking medications are monitored and that their response – and the effectiveness of the drugs – is documented. Licensees must also ensure that appropriate actions are taken in response to any medication incident or adverse drug reaction, and that a documented reassessment of each resident’s medication regime takes place at least quarterly. Nurses do the daily work associated with these obligations. They must chart all the medications they administer, and monitor and document the resident’s response to medications, looking particularly for adverse reactions.

Section 135 of the Regulation requires licensees to ensure that every medication incident involving a resident and every adverse drug reaction is documented, reported, reviewed, and analyzed, and that necessary corrective action is taken. Licensees must also ensure that quarterly reviews of these medication incidents and adverse drug reactions are conducted to reduce and prevent such occurrences. They must also implement any changes or improvements identified in the review and keep written records of the reviews.

As noted earlier, the DON must supervise and direct the staff and the care they provide. The DON also has responsibilities specific to the oversight of the home’s medication management system. All medication incidents and adverse drug reactions involving residents must be reported to the DON.⁶⁹ It is the DON who must appoint a member of the registered nursing staff to destroy controlled substances in the home (with either a physician or the pharmacy service provider) and to destroy non-controlled drugs (with one other staff member).⁷⁰ The DON also works in collaboration with the pharmacy service provider and/or medical director to do such things as create the written policies and protocols relating to the medication management system⁷¹ and the drugs to be stored in the emergency drug supply,⁷² and to decide what medications should be with a resident when he or she leaves the home on a temporary basis.⁷³

⁶⁹ O Reg 79/10, s 136(1)(b).

⁷⁰ O Reg 79/10, s 136(3).

⁷¹ O Reg 79/10, s 114(3)(b).

⁷² O Reg 79/10, s 123.

⁷³ O Reg 79/10, s 128.

2. Medical Director

As noted earlier in this chapter, the role of the medical director is broader than that of a physician who cares for one or more residents. The medical director must “advise on matters relating to medical care” in the home and perform any duties provided for in the legislation.⁷⁴ Among other things, medical directors must participate in interdisciplinary committees and quality improvement activities.⁷⁵ They must also be involved in various aspects of the interdisciplinary medication management system that licensees must develop for the home. Every medication incident and adverse drug reaction involving a resident must be reported to the medical director.⁷⁶ Medical directors are members of the interdisciplinary team tasked with the quarterly and annual evaluations of the home’s medication management system.⁷⁷ I discuss the interdisciplinary team and its responsibilities below.

3. Pharmacy Service Provider

Pharmacy service providers play an important role in the medication management system within an LTC home. Section 120 of the Regulation requires the licensee of the home to ensure that the pharmacy service provider participates in a range of activities relating to medication management, including:

- development of medication assessments, medication administration records, and maintenance of medication profiles;
- evaluation of therapeutic outcomes of drugs for residents;
- risk management and quality improvement activities;
- development of audit protocols to evaluate the medication management system;
- educational support to staff in the home regarding medications; and
- in some circumstances, drug destruction and disposal.⁷⁸

⁷⁴ LTCHA, s 72(3).

⁷⁵ O Reg 79/10, s 214(3).

⁷⁶ O Reg 79/10, s 135.

⁷⁷ O Reg 79/10, ss 115 and 116.

⁷⁸ O Reg 79/10, s 120.

The pharmacy service provider is also a required member of the interdisciplinary team tasked with evaluating the medication management system in the home.⁷⁹

4. Interdisciplinary Team

Section 114 of the Regulation requires all licensees to develop an “interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.” Licensees must establish policies and protocols for that system relating to all aspects of medication management, including storage and administration, in the home. These must be reviewed by the DON and pharmacy service provider and, where appropriate, the medical director.⁸⁰

Sections 115 and 116 of the Regulation require the licensee to ensure that the home’s medication management system is regularly evaluated and modified as necessary, based on quarterly and annual reviews. Quarterly reviews must be carried out by the home’s interdisciplinary team, to include, at a minimum, the medical director, the administrator, the DON, and the pharmacy service provider. For the annual reviews, a dietitian must also be part of the team.

Section 115 dictates that, through the quarterly reviews of the medication management system:

- drug utilization trends and patterns in the home are reviewed, including the use of any drug or combination of drugs (including psychotropic) that could potentially place residents at risk;
- reports of any section 135 medication incidents and adverse drug reactions are reviewed, as are all instances of restraining of residents by the administration of a drug; and
- changes to improve the system are identified in accordance with evidence-based or prevailing practices.⁸¹

The licensee must ensure that changes identified in the quarterly evaluation are implemented⁸² and a written record is kept of the results of the evaluation and changes that were implemented.⁸³

⁷⁹ O Reg 79/10, ss 115 and 116.

⁸⁰ O Reg 79/10, s 114.

⁸¹ O Reg 79/10, s 115(3).

⁸² O Reg 79/10, s 115(4).

⁸³ O Reg 79/10, s 115(5).

Section 116 of the Regulation requires the licensee to ensure that there is an annual evaluation of the medication management system by the interdisciplinary team, which is to include a review of the quarterly evaluations of the previous year, using an assessment instrument designed specifically for this purpose.⁸⁴ The Medication Safety Self-Assessment for Long-Term Care offered by the Institute for Safe Medication Practices (ISMP) Canada is one such instrument. (ISMP is a not-for-profit organization committed to the advancement of medication safety in all healthcare systems.) This online survey is completed voluntarily by homes that provide information on medication safety best practices. Of the almost 630 LTC homes across Ontario, 194 homes used ISMP Canada's self-assessment tool in 2017.⁸⁵ Data from all the homes that complete the self-assessment are then shared among the participating homes. The evaluation must identify changes to improve the home's medication management system, and the licensee must ensure that those changes are implemented.⁸⁶

C. Types and Packaging of Medications

Medications in LTC homes are generally for the ongoing treatment of chronic conditions (e.g., hypertension, diabetes, depression) and for the episodic treatment of acute conditions such as an injury. The manner in which medications are packaged helps to ensure that the right resident gets the right medications.

1. Strip Packaging

Non-controlled medications commonly prescribed for residents in LTC homes include blood pressure medication, oral hypoglycemic agents, arthritic medications, and vitamins. Many residents take multiple medications at the same time of day.

For some time now, pharmacies have dispensed oral solids such as tablet medications⁸⁷ to LTC homes in strip packages. These are small plastic pouches which contain a number of medications that are to be taken at the same time. Each pouch is attached to the next one, separated by a perforated strip. The person's name, the date and time for administration, the name of

⁸⁴ O Reg 79/10, s 116(3).

⁸⁵ Expert Report of Julie Greenall, June 1, 2018, p 19.

⁸⁶ O Reg 79/10, s 116(3)–(5).

⁸⁷ There are also capsule-form medications that are packaged the same way. For ease of reference, I use the word tablet when describing this system.

each medication, the dose, and a short-form description of each medication are printed on the pouch. The pouch contains all the medications to be administered to the resident at the same prescribed time – at breakfast, for example. If one pouch is not large enough, the next pouch in the strip includes the balance.

The strips are dispensed from an automated dispensing machine. Typically, the homes receive a one-week supply per resident.

2. Tablet-Form Narcotics

Controlled drugs that are prescribed in tablet form, including narcotics, come in blister cards. (Before strip packaging for non-controlled drugs were introduced, they too were delivered in this way.) Each card contains a specific number of blisters – generally 31 per card although, to reduce the number of narcotics stored on-site, some homes have now moved to cards containing only seven blisters. The card is labelled with the resident's name, order date, LTC home name, location in the LTC home, drug name, drug dose, prescription number, directions for administering, and other relevant information. The pharmacy name is also on the card. If a resident has a prescription for a PRN (as needed) controlled medication, the card is labelled as such to distinguish it from a regular-dose card. For instance, a resident with sporadic rather than continuous pain may indicate when he or she needs a pain pill or a nurse may assess that the resident requires a pill, which may be given if it fits within the dose and time parameters set by the physician.

Inside each blister is one tablet. The tablet is popped out when the nurse is ready to administer the drug. Nurses start with tablet number 31 (or 7 as the case may be) and work their way down to the last tablet in the card, number 1. A visual reminder on the card indicates when the medication should be reordered.

3. Emergency Drug Supply

In addition to medications specifically prescribed to a resident, each LTC home has an emergency drug supply, often called the emergency drug box. The emergency drug supply ensures that medications which may be needed urgently or outside regular pharmacy hours are always on hand. Typically, an LTC home has only one emergency drug box, which is kept in one of the locked medication rooms.

Every licensee who maintains an emergency drug supply must ensure that only drugs approved for this purpose by the medical director, in collaboration with the DON, administrator, and pharmacy service provider, are kept in the supply.⁸⁸ There must be a written policy addressing the location of and access to the supply, procedures and timing for reordering drugs, use of drugs in the supply, and tracking and documentation of the drugs in the supply.⁸⁹

The emergency drug supply typically includes glucagon, which is a rescue agent for hypoglycemic episodes. Glucagon is a naturally occurring substance in our bodies which stimulates the liver to produce more sugar. An injection of glucagon makes the body manufacture sugar and generally produces a quick response.

The use of a rescue drug strongly suggests there is a need to investigate why it had to be used. A medication error may have been made, or perhaps there was even an intentional misuse. When glucagon is used, a record of its use should be made and reviewed by the pharmacist and the interdisciplinary committee.⁹⁰ I address this matter in Chapter 17.

D. Ordering Medications

Section 133 of the Regulation requires licensees to establish and maintain a drug record book that is kept in the home for at least two years. The following information must be recorded for every drug that is ordered and received in the home:

- the date the drug is ordered;
- the signature of the person placing the order;
- the name, strength, and quantity of the drug;
- the name of the place from which the drug is ordered;
- the name of the resident for whom the drug is prescribed, where applicable;
- the prescription number, where applicable;
- the date the drug is received in the home;

⁸⁸ O Reg 79/10, s 123(a).

⁸⁹ O Reg 79/10, s 123(b).

⁹⁰ Testimony of Julie Greenall, Transcript, Sept. 13, 2018, pp 8287–88.

- the signature of the person acknowledging receipt of the drug on behalf of the home; and
- information relating to the destruction of controlled substances (as required by section 136(4) of the Regulation).⁹¹

The Offences were committed over almost a decade. During that period, two different ordering systems were used in LTC homes – one manual and the other electronic. (Both systems remain in use.) Under the manual system, the physician places new prescriptions directly on the resident’s chart, usually on a physician’s order sheet or a prescriber’s order form. If the physician is not in the home at the time a new prescription is ordered – for example, if he or she had been telephoned in response to a resident’s change in condition – the doctor sends the prescription either directly to the pharmacy or to the LTC home for a nurse to send to the pharmacy. In such instances, the nurse records the prescription on the resident’s chart for the physician to sign the next time he or she is in the home.

Under the manual system, the nurse enters the order into the drug record book, which contains a record of all medications ordered and received from the pharmacy. To obtain the medication, the nurse then faxes the page from the drug record book to the pharmacy. The pharmacy inputs the information into a medication administration record (MAR), which identifies, among other things, the resident, the resident’s physician, the type and strength of the medication, and the time and directions for use. When a medication is administered, the nurse confirms its administration on the MAR.

Over time, some LTC homes have transitioned to an electronic transmission of a physician’s order (or that of a nurse practitioner). One mechanism is a “digipen,” which a prescriber uses for writing the order; then, “when the pen is returned to the docking station, it transmits an exact replica of the order to the pharmacy.”⁹²

E. Delivery and Receipt of Medication

Each week, the pharmacy service provider delivers doses of regularly scheduled medications that have not changed. Controlled and non-controlled medications are typically delivered at the same time but are separately packaged. For instance, some pharmacies use differently coloured bags so that the pharmacy and LTC staff can easily distinguish them.

⁹¹ O Reg 79/10, s 133.

⁹² Expert Report of Julie Greenall, p 7.

Standard practice is for the pharmacy driver to hand the medication to a nurse at the LTC home. The hand-off may take place in a designated area near the home's entrance. At some homes, the driver may deliver each unit's medications directly to the unit. The nurse who receives the medication signs the driver's delivery slip, showing that the home received the delivery. The driver's delivery slip goes back to the pharmacy for its records.

The nurse then checks what was delivered against what was ordered. When this reconciliation is done manually, the nurse checks the prescription received from the pharmacy against the drug record book. The nurse then signs the book to signify that what was ordered had been received. Since the electronic medication administration record (eMAR) has been implemented, medications can be scanned into the system by barcode. Where a prescription has been ordered but has not yet been received, the resident's eMAR reads "pending." When the prescription is received and scanned into the system, the pending message disappears from the resident's profile.

Generally, medications are not placed into the medication cart until they have gone through the reconciliation process. Because medications are often delivered around the dinner hour and may arrive during a medication pass, at times the medication is placed in the locked medication room, to be reconciled later, when the nurse is not as busy or by the nurse on the next shift.

F. Medication Storage

When received, medications must be safely stored. The licensee must ensure they are kept in a locked medication room or locked medication cart⁹³ and remain in their original labelled container or package until administered to a resident.⁹⁴ Controlled substances, such as narcotics, must be stored separately in a locked box in the locked medication room or stored separately in a locked area in the locked medication cart.⁹⁵ Access to these locked areas is restricted to "persons who may dispense, prescribe or administer drugs in the home" and the administrator.⁹⁶

Medications that do not require refrigeration, such as strip packages, are stored in a locked medication cart. Although there are different types and

⁹³ O Reg 79/10, s 129(1).

⁹⁴ O Reg 79/10, s 126.

⁹⁵ O Reg 79/10, s 129(1).

⁹⁶ O Reg 79/10, s 130.

sizes of medication carts, typically each resident has a small bin, identified with his or her room number and name, stored in one of the drawers in the cart. That bin is used to store the resident's strip packages and, if there is enough room, an insulin pen if required. I learned that, if there is not enough room in the resident's bin for his or her pen, some homes have a separate bin beside it or store the pens elsewhere in the cart. When not in use, the locked medication carts are stored in the locked medication room.

Medications that need refrigeration, such as injectable insulin, are stored in the refrigerator in the locked medication room.

G. The Medication Pass

The burden of medication administration is obviously heavy in LTC homes. A 2014 report from the Canadian Institute for Health Information identified that older adults living in LTC homes take more prescription medications, and more potentially dangerous medications, than those living at home. More than three-fifths (60.9%) of Canadians aged 65 and older who live in LTC homes take 10 or more different prescription drugs.⁹⁷ Not surprisingly, medication administration takes up a significant portion of a typical nursing shift. Administering medication to 30 residents can take two-and-a-half to three hours – a process that must be repeated multiple times every day.

It is not just the number of residents and number of medications that complicate medication administration in long-term care. In administering a medication, nurses consider the following eight "rights," with the goal of ensuring that the proper medication is given to the appropriate person:

- right medication;
- right dosage;
- right time;
- right resident;
- right route – e.g., orally, subcutaneously, or intramuscularly;
- right reason;
- right documentation; and
- right response.

⁹⁷ Expert Report of Julie Greenall, p 16.

The nurse must ensure that the right resident gets the right medication – a job that is not always easy in the LTC setting. For instance, hospital patients are likely to be found in their assigned beds in assigned rooms. In LTC homes, however, given that the setting is the resident’s home, residents may be outside their rooms – perhaps in the dining room, the lounge, or the activity room, or out with their family or friends. To complete their medication passes, nurses in LTC must locate and identify each resident.

At times, it may be difficult for a nurse to identify the right resident. A nurse may normally work the night shift but be temporarily filling in on days. At night, a nurse may see the resident only in bedclothes and without glasses. During the day, when dressed and wearing glasses, the resident may look quite different. To assist the nurse, a picture of the resident appears on the resident’s MAR or eMAR. If a nurse is not sure of a resident’s identity, he or she will check with the individual or another staff member who is more familiar with the resident.

Along with ensuring that the right resident is being given the medication, the nurse must make sure the resident is given the right medication at the right time. Some residents know the medications they are on, the times they are to get them, and whether they are receiving the right medications. Many others, however, do not.

Because prescribed daily medications are usually given with breakfast, the most intensive medication pass in LTC homes is the morning pass. Lunchtime and dinnertime passes are also significant. Smaller medication passes may take place at other times in the morning, afternoon, and evening. As noted earlier, some medications are also prescribed to be given “as needed” and thus may be given at times other than during a medication pass.

The medication carts in which many of the medications are stored – such as the strip packages, narcotics, and insulin pens in use – are movable. As the nurse moves from resident to resident within an area of the home, the cart moves with the nurse. Each time the nurse leaves the cart to administer a medication to a resident, the cart must be locked. It must never be left unlocked.

One RN at Caressant Care (Woodstock) described her typical morning medication pass, underscoring the demands of the task:

- Almost all the residents for whom she was responsible were on medications.

- Those on medications would, on average, be on more than five medications.
- The morning medication pass was the heaviest pass, with an average of five to 10 medications being given per resident.
- During the morning medication pass, she would give between 400 and 600 medications, most of which were non-controlled medications.
- She attempted to give the residents their medications as they entered the dining room for breakfast.
- During mealtime medication passes, as the registered staff member, she had other tasks such as supervising textures (e.g., checking that residents are capable of chewing and swallowing their food) and supervising PSWs.

Given the environment in LTC homes, it is virtually inevitable that nurses are interrupted during the medication pass. Witnesses at the public hearings said there is no such thing as an “uninterrupted pass.” Nurses are interrupted during the pass to answer family questions, deal with emergencies such as falls or choking episodes, and respond to calls.

V. Handling of Insulin

Wettlaufer’s weapon of choice was injectable insulin. She chose it because, as she told Commission counsel, “it wasn’t counted, and because I knew that it was something that could kill people.” I heard evidence from staff at Caressant Care (Woodstock), Meadow Park (London), and Telfer Place about how each home handled insulin. In general, they followed similar processes in its ordering, storage, administration, and disposal. These processes are discussed next. To the extent there were any differences among the homes on these matters, I identify those differences in the chapters dedicated to each of those homes.

A. Overview

Oral hypoglycemic medications are used to manage insulin for people who are unable to produce sufficient insulin or have become insulin resistant. For individuals who are unable to produce insulin, insulin is given by injection. At the time of the Offences, the delivery system for the administration of insulin had evolved from that of a vial and syringe to the use of an insulin “pen” – a device into which a cartridge of insulin is inserted. This portable device simplifies insulin administration because the syringe and needle are

integrated into the pen's design. The pen includes a dial that makes it easier to correctly measure the desired dose and verify that the dose has been prepared. These features make the use of insulin pens popular in institutional settings. Currently, the pens used in many LTC homes are disposable.

At the time of the Offences, however, most LTC homes used the pen and cartridge system. The pens were not disposable. Each pen was labelled with the resident's name. A pen would be reordered if it malfunctioned or was lost, but otherwise it remained in use. The cartridges containing the insulin were ordered when a resident needing insulin first entered the home and, thereafter, when his or her supply was getting low. The ordering of insulin cartridges was the same as for other non-controlled drugs: either manually, through a fax to the pharmacy, or electronically.

Cartridges of insulin come in a box. Typically, each box contains five cartridges. The box is labelled by the pharmacy with the resident's name, date of birth, and prescribing doctor's name, as well as with the type of insulin, dosage frequency, date the prescription was filled, and prescription number. The box also has an expiry date.

In contrast to the boxes in which the cartridges come, the cartridges themselves are not large enough to accommodate a label identifying the resident. Therefore, the cartridges show the name of the drug they contain, but not the name of the resident.

Each cartridge contains 3 ml of insulin. There are 100 units in each millilitre and, therefore, 300 units in each cartridge. Residents may need five, 10, or 50 units (or another amount), depending on the doctor's orders. Some residents have set doctor's orders for the amount and type (or types) of insulin they are to receive, as well as for injection times. For others, there are orders for a "sliding scale" of insulin, meaning that the amount to be given depends on the resident's blood sugar level at the time of administration. For those receiving a sliding scale of insulin, there would be a separate MAR or eMAR to record the blood sugar and the number of units that had been given.

No matter what type of insulin is prescribed, the amounts to be administered are so small that they cannot be determined simply by "eyeballing" them. That is why each pen has a dial – it allows for accuracy in the number of units to be administered.

B. Storage of Insulin – Cartridges

Once received from the pharmacy, insulin cartridges must be stored in a refrigerator. One cartridge is used at a time until it is depleted. However, once inserted into the pen, the cartridge must be used within 28 days.

Under this system, a significant amount of insulin is on hand in an LTC home. If just five residents in one wing of an LTC home are on two types of insulin, at any given time there would be 10 open boxes of insulin cartridges in the refrigerator in the medication room, with as many as four cartridges remaining in each box (assuming one cartridge is in use in each pen).

C. Administration of Insulin

When insulin needs to be administered, the nurse first inserts a needle into the rubber-tipped end of the pen. Then the nurse “primes” the pen – making sure the end of the needle forms a drop so that the nurse knows no air is in either the needle or the tunnel going into it. This process necessarily wastes a tiny bit of insulin. The amount of insulin used to prime the pen varies.

After the needle is primed, the nurse dials up the insulin to the prescribed dosage. As noted, the nurse injects the insulin once he or she has confirmed the “rights” – the right resident, the right time for the injection, the right insulin, and the right dose, and so on.

Once the insulin is injected into the resident, the dial on the pen returns to zero. After a dose has been administered, a second person has no way of knowing how many units had been injected.

To finish the process, the nurse signs off the MAR, or electronically confirms in the eMAR, that the insulin has been administered.

D. ISMP Standards and the Independent Double-Check

The Institute for Safe Manufacturing Practices (ISMP) has classified insulin as a high-alert medication. Julie Greenall, the registered pharmacist who gave expert evidence at the public hearings, explained that a high-alert medication is more likely to cause harm if used incorrectly.⁹⁸ Put another way, high-alert

⁹⁸ Expert Report of Julie Greenall, p 10.

medications are not more likely to be administered incorrectly than other medications but, rather, if they are administered incorrectly, there is a higher risk of causing significant harm to the recipient.

Incorrectly used, insulin can lead to hypoglycemia, which can lead to a loss of consciousness and even death. A fuller description of this matter is found in Chapter 2. The ISMP publishes bulletins regarding high-alert medications. As Ms. Greenall explained, these bulletins are meant to:

increase awareness among people who work in long-term care that these are medications that they basically need to be more careful of, that there are additional safeguards ... recommended with them and it's all with the intent of reducing the likelihood of harm to residents.

According to the ISMP, hospitals and some LTC homes have introduced additional precautions for high-alert medications, such as limiting access through reduced supply on-site or by implementing independent manual or electronic double-checking. Different methods are used for completing an independent double-check. A check by one nurse would require a second nurse to look at the type of insulin being given, who it is being given to, and the number of units to be given, as identified on the MAR or eMAR. The second nurse would check that the correct dose has been dialled up. During the years in which the Offences were committed, it was not the practice of the homes to have a second nurse check that the correct dosage of insulin had been dialled up for the resident. In fact, witnesses who testified at the Inquiry indicated that such a practice would be impractical. In any event, it is unlikely that an independent double-check would have prevented the Offences. Nothing would have prevented Wettlaufer from increasing the dosage after she walked away from the nurse who had checked the dose or from giving the insulin to someone for whom it was not prescribed.

A second method of independent double-checking relies on an electronic barcoding system, where the medication record, the resident, and the medication to be given all have a barcode. The nurse administering the medication, such as insulin, scans the barcodes to ensure they all match. Although barcoding can reduce medication errors by assessing whether the nurse is about to give the right type of insulin – or any other drug – to the right resident, the barcoding system cannot assess that *the correct dosage* of insulin has been dialled up in the pen or administered.

E. Disposal of Insulin Cartridges

Sometimes a pen contains a cartridge that does not have sufficient insulin to provide a resident with the full required dose. For example, a resident may require 30 units at breakfast, but only 20 units remain in the cartridge. In such a situation, the dial would stop at 20 because there would be no more insulin in the cartridge. I heard testimony that while it is possible to dial up the remaining 20 units and administer them to the resident, then insert a new cartridge, dial up the remaining 10 units, and give those to the resident, this is not the general practice because it subjects the resident to two injections. The general practice is to take out the old cartridge and discard it, then insert a new cartridge and give the resident his or her full dose.

The methods of disposing of empty or near-empty insulin cartridges at Caressant Care (Woodstock), Meadow Park (London), and Telfer Place varied among staff members. Some disposed of empty, or near empty, cartridges in the sharps container – a hard plastic receptacle used for the disposal of hypodermic needles and other sharp medical instruments. Once a cartridge is disposed of in a sharps container, it is difficult to retrieve it. If someone tried to do so, it is likely that he or she would be injured or would damage the container. Others put the cartridges in the non-controlled drug destruction bin or bucket. That container is kept in the locked medication room and used for the disposal of all non-controlled medications.

Under section 136 of the Regulation, licensees must have a written policy in the home for the ongoing identification, destruction, and disposal of:

- all expired drugs;
- all drugs with illegible labels;
- all drugs that are in containers that do not meet the requirements for marking containers specified under section 156 of the *Drug and Pharmacies Regulation Act*; and
- all drugs of a resident where the use of the drugs has been discontinued or the resident has died or been discharged (or the prescriber orders the use of the drug be discontinued).⁹⁹

⁹⁹ The Ontario Pharmacists Association (OPA), *Best Practice Guidelines for Long-Term Care*, specifies that the best practice guidelines for section 126 of the Regulation require there be a written drug destruction and disposal policy that provides for the ongoing identification, destruction and disposal of a number of different medications, including “excess or surplus medication surplus.”

The drug destruction and disposal policy must provide for the safe and secure storage of the drugs until destruction occurs. Non-controlled substances (such as insulin) must be destroyed by two staff members appointed by the DON for that purpose, one of whom must be a member of the registered nursing staff.¹⁰⁰ A drug is considered destroyed when “it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.”¹⁰¹ The licensee must also ensure that the drug destruction and disposal system is audited at least annually and that the procedures are both effective and being followed.¹⁰²

F. Tracking Insulin Use

On the evidence at the public hearings, it appears that no record is maintained showing when a nurse removes a new cartridge from the refrigerator in the locked medication room. Similarly, no record is kept of when, or where, a nurse disposes of the insulin cartridge. Further, no record is kept of the amount of insulin left in the cartridge at the time it is thrown away.

As a result, the only record of how much insulin is used for a resident is the MAR or eMAR. Theoretically, the MAR or eMAR can be reviewed to calculate the amount of insulin a resident received in a month. However, the amount recorded as being received would not necessarily equal the amount of insulin that had been used. Small amounts of insulin are lost when the nurse primes the needle, and there is wastage when a cartridge is thrown away because it does not contain enough insulin for the resident’s correct dose. Tracking quantities of insulin would be very time-consuming and is likely to trigger alarms only if a significant quantity of insulin for a resident could not be accounted for.

VI. Handling of Narcotics

In Canada, certain drugs have been designated as controlled substances that require additional controls to prevent misuse and diversion. Narcotics are among these controlled substances. In this section, I explore how narcotics are handled in LTC homes – the processes by which they are ordered, delivered, administered, and stored. I also discuss the internal controls used to prevent a person from diverting narcotics away from their intended use.

¹⁰⁰ O Reg 79/10, s 136(2)–(3).

¹⁰¹ O Reg 79/10, s 136(6).

¹⁰² O Reg 79/10, s 136(5).

A. Ordering and Delivery of Narcotics

Within the LTC home, controlled and non-controlled medications are ordered in the same way. If an LTC home tries to order a refill of a controlled medication too early, the pharmacy service provider will likely flag the order. For example, if a home ordered a refill on a PRN card that had 31 doses in it and then tried to order another PRN for the same resident a week later, the pharmacy's computer system would catch this attempt. In such a situation, the pharmacy would contact the home to ensure it had received the first PRN card or that there had not been another error. Such a scenario played out in Meadow Park (London) in the fall of 2014,¹⁰³ as discussed in Chapters 6 and 10.

Although controlled and non-controlled drugs are packaged separately, the pharmacy service provider generally delivers them to the LTC homes at the same time.

B. Administration of Narcotics

Within LTC homes, extra steps must be taken when administering controlled drugs to ensure that each dose of medication is accounted for. Other than that, controlled and non-controlled medications are administered in the same way.

After verifying the controlled drug on the MAR or eMAR, the nurse administers the medication to the resident using the "rights" referred to earlier in this chapter. Then, after administering the medication, the nurse records on a narcotic and controlled drug count sheet (count sheet) the date and time the medication was given, along with the quantity given and the quantity remaining.¹⁰⁴ The nurse must also document the administration of the medication on the MAR or eMAR. This documentation must be completed before the nurse moves on to the next resident.

Sometimes, the pharmacy consultant catches a discrepancy or error in the documentation through an audit of the resident's chart or the narcotic records, or at the quarterly medication review. For example, a nurse might have signed the MAR but forgotten to sign the count sheet. In such instances, the pharmacy service provider would report the discrepancy or error to the DON for follow-up purposes. The pharmacy service provider might also

¹⁰³ The mistake was made in late September but not noticed until the home ordered again in October.

¹⁰⁴ Sometimes called a controlled substance administration record, a monitored medication count, or something similar.

suggest holding an education session on documentation, but the decision to hold such a session lies with the home.

If the resident was prescribed a regular dose and a PRN dose, there would be two count sheets – one for each prescription. The two prescriptions are not meant to be interchangeable; the PRN is always meant to be kept as a PRN medication. For example, it is not advisable to substitute a regular dose with a PRN dose. A separate prescription exists for each, and each must be administered as it was prescribed.

C. Controlled Drug Storage

Section 129 of the Regulation requires licensees to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or in a separate locked area within the locked medication cart.¹⁰⁵ I heard that, generally, controlled substances were locked in a separate bin within the locked medication cart. There are separate keys to the medication room, the medication cart, and the locked bin.

D. Controlled Drug Counts

Controlled drug counts are done at the end of each shift by two nurses – the off-going nurse and the oncoming one. Licensees must also ensure that a monthly audit is conducted of the daily controlled medication count sheets and that immediate action is taken if any discrepancies are discovered.¹⁰⁶

E. Disposal and Destruction of Controlled Medications

The Regulation to the LTCHA imposes very strict rules for the disposal and destruction of narcotics. The licensee is required to ensure the home has a written policy for dealing with drug destruction and disposal. In the case of narcotics requiring destruction, such as when a resident passes away or his or her prescription is changed, the licensee's drug destruction and disposal policy requires that narcotics be stored in a double-locked storage area of the home, separate from any controlled drugs that could be administered to residents, until the drug is destroyed and disposed of. Controlled substances are to be destroyed by a team, acting together, made up of a physician or pharmacist as well as the member of the registered nursing staff appointed

¹⁰⁵ O Reg 79/10, s 129(1).

¹⁰⁶ O Reg 79/10, s 130(3).

for that purpose by the director of nursing. The team is required to include detailed records in the drug record about the drugs destroyed.¹⁰⁷

I heard evidence that the homes keep a controlled medication destruction bin (sometimes referred to as a box) in the locked medication room. Usually, an LTC home has just one controlled medication destruction bin, which is attached to the floor.

When a resident's narcotic medication use is discontinued, the PRN (as needed) and regular dose narcotic cards are immediately removed from the medication cart, along with the resident's narcotic count sheet. On the count sheet, the nurse circles the amount remaining, writes the number of pills remaining, and draws an X across the bottom portion of the sheet where it has not yet been recorded that the narcotic was administered. This information must be signed off by a second nurse, who checks the information against the MAR or eMAR.

The card and count sheet are wrapped together and dropped into the controlled medication destruction bin. The process is the same for cards that are empty because their contents were properly delivered to residents.

Depending on the home, either both the director of nursing and the pharmacy service provider each have a key to the controlled medication destruction bin, or only the director of nursing has the key. I heard evidence that, where the pharmacy service provider has a key, the box is sometimes more frequently emptied because the pharmacy service provider does not have to rely on the DON for access. In such circumstances, discrepancies or errors may be spotted earlier and addressed more contemporaneously.

When the pharmacist empties the controlled medication destruction bin, he or she is accompanied by a member of the registered nursing staff, appointed by the DON.¹⁰⁸ Together, they empty the bin, reconcile all the medication inside the bin against the count sheets, and then destroy or denature the controlled drugs. As one witness described the process, the narcotic tablets or capsules are "punched out," ampoules are broken, patches (i.e., fentanyl) are cut, and then the various elements are mashed with soap and water in a plastic container to render them unusable. The substance is then put in a separate, lined container for pickup by a waste disposal contractor, arranged for by the home. Pickup times vary from home to home.

¹⁰⁷ O Reg 79/10, s 136(2)–(4).

¹⁰⁸ O Reg 79/10, s 136(3), requires that controlled substances must be destroyed by a team consisting of both the member of the registered nursing staff appointed by the director of nursing and a physician or pharmacist.

VII. Medication Incidents and the Philosophy of a Positive Safety Culture

A. Medication Incidents

Medication incidents – or errors¹⁰⁹ – can, and do, occur in all healthcare environments. Well-meaning, excellent nurses can, and do, make mistakes. Three factors contribute to medication incidents in LTC homes. First, the number of residents with multiple chronic health conditions in LTC continues to rise. As noted, many residents may be prescribed 10 or more different types of medication, meaning that more and more medications must be administered several times a day, within a fixed time window. Second, there is a high resident-to-nurse ratio. We heard from witnesses at the public hearings that, on a single medication pass, a nurse may administer hundreds of medications. Third, environmental factors contribute to an increased risk of errors. For example, nurses are frequently interrupted during medication passes to deal with such things as a resident who has fallen. Also, we must remember that an LTC home is the residents' home. Therefore, when the morning medication pass takes place, residents are being readied for the day and going to breakfast. As described above, unlike a hospital setting where a patient is typically in his or her bed and available to have medication administered, in LTC the nurse may need to look for the resident in different locations and may have to administer the medications in various places, such as the dining room.

No matter the healthcare setting, it is always important to identify medication errors as quickly as possible after they have been made so that any harm, or the potential for harm, is minimized. However, it is not sufficient to identify a medication error and take steps to rectify it, if necessary. It is also crucial that medication errors are promptly reported to management so that the errors can be investigated and analyzed. It is through these steps that the "root cause" of the error can be identified and addressed. Typically, the root cause will be a process problem, an environmental issue, or human error. Each requires a different response to ensure the error is not repeated. As I explain below, the need for immediate reporting underpins the prevailing philosophy of a positive safety culture.

¹⁰⁹ "Medication incident" is recognized as an alternative term to "medication error": Expert Report of Julie Greenall, p 31. In this Report, I treat the two terms as synonymous.

1. What Is a Medication Incident?

Section 1 of the Regulation defines a medication incident as a:

preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes:

- (a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
- (b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

The College of Nurses of Ontario describes a medication error in its Practice Standard regarding medication as:

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.¹¹⁰

A near miss occurs when a nurse catches an error before it reaches the resident. The thought process accompanying a near miss is along the lines of, "I almost gave this to the resident, but I realized it was wrong before I administered it." Reporting near misses is important because, even though the resident was not harmed and there was no risk of harm, there may be lessons to be learned, and shared, from doing so.

The following are examples of some types of medication incidents that witnesses described during the public hearings:

- forgetting to give a medication;
- giving too much or too little of a medication;
- giving a medication to the wrong person;
- giving a medication at the wrong time;
- giving medication doses too close to one another;
- giving the wrong medication; and
- giving a person medication prescribed for another, even if it was the right medication to give.

¹¹⁰ *Practice Standard: Medication*, College of Nurses of Ontario (2017), p 7.

As the above list demonstrates, a wide breadth of matters falls within the meaning of a medication incident. Medication incidents can occur at any point in the medication management process, from the time a medication is prescribed to the period after it is administered. The list also serves to underscore that a medication incident does not depend on a resident suffering harm. All medication incidents, regardless of severity and regardless of whether they have led to harm, must be reported. Anything that has “the capacity to cause harm” is a reportable incident.¹¹¹

2. To Whom Are Medication Incidents Reported?

The incident-reporting process starts in the LTC home. During the years in which Wettlaufer committed the Offences, the internal process for reporting medication incidents within each home she worked was generally similar, beginning with the completion of an incident report. Today, some homes continue to use manual reports while others use electronic reporting.

As discussed above, under the current regulatory regime, licensees must ensure that *every* medication incident and *every* adverse drug reaction involving a resident is documented and a record kept of the immediate actions taken to assess and maintain the resident’s health.¹¹²

The licensee must also ensure that all medication incidents, including those of a nursing origin (e.g., errors in documentation) and those of a pharmaceutical origin (e.g., an error in labelling), are reported to the resident, his or her substitute decision-maker (if there is one), the DON, the medical director, the prescriber of the drug, the resident’s attending physician or nurse practitioner, and the pharmacy service provider.¹¹³ Every medication incident and adverse drug reaction must be reviewed and analyzed,¹¹⁴ a process that requires an investigation – generally conducted, as I heard, by the director of nursing and administrator. On the evidence at the public hearings, it appears that administrators and directors of nursing receive little, if any, training on how to effectively conduct medication incident investigations.

¹¹¹ Testimony of Julie Greenall, Transcript, Sept. 13, 2018, p 8296.

¹¹² O Reg 79/10, s 135(1)(a).

¹¹³ O Reg 79/10, s 135(1)(b).

¹¹⁴ O Reg 79/10, s 135(2).

In some cases, a medication incident can be a reportable critical incident under section 107 of the Regulation. In particular, licensees must submit a report to the Director under the LTCHA where a medication incident or adverse drug reaction requires a resident to be taken to hospital or where there are missing or unaccounted for controlled substances.¹¹⁵

B. A Positive Safety Culture in LTC Homes

A positive safety culture is best explained as one in which the entire team focuses primarily on the safety of the people they are looking after. Such a culture is meant to promote the open discussion of incidents and strategies for resident safety by using a system-wide focus rather than treating errors as an assessment of personal competence. Incident reports are tracked for the purpose of informing the system – not accumulated against individuals like demerit points.

A positive safety culture translates into a robust medication incident-reporting system in which any kind of unusual occurrence – regardless of whether it reached the level of harming a resident – is reported. As well, it involves regular discussions about safety, principles of safety, and strategies to reduce the likelihood of untoward events. Such a system represents an entire philosophy of how an organization operates.

Instead of focusing on the actions of the individual who made the medication error, a positive safety culture considers the steps in the process or the medication system as a whole, with an eye to improving it so that the error does not occur again. One director of care explained that, by removing discipline from medication incidents, nurses are comfortable reporting themselves and others. Corrections, if necessary, can be made more quickly.

Throughout this chapter I have referred to the vulnerability of the residents in LTC. Nowhere is this vulnerability more obvious than in the handling of medication. Although there are residents in LTC who understand what medications they are being given, and what those medications look like, a significant portion of the resident population lacks that understanding. Those individuals cannot report that they have been given the wrong medication, or that they received their medication at the wrong time. They must rely on the observation skills of all staff to detect that something is wrong.

¹¹⁵ O Reg 79/10, s 107(3).

This means there is a strong need for self-reporting in LTC. If a nurse realizes he or she has made a medication error, we would all want that nurse to disclose the error as soon as possible, and see any potential harm promptly addressed. As well, we would want the incident reported and analyzed so that changes can be implemented to prevent similar incidents from occurring in the future. A positive safety culture is key to achieving early and complete reporting.

C. Use of Discipline in Response to Medication Errors

A positive safety culture means that LTC homes generally follow a non-disciplinary approach to reported medication errors. However, a positive safety culture does not mean that nurses are not accountable for their work performance. Nurses, like other healthcare providers, should be held accountable for behaviours that “any healthcare provider would agree are a completely inappropriate way to provide care.”¹¹⁶

Consequently, there is an intersection of the positive safety culture with the disciplinary process. In a home with a positive safety culture, discipline may be imposed for medication incidents involving reckless behaviour in the administration of medication that resulted in harm. Another example might be where a nurse continues to make repeated errors of the same sort, despite having been given counselling, training, and education on the matter.

As you will see in later chapters, Wettlaufer made many medication errors in her career as an RN in LTC. Those chapters also illustrate the challenge that homes face in cultivating a positive safety culture while having to transition to disciplinary action, from time to time.

¹¹⁶ Testimony of Julie Greenall, Transcript, Sept. 13, 2018, p 8294.

RECOMMENDATIONS

Many chapters in this Report contain the information that is the basis for recommendations directed at licensees and long-term care homes. For the convenience of the licensees and homes, the majority of those recommendations are set out at the end of Chapter 4. Please note, however, that the recommendations at the end of Chapter 17 are also directed at licensees and homes.

Recommendation 3: Licensees must provide management and registered staff with the following training:

- a. Administrators and directors of nursing should receive training:
 - on best practices in the screening, hiring, and management and discipline of registered staff;
 - on conducting workplace investigations;
 - as recommended elsewhere in this Report, such training to be provided by the Ministry of Health and Long-Term Care (Ministry), the College of Nurses of Ontario (College), and the Office of the Chief Coroner / Ontario Forensic Pathology Service; and
 - on their reporting obligations to the Ministry and the College.
- b. Registered staff must receive comprehensive ongoing training on:
 - the requirements of the *Long-Term Care Homes Act, 2007* (LTCHA), relating to the prevention of resident abuse and neglect, and their reporting obligations under section 24(1) of the LTCHA;
 - the home's medication administration system, and the identification and reporting of medication incidents; and
 - the redesigned Institutional Patient Death Record, once it is created, such training to be provided by the Office of the Chief Coroner / Ontario Forensic Pathology Service.

Rationale for Recommendation 3

- Evidence at the public hearings indicates that management at long-term care (LTC) homes need additional training to effectively hire, oversee, and respond to staff performance issues.
- The evidence also shows that management in LTC homes needs formal training on how to conduct a workplace investigation. In the absence of such training, investigations may be conducted inconsistently, may miss important information, and may arrive at erroneous conclusions.
- A management team that is skilled in hiring and managing staff, and that responds consistently and appropriately to issues arising in the LTC home, will increase resident safety, improve staff morale, and inspire confidence in residents and their families.
- The reporting requirements under the *Long-Term Care Homes Act, 2007* (LTCHA), and the *Regulated Health Professions Act* are not well understood by those in management positions in LTC homes. Both the Ministry of Health and Long-Term Care (Ministry) and the College of Nurses of Ontario depend on the homes' reporting as required by the legislation. More and better education is the key to improved reporting.
- The evidence at the public hearings showed that registered staff did not appreciate that they had a mandatory obligation, under the LTCHA, to report suspected or actual abuse or neglect of residents to the Director (a position created by the LTCHA and filled by a person in the Ministry) and not simply to management.
- The evidence also showed that registered staff need additional training on the home's medication administration system and how to identify and report medication incidents.

Recommendation 4: Licensees should amend their contracts with medical directors to require them to complete:

- the training required under section 76(7) of the *Long-Term Care Homes Act, 2007*; and
- the Ontario Long Term Care Clinicians' Medical Director course within two years of assuming the role of medical director.

Recommendation 5: To ensure management and registered staff can regularly attend training, licensees must pay for the costs of the training, cover staff salaries during the training, and backfill shifts as necessary.

Rationale for Recommendations 4–5

- Evidence at the public hearings shows that those working in long-term care homes often cannot take the training that is provided because they are expected to do it either at the same time as they perform their regular duties or on their own time without compensation. Licensees must ensure that all employees have true opportunities to take training. To support this objective, elsewhere in this Report, I recommend that the Ministry of Health and Long-Term Care create a new, permanent funding envelope for the education, training, and staff development of those who work in long-term care homes.
- Investing in training will enhance the skills of the workforce, enhance resident safety, and improve morale.

Recommendation 6: Licensees should adopt a hiring / screening process that includes robust reference checking, background checks when there are gaps in a resumé or if the candidate was terminated from previous employment, and close supervision of the candidate during the probationary period.

Rationale for Recommendation 6

- Although Wettlaufer admitted on her application and in the hiring process at Meadow Park (London) that Caressant Care (Woodstock) had terminated her employment, her version of events did not tell the whole story. The referees she listed from Caressant Care (Woodstock) were not at a sufficiently high level in management to be aware of the seriousness of the medication error that precipitated the termination of her employment, nor did they understand the nature and extent of her disciplinary record at Caressant Care (Woodstock).

Recommendation 7: Licensees should require directors of nursing to conduct unannounced spot checks on evening and night shifts, including weekends.

Rationale for Recommendation 7

- Evidence at the public hearings shows that management was rarely onsite for the evening, night, and weekend shifts. Wettlaufer committed the Offences at those times.
- An individual intent on harming a resident may be deterred if there is greater supervision on the shift or the possibility of an unannounced spot check by the director of nursing.

Recommendation 8: Licensees must maintain a complete discipline history for each employee so management can easily review it when making discipline decisions.

Rationale for Recommendation 8

- Maintaining complete and accurate records will assist licensees in making informed discipline decisions. The records will also assist the licensee in reporting to the College of Nurses of Ontario, if that becomes necessary.

Recommendation 9: Management in homes must ensure staff submit the Institutional Patient Death Record electronically to the Office of the Chief Coroner / Ontario Forensic Pathology Service.

Rationale for Recommendation 9

- As I explain in Chapter 14, the Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) is not able to aggregate Institutional Patient Death Record data that are submitted by fax. This results in an incomplete data set and prevents the OCC/OFPS from tracking trends, spikes, and clusters of resident deaths in long-term care homes.

Recommendation 3: Licensees should take reasonable steps to limit the supply of insulin in long-term care homes.

Rationale for Recommendation 10

- Insulin is a high-alert medication, which means there is a significant likelihood of its causing harm if used incorrectly. Limiting the supply of insulin helps reduce the chances of diversion and misuse.

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I. Introduction

Caressant Care Nursing Home in Woodstock, Ontario, is a 163-bed for-profit long-term care (LTC) home – one of 15 LTC homes operated by Caressant Care Nursing and Retirement Homes Limited (corporate Caressant Care). Caressant Care (Woodstock) is attached to a retirement home; however, for the purposes of this Report, all references to Caressant Care (Woodstock) are to the LTC residence alone. Caressant Care (Woodstock) was the home where Wettlaufer worked as a registered nurse (RN) for the longest period (from June 2007 through March 2014). It was the first of three LTC homes in which she committed the Offences – 11 in all – including, tragically, the murders of seven residents, the aggravated assault of two others, and the attempted murder of two more.

I begin this chapter by setting out the processes that were in place during the period Wettlaufer worked at Caressant Care (Woodstock) for the hiring, orientation, and training of nursing staff, and also for performance management and discipline. I then consider the medication management system, with particular attention to the home's handling of insulin and narcotics as well as its incident reporting system for medication errors. Because so many of Wettlaufer's victims passed away while at Caressant Care (Woodstock), I also review the process the home followed when a resident died.

Next, I turn to the home's hiring and orientation of Wettlaufer in the summer of 2007. I review how Wettlaufer committed the 11 Offences in that home, drawing on both the evidence from the criminal proceedings and the records from the home. In addition to describing the Offences, I examine the circumstances that contributed to Wettlaufer's ability to avoid detection.

Wettlaufer's employment at Caressant Care (Woodstock) was terminated in March 2014. Under the circumstances of this termination, Caressant Care (Woodstock) had a mandatory reporting obligation to the College of Nurses of Ontario (College), and I next turn to the termination report that Caressant Care (Woodstock) filed in connection with this obligation. However, through the Ontario Nurses' Association (ONA), Wettlaufer grieved her termination. When the grievance was ultimately settled, the terms of the settlement required corporate Caressant Care to provide a letter of reference for her. These matters are the subject of the penultimate section in this chapter.

In the fall of 2016, Wettlaufer confessed to her wrongdoing. Once the Offences became known, the Ministry of Health and Long-Term Care (Ministry) conducted inspections in all the homes in which the Offences had been committed. This chapter concludes with a brief description of the Ministry inspection at Caressant Care (Woodstock). I also make passing reference to relevant findings from that inspection throughout this chapter. I do not, however, review the inspection or the findings in detail because they are covered in full in Chapter 11.

II. The Home

A. Key Physical Aspects

In 2007, when Wettlaufer was hired, Caressant Care (Woodstock) was divided into two sections:

- Section A, consisting of 64 beds, 32 on each of Levels 1 and 2; and
- Section B, consisting of 99 beds in three wings – North, South, and East.

In Section A, there was one nursing station on Level 1 and one on Level 2. Each level had a locked medication room containing a medication cart, a treatment cart, and fridges. Section B had one nursing station, a locked medication room, and a locked treatment room. Inside the locked treatment room were the fridges that stored the vaccines and medications, such as insulin, that required refrigeration.

The registered staff member in charge of Section B, and each of Level 1 and Level 2 in Section A, had master keys to all medication rooms. Thus, in case of emergency, a nurse with the key to the Level 1 medication room could also access the medication rooms on Level 2 and Section B.¹

The medication and treatment rooms were supposed to be kept locked when the nurse was not in the room. None had cameras in them. The doors to the Level 1 and Level 2 medication rooms had glass panes in them, but the door to the Section B medication room and the treatment room did not.

¹ As of 2017, the registered staff members in charge of Section B and Levels 1 and 2 of Section A are given a key only to the medication room in their respective area. For the purpose of auditing, the director of nursing and the assistant director of nursing have a master key to all the medication rooms.

B. Key Home Personnel

The administrator was the most senior member of management at Caressant Care (Woodstock). When Wettlaufer began working there in 2007, Bonnie Hughes was the administrator. Brenda Van Quaethem succeeded her in 2009 and continued to serve in that role until she retired in 2016. She was not a nurse but had previously worked as a nurses' aide. As the administrator, she was responsible for the overall operation and administration of the home – including human resources; addressing staffing issues and concerns; attending Professional Advisory Committee (PAC) meetings;² and liaising with the Ministry, the Ministry of Labour, the Community Care Access Centre (CCAC), and the Local Health Integration Network (LHIN).³

The director of nursing, Helen Crombez, reported to the administrator. Corporate Caressant Care initially hired her in 1983 to work as a full-time registered nurse at Caressant Care (Woodstock); within approximately five years, she became its director of nursing. She continued to hold that position until she retired in 2017. Among other things, her duties included hiring nursing staff; addressing resident complaints and family concerns; investigating and reporting critical incidents to the Ministry; responding to Ministry inspections; leading the PAC meetings; and ensuring the safe-keeping, administration, and proper disposal of medications.

Caressant Care (Woodstock) also had an assistant director of nursing who, among other things, was responsible for ensuring that staff received the orientation and training required under the governing legislation.

Dr. Richard Reddick, a local physician, was the medical director at Caressant Care (Woodstock) when Wettlaufer worked there. He served in that role for nearly 40 years.⁴ Dr. Reddick estimated that while Wettlaufer worked at

² The PAC brought together an interdisciplinary group, consisting of the administrator, director of nursing, assistant director of nursing, resident care coordinator, pharmacy consultant, public health nurse, and the medical director. The PAC met quarterly to discuss a broad range of issues specific to the home, including staffing changes, compliance visits, major incidents, and medication incidents.

³ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received royal assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC system, including Ontario Health.

⁴ Like other medical directors, Dr. Reddick had a contractual relationship with Caressant Care (Woodstock); he was not its employee.

Caessant Care (Woodstock), he was the physician for approximately 100 of its residents. During that period, he was also part of a physicians' on-call team that covered many of the LTC homes in the area, including Caessant Care (Woodstock). As the medical director for the home, he was also a member of the PAC, although he did not always attend the meetings.

Caessant Care (Woodstock)'s pharmacy service provider for the period 2007–14 was Medical Pharmacies Group Limited.

C. The Home's Nursing Levels

The *Nursing Homes Act*⁵ (NHA) and its regulations (Regulation 832) governed Caessant Care (Woodstock) until July 1, 2010, when the *Long-Term Care Homes Act, 2007* (LTCHA), and its regulations (Regulation) came into effect.⁶ Under Regulation 832, the home was required to have 24-hour nursing service, including "at least one registered nurse who is a member of the regular nursing staff of the home," on duty and present in the home at all times.⁷

In addition to this requirement, the Long-Term Care Home Service Accountability Agreement between Caessant Care (Woodstock) and the South West LHIN required it to comply with the standards and criteria set out in the *Long-Term Care Homes Program Manual* (Program Manual). The Program Manual obliged the home, among other things, to have an organized program of nursing services to meet residents' nursing and personal care needs – one that was consistent with the professional standards of the College. To meet these standards, Caessant Care (Woodstock) had, for example, to have a 24-hour staffing pattern that was "consistent with the care and safety needs of the residents."

The LTCHA and the Regulation did not significantly change these nursing or staffing obligations. It did, however, shift the onus of the obligations to the licensee, and it also shifted the focus to resident-centred care. For instance, it required licensees to promote continuity of care by minimizing the number of staff caring for each resident.⁸ As a result, Caessant Care (Woodstock) altered its staff-scheduling to dedicate particular staff members to each wing of the home.

⁵ RSO 1990, c N.7.

⁶ SO 2007, c 8; O Reg 79/10.

⁷ Reg 832, s 59.

⁸ O Reg 79/10, s 31(3).

Table 5.1 sets out the staffing levels for RNs and registered practical nurses (RPNs) at Caressant Care (Woodstock) in the years Wettlaufer worked at the home.

Table 5.1: Staffing Levels for RNs and RPNs at Caressant Care (Woodstock), 2007–13

SHIFT	SECTION B (99 RESIDENTS)	SECTION A, LEVEL 1 (32 RESIDENTS)	SECTION A, LEVEL 2 (32 RESIDENTS)
Days (07:00–15:00)	1 RN	1 RN	1 RN
	2 RPNs	No RPNs	No RPNs
Evenings (15:00–23:00)	1 RN	1 RN	
	1 RPN	1 RPN	
Nights (23:00–07:00)	1 RN	No RNs	
	No RPNs	1 RPN	

Source: Compiled by the Commission.

As Table 5.1 shows, there were fewer nurses on the evening and night shifts, meaning that those nurses were responsible for more residents than were the nurses who worked the day shifts. During the day, five registered staff worked in the two sections of the home. At night, there were only two: one RN and one RPN. The RN was the charge nurse on the shift and, as such, was responsible for overseeing the other staff, among other things. In practical terms, however, these RNs would not have been able to provide significant oversight because they also had a roster of residents to care for while on shift.

There was little oversight of the nursing staff on the evening and night shifts. The administrator's normal work hours overlapped with the evening shift by only a few hours, and neither the administrator nor the director of nursing would typically go into the home during the night shift. Ministry inspections almost never happened during the night shift. As a result, RNs working the night shift would not have anticipated oversight of their acts through unannounced visits.

In 2014, the number of RPNs on the day and evening shifts increased to three, but the number of RNs remained the same. The staffing levels of registered staff on the night shift did not change (see Table 5.2).

Table 5.2: Staffing Levels for RNs and RPNs at Caressant Care (Woodstock), 2014

SHIFT	SECTION B (99 RESIDENTS)	SECTION A, LEVEL 1 (32 RESIDENTS)	SECTION A, LEVEL 2 (32 RESIDENTS)
Days (07:00–15:00)	1 RN	1 RN	1 RN
	1 RPN	1 RPN	1 RPN
Evenings (15:00–23:00)	1 RN	1 RN	
	1 RPN	1 RPN	1 RPN
Nights (23:00–07:00)	1 RN	No RNs	
	No RPN	1 RPN	

Source: Compiled by the Commission.

Even with this change, there was still little to no oversight of the nursing staff working the night shift.

III. Hiring, Orientation, and Training of Nurses

When Wettlaufer was hired in 2007, the NHA stipulated no specific requirements for hiring nurses. The Program Manual, however, required all RNs and RPNs to have a “current certificate of competence with the College of Nurses.”

When the LTCHA came into effect in July 2010, it required LTC homes to conduct screening measures before a new staff member was hired, including a criminal record check, a vulnerable sector screen, and verifying that registered staff had current registration with the College.⁹

A. Hiring

As the director of nursing, Ms. Crombez was responsible for the hiring of nursing staff and personal support workers (PSWs). At the time that Wettlaufer was hired, Ms. Crombez’s hiring process included an interview, a reference check, and a College registration check. If hired, the new nurse would be on probation for a period of time, in accordance with the collective agreement between corporate Caressant Care and the ONA (Collective Agreement).

⁹ LTCHA, s 75; O Reg 79/10, ss 215 and 234.

Like other LTC homes, Caessant Care (Woodstock) consistently struggled to recruit and retain registered nurses. It would often hire and train them, only to have them leave soon after for better-paying jobs elsewhere. Where possible, the home took advantage of incentives offered by the Ministry, such as the Late Career Nursing Initiative.¹⁰ At times, the home also offered incentives of its own to recruit nurses, such as a monetary reward for staff members who recommended a new nurse. Nevertheless, the home's struggle to attract and retain registered nurses continued; many of them found the workload in long-term care too demanding and would move to hospital employment as soon as the opportunity arose.

B. Orientation

The regulations to the NHA required licensees to have in-service training for both staff orientation and continuing education.¹¹ The Program Manual stipulated that the program should include a general orientation and a department-specific orientation tailored to the responsibilities of the staff member's position. It also obliged the home to document the information it provided to new employees and to obtain the new employee's signature acknowledging receipt of that information.

At Caessant Care (Woodstock), new nurses received one day of general orientation, during which the nurse reviewed the home's policies and procedures as well as the regulatory requirements. When Wettlaufer was hired in June 2007, the home used a general orientation checklist for all employees. The topics covered included: the privacy and dignity of residents; procedures for dealing with accidents of employees and residents; professional development; and policies on abuse, discipline, and the use of alcohol and intoxicants. Both the instructor and the new nurse were required to initial each section of the general orientation that was completed, and the department head was required to review, sign, and date the checklist. At some point, Caessant Care (Woodstock) updated its orientation checklists to include more detailed requirements for registered staff, including topics related to pharmacy services processes; College standards; the LTCHA and the

¹⁰ This program provided funding to LTC homes to allow nurses 55 and over to spend a portion of their time in less physically demanding roles, thereby encouraging them to remain in the workforce longer.

¹¹ Reg 832, s 61.2.

Regulation; resident assessments; quarterly reviews; and the process to follow on the death of a resident.¹²

Following the day of general orientation, new nurses received orientation on the floor, the length of which varied depending on their level of experience. Their orientation generally occurred during the shift(s) they were hired to fill. If new nurses were hired to work all three shifts, then their floor orientation usually consisted of two days, two evenings, and two nights.

During orientation, new nurses began by watching the medication pass. They gradually began to give out medications and moved on to doing the entire medication pass, overseen by the RN or the RPN who was conducting the orientation.

C. Annual Training

The NHA regulatory regime required the licensee to ensure in-service training for continuing education for all staff of the home. The Program Manual specifically required the in-service education program to respond to the assessed learning needs of staff and to involve a minimum of 10 in-service programs annually, including quality of life issues facing residents; infection control practices; emergency procedures; and understanding residents with cognitive impairments and responding to disruptive behaviours. The Program Manual also suggested – but did not require – that staff be provided with an in-service program to address topics such as communication with and support for residents and their families; stress management; palliative care; medications and drug interactions; ethical issues; and dealing with conflicts.

When the LTCHA and the Regulation came into effect, they required mandatory ongoing training on a new range of issues, including the Residents' Bill of Rights; promotion of zero tolerance of abuse and neglect; complaint processes; whistle-blowing protection; and mandatory reporting.¹³

At Caressant Care (Woodstock), the assistant director of nursing was responsible for ensuring that staff completed the mandatory annual training. The home provided that training in different forms – at staff meetings, for instance, and, at times, through an “education fair,” where a variety of workstations enabled staff to read materials and answer questions.

¹² Ms. Crombez believed that a checklist was in use in 2007, but none could be located for Wettlaufer.

¹³ LTCHA, s 76; O Reg 79/10, ss 216, 219.

1. Mandatory Reporting of Abuse and Neglect

Section 25 of the NHA contained the following mandatory reporting requirement for suspected resident abuse or neglect:

A person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect shall forthwith report the suspicion and the information upon which it is based to the Director.

None of the key terms in section 25 were defined in the NHA or its regulations. The Program Manual provided examples of different types of resident abuse and neglect; the prevention of abuse; the actions to be taken when abuse was alleged, including notifying the family / representative, police, and the Ministry; and the resources available to assist an abused resident and the person responsible for perpetrating the abuse.

Under the Program Manual, the administrator (or designate) was also required to report “unusual occurrences” – defined as “an occurrence which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member, or to the safety and security of the facility, which requires action by staff.” Occurrences that posed an immediate risk to residents and involved intervention by an outside agency had to be reported immediately – for example, the abuse or assault of a resident in any form, including sexual assault and the wilful infliction of physical pain or injury.

Under the LTCHA, licensees are required to have a written policy to promote zero tolerance of abuse and neglect of residents and to ensure compliance with that policy. The policy must contain an explanation of the duty, under section 24 of the LTCHA, to report suspected abuse or neglect.¹⁴ Section 24(1) of the LTCHA provides:

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

¹⁴ LTCHA, s 20.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act, 2006, 2007*, c. 8, ss. 24(1), 195(2).

Like the NHA, the LTCHA does not define the term "reasonable grounds to suspect" or "improper or incompetent treatment." "Abuse" and "neglect" are both defined in the Regulation.¹⁵

2. Caressant Care's Policies on the Reporting of Abuse and Neglect

Corporate Caressant Care's policies on abuse, which were used in all its homes, were periodically updated over the years. Wettlaufer's training documents indicate that she received training on the policy that was in place in 2007. The Inquiry received a copy of the policy that took effect in August 2014 (Abuse and Neglect Policy). This document shows that corporate Caressant Care had adopted a policy of zero tolerance of abuse and neglect, as required by the LTCHA, with the following reporting process:

1. All cases of suspected or actual abuse are to be reported immediately in writing to the director of nursing or administrator. If no one from management is available, concerns are to be reported to the charge nurse, who will notify the member(s) of management on call. The written report must include the name of the resident or staff member who suffered the abuse, the date and time of the incident, where the incident occurred, the name of the person who committed the abuse, the names of any witnesses, the nature of the abuse, and any injuries that resulted.
2. The director of nursing who receives the notice of abuse must immediately notify the administrator that an investigation has been initiated. In the absence of management staff, the charge nurse who receives the notice of abuse must notify the management staff on call of the initiation of an investigation.
3. The administrator must notify corporate Caressant Care's Head Office of the investigation and take direction from it.
4. The director of nursing and/or administrator must provide a supportive environment for the victims, family, and employees, by allaying fears of reprisal and promoting open expression of concerns or questions.

¹⁵ O Reg 79/10, ss 2 and 5.

5. If a person has reasonable grounds to suspect that the situation falls into any of the mandatory reporting categories in section 24 of the LTCHA, that person must immediately report the suspicion and the information on which it is based to the Director. In addition, the administrator must immediately report to the Director any allegation of abuse or neglect of a resident that resulted in harm or a risk of harm.

Although the Abuse and Neglect Policy requires staff to report cases of suspected or actual abuse to the director of nursing or the administrator *and* to the Director under the LTCHA, the nurses' practice at Caressant Care (Woodstock) was to report the issue to the administrator, director of nursing, or, if after office hours, to the manager on call, who would then report it to the director of nursing and administrator. At the public hearings, health care aides and PSWs testified that they reported incidents to the nurse on the floor, who in turn reported the incidents to management. Staff testified that, based on the training they received, they understood that incidents of abuse and neglect *could* be reported directly to the Ministry, but they did not realize that they had a mandatory obligation to do so.

IV. Performance Management and Disciplinary Processes

A. Performance Appraisals

As director of nursing for Caressant Care (Woodstock), Ms. Crombez was responsible for assessing the performance of registered staff, and she attempted to complete annual performance appraisals for them. The home's performance appraisal form required both Ms. Crombez and the nurse being reviewed to rate the nurse's performance in various areas, such as clinical, organizational, interpersonal, communication, knowledge, and leadership skills. At the time of the review, they were also to decide on an "agreed rating" for the nurse. The ratings ranged from 1 to 4, with 1 being "poor," 2 being "provisional," 3 being "competent," and 4 being "commendable."

The performance appraisal process at Caressant Care (Woodstock) did not include a formal peer review component. Although Ms. Crombez informally sought input from nurses about their peers, she eventually phased this out of the appraisal process because the nurses were too busy and did not want to participate.

B. Progressive Discipline

The decision to discipline a staff member was usually made jointly by the administrator and the director of nursing. However, when incidents occurred, discipline was not typically their first response. Instead, Ms. Van Quaethem or Ms. Crombez brought the matter to the staff member's attention and provided counselling. Counselling was not considered discipline and could not be grieved (i.e., the subject of a formal complaint brought by the union on behalf of the employee).

When discipline was necessary, they adopted corporate Caressant Care's "progressive discipline" approach. Under this process, the staff member typically received a verbal warning for a first incident. For subsequent incidents of a similar nature, the response increased in severity, progressing from a written warning to a series of suspensions ranging from one to five days, and, eventually, could lead to termination. Corporate Caressant Care's policy on progressive discipline was that an employee could receive one or more verbal warnings and written warnings, a suspension without pay, and, ultimately, termination. A step in the progressive discipline ladder could be skipped, if warranted.

Ms. Van Quaethem and Ms. Crombez did not have the authority to impose all types of discipline. Given the financial implications, if the proposed discipline was a suspension or a termination, they had to notify corporate Caressant Care's head office and receive approval first.

1. Employees Were Encouraged to Come Forward

The witnesses who testified at the hearings described Ms. Crombez as being strict with her staff. They said that Ms. Van Quaethem and Ms. Crombez encouraged employees to come forward with their concerns and followed through by investigating those concerns. They asked staff members to write out what had happened, and, after their investigation, they administered discipline if they believed it was warranted.

2. Investigations into Incidents Involving a Nurse

Both Ms. Crombez and Ms. Van Quaethem generally investigated incidents involving the nursing staff. Ms. Van Quaethem testified that she may have received some general information about conducting investigations, but

neither she nor Ms. Crombez had formal training on how to investigate incidents, gather evidence, conduct interviews, document the investigation, or assess credibility.

When they received a complaint about a nurse, Ms. Crombez and Ms. Van Quaethem held a meeting with the nurse, who was entitled to have the home's ONA representative present. If the representative could not attend, another nurse staff member was asked to attend the meeting as a witness. During the meeting, management described the incident and gave the nurse the opportunity to explain, from his or her perspective, what had happened.

3. Determining the Appropriate Level of Discipline

Once Ms. Crombez and Ms. Van Quaethem understood factually what had occurred, they decided how to respond by considering the nature and type of the incident, whether the employee had previously been disciplined for that type of incident, the seriousness of the conduct, and the length of time that had elapsed between the incident and previous incidents of a similar nature.

Among the different types of incidents that were addressed – medication errors, absenteeism, performance, and conduct – they treated each type independently. For example, if a nurse had two incidents, the first relating to a medication error and the second to absenteeism, each one was treated separately. In other words, the nurse had a single incident of a medication error and a single incident of absenteeism. Typically, they responded to a first instance of each type of incident by offering counselling. They would progress to a more serious response only if the same type of incident reoccurred. Thus, a nurse's first medication error would typically result in counselling, even if the employee had been previously disciplined for absenteeism, poor conduct, or other performance issues. They based their approach to discipline on their understanding of the Collective Agreement with the ONA.

Both Ms. Crombez and Ms. Van Quaethem were concerned about the potential for a disciplinary decision to be grieved, and they considered this possibility when deciding on the appropriate disciplinary response to an incident. Sometimes they would repeat a step in the progressive discipline process to resolve a situation or avoid a grievance. They would also avoid skipping a step in the process because this response could be grieved. If a grievance was successful, the home could be forced to reinstate the employee and pay for any missed shifts (as, for example, due to a suspension).

4. The Discipline Meeting

After Ms. Crombez and Ms. Van Quaethem decided on the appropriate discipline, they held a meeting with the employee. At the disciplinary meeting, the ONA representative or a witness was again present and took minutes of the meeting. The employee was informed of the discipline being given and provided with a disciplinary action form or other form of notice, such as a letter, containing that information. A copy was also given to the ONA representative or witness.

5. Record-Keeping

During discipline meetings, either Ms. Van Quaethem or Ms. Crombez took notes while the other spoke. They attached those notes to the disciplinary action form, or other form of notice, and put the documents in the employee's file maintained by the home.

The ONA representative also kept records of these meetings. This representative maintained a locked filing cabinet in a locked room in one of the home's storage areas where the ONA tended to keep minutes of the meetings and copies of the disciplinary action form or other form of notice in the employee's file. If a witness attended the discipline meeting in place of the ONA representative, the witness typically gave the ONA representative the minutes of the meeting. However, that did not always happen.

Karen Routledge, a senior nurse at Caessant Care (Woodstock) who also served as the home's ONA representative at one time, testified that because of record-keeping gaps, she felt that she "didn't have all the pieces of the puzzle [regarding Wettlaufer] at any given time."

V. Medication Management

A. Medications

Nursing staff in LTC homes are responsible for most of the duties involving medication. Among other things, they are responsible for:

- reconciling and ordering a resident's medication upon admission to the home;
- receiving medications from the pharmacy service provider and stocking the medication carts;

- administering medications numerous times each shift to the residents in the unit in which the nurse is working;
- counting narcotics at the end of each shift;
- participating in quarterly medication reviews; and
- disposing of both controlled substances and non-controlled medications that residents no longer need.

As in other LTC homes, when residents entered Caressant Care (Woodstock), their medications were “reconciled” to ensure that the home had an accurate and complete list of their medications and the relevant directions for use. To this end, the home obtained a list of each resident’s medications from at least two sources, such as the resident (or the family) and the resident’s previous pharmacy. The nurse would set out details of the doctor’s admission orders on a pharmacy form and then provide the form to the home’s pharmacy service provider in order to obtain the resident’s medications.

Each resident’s medications were reviewed every quarter. In that review, the nurses checked the medications each resident was then receiving, signed off on the list, and gave it to the doctor for review. The pharmacist also reviewed the list of medications during the quarterly review.

The pharmacy service provider typically delivered a week’s supply of non-controlled medications for each resident during the evening shift. Oral solid medications were in strip packaging, as described in Chapter 17. Controlled medications, such as narcotics, were in blister cards, with single doses of 31 pills or tablets. When the home received the delivery, the medications were manually entered into the drug record book or, after the systems became electronic, scanned in by the night-shift nurse. If the medications could not be scanned in right away, the nurse locked them in the medication room, and, if narcotics, placed them in the medication cart until they were scanned in. Both the nurse and the pharmacy delivery person signed off on the delivery sheet to record that the medications had been delivered to the home.

Residents’ medications were kept in medication carts. The nurses were required to lock the cart each time they walked away, even when they left the cart only briefly to administer a medication. The carts were opened using a key, but were locked with the push of a button. The residents’ oral solid medication (in strip packaging) was contained in the top drawers of the carts. The strip packaging was placed in separate bins, labelled with the resident’s

name and room number. If there was more than one resident per room, there was a separate bin for each bed and the resident in it. The residents' controlled substances were kept in a separate, locked narcotics bin in the bottom drawer of each medication cart. When not in use, the medication carts were stored in the locked medication rooms.

In addition to the residents' own medications, Caressant Care (Woodstock) maintained a store of non-prescription drugs provided by the Ontario Government Pharmacy (government stock). Government stock includes common medications such as acetaminophen, laxatives, and antacids. These medications were kept in the locked medication rooms.

B. The Emergency Drug Box

In addition to the residents' medications and the government stock, Caressant Care (Woodstock) had an emergency drug box (EDB) containing medications that might be required urgently or outside pharmacy hours. The EDB included medications for symptom management (e.g., Prednisone) and rescue agents (e.g., glucagon) as well as those that might be needed outside the daily delivery schedule (e.g., oral antibiotics). The contents of the box were decided on annually at the home's PAC meetings. Before EDB medications could be administered to residents, they required either a specific prescriber's order or a medical directive (a standing, pre-prescribed order to be used for symptom management).

Section 123 of the Regulation to the LTCHA requires licensees to ensure that:

- only medications designated as emergency medications by the medical director, pharmacy service provider, director of nursing, and the administrator are kept in the EDB;
- the home has a written policy in place that covers where the EDB is stored and how and when medications are accessed, restocked, used, tracked, and documented;
- at least annually, the medical director, pharmacy service provider, director of nursing, and the administrator evaluate the use of, and need for, the medications in the EDB; and
- any changes agreed on during the annual evaluation are implemented.

Corporate Caressant Care's EDB policy set out the steps that staff had to take when they removed a drug from the box. Among other things, staff were

required to check the medication's expiry date; verify the drug name, strength, and dosage against the physician's order; enter the physician's order and the amount of medication removed from the box in the drug record book; record on the physician's order form the amount of medication removed from the box; and fax the physician's order form and the drug record book page to the pharmacy. The pharmacy would then replace the medication used from the EDB, which would be documented by the nursing staff, once received.

C. The Handling of Insulin

During the period when Wettlaufer worked at Caressant Care (Woodstock), residents receiving insulin were on the pen and cartridge system. When a pen was received, it was removed from its case and labelled with the resident's name. It was kept in the resident's bin with the strip packaging or in a separate bin next to it.

Insulin was ordered through the unit's drug record book or, once the electronic medication administration record (eMAR) was instituted, it was ordered electronically. The pharmacy delivered it along with the other medications in the evening, and its receipt was recorded in the drug record book or, after the eMAR was in use, scanned by the evening or the night nurse.

Insulin cartridges came in boxes of five and the boxes were labelled with the resident's name, date of birth, dosage, type of insulin, and doctor. These boxes were stored in the fridge in the locked medication rooms in Section A and in the treatment room in Section B. The fridges themselves were not locked.

There was a large supply of excess insulin in the fridges at any given time. One witness at the hearings estimated that of the 99 residents in Section B, 10 to 14 were on insulin, and some of them were on more than one type of insulin. To illustrate the quantity of insulin that could be on hand, if just 10 residents were each on a single type of insulin, as many as 40 extra cartridges might be stored in the fridge (assuming that one cartridge from each box of five was in the resident's pen stored in the medication cart).

When nurses needed to administer insulin to a resident, they were to verify the type of insulin and the dose against the resident's MAR or eMAR and, at one time, against the "med cards" kept in the medication room. Med cards were small cards grouped together in a box according to the time insulin was to be administered (morning, noon, afternoon, and evening). Each card

listed a resident whose insulin was due at that particular time, along with the doctor's name, the type of insulin, and the dosage. By pulling out the med cards for the time of day in question, nurses could quickly see which insulin pens needed to be prepared.¹⁶

If nurses found, after they began to prepare a resident's insulin pen, that the cartridge contained only a partial dose of insulin, they disposed of the near-empty cartridge in either the "sharps" container or the non-controlled drug destruction box and used a new cartridge. As they took the new cartridge from the fridge, they verified that they were removing the insulin from the correct resident's box and inserting it into that same resident's insulin pen.

To administer a dose of insulin, a nurse "dialled up" the dose on the insulin pen. Once administered, the dial automatically reset to zero. As a result, the pen did not indicate how much insulin had been given.

When Wettlaufer worked at Caressant Care (Woodstock), the home did not require a second nurse to double-check that the correct dose had been dialled up. Given that only one RN or RPN worked in each area of the home, it would have been challenging to find another RN or RPN to perform this double-check. Moreover, the nurse administering insulin could easily dial up more insulin after a double-check had been performed. Despite these difficulties, Caressant Care (Woodstock) instituted an independent double-check policy after the Offences came to light.

The removal of insulin cartridges from the fridge and the disposal of insulin cartridges was not documented or tracked at Caressant Care (Woodstock). For that reason, a full insulin cartridge could be taken from the fridge without being noticed, although a concern might be raised if insulin was reordered unusually soon. Similarly, nothing would prevent a nurse from pocketing a near-empty cartridge instead of disposing of it. Although the pharmacy service provider conducted certain audits related to insulin, it did not audit the amount of insulin stored in the home. Among other things, these audits would verify the correct labelling and dating of cartridges; proper storage; proper disposal of lancets and needles; proper documentation of insulin administration; the correct use of insulin as indicated in the resident's MAR; the availability of hypoglycemic rescue medication; and guidelines for the use of hypoglycemic rescue medication.

¹⁶ At some point after 2008, Caressant Care (Woodstock) stopped using med cards.

D. The Handling of Narcotics

Controlled drugs such as narcotics were kept in a separate locked box within a drawer of the locked medication cart at Caressant Care (Woodstock). The medication carts were stored in the locked medication room when not in use. Each of the locks (the medication room, the medication cart, and the locked box within the medication cart) required a separate key.

When nurses administered a controlled drug, they signed off on the MAR or eMAR and also on an individual narcotic medication record, which tracked both when an individual pill in the blister card was given and how many pills remained.

At each shift change, two registered nursing staff members had to perform a narcotic count. According to corporate Caressant Care's Narcotic Drug Count Policy, the nurses recorded the resident's name, medication name, and medication strength on the shift change narcotic count form. Together, the two nurses also counted the actual quantity of each narcotic medication remaining; confirmed that the quantity matched the amount recorded on the narcotic medication record; and then recorded the date, time, quantity of medication, and their signatures on the shift change narcotic count form. Any discrepancies had to be reported immediately to the director of nursing. At one point, one nurse would count the medications and the other would record the numbers, but that process later changed so that the two nurses together would look at the narcotics and document the count.

If a resident's prescription changed or a resident passed away, nurses disposed of the resident's leftover narcotics using the home's controlled-drug destruction box. Two nurses worked together: first, they verified the number of pills remaining and signed off on the narcotic medication record; then they wrapped the narcotic medication record around the narcotic card, using an elastic band, deposited the card in the controlled-drug destruction box, and signed off on the surplus monitored medication list that identified the resident's name, medication name, prescription number, quantity, and the reason the drug was being destroyed.

Periodically, the pharmacist would reconcile the contents of the controlled-drug destruction box and denature (alter) the contents of the box so it could not be reused. The denatured medication would be picked up and destroyed by a company engaged by the home for this purpose.

Despite these safeguards, Wettlaufer diverted narcotics for her own personal use. She told the police of different ways that a nurse could divert narcotics:

- sign off that a resident was given a PRN (take as needed) narcotic but, instead, steal it;
- divert a resident's regular medication if the resident was unable to identify what medications were to be given; and
- if a drug was in capsule form, remove the capsule's contents.

Three incidents of missing narcotics occurred at Caessant Care (Woodstock) during Wettlaufer's employment – in August 2012 and in March and April 2013.

1. August 2012

During a narcotic count on August 28, 2012, two nurses discovered that a box of five fentanyl patches was missing, along with another single fentanyl patch. They reported this loss immediately to Ms. Van Quaethem. Although the nurses and management searched for the missing patches, they were not found. Ms. Van Quaethem submitted a Critical Incident report to the Ministry that same day, and the police were called. Neither the home nor the police were able to determine who took the patches.

2. March 2013

On March 14, 2013, Wettlaufer was involved in a medication incident in which one capsule of Kadian SR 10 mg, a narcotic, could not be located. Wettlaufer had signed off on the eMAR that the medication had been given but had not signed the narcotic medication record. This omission was noted when Wettlaufer was performing the narcotic count with the oncoming nurse at the end of the evening shift. Wettlaufer notified Ms. Crombez of it.

Caessant Care (Woodstock) submitted a Critical Incident report to the Ministry and called the police, but they did not lay any charges. Ms. Crombez and Ms. Van Quaethem also met with Wettlaufer. She claimed that she may have given the resident the medication but forgot to sign off that she had done so, and she acknowledged that she had not followed the proper procedure. She was given a one-day suspension (see below).

3. April 2013

On April 16, 2013, the pharmacist carrying out the drug destruction process discovered that a card of 31 tablets of hydromorphone was missing.

The documentation showed that the card had been deposited in the controlled-drug destruction box on March 21, 2013, by two RNs, neither of whom was Wettlaufer. During the internal investigation that followed, Ms. Crombez and Ms. Van Quaethem found a gap in the controlled-drug destruction box that may have allowed someone to remove a card. The pharmacy was asked to provide a replacement box.

The police also conducted an investigation but were not able to determine who was responsible. They suggested that a security camera be installed in the medication room, and its installation was approved by corporate Caressant Care. Although the camera was never installed, Ms. Crombez testified that management acted as though it had been, hoping that this perception might deter someone from taking medication in the future.

E. Philosophy Regarding Medication Errors

A large number of medications must be given during medication passes in LTC homes. Ms. Routledge estimated that during her morning medication pass at Caressant Care (Woodstock), she would give out 400 to 600 medications to her 32 residents. The majority would be non-controlled medications such as blood pressure medications, oral hypoglycemic agents, and arthritis medications contained in strip packaging. The morning medication pass was particularly busy: while registered nursing staff were giving out medications, they were also responsible for supervising the residents and the PSWs and responding to emergencies. All this activity took place while residents were also going to the dining room for breakfast and returning.

Given the number of medications administered, errors could occur. Medication errors might involve medications that were administered to the wrong resident, at the wrong time, or in the wrong dose. To encourage nurses to report medication errors, Caressant Care (Woodstock) typically did not immediately proceed to discipline for such errors. Prompt reporting of medication errors was crucial so that corrective action could be taken quickly to prevent harm to the residents.

Ms. Routledge testified that in her experience, nurses typically felt “devastated” if they made a medication error. When an error occurred, Ms. Crombez’s usual practice was to discuss it with the nurse and provide counselling on the issue, with the goal of improving the nurse’s practice. However, if a nurse made repeated errors, formal discipline followed.

F. Reporting of Medication Incidents and Adverse Drug Reactions

1. The Legislative Requirements

The NHA did not specifically require the reporting of medication errors. However, the Program Manual required homes to report to the Ministry, within 10 working days, any “injury, medication error or treatment error resulting in transfer of a resident to hospital for treatment and/or admission.” The Program Manual also required the home to have a system for the immediate reporting of medication errors and adverse drug reactions, although it did not define either term. Under the Program Manual, the home’s system had to include:

- prompt reporting of all medication errors and adverse drug reactions to the director of nursing, prescriber, and pharmacist, and quick follow-up action;
- documenting of the medication error or adverse drug reaction in the resident’s clinical record immediately after the report was made; and
- documenting of any adverse drug reaction in the resident’s medication profile and the reporting of the reaction to the pharmacist. In turn, the pharmacist had to report the adverse drug reaction to the Canadian Adverse Reaction Monitoring Program.

The Regulation to the LTCHA contains several provisions relating to medication incidents and adverse drug reactions. Under the Regulation, “medication incident” and “adverse drug reaction” are defined as follows:

“medication incident” means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,

- (a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
- (b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

“adverse drug reaction” means a harmful and unintended response by a resident to a drug or combination of drugs which occurs at doses normally used or tested for the diagnosis, treatment or prevention of a disease or the modification of an organic function.¹⁷

¹⁷ O Reg 79/10, s 1.

Section 107 of the Regulation requires licensees to inform the Ministry within one business day of a medication incident or adverse drug reaction in which a resident is taken to hospital, among other things.

The Regulation also stipulates the process to be followed by the home when a medication incident or adverse drug reaction occurs. Under section 135 of the Regulation, the licensee must take immediate action to assess and maintain the resident's health; document, review, and analyze all such events; and take corrective action as needed. A record must be kept of each of these actions.

Section 135 also requires licensees to report every medication incident involving a resident, and every adverse drug reaction, to the resident, the resident's substitute decision-maker (if there is one), the director of nursing, the medical director, the prescriber, the resident's attending physician or nurse practitioner, and the pharmacy service provider. Licensees must conduct a quarterly review of all medication incidents and adverse drug reactions, and they must implement any changes and improvements identified in the review. A written record must be kept of these actions.

2. Reporting of Medication Incidents at Caressant Care (Woodstock)

At Caressant Care (Woodstock), when a medication error occurred, the staff member was obliged to complete an internal incident report form. Although the legislation required all medication incidents to be reported to a number of individuals, including the pharmacy, the home did not follow this practice before 2017.

During Wettlaufer's time at Caressant Care (Woodstock) (and until sometime in 2017), medication incidents that were not attributable to a pharmacy error were not reported to the pharmacy. For errors that the pharmacy made, such as missing pills or medication received in the incorrect dosage, staff reported the issue to Ms. Crombez, who then filled out a form outlining the error and submitted it to the home's pharmacy service provider, Medical Pharmacies Group. Ms. Crombez would also report medication errors every quarter when the PAC met.

At one point, Ms. Crombez reviewed all medication errors, although that responsibility was eventually taken over by the assistant director of nursing. At monthly staff meetings, attendees would also discuss the number of medication errors, whether such errors were on the rise, and what could be done about these incidents. However, the home did not track and trend

medication errors on a broader level. The pharmacist would also go to Caessant Care (Woodstock) periodically to discuss medication errors and their prevention with staff.

By early 2017, Caessant Care (Woodstock) had changed some of its practices in regard to medication errors. In particular, in addition to obliging nurses to complete the internal resident incident report, it began requiring them to complete and submit the form for reporting medication errors to the pharmacy.

G. Oversight and Evaluation of the Medication Management System

1. The Legislative Requirements

Under the NHA regime, the Program Manual required homes to have an “organized interdisciplinary review process for directing the home’s pharmacy program and service.” As part of this process, homes had, first, to document the findings of the review and any actions taken on a quarterly basis; and, second, to review the Quality and Risk Management Program related to pharmacy services, with a focus on improving residents’ pharmacotherapy. The homes were also required to have written policies and procedures in place for their pharmacy services.

The Pharmacy and Therapeutics Committee in the home was responsible for, among other things:

- developing, promoting, and reviewing the home’s written policies and procedures to address all aspects of pharmacy services, in order to provide consistent direction for staff;
- making recommendations to improve pharmacy programs and monitoring their adequacy in achieving safe, effective, and cost-effective pharmacotherapy drug distribution, control, and usage;
- reviewing all medication error reports and error rates to identify their causes, and developing policies or procedures to prevent similar occurrences in the future; and
- reviewing the audit records of the drug storage and distribution system.

Similarly, section 115 of the Regulation to the LTCHA requires the licensee to ensure that the LTC home has an interdisciplinary team, consisting of, at minimum, the medical director, administrator, director of nursing and

personal care, and pharmacy service provider, which must meet at least quarterly to evaluate the effectiveness of the home's medication management system and to identify, recommend, and implement any necessary changes to improve the system. As part of this task, the interdisciplinary team must review drug use trends and patterns in the home as well as reports of any medication incidents or adverse drug reactions. The licensee must keep a written record of the results of the quarterly evaluation and any changes that were implemented.

Section 116 of the Regulation also requires that the licensee ensure that the interdisciplinary team, along with a registered dietitian, conducts an annual evaluation of the medication management system, using an assessment instrument specifically designed for this purpose. The annual evaluation must include a review of the previous year's quarterly evaluations. The staff who conduct the evaluation must identify changes to improve the system in accordance with evidence-based practices or, if there are none, with prevailing practices. As with the quarterly evaluations, the licensee is required to ensure that the recommended changes are implemented and that a record is made of the results and any implemented changes.

2. Medication Management and Oversight at Caressant Care (Woodstock)

At Caressant Care (Woodstock), the interdisciplinary group who formed the PAC – including the administrator, director of nursing, assistant director of nursing, resident care coordinator, pharmacy consultant, public health nurse, and medical director – met quarterly to discuss issues of concern to the home. Although all PAC members were supposed to attend each meeting, the medical director was not always there.

At the quarterly PAC meetings, they discussed topics such as staffing changes, compliance visits, accreditation, the RAI-MDS (Resident Assessment Instrument–Minimum Data Set) system, educational and training events, staffing and nursing concerns, major incidents (such as a resident injury that required hospitalization or surgery), and information about recent infections and their treatment. The PAC also reviewed reports prepared by the consultant pharmacist that compared the home's use of medications to the LHIN- and province-wide use of those medications. These reports included information about the different therapeutic classes of medications that were used in the home, the number of medications per resident, and the number of residents on insulin. For instance, in April 2011, the report indicated that 13 residents –

or 8.2% of the resident population – were on insulin. If particular medications were causing issues, the PAC discussed how to reduce the use of those medications.

The PAC also reviewed medication incidents. In doing so, its members looked at the number of medication errors and whether they were attributable to a staff error, a pharmacy error, or both. Sometimes the pharmacy consultant provided education at PAC meetings – one topic, for example, on glycemic targets for the frail older person.

Several PAC members were also involved individually in the oversight and evaluation of medications and the medication management system. For instance, the consultant pharmacist might suggest improvements to medication management policies and procedures and train staff about specific medications and changes to policies and procedures. When training staff about insulin, the pharmacist educated them about its use and administration, the different types of insulin, and how to recognize and treat hypoglycemia.

The pharmacy service provider also conducted regular audits of the medication management and medication administration in the home. Among other things, these audits involved checking that drugs were stored in the correct locations and locked in the medication room or medication cart. The pharmacy service provider would also verify that MAR/TAR (medication administration record / treatment administration record) and medication review documentation were accurate. In addition, it audited medication administration, resident safety and medication reconciliation, narcotic requirements, medication disposal, proper insulin use, emergency starter supply inventory, and use of the drug record book.

Although Joanne Polkiewicz, the consultant pharmacist at Caressant Care (Woodstock) from 2006 to 2013, did not recall conducting a formal “medication management system program evaluation,” the quarterly audits involved a review of the home’s compliance with medication management safety. The results were reported to the director of nursing and used for quality improvement planning. Ms. Polkiewicz would also, in responding to errors or as part of her reports to the home, collaborate with the director of nursing and staff to implement improvements through informal discussions. She testified that the audits were helpful in improving quality in the home – for example, by identifying and disposing of expired medications. She frequently saw improvements after these audits.

Despite these audits by the pharmacy service provider, and the discussion of medication incidents and medication-related issues at PAC meetings, the PAC did not carry out a formal quarterly or annual review of the medication management system, as required by the LTCHA and the Regulation. During the Ministry inspection conducted at Caressant Care (Woodstock) in 2016–17, after the Offences came to light, inspectors found that the licensee had failed to ensure that an interdisciplinary team met both quarterly and annually to evaluate the effectiveness of the home’s medication management system (see Chapter 11).

VI. Reporting the Death of a Resident

A. To the Office of the Chief Coroner

When a resident dies in an LTC home, a medical certificate of death must be completed before the body is removed from the home. At Caressant Care (Woodstock), some of the information on the certificate is completed by the nurse – such as the resident’s name, age, and date of death – and the rest is completed by the physician.

Since 2007, the *Coroners Act*¹⁸ has required every death of a resident in an LTC home to be reported to the Office of the Chief Coroner (OCC) (see Chapter 14). Deaths are reported using a form known as the Institutional Patient Death Record (IPDR), which asks a series of questions about the resident’s death and must be completed immediately after the death of a resident. A copy of the IPDR is located at Appendix D to this volume of the Report.

In 2007, the IPDR asked 10 questions that had to be answered with either “yes” or “no.” Those questions can be summarized as follows:

- Was the death accidental?
- Was the death a suicide?
- Was the death a homicide?
- Was the death undetermined as to cause?
- Was the death both sudden and unexpected?
- Has the family or any of the care providers raised concerns about the care provided to the deceased?

¹⁸ RSO 1990, c C.37, s 10(2.1).

- Has there been a recent increase in the number of deaths at the home?
- Has there been a recent increase in the number of transfers to hospital?
- If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?
- Is this a threshold case? (A threshold case was the 10th death in a home. Threshold cases were to be investigated by a local coroner, regardless of whether any of the previous nine deaths in the home had been investigated.)

If any of the questions were answered “yes,” the home had to report the death to a local coroner immediately.

When Wettlaufer worked at Caressant Care (Woodstock), the IPDR was completed by the nurse in charge. There was no formal training on how to complete it; new nurses were simply trained on the IPDR by the charge nurse. When a resident died, the RN or RPN on duty completed the IPDR and faxed it to the OCC. After 2011, when the Provincial Dispatch System began to be rolled out, the OCC requested that all homes submit the form electronically. The director of nursing was given a copy of the IPDR, but only for informational purposes, not to review its contents in any detail.

Before the implementation of the Provincial Dispatch System, if any of the questions on the IPDR were answered “yes,” the home had to report the death directly and immediately to a local coroner. Following the system’s implementation, the home was required to call the Provincial Dispatch number immediately. This process is discussed further in Chapter 14.

It could be difficult for the nurses completing the IPDR to know if the death was “sudden or unexpected,” and the nurses at Caressant Care (Woodstock) did not receive training on this issue. Corporate Caressant Care’s policy, “Death of a Resident – Registered Staff Role,” explained that a death was expected when members of the healthcare team were of the opinion that the resident was irreversibly and irreparably terminally ill, no treatment would restore health, and the team anticipated death. Ms. Crombez explained her view of a “sudden or unexpected” death in LTC:

In determining whether a death is “sudden or unexpected,” we would look to see if a resident had been deemed palliative [in which case the death was likely not sudden or unexpected] or, for instance, if the resident was just sitting in a chair and suddenly passed away [in which case the death was likely sudden and unexpected].

As outlined above, the IPDR asked whether the deceased's family had expressed concerns about the care the resident had been receiving, and whether there had been a recent increase in the number of residents transferred to hospital. Several nurses who testified at the hearings indicated that they would answer these questions based on their own direct knowledge rather than on a broader, institutional perspective.

It was relatively rare for the coroner to be called. Dr. Reddick, the medical director for Caressant Care (Woodstock), stated that he had pronounced several hundred deaths and that the coroner had perhaps been called a dozen times. He explained that residents in LTC homes are frail and have several illnesses, so only rarely did he consider a death to be unexpected.

To assist staff, Caressant Care (Woodstock) maintained a folder containing resources outlining the steps to take when a resident died; the forms that needed to be completed; the contact information for doctors and funeral homes; and instructions about when to call the family, the coroner, and the doctors. The home's death registry was also kept with this folder. The death registry contained a running list of all the residents who died either at the home or in hospital. Until September 2013, it was also used to keep track of every 10th death, as those "threshold deaths" had to be reported automatically to the Coroner's Office. As of September 2013, that requirement no longer applied.

B. To the Ministry

Although the OCC is notified of every death in an LTC home, the Ministry is not. Under the regulations to the NHA, the licensee was required to report "a death resulting from an accident or an undetermined cause."¹⁹ The Program Manual also stipulated that if the home had contact with the police related to an "unusual / accidental death including suicide," the administrator had to report that death to the Ministry immediately as an "unusual occurrence."

Under the Regulation to the LTCHA, licensees must submit a Critical Incident report to the Ministry where there has been "an unexpected or sudden death, including a death resulting from an accident or suicide." Neither the LTCHA nor the Regulation defines "unexpected or sudden death."²⁰

¹⁹ Reg 832, s 96.

²⁰ O Reg 79/10, s 107.

VII. Wettlaufer's Hiring and Orientation

A. Wettlaufer's Resumé

Wettlaufer applied to corporate Caressant Care in June 2007. Her resumé stated that she had received her nursing diploma in April 1995. In terms of work experience, it indicated that she had been a support worker at Geraldton and District Association for Community Living from April 1995 to March 1996; a staff nurse at Victoria Rest Home from March 1996 to October 1996; and that she had been working as a support worker at Christian Horizons since 1996.

Wettlaufer's resumé did not disclose her brief employment with the Geraldton District Hospital. In fact, she did not disclose her employment with that hospital to any prospective employer after she was terminated from the hospital in 1995.

Wettlaufer indicated that in her role as a support worker at Christian Horizons, she administered medication; assisted developmentally challenged individuals in all aspects of their daily living; coordinated staff training about medication administration; and ensured that staff regularly reviewed medication procedures, classifications, and side effects. She indicated that through these tasks, and a course she taught on lifting techniques, she had developed solid teaching skills. She also noted that at Christian Horizons she was the health and safety coordinator and part of a panel of staff and management that investigated allegations of abuse.

B. Wettlaufer's Interview

Ms. Crombez interviewed Wettlaufer for a position at Caressant Care (Woodstock) in 2007. She found her to be pleasant and well-spoken.

C. Reference Check

Wettlaufer provided Ms. Crombez with a positive reference letter from Mark Lambley, program manager at Christian Horizons (the letter is set out in Chapter 2). Ms. Crombez also called Mr. Lambley, who was supportive of Wettlaufer.

D. College of Nurses Registration Check

When Wettlaufer was hired at Caressant Care (Woodstock), there was not yet an online Find a Nurse function on the College of Nurses of Ontario website. Ms. Crombez testified that she would have verified Wettlaufer's registration by checking her registration card. In June 2007, Wettlaufer had a valid certificate of registration with the College, and there were no restrictions on it. Had inquiries been made to the College at that point, the College would not have disclosed the restrictions that had been imposed on Wettlaufer's licence following the Geraldton District Hospital incident and the finding of incapacity made at that time. When that finding was made, the College was authorized under the legislation to make such findings publicly available for only six years.²¹ By 2007, when Wettlaufer was hired, more than six years had elapsed.

Ms. Crombez decided to hire Wettlaufer and felt they were "lucky to have her come through the door." Wettlaufer was hired and placed on a probationary period in accordance with the Collective Agreement.

E. Wettlaufer's Orientation

New nurses at Caressant Care (Woodstock) received orientation both on its general policies and on the floor for the various shifts they would work. Wettlaufer's general orientation took place on June 27, 2007, and was provided by the assistant director of nursing. Ms. Crombez explained that if a registered staff member was to work all shifts – as Wettlaufer was – she would normally schedule orientation for two day shifts, two evening shifts, and two night shifts. In her interview with Commission counsel, Wettlaufer said she had received two full weeks of orientation at Caressant Care (Woodstock).

²¹ Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18, s 23.

VIII. The Offences Committed at Caressant Care (Woodstock)

Wettlaufer was hired in June 2007. She began in a part-time position in Section B, working all shifts. She described the early days of her employment in her interview with Commission Counsel as follows:

It was busy. As an RN on days and afternoons I had 32 patients to give meds to; and then also expected to do the treatments for them; change dressings, put on lotion, things like that; and keep up with the paperwork. And initially I kept up with it okay but it was really busy.

Wettlaufer's work performance went quickly from one of being "okay" and "busy" to one in which she intentionally harmed residents.

A. 2007

1. Ms. Adriano

Within a few months of being hired, Wettlaufer began experimenting with giving residents insulin overdoses. Her first victim at Caressant Care (Woodstock) was Clotilde Adriano, who had moved there in March 2007 from its adjoining retirement residence. Ms. Adriano was diabetic and treated with insulin. She also had dementia. Wettlaufer described her decision to intentionally harm Ms. Adriano:

So when I got to Caressant Care eventually it got to the point like fairly quickly that I was finding it hard to handle things emotionally with being at Caressant Care, and all the workload, and having a partner living with me with two teenage kids.

And one night I was working and Clotilde was on insulin. And it just – this thought came into my head, just give her too much insulin and see what happens; so I did.

Given that Ms. Adriano was a diabetic and had her own insulin, Wettlaufer used Ms. Adriano's own pen and "dialled up" more insulin than was prescribed. Wettlaufer recalled that she first gave Ms. Adriano an insulin overdose before August 12, 2007, and that she overdosed her on more than one occasion, though she did not intend to kill her.

When Ms. Adriano experienced low blood sugar levels as a result of Wettlaufer's actions, she was successfully treated by other nurses.

a) The Incident Report of October 7, 2007

Even before Wettlaufer was hired by Caressant Care (Woodstock), Ms. Adriano had been experiencing hypoglycemic episodes. Her insulin dose had been adjusted a number of times because of those episodes. After Wettlaufer began working in the home, Ms. Adriano continued to have episodes of low blood sugar. In September and early October 2007, Ms. Adriano's diet and insulin dose continued to be adjusted in an attempt to address her recurring hypoglycemic episodes. Dr. Reddick testified that, given Ms. Adriano's history of unstable blood sugars, it would have been difficult to detect whether something untoward was going on.

On October 6, 2007, Wettlaufer was working a double shift – day and evening. Ms. Adriano's MAR indicates that on that day, a nurse (not Wettlaufer) administered her prescribed insulin at 07:30. At 16:30, another nurse (again not Wettlaufer) administered Ms. Adriano's prescribed insulin dose. Wettlaufer took Ms. Adriano's blood sugar level at 20:00 and recorded that it was 8.3.

At the beginning of the night shift on October 6, a PSW found Ms. Adriano weak, cold, and clammy. The RN on duty that night, Bradley Layne, was summoned immediately. Ms. Adriano's blood sugar level was 1.9 but, after she was given some corn syrup, sugar, and apple juice, her blood sugar level increased to 3.8. However, by 03:30 on the morning of October 7, her blood sugar level had dropped to 2.2. She was given glucagon along with more apple juice, and Mr. Layne called Dr. Norman Yu, the on-call physician. Mr. Layne continued to monitor Ms. Adriano's blood sugar and gave her juice and carbohydrates.

During Mr. Layne's call, Dr. Yu told him that a nurse from Caressant Care (Woodstock) had phoned him earlier in the evening and said that Ms. Adriano had been given an insulin overdose. Mr. Layne's progress notes indicate that Dr. Yu stated that the nurse who had called said that Ms. Adriano had received a dose of almost 30 units of insulin – more than the prescribed amount.²²

Although Mr. Layne looked for an internal resident incident report, he could not find one. He had not been informed of an insulin overdose at shift change. Mr. Layne completed an internal resident incident report that day in which he identified the incident as a medication error involving an "insulin overdose." He did not, however, indicate the specifics conveyed by Dr. Yu – that Ms. Adriano had been given 30 units of insulin.

²² Ms. Adriano's medication administration record indicates that the prescribed amount she was to receive at 16:30 was 11 units.

Ms. Adriano's blood sugar levels continued to fluctuate. She was transferred to hospital later that same day.

The internal resident incident report completed by Mr. Layne was reviewed by the director of nursing and the administrator approximately two weeks later. Dr. Reddick did not review that report until the end of the month, but he testified that he would have been informed of what had happened the following day.

Dr. Reddick explained that, at the time, he had not understood the words "insulin overdose" in the report to be referring to a medication error. He said that different meanings can be given to this phrase. In some situations, residents can be given the correct, ordered amount of insulin, yet their blood sugar levels continue to decrease. Some people refer to these cases as an "insulin overdose" because the residents had more insulin than they needed. In other situations, an "insulin overdose" may refer to a situation in which a resident was given extra insulin beyond the prescribed amount. Because Ms. Adriano had experienced several hypoglycemic episodes when she had been given insulin as prescribed, he understood the reference to an "insulin overdose" to mean she had been given the correct dose of insulin, but it appeared to be more than she needed at the time.

There was no evidence that this incident was investigated at the time or that Wettlaufer had any involvement in it. The Agreed Statement of Facts filed in the criminal proceedings against Wettlaufer does not identify specific dates on which Wettlaufer committed her aggravated assaults on Ms. Adriano. However, Wettlaufer admitted that she committed them between June 25 and December 31, 2007, and this incident falls within that time frame.

During its inspection at Caressant Care (Woodstock) in 2016–17, after the Offences became known, Ministry inspectors reviewed the home's internal incident report and determined that the home had not met the standard and criteria in the Program Manual requiring reporting of this unusual occurrence – namely, a "medication / treatment error resulting in hospital admission." The details of that inspection are found in Chapter 11.

2. Ms. deMedeiros

Wettlaufer's second victim was Albina deMedeiros, who moved into Caressant Care (Woodstock) in December 2006. Ms. deMedeiros was diabetic and had been prescribed insulin. Like Ms. Adriano, Ms. deMedeiros experienced hypoglycemic episodes before Wettlaufer began working at Caressant Care

(Woodstock). In response to those episodes, Ms. deMedeiros's insulin doses were being reviewed and adjusted.

Between June and December 2007, Wettlaufer gave Ms. deMedeiros more than one unnecessary dose of insulin. She selected Ms. deMedeiros as a victim because "she was diabetic and that made it easier to use her own available insulin." Wettlaufer said she did not intend to kill Ms. deMedeiros.

Ms. deMedeiros was successfully treated by other nurses when she experienced low blood sugar levels as a result of Wettlaufer's actions.

3. Mr. Silcox

Wettlaufer committed her first murder at Caressant Care (Woodstock) in August 2007. Her victim was James Silcox, who had entered the home on July 25, 2007. He had a number of ailments, including Alzheimer's disease. He was diabetic and being treated with insulin. On July 30, 2007, Mr. Silcox fell and, on August 1, 2007, he was transferred to the hospital after his daughter found him in severe pain and unable to bear weight. He was diagnosed with a fractured femur, for which he had surgery on August 4, 2007. He returned to Caressant Care (Woodstock) on August 10, 2007.

Wettlaufer confessed that she injected Mr. Silcox with 50 units of short-acting insulin on August 11, 2007. She admitted she was angry with Mr. Silcox and wanted him to die. Wettlaufer was still on shift when Mr. Silcox died hours later – the first and only time she was on shift when a victim of the Offences died. She noted in the progress notes that a PSW found Mr. Silcox at approximately 03:55 on August 12, 2007, with "vital signs absent."

Wettlaufer completed the IPDR for Mr. Silcox and answered two questions in the affirmative, indicating that the death was both "accidental" and "sudden and unexpected." The IPDR was faxed to the OCC on August 12, 2007, and Dr. William George, a local coroner, was contacted. He determined that a death investigation was warranted because the death may have been accidental (given the history of the fall and subsequent fracture). He identified the cause of death on both the Coroner's Investigation Statement and the medical certificate of death as "complications of fractured right hip" and also noted that Mr. Silcox had other significant conditions that contributed to his death. The process the OCC undertook after it received this IPDR as well as the steps Dr. George followed in his death investigation are explored in Chapter 14.

No unusual occurrence report was filed with the Ministry, even though such reports were necessary in the event of an “unusual or accidental death.” The Ministry discovered this omission during its inspection after the Offences became known, as explained in Chapter 11. The inspectors found that the home had not met the reporting standards and criteria set out in the Program Manual.

4. Mr. Granat

Maurice Granat entered Caressant Care (Woodstock) in December 2006. Although he had a number of ailments and, by late 2007, was very frail, he was not diabetic. Therefore, he did not have an insulin pen.

Wettlaufer explained that to obtain the insulin needed to commit some of the Offences, she would take spare insulin cartridges from the fridge in the treatment room, put them in her pocket, and then take a spare insulin pen from the medication room.²³ After administering an overdose of insulin, Wettlaufer would take the cartridge out of the pen, throw it away, and put the pen back where she found it.

During her shift on December 22–23, 2007, Wettlaufer “got that feeling inside that this is [Mr. Granat’s] time to go.” She gave Mr. Granat an overdose of insulin and, to conceal her true intention, told him she was giving him a vitamin shot. Later the same shift, she found him diaphoretic and struggling to breathe, but she did not treat him for hypoglycemia. Mr. Granat’s good friends were called and, at the public hearings, one of them said that, while they were with him, Wettlaufer gave him an injection to “calm him down.” Mr. Granat passed away later during the morning of December 23, after Wettlaufer had finished work for the day.

A nurse prepared an IPDR for Mr. Granat and sent it to the OCC. His death was not a threshold death, and all the questions were answered “no.” As a result, no death investigation took place. The medical certificate of death was completed by Dr. Yu. It indicated that the immediate cause of death was “old age debility” and that metastatic prostate cancer was a significant condition contributing to his death.

²³ Some witnesses from Caressant Care (Woodstock) indicated that the home did not keep any extra insulin pens on hand, while others indicated that one was kept in the EBD. As a result, it is not clear what Wettlaufer was referring to when she indicated she would take a spare insulin pen.

B. 2008–09

Although Wettlaufer did not murder another resident until 2011, she admitted to overdosing two residents, Wayne Hedges and Michael Priddle, in 2008 and 2009, with the intention of ending their lives. Both survived.

1. Mr. Hedges

Mr. Hedges began living in Caressant Care (Woodstock) in 2000. He had schizophrenia, a seizure disorder, and developmental disabilities. He was also diabetic and on insulin. Wettlaufer admitted giving him an overdose of insulin in the fall of 2008. Records show that he had a hypoglycemic incident in October 2008, around the time that Wettlaufer was working in the home.

Wettlaufer was on duty on October 26 and 27, 2008. Early in the morning on October 27, 2008, she charted that Mr. Hedges was “awake and persistently yelling at 01:00.” Later that same day, an RPN charted that Mr. Hedges was lethargic and non-responsive to verbal stimuli. His blood sugar level was 2.4, and he was given glucagon at 16:40. His blood sugar level began to rise, he awoke, and staff continued to monitor him for signs of hypoglycemia.

Wettlaufer came back on shift the night of October 27, 2008. She charted that Mr. Hedges’s blood sugar at midnight was 13.6, but that his respirations were noisy and he had periods of apnea. By 06:35 his blood sugar was 1.4, and he was unresponsive. For the second time within two days, Mr. Hedges was given glucagon, and within 20 minutes his blood sugar had risen and he was responsive to voice and touch.

While the use of glucagon was tracked to ensure that it was replaced in the emergency drug box, it was not treated as a medication incident. Therefore, the use of glucagon did not typically trigger an investigation.

2. Mr. Priddle

Mr. Priddle entered Caressant Care (Woodstock) in October 2006. He had Huntington’s disease that had progressed to the point where he was incapacitated and in need of 24-hour care. Wettlaufer admitted that she injected Mr. Priddle with insulin in 2008 or 2009. Because he was not diabetic, his blood sugar levels during that period were not measured. The medical records from July 2008 confirm that Wettlaufer was attending Mr. Priddle and

that he had an episode “that appeared to be hypoglycemic in nature” – at the end of dinner, his colour was dusky, his extremities were cool, he was diaphoretic, and his breathing was wheezy and congested. He survived without any intervention.

C. 2011

Wettlaufer did not murder another victim until the fall of 2011. She did not explain during her police interview why she stopped harming residents for a time. Like her previous victims, all three victims from 2011 lived in Section B of the home.

1. Ms. Millard

Gladys Millard entered Caressant Care (Woodstock) in September 2006. She had Alzheimer’s disease and other conditions but was not diabetic.

Wettlaufer worked the night shift on October 13, 2011. That evening, she felt that Ms. Millard was going to be her next victim. She took both long- and short-acting insulin from the fridge and injected Ms. Millard at approximately 05:00 on October 14, 2011. At 07:23 Wettlaufer noted in the progress notes that Ms. Millard had been awake all night, that she was currently sleeping, and that staff had been instructed to leave her in bed asleep. She instructed the RPN to hold Ms. Millard’s medications until she was awake. Just before breakfast, Ms. Millard was found diaphoretic, cold, clammy, and foaming and drooling at the mouth. By 15:40 she had stopped breathing – and passed away.

Dr. Reddick was called and completed the medical certificate of death, identifying “Alzheimer’s Disease” as the cause of death, with CVA (cerebral vascular accident, or stroke) as a significant condition contributing to her death. The nurse who completed the IPDR answered “no” on all the questions. As a result, no coroner was contacted.

2. Ms. Matheson

Helen Matheson entered Caressant Care (Woodstock) in January 2010. She had dementia but was not diabetic. Wettlaufer gave her an insulin overdose on October 25, 2011. She told police that Ms. Matheson was lucid on the night in question and the two of them discussed Ms. Matheson’s fondness for blueberry pie and ice cream. Wettlaufer felt that Ms. Matheson was “the person to go next” and, after giving her some blueberry pie and ice cream, Wettlaufer took insulin from the fridge and gave her an overdose.

Wettlaufer also worked the evening shift on October 26, 2011, and noted Ms. Matheson's deteriorating condition. At 22:28 she charted: "Helen was flinching and appeared uncomfortable so 10 mg [morphine] was given [subcutaneously]. She now appears to be resting comfortably." Wettlaufer then went off shift. On October 27, 2011, at approximately 01:00, Ms. Matheson's son notified the staff that his mother had stopped breathing.

Dr. Michelle Andersen-Kay was on call that evening and completed the medical certificate of death. She noted the immediate cause of death as natural causes (cancer), with additional antecedent causes of weight loss, failure to thrive, and old age debility. All questions were answered "no" on the IPDR, so no coroner was contacted about the death.

3. Ms. Zurawinski

Mary Zurawinski entered Caressant Care (Woodstock) in May 2011. She had dementia and a number of other conditions but was not diabetic. Wettlaufer told police that on November 6, 2011, Ms. Zurawinski believed she was going to die and asked to be placed into the "deathbed." In light of this request, Wettlaufer and another staff member moved Ms. Zurawinski into the palliative care room in Section B, even though there were no signs that Ms. Zurawinski was going to die.

That afternoon, Wettlaufer gave Ms. Zurawinski an overdose of insulin, concealing her true intentions by telling Ms. Zurawinski that the injections were "for pain." Wettlaufer charted that, at dinner, Ms. Zurawinski was pale and breathing in small gasps. She was taken back to the palliative care room, a PSW prayed with her, and her son was called.

Wettlaufer went off shift, and Ms. Zurawinski passed away early the next morning. Dr. Pongrac Kocsis was on call and completed the medical certificate of death, indicating CVA as the immediate cause of death. The nurse who completed the IPDR answered "no" to all 10 questions, so a coroner was not contacted about the death.

D. 2013–14

Wettlaufer transferred to Section A at Caressant Care (Woodstock) in 2013. Her last two victims at the home, Helen Young and Maureen Pickering, both lived in that section.

1. Ms. Young

Ms. Young entered Caressant Care (Woodstock) in December 2009. She had dementia but not diabetes. She was aggressive at times and would sometimes say that she wanted to die.

Wettlaufer was working the evening shift on July 13, 2013. She told the police that Ms. Young once again said she wanted to die and, on that day, Wettlaufer thought, "Okay, you will die." Before dinner, she gave Ms. Young an injection of short-acting insulin, telling her that it was for pain. After dinner, Wettlaufer injected Ms. Young with long-acting insulin, again telling her it was for pain. Wettlaufer charted that after dinner, Ms. Young was diaphoretic and slurring her words. She recorded Ms. Young's vital signs but not her blood sugar level. At 21:40, Wettlaufer was summoned to Ms. Young's room. Ms. Young was moaning loudly, with her arms and legs bent in, and she indicated that she was in pain. Wettlaufer pretended to take Ms. Young's blood sugar reading. She told the PSWs in the room that Ms. Young's blood sugar level was "good" and gave an average number for it. She did not chart Ms. Young's blood sugar level.

Wettlaufer then contacted the doctor on call, who ordered that morphine be given. After receiving the morphine, Ms. Young was calm and relaxed. However, her breathing rate was low and she was having periods of apnea. Wettlaufer went off shift, and Ms. Young passed away later that morning.

Dr. Michelle Andersen-Kay was on call, and she completed the medical certificate of death for Ms. Young. She identified old age debility as the immediate cause of death, and atrial fibrillation as a significant contributing factor. The nurse who completed the IPDR answered "no" to all the questions, so no coroner was contacted about the death.

2. Ms. Pickering

Ms. Pickering was Wettlaufer's last victim at Caressant Care (Woodstock). She entered the home in September 2013 with dementia and Alzheimer's disease, but she was not diabetic. She exhibited aggressive and wandering behaviour and needed one-on-one care, but that was not always possible.

In January 2014, Ms. Pickering was involved in an incident with another resident (see below). Wettlaufer was on shift, and her actions toward Ms. Pickering at that time ultimately led to a five-day suspension, which she grieved. Wettlaufer told police that Ms. Pickering was getting more difficult to look after and that she wanted to "somehow give her enough of a dose

to give her a coma." On March 22, 2014, when Wettlaufer was working the afternoon shift, Ms. Pickering was in a highly agitated state. Wettlaufer gave her medication to calm her down.

At approximately 20:00 that night, Wettlaufer stole insulin from the fridge in the medication room and gave Ms. Pickering two insulin injections, approximately two-and-a-half hours apart. She first gave Ms. Pickering long-acting insulin and then, later, short-acting insulin. When Ms. Pickering asked her what the injection was for, Wettlaufer said it was her vitamin injection. At the end of her shift, Wettlaufer charted that Ms. Pickering had gone to bed at 19:30 and had called out twice but had "been asleep each time she was checked on."

The morning of March 23, 2014, PSWs reported to Ms. Routledge that Ms. Pickering "didn't seem herself and wasn't coming to breakfast." When Ms. Routledge checked on her around 08:00, Ms. Pickering was drowsy. Later that morning, Ms. Routledge found Ms. Pickering diaphoretic and unresponsive. Ms. Routledge took Ms. Pickering's vital signs at the time but did not measure her blood sugar level because she was not diabetic. Ms. Routledge phoned 911, and Ms. Pickering was transferred to the Woodstock General Hospital.

Wettlaufer charted at 17:11 that Dr. Elizabeth Urbantke had called from the hospital and indicated that Ms. Pickering "continues to be unresponsive and tests show the possibility of a 'mid brain' stroke." Wettlaufer also noted that:

Dr. Urbantke mentioned that Maureen's blood sugar was extremely low when she arrived at the hospital, and the cause is unknown. She stated that if Maureen passes, "it might be a good idea to call the coroner on this one."

Ms. Pickering returned to Caressant Care (Woodstock) as a palliative patient that evening. She passed away five days later on March 28, 2014.

a) Steps Taken Immediately Following Ms. Pickering's Death

Ms. Routledge was on shift when Ms. Pickering passed away. She called the OCC's centralized Provincial Dispatch number and told the dispatcher about Dr. Urbantke's comments, adding that she too was puzzled about why Ms. Pickering's blood sugar level had been so low.

The dispatcher initially contacted Dr. Urbantke to assign her the case. Dr. Urbantke confirmed that Ms. Pickering had a very low blood sugar, which was unexplained, but indicated that she could not accept the case because

she had provided care to Ms. Pickering. Dispatch then contacted the next coroner, Dr. George. While neither Dr. George nor the dispatcher had any recollection of the call, it was accepted that, based on the dispatcher's normal practice, she would have notified him of Ms. Routledge's call, including the information that Ms. Pickering had experienced an incident of low blood sugar and that Dr. Urbantke had recommended that a coroner be called. According to Ms. Routledge, when she spoke with Dr. George, she reiterated this information and reviewed Ms. Pickering's other medical conditions with him, including the fact that Ms. Pickering may have had a stroke. Dr. George concluded that no death investigation was needed. Dr. Reddick completed the medical certificate of death for Ms. Pickering, which indicated that the cause of death was a stroke.

Ms. Routledge completed the IPDR for Ms. Pickering. She answered "no" to all eight questions on it.²⁴ In explaining why she indicated that Ms. Pickering's death was not sudden and unexpected, Ms. Routledge testified:

It is not unusual for a long-term care patient to have a stroke, and that was the indicator that Woodstock General Emergency had given us – that it was possible she had a stroke. And that was what I was basing the [answer on] – and the fact that the coroner wasn't alarmed with any of the information that I had given him, that is why that answer was no.

E. Wettlaufer Is Nicknamed the "Angel of Death"

At one point, Robyn Laycock, an RPN at Caressant Care (Woodstock), nicknamed Wettlaufer the "Angel of Death." Ms. Laycock testified that she gave Wettlaufer the nickname because of interactions, outlined below, she had with her.

Ms. Laycock overheard Wettlaufer leaning over a palliative resident and saying: "If you want to go, let go, it's okay. Your family will understand. Your time is here. See the light. If you want to let go, it's okay. Your body needs to rest." Although Ms. Laycock felt Wettlaufer was attempting to be soothing, she disapproved of Wettlaufer's comments because she thought it was not a nurse's place to have that conversation with residents. On another occasion, Wettlaufer asked Ms. Laycock to administer an injectable "use as needed"

²⁴ The questions on the IDPR were revised in 2014 to remove the last two questions, which read as follows:

- whether the death occurred during, and was believed to be related to, a disease or outbreak; and
- whether the death was a (10th) threshold death.

medication to a palliative resident. When Ms. Laycock refused on the grounds that the resident did not appear to be in distress, Wettlaufer administered the medication herself.

At another point, Ms. Laycock noticed that several palliative patients had passed away on Wettlaufer's shifts. However, Ms. Laycock acknowledged that Wettlaufer worked nights and that a majority of deaths in LTC occur during the night shift. Ms. Laycock testified that she had no proof that anything was amiss and that, apart from the fact that the two of them had butted heads in the past, she had no reason to question Wettlaufer's conduct. She never saw anything in Wettlaufer's behaviour that caused her to think Wettlaufer was intentionally harming residents. Accordingly, Ms. Laycock did not report her concerns to anyone in management.

F. Circumstances Contributing to Wettlaufer's Ability to Avoid Detection

Several factors contributed to Wettlaufer's Offences at Caressant Care (Woodstock) going undetected. Wettlaufer carefully selected her victims, choosing those with dementia or others whom she viewed as particularly vulnerable. She also chose to commit the Offences at times when the chances of detection were minimized. In addition:

- Wettlaufer used insulin, a drug that was not tracked within LTC homes;
- Wettlaufer's initial victims were diabetics who had suffered hypoglycemic events before she was hired;
- apart from using the first two victims' own insulin, Wettlaufer used cartridges of insulin taken from the fridge so that no significant quantity of insulin from one resident went missing;
- she frequently used a combination of long- and short-acting insulin;
- the symptoms associated with hypoglycemia are also associated with other conditions;
- for the Offences she committed on the night shift, she was the only RN on duty, and the RPN on duty was assigned to a different section in the home;
- there was little or no management oversight;

- none of her murder victims were the 10th, or threshold, death in the home²⁵ – the category that automatically triggered a death investigation;
- she misled victims if they asked what she was doing – by saying she was giving them a vitamin or a pain injection;
- the first nine crimes were committed in Section B, in which there was no glass pane in the treatment-room door where the insulin was stored;
- there were no cameras in the medication rooms or the treatment room; and
- Wettlaufer's crimes were spread out over many years. While some occurred in clusters (notably the three murders in the fall of 2011), at other times almost two years passed between offences.

IX. Wettlaufer's Performance

A. Wettlaufer's Interactions with Residents and Families

With few exceptions, Wettlaufer was generally considered to be good with residents and their families. Ms. Van Quaethem described her as friendly, polite, and having a good sense of humour. Wettlaufer's colleagues also described her as generally friendly and kind to the residents. She brought her dog in to visit residents and sometimes treated both the residents and staff to food. Despite these generally favourable descriptions, Wettlaufer occasionally had altercations with residents and staff members. However, none of her colleagues saw anything that caused them to believe she was deliberately harming residents.

B. Mental Health Issues

Wettlaufer revealed to management and some of her colleagues that she was dealing with mental health issues. None of them viewed these issues as affecting her performance as a nurse.

On one occasion, during a disciplinary meeting in August 2012, Wettlaufer stated that she had obsessive compulsive disorder (OCD) and bipolar

²⁵ Wayne Hedges was a "threshold case," requiring a death investigation, but he was not one of Wettlaufer's murder victims. She gave him an overdose of insulin in late October 2008, with the intention of killing him, but he did not die because he was given glucagon. When he passed away in January 2009, a local coroner conducted a death investigation and identified the likely cause of death as a stroke. This case is discussed in more detail in Chapter 14.

disorder. She did not raise her mental health with management again after that meeting. At the time, Ms. Van Quaethem understood that Wettlaufer was seeing a doctor and adjusting to a medication change. She believed that Wettlaufer's doctor would monitor her and take her off work if necessary. She also believed that Wettlaufer still had the ability to be a good nurse. Ms. Routledge noticed that sometimes Wettlaufer was quieter and more withdrawn than usual when she arrived for a shift, but this mood change did not appear to affect her work. Ms. Van Quaethem testified that at some point she and Ms. Crombez had a conversation with corporate Caressant Care's head office about the fact that Wettlaufer was making more mistakes. However, while she recognized that this was a concern, she also took into consideration that they were short-staffed and the nurses were overloaded with work.

Wettlaufer also told a colleague that she had OCD and that she would repeat Bible verses in her head. She revealed that she was on Seroquel, a psychotropic medication, to treat this problem. Her colleague never noticed anything to suggest that Wettlaufer was experiencing side effects from the Seroquel and never had any concerns about Wettlaufer's performance while on it. Wettlaufer told a different colleague that, after she and her husband separated, she realized she was bisexual, and her family abandoned her. Wettlaufer added that she suffered from depression. Again, her colleague did not see any performance concerns linked to these revelations.

C. Alcohol and Drug Abuse

Neither Wettlaufer's colleagues nor the management at Caressant Care (Woodstock) saw any indication that Wettlaufer was incapacitated while at work. Ms. Crombez and Ms. Van Quaethem both testified that they could not recall anyone coming to them with concerns of this nature, and there is no evidence that anyone in management suspected that Wettlaufer had a substance abuse problem.

Only in one instance did a colleague wonder if Wettlaufer had been drinking. Ms. Laycock testified that one day when she was leaving her shift and Wettlaufer was coming on duty, she thought she smelled alcohol on Wettlaufer's breath. Ms. Laycock did not believe Wettlaufer was incapacitated, and she did not appear to be under the influence of alcohol. Ms. Laycock told the other nurse on shift about her concern. Later, the nurse responded that she had approached Wettlaufer but had not smelled any alcohol on her breath.

Apart from this instance, the nurses who interacted with Wettlaufer at shift change testified that her behaviour always appeared normal and that they never smelled alcohol or saw any signs of impairment. Nurses and PSWs who worked the same shift as Wettlaufer also testified that they never noticed any concerning behavioural changes and saw no indication she was using drugs or alcohol. None ever suspected that Wettlaufer was under the influence of drugs or alcohol at work. Similarly, Dr. Reddick had no concerns that Wettlaufer might have been under the influence of drugs or alcohol.

D. Wettlaufer's Performance Appraisals

Although Ms. Crombez tried to complete annual performance appraisals for her staff, there were only two appraisals for Wettlaufer in the files at Caressant Care (Woodstock). One was completed in 2008 and the other in 2013.

1. 2008 Appraisal

In Wettlaufer's 2008 performance appraisal, Ms. Crombez rated Wettlaufer as a 2.5 in several areas. A grade of 2 was "provisional," and 3 was "competent." A grade of 2.5 meant that Wettlaufer "needed to improve." The areas in which Wettlaufer was rated as 2.5 were:

- medication administration;
- assumes and accepts responsibility of position;
- knowledge of, and adherence to, policies, procedures, and applicable legislation;
- attends in-service training; and
- interacts well with residents and their families.

Ms. Crombez rated Wettlaufer a "2" for her participation on committees. In the "areas for development" section of the performance appraisal, she indicated that Wettlaufer needed to learn the policies and procedures of the home and noted that Wettlaufer planned to take a course on performing assessments. On the form, Wettlaufer indicated that her goals were to improve her attendance record and take a course on assessments. Wettlaufer signed off on the appraisal, writing, "I enjoy working at Caressant Care. I agree to do my best to meet my goals this coming year."

2. 2013 Appraisal

The second performance appraisal was dated December 19, 2013. At this time, Ms. Crombez rated Wettlaufer a “2” in the following areas:

- medication administration and assessment skills;
- develops, implements, and evaluates multidisciplinary plan of care;
- assumes and accepts responsibility of position;
- completes work in a timely manner;
- participates in committees;
- follows established dress code; and
- relates well with supervisors, co-workers, other disciplines, and volunteers.

Ms. Crombez summarized Wettlaufer’s performance in the 2013 appraisal as follows:

Beth, your performance this year has been below what is expected. I do feel you have the capability and potential to do better. This is what we need and want from you. Let’s get 2014 off to a great start.

The matters contributing to Wettlaufer’s low ratings are explored below.

X. Wettlaufer’s Disciplinary Record

There were several issues with Wettlaufer’s performance during her career at Caressant Care (Woodstock). At first, they were generally addressed through counselling, in the hope that Wettlaufer would change if issues were brought to her attention. However, when counselling did not succeed in changing her behaviour, she was given formal discipline, including verbal and written warnings, suspensions, and, ultimately, termination of her employment in March 2014.

Neither the home nor the union had a complete list of Wettlaufer’s discipline history to review when making decisions about how to deal with issues as they arose. Both Ms. Van Quaethem and Ms. Crombez testified that they did not maintain a list of all the counselling or discipline that had been given to Wettlaufer. When deciding what level of discipline was appropriate for any given incident, they would not review her entire file. Rather, they would glance back to see what the previous discipline had been for a similar incident.

Similarly, there is no evidence that the Ontario Nurses' Association representative at Caressant Care (Woodstock) maintained a list of all the discipline Wettlaufer had received. The ONA filing cabinet contained some, but not all, of the disciplinary action forms and other forms of notice given to Wettlaufer. Jill Allingham, the labour relations officer for Caressant Care (Woodstock) in 2013 and 2014, testified that she was unaware of the existence or contents of the ONA filing cabinet at Caressant Care (Woodstock) until it came to light during the Inquiry's public hearings.

Below, Tables 5.3 to 5.6 summarize Wettlaufer's performance on issues that are grouped by topic. The more detailed discussion following the tables focuses on the incidents that received the most attention during the hearings.

A. Wettlaufer's Attitude in Disciplinary Meetings

Wettlaufer generally accepted the discipline she was given. Ms. Van Quaethem and Ms. Crombez testified that she was respectful, open, and frank during discipline meetings. Ms. Routledge, who attended many of these meetings as the ONA representative, described Wettlaufer's behaviour during discipline meetings similarly, saying:

But Beth, in general, at these meetings would be very contrite and apologetic. And, you know, "I'm sorry. I don't know what happened."

She was remorseful, often tearful. I, at one point before the meeting, said[,] "Listen Beth, I think I know that you're getting called in." I may have even written the incident myself, "but you're not pulling your workload. You know, other people are having to follow you and pick up on your slack."

And she would say, "I'm so sorry. I didn't know." And then she would burst into tears, and she would say, "I'll try to do better."

And then for a couple of weeks, whether it was discipline or whether it was someone talking to her, things would improve work-wise at least, because that was the most obvious thing that we could see as co-workers, the workload.

There was no indication that she wasn't being genuine.

B. Absenteeism

Absenteeism is an issue in LTC. Caressant Care (Woodstock) monitored staff absences because nurses who had attendance issues put a strain on the nursing department. However, absences related to illness or injury were generally not dealt with by way of discipline unless management felt that a staff member was taking too many sick days.

Absenteeism was also an issue for Wettlaufer. Starting in March 2011, Caressant Care (Woodstock) required Wettlaufer to bring in doctor's notes to substantiate her absences. Because of Wettlaufer's frequent absenteeism, she received progressive discipline for it (see Table 5.3).

Table 5.3: Wettlaufer's Absenteeism, 2008–13

YEAR	DATE OF COUNSELLING OR DISCIPLINE	ACTION
2008	June 19	Counselling
2009	December 3	Counselling
2010	July 7	Verbal warning
2011	March 31	Written warning
	May 25	Written warning
	August 26	One-day suspension
2013	January 18	Counselling

Source: Compiled by the Commission.

C. Conduct Issues

Caressant Care (Woodstock) also had to deal with issues related to Wettlaufer's interactions with co-workers (see Table 5.4).

Table 5.4: Conflict Incidents with Co-workers, 2009–13

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT(S)	WETTLAUFER'S EXPLANATION (IF KNOWN)	ACTION (IF KNOWN)
2009	September 11	Wettlaufer was involved in a conflict between two other staff members and revealed what one staff member had said about the other.	Wettlaufer had hoped these two staff members would talk and resolve the issue, and she apologized for handling this issue poorly.	Counselling
	December 3	Wettlaufer made inappropriate remarks about a co-worker's English, allegedly saying, "Those English as a second language classes didn't help."	Wettlaufer claimed that it was meant as a joke.	Verbal warning
2010	January 21	Wettlaufer arrived late on January 10 and then criticized another nurse during the shift-change report. On January 18, she showed a co-worker a boil, inadvertently exposing part of her groin.	Wettlaufer stated that if she was late, it was only by a few minutes. Wettlaufer explained that she criticized the nurse giving the report because the nurse was referring to residents by their last names, which was impersonal.	Counselling
2011	June 17	Wettlaufer made an inappropriate comment about how a staff member looked.	Wettlaufer claimed the complaint may have been made because she was a lesbian.	Counselling

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT(S)	WETTLAUFER'S EXPLANATION (IF KNOWN)	ACTION (IF KNOWN)
2012	March	Wettlaufer was not carrying out narcotic counts properly on the night shift and reacted inappropriately when challenged about this lapse.	Unknown	This issue was not addressed with Wettlaufer directly.
2013	November 8	A PSW complained that Wettlaufer was a bully, telling the staff member what to do during dinner and on other occasions. The PSW also claimed that Wettlaufer made an insulting comment about her age.	Unknown	Unknown

Source: Compiled by the Commission.

1. January 2010

On January 19, 2010, Ms. Van Quaethem received a note from a nurse staff member regarding Wettlaufer's conduct during shift change on January 10, 2010. The nurse reported that Wettlaufer arrived late and, while the nurse was giving her report, Wettlaufer called her "cold" and "insensitive" when the nurse referred to residents by their last names. The nurse also reported that on January 18, 2010, Wettlaufer stated that she had a boil and pulled down the right side of her uniform to reveal it, exposing part of her groin in the process.

At the investigative meeting, Wettlaufer told Ms. Van Quaethem and Ms. Crombez that if she was late, it was by only a few minutes. In regard to the nurse's shift-change report, she felt the nurse's use of the residents' last names was impersonal. Wettlaufer received counselling, despite having received a verbal warning in December 2009 for a conflict with a co-worker.

Ms. Crombez and Ms. Van Quaethem testified that they did not impose more serious discipline because they felt that Wettlaufer had a valid point about the importance of referring to residents in a more respectful manner. Although they felt that Wettlaufer could have handled the situation better, they did not feel it warranted a more severe form of discipline.

2. June 2011

In June 2011, a discipline meeting was held about a comment Wettlaufer had made about another staff member's appearance. During the meeting, Wettlaufer was told that the comment was inappropriate, that she was in a position of authority, and that she had to be careful what she said. Wettlaufer indicated that she felt the complaint was being made because she was a lesbian. Because Wettlaufer had raised this concern, Ms. Van Quaethem alerted Cheryl McDonald of corporate Caressant Care's human resources department to this conversation.

Ms. Van Quaethem testified that she believed Wettlaufer's sexual preference may have been an issue for some staff members because a few of them had raised concerns about how openly Wettlaufer discussed her sexual orientation in the workplace. Ms. Crombez testified that she had encouraged Wettlaufer not to raise the subject at work and told Wettlaufer's colleagues to set boundaries with her if they were uncomfortable discussing her sexual orientation.

There was also evidence that Wettlaufer may have raised the issue of her sexual orientation in order to avoid harsher discipline. One of the RPNs at Caressant Care (Woodstock) testified that on one occasion when Wettlaufer was called to the office, Wettlaufer said, "It doesn't bother me when I get called in because I just throw around my lesbian card."

3. March 2012

In March 2012, an RPN raised concerns about how the narcotic count was being handled and Wettlaufer's response to him when he challenged her on the issue. The narcotic count was being done by Wettlaufer and the RPN before the end of their night shift, instead of by Wettlaufer and the incoming nurse who worked the day shift. When the RPN told Wettlaufer he would not continue with the existing system, she responded that she was his boss.

Ms. Van Quaethem believed that the issue of how the narcotic count was being done was system-wide and did not relate solely to Wettlaufer. As a result, Caressant Care (Woodstock) reviewed, with all staff, the correct process for completing narcotic counts. The issue was never raised directly with Wettlaufer.

4. November 2013

On November 8, 2013, Ms. Van Quaethem received a note from a PSW indicating that Wettlaufer was a bully. As examples, the note said that Wettlaufer would interrupt PSWs' work to tell them to do something she wanted, dictate when they could start serving food in the dining room, and tell them to toilet residents during dinner. The note also relayed that Wettlaufer had spoken loudly to the PSW but later apologized. On another occasion, Wettlaufer had told the PSW that she was the supervisor, and the PSW had to obey her. Finally, the note indicated that Wettlaufer had also made insulting comments about the PSW's age by stating that some residents were younger than she was and were asking her, "When are you going to retire?"

Ms. Van Quaethem believed that the first part of the PSW's complaint related to instances when Wettlaufer was appropriately carrying out her duties as a nurse, but the comments about the PSW's age were inappropriate. Ms. Van Quaethem provided the PSW with a harassment complaint form to complete, but there was no evidence that the form was ever completed. It is unclear whether the comment about the PSW's age was formally addressed with Wettlaufer.

D. Work Performance Issues

In addition to issues related to absenteeism and her interactions with other staff, a number of other incidents involved Wettlaufer's work performance (see Table 5.5).

Table 5.5: Incidents Related to Wettlaufer's Work Performance, 2009–13

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION (IF KNOWN)	ACTION (IF KNOWN)
2009	February 27	<p>Wettlaufer was said to be:</p> <ul style="list-style-type: none"> • eating at the desk; • taking and eating the home's food; • leaving the building on her break and taking keys with her; and • not following through on nursing duties. 	Wettlaufer claimed she did not know she had taken the keys with her. She acknowledged having eaten the home's food because she had forgotten her lunch.	Counselling
2011	February 8	Wettlaufer allegedly had not done any treatments on Level 2 and had not completed bedside assessments for the RAI-MDS system between December 25 and February 7.	Wettlaufer claimed she did all treatments except for one, but had not signed for them.	Verbal warning
	March 8	Wettlaufer did not start a 24-hour care plan.	Wettlaufer stated that she did start the 24-hour care plan and stayed late to do so, although she did not put in for overtime. However, she did not tell incoming staff to continue the care plan.	No discipline because Wettlaufer had completed part of the assessments needed to prepare the 24-care plan and had stayed late to do them.
2012	January 12	A resident complained that Wettlaufer had slapped her.	See the incident particulars outlined below.	No discipline because management believed the incident did not happen.

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION (IF KNOWN)	ACTION (IF KNOWN)
2012	January 16	Several complaints about Wettlaufer's interactions with residents.	See incident particulars outlined below.	Written warning
	February 22	Wettlaufer told the resident involved in the January 12 complaint that she would "no longer stand for being bullied."	Wettlaufer claimed she told the resident, "Thank you for apologizing but stop bullying me."	Counselling
	April 20	Wettlaufer had not completed the admission work for a new resident.	Wettlaufer advised that this shift was her seventh in a row and that she "can and will do better."	Verbal warning
	June 2	Wettlaufer was not responding immediately to resident complaints of pain, was talking to staff about the money she made and her sexual orientation, and was never seen giving suppositories.	Wettlaufer acknowledged that with one resident she would wait until the resident rang again for pain medication. She stated she might have commented on her wages, but she claimed that any complaints about comments she had made about her sexual orientation must be old because she had "left that lifestyle" six months earlier. Wettlaufer also claimed that she did not ask for help to give suppositories if she did not need it, and sometimes residents would refuse to receive one.	Action not noted
	August 31	Wettlaufer had not assessed a resident when it was reported that the resident "was not herself."	Wettlaufer claimed that she (Wettlaufer) was adjusting to a change in her medications at the time.	Written warning

continued

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION (IF KNOWN)	ACTION (IF KNOWN)
2012	September 4	Wettlaufer initialled the narcotic count on September 3 but did not do the count with the oncoming nurse. Also, she did not check the refrigerator temperatures, as she was required, on August 27, 29, and 31.	Wettlaufer claimed that she "didn't think of it."	Written warning
2013	April 1	There were complaints that on March 31 and April 1, Wettlaufer spoke inappropriately to a resident, asking if he needed a psychiatric evaluation.	Unknown	Counselling
	June 7	To entertain a resident, Wettlaufer turned around and proceeded to "shake her butt in the resident's face."	Wettlaufer stated that she liked to make the resident laugh, and it was all in good fun.	Counselling
	November 25	Wettlaufer did not process a resident's urine sample.	Wettlaufer claimed that she had been busy, that the resident had no signs of a urinary infection, and that she forgot to leave a note. Wettlaufer apologized for the oversight.	Counselling

Source: Compiled by the Commission.

1. Allegations Raised by a Resident in January and February 2012

On the morning of January 12, 2012, a resident (Resident A) told Ms. Crombez that she had attempted to sign herself out of the building at 00:30. At the time, Resident A was exhibiting cold symptoms and was on isolation protocol. Wettlaufer told her to return to her room. Resident A reported that she did so but came back at 01:15, signed herself out, and went to leave the building.

She stated that when she did so, Wettlaufer slapped her. Resident A was asked to demonstrate the “slap” and demonstrated instead a closed-fist punch. After speaking to the resident about the alleged incident, Ms. Crombez also interviewed Wettlaufer and the PSW who had been on duty at the relevant time.

Ms. Crombez was extremely close to Resident A, and this relationship was known to staff. Staff members testified that they needed to be on their best behaviour around Resident A because she would complain to Ms. Crombez if she was unhappy. Both Ms. Crombez and Ms. Van Quaethem were aware that Resident A had not told the truth on previous occasions. They ultimately came to the conclusion that Resident A was not being truthful when she accused Wettlaufer of slapping her.

Their view seemed to be confirmed when, on January 16, 2012, Resident A and Wettlaufer went to Ms. Crombez’s office and Resident A said she “came to apologize” because Wettlaufer had not actually slapped her. Ms. Van Quaethem testified that at the time she had not considered whether Resident A might have retracted her statement because she felt intimidated by Wettlaufer; however, she stated she did not believe that Resident A would be intimidated.

Given that Ms. Crombez and Ms. Van Quaethem did not believe Resident A’s allegations, they did not report the incident to the Ministry because they did not think it fell within the mandatory reporting obligations in the LTCHA. Section 24(1) of the LTCHA requires a person who has reasonable grounds to suspect, among other things, abuse or neglect of a resident that resulted in harm or a risk of harm to the resident to report the suspicion and information on which it is based immediately to the Director. Section 23 of the LTCHA requires all licensees of LTC homes to investigate every alleged, suspected, or witnessed incident of resident abuse or neglect immediately and to take appropriate action to respond to the incident.

Ms. Crombez’s understanding of the reporting requirements was that they were first to investigate to determine *if there were reasonable grounds to suspect* abuse and, if their investigation led them to conclude the incident did not happen, there was no need to report to the Ministry. Ms. Crombez testified that it was not until a Ministry inspection in 2016 that the inspector told them they should report such allegations to the Ministry before conducting their own internal investigation.

Despite the home's decision not to report the incident, Resident A's allegations ultimately came to the Ministry's attention. On January 23, 2012, a week after Resident A retracted her allegations, the resident herself phoned the Ministry to report that she had been slapped. The Ministry phoned Caressant Care (Woodstock) the next day and told them that they needed to report the incident. The home then filed a Critical Incident report on January 30, 2012.

Then, on February 8, 2012, Resident A reported that Wettlaufer had entered her room while she was sleeping and hit her on the shoulder to wake her up so Wettlaufer could measure her blood sugar levels. Again, Ms. Van Quaethem did not believe that incident had happened. However, given the allegation, and based on their discussions with the Ministry regarding the previous incident, Caressant Care (Woodstock) filed a Critical Incident report the same day and called the police.

Yet another incident occurred between Resident A and Wettlaufer on February 16, 2012, in which Wettlaufer reportedly said, "Thanks for apologizing but stop bullying me." Wettlaufer was given counselling as a result of this incident. Ms. Van Quaethem and Ms. Crombez felt at the time that Wettlaufer was perhaps being bullied by Resident A, so they did not impose more serious discipline. However, they told Wettlaufer that she needed to be calm and professional with the resident.

On February 24, 2012, a family meeting was held to discuss the situation between Resident A and Wettlaufer. It was noted that Resident A apologized and seemed "relaxed and happy."

The Ministry did not conduct an inspection related to these incidents.

2. Allegations Raised by Staff in January 2012

Several other concerns were brought to the attention of Ms. Van Quaethem and Ms. Crombez in January 2012:

- Wettlaufer did not attend to a resident who had shortness of breath and laboured breathing;
- Wettlaufer was found sleeping in the chapel and delayed responding to residents' requests for pain medication;
- Wettlaufer did not stop a disimpacting procedure when a resident was in pain; and
- Wettlaufer inappropriately handled a resident's injury arising from a fall.

When they looked into these incidents, Ms. Crombez and Ms. Van Quaethem concluded that Wettlaufer's conduct was inappropriate, with the exception of the way in which she handled the resident's disimpacting procedure.

a) Complaint That a Resident Had Laboured Breathing

One of the PSWs reported that on December 5, 6, and 7, when she advised Wettlaufer that a resident was having difficulty breathing, Wettlaufer responded that the resident had chronic obstructive pulmonary disease (COPD). The PSW indicated that it was not until December 8, 2012, when another staff member reported the same issue, that Wettlaufer obtained an oxygen machine for the resident.

b) Complaint That Wettlaufer Delayed in Responding to Requests for Pain Medication

Around the same time, a staff member reported that Wettlaufer was found sleeping in the chapel and, when PSWs told her that a resident had asked for pain medication, she responded that the resident would have to wait until she was "done her break." Staff testified that Wettlaufer would make comments such as "Oh, they can wait half an hour," "I'm going to go for my lunch and after my lunch [I'll get the medication]," or "I'll have a nap first and then I'll go." Wettlaufer would eventually give the residents their pain medication, but at the time of her choosing. None of the staff interpreted this delay as neglect or felt that Wettlaufer was intentionally leaving residents in pain. Rather, they felt she was being lazy.

During her testimony, Ms. Crombez acknowledged that a failure to respond promptly when a resident was complaining of pain amounted to neglect and should have been reported to the Director, as required by section 24 of the LTCHA. She also felt that the staff members who had witnessed such behaviour should have immediately reported the issue to management. In that case, management could have interviewed the resident while the incident was fresh and assessed the appropriate disciplinary response.

c) Complaint About Disimpacting a Resident

A staff member alleged that during a disimpaction procedure, a resident was in pain, but Wettlaufer did not stop to administer a pain medication before continuing. Disimpaction is a procedure to remove stool manually from the rectum when the individual is unable to have a bowel movement and is experiencing considerable discomfort. Ms. Crombez testified that the

procedure is painful, but a nurse typically “wouldn’t stop in the middle of the process if a resident was in pain to give a PRN [as needed medication].”

Wettlaufer indicated that the resident was uncomfortable during the procedure but not screaming. Following the incident, Ms. Crombez spoke to the resident and reviewed the resident’s bowel protocol in an attempt to ensure that the situation did not arise again.

d) A Resident’s Fall and Hematoma

Staff also raised concerns about Wettlaufer’s handling of a resident’s fall on January 12, 2012. The resident was on the floor, with an open wound on one leg and a large hematoma (blood blister) on the other. Although Wettlaufer indicated that the resident might have broken her hip, she moved the resident to her bed without assistance. The PSW on duty, Wendy MacKnott, told Wettlaufer that she disagreed with Wettlaufer’s decision to move the resident. Ms. MacKnott testified that Wettlaufer responded that she was the nurse and knew what she was doing, and if Ms. MacKnott didn’t like it, she could leave the room. Ms. MacKnott also reported that Wettlaufer then took a pair of scissors from the treatment cart and, without first sterilizing the scissors, used them to pinch the skin until the hematoma opened and drained. After draining the hematoma, Wettlaufer applied gauze and wrapped the leg.

The same night, another resident was found with a wound on her finger. Ms. MacKnott asked Wettlaufer to look at it, but Wettlaufer responded that she would have to do it after she finished arranging for the resident who had fallen to be transferred to the hospital. Because it was the night shift, Wettlaufer and an RPN were the only nurses on duty in the home, and Wettlaufer directed Ms. MacKnott to bandage the finger with gauze in the meantime. However, Wettlaufer never returned to assess the resident’s finger.

Ms. Crombez testified that it was inappropriate for Wettlaufer to have moved the resident who fell because the home had given staff a memo telling them not to move residents after a serious fall. However, she believed that Wettlaufer moved the resident after concluding that the resident’s hip was not broken; moreover, when the resident was transferred to the hospital, no fracture was identified. In regard to the hematoma, Ms. Crombez stated that the hematoma should have been covered so that it would not break open.

Notes from the discipline meeting indicate that Wettlaufer said she moved the resident because there was blood on the floor, and she picked up the resident to assess her. Wettlaufer also indicated that she had been trained to puncture a hematoma in the way she had, but she admitted that she had not sterilized

the scissors before doing so. Despite Wettlaufer's actions, the wound did not become infected and healed well.

Regarding the resident's finger, Wettlaufer explained that she did not get around to assessing it because she was dealing with the resident who had fallen. In the circumstances, Ms. Crombez did not view this delay as neglect because Wettlaufer had been occupied with the resident who needed to be transferred to the hospital. She noted that the injured finger had been temporarily treated with gauze, and other staff were coming on shift who could address the issue. Ms. Crombez viewed resident care as a team approach, and she was confident that someone else on staff had looked after the wound on the resident's finger.

3. The Ensuing Discipline

Following investigation of these complaints from the staff, Wettlaufer was disciplined for her actions. Ms. Crombez and Ms. Van Quaethem dealt with all the concerns together. They gave Wettlaufer a written warning for not meeting residents' needs in a timely manner and not following the proper policies and procedures after a fall. Wettlaufer had last been disciplined for work performance issues in February 2011, at which time she had received a verbal warning. Ms. Van Quaethem explained at the hearings that the next available discipline option was a suspension, had they decided to skip the written warning step. However, she said they typically would not skip steps in the progressive discipline process because they were worried it would be grieved by the union. If successful, in the event they imposed a suspension, the home would then owe the employee back-pay. Given the potential costs involved in imposing a suspension, they decided to issue a written warning for all these issues together.

During the Ministry's investigation of the Wettlaufer Offences, inspectors determined that Wettlaufer's transfer of the resident after the injury and her treatment of the resident's hematoma should, under section 24 of the LTCHA, have been reported to the Director as suspected improper or incompetent treatment.

a) April 2012

On April 20, 2012, Wettlaufer received a verbal warning for not completing the admission work for a new resident. Wettlaufer's explanation was that she had worked seven shifts in a row. However, Ms. Crombez testified that it was not unusual for a full-time nurse to be scheduled for seven shifts in a row, particularly if the nurse wanted weekends off.

b) August 2012

In August 2012, a concern was raised that Wettlaufer had failed to assess a resident when staff informed her that the resident was “not herself.” When Ms. Crombez and Ms. Van Quaethem discussed the incident with Wettlaufer, she disclosed that she had OCD and bipolar disorder, and that she was undergoing a change in medications. Wettlaufer had never previously alerted management to these issues. She did not ask for any accommodation, and the union never requested any accommodation for her. Wettlaufer was given a written warning, and Ms. Crombez noted on the disciplinary form that:

If continued poor performance related to health issues continues, consideration may be given to report to the College of Nurses for “fitness to practise for review.” Your health and well being is our outmost concern. Please follow up with the medical issues you discussed with us.

Explained to Beth that she brought her health issues to us & we are obligated to ensure the safety of the Residents.

Ms. Crombez testified that, by advising Wettlaufer that ongoing issues might result in a report to the College, she hoped she would change her behaviour. However, Ms. Crombez was not concerned about Wettlaufer’s competency or capacity following her disclosure that she had OCD and bipolar disorder. Ms. Van Quaethem reached a similar conclusion and assumed that Wettlaufer’s doctor would request that she be put on leave if the new medication caused side effects that compromised her work performance.

There is no indication that Wettlaufer ever raised the fact that she had OCD and bipolar disorder again.

c) April 2013

Two staff members reported concerns about how Wettlaufer had treated a male resident who had ongoing issues with a female resident. The female resident would wake early and visit the nurses’ station. Her laughter annoyed the male resident, who was trying to sleep.

On April 1, 2013, Ms. MacKnott submitted a note that, the previous day, the male resident was making fun of the female resident. Wettlaufer asked him to stop, told him he was being ignorant, and asked him if he needed a psychiatric evaluation. Ms. MacKnott felt that Wettlaufer’s comments were inappropriate.

Also on April 1, 2013, Laura Long, the RPN on shift, reported to management that she had heard the male resident laughing loudly and, in response,

Wettlaufer asking him, "Do you need a Haldol injection? Do you need a psychiatric evaluation." She noted that it was not the first time she had heard Wettlaufer make comments of this nature to the male resident. Ms. Long felt that Wettlaufer was being "sarcastic and mean" and that these comments constituted verbal abuse.

That same day, but before Ms. Long reported the incident, the male resident complained about Wettlaufer to Ms. Crombez. In the Critical Incident report filed that day, Ms. Crombez wrote:

Resident came to my office this morning to say he did not want Beth Wettlaufer giving him medication again as he did not trust her to give him his correct medication. He said "if she comes near me again" he would kick her and punch her in the teeth. Resident said he "would kill her," "kick the shit out of her," "kick her until her bowels are on the floor," "I'll kill her and go to another nut house. I'll go to jail."

Because of the resident's behaviour, Ms. Crombez suspected he had a urinary tract infection and had him tested. The test was positive, the resident was treated, and Ms. Crombez asked both the doctor and the pharmacist to review the resident's medications. Ms. Crombez also reported the male resident's threats to the police and told Wettlaufer not to approach the resident without a PSW present.

Later that day, Ms. Van Quaethem and Ms. Crombez received Ms. Long's complaint outlining what Wettlaufer was alleged to have said to the male resident. Although they felt that Wettlaufer's conduct was inappropriate, they did not view it as abuse and did not discipline her for the incident. Ms. Van Quaethem's understanding was that the male resident had asked the female resident if she was crazy and if she needed Haldol, which reduced the female resident to tears. Wettlaufer then made the same comments to the male resident, to emphasize how hurtful these comments could be. Ms. Crombez encouraged Wettlaufer and the male resident to try to talk through their issues and, ultimately, the male resident reported that things were fine between him and Wettlaufer.

During the Ministry's investigation after the Wettlaufer Offences were disclosed, the Ministry inspectors found that Wettlaufer's comments to the resident should have been reported to the Director as there were reasonable grounds to suspect verbal abuse. They also found that the licensee had failed to immediately investigate the suspected abuse, as required by section 23 of the LTCHA.

d) June 2013

On June 7, 2013, Brenda Black reported that the previous week, when she was taking a resident to the dining room, Wettlaufer said to her, "Oh wait, she loves it when I do this" – and then turned around to "shake her butt in the resident's face." Ms. Black felt that this behaviour was unprofessional and inappropriate, but did not view it as abuse. The matter was investigated, and Wettlaufer indicated that she had been joking with the resident.

Wettlaufer had a good relationship with this resident, and Ms. Crombez felt that Wettlaufer was trying to make the resident smile. Wettlaufer was not disciplined for this incident; however, Ms. Van Quaethem told her that this conduct was not appropriate.

e) November 2013

By November 2013, Ms. Crombez and Ms. Van Quaethem were dealing with several issues with Wettlaufer, and the situation was headed toward terminating her employment with Caessant Care (Woodstock). That month, Wettlaufer failed to process a urine sample that had been given to her by a resident's family member. When asked why she had not done a dip test on the urine right away, Wettlaufer responded that she was busy, there were no signs of a urinary tract infection, the "doctors won't do anything" because there was no paperwork with it, and she had forgotten to do it.

Instead of the usual disciplinary action form, Wettlaufer was given a letter advising that her work performance was inadequate. The letter, dated November 25, 2013, read as follows:

This is to inform you that you are not working to the best of your ability. A resident's family complained that they gave you a urine sample for their loved one. This urine sample was put in the refrigerator and later discarded as it was stale. The family was upset and reported the issue to management. It was your responsibility as an RN to ensure this sample was processed properly. You failed to do this.

Also your work performance is not adequate. You are not doing assessments, processing and following up on doctor's orders, or other work as required of the Registered Staff. There is daily work that is required to be done in a timely manner.

This letter is to inform you that it is expected that you do the required work in a timely fashion. The Registered Staff must work as a team in order to meet the needs of the residents. We expect you to do your part.

Beth, you are a good nurse and a valuable member of the nursing department. We hope that you take this counselling seriously. Your file indicates that you are up to a five-day suspension. We do not want to proceed to further discipline. We want to give you every opportunity to improve. We know you are capable.

If there are any reasons preventing you from doing your duties you need to advise us.

At the hearings, Ms. Van Quaethem said that, by this time, she was communicating about Wettlaufer with Wanda Sanginesi, vice-president of human resources at corporate Caressant Care, because Wettlaufer was “making more and more mistakes and discipline was not getting through.” Ms. Van Quaethem believed that she consulted with Ms. Sanginesi on this matter and that, together, they decided to send Wettlaufer this letter in lieu of the typical disciplinary action form to impress on her the severity of the situation. Ms. Sanginesi did not recall having been consulted on this issue or preparing the letter but noted that such a letter would not be unusual or improper. The letter was also designed to show that the home had given Wettlaufer every opportunity to improve in case it ultimately terminated her employment and the ONA grieved the termination.

E. Medication Errors

In the course of her career at Caressant Care (Woodstock), Wettlaufer made a number of medication errors. The home’s approach to medication errors was focused on the recognition and prompt reporting of the errors. Thus, rather than imposing discipline, Wettlaufer was given counselling for her initial medication errors. However, by 2013, Caressant Care (Woodstock) began imposing progressive discipline for her many such errors.

Table 5.6 outlines the medication errors for which Wettlaufer was either counselled or disciplined but excludes incidents that could not be attributed to an error made by Wettlaufer.

Table 5.6: Wettlaufer's Medication Errors, 2007–14

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION	ACTION
2007	November 12	Wettlaufer signed to indicate she had given medication, but she had not done so.	<p>Wettlaufer said she had been interrupted by another staff member and did not finish the task.</p> <p>Wettlaufer did not deny that she failed to give the medication and indicated she realized immediately that she had made an error.</p>	Counselling
2008	March 28	Wettlaufer signed that she gave Tylenol 3 on March 23 but had not in fact done so (the pill was still in the blister card).	Wettlaufer claimed that she was "in a hurry and did not follow her usual process."	Counselling – Wettlaufer was advised by Ms. Crombez to "give meds correctly and sign as she went, even if it took her past the end of her shift and she had to ask for overtime."
	April 7	On March 24 Wettlaufer failed to give insulin to two residents. The error was discovered by the nurse on the shift that followed Wettlaufer's.	At the time, nurses used a "med card" to remind them when insulin was due. Wettlaufer claimed not to have placed those med cards on the top of the medication cart.	Counselling
	June 22	Wettlaufer signed to indicate that she gave 3 mg of hydromorphone when she had not (the pill was still in the blister card).	Unknown	Counselling

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION	ACTION
2011	June 15	Wettlaufer had put a new nitro patch on a resident without removing the old one.	Unknown	Counselling
2012	February 14	Two incidents occurred on February 12: <ul style="list-style-type: none"> • Wettlaufer poured medication and left it in front of a resident at supper time. • Wettlaufer did not give mineral oil to a resident later in the evening and left a syringe, with no needle, in the med room. 	In relation to the first incident, Wettlaufer said she had gone to attend to another resident who appeared to be escalating. In relation to the second incident, Wettlaufer claimed that something distracted her, but she could not remember what it was.	Counselling
2013	February 21	Two incidents occurred on February 12: <ul style="list-style-type: none"> • Wettlaufer did not follow the proper procedure when administering a medication. • Wettlaufer did not administer a mineral oil treatment to a resident's ears. 	Unknown	Written warning

continued

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION	ACTION
2013	March 19	Wettlaufer reported that one capsule of Kadian SR, a narcotic, was found to be missing during the narcotic count between the evening shift and the night shift and that it was possible she had given the resident an extra dose.	Wettlaufer admitted to "doing three things wrong": <ul style="list-style-type: none"> • not signing the eMAR; • not signing the narcotic count sheet; and • giving medication earlier than ordered. 	One-day suspension
	April 12	Wettlaufer signed that she gave a resident medication on April 8 when she had not.	Wettlaufer acknowledged the mistake but did not know how it happened.	Five-day suspension
	December 19	Wettlaufer gave a resident two different types of eye drops in immediate succession when they should have been given several minutes apart. The resident's wife informed Wettlaufer that the drops needed to be given at least five minutes apart, to which she replied, "I know." She then proceeded to give the drops one after another, with no break in time.	Wettlaufer acknowledged that she used an incorrect procedure and that she understood the concern expressed by the resident's wife. Wettlaufer commented that it was "definitely an error on my part – it was a busy night."	Counselling

YEAR	DATE OF COUNSELLING OR DISCIPLINE	INCIDENT	WETTLAUFER'S EXPLANATION	ACTION
2014	January 28	<p>Various issues arose:</p> <ul style="list-style-type: none"> • There were concerns that Wettlaufer did not follow the proper procedures for various treatments. • Wettlaufer did not follow the correct procedure in dealing with a diabetic resident. • Wettlaufer allegedly told Ms. Pickering that she was confused and could not remember things, and that she needed to trust the staff. Wettlaufer also gave Ms. Pickering her medication outside the allowable time frame. 	Wettlaufer claimed that she told Ms. Pickering that "she forgets" and that she gave the medication early as an "evidence-based nursing decision."	Five-day suspension
	March 31	Wettlaufer gave a resident the wrong insulin.	Wettlaufer thought that another resident was on the same insulin and decided to "borrow" insulin from that other resident.	Termination

Source: Compiled by the Commission.

1. March 2008

On March 24, 2008, the home discovered that Wettlaufer had not given two residents their insulin. The error was discovered because a resident reported that she had not received her insulin. By that time, Wettlaufer had gone off shift. When she was contacted, she said she had given the resident insulin. The resident continued to insist that Wettlaufer had not given her the medication, so Wettlaufer was contacted again and, that time, she acknowledged that perhaps she had not done so. Wettlaufer was also asked about a second resident's insulin, and she admitted that she had not administered that resident's insulin either.

On this occasion, Wettlaufer had not used the med cards or checked the MAR. Given how busy it could be on the evening shift, Ms. Crombez believed that Wettlaufer had honestly forgotten to give the insulin. Wettlaufer was given counselling for these errors. Caressant Care (Woodstock) later discontinued the use of the med cards.

2. March 2013

When Wettlaufer and the oncoming nurse performed the narcotic count at shift change, they discovered that a pill was missing. It was unclear whether it had been stolen or lost, or whether the resident had been given a double dose. The resident appeared to be fine, and the incident was reported to both the police and the Ministry.

Wettlaufer had received several warnings by this point, including a written warning for a medication error the previous month. This time, Ms. Crombez gave her a one-day suspension and reviewed the correct procedure with her. Wettlaufer acknowledged that she had not followed the proper procedure, and she did not grieve the suspension. Ms. Crombez also instituted an additional measure requiring all staff to initial not only the the resident's narcotic medication record but also the specific bubble on the medication card from which they took the narcotic or controlled substance.

3. April 2013

On April 8, 2013, Wettlaufer signed off on a resident's eMAR to indicate that she had given the resident the medications from the strip pack which were due at 16:30 and 20:00. However, the next nurse on shift discovered the medications still in the strip pack in the medication cart. Ms. Crombez reminded Wettlaufer that she had spoken to her the previous month about the importance of following the proper procedure and that this was a serious incident. She gave her a five-day suspension.

Wettlaufer initially grieved the suspension, seeking its removal from her file and compensation for lost wages. However, on July 30, 2013, the ONA advised corporate Caressant Care that Wettlaufer had asked it to withdraw the grievance.

4. December 2013

On December 14, 2013, Agatha Krawczyk, an RN at Caressant Care (Woodstock), informed Ms. Crombez of a complaint she had received from a resident's family member. The family member had told Ms. Krawczyk that Wettlaufer had put two different types of eye drops into the resident's eyes at the same time, when they should have been given at least five minutes apart. According to the resident's wife, when she told Wettlaufer of the proper procedure, Wettlaufer responded "I know," and then administered the drops one after the other. Notes from the investigatory meeting indicate that the resident's eye drops were to be given more than 3 hours apart but that Wettlaufer had missed the time for administering one of the doses and gave them both together.

When Ms. Krawczyk approached Wettlaufer about the complaint, Wettlaufer answered that "she [knew]" and acknowledged that she had given both eye drops at the same time. Ms. Krawczyk testified that when Wettlaufer was confronted about issues like this one, she typically denied doing anything wrong and said, "I'm doing everything that I'm supposed to be doing."

Ms. Van Quaethem and Ms. Crombez met with Wettlaufer about this incident. During the meeting, Ms. Crombez told Wettlaufer that if they informed head office about the incident, it "would not be good." Ms. Van Quaethem testified that, by this time, they were "building a case" against Wettlaufer but did not want to terminate her employment just before Christmas. Ms. Crombez and Ms. Van Quaethem ultimately concluded that the incident did not warrant termination. Accordingly, they sent Wettlaufer a second letter, similar to the one of November 25, 2013. The second letter, dated December 19, 2013, advised Wettlaufer that she needed to take these issues seriously and that they could not continue to have a "good working relationship" if her performance issues continued.

5. January 2014

A number of issues arose in January 2014 which led to another five-day suspension for Wettlaufer. The first issue occurred on January 20, 2014, when Ms. Pickering was found wandering in and out of another resident's room. Wettlaufer charted that she had "attempted to explain to Maureen that she was forgetful and needed to trust staff." However, another staff member reported that Wettlaufer had in fact told Ms. Pickering that she had Alzheimer's, was confused, and that she forgot things. In response, Ms. Pickering grabbed Wettlaufer and yelled angrily, "I don't forget."

Ms. Pickering remained agitated and was involved in an altercation with another resident. A few hours later, Wettlaufer charted that “as a nursing measure she had given her 20:00 Risperidone at this time even though it was 40 minutes early,” noting that it would benefit Ms. Pickering to receive the medication early.

A second issue came to light on January 20, 2014, when a PSW complained that on January 15, 2014, Wettlaufer had told him that PSWs were not allowed to sit behind the desk. The PSW indicated that Wettlaufer told him that he was “not a part of the healthcare team” and was “not valued.”

A third issue occurred on January 21, 2014, when Ms. Krawczyk expressed concerns that Wettlaufer was not following the correct procedure when completing certain treatments, including flushing a catheter, giving medicated creams, and irrigating a feeding tube. Ms. Krawczyk also indicated that PSWs were coming to her with concerns, and she attached notes from those staff members.

A fourth issue arose on January 22, 2014, about how Wettlaufer handled a diabetic resident whose blood sugar was low. Wettlaufer reportedly gave the resident orange juice and a piece of toast but did not complete the required charting or refer the resident to the dietitian.

On January 23, 2014, management again met with Wettlaufer. The notes of the meeting suggest that the discussion focused on Wettlaufer’s interactions with Ms. Pickering and her response to the diabetic resident. Wettlaufer denied telling Ms. Pickering that she was confused and maintained that she administered Ms. Pickering’s medication early in accordance with evidence-based nursing practice. She also claimed she was unaware of any policy related to the handling of diabetic residents.²⁶

Wettlaufer was given a five-day suspension on January 28, 2014. On January 29, 2014, she informed Ms. Allingham, the ONA labour relations officer, that she wanted to grieve the suspension because it was “unnecessarily punitive and reflective of an opinion, not facts.” She also insisted that it was a valid exercise of nursing judgment to administer Ms. Pickering’s medication early. The ONA filed a grievance on Wettlaufer’s behalf on January 30, 2014.

Wettlaufer’s next medication error occurred in March 2014 and resulted in the termination of her employment.

²⁶ The notes indicate that the RN who acted as the witness in the meeting also stated that she was unaware of the policy.

XI. Wettlaufer's Termination of Employment

A. Medication Error

The event that led to Wettlaufer's termination from Caressant Care (Woodstock) was a medication error involving injectable insulin. On March 20, 2014, Ms. Krawczyk was working the day shift. After administering insulin to Resident B, she saw that the cartridge did not have enough insulin for another dose. When she went to replace it, she found that there were no more cartridges for Resident B. She reordered the insulin and told the pharmacy that it was needed for Resident B's evening dose. She then left the empty insulin pen in three pieces on the medication cart. When Wettlaufer arrived for her shift, they discussed the fact that no insulin was left for Resident B, that more was coming from the pharmacy, and that Wettlaufer would have to replace the cartridge. Ms. Krawczyk reminded Wettlaufer again before she went home.

Ms. Krawczyk next worked on March 24, 2014. As she was about to administer Resident B's insulin, she noticed that Resident B's insulin pen contained the wrong insulin cartridge: Resident B's prescribed insulin was "milky," whereas the insulin in the pen was "clear." When she investigated, Ms. Krawczyk found a new, unopened box of Resident B's insulin in the fridge in the medication room. She inferred that Wettlaufer had put the wrong cartridge in Resident B's insulin pen and given Resident B the wrong insulin the evening of March 20. In addition, other nurses then administered the same, incorrect insulin to Resident B between March 20 and March 24, 2014.

Ms. Krawczyk immediately reported the incident to Ms. Crombez and Ms. Van Quaethem and completed a medication incident report. In addition, the doctor was contacted, and he told them to monitor Resident B's blood sugar levels.

At a meeting on March 26, 2014, with Wettlaufer, Ms. Crombez, Ms. Van Quaethem, and Ms. Routledge in attendance, Wettlaufer said she did not remember Ms. Krawczyk telling her that Resident B's insulin had been ordered and would arrive that evening. She acknowledged using another resident's insulin, saying she thought it was the same type. Wettlaufer claimed that the error was an honest mistake and that it had been "a busy time with the supper med pass." When the police later investigated the Offences,

Wettlaufer also told them that she had not made this error on purpose: she knew Resident B's insulin was coming from the pharmacy and, in the meantime, she took what she thought was the same insulin from another resident's supply.

Wettlaufer was suspended with pay following this meeting.

B. Decision to Terminate Employment

Ms. Van Quaethem and Ms. Crombez did not have the authority to terminate a registered nurse's employment unilaterally. They reported the incident to Ms. Sanginesi, who in turn wrote to Jim Lavelle, corporate Caressant Care's owner; Carol Hepting, vice-president operations for corporate Caressant Care; and Tim Dengate, its chief financial officer. In this letter Ms. Sanginesi sought authorization to proceed with Wettlaufer's termination of employment. All three agreed that termination was appropriate.

C. Termination Meeting

The termination meeting was held on March 31, 2014. Ms. Van Quaethem, Ms. Crombez, Wettlaufer, and Ms. Allingham from the ONA were present. Ms. Crombez gave Wettlaufer a termination letter that stated:

I met with you on March 26, 2014 to discuss a medication error.
Karen Routledge, R.N. attended our meeting as your ONA representative.

On March 26, 2014, I became aware of a serious situation involving [Resident B]. Upon investigation it became apparent that you had administered the wrong medication to [Resident B]. Instead of giving her the medication that had been prescribed for her, you gave her medication that was prescribed for another resident. This then resulted in her being incorrectly medicated and over-medicated as well. The resident experienced distress as a result of this.

At our meeting you acknowledged that this was an error on your part and explained that it was inadvertent. Beth, although you have acknowledged this latest error, this is another incident in a pattern of behaviours that are placing residents at risk. You have an extensive disciplinary record for medication-related errors which includes numerous warnings as well as 1, 3 and two 5-day suspensions.

As a result of this most recent occurrence, the termination of your employment is warranted. Please be advised that your employment is terminated effective immediately. Any monies owing to you will be paid in our normal payroll cycle. A Record of Employment will be issued electronically and may be accessed at the Service Canada web site.

The same day, Ms. Allingham notified Ms. Sanginesi that ONA would grieve Wettlaufer's termination. She also asked corporate Caressant Care to provide a letter to Wettlaufer, as required by the Collective Agreement, setting out the dates of her employment, her length of service, and her experience.

XII. Caressant Care's Report to the College

A. Legislative Obligation

Employers are required to file reports with the College of Nurses of Ontario in certain situations, including when they terminate a nurse's employment in the circumstances outlined below. After terminating Wettlaufer's employment, Ms. Van Quaethem filed such a report (Termination Report). At the time of Wettlaufer's termination of employment, section 85.5 of the *Health Professions Procedural Code (Code)*²⁷ required employers to report to the College of Nurses within 30 days if:

- they terminated the employment or revoked, suspended, or imposed restrictions on the privileges of a nurse ... for reasons of professional misconduct, incompetence, or incapacity; or
- they intended to terminate a nurse's employment or to revoke the nurse's privileges for reasons of professional misconduct, incompetence, or incapacity, but did not do so because the nurse resigned or voluntarily relinquished his or her privileges.

At the time of the termination, the Code also required facility operators to file a report with the College if the operator had reasonable grounds to believe that a nurse practising at the facility was incompetent, incapacitated, or had sexually abused a patient.²⁸

²⁷ Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c 18.

²⁸ Code, s 85.2(1).

B. Contents of the Termination Report

Ms. Van Quaethem began preparing the termination report on March 31, 2014, the date on which Wettlaufer's employment was terminated. She obtained a copy of the College's Report Form for Facility Operators and Employers and began filling out this template online. Ms. Van Quaethem could not recall having received any training regarding reporting obligations to the College. It was not common for nurses to be fired: during her seven years as administrator, Ms. Van Quaethem had terminated the employment of only one other nurse, and Ms. Crombez could remember terminating the employment of only two other nurses during her 30 years as the director of nursing.

On the report form, Ms. Van Quaethem indicated that Caressant Care (Woodstock) was making the report as an employer regarding a termination for reasons of professional misconduct, incompetence, or incapacity. The report form asked whether the nature of the report was related to practice, conduct, or incapacity. This section was not completed by Ms. Van Quaethem.

The report form instructed the reporter to describe the event(s) that led to the report (who, what, where, when, and why), in (reverse) chronological order, starting with the most recent. It included a table outlining the information that the reporter was asked to provide (see Table 5.7).

Table 5.7: Report Form for Facility Operators and Employers

DATE	INCIDENT/ EVENT	CONSEQUENCES TO CLIENT / OTHER	MEMBER RESPONSE / EXPLANATION	EMPLOYER ACTION
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[To be filled in by the reporter.]

Source: College of Nurses of Ontario.

Ms. Van Quaethem filled out the report form, starting with the incident that led to termination and working backward chronologically. The information included both medication errors and other incidents. In total, Ms. Van Quaethem reported 10 events between August 2012 and March 2014. Although Ms. Van Quaethem provided more detail in the report itself, the incidents set out in the termination report are summarized in Table 5.8.

Table 5.8: Summary of Incidents Set Out in Wettlaufer's Termination Report

DATE OF INCIDENT REPORTED	DETAILS OF INCIDENT	DISCIPLINE GIVEN FOR INCIDENT
March 2014	Administering the wrong insulin.	Termination
January 2014	Speaking to a resident in an inappropriate manner and giving medication outside the allowable time frame.	Five-day suspension
January 2014	Incorrect treatment of a hypoglycemic episode.	Counselling
December 2013	Administering eye drops incorrectly.	Letter of warning
November 2013	Failing to test a urine sample.	Letter of warning that also set out other examples of work performance that were not up to standard – not doing assessments, not following up on doctor's orders, and not doing other tasks required of registered staff.
April 2013	Four medications charted but not given over two medication passes.	Five-day suspension
March 2013	Narcotic given but not signed for – narcotic missing at count.	One-day suspension
February 2013	Did not administer medication following proper procedure, leaving medication at dining-room table, not administering mineral oil to a resident.	Written warning
September 2012	Not taking medication and vaccine refrigerator temperatures and not properly counting narcotics.	Written warning
August 2012	Not assessing a resident when it was reported that the resident was not acting like herself.	Written warning

Source: Compiled by the Commission, based on the report prepared by Ms. Van Quaethem.

Ms. Van Quaethem continued filling out the form until no more boxes came up. By that point, she felt she had included sufficient incidents for the College to conduct its investigation. In a place on the form designated for other comments, Ms. Van Quaethem also noted that other issues related to attendance and professional behaviour had not resulted in discipline but were considered at the time of termination.

Ms. Van Quaethem mailed the report to the College on April 17, 2014, and the College received it on May 1, 2014.

C. Timing of the Termination Report

The report form itself did not stipulate how soon a report had to be filed, nor did it indicate where this information could be found. However, the College had a guide, *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses* (Mandatory Reporting Guide), which provided guidance on this issue. It directed employers to file reports within 30 days of the termination or resignation, and facility operators to file a report within 30 days of the date the operator determined it had a reporting obligation. However, the Mandatory Reporting Guide noted that if the facility operator was concerned that the nurse posed a continuing risk, the operator must file a report immediately.

Ms. Van Quaethem did not refer to the Mandatory Reporting Guide while preparing Wettlaufer's termination report.

D. Contact Between the College and Caressant Care (Woodstock)

The College's response to the termination report is discussed in detail in Chapter 13. In summary, on July 17, 2014, the College sent a letter by regular mail to Ms. Crombez's attention, acknowledging receipt of the termination report and stating that the College was considering whether further action should be taken. The letter noted that all information about the matter was confidential, meaning that the College could not inform Caressant Care (Woodstock) of the proceedings or the outcome. It informed Ms. Crombez that an investigator would be in contact if further information was needed and asked that any relevant documentation be retained for two years. It also noted that Wettlaufer would receive a copy of the information that had been reported to the College.

Ms. Crombez had not seen the termination report before it was submitted to the College, so she did not know what information Ms. Van Quaethem had included about Wettlaufer's performance. However, she believed that Ms. Van Quaethem had likely identified her as the contact person for the College.

Karen Yee, an intake investigator at the College, telephoned Ms. Crombez on July 28, 2014, and left a message asking her to return her call. Ms. Yee and Ms. Crombez spoke on July 30, 2014. Ms. Crombez did not have Wettlaufer's file at the time of that conversation. She testified that she did not believe it was in the home because, by then, corporate Caessant Care's head office was dealing with Wettlaufer's grievance.

Ms. Yee did not attempt to verify whether Ms. Crombez had seen the termination report or suggest that Ms. Crombez review Wettlaufer's personnel file before they spoke. She stated in her evidence that she assumed Ms. Crombez would tell her if she needed to review information before speaking with her. Ms. Crombez was not given the opportunity to review the memo Ms. Yee wrote summarizing their conversation to verify its accuracy. No one else from the College spoke to Ms. Crombez or any one else at Caessant Care (Woodstock) about the termination report.

XIII. Wettlaufer's Grievance and Its Settlement

As noted earlier, Wettlaufer grieved the five-day suspension she received in late January 2014. When her employment was terminated on March 31, 2014, the Collective Agreement gave the ONA 10 days in which to file a grievance. It filed a grievance of the termination that same day. As a result, on March 31, 2014, Wettlaufer had two outstanding grievances in respect of her employment with corporate Caessant Care.

Corporate Caessant Care and the ONA soon began settlement discussions. At the time of those discussions, Ms. Allingham did not know that Wettlaufer had been dismissed from Geraldton District Hospital in 1995 and that a different local of the ONA had grieved that dismissal. She was also unaware that the ONA representatives at Caessant Care (Woodstock) maintained a filing cabinet in the home containing notes, letters, and disciplinary action forms from previous discipline meetings held with Wettlaufer.

In early May 2014, Ms. Allingham and Ms. Sanginesi spoke about the possibility of settling the grievance. Ms. Allingham proposed a monetary

payment equivalent to one week per year of service, a reference letter from either Ms. Van Quaethem or Ms. Crombez, and that Wettlaufer be allowed to tender a letter of resignation. She also proposed that Wettlaufer's personnel file be sealed and that her termination of employment be changed to a resignation for personal reasons.

The Collective Agreement required corporate Caressant Care, on request, to provide a letter setting out Wettlaufer's employment dates, length of service, and experience. Ms. Sanginesi testified that Ms. Allingham told her that any reference letter would need to speak positively about Wettlaufer's skills as a registered nurse. Ms. Sanginesi responded that they would not agree to a letter commenting positively about Wettlaufer's skills as a nurse but indicated she would look into whether Wettlaufer had any strengths that could be mentioned.

Ms. Allingham testified that she would not have dictated the content of the letter but would have asked that a reference letter say something positive about Wettlaufer. She did not recall rejecting the concept of a letter that simply outlined what Wettlaufer's duties had been.

Ms. Sanginesi believed that she phoned Ms. Van Quaethem to inquire about Wettlaufer's strengths, and that Ms. Van Quaethem reviewed Wettlaufer's performance appraisal and listed some potential strengths. Ms. Crombez testified that Ms. Sanginesi called her one day and said, "Helen, if you could say some positive things about Beth, what would they be?" Ms. Crombez stated that Ms. Sanginesi did not indicate why she was asking, but Ms. Crombez gave Ms. Sanginesi information that was ultimately included in the reference letter for Wettlaufer.

On May 22, 2014, Ms. Allingham received a draft letter of reference from Ms. Sanginesi. She testified that she did not suggest or provide any of the contents of the letter of reference and that neither the ONA nor Wettlaufer sought any changes.

Minutes of Settlement were signed by Wettlaufer on June 4, 2014. The Minutes of Settlement included the following:

1. Ms. Wettlaufer hereby voluntarily and irrevocably resigns from her employment with the Employer effective March 31, 2014. The Employer shall amend its personnel file for Wettlaufer to reflect her resignation in place of and in substitution for her termination. The Employee file shall remain sealed, except where as may be required by law.

2. The Employer agrees to make a lump-sum payment of two thousand (\$2,000), as damages to Ms. Wettlaufer.
3. The Employer will provide Ms. Wettlaufer with a letter of employment attached hereto as Appendix A.

Pursuant to the Minutes of Settlement, the ONA withdrew the two outstanding grievances. The minutes made it clear that corporate Caressant Care would co-operate with the College if it requested information or documentation related to Wettlaufer.

The draft reference letter was attached to the Minutes of Settlement. On June 11, 2014, corporate Caressant Care paid the \$2,000.00 in settlement funds and provided the signed reference letter, which read as follows:

This will confirm that Beth Wettlaufer was employed by Caressant Care Nursing and Retirement Homes at our nursing home in Woodstock, Ontario from June 27, 2007 to March 24, 2014 in the capacity of Registered Nurse.

In this capacity she was responsible for providing nursing care to our elderly residents and for supervising the work of RPN's and PSW's.

During her time with us Ms. Wettlaufer proved herself to be a good problem-solver with strong communication skills. She was punctual and enjoyed sharing her knowledge with others.

Ms. Wettlaufer left our employ to pursue other opportunities. We wish her well and are pleased to provide her with this reference.

The reference letter came after Wettlaufer had been hired by Meadow Park Nursing Home (London). Wettlaufer gave this home a copy but did not provide it to any of her subsequent employers.

XIV. Caressant Care Is Notified of the Offences, and the Ministry Investigates

After having been with Caressant Care (Woodstock) since 2009, Ms. Van Quaethem retired on September 30, 2016. Just days later, police attended the home and informed Ms. Crombez that Wettlaufer had confessed to harming four residents and killing seven others in that home. Ms. Crombez testified that the police asked her to assist by reviewing the residents' records. She described her reaction:

When the policewoman came to talk to me I took her to the Administrator's office. There we reviewed the residents' files.... I felt sick to my stomach. I kept thinking this can't be real. Elizabeth Wettlaufer wouldn't murder residents. She is causing trouble for the Home because we fired her.

As we reviewed the documentation together it was clear that what she had said was probably true. There were three residents who had symptoms of sweating which is a symptom of low blood sugar. How could she do this? Take the lives of these people who had worked hard all of their lives, raised families, had friends and made it this far in life. They deserved a peaceful, natural death.

Shortly thereafter, Ms. Crombez informed Ms. Van Quaethem of Wettlaufer's confessions. Ms. Van Quaethem was similarly devastated to learn what Wettlaufer had done. The staff at Caressant Care (Woodstock) were also deeply affected. Ms. Crombez testified:

The shock was unimaginable. It felt like the wheels were falling off. All staff were impacted the same way.

Some staff would be crying when I saw them. I would get teary or cry when I saw them. There were a lot of hugs and pats of support for each other.

Even in the midst of this shock, the staff had to continue providing care for the residents. As one staff member explained, "We were left to pick up all the pieces and restore confidence." They also suffered backlash when they were out in public. As one of them testified:

I was at a funeral and someone asked why would I stay working there? I responded to those types of comments, "If everyone left then who is going to be there to help these people?"

I love my job and I am proud of the work that we do, so it hurts when people say, "How can you work at Caressant Care?"

Residents of Caressant Care (Woodstock) were also upset by the news, but they were very supportive of the home's staff.

At the same time, the Ministry began investigating the Offences at Caressant Care (Woodstock). The details of that investigation are discussed in Chapter 11.

The Ministry initially went to Caessant Care (Woodstock) on October 5, 2016, to meet with Ms. Van Quaethem. Because Ms. Van Quaethem had retired, they met with Ms. Crombez. They began their inspections in the home on October 28, 2016, the same day the police announced the charges against Wettlaufer. Inspectors were on-site over many days in the following months to interview staff members and review documentation. During the Ministry inspection, it became evident that no one at Caessant Care (Woodstock) had ever suspected that Wettlaufer was intentionally harming residents.

On January 24, 2017, the Ministry inspectors issued eight compliance orders to Caessant Care (Woodstock). Six of the compliance orders were issued as a result of other critical incident, complaint, and follow-up inspections conducted concurrently with the inspection following Wettlaufer's confessions. The two other compliance orders were issued for current medication errors and medication management problems that had been identified in the home during the Wettlaufer-related inspection.

On January 25, 2017, the Director under the LTCHA, Karen Simpson, wrote to James Lavelle, the president of corporate Caessant Care, to advise that the Ministry had directed the South West CCAC to cease authorizing admissions to Caessant Care (Woodstock), given her concerns about the range of compliance problems in the home and the risk it posed to residents.

The Ministry completed its inspection in March 2017, but it did not issue its inspection report until August 2017, to avoid interfering with the criminal proceedings against Wettlaufer. The final inspection report included three findings of unmet standards under the NHA, 18 written notifications of non-compliance under the LTCHA (five of which were issued with voluntary plans of correction), and two compliance orders. The Ministry's findings are discussed in detail in Chapter 11.

After the inspection was completed in March, Ministry inspectors returned to the home to complete multiple follow-up inspections throughout the summer and into the fall. On September 1, 2017, after further follow-up inspections revealed ongoing compliance concerns, Ms. Simpson issued a mandatory management order to Caessant Care (Woodstock). Once further follow-up inspections in the fall revealed that the compliance concerns had been addressed, the cease admissions order was lifted. Ms. Simpson notified corporate Caessant Care that admissions to Caessant Care (Woodstock) were reinstated as of December 4, 2017.

RECOMMENDATIONS

The situation at Caessant Care (Woodstock) was similar to that at Meadow Park (London), and the same recommendations apply. I therefore direct the reader to the recommendations set out at the end of Chapter 4.

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I. Introduction

Meadow Park Nursing Home (London) is a 126-bed for-profit long-term care (LTC) home located in London, Ontario. It is one of 14 LTC homes in Ontario operated by Jarlette Health Services (Jarlette). Meadow Park (London) faced the same challenges as Caessant Care (Woodstock) and other LTC homes in Ontario: a rising level of acuity in the residents who entered its doors, and a shortage of registered nurses to care for those residents. It was into that setting that Wettlaufer walked in April 2014, just weeks after Caessant Care (Woodstock) had terminated her employment. Meadow Park (London) hired her within days. In this chapter, I examine some of the home's processes and practices, particularly those in relation to the hiring, orientation, and training of nursing staff. I also review how Meadow Park (London) dealt with medication management, including the handling of insulin and narcotics, and alleged incidents of abuse.

After explaining the hiring process, I address Wettlaufer's performance in the approximately five months she worked at Meadow Park (London). Few issues about her conduct were raised during that time. No known medication errors occurred, and no concerns were raised about her nursing skills.

I then address the murder of Arpad Horvath in August 2014.

On September 25, 2014, Wettlaufer tendered her resignation to Meadow Park (London). She worked her last shift on September 26, 2014, never to return. Shortly after, Wettlaufer admitted to the director of care at Meadow Park (London) that she had overdosed the previous weekend and that she had a drug and alcohol addiction. Within days of this disclosure, the home discovered that some narcotics were missing. Given the circumstances, Wettlaufer was suspected of stealing them. I explore the investigations that took place at the time of this discovery – by the home, by the police, and by the Ministry of Health and Long-Term Care.

More than two years later, Wettlaufer confessed to the Offences, including the one she committed at Meadow Park (London). I briefly review the results of the Ministry's investigation of Meadow Park (London) after Wettlaufer's confession. The chapter concludes with a summary of the steps the home took after learning of Wettlaufer's murder of Mr. Horvath.

II. The Home

In 2014, the 126 LTC residents of Meadow Park (London) lived within four areas on one floor: Kent (33 beds), Lambton (33 beds), Oxford (32 beds), and Elgin (28 beds). The responsibility for managing Meadow Park (London) and ensuring there were sufficient staff to meet the needs of the residents fell primarily to the home's administrator, Robert VanderHeyden; its director of care, Heather Nicholas; and its co-director of care, Melanie Smith. Like other long-term care homes in 2014, Meadow Park (London) was experiencing an increase in the acuity of residents.

Table 6.1 outlines, in general terms, 2014 staffing levels for registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs).

Table 6.1: Meadow Park (London): Staffing Levels, 2014

SHIFT	NURSING STAFF	PSWS
Day shift (06:30–14:30)	2 RNs 3 RPNS	16
Evening shift (14:30–22:30)	2 RNs 2 RPNS	12
Night shift (22:30–06:30)	1 RN 1 RPN	4

Source: Compiled by the Commission.

In terms of staff supervision, managers worked weekdays. They were on-site during the day and for part of the evening shift, but no managers were on-site during the night shift or on weekends. A nurse manager would, however, be on call. On the night shift, the registered nurse served as the charge nurse and was responsible for approximately half the residents. A registered practical nurse was responsible for the other half.

III. Hiring and Orientation Practices

A. Hiring

In 2014, Meadow Park (London) was governed by the *Long-Term Care Homes Act, 2007*¹ (LTCHA). In Chapter 4, I examined the legislative framework set out in that Act. In this section, I focus on those legislative requirements that touch on the hiring and orientation of nurses.

A long-term care home is required to take steps to ensure it hires qualified and suitable staff. A review of the LTCHA and the *General* regulation² indicates that screening measures must include:

- if the applicant is over 18 years of age, a criminal reference check, including a vulnerable sector screen, within six months of the applicant being hired; and

if the applicant is a nurse, ensuring that he or she has a current registration with the College of Nurses of Ontario (College).³

In April 2014, the hiring process for nurses at Meadow Park (London) began with a review of applications or resumés by the director of care. Based on that review, suitable applicants would proceed to:

- a group interview;
- an individual interview;
- an employment reference check; and
- a criminal reference check and confirmation from the College.

Upon hire, employees were placed on probation for three months.

Heather Nicholas was hired as the home's director of care in March 2014, a month before Wettlaufer was hired at Meadow Park (London). In that role, Ms. Nicholas was responsible for the hiring, performance management, and termination of employment of the home's nurses and PSWs. In her testimony, she explained that Jarlette had developed a corporate process, called "Hiring the Jarlette Way" (the Jarlette Way), which was used to "assist managers in the selection and interview process."

¹ SO 2007, c 8.

² O Reg 79/10.

³ LTCHA 2007, s 75; O Reg 79/10, ss 46 and 215.

The Jarlette Way provided guidance on qualities to look for in a potential employee:

- stability and career direction;
- evidence of progressive upgrading;
- signs of achievement / results; and
- positive interpersonal relationships.

By way of contrast, it also provided qualities of which to be wary:

- attendance issues;
- an applicant who takes a cut in pay;
- an applicant who is taking the job as a supplement (second job); and
- an applicant who is overqualified for this position.

1. Group Interview

Ms. Nicholas testified that she kept “a pool” of resumés on file from which she selected applicants for an interview in a group setting. This pool included resumés from RNs, RPNs, and PSWs.

The group interview often included a mix of PSWs and nurses. The Jarlette Way outlined a number of elements, including an “ice-breaker question,” a “survival group exercise,” a “skills test,” and a number of profile forms to be completed by the applicants. The interviewers scored the applicants using a Mass Interview Candidate Score Sheet, which addressed characteristics such as professionalism, energy level, level of self-direction, politeness, communication, attitude, and being service- and team-oriented. The group interview allowed the interviewers to observe the applicant’s “critical thinking” and “how they can work as a team.” A single form was completed for the entire group being interviewed at the time.

Ms. Nicholas stated that certain qualities which interviewers might observe during the interview would make an RN undesirable as an employee. Among those qualities were:

- an inability to answer the questions correctly;
- a lack of leadership; and
- problems with critical thinking.

2. Individual Interview

Interviewers then examined the results of the group interview, and successful applicants went on to individual interviews. In the individual setting, applicants were again asked a series of questions drawn from the Jarlette Way. Described as “behavioural questions,” they were designed to measure “skills, knowledge and skills / behaviours.” A scale rated each applicant’s response. Where more than one person met the organization’s needs and had the appropriate qualifications, the Jarlette Way provided that a third interview be conducted of the applicants.

3. Employment References

If applicants were successful at the individual interview stage, their employment references were checked. The Jarlette Way included the following requirements for references:

- One of the references must be a direct supervisor from the present or most recent job. If the candidate is reluctant to provide this information, check all other references first. If this applicant is identified as the most qualified candidate, advise him/her that a job offer is pending but a reference from the current supervisor is mandatory prior to making a job offer. This will allow the applicant time to determine if he/she is truly serious about the position and to advise their current supervisor of the pending telephone reference.
- During the reference check, verify what the candidate said in terms of title, length of service, responsibilities, salary, and accomplishments.
- Press for a “yes” or “no” answer to the question of whether or not the previous employer would re-hire. If the response is “no,” remove the applicant from the pool of candidates.

Meadow Park (London) used Jarlette’s Applicant Reference Check form, which provided questions to ask references related to:

- the capacity in which they knew the applicant, and for how long;
- the circumstances of leaving;
- whether peers liked / respected the applicant; and
- strengths and weaknesses.

The form also included a series of questions to ask the reference, including how the reference would rate the applicant on:

- performance (quality and quantity);
- problem-solving ability;
- ability to work independently;
- work habits; and
- attendance.

4. Criminal Reference Check and Confirmation from the College

The hiring process at Meadow Park (London) required a criminal reference check, including vulnerable sector screening, for each applicant. In addition, the home checked with the College to ensure that the candidate was entitled to practise nursing and had no restrictions on his or her nursing licence.

B. Orientation and Training of Nursing Staff

The LTCHA required the licensee to ensure that new staff were provided with orientation and training before allowing them to provide care to the residents.

As noted in Chapter 4, under the LTCHA, licensees must ensure all staff have training in the following areas before they begin to work in the home:

- the Residents' Bill of Rights;
- the home's mission statement;
- the home's policy to promote zero tolerance of abuse and neglect of residents;
- the duty under section 24 of the LTCHA to make mandatory reports;
- the whistle-blowing protections afforded by section 26 of the LTCHA;
- the home's policy to minimize the restraining of residents;
- fire prevention and safety;
- emergency and evacuation procedures;
- infection prevention and control; and

- all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.⁴

The LTCHA requires additional training of direct care staff in these areas:

- abuse recognition and prevention;
- mental health issues, including caring for persons with dementia;
- behaviour management;
- how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the regulations; and
- palliative care.⁵

In 2014, nursing staff received two full days of general orientation specific to Meadow Park (London). Ideally, various members of the home's management – such as the director of care, the staff educator, and the administrator – were to participate in the training. If, however, they were not available, the staff educator was responsible for ensuring that the orientation was completed.

General orientation included a mixture of policy review, PowerPoint presentations, learning modules, quizzes, and videos. Each new employee received a binder of policies and procedures. Topics included in the orientation were those required by the LTCHA and:

- concerns and complaints;
- dementia care and responsive behaviours; and
- violence prevention, including responsive behaviour review.

In addition, the home's pharmacy service provider supplied orientation for new nurses on the electronic medication administration record (eMAR).

New nurses then completed a floor orientation, where they partnered with current nursing staff. The floor orientation in 2014 consisted of two day shifts, two evening shifts, and one night shift. New nurses would first observe the current nursing staff member as he or she worked – for example, as he or she

⁴ LTCHA 2007, s 76(2).

⁵ LTCHA 2007, s 76(7).

carried out the medication pass during the day shift. They would then carry out tasks themselves, with the supervision and assistance of the current nursing staff member.

During the floor orientation, new nursing staff were not given the keys to the medication rooms or medication carts.

The nurses conducting orientation could offer verbal comments about whether the new nurse was “doing okay or not,” but they were not required to prepare an evaluation or complete any other written documentation.

Meadow Park (London) also conducted monthly education sessions. For instance, the March 2014 session was Abuse Prevention Focus. Much of the education was provided through e-learning. For example, the Abuse Prevention Focus session included online education entitled, “Abuse and Neglect (for Canada).” Jarlette also held annual education days for its administrators and directors of care.

As noted in Chapter 4, the delivery of effective education is sometimes a challenge for long-term care homes. Ms. Nicholas confirmed that Meadow Park (London) did not allocate additional time to staff to complete their educational requirements. As a result, they had to fit in any training sessions while on shift. To assist with training, Mr. VanderHeyden explained that the home retrofitted a room and installed computers for the staff to use.

Lia McInnes, staff educator at Meadow Park (London) in the summer of 2014, explained that she had to speak to nursing staff when they were not with a resident, in order to get them to complete their training. Nursing staff had to take time away from their duties on the floor when completing training.

Ms. Nicholas noted that staff would complain that training took them away from their duties. Although nursing staff could complete the training at home, they wanted to be compensated for that time.

Tanya Adams, the clinical consultant pharmacist for Classic Care – the home’s pharmacy service provider in 2014⁶ – explained that she sometimes struggled to successfully schedule education sessions at the home. She added that attendance at these sessions was “not always the best,” as the sessions were not mandatory.

⁶ In 2016, Meadow Park changed pharmacy service providers to Silver Fox Pharmacy.

IV. Medication Management

The Oxford and Elgin units shared a medication room and a nursing station, while the Kent and Lambton units each had its own medication room and nursing station. In 2014, one medication room (Oxford) had a window. Each room was kept locked. Registered staff members assigned to each unit had a key for their medication room only – not for the other two. The doors to the medication rooms automatically locked when closed.

The types and packaging of medications used at Meadow Park (London) were in keeping with what was described in Chapter 4. Medications were prescribed by the medical director (if he or she was also the resident's doctor) or the resident's personal doctor. Non-controlled medications in tablet form came in strip packages. Controlled medications in tablet form, such as hydromorphone, came in blister cards.

Medications were delivered from Classic Care to Meadow Park (London) in bags. Each bag was labelled with "MPLN" and the section of the home for which the medications were destined. The bags each contained an automatically generated delivery sheet, which detailed each resident's order. Controlled substances arrived in white bags which were sealed at the pharmacy with red, tamper-resistant tape.

Because medications were generally delivered at suppertime, a busy time at the home, the nursing staff on the Oxford or Elgin Unit (the units closest to the front door) would sign off on the delivery of all of the medications. Typically, nurses would not have time to process and count the medication immediately after delivery. They would either deliver the medications to the other nurses' stations, locking the medications in the medication rooms until they could be processed, or call the nurses from the other units and advise them that their medication had been delivered. Processing and counting the medication would take place later, when the nurses had time.

A. Medication Incident Reporting

The internal process for documenting incidents occurring within Meadow Park (London) started with the completion of a Risk Occurrence form, an internal reporting form that staff members completed whenever something unusual took place. All staff received training on this procedure.

Once completed, reports were left at the nurses' station for collection and review by the director of care (Ms. Nicholas) or the co-director of care

(Ms. Smith), or they were placed in Ms. Nicholas's office. Ms. Nicholas testified that she would review these forms when she arrived at the home in the morning. She would then follow up on the incidents as she considered necessary and appropriate.

Ms. Nicholas testified that, if an incident concerned missing controlled medication, she would conduct an investigation. If the medication still couldn't be located, either she, Mr. VanderHeyden, or Ms. Smith would complete a Critical Incident report and submit it to the Ministry. The police would also be contacted.

If the incident involved a medication error, the resident's physician and the resident's substitute decision-maker, if there was one, would be notified. As noted in Chapter 4, if a medication incident or adverse drug reaction resulted in a resident being taken to hospital, the home was required to file a Critical Incident report with the Ministry.⁷

The pharmacy service provider was also to receive a copy of all Risk Occurrence forms related to medication incidents, so that it could investigate and respond. Ms. Adams testified that Meadow Park (London) staff were required to fill out an internal form for the home, and a second form for the pharmacy. She indicated that both forms needed to be received by the pharmacy service provider.⁸ She did not think that the pharmacy service provider received reports for all medication incidents.

B. Interdisciplinary Team Meetings and Medication Audits

As noted in Chapter 4, under the regulations to the LTCHA, licensees are required to have an interdisciplinary team, which must include the medical director, administrator, director of nursing, and pharmacy service provider. Among other tasks, this interdisciplinary team must meet quarterly to evaluate the effectiveness of the home's medication management system and recommend changes necessary to improve it.⁹ At Meadow Park (London), that interdisciplinary team was called the Professional Advisory Committee (PAC).

⁷ O Reg 79/10, s 107.

⁸ Although Ms. Adams spoke of the staff completing two different forms, the witnesses from Meadow Park generally spoke only of the Risk Occurrence form.

⁹ O Reg 79/10, s 115. The team was also required to conduct an annual evaluation of the home's medication management system. For the purpose of the annual evaluation, the team had also to include a registered dietitian who was a member of the staff of the home: O Reg 79/10, s 116.

At the PAC meetings, the team reviewed drug utilization statistics provided by the pharmacy service provider for drugs such as tranquilizers, pain medication, and psychotropics. The meetings did not address insulin utilization statistics, though the pharmacy could, if requested, report on how much insulin was ordered and how many residents were on insulin. The team discussed medication incidents, including their causes, whether they had been resolved, and how to prevent them moving forward.

Meadow Park (London) also conducted medication audits. Such audits were primarily completed by a pharmacy liaison, employed by the pharmacy service provider. Audits were completed in the areas of controlled medication; medication handling and storage; medication administration; and a general systems audit that looked at various pharmaceutical processes, including the drug record book. Once completed, the audits were posted to the pharmacy service provider's portal. The home's administrator, director of care, and co-director of care would be alerted when the results were available. These audits sometimes led to additional education for the staff.

Monthly audits were also completed of the emergency drug box, reconciling inventory, checking for expired or illegible medications, and ensuring that the drug reordering process was correct.

As noted in Chapter 4, glucagon is a rescue drug maintained in the emergency drug box. Jarlette had an emergency drug box (EDB) policy that outlined the following process for nursing staff members when medication was used from the EDB:

- ensure that a written physician's order has been obtained for the medication to be administered;
- document the removal of the medication from the emergency drug box in keeping with policy and procedure outlined by the contracted pharmacy vendor;
- take action to replenish the medication removed from the emergency drug box in keeping with policy and procedure outlined by the contracted pharmacy vendor;
- contact the contracted pharmacy vendor and or emergency after-hours pharmacy if a medication is required that is not contained within the emergency drug box; and
- document actions taken in the progress notes.

Classic Care's Emergency Medication Box Procedure in 2014 provided that:

The Administrator, Director of Care, Medical Director, and Classic Care Pharmacist / representative review the contents and utilization of the eBox at least annually and make any necessary changes based on need and usage.

Silver Fox, the pharmacy service provider, had a similar requirement for the annual review of the emergency drug box. In respect of the specific use of glucagon from the EDB, Jonathan Lu, Silver Fox's pharmacist, told the Inquiry that there was no process for "glucagon tracking in the home, other than to refill the emergency box. If it [glucagon] was being used a lot, it could be caught when filling the emergency box because glucagon use is a sign of poorly managed diabetes."

C. Handling of Insulin

As at Caressant Care (Woodstock), residents who were diabetic and required insulin were on the pen and cartridge system. In 2014, residents of Meadow Park (London) were not yet using disposable pens.

1. Delivery, Receipt, and Storage

When insulin was ordered, it was delivered by the pharmacy service provider. The boxes of insulin cartridges were stored in an unlocked refrigerator in each (locked) medication room. There were no bins to store each resident's insulin separately. If a resident was prescribed more than one type of insulin, the individual's boxes of cartridges would be stored together, bound with an elastic.

In 2014, the residents' insulin pens were stored in the same drawer in the locked medication cart. If a resident had two or more pens, they would be bound together.¹⁰

2. Administration

Jarlette's Diabetic Care policy for use in all its homes, implemented in 2007 and revised in 2013, addressed topics including the administration of insulin. It provided that "Where practical, two Registered staff shall conduct

¹⁰ When Meadow Park (London) changed pharmacy service providers in 2016, its new provider changed medication carts and implemented a practice to separate residents' insulin pens. As a result, pens were stored in a bin next to a resident's other non-controlled medications.

an ‘independent double-check’ to be in line with ISMP [Institute for Safe Medication Practices] which includes the dosage and type of insulin to be administered.”

Ms. Nicholas stated that she did not recall ever having seen the Diabetic Care policy before, and that it would have been impractical to have a second nurse independently check the dosage and type of insulin to be administered.

Ms. Smith, the co-director of care, was aware of the Diabetic Care policy, but also believed it was not practical to involve two staff members in insulin administration at Meadow Park (London). However, she noted, if new staff had not previously worked with insulin pens, it would be suggested that they conduct a double-check until they became comfortable using the pens.

One nurse from Meadow Park (London) testified that she would not have a peer double-check the dose she had calibrated unless she had received a “stat order.” In other words, if the insulin dose was a regular, prescribed dose, there would be no double-check. If, however, the doctor ordered a new dose that was not yet entered into the eMAR, she would ensure that a peer double-checked what she was doing.

3. Tracking and Disposal

Other than recording its administration on the eMAR, there was no tracking of insulin usage or cartridge disposal by either Meadow Park (London) or its pharmacy service provider.

At Meadow Park (London), used or expired insulin cartridges could be disposed of in the sharps container or the non-controlled-drug destruction box. Nurses were not required to document disposal of a cartridge or note that a new one had been taken from the resident’s supply in the refrigerator. Further, as explained in Chapter 4, cartridges would often still have some insulin remaining in them when they were disposed of.

D. Handling of Controlled Substances

In this section, I review how Meadow Park (London) handled controlled substances, including the controls the home had in place to prevent these medications from going missing.

1. Delivery and Receipt

At Meadow Park (London), a nursing staff member would receive controlled substances from the pharmacy service provider's driver, usually in the evening. Both the nurse and the driver would sign to indicate that the medications had been delivered. The medication bags were labelled to indicate the unit to which they were to be delivered. The recipient nurse would then deliver the controlled substances to the nurse on the specified unit. The unit nurse was responsible for reconciling what had been ordered with what had been received, and for recording what had been received in the drug record book.

2. Storage and Administration

Narcotics were kept in a separately locked bin in the locked medication cart. Only the nurse in charge of the unit had the keys to that unit's medication room, medication cart, and the narcotics bin within the medication cart. When a nurse administered a narcotic at Meadow Park (London), he or she would have to sign off on both the eMAR and the individual narcotic count sheet. At the end of each shift, the nurse who had been on duty would hand the keys to the incoming nurse. A narcotic count would then have to be conducted by both nurses.

3. Disposal and Destruction

The disposal and destruction of controlled medications at Meadow Park (London) generally followed the process outlined in Chapter 4. Two nurses were required to dispose of narcotics. The nurses would compare the number of tablets remaining in the blister card with the number of tablets recorded on the narcotic count sheet. They would note the date on which the card was being disposed of on the narcotic count sheet, and both nurses would sign off that the quantity left to be destroyed matched what was recorded on that sheet. They would then attach the narcotic count sheet to the narcotic card and deposit it into a controlled-drug destruction box. This was a locked box, nailed to the floor and located in a locked room in the Oxford Unit.

The pharmacist and the director of care (or the nursing staff member appointed by the director of care) would both be present for the destruction of controlled drugs. The drugs would be removed from the controlled-drug destruction box, counted by both individuals, and then denatured by the pharmacist. That process would include the removal of the medication from any packaging or vials, combining the medications together in a drug destruction bucket and diluting them with water. A locked lid would then be placed on the bucket for pickup by a waste management company.

4. Missing Narcotics in April 2014

On April 24, 2014, Ms. Adams and Ms. McInnes were completing the destruction of controlled medications. At that time, they reviewed the narcotic count sheet from the controlled-drug destruction box. It identified that a blister card, containing 11 tablets of hydromorphone, had been signed for by two nurses on February 14, 2014, as being deposited into the box. However, they could not locate that blister card in the controlled-drug destruction box.

That same day, Ms. McInnes completed an internal Risk Occurrence form. Ms. Adams, along with Ms. McInnes, conducted an investigation into the missing narcotics. They examined the shift count sheets to check for any errors and looked at the chart of the resident for whom the narcotics had been prescribed. They determined that the hydromorphone was supposed to have been removed from circulation, as the resident was no longer to receive it.

In Ms. Adams's opinion, while two nursing staff members had signed to indicate that the narcotics had been removed from the medication cart, the drugs had never been put in the controlled-drug destruction box. In contrast, Ms. McInnes believed that the hydromorphone had been deposited into the drug destruction box on February 14, 2014. Accordingly, the narcotics would have gone missing from the controlled-drug destruction box at some point between February 14 and April 24, 2014.

Only Ms. Nicholas had the key to the controlled-drug destruction box. Ms. Nicholas advised that she had never noticed, nor had anyone reported to her, that the controlled-drug destruction box looked as though it had been damaged or had any flaw that would allow access. Ms. Smith similarly testified that she never had any indication that this box had a flaw or had been tampered with.

Although the incident was internally reported, the home did not prepare the required Critical Incident report for the Ministry, nor did it call the police. Ms. Nicholas, who signed the Risk Occurrence form, was unable to advise the Inquiry about why those steps were not taken and could not recall whether there was ever any indication of how the drugs had gone missing. Following this incident, Meadow Park (London) implemented a ledger for the controlled-drug destruction box in which the two nurses were required to record and sign for all controlled substances placed into the box. This process was meant to provide verification that two people had witnessed both the medication and the narcotic count sheet being deposited into the box.

Regardless of whether the drugs were diverted before they went into the box or were somehow removed from the box at a later date, there was no evidence before the Inquiry to show that Wettlaufer had stolen those drugs. If the drugs never made it into the box on February 14, 2014, then they were diverted before Wettlaufer began working at Meadow Park (London). For Wettlaufer to have been involved in the diversion after the drugs went into the box, she would have needed access to the medication room and the locked controlled-drug destruction box at some point between April 22 and April 24, 2014. Wettlaufer attended in-class orientation at Meadow Park (London) on April 22 and 23, 2014, and would have had no access to the medication rooms. On April 24, 2014, Wettlaufer was completing her first day of orientation on the floor and would not have had a key or access to the medication room without being accompanied by a nursing staff member.

V. Abuse and Neglect Incident Reporting

As of 2014, Meadow Park (London) had a detailed “Abuse–Zero Tolerance” policy for resident abuse (Abuse Policy), on which all staff received orientation.¹¹ The general process was for staff to approach management to report their concerns. The process that Meadow Park (London) would undertake following an allegation of abuse is demonstrated by an incident that occurred in July 2014 involving Mr. Horvath.

A. Incident of July 25, 2014

According to a Critical Incident report filed by Meadow Park (London) the morning of July 26, 2014, an incident involving Mr. Horvath and a staff member took place the previous evening. There was an allegation that Mr. Horvath had slapped a PSW and she had slapped him back, and that he had then spat at her and she had spat back at him. Wettlaufer was not involved in the incident.

In terms of the immediate handling of the incident, the evidence indicates the following:

- the incident was immediately reported to the charge nurse;
- the co-director of care was notified, as was the administrator;

¹¹ Although Jarlette updated its Abuse Policy in September 2013, when Wettlaufer was hired in April 2014 she signed off on its January 2013 version. It is that version which I will refer to in this chapter.

- the co-director of care contacted the Ministry through its after-hours reporting line;
- the police were contacted;
- the staff member involved was sent home pending investigation;
- the charge nurse completed a head-to-toe assessment of Mr. Horvath and noted no injury or bruising; and
- a Critical Incident report was filed the following morning.

Mr. VanderHeyden described the general process of the home's investigation into allegations of abuse:

- the staff member who was alleged to have abused a resident would immediately be put on paid administrative leave;
- the appropriate manager would conduct an investigation at the time and prepare and file a Critical Incident report;
- the police would be contacted;
- the resident's substitute decision-maker would be notified;
- the administrator and/or the director of care would interview the witnesses;
- the incident and investigation would be communicated to Jarlette's Human Resources Department; and
- disciplinary measures would be decided and taken by human resources (if necessary).

Following its investigation into the incident involving Mr. Horvath, Meadow Park (London) terminated the employment of the individual involved in it. The Inquiry learned that the employee had received orientation on the Abuse Policy and had signed off on it.

After the incident, Meadow Park (London) took steps to ensure that everyone had reviewed and signed off on the Abuse Policy, and the home created additional educational material for its staff.

The Ministry conducted an inspection of this incident and made no findings of non-compliance.

B. Incident of August 10, 2014

A possible incident of abuse involving Mr. Horvath occurred on August 10, 2014. Wettlaufer recorded in Mr. Horvath's progress notes that she had noticed that the drawstring on Mr. Horvath's pants was wrapped around his bed rail and tied in a tight knot. As a result, Mr. Horvath was unable to turn onto his left side. Wettlaufer noted that she untied the knot, unwrapped the drawstring, and checked Mr. Horvath for injuries. She spoke to the two PSWs working that shift and recorded that neither of them had noticed that Mr. Horvath was tied to the rail.

Wettlaufer did not complete an internal Risk Occurrence form to notify management of the incident, although she did note that she had called the "manager on call to report the occurrence as it was unusual." Ms. Nicholas, Ms. Smith, and Mr. VanderHeyden were unaware of this incident. A Critical Incident report for the Ministry was not completed.

In 2016, after the Offences became known, the incident came to the Ministry's attention. The inspectors issued a written notification, accompanied by a voluntary plan of correction, to the licensee of Meadow Park (London) for failing to "ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director." This inspection is addressed further in Chapter 12.

VI. Hiring of Wettlaufer

The previous sections of this chapter dealt with general processes at Meadow Park (London). In this section, I turn my attention to Wettlaufer, who was hired at Meadow Park (London) within weeks of losing her job with Caressant Care (Woodstock). I focus on the home's hiring of Wettlaufer, the information Wettlaufer disclosed regarding her employment history, and the information available to Meadow Park (London) from other sources before it hired her.

A. Wettlaufer's Resumé

There was some confusion over whether Wettlaufer "applied" for a job at Meadow Park (London) or whether the home contacted her. It is not clear how Wettlaufer's resumé came into the possession of Meadow Park (London).

On Wettlaufer's resumé, under "Professional Summary," she stated that she was a registered nurse, "with 18 years experience in long term care and assisted living care." She stated that she was most recently a charge nurse with Caessant Care (Woodstock) (from 2007 to 2014) and before that had worked as a support staff at Christian Horizons (from 1996 to 2007). She indicated on her resumé that she became a registered nurse in 1995 and started working in 1996. Wettlaufer's resumé did not reflect her short-lived employment at Geraldton District Hospital in 1995 (Wettlaufer did not disclose this information in her later applications to Life Guard Homecare and Saint Elizabeth Health Care).

B. Wettlaufer's Group and Individual Interviews

Wettlaufer participated in both a group interview and an individual interview before being hired by Meadow Park (London).

1. Group Interview

Wettlaufer attended a group interview on April 14, 2014. Although Ms. Nicholas could not recall the number of other applicants who participated in that session, she believed there was at least one other at that time. Ms. Nicholas found Wettlaufer to be very nice and professional, and she asked Wettlaufer to attend for an individual interview later that day.

Although both the interviewees and the interviewers in group interviews needed to complete a number of forms, Meadow Park (London) was unable to locate any documents that specifically related to Wettlaufer's group interview.

2. Individual Interview

Ms. Nicholas interviewed Wettlaufer individually on April 14, 2014. Using the Jarlette Way method, she asked Wettlaufer a series of questions. Ms. Nicholas could not recall precisely which questions she asked, although she did make some notes of the various responses that Wettlaufer gave.

At the top of her notes from her interview with Wettlaufer, Ms. Nicholas wrote, "Caessant Care put wrong insulin mistake got noticed." Ms. Nicholas explained that Wettlaufer told her that she had made a medication error with insulin while at Caessant Care (Woodstock).

Although there is some confusion over the timing of Wettlaufer's disclosure to Ms. Nicholas that she had been dismissed from Caessant Care (Woodstock), it

appears that, at this initial interview, Wettlaufer advised Ms. Nicholas that the reason for her leaving was that she “was not getting along with her coworkers.”

Ms. Nicholas expressed that, during this interview, Wettlaufer was “very knowledgeable and very professional” and “seemed to know her stuff.”

C. Employment Reference Checks

At the time of her interview, Wettlaufer provided Ms. Nicholas with a list of the following references:

- David Petkau – former supervisor at Christian Horizons;
- Sandra Fluttert, RN – former supervisor at Caressant Care (Woodstock);
- Jennifer Hague, RN – former co-worker at Caressant Care (Woodstock);
and
- Karen Routledge, RN – former co-worker at Caressant Care (Woodstock).

On April 21, 2014, Ms. Nicholas was able to contact three of Wettlaufer’s four references. She spoke to Mr. Petkau, Ms. Fluttert, and Ms. Hague. Ms. Nicholas recorded her conversations on Jarlette’s Applicant Reference Check form.

According to Ms. Nicholas’s notes, Mr. Petkau told her that he had supervised Wettlaufer for six years, during which time she worked as a primary support worker for individuals. Among other things, Ms. Nicholas noted that Mr. Petkau had a lot of trust in Wettlaufer; that Wettlaufer was very valued and was an active team member, with “very good” work habits; and that there were no issues with her attendance. Mr. Petkau said that Wettlaufer left Christian Horizons to pursue her nursing career and that he would rehire her. No negative aspects or weaknesses were listed.

Ms. Fluttert was the resident care coordinator at Caressant Care (Woodstock) in 2014 (she later became its assistant director of care). According to Ms. Nicholas’s notes, Ms. Fluttert told her that Wettlaufer was very good with residents. She was liked and respected by her peers; she had a problem-solving ability; she was able to work independently; she was slow at some tasks but completed her work; and she was always early for her shift. Under “Attendance,” Ms. Nicholas identified that Ms. Fluttert had stated “health issues working great now.”

In response to the question, “What were the circumstances surrounding his/her leaving?” Ms. Nicholas’s notes of her discussion with Ms. Fluttert say,

“Personality conflict both sides [with] manager other involved in med error not just her.”

Ms. Fluttert also provided the additional comment, “As coworkers we make mistakes but there was more than just her several nurses.”

Ms. Fluttert identified Wettlaufer’s strengths as “caring for residents, always early, loved to mentor and teach, good with students, healthcare professional, good teacher.” No negative aspects were listed.

Finally, Ms. Nicholas contacted Ms. Hague, a former co-worker at Caressant Care (Woodstock). According to Ms. Nicholas’s notes, Ms. Hague identified that Wettlaufer had had a “health issue,” but that it was resolved. Ms. Nicholas noted Ms. Hague’s response to the question about the circumstances surrounding Wettlaufer’s leaving:

Med error. I wasn’t in on it. Multiple people were involved couple med errors.

No other negative aspects or weaknesses were listed.

Ms. Nicholas did not speak with Ms. Routledge.

Ms. Nicholas did not attempt to contact anyone else at Caressant Care (Woodstock). Ms. Nicholas testified that it was the practice at Meadow Park (London) not to call the applicant’s “boss.” As a result, if someone had experience in long-term care, she would not call the administrator or the director of care of their current place of employment unless the applicant listed those individuals as references.

D. Registration Check from the College

On April 21, 2014, Meadow Park (London) conducted a Find a Nurse search on the College’s Register. The search showed that Wettlaufer was entitled to practise, with no restrictions.

E. The College’s Medication Self-Test

Ms. Nicholas testified that she would ask nurses to complete a medication self-test on the College’s website if they had made medication errors. She believed that medication errors were common in nursing and that best practices included self-reporting of errors.

In light of Wettlaufer's medication error at Caressant Care (Woodstock), Ms. Nicholas asked Wettlaufer to complete this test to ensure that her skills and knowledge were sufficient. Ms. Nicholas was not sure if the quiz had any questions related to insulin, or the type of medication error that Wettlaufer described to her. Wettlaufer completed the College's self-test on April 22, 2014. She obtained a perfect score: 9/9.

F. Criminal Reference Check

On April 22, 2014, a criminal reference check, including a vulnerable sector screen, was produced by Wettlaufer. The check was clear.

G. Orientation and Application for Employment

Wettlaufer began her orientation at Meadow Park (London) on April 22, 2014. Her first day of general orientation consisted of a review of various policies, videos, PowerPoint presentations, and quizzes. She signed off as having completed each part, and continued with her general orientation the next day. Again, she signed off as having received all the required training. On April 25, Wettlaufer received four hours of eMAR training. Thereafter, she was oriented to the various shifts as described earlier in this chapter.

During the second day of orientation, Wettlaufer completed an Application for Employment. Ms. Nicholas advised that this application was completed on that date because "that's when she was actually going to be working for us."

In completing the application, Wettlaufer wrote "dismissed" under "Reason for Leaving" Caressant Care (Woodstock). Ms. Nicholas advised the Inquiry that Wettlaufer told her that "because she was under a union there was an investigation and that she knew she didn't do anything wrong." Wettlaufer told Ms. Nicholas that she would be cleared. When asked at the Inquiry whether this disclosure had any impact on hiring Wettlaufer, Ms. Nicholas advised:

Yes, because I've made med errors as a nurse, and it does happen, and so – and I thought I had done correct in making sure that she, you know, did the medication thing from the College of Nurses.

Ms. Nicholas testified that, on learning of Wettlaufer's dismissal from Caressant Care (Woodstock) because of a medication error, she was not concerned that that home may have made a report to the College. Ms. Nicholas had already completed a licensing check with the College, and it had not revealed any restrictions on Wettlaufer's practice. As addressed in Chapter 13, the College

did not receive the report of Wettlaufer's termination of employment from Caressant Care (Woodstock) until May 1, 2014. In any event, at no time did the College place any restrictions on Wettlaufer's licence as a result of the Caressant Care (Woodstock) report.

VII. The Offence

In August 2014, Wettlaufer murdered Arpad Horvath.

Mr. Horvath had a number of medical conditions, including diabetes. His diabetes was managed through an oral tablet medication, Metformin.

Wettlaufer confessed to attending Mr. Horvath's room at approximately 20:00 on August 23, 2014, while she was working the evening shift, and injecting him with 80 units of short-acting insulin and 60 units of long-acting insulin.

Felina Cabrera, a registered nurse who worked full-time nights at Meadow Park (London), was on duty that night. Wettlaufer gave Ms. Cabrera the nursing report at shift change. She mentioned difficulties with Mr. Horvath's behaviour but did not report a worsening of his condition. In keeping with her usual routine, Ms. Cabrera did her rounds at approximately 24:00. She checked on Mr. Horvath. There was no indication that anything was wrong.

Early the next morning, two PSWs told Ms. Cabrera that Mr. Horvath was verbally unresponsive. Ms. Cabrera checked his vital signs. Her practice was to check blood sugar levels, which she thought of as the "fifth vital sign." Mr. Horvath's blood sugar level was 3.1,¹² which indicated to her that he was hypoglycemic.

Ms. Cabrera called emergency medical services (EMS) to take Mr. Horvath to hospital. While waiting for EMS to arrive, Ms. Cabrera directed the registered practical nurse on duty to administer glucagon, an emergency drug, to Mr. Horvath. The drug did not result in an increase to Mr. Horvath's blood sugar level. Mr. Horvath continued to be verbally unresponsive and was transferred to hospital.

Mr. Horvath passed away at London Health Sciences Centre on August 31, 2014. Ms. Cabrera advised that she could not recall Mr. Horvath previously having a hypoglycemic event on the night shift. However, she further indicated that when she learned he had passed away in the hospital, she "did not find it suspicious or unusual."

¹² Taken from Mr. Horvath's progress notes at para 56. Ms. Cabrera's affidavit said it was 2.0.

VIII. The Caressant Care (Woodstock) Reference Letter

As I noted in Chapter 5, in June 2014, Wettlaufer's grievance with Caressant Care (Woodstock) was settled and she was given a reference letter. At some point after having received that letter, Wettlaufer provided a copy to Ms. Nicholas.

Ms. Nicholas indicated that Wettlaufer gave her the letter and said words to the effect that she had been "cleared." Given that no issues with Wettlaufer's performance had been reported to management at the time Meadow Park (London) received this letter, it was simply placed in Wettlaufer's file.

IX. Wettlaufer's Performance

Two performance issues were raised regarding Wettlaufer during her time at Meadow Park (London). The first related to her attendance, and the second to concerns raised by a night shift nurse in September 2014, after the Offence was committed and a few weeks before Wettlaufer tendered her resignation. Aside from those two concerns, there do not appear to have been significant performance issues with Wettlaufer while she worked at Meadow Park (London).

A. Attendance Issues

Ms. Nicholas testified that Wettlaufer had called in sick for more than two days in one month. The calls were usually just before the start of her shift, which meant the staff scheduler or, if after hours, the nurse, had to start the process of calling in another nursing staff member. There was never any indication that Wettlaufer's absences related to drug or alcohol abuse.

On August 8, 2014, Ms. Nicholas gave Wettlaufer a letter which said that Meadow Park (London) had implemented an attendance awareness program and that Wettlaufer's attendance was on the threshold parameters of the program: "2 days [absent] in one month or 3 months with one occurrence in each month." Wettlaufer was encouraged to maintain regular attendance, failing which she would have to meet with Ms. Nicholas and develop an attendance plan.

After Wettlaufer received the letter, Ms. Nicholas did not have to address her attendance again.

B. Letter of September 16, 2014

On September 16, 2014, Ms. Cabrera wrote directly to Wettlaufer, outlining her frustrations and concerns with her. In this letter, Ms. Cabrera described how Wettlaufer had left her shift on two or three occasions without completing the controlled drug count. Ms. Cabrera testified that Wettlaufer would not pick up trash from the medication cart or the medication room, and would not clean and organize the medication cart.

Ms. Cabrera provided Ms. Nicholas with a copy of the letter she had given to Wettlaufer. This was the only time she expressed any concerns about Wettlaufer to management and the only notification Ms. Nicholas received that concerned Wettlaufer's performance.

On investigation, Ms. Nicholas found that Wettlaufer was not alone in failing to do a narcotic count. She testified that other nurses had been leaving their shifts before counting the controlled medications. Ms. Nicholas met with all registered staff, instructing them to stay and make sure they completed the count together. According to Ms. Nicholas, this issue was not raised again.

C. Wettlaufer's Overall Performance

There do not appear to have been significant performance issues with Wettlaufer while she was at Meadow Park (London). There were no reports of inappropriate comments or of medication errors. With one exception, the home's administrator, director of care, and co-director of care all testified that they did not receive any complaints from residents or families regarding Wettlaufer's practice as a nurse or the care she provided to residents. Ms. Smith described the one exception: a resident wanted his medication before its prescribed time for administration, and Wettlaufer would not administer it outside of that prescribed time.

Wettlaufer was observed as being cordial and polite with residents. One co-worker described her as follows:

I actually thought she was really nice. She seemed to be conscientious. She seemed to care for her residents. She was intelligent, it was obvious by the way she spoke and the knowledge base that she had.

So I did not think that she would turn out to be the person she did turn out to be. She seemed nice. She seemed conscientious when I worked with her.

Ms. Smith, who was often on the floor and would see Wettlaufer for the first few hours of her evening shift, described Wettlaufer in this way:

So Beth was a very jovial person. She was one that I felt maybe lacked some confidence just because she had that presentation of wanting to fit in with people. She was very nice to the residents, she was very nice to me, to staff.

X. Wettlaufer's Letter of Resignation

In a letter dated September 25, 2014, to Ms. Nicholas, Wettlaufer wrote:

Dear Heather: Thank-you for the opportunity to work as a registered nurse here at Meadow Park Nursing Home. I have enjoyed and appreciated the opportunity to use my skills and knowledge. I have also enjoyed the opportunity to continue to learn people management skills.

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.

It is therefore with huge regret that I tender this resignation effective Wednesday October 15, 2014.

Thank you

Ms. Nicholas did not at this time have a discussion with Wettlaufer about what she meant by "an illness which will require long term treatment," but assumed that Wettlaufer was seeking medical treatment.

XI. Wettlaufer's Disclosure of Overdosing

Wettlaufer's last day of work at Meadow Park (London) was September 26, 2014. On or about September 30, 2014, Wettlaufer told Ms. Nicholas that "she had had a terrible weekend and had been in the hospital with an overdose and that she had a drug and alcohol addiction." Ms. Nicholas told Mr. VanderHeyden that Wettlaufer had disclosed that she had a substance abuse problem. Ms. Nicholas, Mr. VanderHeyden, and Ms. Smith all testified that Wettlaufer never appeared to be under the influence of drugs or alcohol at work, nor had any staff member raised such a suspicion. Ms. Nicholas was never concerned about Wettlaufer's nursing skills, nor had anyone

reported any concerns related to Wettlaufer's "ability to practise as a nurse." Ms. Smith similarly advised that she did not have concerns over Wettlaufer's performance or her nursing skills.

The next day, October 1, 2014, Wettlaufer came into work and met with Ms. Nicholas. She brought a note from a doctor that read: "This letter is to certify that the above patient was assessed in this office and is recommended to be off until further notice." Ms. Nicholas testified that Wettlaufer also told her that she wanted to rescind her resignation and return to work. Wettlaufer said she thought she should be given another chance.

Mr. VanderHeyden believed he found out that Wettlaufer had resigned when Ms. Nicholas told him that Wettlaufer had disclosed her overdose and substance abuse problem. He testified that he had a vague recollection of a conversation with Ms. Nicholas about the need to support Wettlaufer if she had a substance abuse problem. He could not recall specifically when this conversation with Ms. Nicholas occurred, but speculated that it might have been around the time Wettlaufer asked Ms. Nicholas to consider allowing her to rescind her resignation.

Ms. Nicholas did not accept Wettlaufer's request to rescind her resignation. Wettlaufer never returned to work at Meadow Park (London).

After Wettlaufer tendered her resignation, Meadow Park (London) did not report her to the College either when she told Ms. Nicholas that she had overdosed and had a drug and alcohol addiction or when the home found that narcotics were missing and strongly suspected Wettlaufer was responsible.

In identifying why she felt it was not necessary to report either matter to the College, Ms. Nicholas testified that it was because Wettlaufer had resigned and because Wettlaufer's doctor's note did not identify an addiction; there had been no police charges laid against Wettlaufer; Wettlaufer's resignation letter stated she would not be working for a period of time; and Wettlaufer was going for medical treatment. Ms. Nicholas advised that, to her, the context to Wettlaufer's admission of a drug and alcohol addiction was that Wettlaufer "was going to be taking care of herself. Under medical attention. She was going for treatment."

XII. Discovery of Missing Narcotics

On October 2, 2014, Meadow Park (London) discovered that a resident's narcotics order, which had been ordered from the pharmacy service provider on September 26, 2014, had never been entered into the home's system as having been received. That discovery set off a number of investigations, which would eventually focus on Wettlaufer.

During the day shift on September 26, 2014, 15 tablets of a narcotic, hydromorphone, were ordered from the pharmacy for a Meadow Park (London) resident who lived in the Kent Unit. The resident's prescription called for one-half-tablet doses and, therefore, the medication would come from the pharmacy in a 30-dose blister card. The resident had two prescriptions for this drug. One was a regular prescription, to be given four times a day. The other was a prescription to be given when necessary (PRN). On September 26, 2014, staff reordered the resident's regular prescription. Once the few remaining doses of the resident's regular prescription were finished, on September 29, 2014, the nursing staff started to use the resident's PRN prescription as a substitute.

On October 2, 2014, staff ordered the regular prescription for a second time. When reviewing this order, the pharmacy determined that the same prescription had been ordered on September 26, 2014, and delivered to the home that same day. The hydromorphone, however, had never been entered into the home's system as having been received.

Ms. Smith, the co-director of care, testified that she learned on October 2, 2014, that the pharmacy service provider had identified that a narcotic card had been delivered to Meadow Park (London), but could not be located. Ms. Smith acknowledged that staff at the home should have identified the missing prescription to management earlier, rather than using the resident's PRN medication as a substitute for the regular supply.

A search of the home ensued, without success. The police were notified, and a Critical Incident report was filed with the Ministry. Thereafter, Meadow Park (London) (in conjunction with the pharmacy service provider), the police, and the Ministry each carried out investigations.

A. Investigation by Meadow Park (London) in Conjunction with the Pharmacy Service Provider

After learning about the missing hydromorphone on October 2, 2014, Ms. Adams and Ms. Smith, along with Ms. Nicholas and Mr. VanderHeyden, immediately began an investigation. They checked with the pharmacy service provider and confirmed that the prescription had been ordered, filled, and shipped on September 26, 2014.

On that day, the pharmacy service provider had delivered all of the home's ordered medications to the Elgin / Oxford Unit, and a registered practical nurse on duty on the evening shift, Smitha Beeny, had taken receipt of them and signed the driver's log. The pharmacy delivered four bags in total: three white bags containing controlled drugs, and one brown bag containing non-controlled drugs.

Meadow Park (London) obtained the shipping reports from the pharmacy service provider. All the reports for the September 26 medications had been signed by the pharmacy. All the reports for that day's medications were also signed as having been received on the units – except the report for the card of hydromorphone destined for the Kent Unit. That report, although signed by the pharmacy service provider, had never been signed as having been received by the Kent Unit.

The drug record book, which recorded the orders for both the controlled and the non-controlled medications for the Kent Unit, was examined. It indicated that a narcotic and a non-controlled medication had been ordered for the Kent Unit on September 26 but that Wettlaufer, the nurse on duty, had signed only for the receipt of the non-controlled medication. There was no signature to indicate that the controlled medication had ever been received by the Kent Unit.

Various staff members were interviewed during the course of the internal investigation at Meadow Park (London). Wettlaufer was not one of them. By this time, Wettlaufer had tendered her resignation and submitted the doctor's note that indicated she could not work until further notice.

During the home's investigation, Ms. Beeny confirmed that she had signed for four bags of medication. Ms. Beeny told the internal investigation team that Wettlaufer had given her the keys to the medication room (only Wettlaufer would have had the keys to the medication room on the Kent Unit) and that she (Ms. Beeny) placed the medications in the medication room, because Wettlaufer was too busy to do this herself.

Wettlaufer never told Ms. Nicholas that she had taken the hydromorphone from Meadow Park (London). When interviewed by the police in 2014, Wettlaufer claimed that Ms. Beeny had left the medications on the desk “and there was never a narcotic bag there” or “someone else took it.”

Although there were strong suspicions that Wettlaufer was responsible for the missing hydromorphone, the internal investigation was unable to definitively conclude what had happened to the narcotics.

B. Police Investigation

The police were notified of the missing hydromorphone on October 2, 2014. They went to Meadow Park (London) that day and interviewed Ms. Nicholas, Ms. Smith, Mr. VanderHeyden, and Ms. Adams as a group. The police prepared only one witness statement, which contained the information from all four individuals but was entitled “Civilian Witness Statement – 1 – Smith, Melanie.” Although the Civilian Witness Statement was a combination of comments from all four individuals, none of the comments were attributed to a specific person.

The Civilian Witness Statement referenced the following comments:

Yesterday afternoon Beth came into my office. She had resigned to say she was leaving us for medical reasons. And her last day is to be October 15, 2014. And so she worked September 26, 2014 it's on the roster. She came into my office yesterday. I asked Valerie [Valerie Boulton, staff educator] to be in the office. She had missed days at work. She brought a doctor's note in and it said she has an alcohol and drug problem. And she said she almost died last weekend.

She said she was reconsidering to come back after getting treatment but she would be off until January for sure. But she asked to come back here to work. I said I was sorry she was having this problem. And I told her I would think about it. But I had already accepted her resignation.

Ms. Nicholas testified that she made these comments to the police, as she had met with Wettlaufer on October 1, 2014. She acknowledged, however, that the note from Wettlaufer's doctor did not reference that Wettlaufer had a drug and alcohol problem, but that Wettlaufer had told her that directly.

On October 7, 2014, Constable Derek Wheeler interviewed Ms. Beeny. His Case Summary indicates that she advised him that:

- she received four medical packages for her Elgin / Oxford Unit and three medical packages for the Kent Unit;
- she did not look at what specific packages were prescribed for the Kent Unit;
- at approximately 18:00 she took the packages to the Kent Unit and placed them next to the wash basin in the locked medication room;
- the door locked behind her when she left;
- she did not open or remove any of the Kent medication packages;
- she told Wettlaufer where she had put the medication packages and returned to the Elgin / Oxford Unit; and
- she did not see Wettlaufer open or remove any of the Kent medication packages.

That same day, the police interviewed Wettlaufer, who confirmed that she worked from 14:30 to 22:30 on September 26, 2014. Wettlaufer's story differed from Ms. Beeny's account. According to the Case Summary, Wettlaufer described the events of September 26, 2014, as follows:

- Ms. Beeny came into the Kent Unit at approximately 18:30, when Wettlaufer was with a resident;
- Ms. Beeny told her that she had left her medication on the nursing desk;
- the nursing desk is outside the medication room and accessible to all staff and residents;
- roughly five to 10 minutes later, Wettlaufer went to the nursing desk but there were only two brown bags (non-controlled medications) and no white bags (controlled medications); and
- although she should have immediately retrieved and secured the medication, she did not steal it.

Ms. Nicholas called the police on October 10, 2014, and again on October 17, 2014, to ask about the status of their investigation since there had not yet been a report back to Meadow Park (London). She testified that the police told her they were still investigating at that point.

The Case Summary prepared by the police concluded that there was "not enough evidence to support a criminal charge."

C. Ministry Inspection

Meadow Park (London) reported the missing hydromorphone to the Ministry of Health and Long-Term Care on the same day that management learned they were missing. Rhonda Kukoly, an inspector with the Ministry, conducted the inspection, which focused on the home's compliance with the LTCHA and its regulations. A more detailed review of the Ministry's processes and procedures and the way in which the Ministry conducts its inspections can be found in Chapter 9.

As part of her inspection, Ms. Kukoly reviewed the policies of the Meadow Park (London) pharmacy, determining that:

- Meadow Park (London) was following the policy related to ordering and receiving drugs;
- the policy was up to date and comprehensive, it provided clear direction, and it was compliant with legislation and regulations; and
- no concerns were noted related to the medication policy.

Ms. Kukoly determined that the resident had not missed any medication and the narcotic counts were being completed in accordance with the applicable policy. She indicated that the inspection was "being closed with no findings of non-compliance. The home has a policy, it is being followed and the home completed a thorough investigation and took appropriate actions." Her report was released on November 5, 2014, with no findings of non-compliance.

D. Changes Made by Meadow Park (London)

After the investigation into the missing narcotics was completed, the home's pharmacy service provider gave an in-service education session to all staff on "ordering medications, receiving medications, and handling of medications, specifically narcotic and controlled." This session included an instruction to notify the pharmacy service provider or management immediately if an order was placed but not received.

A change was also made to the delivery of medications to Meadow Park (London). Instead of the single nurse from the Elgin / Oxford Unit signing for all the home's medications and delivering them to the units, the pharmacy driver began taking the medication to each unit and requiring the nurse from that unit to sign off on receipt of the medications.

XIII. Ministry's Inspection of Meadow Park (London) After the Offences Became Known

On October 5, 2016, Meadow Park (London) submitted its Critical Incident report relating to Mr. Horvath to the Ministry, after the police had notified management of Wettlaufer's confession to his murder. The Ministry began its inspection on October 28, 2016. On February 6, 2017, the Ministry issued a compliance order that outlined numerous requirements related to the medication management system at Meadow Park (London). Among other things, the compliance order addressed the problems with the education that had been provided to staff on medication policies, the labelling on insulin pens, and various issues with the handling of controlled medications at the home.¹³

The Ministry's inspection report, issued in August 2017, contained eight written notifications of non-compliance, seven of which were accompanied by voluntary plans of correction.

I discuss the Ministry's inspection of Meadow Park (London) after the Offences became known, in Chapter 11.

XIV. Changes Made by Meadow Park (London) Since the Wettlaufer Offences

Jonathan Lu, Silver Fox's pharmacist, testified that, after the Offences became known, he worked with Jarlette to "develop medication management education." He advised that the training lasted for eight hours, and addressed the entire medication management system as outlined in the regulations to the LTCHA. This training was mandatory and provided to all of Jarlette's homes.

Another change, identified through the annual Medication Safety Self-Assessment tool created by the Institute for Safe Medication Practices, involved the labelling of high-alert medications. Mr. Lu testified that Silver Fox changed its work flow so that the packaging of these medications, including insulin, would indicate that they were high alert.

¹³ As noted, in 2016, before the Offences were known, Meadow Park (London) changed its pharmacy provider from Classic Care to Silver Fox Pharmacy. Meadow Park (London) staff were educated on Silver Fox's policies and procedures on Aug. 22 and 23, 2016.

RECOMMENDATIONS

The situation at Meadow Park (London) was similar to that at Caressant Care (Woodstock), and so the same recommendations apply. I therefore direct the reader to the recommendations set out at the end of Chapter 4.

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I. Introduction

The *Long-Term Care Homes Act, 2007* (LTCHA)¹ seeks to ensure that residents in long-term care (LTC) homes receive continuous and consistent nursing care. However, emergencies occasionally arise that prevent nurses from working their shifts. When this happens on very short notice and homes cannot get a member of their nursing staff to cover the shift, they turn to agencies that provide temporary personnel, including registered nurses. Within the LTC home system, these nurses are called agency nurses. In 2017, there were 6,104 agency nurses in Ontario, 621 of whom worked in LTC homes.²

In 2015, Wettlaufer was working as an agency nurse for Life Guard Homecare (Life Guard), which provides temporary personnel – including registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs) – to LTC homes. Its employees also provide home care services, either through private arrangements with clients or as subcontractors to service providers under the *Home Care and Community Services Act, 1994*. The provision of home care services is discussed in Chapters 8 and 12 of the Report.

Wettlaufer was assigned by Life Guard to cover shifts in a number of LTC homes, including Telfer Place, which is located in Paris, Ontario. There she committed one of the Offences: the attempted murder of Sandra Towler in September 2015.

This chapter considers two main themes: the role of agency nurses in the LTC home system; and the lessons we can learn from the Offence Wettlaufer committed while working as an agency nurse. I begin by exploring why LTC homes need to use agency nurses. The challenges homes face in recruiting and retaining nursing staff make it clear that this need will not go away. I also examine the legislative and contractual framework governing the use of agency nurses in LTC homes. I then turn to Telfer Place and its use of agency nurses. I focus in particular on the 20-month period in which Wettlaufer worked for Life Guard, from the time she was hired in January 2015 to her abrupt resignation in August 2016.³

¹ SO 2007, c 8.

² *Nurses in Ontario Long-Term Care Homes*, Ministry of Health and Long-Term Care, December 2018.

³ The date of her resignation is taken from the Agreed Statement of Facts in the criminal proceedings against Wettlaufer (see Appendix B). Some evidence provided to the Commission showed her resignation as having been made in September 2016.

Shortly after Wettlaufer confessed to having committed the Offences, Revera Long Term Care Inc. (Revera), the licensee of Telfer Place, undertook an internal investigation of her work while at Telfer Place. The Ministry of Health and Long-Term Care (Ministry) also conducted an inspection at Telfer Place and some of the other LTC homes in which Wettlaufer worked while employed as an agency nurse. I summarize that investigation and those inspections before concluding this chapter with recommendations relating to the use of agency nurses in LTC homes.

II. Need for Agency Nurses in LTC Homes

A. Circumstances Leading to the Use of Agency Nurses

Section 8(3) of the LTCHA requires every licensee of an LTC home to ensure that there is at least one registered nurse on duty in the home at all times – in other words, “24/7.” However, for many reasons, homes have difficulty recruiting and retaining RNs. LTC homes have to compete with other sectors that employ RNs and are disadvantaged by the heavy workload, the need for shiftwork, the high patient-to-staff ratio, and the comparatively low wages in these homes. If a home is rural or small, it may face additional challenges in hiring and retaining registered nurses.

Homes may not have sufficient full-time, part-time, and casual nurses to cover emergencies, medical leaves, and vacations. When only one registered nurse is scheduled to be on duty and cannot work the shift at the last minute, the LTC home must immediately find a replacement registered nurse to meet its obligations under the LTCHA. In these situations, it is common for many homes – including Telfer Place – to turn to agencies, such as Life Guard, to assist with staffing.

B. Challenges Faced by Agency Nurses in LTC Homes

The regular nursing staff in LTC homes have a heavy workload, and agency staff face additional challenges. Agency nurses who work in a particular home only sporadically are less familiar with the residents. This inevitably means the agency nurse will be slower in completing various tasks and will accomplish less work than regular nursing staff during a shift. Lack of familiarity with residents also affects the amount of detail agency nurses can provide about a resident to other members of the care team.

A physician who testified at the public hearings stated, for example, that, in his experience, agency nurses are sometimes not able to provide a complete contextual briefing on residents. Other witnesses testified that at Telfer Place, the charting completed by agency nurses was not as in-depth as that done by regular staff, their daily reports were less detailed, and their verbal reports at shift changes tended to be quick.

III. Legislative and Contractual Framework Governing the Use of Agency Nurses in LTC Homes

A. Legislative Framework

The LTCHA limits the use of agency nurses by LTC homes “in order to provide a stable and consistent workforce and to improve continuity of care to residents.”⁴ However, the LTCHA does not apply to staffing agencies such as Life Guard. The legal relationship between the LTC home and a staffing agency is governed by a contract between the two; it is the contract that governs the agency’s supply of nurses to the home.

The LTCHA defines “staff” of an LTC home to include agency nurses.⁵ Therefore, apart from a few exceptions, the obligations the LTCHA places on licensees with respect to “staff” also apply to agency nurses who are placed in LTC homes.

1. Use of Agency Nurses in Emergencies

As discussed in more detail in Chapter 5, section 8(3) of the LTCHA requires licensees to ensure that an RN who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times (24/7 RN requirement). To ensure that a nurse who meets these criteria is always present, licensees must ensure there is a backup plan in place to address situations where nursing staff cannot come to work.⁶

Agency nurses do not satisfy the criteria in section 8(3) because they are neither employees of the licensee nor members of the regular nursing staff. This means that an agency RN cannot be the only registered nurse on duty in

⁴ LTCHA, s 74(1).

⁵ LTCHA, s 2(1).

⁶ O Reg 79/10, s 31(3).

a home, subject to narrow exceptions outlined below. However, in many LTC homes, only one registered nurse may be scheduled to work a certain shift – particularly on evening and night shifts. In those situations, if the scheduled registered nurse is suddenly unable to work, the home is not permitted to call in an agency nurse unless it can fit within one of the exceptions to the 24/7 RN requirement.

Section 45 of Ontario Regulation 79/10 (Regulation) provides limited exceptions to the 24/7 RN requirement, depending on the size of the home and whether there is an “emergency.” For homes with a licensed capacity of 64 beds or fewer, the 24/7 RN requirement can be satisfied in one of the following ways:

- by using a registered nurse who works at the home under a contract or agreement with the licensee and who is a member of the regular nursing staff of the home, provided he or she is on duty and present in the home at all times; or
- in the case of an emergency where the home’s backup plan does not succeed in ensuring that the requirements of section 8(3) are met, by using either an agency registered nurse or a registered practical nurse who is a member of the home’s regular nursing staff, provided the director of nursing and personal care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by phone.

For homes with a licensed capacity of more than 64 and fewer than 129 beds, the 24/7 RN requirement can be satisfied in one of the following ways:

- in the case of a planned or extended leave of absence of a registered nurse who is a member of the home’s regular nursing staff, the home can use a registered nurse who works at the home under a contract or agreement with the licensee and who is a member of the regular nursing staff; or
- in the case of an emergency where the home’s backup plan does not succeed in ensuring that the requirements of section 8(3) are met, the home can use an agency registered nurse if two requirements are met: (1) the director of nursing and personal care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone; and (2) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

For homes with a licensed capacity of 129 beds or more, there are no exceptions to the 24/7 RN requirement. These homes must always have a registered nurse who is both an employee of the home and a member of the regular nursing staff on duty and present in the home. An agency RN can never be the only registered nurse on duty.

When a home learns on short notice that the scheduled registered nurse cannot work, and neither the director of care nor any of its full-time, part-time, or casual registered nurses can cover the shift, the home still may not be permitted to use an agency RN. Before a home can use an agency RN, the situation must also qualify as an “emergency.” Section 45(2) of the Regulation defines “emergency” as “an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.” The Ministry’s interpretation of the circumstances that qualify as an emergency are narrow. For instance, Lisa Vink, a Ministry inspector, testified how she explained the meaning of “emergency” as follows:

[S]o if someone calls in sick with “I’ve just fallen, and I’ve broken my leg, and I have surgery scheduled for today, I’m supposed to be there at 3 o’clock and it’s 2:30,” that would meet the burden of an emergency and unforeseen.

However, that individual now can’t come to work tomorrow, and you know that now when she makes her original phone call. That would no longer be an unforeseen situation.

This interpretation of the term “emergency” means that if, for example, a full-time registered nurse calls the home on a weekend and explains that she has broken her leg, but is not scheduled to work until Monday night, finding a replacement for that shift and those that follow is not an emergency.

A home’s ability to comply with the 24/7 RN requirement can also be affected when a registered nurse resigns. Small homes in particular often have difficulty covering that nurse’s shifts while they look for a replacement because they have a very small complement of registered staff to begin with. Many small homes use agency RNs in these circumstances – meaning that they are not in compliance with section 8(3).

2. Screening Requirements When Hiring Registered Staff

Section 75 of the LTCHA requires licensees to ensure that various screening measures are completed before hiring any nurse. An agency nurse is considered to be “hired” when he or she begins to work at the home.⁷ These screening measures include a criminal reference check and a vulnerable sector screen that are no older than six months.⁸

Agencies that supply nurses to LTC homes are not required by the LTCHA to conduct criminal reference checks when they hire those nurses. However, because of the LTCHA screening provisions, homes must have processes and procedures in place to ensure that any agency nurse has been appropriately screened, either by the home or by the agency, within the previous six months of working the first shift.

Along with the criminal reference check, licensees must ensure that nurses working in the home are registered and in good standing with the College of Nurses of Ontario (College).⁹ The homes can check the College’s Find a Nurse Register on the College’s website to verify that a nurse is currently qualified to practise with no restrictions.

3. Requirement to Provide Orientation and Training to Agency Staff

When agency nurses are first assigned to an LTC home, they are not familiar with the layout of the home, its residents, or its policies and procedures. In order to ensure the safety and security of residents, section 76(2) of the LTCHA and section 218 of the Regulation require all staff working in a home, including agency nurses, to receive training on the following topics before they begin performing duties in the home:

- the Residents’ Bill of Rights;
- the home’s mission statement;
- the home’s policy to promote zero tolerance of abuse and neglect of residents;
- the duty under section 24 of the LTCHA to make mandatory reports;
- the whistle-blowing protections in section 26 of the LTCHA;
- the home’s policy to minimize the restraining of residents;

⁷ LTCHA, s 75(3).

⁸ O Reg 79/10, s 215.

⁹ O Reg 79/10, s 46.

- fire prevention and safety;
- emergency and evacuation procedures;
- infection prevention and control;
- all Acts, regulations, Ministry policies, and similar documents, including policies of the licensee that are relevant to the staff member's responsibilities;
- the licensee's written procedures for handling complaints, and the role of staff in dealing with complaints;
- safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids, and positioning aids, that is relevant to the staff member's responsibilities; and
- cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

The only situation in which an agency nurse can begin work without receiving this training is in the case of "emergencies or exceptional and unforeseen circumstances," in which case the training must be provided within one week.¹⁰ Agency staff, like the regular nursing staff in an LTC home, must also receive retraining on certain of these topics every year.¹¹ In addition, homes must assess the training needs of all staff, including agency nurses, at least annually and provide further training as appropriate.¹²

As a condition of providing direct care to residents, agency nurses must also receive training on:

- abuse recognition and prevention;
- mental health issues, including caring for persons with dementia;
- behaviour management;
- how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the LTCHA and its regulations;
- palliative care;
- falls prevention and management;
- skin and wound care;
- continence care and bowel management;

¹⁰ LTCHA, s 76(3).

¹¹ LTCHA, s 76(4); O Reg 79/10, s 219(1)–(2).

¹² LTCHA, s 76(6); O Reg 79/10, s 219(3).

- pain management, including recognition of specific and non-specific signs of pain; and
- for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use, and potential dangers of these physical devices.¹³

If the home assesses the individual training needs of an agency nurse, that nurse need only receive training in these areas based on his or her assessed needs. However, if the home does not perform such an assessment, the agency nurse must receive annual training on all these topics.¹⁴

The difficulty LTC homes face is how to meet their obligations to orient and train agency nurses – and incur the associated expenses – particularly when the nurses may never return to work at the home again. How Telfer Place balanced these competing considerations is discussed below.

4. Record-Keeping

Once an agency nurse is assigned to an LTC home, the licensee is required to keep a record containing a verification of the nurse's current certificate of registration with the College and the results of the nurse's criminal reference check.¹⁵ This provision requires LTC homes to ensure that agency nurses receive the same screening as members of their regular nursing staff.

B. Contractual Framework Governing the Use of Agency Nurses

The LTCHA does not govern agencies that provide registered nurses to work in LTC homes nor does it govern the relationship between these agencies and LTC homes. Instead, the parties are governed by the terms and conditions of whatever contract they negotiate between themselves. There are no standard contracts or legislative requirements in regard to the terms and conditions these contracts should contain. As a result, the contents of such contracts vary among agencies and homes.

¹³ LTCHA, s 76(7); O Reg 79/10, s 221(1).

¹⁴ O Reg 79/10, s 221(2).

¹⁵ O Reg 79/10, s 234.

IV. Use of Agency Nurses by Telfer Place

A. Need for Agency Nurses at Telfer Place

Telfer Place is a multi-level retirement community located in Paris, Ontario. It includes independent living for seniors, assisted living, and a 45-bed for-profit LTC home. As a result of its multi-use function, Telfer Place residents can transition from one section to another as their need for care increases.

Given its small size, in 2015, Telfer Place scheduled only one RN per shift. On certain day shifts, it also scheduled a registered practical nurse. On the evening and night shifts, no other nurses were present. In addition to the registered nurse, only one PSW was scheduled to work at night.

The heavy workload meant that the day and evening nurses often had to stay late to finish their charting. The sole registered nurse on duty at night also assisted the PSW in duties that required more than one person, such as transferring residents from wheelchairs to beds.

Telfer Place had particular difficulty recruiting and retaining nurses in its LTC section. There were several reasons for this, including the heavy physical workload, the home's rural location, and, depending on the shift, its resident-to-nursing staff ratio of 45 to one.

Telfer Place was facing additional staffing challenges in 2015 and 2016. One nurse was off work because of a long-term illness, and a second nurse who typically worked nights had resigned. A third nurse was off on long-term medical leave and, although she was preparing to return, she could not work shifts independently because of mobility issues. Dian Shannon, the executive director of the home, summarized the impact of these staffing challenges:

So in a very short period of time we lost several nurses. And it was challenging to recruit nurses. So we had both our full-time and our part-time, in essence our entire night line was empty. We're a small home. We didn't have that many nurses that could plug in an extra 14 shifts per pay period.

The circumstances described by Ms. Shannon did not fit within the definition of "emergency" as described above. However, given the loss of some of its regular nursing staff and the general shortage of nurses, Telfer Place faced an immediate and pressing need to find registered nurses. It turned to companies such as Life Guard to assist with its staffing needs.

B. Telfer Place Contracts with Life Guard

Telfer Place entered into an arrangement with Life Guard, which had been in business since 2004. The earliest contract between Life Guard and Telfer Place that the Inquiry received is dated July 24, 2015 (although both parties testified that they believed there had been an earlier contract or contracts). This contract was prepared by Life Guard and signed without change by Telfer Place. A second contract from August 2015 (Life Guard Contract) was in effect at the time Wettlaufer committed the Offence at Telfer Place. This contract was short and imposed only a handful of obligations on each party.

The terms of the contract were unclear. It appears that the Life Guard Contract required Life Guard to:

- provide Telfer Place with the services of healthcare staff, including registered nurses, registered practical nurses, and PSWs, at rates set out in the contract; Life Guard would endeavour to provide staff who were best suited to Telfer Place's requirements.
- ensure that the nursing staff provided to Telfer Place had a valid certificate of registration and were in good standing with the College; on request, Life Guard would endeavour to provide this documentation to Telfer Place;
- endeavour to provide Telfer Place on request with proof of Workplace Safety and Insurance Board (WSIB) and liability insurance coverage;¹⁶ and
- endeavour to respond to all scheduling requests in a timely and responsive manner and to submit overtime requests only after receiving written approval from Telfer Place.

It appears the Life Guard Contract required Telfer Place to:

- refrain from recruiting or hiring Life Guard staff within 12 months of their last day of employment with Life Guard;
- provide one business day's notice for cancellation of regular shifts;
- pay Life Guard's invoices within 30 days unless otherwise arranged;

¹⁶ Elsewhere, the contract indicates that Life Guard *will* provide proof of WSIB and liability coverage on request.

- accept staff substitutions deemed necessary by Life Guard because of staff illness, provided they met the correct licensing and orientation requirements;
- advise Life Guard, at the time Telfer Place requests staff, if the facility is in a communicable outbreak situation; and
- absolve Life Guard and its employees, directors, officers, and representatives of liability in connection with the provision of all services provided by Life Guard.

The Life Guard Contract did not place any conditions on Life Guard with respect to the nurses it supplied to Telfer Place other than stipulating that they had to be registered and in good standing with the College – and that Life Guard would provide proof of that on request. It did not oblige either party to conduct a criminal reference check or to provide orientation and training before a Life Guard nurse began to work at the home. At the public hearings, however, representatives from both Life Guard and Telfer Place testified that it was understood that Life Guard would conduct criminal reference checks before placing agency nurses in Telfer Place. In addition, Telfer Place did provide orientation and training for agency nurses.

Life Guard was not the only company to assign agency nurses to Telfer Place – the home entered into a contract with another staffing agency in January 2016. That contract contained more detailed terms and conditions relating to the screening, orientation, training, and performance management of agency nurses, although it is somewhat difficult to follow. It appears that, among other things, this contract required the agency to:

- ensure that any staff provided to Telfer Place were screened and properly qualified for the position to be filled; when sending a staff member to Telfer Place, the agency was to provide a current criminal record check as well as the staff member's College of Nurses registration status and registration number;
- address clinical performance issues with agency staff in order to protect patient interests, ensure the quality of care delivered by the agency's staff, and protect Telfer Place from possible claims;
- use best efforts to assign the same staff to Telfer Place to ensure maximum staffing continuity;
- provide agency staff with orientation information;

- provide proof of annual competencies and evaluations for each staff member placed in Telfer Place, including qualifications of skills, universal precautions, bloodborne pathogens, infection control, pain, restraints, and the Residents' Bill of Rights; and
- conduct annual performance evaluations of agency personnel by a registered nurse who is a director of care.

The contract specified that, in caring for Telfer Place's residents, the agency's staff were required to abide by all laws and regulations under which they are licensed as well as Telfer Place's policies and procedures. In addition, it appears that the contract gave Telfer Place various rights, protections, and obligations as follows:

- if Telfer Place determined that a nurse provided by the agency did not have a current and valid certificate of registration with the College, was unqualified, or was physically or mentally incapable of performing the required duties, this staff member would not be permitted to work at Telfer Place;
- Telfer Place was to verify the identity and credentials of each agency staff member attending for a shift by checking the staff member's photo identification and professional licence or certification;
- Telfer Place was responsible for providing the assigned agency staff with the home's orientation information related to its rules, regulations, policies, and procedures;
- Telfer Place was to assign duties and clinical care assignments appropriate to the agency staff member's clinical expertise and to provide agency staff with an environmental orientation; and
- Telfer Place was to ensure that agency staff completed "hands-on" competencies, such as the use of restraints and electronic medication administration records, during their first shift at the home.

As the summaries of these two contracts between an LTC home and two staffing agencies indicate, the content and the amount of detail in regard to arrangements in these types of contracts can vary considerably.

In the remainder of this chapter, I will deal only with the Life Guard Contract. Wettlaufer was assigned to Telfer Place under the conditions set out in that document.

C. Screening of Agency Nurses

As of 2015, Revera had implemented an External Service Provider Agencies Policy (ESPA Policy), which outlined the requirements each Revera location was expected to follow when engaging external agencies. In terms of the screening of agency employees, it stated that any external agency was required to provide evidence that, among other things, it had a process in place to ensure that all agency staff assigned to a Revera home had a clear criminal record check and vulnerable persons screening. In practice, Ms. Shannon testified that she relied on Life Guard to obtain the criminal reference checks, but no process was in place in 2015 that required Life Guard to provide proof to Telfer Place that it had done so.

The Life Guard Contract required the agency to ensure that its nurses had a certificate of registration and were in good standing with the College, though it did not require Life Guard to provide proof of this check to Telfer Place. However, Sherri Toleff, Telfer Place's director of care, testified that she completed a College of Nurses registration review for each new agency nurse.

D. Orientation and Training of Agency Staff

For new members of the nursing staff, Telfer Place provided orientation on its policies and procedures for each floor and for every shift. New employees received orientation for six shifts in total: two shifts on each of the day, evening, and night shifts.

Agency nurses, however, are not employees of LTC homes. They are brought in when a home's regular nursing staff are not available. They may be needed for one shift only and never return. Moreover, both the home and the staffing agency may have only a few hours' advance notice that they need to find someone to fill a shift. Telfer Place provided agency nurses with four hours of orientation in rush situations, and eight hours if there was more time. When asked why there was such a difference in the orientation received by new Telfer Place employees and agency nurses, Ms. Shannon explained:

Agency nurses were not viewed as a member of the staff, for one thing. Also, when we're using an agency nurse in general it tended to be a last-minute emergency or urgent-type scenario. So we would train somebody for two days and then maybe never use them again.

And I'm going to say that has happened where we would train agency nurses in anticipation that we knew we were going to book some shifts

with them, because there was absolutely no way we could cover them, and I believe on at least one occasion that agency nurse never came back again.

Telfer Place attempted to design orientation processes that balanced their need to get agency nurses up to speed quickly with the LTCHA's requirements for direct care staff to have appropriate training before they provide care to residents. One of Telfer Place's regular registered nurses would be paired with a new agency registered nurse to provide orientation based on an "Agency Staff Orientation Checklist" that covered various policies, procedures, and documents used in the home. Topics included: reporting; team responsibilities; location of items such as the home's pharmacy manual and nursing supplies; medication; keys; resident charts and documentation; and safety. An agency staff member's orientation on these topics would cover policies and procedures related to fire and emergencies, non-abuse, the use of least restraint, and the home's medication system, among others. However, Telfer Place's orientation did not cover all the mandatory requirements under the LTCHA, such as orientation on compulsory reporting procedures and the Residents' Bill of Rights.

In addition to the checklist items, new agency nurses would be oriented to the floor during the same four- to eight-hour period. That orientation included shadowing the registered nurse on duty, learning the emergency procedures, and observing the medication pass. If agency nurses had been given computer access, they could participate in the medication pass during orientation along with the Telfer Place nurse.

Even for agency nurses with experience in long-term care, it can be challenging to work as an agency nurse in an LTC home. When starting a placement in a new LTC home, there is a high volume of information to review, and agency nurses are not familiar with the home's residents or routines. The orientation process is also hard on the registered nurses who deliver the orientation, because they have to carry out their regular duties as well as orient the new agency nurse.

In small LTC homes such as Telfer Place, agency nurses not only had to absorb a significant amount of information in a relatively short period but, possibly, be in charge of the home during their shifts immediately after orientation. If in charge, the agency RNs would have the keys to the building, the medication room, the medication cart, and the narcotics bin. In addition, if scheduled on the evening or night shift, the agency RN might be the only nurse on duty, although one of the managers would also be available on call.

E. Process to Address Incidents Involving Agency Nurses at Telfer Place

Issues such as medication errors or conflicts with regular staff may occur when agency nurses work in LTC homes. The issue is complicated because both the home and the agency (as the nurse's employer) have to be involved. For instance, if there is a medication error, the home needs to know what happened, whether the medication error had an impact on the resident, and whether the error must be reported to the Ministry. At the same time, the agency, as the nurse's employer, needs to know what happened in order to determine what action, if any, it should take – such as further training for the nurse or discipline.

Telfer Place had no formal process for evaluating the performance of agency nurses. Because agency nurses were not employees of the home, Telfer Place was not responsible for disciplining them. Ms. Toleff testified that, if concerns were brought to her attention, she would typically discuss the matter with the agency nurse and follow up with the agency. If Telfer Place found an agency nurse to be unsatisfactory, the home's management would tell the agency that it did not want that particular nurse to be assigned to future shifts at the home.

It was often difficult for both parties to investigate an incident. The home might not have the contact information for the agency nurse, so, if a concern was raised, often the only way the home could obtain the nurse's version of events was to go through the staffing agency. Similarly, agency representatives could not simply show up at Telfer Place and start questioning its staff and residents. Accordingly both Telfer Place and the agency had to deal with one another's management to discuss concerns and obtain information with respect to an incident. This process could lead to communication challenges. For example, Life Guard did not receive notification of all the concerns that had been raised about Wettlaufer. And, on a different occasion, it was Wettlaufer, not Telfer Place, who told Life Guard that she had made a medication error. These communication challenges were compounded because neither Life Guard nor Telfer Place recorded what steps they took, if any, to investigate concerns raised about Wettlaufer or evidence they had gathered.

F. Record-Keeping

As part of the LTCHA record-keeping requirements, Telfer Place was required to retain a record of its verification of all nursing staff members' current registrations with the College of Nurses as well as the results of their criminal reference checks. However, at the time Wettlaufer worked at Telfer Place, it did not keep files on agency nurses who were placed there. Telfer Place relied on Life Guard to conduct the criminal reference check, but did not request or require proof of Life Guard's having done so. Nor did Telfer Place require Life Guard to provide proof that the agency nurse was registered to practise with no restrictions. As a result, Telfer Place did not have any records confirming Wettlaufer's status with the College.

V. Handling of Injectable Insulin at Telfer Place

Telfer Place has two hallways for its LTC residents – one with 21 beds, and one with 24 beds. These two hallways branch out from the nurses' station. The only medication room is located near the nurses' station and does not have any windows. In 2015, the home had one medication cart. The registered nurse on duty had the keys to the medication room, the medication cart, and the locked narcotics bin within the medication cart.

Telfer Place also had a locked chart room that contained the residents' charts and the treatment cart. The registered nurse had a key to the chart room, and another key was kept at the nurses' station for the PSWs, so they could have access to the treatment cart. Another key at the nurses' station opened all the exterior doors.

Telfer Place was equipped with video surveillance in certain areas, including at the nurses' desk in the LTC section. The camera was positioned so that it provided a view down each hallway, but not into the medication room. It retained footage for only 30 days. As a result, because Wettlaufer was no longer assigned to Telfer Place after April 20, 2016, and she confessed her crimes in October 2016, no footage is available for the time she worked there.

In 2015, Telfer Place's residents who needed injectable insulin were on the pen and cartridge system. They each had their own pens, labelled with their names. If a resident's insulin orders changed, a green sticker was placed on the pen to alert the nurses to the change. For the storage of non-controlled medication, all the residents had separate boxes in the medication cart with their names and room numbers on them. Their insulin pens were kept in that box or in a second empty box next to it.

Telfer Place's handling of injectable insulin in 2015 was the same as at Caressant Care (Woodstock) and Meadow Park (London) (see Chapters 5 and 6). The insulin was stored in an unlocked fridge in the locked medication room. The only person with access to the medication room was the registered nurse on duty. Although the ordering and receiving of insulin was tracked at Caressant Care (Woodstock), Meadow Park (London), and Telfer Place, the amount stored in the home was not. At Telfer Place, no count was made of the insulin used or of the disposed cartridges.

In 2015 at Telfer Place, there was no independent double-check by another nurse of either the dosage drawn up into the pen or the actual administration of the insulin. It would not have been possible to have another nurse perform an independent double-check on either the evening or the night shift during 2015 and 2016 because no other registered staff was on duty during those shifts.

Revera had a corporate policy entitled "High Alert / High Risk Medications – Independent Double-Check" (High Alert / High Risk Policy), which referenced the list of high-alert medications identified by the Institute for Safe Medication Practices. Under the policy, high-alert medications were drugs that had a heightened risk of causing significant resident harm if they were used in error. The High Alert / High Risk Policy identified hypoglycemics, including oral hypoglycemics and insulin products, as being high-alert medications. According to that policy, nurses were required to seek an independent double-check before administering high-alert / high-risk medications, where possible. It outlined different ways this double-check could be performed:

- two nurses could check the medication before administration;
- if the medication had been prepared in unit doses and dispensed by a pharmacist, that was considered the first check; the second independent check could then be performed by one nurse checking the medication before administration;
- if neither of the previous situations was possible, the nurse was to prepare the medication, leave and perform a different task, and return five to 10 minutes later to do a second independent check on the medication before administration; and
- if none of the above was possible due to the use of a "stat / emergency" medication requirement by a resident, the nurse was to use critical judgment in checking that medication.

The policy also noted that manual independent double-checks might not be practical for every high-alert medication and might not always be the optimal strategy for error reduction.

Although Revera had this corporate policy in place, frontline staff at Telfer Place appear to have been unaware of it. Two senior, full-time registered nurses who worked at Telfer Place testified at the public hearings that they were unaware of the policy.

VI. Life Guard's Hiring, Orientation, and Performance Management Processes

A. Life Guard's Hiring Process

Life Guard's hiring process for nurses included the following steps:

- reviewing the applicant's resumé;
- checking the current status of the applicant's College of Nurses registration;
- verifying the applicant's criminal reference check, including a vulnerable sector check;
- interviewing the applicant; and
- checking the applicant's references.

Heidi Wilmot-Smith is the president of Life Guard. Her responsibilities included the hiring, discipline, and termination of its staff. She testified that she conducted all the interviews of registered nurses and that her daughter, Taryn Smith, a registered nurse who worked part-time for Life Guard, would occasionally assist. When checking references, it was Ms. Wilmot-Smith's practice not to contact current employers without the applicant's permission because she believed doing so could compromise the applicant's current employment.

Life Guard required its nursing applicants to provide a criminal reference check, including a vulnerable sector check, at the time they were hired. Ms. Wilmot-Smith testified that the organizations she works with, including LTC homes, had told her they were required, annually, either to have their staff provide a new check or to make a declaration. She therefore asked candidates to submit proof of a criminal reference check that had been completed within a year of their application for employment with Life Guard.

B. Orientation and Training

Life Guard provides its employees with an employee handbook that includes information about its procedures for home visits, code of conduct guidelines, and health and safety policies. The handbook does not cover the orientation requirements of the LTCHA. Ms. Wilmot-Smith testified that she did not have “internal access to information with respect to the Long-Term Care Act.”

Life Guard does not provide any orientation to its nurses regarding the long-term care home to which they are assigned but, rather, relies on the home to provide the appropriate orientation. However, Life Guard’s “Facility Staff Replacement Shifts” guidelines direct staff to:

- become familiar with the home’s internal health and safety policies;
- know the emergency protocol of the home in case of fire; and
- work only in sections of the facility in which they have received orientation.

The amount of notice Life Guard received when an LTC home needed agency staff varied widely. These requests could be made at the last minute if a home had a scheduled staff member call in sick, or they could be made well in advance – for example, when a home knew that its regular staff would be on vacation.

After Life Guard received a request for agency staff to cover a shift, the opportunity would be communicated to its staff. Life Guard would generally attempt to fill shifts with someone who had already been trained at the home. When placing an employee for the first time at an LTC home, Life Guard would tell the home that, in order to fill the open shift, the employee would have to be oriented to the home.

Ms. Wilmot-Smith testified that she always tried to get as much orientation time as possible because staff felt more confident when they were familiar with a home’s policies and procedures. The length of orientation negotiated between Life Guard and the home generally ranged between four and eight hours. In Ms. Wilmot-Smith’s opinion, agency nurses needed to know where the fire exits were, how to access the eMAR to provide medications to the residents, and where the medication room was located. Ms. Wilmot-Smith’s view was that it would be unsafe to send an agency staff member to a home without proper orientation, unless there was an exceptional circumstance and the home agreed to have an extra staff member on duty to shadow the agency nurse.

Life Guard had no information about the actual content of the orientation its staff received once they were assigned to an LTC home. All it knew was that agency staff had to abide by a home's policies when they worked there. Life Guard assumed that training on medication handling, receipt, storage, administration, and disposal were included in the home's orientation. Further, Life Guard relied entirely on the home to ensure that the LTCHA's mandatory educational requirements had been provided.

C. Performance Management Processes

Telfer Place had no process to evaluate the work of agency nurses in the home. If an incident happened, it simply dealt with the nurse, with Life Guard, or both. If it did not want the agency nurse to work at Telfer Place again, management would tell Life Guard not to assign that nurse to the home.

On Life Guard's part, Ms. Wilmot-Smith testified that she would conduct performance reviews of staff. However, she did not ask the homes about the performance of Life Guard staff; rather, she relied on the LTC homes to contact her if they had concerns. Because Life Guard had no specific process in place for the reporting of medication errors or other incidents, it is unclear how Life Guard could complete an evaluation of an agency nurse's performance in an LTC home setting.

The majority of the complaints that Life Guard received were non-clinical in nature. When clinical issues arose, they were dealt with by a registered nurse on Life Guard's staff. When concerns were raised, Life Guard would first attempt to resolve the issue verbally with the home's director of care. If the concern could not be addressed or if further issues arose, the next step was to consider whether the employee would continue to be assigned to the home. Life Guard did not have a standard complaint form for its clients to use. Complaints were documented through internal notes, texts, and emails. At times, management also documented issues in Life Guard's software system.

In addressing complaints about its staff, Life Guard's standard practice was to make an initial phone call to the staff member and, if the concern did not get resolved, to bring the staff member in for counselling. Subsequent issues might be addressed through written warnings and, ultimately, termination. If the incident raised concerns about health and safety, it was addressed immediately in an interview with the staff member.

Life Guard would typically not be actively involved in addressing medication errors, on the basis that any remedial action would be taken by the LTC home

itself. Ms. Wilmot-Smith stated that if the medication error was significant or serious and additional follow-up needed to be done, the home would reach out to Life Guard.

VII. Life Guard Hires Wettlaufer

A. Wettlaufer's Resumé and Application for Employment

As described in Chapter 6, Wettlaufer resigned from Meadow Park (London) on September 25, 2014, saying that she was entering long-term treatment for an "illness." She later admitted that the problem at the time was alcohol and drug addiction and confirmed that she had entered and completed a drug treatment program in the fall of 2014.¹⁷

On January 26, 2015, Wettlaufer applied by email to an online job posting for a position with Life Guard as a "Registered Nurse – Public and Community." The information she provided Life Guard in that application was inconsistent with some aspects of her work history. Her covering note stated that she had 18 years' experience working "as a nurse" in both a community group home and in LTC facilities. This claim was inaccurate because Wettlaufer had not worked as a nurse at Christian Horizons. In contrast, the resumé Wettlaufer provided to Life Guard accurately stated that she had been a support worker at Christian Horizons from 1996 to 2007 and a charge nurse at Caressant Care (Woodstock) from 2007 to 2014. In her interview, Wettlaufer similarly stated that she had worked as the equivalent of a PSW at Christian Horizons.

Wettlaufer did not disclose to Life Guard that her first nursing job was with Geraldton District Hospital in 1995 (see Chapter 3). The resumé she submitted earlier to Meadow Park (London) contained the same omission.

B. The Interview

Ms. Wilmot-Smith interviewed Wettlaufer in late January 2015. She recalled speaking to Wettlaufer about her employment with Caressant Care (Woodstock), but she had no recollection of Wettlaufer telling her that the home had terminated her employment. By this time, Caressant Care (Woodstock) and Wettlaufer had agreed to classify her departure as a voluntary resignation.

¹⁷ Wettlaufer confirmed this information in her police interview.

Ms. Wilmot-Smith could not recall whether Wettlaufer mentioned during her interview that she was still employed by Meadow Park (London). She believed that she was more interested in the length of Wettlaufer's experience at Caressant Care (Woodstock).

Ms. Wilmot-Smith described Wettlaufer as being pleasant, a good communicator, and someone who appeared to have a good understanding of the requirements of long-term care. From Ms. Wilmot-Smith's perspective, the interview was positive. At the time, Life Guard was in significant need of registered nurses with experience in long-term care.

C. Reference Checks

Wettlaufer did not submit any reference letters to Life Guard. The fact that Caressant Care (Woodstock) had provided her with a reference letter in June 2014 did not factor into Life Guard's decision to hire her. Wettlaufer did, however, submit the names of four references to Life Guard – three from Caressant Care (Woodstock) and one from Christian Horizons.

Ms. Wilmot-Smith was able to contact two of Wettlaufer's four references: Sandra Fluttert, the assistant director of nursing at Caressant Care (Woodstock), and David Petkau, program manager with Christian Horizons. Both were members of management at their respective organizations, and both provided positive references for Wettlaufer. Ms. Wilmot-Smith made notes during her conversation with Ms. Fluttert, who described Wettlaufer as "very caring" with the residents, a "team-player," and as having "good critical thinking skills." She indicated that Wettlaufer had left Caressant Care (Woodstock) because of "personality conflicts" but was overall a "very good nurse."

Wettlaufer did not provide the names of any references from Meadow Park (London). Wettlaufer's resumé indicated that she began working at Meadow Park (London) as a charge nurse in 2014. However, she did not list an end date for her job at Meadow Park (London), despite the fact that she had resigned in September 2014. Ms. Wilmot-Smith testified that when she read Wettlaufer's resumé, she assumed that Wettlaufer was still employed by Meadow Park (London). It did not strike Ms. Wilmot-Smith as odd that Wettlaufer had not provided the name of a reference from Meadow Park (London), given that she believed that Wettlaufer still worked there. As noted earlier, Ms. Wilmot-Smith's practice was not to call current employers without an applicant's permission, so she did not contact Meadow Park (London) to discuss Wettlaufer's work there.

D. Wettlaufer's Criminal Reference Check and Status with the College of Nurses

Wettlaufer was asked to provide Life Guard with a criminal reference check, including a vulnerable sector screen (Criminal Reference Check). Life Guard received a copy of Wettlaufer's Criminal Reference Check dated April 22, 2014. It was the same document that had been provided to Meadow Park (London) when Wettlaufer was hired at that home.

When Wettlaufer applied for employment at Life Guard, her Criminal Reference Check was nine months old. Because the LTCHA requires homes to ensure all staff have criminal reference checks that are no more than six months old, none of the homes in which Wettlaufer was placed by Life Guard could rely on the Criminal Reference Check to comply with this requirement. Further, because Telfer Place did not have a process to verify the criminal reference checks of agency staff provided by Life Guard, it was unaware that it was not in compliance with the LTCHA until after the Offences became known. However, even if a criminal reference check had been completed within six months of Wettlaufer's first shift in Telfer Place, it would have come back clear.

In addition to obtaining the Criminal Reference Check, Life Guard took steps to verify Wettlaufer's status with the College of Nurses. On January 28, 2015, Life Guard searched the Find a Nurse Register on the College's website. The search revealed that Wettlaufer was entitled to practise with no restrictions. By October 2014, the College had closed its file on the report from Caressant Care (Woodstock) about the termination of Wettlaufer's employment there, having decided to bank the report with notice. As a result, in accordance with the legislation governing the College, no information was publicly available to indicate that Wettlaufer had been reported to the College by Caressant Care (Woodstock). For the same reason, Wettlaufer's previous Fitness to Practise proceeding related to her work at Geraldton District Hospital was not publicly available. Further details about Wettlaufer's involvement with the College are discussed in Chapter 13.

E. Wettlaufer Is Hired

On January 28, 2015, Wettlaufer signed off on various Life Guard policies and guidelines. The following day she entered into Life Guard's employment contract and received the agency's employee handbook.

Life Guard's records indicate that Wettlaufer's first assignment for Life Guard was on January 30, 2015.

F. Ms. Wilmot-Smith Reaches Out to Caessant Care Nursing and Retirement Homes

Ms. Wilmot-Smith testified that over a number of years, she had tried to solicit business for Life Guard from Caessant Care (Woodstock). Within days of hiring Wettlaufer, she reached out to Carol Hepting, the director of operations for Caessant Care Nursing and Retirement Homes Limited. Ms. Wilmot-Smith said she told Ms. Hepting that she had just hired someone who had previously worked for Caessant Care (Woodstock) whom she felt would be an "ideal fit." When she identified Wettlaufer as her new hire, Ms. Hepting responded that Caessant Care (Woodstock) would not be interested in having Wettlaufer return and declined to expand on that comment. Ms. Hepting testified that she had no independent recollection of that conversation.

Ms. Wilmot-Smith said she found that conversation odd but consistent with Ms. Fluttert's comment that Wettlaufer had personality conflicts with management. She explained that she had previously hired two registered nurses who had been similarly described but who turned out to be excellent nurses. Because Wettlaufer would be on probation for the first three months she worked for Life Guard, Ms. Wilmot-Smith decided she would watch Wettlaufer closely during that period.

G. Wettlaufer Is Assigned to Telfer Place

Wettlaufer's orientation shift at Telfer Place was on February 15, 2015 – an eight-hour shift from 14:00 to 22:00. She received her orientation from Susan Farley, a senior registered nurse at Telfer Place. They followed Telfer Place's "checklist," and both Wettlaufer and Ms. Farley signed off on various items on it. Other items were not checked off, including the following requirements:

- emergency preparedness;
- resident non-abuse policy;
- care of aggressive residents;
- wanderer's checklist; and
- least restraint policy.

When she reviewed the checklist, Ms. Toleff indicated that the missing initials by both parties would indicate that they potentially were not covered during Wettlaufer's orientation. She testified that, typically, she would follow up on any items that were missing, but she has no specific recollection of doing so in this case.

The next day, February 16, Wettlaufer worked her first shift at Telfer Place – an evening shift. Because of its staffing levels, Wettlaufer would have been the only registered nurse on duty, and, after management left the building at the end of the business day, she would have been in charge of the home.

VIII. Wettlaufer's Offence at Telfer Place

In 2015, Telfer Place routinely used agency nurses provided by Life Guard. Wettlaufer filled shifts at Telfer Place on numerous occasions leading up to her attempted murder of Sandra Towler in September 2015.

Life Guard's records show that Wettlaufer was assigned to Telfer Place on September 6 and worked the evening shift from 14:00 to 22:00. As the only registered nurse on duty, she would have been in charge of the building and of the four PSWs who were working that shift.

During her shift, Wettlaufer injected Ms. Towler with 80 units of long-acting and 60 units of short-acting insulin. Ms. Towler was diabetic but was not being treated with insulin. Ms. Towler did not die that evening because of the commendable actions of the staff who worked on the subsequent shift.

Dianne Beauregard, a registered nurse with Telfer Place since 2000, began her shift at 22:00. She could not recall Wettlaufer mentioning any concerns about Ms. Towler during shift change. As a result, Ms. Beauregard followed her normal routine that night.

Ms. Beauregard testified that during her shift, she would generally complete two rounds with the PSW to change incontinence products and reposition or turn residents. Toward the end of their first round, at approximately 01:20, Ms. Beauregard and Beverly Gamble, a PSW with Telfer Place, found Ms. Towler cold, clammy, and diaphoretic (sweaty). Normally, Ms. Towler would wake up during rounds, but that night she did not. Ms. Beauregard took Ms. Towler's vital signs, including her blood sugar levels. She determined that Ms. Towler was hypoglycemic. Ms. Beauregard testified that she could not remember Ms. Towler ever having had a hypoglycemic episode before.

Ms. Beauregard called for assistance and, when the paramedics arrived, they gave Ms. Towler dextrose through an IV. Within minutes, Ms. Towler was alert, conversing normally, and able to eat some cookies. Ms. Towler was not transferred to the hospital at that time. However, later during that same shift, Ms. Beauregard again found that Ms. Towler's blood sugar level had decreased, despite the fact that she had earlier been given the dextrose and some cookies. Ms. Beauregard called the on-call doctor, who ordered that one of Ms. Towler's medications be withheld and that her blood sugar level be monitored every hour. Ms. Beauregard passed that information on to the day shift.

Wettlaufer worked the evening shift again the following night, September 7, 2015. As the only registered nurse on duty, she would have been responsible for complying with the doctor's orders to monitor Ms. Towler's blood sugar levels for further signs of hypoglycemia. There is nothing to suggest that Wettlaufer took further steps to harm Ms. Towler that evening.

Once again, Ms. Beauregard's shift followed Wettlaufer's shift. When she arrived at the home, she was told that the previous shifts had had difficulty in stabilizing Ms. Towler's blood sugar. Ms. Beauregard does not recall how Wettlaufer behaved during shift change, though she indicated that, if anything had stood out regarding Wettlaufer's behaviour, she would have picked up on it at the time.

When Ms. Beauregard went to check on Ms. Towler, she found that her blood sugar level was still quite low. She gave Ms. Towler apple juice and a packet of sugar. Despite her efforts, in her opinion Ms. Towler's blood sugar level was not rising enough, and she decided to send Ms. Towler to the hospital for assessment. When Ms. Towler returned four hours later, she was alert and conversing, and her blood sugar level was higher. The staff at Telfer Place continued to monitor Ms. Towler's blood sugar level every two hours. That monitoring was gradually reduced over a number of days until her blood sugar level was stabilized.

Ms. Beauregard testified that she did not suspect Ms. Towler had been intentionally harmed. Neither the hospital nor the doctor raised such a concern. Ms. Beauregard stated that even with the benefit of hindsight, she could not think of anything that would have alerted her to what had actually happened.

IX. Wettlaufer's Performance as an Agency Nurse at Telfer Place

Ms. Shannon testified that Telfer Place was happy at first to have Wettlaufer as a nurse because she understood long-term care. The members of management and the nursing staff described Wettlaufer as being pleasant, jovial, and knowledgeable. They did not recall receiving any complaints about her conduct from either families or residents. However, certain concerns were raised by others who worked in the home, both verbally and in writing, about Wettlaufer's conduct with other staff members and, at times, in relation to the care she provided to residents.

A. Incomplete Documentation

As noted above, agency nurses face challenges when they are assigned to multiple LTC homes, particularly in learning the processes and procedures at each location. Wettlaufer was no exception. Early on in her placement at Telfer Place, Wettlaufer noted in the required fall assessment documentation that a resident had fallen during her shift, but she did not describe the incident in sufficient detail. According to Ms. Toleff, when she addressed this issue, Wettlaufer accepted responsibility and stated that in the future she would provide more detail. There is no indication that a similar issue arose again during Wettlaufer's time working at Telfer Place.

Ms. Shannon also testified that other staff expressed frustration that Wettlaufer was not making referrals and completing paperwork as required. Ms. Shannon described Wettlaufer as lazy and as someone who would "put things off." When she spoke to Wettlaufer about these issues, Wettlaufer said she would do a better job getting these tasks finished in the future.

B. Wettlaufer's Missed Shift in October 2015

On October 24, 2015, Wettlaufer did not show up for her scheduled shift at Telfer Place. Ms. Wilmot-Smith testified that Life Guard received an urgent page to that effect from the home. Because Wettlaufer was the only registered nurse scheduled for that shift, to comply with the LTCHA "24/7" RN requirement, the registered nurse on the previous shift had to work a double shift.

When Ms. Wilmot-Smith contacted Wettlaufer about not having arrived for her shift, Wettlaufer said she had misunderstood her schedule and had not

checked Life Guard's computerized staff-scheduling-system. Ms. Wilmot-Smith asked her to go in for her shift, but Wettlaufer replied that she had been drinking and was not able to go in to work. She also said that she was out of town.

Following this incident, Wettlaufer wrote a letter to Ms. Wilmot-Smith apologizing for missing her shift and promising to be diligent about checking Life Guard's staff-scheduling system in the future. Ms. Wilmot-Smith emailed Wettlaufer's letter of apology to Ms. Toleff.

C. Wettlaufer's Disclosure of Her Addiction to a Telfer Place Employee

In the fall of 2014, Wettlaufer had entered a treatment centre for her drug and alcohol addiction. She was hired by Life Guard at the end of January 2015 and, in mid-February, was assigned her first shift at Telfer Place. Ms. Beauregard testified that during a shift change one day, Wettlaufer told her that she was "one year sober." At the time, Ms. Beauregard said that, because she had seen no evidence that Wettlaufer was ever impaired or under the influence of alcohol or drugs, she did not consider reporting Wettlaufer's comment to management. However, by January 2016, management at Telfer Place had become aware that Wettlaufer was a recovering alcoholic, as discussed below.

D. Wettlaufer's Missed Shift in December 2015

On December 28, 2015, Wettlaufer called in 30 minutes before her shift at Telfer Place was due to start, saying she was not able to go in to work because of illness. This time the consequences for Telfer Place were more drastic than they had been in October because neither the regular Telfer Place nurses nor the director of care were available to cover the shift. When Wettlaufer did not arrive for her shift, Life Guard provided a registered practical nurse to Telfer Place for part of the shift, though that individual had never worked there previously. As a result, Telfer Place was not in compliance with the LTCHA "24/7" RN requirement, and it was forced to rely on a registered practical nurse who had no familiarity with Telfer Place or its residents.

Ms. Shannon, who is not a nurse, decided that she would work with the agency registered practical nurse because there was insufficient time to arrange for the nurse's orientation. She wanted to ensure that the agency RPN gave the medications to the right residents, and she also wanted to be present to manage any non-nursing issues that might arise during the shift. When the

agency RPN fell behind in her medication pass, Ms. Shannon began to assist by taking the non-controlled medications, which the nurse had poured, to the residents.

In the midst of the shift, Ms. Shannon described how one resident became upset, saying she needed her insulin. Ms. Shannon, who is diabetic and uses injectable insulin, offered to give the resident insulin if the agency RPN dialled up the dose. The agency RPN agreed and dialled up the dosage before Ms. Shannon gave the resident the injection. Ms. Shannon acknowledged that neither she nor the agency RPN acted appropriately in this situation, but she said she was concerned about this resident at the time. She reported the incident to Cheryl Muise, Revera's regional manager, clinical services, and to John Beaney, the vice-president operations for Revera's LTC homes.

The Regulation provides that, with limited exceptions that are not applicable to this situation, the licensee must ensure that no person administers a drug to a resident in the home "unless that person is a physician, dentist, registered nurse or a registered practical nurse."¹⁸ The Ministry inspected this incident as part of its resident quality inspection at Telfer Place in 2016. On March 8, 2016, inspectors issued a compliance order to Revera to make sure that its executive director did not administer a drug to a resident because she was not a "physician, dentist, registered nurse or registered practical nurse."

During the same inspection, inspectors issued a written notification for failing to comply with section 8(3) of the LTCHA. Telfer Place did not have an RN on duty on December 28, 2015, and it did not meet the criteria for any of the exemptions because the agency RPN who was on duty was not a member of the regular nursing staff.

E. Wettlaufer's Disclosure of Her Relapse to Life Guard

When Wettlaufer missed her shift at Telfer Place on December 28, 2015, Ms. Wilmot-Smith was out of the country. Life Guard staff contacted her to report what had happened. Ms. Wilmot-Smith testified that she thought Wettlaufer must have had an illness that came on very quickly, such as food poisoning or an enteric infection. She told her staff to ask Wettlaufer to produce a "Doctor's Return to Work Clearance," signed by a physician, before returning to work.

¹⁸ O Reg 79/10, s 131(3).

The day after her missed shift, Wettlaufer produced a doctor's note stating that she "may return to work December 30, 2015." Wettlaufer was assigned to work at Telfer Place on January 1, 2016, and Life Guard's records indicate that she completed that shift.

Ms. Wilmot-Smith, who was still out of the country, directed Taryn Smith, a registered nurse, to meet with Wettlaufer to discuss the missed shift. On January 4, 2016, Ms. Smith wrote to Ms. Wilmot-Smith with details of that discussion:

Hi there,

I spoke with Beth at length in regards to sick time. She acknowledges that it is inappropriate to call in late for scheduled shifts. I did investigate further and Beth stated to me that she has started to drink again and that she is seeking help and going to AA meetings etc. I advised Beth to keep the lines of communication open so that we can assist her to the best of our ability. I'm not sure how you want to proceed with this information. She did give her availability for January.

Thus, as of January 4, 2016, Life Guard was aware that Wettlaufer was "a recovering alcoholic, was drinking again, and was a member of Alcoholics Anonymous." Ms. Wilmot-Smith testified that she was "stunned" by the information she had received from Ms. Smith:

Up until that point, Life Guard had never had a situation like this before. It was a first. And I think very quickly I tried to understand my obligations to Beth as an employer under the Human Rights Code.

And I think a couple of things that were on my mind at that point was we had that Return to Work Doctor's Clearance.

The thing with being an employer is we are just not allowed to ask a lot of questions, so I didn't know who the doctor was, I wasn't sure whether it was a walk-in clinic or a GP.

The other thing that was in my mind is we had had no complaints, no concerns, not a phone call, not an email, nothing to ever indicate she had ever attended work under the influence.

Ms. Wilmot-Smith testified that Ms. Smith told her that Wettlaufer was "very specific she had started drinking again, but it was on her own time." Wettlaufer understood that she was not to attend work under the influence of alcohol, and she had confirmed she had never done so and would never do so.

According to Ms. Wilmot-Smith, Wettlaufer was offered “accommodation,”¹⁹ but she declined any assistance. Ms. Wilmot-Smith testified that she spoke with Wettlaufer by phone on or about January 16, 2016, and that she reiterated Life Guard’s offer of accommodation.

Life Guard took no further steps to monitor Wettlaufer’s performance. The agency did not contact any of the other LTC homes to which it assigned Wettlaufer, and it did not seek legal assistance about its rights or obligations as an employer in relation to the information Wettlaufer had disclosed. Ms. Wilmot-Smith testified that she had no indication that Wettlaufer had been under the influence while at work, and she felt there was nothing else she could do.

All the witnesses from Telfer Place testified that they never saw any evidence of Wettlaufer being impaired while on duty, smelled alcohol on her breath, heard her slur her words, or saw her stumble. There is no evidence that Wettlaufer was suspected of drinking on shift or being under the influence of alcohol while working at Telfer Place.

Similarly, there is no evidence from the other LTC homes to which Wettlaufer was assigned, or from Life Guard, raising a concern about Wettlaufer’s use of alcohol or drugs. Finally, Life Guard’s records do not indicate that any concerns were raised by home care clients to whom Wettlaufer was assigned.

During the hearings, the question was raised as to whether Life Guard had any duty to report Wettlaufer’s disclosure to the College of Nurses. Pursuant to section 85.5 of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, in January 2016 the following requirements applied to employers:

- A person who terminates the employment or revokes, suspends, or imposes restrictions on the privileges of a nurse, or who dissolves a partnership, health profession corporation, or association with a nurse for reasons of professional misconduct, incompetence, or incapacity, must make a report to the College of Nurses.

¹⁹ Ms. Wilmot-Smith did not specify what accommodation was offered. I understood her to be referring to an employer’s duty, under the Ontario *Human Rights Code*, RSO 1990, c H19, to accommodate an employee with a disability.

- If a person intended to terminate the employment or revoke the privileges of a nurse for reasons of professional misconduct, incompetence, or incapacity, but does not do so because the nurse resigns or voluntarily relinquishes his or her privileges, the person must make a report to the College of Nurses.

Neither of these provisions applied at the time of Wettlaufer's disclosure. Life Guard had not terminated Wettlaufer's employment, nor did it intend to do so.

F. Verbal Reports of Concerns About Wettlaufer

Tracy Raney, a registered nurse at Telfer Place, testified that she verbally reported concerns about Wettlaufer to Ms. Toleff. Neither Ms. Raney nor Ms. Toleff documented those conversations, so few particulars were presented to the Inquiry. However, Ms. Raney testified that she overheard the PSWs talking among themselves about comments Wettlaufer had made to them. She said she was uncomfortable with what she had overheard. She encouraged the PSWs to go directly to management, but she never heard whether they had.

Ms. Raney was unsure what steps, if any, Ms. Toleff followed after becoming aware of her concerns. She said that Ms. Toleff told her that she could not do anything because Wettlaufer was not an employee. On her part, Ms. Toleff testified that she did not recall Ms. Raney coming to her with concerns about Wettlaufer.

G. Written Complaints in January 2016

By early January 2016, Ms. Raney started to document her concerns. She wrote to Ms. Toleff on January 6, reporting that Wettlaufer had been leaving the medication room and chart room doors "wide open." According to Telfer Place policy, the medication room and the chart room were to be locked at all times when the registered nurse or the registered practical nurse was not present. Ms. Toleff testified that she believed she followed up with Wettlaufer about her leaving the doors open, but she had no memory of the conversation with Wettlaufer.

On January 10, 2016, Ms. Raney sent another email to Ms. Toleff and this time she included Lindsay Astley, Telfer Place's associate director of care, in the email. She noted that, in her opinion, Wettlaufer did not always relay important information to the doctors and the other registered nurses. As an

example, she mentioned that one resident had suffered a bleed after nail care on January 7, but that Wettlaufer had not passed on that information at shift change, nor had she charted it or written it in the report book. As a result, there was no formal assessment of the resident's toenail for three days.

In her email of January 10, Ms. Raney further reported an incident in which Wettlaufer had called the family about a resident's apnea, but did not call the resident's doctor. When Ms. Raney ultimately called the doctor, the doctor changed the resident's status to palliative and altered her medication. Those changes would have involved both pain and respiratory medication as well as comfort measures. Wettlaufer's failure to call the doctor meant that the resident's status and need for these measures was not assessed earlier.

H. Ms. Wilmot-Smith's Discussion with Ms. Toleff in January 2016

On January 15, 2016, Ms. Wilmot-Smith received a message that Ms. Toleff wanted to speak to her. She called Ms. Toleff and, according to Ms. Wilmot-Smith, Ms. Toleff told her that a PSW had alleged that Wettlaufer had said something that had a sexual connotation – to the effect that the PSW “could leave his shoes underneath her bed anytime.” Ms. Wilmot-Smith stated that, during that same conversation, Ms. Toleff told her that Wettlaufer had been overheard telling people that she was a “recovering alcoholic.” However, Ms. Toleff confirmed that she never saw any signs that Wettlaufer was under the influence of drugs or alcohol while at work.

Ms. Wilmot-Smith testified that she spoke to Wettlaufer on or about January 26, 2016, in connection with Wettlaufer's allegedly inappropriate comment to the PSW. Ms. Wilmot-Smith emphasized the importance of maintaining professional boundaries in the workplace. She described Wettlaufer as being “receptive” to this advice. Wettlaufer told her that she had apologized to the PSW at the end of the shift, that she had meant the comment in jest, and that she had not meant to offend. In terms of her demeanour in these discussions, Ms. Wilmot-Smith describes Wettlaufer as follows:

The thing with Beth, she always acknowledged and took ownership of a shortcoming, which would have been the first indicator to me as a manager that she still was potentially a good nurse. The first sign of a problem that I have when I perceive or when I bring somebody in for a review is if they are totally in denial and will not take ownership of the issue at hand.

With Beth, she would acknowledge, take responsibility, apologize. And having said that, she would also bring up aspects of her response that seemed totally logical and you could understand from her perspective how it seemed that she had taken appropriate steps in some ways.

I. Written Complaint of February 7, 2016

On February 7, 2016, Ms. Raney again wrote to Ms. Astley. She reported concerns about another agency nurse, and also reported that Wettlaufer had been trying to determine the name of the other agency that Telfer Place was using for temporary personnel because Ms. Wilmot-Smith believed that the other agency was undercutting her. Ms. Astley responded that she had passed Ms. Raney's concerns on to Dan Relic, who became the director of care for a short period after Ms. Toleff resigned from Telfer Place in January 2016. Ms. Raney testified that there was no follow-up.

J. The Enteric Outbreak

Ms. Shannon testified that she worked with Wettlaufer during one shift in or about February 2016 when Telfer Place was experiencing an enteric outbreak that was affecting both residents and staff.

During the shift, Ms. Shannon found that Ms. Towler had been incontinent and was soiled from her mid-back to her knees. Wettlaufer and Ms. Shannon washed her. When Wettlaufer finished cleaning Ms. Towler's back, Ms. Shannon could see that some soiling remained. She pointed this out to Wettlaufer and indicated they needed to ensure that Ms. Towler was completely clean. Ms. Shannon testified that at the time she was concerned and felt that Wettlaufer was being lazy.

Ms. Shannon then looked at the residents Wettlaufer had attended to earlier that night because she suspected that Wettlaufer may not have given them proper care. She testified that some residents were fine, but others had feces in their incontinence product. However, given the virulence of the outbreak, she could not tell whether the residents' condition resulted from improper care or from another bout of diarrhea after Wettlaufer had walked away. She did not revisit the issue with Wettlaufer, nor did she report her experience with Wettlaufer to Life Guard.

K. Wettlaufer's Medication Error on March 31, 2016

On March 31, 2016, Wettlaufer notified Life Guard that she had made a medication error at Telfer Place and that she had completed Telfer Place's medication incident report. On that report, Wettlaufer stated that she had signed for, but not administered, two doses of Kadian, an opioid. On the report form, Wettlaufer attributed her error to the noise level and to frequent interruptions. She indicated that going forward, she would pour each medication immediately after pre-signing and double check that the medication was given before doing the final sign-off. No evidence was presented at the Inquiry that this medication incident was investigated by Telfer Place, reviewed with Wettlaufer, or reported by Telfer Place to Life Guard.

L. Ms. Wilmot-Smith's Email to Wettlaufer of April 12, 2016

On April 12, 2016, Ms. Wilmot-Smith wrote to Wettlaufer reminding her to refrain from discussing controversial topics when making small talk at Telfer Place. She emphasized that Wettlaufer was acting as management when she was working as the charge nurse, and that she needed to set a high standard. Ms. Wilmot-Smith could not recall what led her to write this email to Wettlaufer, though she believed it was related to the conversation she had in January 2016 with Ms. Toleff.

X. Telfer Place Bans Wettlaufer on April 20, 2016

On April 20, 2016, Michelle Cornelissen, who had been hired earlier that month as the director of care, raised two issues about Wettlaufer's conduct in an email to Ms. Wilmot-Smith:

- Wettlaufer failed to properly document issues with a resident's behaviour, to check on the resident as required, and to inform oncoming staff about issues with the resident. The incident had resulted in injury to another staff member, but no incident report was completed.
- A physician who had several patients at Telfer Place stated that he did not feel confident in Wettlaufer's abilities to assess residents or to carry out basic nursing duties. The physician had indicated to Ms. Cornelissen that he felt Wettlaufer "lacked accountability as a nurse and to residents of the home."

Ms. Cornelissen also noted that Ms. Wilmot-Smith had previously been made aware that Wettlaufer had made vulgar and inappropriate comments to other Telfer Place staff.

In light of these issues, Ms. Cornelissen stated that Telfer Place was no longer comfortable having Wettlaufer work there, and Wettlaufer was banned from Telfer Place going forward. Wettlaufer's shift on April 18, 2016, two days before Ms. Cornelissen's email, was the last shift that she worked at Telfer Place.

A. Wettlaufer's Failure to Respond to Concerns Regarding a Resident's Behaviour

The incident involving the resident referred to in Ms. Cornelissen's April 20, 2016, email had been reported by Lauren Gallant, a PSW at Telfer Place. She stated that a resident had grabbed her wrist and kicked her in the side. When Ms. Gallant asked Wettlaufer to give the resident medication to help him calm down, Wettlaufer refused. Ms. Gallant then asked Wettlaufer to look after the resident, but Wettlaufer did not, so Ms. Gallant checked on the resident every 15 minutes. When Ms. Gallant came in the next day, she saw that Wettlaufer had not completed any documentation about the incident.

Ms. Shannon testified that Ms. Gallant had indicated that her back was getting sore because Wettlaufer was not doing rounds with her. Although she did not recall specific details about the incident referred to in Ms. Cornelissen's email of April 20, 2016, she thought Ms. Gallant may have had an injured wrist.

B. A Physician's Concerns

The physician who had raised concerns about Wettlaufer to Ms. Cornelissen was Dr. John McDonald. He is the physician for a number of residents in Telfer Place but is not the medical director for the home. He testified that in April 2016, he was called to Telfer Place to respond to a resident but did not have details about the incident. He recalled looking for Wettlaufer, as the nurse in charge, to get more information. He found her in the chart room and attempted to get information from her about the incident and any concerns relating to the resident. "Very quickly it became clear that that interaction was lacking details, lacking knowledge," he said. She was not helpful in providing even basic information about the resident and was unable to answer his questions. He then spoke to some of the PSWs who were on shift that night and was able to get enough information about the resident's condition to

assess the resident, evaluate the situation, and satisfy himself that the resident was fine and the orders had been correctly and reasonably carried out.

Dr. McDonald described his interaction with Wettlaufer as uncomfortable and stated that he felt Wettlaufer lacked the knowledge and skills he expected of the nurse in charge. Dr. McDonald testified that he had never had a professional interaction like that before, and that he was left feeling uneasy about Wettlaufer. In terms of Wettlaufer's demeanour during their interaction, Dr. McDonald said:

I do not believe that she was on drugs or alcohol. Her pupils were not dilated. She was tense and not relaxed. She was not responding with the clinical information that she should have had, so much so that I had to search for the information in the patient's chart. She appeared to have a complete lack of ability to be forthcoming.

At the hearings, Ms. Cornelissen was asked whether she should have reported Dr. McDonald's concerns to the College. She replied that she did not do so because she did not have specific incidents that "were repetitive and [a] serious cause for concern."

C. Inappropriate Comments

Ms. Cornelissen testified that in April 2016 she became aware of another previous incident in which Wettlaufer made inappropriate comments of a sexual nature to a male staff member. Ms. Cornelissen said that there was an ongoing concern about comments Wettlaufer would make at work.

D. Life Guard's Response to the Email of April 20, 2016

Life Guard conducted a search of the Find a Nurse Register on the College's website on April 27, 2016, to determine whether Wettlaufer's status had changed since she was hired. The search revealed that Wettlaufer was still in good standing with the College.

Ms. Wilmot-Smith and Ms. Smith met with Wettlaufer on May 4 or 5, 2016. They set out the concerns that Telfer Place had raised about her and asked Wettlaufer to respond in writing. Wettlaufer provided her version of events by email to Ms. Wilmot-Smith on May 5, 2016. She stated:

This email is to address the three issues we discussed yesterday regarding my performance and professionalism at Telfer Place.

1. Regarding the issue of not charting or reporting an incident with an aggressive patient and not checking on that patient:

As discussed, I did check on the patient involved 3 times during the night. I did not chart on the incident or behaviour and I did not pass on the information to the next shift. In retrospect, I should have charted on the incident as soon as I had an opportunity to. Because the incident occurred at the beginning of a busy shift and because the patient remained settled for the rest of the shift, I forgot to chart and to communicate. This was not acceptable.

Regarding it being a staff injury, I did ask the staff involved if they were ok later on in the shift and they indicated that they were.

Going forward, I will take the time to document incidents immediately after their occurrence.

I will insist that any staff reporting a work place injury fill out the appropriate forms.

2. Regarding a Doctor who stated that I am not accountable and that they are not confident in my assessment skills:

It was not communicated which Doctor this was. I have assisted 2 different doctors when they have attended clients at Telfer Place. When calling a Doctor, I do make sure I have done the assessments I think are indicated. When communicating with a Doctor who has come in, I do follow their direction and orders and document and communicate.

3. Regarding my inappropriate and vulgar comment. This was an unprofessional and inappropriate action on my part. It was unacceptable for me to make such a comment. It will not happen again.

XI. Wettlaufer's Performance as an Agency Nurse at Other LTC Homes

Like Telfer Place, other LTC homes turn to staffing agencies when they do not have enough nurses to cover shifts. During the time that Wettlaufer worked for Life Guard, she was assigned to shifts at six other LTC homes as well as a retirement residence. Although none of the Offences were committed at those sites, the Inquiry obtained documentation from all of them relating to their relationship with Life Guard and their experience with Wettlaufer as an agency nurse.

A. Anson Place Care Centre

Anson Place Care Centre is an LTC home located in Hagersville, Ontario, and licensed to Rykka Care Centres LP. It is a small home with 61 beds and, like Telfer Place, scheduled only one registered nurse on each shift. It did not have a sufficient number of registered nurses to fill all shifts when emergencies occurred or when its regular nursing staff could not cover sick calls or vacations.

Anson Place engaged Life Guard in 2014 and, on November 11, it signed Life Guard's template contract (Anson Place Contract). Like Telfer Place, it did not complete its own criminal reference check for agency nurses, relying on Life Guard to do that. Given that Wettlaufer's criminal reference check was dated April 22, 2014, it was more than six months old when the Anson Place Contract was signed and therefore did not meet the requirements of the LTCHA. Wettlaufer was assigned her first shift at Anson Place on April 5, 2015.

Anson Place had an orientation process in place for agency nurses – a full day of orientation and a requirement that agency nurses sign off on its "Risk Management Binder." Wettlaufer received four hours of orientation and did not sign the binder. Wettlaufer worked a nightshift immediately after her orientation. She would have been the only registered nurse on duty.

In total, Wettlaufer worked 10 shifts at Anson Place between April 5, 2015, and February 25, 2016. No one complained about her while she was assigned there or reported any medication errors. However, an incident arose between Wettlaufer and an Anson Place registered practical nurse on February 25, 2016, which Wettlaufer reported to both Life Guard and Anson Place. Wettlaufer wrote to Ms. Wilmot-Smith indicating that a registered practical nurse at Anson Place had told her to do work that Wettlaufer believed was the responsibility of the registered practical nurse. Wettlaufer described the confrontation that ensued. She also phoned Anson Place's director of care to report her concerns about the other nurse and what had happened. There does not appear to have been any direct communication between Anson Place and Life Guard at the time of the incident. During the Ministry investigations that followed Wettlaufer's confession, however, Anson Place said that, following this incident, it directed its nursing scheduling clerk to inform Life Guard that it did not want Wettlaufer to return. Wettlaufer was never assigned to Anson Place again.

B. Fox Ridge Care Community

Fox Ridge Care Community is an LTC home located in Brantford, Ontario, owned by Sienna Senior Living Inc.²⁰ The company signed Life Guard's template contract on or about September 11, 2011. Wettlaufer's first shift was on April 27, 2015, from 14:00 to 23:00, with one hour of orientation. Fox Ridge's records indicate that Wettlaufer committed a medication error on that first shift, when she missed giving a medication to a resident. A registered practical nurse reported the incident, and a medication incident report was completed. There is no evidence that Life Guard was advised of this medication error, either by Wettlaufer or by Fox Ridge.

C. Park Lane Terrace

Park Lane Terrace, a home with 132 beds, is located in Paris, Ontario.²¹ At the time the Ministry investigated the Offences, Park Lane typically had two registered nurses on the day shift for five days a week, and one registered nurse on the day shift for the remaining two days. On the evening and night shifts, only one registered nurse was scheduled.

Park Lane and Life Guard entered into Life Guard's template contract on July 12, 2015. Life Guard provided Park Lane with Wettlaufer's Criminal Reference Check dated April 22, 2014. Because the Criminal Reference Check was more than six months old, it did not meet the requirements of the LTCHA.

Park Lane required new agency nurses to come in to review and sign off on an agency binder, once they had reviewed it. When the Ministry reviewed this binder during its inspection into the Offences, it confirmed that the binder included all information, policies, and procedures on which the LTCHA and its regulations required nurses to be trained before performing their responsibilities. However, there was no evidence that Wettlaufer signed off as having read the binder at the time of her first shift in May 2015.²²

In total, Wettlaufer worked four shifts at Park Lane in May and June 2015. Her first shift was May 12, 2015. There was no evidence that any issues arose when Wettlaufer worked at Park Lane.

²⁰ Fox Ridge is licensed to 2063414 Ontario Limited as a General Partner of 2063414 Investment LP, owned indirectly through Leisureworld Senior Care LP by Sienna Senior Living Inc.

²¹ Park Lane is licensed to Park Lane Terrace Limited.

²² The binder included an entry signed by Wettlaufer in March 2016, but no evidence was produced to the Inquiry, or to the Ministry when it investigated the issue in 2017, that Wettlaufer worked at Park Lane in 2016.

D. Hardy Terrace

Hardy Terrace is an LTC home located in Brantford, Ontario, and licensed to Diversicare Canada Management Services Co. Inc. On September 16, 2014, rather than using its template contract, Life Guard entered into a “Staffing Services Agreement” with Diversicare (Diversicare Contract). The Diversicare Contract required Life Guard, among other things, to ensure that there were “appropriate background checks in respect of any workers to be supplied to Diversicare, including appropriate reference checks, a criminal reference check and vulnerable persons screening.”

Despite the Diversicare Contract, on December 11, 2014, Hardy Terrace entered into a contract with Life Guard, using the Life Guard template. As noted earlier, Life Guard’s template contract did not oblige either party to conduct a criminal reference check and a vulnerable sector screen.

On May 22, 2014, Wettlaufer had a four-hour orientation at Hardy Terrace. She was scheduled to work the evening shift on May 24 but was absent. She worked the evening shifts on May 27 and 28, 2015, but did not work any further shifts at Hardy Terrace.

There is no evidence that any issues arose when Wettlaufer worked at Hardy Terrace.

E. Delrose Retirement Residence

Life Guard also assigned Wettlaufer to a retirement residence, Delrose Retirement Residence located in Delhi, Ontario. As a retirement residence, Delrose was not governed by the LTCHA. On January 31, 2014, Life Guard and Delrose entered into Life Guard’s template contract for the supply of agency nurses. On September 25, 2015, Wettlaufer was assigned her first shift at Delrose.

On November 13, 2015, Delrose informed Life Guard that Wettlaufer had made medication errors (applying a full nitro patch rather than a half patch as ordered) on the night shifts she had worked on November 1 and November 7. Life Guard spoke to Wettlaufer about the errors and advised Delrose Place of this action.

Between November 13, 2015, and February 1, 2016, Wettlaufer worked four shifts at Delrose. On February 1, Ms. Wilmot-Smith received an email from Delrose indicating that video surveillance had captured Wettlaufer taking

food from the home's fridge and eating it over the top of other food for the residents. Delrose emphasized that her actions were unsanitary and amounted to theft.

Ms. Wilmot-Smith confirmed that Life Guard would no longer place Wettlaufer at Delrose. She then asked Wettlaufer to explain her behaviour. In her emailed response on February 2, Wettlaufer mistakenly referenced Anson Place in her opening sentence:

Heidi I have been thinking about what happened at Anson Place on December 26. I did eat a carrot cake square while wrapping the other squares. I also ate crumbs and icing from the side of the box while wrapping the squares.

It was late at night and I was tired and not thinking. I realize this is food theft as well as extremely poor hygiene.

I am sorry for this lapse and promise it will never happen again. I understand Delrose being upset and I apologize for the situation my actions have placed you in.

F. Brierwood Gardens

Brierwood Gardens is an LTC home with 79 beds located in Brantford, Ontario, and licensed to Revera. On July 25, 2013, Brierwood Gardens entered into Life Guard's template contract. It had no policies or practices for the orientation of agency nurses. In Wettlaufer's case, she received two hours of orientation before working a day shift on May 30, 2015. She worked eight shifts between May 30 and August 2015, but did not work again at Brierwood until 2016. There was no evidence that any issues arose about her performance at Brierwood. In fact, she received a reference from Brierwood when she applied for a position with Saint Elizabeth Health Care (see Chapter 8).

G. Dover Cliffs

Dover Cliffs is an LTC home with 70 beds located in Port Dover, Ontario, owned by Revera. It has a registered nurse on duty 24 hours a day, and a registered practical nurse on duty 16 hours a day.

On July 28, 2016, Life Guard and Dover Cliffs signed Life Guard's template contract. Like most of the other homes, Dover Cliffs assumed that Life Guard obtained the required criminal reference checks for the nurses it assigned to work there.

Wettlaufer received six hours of classroom and floor orientation at Dover Cliffs on August 5, 2016, from 18:00 to 24:00. She signed off as having received that orientation, which included both reviewing policies and taking quizzes on, among other things, the following:

- resident non-abuse training;
- customer service and complaint management;
- all hazards / emergency preparedness, fire prevention, and safety;
- managing responsive / challenging behaviours;
- health and safety;
- building a respectful workplace; and
- Revera's code of conduct.

Following her orientation, Wettlaufer worked the night shifts on August 6 and 7, 2016. There is no evidence that any issues arose during those two shifts.

XII. Wettlaufer Resigns from Life Guard

In July 2016, Wettlaufer was hired by Saint Elizabeth Health Care. Life Guard was aware that she was seeking and had obtained another job. In her later interview with the police, Wettlaufer said that she considered her job at Saint Elizabeth to be her priority. On September 7, 2016, Wettlaufer resigned by an email sent to Ms. Wilmot-Smith:

Please accept this letter as my resignation from Life Guard homecare, effective immediately. I am thankful for the opportunities I have had with your company. I am no longer able to work as a registered nurse.

Ms. Wilmot-Smith testified that she did not speak to Wettlaufer after receiving this email. She was extremely busy and, although she thought Wettlaufer's comment about no longer being able to work as a registered nurse a bit odd, Ms. Wilmot-Smith testified that, at that time, "[] likely had bigger fish to fry"

At the hearings, Ms. Wilmot-Smith was asked whether Life Guard had a duty to report Wettlaufer to the College of Nurses. In September 2016, employers were required to report to the College if a nurse resigns in certain situations, namely:

- if the employer has reasonable grounds to believe that the resignation is related to the nurse's professional misconduct, incompetence, or incapacity; or

- if the nurse's resignation occurs during or as a result of an investigation conducted by or on behalf of the employer into allegations related to professional misconduct, incompetence, or incapacity.

In Ms. Wilmot-Smith's opinion, Wettlaufer's resignation did not fall within either scenario.

By the time that Wettlaufer resigned from Life Guard, she had already resigned from Saint Elizabeth Health Care.

On September 16, 2016, Wettlaufer voluntarily went to the Centre for Addiction and Mental Health in Toronto, where she was admitted for assessment and then held under a Form 3 involuntary admission certificate. While she was a patient there, she confessed to the Offences.

XIII. Investigations After the Offences Become Known

A. Revera's Internal Investigation

After the confession became known, Revera conducted an "Adverse Event Retrospective Review." Several Telfer Place staff members were interviewed as part of that review. Revera concluded that the factor contributing to the circumstances surrounding Wettlaufer's Offence at Telfer Place was that "[s]evere long term staffing shortage at Telfer has led to significant agency use. Measures have been put in place to reduce agency use at Telfer."

Even before knowing about the Offences, Telfer Place / Revera had identified that it needed to address the fact that agency nurses were being used on a regular basis at Telfer Place. By the time that Wettlaufer confessed, Telfer Place had already eliminated its reliance on agency nurses.

B. The Ministry's Inspections

1. Telfer Place

Following Wettlaufer's confession, the Ministry conducted an inspection at Telfer Place. It released its inspection report in May 2017, the details of which are set out in Chapter 11. As an agency, Life Guard was not subject to any Ministry oversight, so there was no inspection of its processes and procedures.

The Ministry inspectors attempted to interview Ms. Wilmot-Smith without success.

The findings of non-compliance issued following this inspection primarily related to Telfer Place's use of agency nurses. In particular, the inspectors found that the licensee:

- had failed to comply with the 24/7 RN requirement, in that an agency RN was at times the only registered nurse on duty in circumstances that did not fall within one of the legislated exceptions;
- had failed to comply with the requirement that criminal reference checks be completed before a staff member was hired;
- had failed to comply with the requirement that all staff receive specified training, including training on the Residents' Bill of Rights, the policy to promote zero tolerance of abuse and neglect of residents, and mandatory reports; and
- had failed to comply with the requirement that it maintain a record for all nurses that includes, among other things, a verification of the nurse's current certificate of registration with the College of Nurses and the results of the nurse's criminal record check.

The final three findings specifically refer to Wettlaufer as one of the staff members to whom the finding of non-compliance related. All four findings were issued with voluntary plans of correction.

2. Other LTC Homes Where Wettlaufer Worked as an Agency Nurse

Once it learned of the confession, the Ministry also conducted inspections at Anson Place, Park Lane, Brierwood Gardens, and Dover Cliffs. All these inspections led to findings of non-compliance in relation to the LTC homes' use of agency nurses, and many of the findings were the same as those against Telfer Place (for more details, see Chapter 11).

RECOMMENDATIONS

Recommendation 11: Licensees should minimize the use of agency nurses. To achieve this, they should develop proactive strategies such as maintaining a roster of casual employees who are members of the regular nursing staff and can cover shifts in the case of an unexpected absence.

Rationale for Recommendation 11

- Agency nurses are less familiar with the residents than are the regular nursing staff, and their use undermines the goal of providing residents with consistency and continuity in care.
- The evidence shows that charting by agency nurses is generally not as in-depth as that by regular staff; their daily reports are less detailed; and their verbal reports at shift changes are less complete.

Recommendation 12: If agency nurses must be used, licensees should thoroughly vet agencies before entering into contracts with them to ensure that the agency's management and staff have the knowledge, skills, and experience required to provide services effectively and safely to the home's residents, including on the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations.

Rationale for Recommendation 12

- Before entering into a contract with an agency or using its staff, licensees should vet the agency by verifying current and past references and speaking to homes that use or have used the agency.
- Vetting enables licensees to confirm the knowledge, skills, and experience of staff and management, and their familiarity with the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations.

Recommendation 13: Licensees should ensure that their contracts with agencies:

- require the agency to, at all times, have a roster of nurses who have been oriented to the licensee's home and meet the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations;
- set out clear responsibilities and expectations for the agency in terms of its hiring, screening, and training of registered staff; and
- set out a clear process for reporting performance concerns from the licensee to the agency.

Rationale for Recommendation 13

- The legal relationship between licensees and staffing agencies is governed by the contract between them. There are no legislative requirements for these contracts. By setting out clear terms and conditions for the agency, licensees will have greater assurance of the quality of the registered staff the agency is providing.
- By requiring a trained and oriented roster of agency staff, last-minute absences can be covered by agency nurses already familiar with the home and its processes. Properly trained and oriented staff improve the safety and security of residents.
- Licensees are not responsible for disciplining agency nurses. Establishing clear communication and reporting channels between the licensee and the agency will assist in addressing performance concerns in a timely manner.

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I. Introduction

Publicly funded home care services, such as nursing, personal support, physiotherapy, and occupational therapy, are used by thousands of people throughout Ontario every day. They assist in a wide range of situations, from short-term use on discharge from hospital to long-term use for ongoing issues. These services allow our aging population to remain in their own homes until those who need constant monitoring and care transition into long-term care (LTC).

The home care setting is different from the LTC home setting in a number of ways. For example, home care clients are responsible for their medication management, whereas that responsibility is given up when a person becomes a resident in an LTC home. As well, home care clients and their caregivers remain in greater control of the environment in which they live. However, like residents in LTC homes, home care clients are vulnerable to the professionals who care for them. Wettlaufer took advantage of that vulnerability when she attempted to murder Beverly Bertram while she was providing her with nursing services in her own home. For ease of reference, throughout this chapter I will refer to this attempt as the Offence.

I begin by examining the legislative and contractual framework governing the delivery of publicly funded home care services. Next, I discuss the changing nature of home care clients and the impact that difficulties in recruiting and retaining nursing staff have had on this sector. Given that Wettlaufer again used insulin to commit the Offence, I also review the way that medication – particularly insulin – is managed in the home care setting.

Thereafter, I focus on Saint Elizabeth Health Care (Saint Elizabeth). Saint Elizabeth was Wettlaufer's last employer before her confession, and it was Saint Elizabeth that assigned her to provide nursing services to Ms. Bertram. I review Saint Elizabeth's role as well as its processes and procedures for hiring and orienting registered nurses and for reporting issues that arise.

Next, I address Saint Elizabeth's hiring of Wettlaufer, the orientation she received, and her performance in the few weeks that she worked as a home care nurse. This discussion includes the circumstances leading up to the Offence and her resignation shortly thereafter. I then briefly address the investigations that took place after Wettlaufer disclosed her crimes.

Finally, I provide recommendations for service providers in the publicly funded home care sector.

II. The Legislative and Contractual Framework Governing Publicly Funded Home Care in Ontario

The legislative oversight of publicly funded home care in Ontario is different from the oversight of LTC homes. The *Long-Term Care Homes Act, 2007* (LTCHA),¹ and Ontario Regulation 79/10 (Regulation) place comprehensive obligations on the licensees, but the extensive oversight and inspection regime created by that legislation does not apply to home care services. Rather, home care is governed by the *Home Care and Community Services Act, 1994* (HCCSA)² and by various contracts.

When Wettlaufer committed the Offence, several parties played a role in the delivery of the home care services that the victim was receiving: the Ministry of Health and Long-Term Care (Ministry); the South West Local Health Integration Network (LHIN); the South West Community Care Access Centre (CCAC); and Saint Elizabeth – a service provider under contract with the South West CCAC.

The role of the CCACs and LHINs is discussed in more detail in Chapter 12. By way of overview, at the time of the Offence in the home care setting, Ontario's 14 CCACs had two systems in place: either they provided publicly funded home care and community services themselves or they paid service providers – such as Saint Elizabeth – to provide those services to clients on their behalf. The second system was far more common. The Ministry provided the funding for these services and gave it to the LHINs, which in turn administered it to the CCACs. The LHINs are Crown agencies established to “plan, integrate and fund health services at a regional level.”

During 2017, the Ministry dissolved the CCACs and transferred their duties to the LHINs. In this chapter, I discuss the practices as they existed under the CCACs at the time that Wettlaufer committed the Offences. Unless otherwise stated, the practices ascribed to the CCACs were performed by the LHINs at the time of the writing of this Report.³

¹ SO 2007, c 8.

² SO 1994, c 26.

³ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received royal assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC system, including Ontario Health.

A. The Home Care and Community Services Act

The HCCSA sets out a Bill of Rights for those receiving publicly funded home care services. It is similar to the Residents' Bill of Rights in the LTCHA,⁴ and the CCACs gave every client a pamphlet listing these rights. Under section 3 of the HCCSA, service providers must ensure that the following client rights are respected and promoted:

- the right to be dealt with by the service provider in a courteous and respectful manner and to be free from mental, physical, and financial abuse by the service provider;
- the right to be dealt with by the service provider in a manner that respects the person's dignity and privacy and that promotes the person's autonomy;
- the right to be dealt with by the service provider in a manner that recognizes the client's individuality and that is sensitive to and responds to that person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial, and cultural factors;
- the right to information about the community services provided and to be told who will be providing those services;
- the right to participate in the service provider's assessment of the client's needs and development of the plan of service, as well as any evaluations and revisions of that plan;
- the right to give or refuse consent to the provision of any community service;
- the right, in connection with the community service provided or the policies and decisions around it, to raise concerns with, or recommend changes to, the service provider, government officials, or any other person, without fear of interference, coercion, discrimination, or reprisal;
- the right to be informed of the laws, rules, and policies affecting the operation of the service provider and to be informed in writing of the procedures for initiating complaints about the service provider; and
- the right to have all records kept confidential in accordance with the law.

⁴ HCCSA, s 3(1).

B. The Services Agreements

The CCACs entered into contracts, known as services agreements, with each service provider they engaged to provide home care services. When the CCACs were dissolved and their responsibilities transferred to the LHINs, the LHINs assumed the services agreements. The requirements of these agreements are discussed in more detail in Chapter 12. In this section, I focus on the requirements in the services agreements related to the qualifications and orientation of nursing staff; the reporting process for risk events and complaints; and the monitoring of nursing staff performance.

1. Qualifications and Orientation of Nursing Staff

The service provider is responsible for assigning the frontline staff who provide direct care to the client. Under the services agreement, the service provider's nurses must be qualified to practise nursing in Ontario; hold a certificate of registration and be in good standing with the College of Nurses of Ontario; be in compliance with all laws relevant to the practice of nursing in Ontario; and be qualified in standard level first aid and cardiopulmonary resuscitation.

The service provider is responsible for recruiting, orienting, training, and supervising nurses. Among other things, service providers must implement appropriate screening measures, including verifying that each nurse has obtained a criminal record check and supplies an annual offence declaration; verify their staff members' qualifications on a continuing basis; keep records of those qualifications; and manage any restrictions on registered staff members' certificates of registration.

Service providers must also provide education and training to their staff members, as specified in the services agreement. In addition to establishing a comprehensive training and development program and providing anti-discrimination and anti-harassment training, service providers must orient staff to their own policies and those of the local CCAC (later, the LHIN). This includes training on policies related to clients' rights, abuse and neglect, and the reporting of abuse and neglect. There is no requirement that such training take place annually. Service providers must also ensure that their staff are familiar with, and follow, the requirements of the Bill of Rights in the HCCSA.

Service providers are not required to supply any proof to the CCACs that their staff have the necessary qualifications or have received the specified training, although periodically the CCAC may audit such practices.

2. Reporting Requirements

The Ministry does not deal directly with issues arising from the care that a service provider gives clients. At the time of the Offence, the CCAC held this responsibility.

a) Risk Events

Service providers were required to report “risk events,” including “adverse events,” to the CCAC. A risk event was defined in the services agreement as “an unforeseen event that has given rise to or may reasonably be expected to give rise to danger, loss or injury relating to the delivery of the nursing services, including danger, loss or injury to the patient, caregiver, service provider personnel or loss or damage to the CCAC or the service provider.” Risk events included – but were not limited to – a medication error, an improper procedure or intervention, a failure to follow medical orders, a client injury or fall, actual or potential abuse of a client, an actual or alleged theft in the home, and the unexpected death of a client.

Risk events also included “adverse events,” the most serious of risk events. A risk event qualified as an adverse event if it:

- was related to a client;
- caused an unintended injury to the client or a complication that resulted in disability, death, or increased use of healthcare resources; and
- was caused by healthcare management, including any care or treatment provided as part of a formal care plan by healthcare workers, formal or informal caregivers, or as self-care by the client.

b) Reporting Risk Events

Service providers were required to immediately notify the CCAC orally of certain events. Among other matters that required immediate oral reporting were all adverse events as well as risk events involving the safety of a client or a person involved in the client’s care. Service providers also had to submit written reports within three days of a risk event, unless the CCAC required the report sooner.

c) Content and Manner of Reporting a Risk Event

When a service provider reported a risk event, it had to include, among other things, and if applicable, the date and time of the risk event, the details of what happened, whether it was an “adverse event,” the names of the personnel involved and any witnesses, and a description of how the service provider responded and what actions it took. They were also required to assign a risk level to the event. At the time of the Offence, they used guidelines provided by the CCAC to determine the appropriate risk level to assign. Also at that time, service providers reported this information to the South West CCAC using the CCAC’s electronic system, known as the Event Tracking Management System (ETMS). This reporting process is outlined in detail in Chapter 12.

Only service provider supervisors and managers were able to report events through ETMS. Therefore, the service providers’ ability to properly report these events depended on their frontline staff, who would typically be the first to hear about them. Frontline staff needed to report the complaint or risk event to their manager or supervisor so the incident could be entered into ETMS. In practical terms, that meant that service providers had to have sufficient processes and practices in place to ensure that frontline staff reported events immediately and accurately, and to ensure that managers and supervisors were adequately trained about reporting through ETMS.

3. Managing the Performance of Service Provider Nursing Staff

Managing the performance of nursing staff is the responsibility of the service provider, and the services agreement requires service providers to regularly evaluate the performance and competency of their frontline staff. Service providers must have nursing service supervisors who are qualified and registered to practise nursing in Ontario; have at least one year of supervisory or equivalent experience; and have the necessary management qualifications and experience to monitor, assist, and supervise the service provider’s nurses.

In practice, nursing service supervisors provide clinical expertise to support nurses in caring for clients. They work with the frontline nurses to ensure that they are meeting practice standards, and they may conduct home visits to evaluate nurses’ skills.

III. The Changing Nature of Home Care Clients

As in LTC homes, the acuity of publicly funded home care clients has increased in recent years. The number of adult long-stay home care clients with high-care needs more than doubled between 2007 and 2017.⁵ There has also been an increase in the number of clients with signs of dementia. These challenges mean that service providers must ensure that staff have the right skills and training to deal with more complex health concerns – including dementia – in the home care setting. For example, Saint Elizabeth has a “Hospital in the Home” program through which it provides intensive support to clients in their homes – often multiple times a day – for treatments such as chemotherapy or advanced medication protocols for end-of-life palliative patients.

Another result of the increased acuity of home care clients is the need for more staff to manage clients’ needs. For instance, the acuity level of some clients may require two staff to attend the client’s home at the same time to provide services. In some cases, a team of up to 30 staff members may be required to meet the needs of one client.

The increase in the acuity of home care clients is attributable to several factors, including that patients are discharged from hospital earlier than in previous years, and many seniors in Ontario want to remain in their homes as long as possible, even when they become very ill. The result is that people are living in their own homes even when they have significant and complex health needs. In recent years, the CCACs – and, later, the LHINs – have developed the capacity to support these individuals in their homes. For example, at the public hearings, a witness from the South West LHIN said that 75% of the palliative patients in that LHIN’s territory now choose to die at home, and the LHIN is able to support them in doing so.

IV. Difficulties in Recruiting and Retaining Registered Nurses in Home Care

Like LTC homes, home care service providers struggle to recruit and retain registered nurses. Some of the reasons are similar, such as staff preferences to work in hospitals and the availability of better compensation in that sector. However, other factors are unique to home care and relate to the environment and workload challenges faced by the home care nurse.

⁵ Information compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the public hearings.

The home care environment can be challenging. For the most part, nurses working in home care have multiple clients to see each day and must travel to the different homes in which they will provide care. A nurse's ability to get from location to location on any given day is subject to weather conditions and traffic patterns. In addition, nurses must travel with some of the equipment and supplies they need to provide services to their clients, such as stethoscopes, blood pressure cuffs, oral thermometers, protective gowns, syringes and needles, client-related educational materials, and non-sterile gloves. In addition, a client's home may not be an ideal environment in which to work: it may lack reliable heat or electricity or have hostile animals.

The isolation of the home care setting is another challenge. Although it is beneficial to be able to spend one-on-one time with the client, uninterrupted by call bells and other individuals, there are many downsides. No supervisory or management staff are present in the client's home, nor are there other regulated health professionals on site to whom the home care nurse, or the client, can turn to for advice or help in dealing with an emergency. For example, home care nurses cannot press a buzzer for direct support if a client or someone else in the home becomes aggressive or violent. Service providers have recognized these risks by putting various safeguards in place. Among other things, Saint Elizabeth asks that clients control their pets, refrain from smoking, and ensure the safe disposal of medical "sharps," such as needles and lancets.

Travelling from location to location, loading and unloading equipment and supplies, and caring for multiple clients with different ailments and personalities all add to the workload of home care nurses. As a result, they often work after hours to complete their paperwork, make phone calls to clients, and organize orders for supplies. The work can also be physically taxing, as nurses are routinely called upon to lift heavy loads, transfer and reposition clients, and bend, kneel, or crouch in the course of providing care.

V. Medication Management in Home Care

Medication is managed differently in the home care setting than it is in LTC homes. Unlike staff in LTC homes, home care nurses typically do not have responsibility for ordering, delivering, or disposing of medication. In addition, unlike nurses in LTC homes, nurses in home care assist one client at a time and administer medication in only a minority of situations.

Service providers do not generally get involved in the ordering or delivery of the client's medications, unless the nurse feels the client needs different dosage packaging or equipment. In those cases, the nurse would communicate the issue to the physician or the pharmacist. While nurses may teach clients how to administer new medications, clients generally administer their own medications. However, there are certain situations where the nurses may administer the client's medication – such as clients who require IV antibiotics or palliative clients who receive narcotic injections for pain and symptom management. The assigned nurses will administer only the medications related to the services they are to provide to the client. Typically, unless the client is unable to administer medications, they will not be responsible for administering all the medications that have been prescribed for a client.

A. Handling of Injectable Insulin

Most home care clients self-administer their own insulin. Home care nurses will generally administer insulin only when a client has recently been diagnosed with diabetes and needs education on how to administer the drug. After the client has learned how to properly administer it, the client will then administer the insulin going forward.

On those few occasions when injectable insulin is part of the nursing services to be provided, insulin is ordered by the client's physician, and the client arranges for the pharmacy to fill the prescription and either picks it up or has it delivered. The insulin is therefore in the client's home when the nurse arrives. The clients decide how they want to store their insulin, although the home care nurse may make suggestions about how to store it safely. When administering insulin, the nurse checks the medical orders and then administers it. There is no independent double-check with another registered staff member. However, if the client is competent, the nurse may confirm the dose with the client. When a home care nurse administers the insulin, the nurse will document the administration in the client's medication administration record.

Disposal of empty cartridges is again up to the client, although the nurse may make recommendations such as the use of a sharps container or remind the client to order a refill when needed. As in LTC homes, there is no tracking of insulin use or cartridge disposal in the home care setting. Tracking insulin use is difficult, especially in home care where the client is generally handling the insulin and, with some exceptions, care is not provided "24/7."

B. Handling of Narcotics and the Opportunity for Diversion

In the home care setting, both controlled and non-controlled medications are generally managed by the client. There are no counts of these medications in the home and no oversight of their disposal. The client decides how to store these medications and, although nurses may make suggestions about best practices for safe storage, they typically do not control access to clients' medications. However, when a narcotic is administered through a pump, the pumps are locked so that the client and family members are not able to change the settings.

When a home care nurse is administering a narcotic, there is no independent double-check. However, the evolution of technology may allow certain remote checks to be done. For example, it is possible to verify pump settings remotely using Skype or video calls.

Saint Elizabeth uses technology to provide remote support to its home care nurses. For example, it provides clinical support using a "virtual team" which allows nurses to call if they have a question. Nurses are also required to call to double-check any calculations they must do for the administration of medication. The virtual team can also review orders for nurses in the field or, after reviewing photographs of a clinical issue, provide the nurse with support about how to proceed.

The danger of diversion is present in the home care setting: Wettlaufer stole insulin from one home care client to commit the Offence and stole hydromorphone for herself at the same time.

C. Medication Errors in Home Care

As in any setting, medication errors can occur in home care. The service provider is responsible for ensuring that its nurses administer medications properly. The need for nurses to self-report medication errors is particularly important in the home care setting because, usually, there are no other nurses in the home at the same time to notice that an error has been made.

To encourage staff to self-report such errors, Saint Elizabeth fosters a "no blame" culture for medication errors. Instead of blaming the nurse, the focus is on ensuring that the client is safe and learning from the mistake to prevent similar errors in the future. When nurses working for Saint Elizabeth in

Oxford County made mistakes, they informed Tamara Condy, who was both their nursing service supervisor (known as a health services supervisor within the organization) and a clinical practice coach at Saint Elizabeth. She would identify any additional education the nurse might need and share the mistake with the team, so everyone could learn from it.

VI. Saint Elizabeth Health Care

Saint Elizabeth is a not-for-profit charitable organization that offers home healthcare services, including the services of registered nurses, registered practical nurses, community health workers, and rehabilitation services. It currently has more than 8,000 employees across Canada. Saint Elizabeth staff conduct more than 20,000 client visits each day.

As a service provider, Saint Elizabeth had services agreements with several CCACs under which it provided publicly funded home care services to CCAC clients.⁶ Under its services agreement with the South West CCAC, Saint Elizabeth provided services in three areas:

- City of London and the County of Middlesex;
- County of Oxford and the portion of Norfolk County residing under the South West LHIN; and
- County of Huron.

To provide the required services to South West CCAC clients, Saint Elizabeth had three service delivery centres in the southwest service area – Oxford, London, and Huron. In Oxford County alone, where Wettlaufer was hired and committed the Offence, Saint Elizabeth staff make more than 1,000 nursing visits each week.

The scope of Saint Elizabeth's services extends beyond home care and includes providing care to clients within LTC homes and schools, as well as education, research, and advisory services. In this chapter, I focus on its home care services as a service provider.

⁶ When the CCACs were dissolved and their responsibilities were assumed by the LHINs, the LHINs assumed these services agreements. Under them, Saint Elizabeth continued to provide services to LHIN clients.

A. Hiring Practices

Like all service providers, Saint Elizabeth is required to hire qualified nurses who are in good standing with the College of Nurses of Ontario (College). It must also have adequate screening measures in place – and, to this end, it required its prospective nurses to obtain criminal record and vulnerable sector checks.

Saint Elizabeth requires all prospective staff members to:

- be eligible to work in Canada;
- provide two satisfactory references from past and/or current employer(s);
- undergo a satisfactory criminal record check;
- undergo a satisfactory Child Abuse Registry check and/or vulnerable sector check, if required; and
- possess the necessary education, skills, and experience set out in the job description.

In general, the resumés of applicants for registered nursing positions are reviewed by the nursing service supervisor in the geographical area in which the nurse is needed. If, based on the review, the nursing service supervisor believes that the applicant is suitable for the position, the Saint Elizabeth recruiters begin the hiring process, which involves:

- pre-screening the applicant in a phone call;
- checking the applicant's registration and status with the College;
- interviewing the applicant;
- completing a criminal record check, including a vulnerable sector check;
- asking references to complete an electronic survey; and
- entering into a written employment agreement with the applicant.

1. Pre-screening

During the pre-screening interview for nurses, the applicants receive information about Saint Elizabeth and its services. The recruiter also asks the applicant questions and records the answers on a pre-screening questionnaire. Among other things, these questions are designed to confirm the applicant's registration and status with the College, willingness to undergo a criminal record check, current employment status, reason for being interested in community nursing, past nursing experience, and the types of clients the applicant cared for in the past.

2. Registration Check with the College of Nurses

After the pre-screening interview, the recruiter confirms the applicant's registration and status with the College by checking its online Find a Nurse Register. In accordance with the College's governing legislation, the Register does not list ongoing investigations that have not yet resulted in restrictions being imposed on a nurse or a referral to the College's Discipline or Fitness to Practise Committees, as discussed in Chapter 13. As a result, when checking the Find a Nurse Register, Saint Elizabeth is not able to determine if there is an ongoing investigation that may ultimately result in restrictions being imposed on the nurse at a later date.

3. Interview

Saint Elizabeth's nursing service supervisors are responsible for interviewing nursing applicants. During a typical interview, the nursing service supervisor reviews applicants' resumés, discusses their job experiences and skill sets, and asks behavioural questions. The nursing service supervisor decides whether to hire the applicant and, following the interview, sends the interview notes to Saint Elizabeth's human resources department, where they are uploaded onto the computer system.

If the nursing service supervisor feels that something in the interview raises a red flag – for example, if a candidate has disclosed a previous drug addiction – either the human resources manager or Saint Elizabeth's corporate integrity officer will become involved. This person may decide to conduct additional interviews and reference checks.

Before Wettlaufer's crimes were disclosed, Saint Elizabeth provided no specific training to supervisors on spotting red flags in a resumé or interview. Nor was there training in best practices for interviews or on how to ask probing questions.

4. Reference Checks

At Saint Elizabeth, the individuals who check employment references follow a standard procedure. All applicants are required to provide two supervisory references on the employment application form. If the candidate does not list the current employer as a reference, Saint Elizabeth informs the candidate that any employment offer will be conditional on obtaining a satisfactory reference from that employer. For applicants who are unable to list two supervisory references, Saint Elizabeth attempts to obtain alternative references from

instructors or professors at the candidate's educational institution, someone in the human resources department or an educator with the candidate's current employer, or a current employer or manager who was the candidate's previous supervisor.

Saint Elizabeth uses either an online reference check process or contacts references by phone and documents the information provided. If a reference is reluctant to provide information, Saint Elizabeth asks him or her, at a minimum, to confirm the candidate's dates of employment, position, and whether the candidate was eligible to be rehired.

Saint Elizabeth uses an online reference checking software system. After experiencing difficulties contacting references in the past and researching several different systems, Saint Elizabeth decided to adopt this software. The online system asks references to complete an electronic pre-hire report in which they rate the job applicant on a number of different competencies, including professionalism, interpersonal skills, problem solving and adaptability, personal value commitment, and alignment with patient satisfaction. Several questions relate to each competency, and references are asked to rate the applicant on a scale of 1 to 7 for each one. Among other things, the pre-hire report identifies the average rating given by references in a management position as well as the average rating given by managers and non-managers combined.

The references are also asked to indicate if they had been involved in the decision to hire the candidate at their company and if they would work with the candidate again. Finally, references are given the option of providing open-ended answers about the applicant's work-related strengths and areas for improvement.

At the time Wettlaufer was hired in 2016, although the system allowed references to provide comments, it did not attribute those comments to the person who made them. Based on Saint Elizabeth's discussions with the system provider, it was thought that this level of anonymity would yield more honest answers. Given the extent of the information asked for within this report, Saint Elizabeth did not phone those references for additional information, nor did it ask candidates to submit written references.

5. Criminal Record Check

Saint Elizabeth requires applicants to produce a criminal record check – including a vulnerable sector check – that is no more than three months old.

6. The Employment Agreement

Saint Elizabeth requires new nurses to enter into an employment agreement that outlines the terms and conditions of their employment. The agreement provides that the nurse is on probation for three months. It also confirms that the employment is conditional on the candidate possessing a current certificate of registration with the College; providing the names of satisfactory references, including supervisors, from their past or current employers; and providing a satisfactory criminal record check and vulnerable sector check.

B. The Nursing Practice Questionnaire

Once hired, new nurses complete a nursing practice questionnaire in which they are asked to self-declare their skill level in performing various nursing interventions, such as taking a patient's blood pressure or administering an injection. Saint Elizabeth uses this information to determine if the nurse needs additional assessment or training. For more complex skills, Saint Elizabeth must assess and sign off on new nurses' abilities before they are permitted to complete the skill independently in caring for clients.

C. Orientation for Home Care Nurses

Saint Elizabeth's orientation process consists of both in-class and field orientation and takes approximately two weeks to complete. The in-class orientation is interspersed with the field orientation. During the field orientation, the new nurse, called the "preceptee," is paired with a mentor / trainer known as a "preceptor," and they travel together to visit home care clients. The preceptee does not care for any clients alone until the in-class orientation has been completed.

1. The Learning Plan

The preceptee is given a Saint Elizabeth Nursing Orientation Preceptee Learning / Developmental Plan (PLP) to keep and complete throughout the orientation and the 90-day probationary period. The PLP is a printed document that preceptees must take to all clinical experiences, whether in-class or when visiting clients with a preceptor.

Preceptees are expected to communicate with their assigned preceptor regularly to ensure that their learning needs are met, that they receive an appropriately individualized orientation, and to document the completion of competencies as they progress through the learning experiences during orientation. In turn, the preceptor is expected to provide a safe and positive learning environment while introducing preceptees to their new role and responsibilities. The preceptor is responsible for developing an orientation plan in collaboration with preceptees, assisting preceptees in developing competencies, evaluating and providing feedback on preceptees' performance, and providing ongoing support as the preceptees begin their new role.

The PLP covers many topics, including human resources, technology, the LHINs (formerly CCACs), professionalism, capacity assessments, documentation, medication administration and safe medication practices, seniors' care, mental health, infusion therapy, and diabetes, among others. Each topic details the competencies that the preceptees are expected to understand and outlines the activities they should undertake to achieve that understanding. Once they complete each activity, the preceptees initial the item on the list. Except where a special certification is necessary, the preceptor is not required to sign off on the activity.

2. In-Class Orientation

In-class orientation for new nurses at Saint Elizabeth involves a mixture of activities – tests, completion of online modules, in-class discussions, demonstrations of competency, and a review of particular policies. At the time of the Offence, the in-class orientation for preceptees also included training required by the CCAC on reporting requirements, the completion of CCAC written reports, CCAC processes for ordering medical supplies, guidelines on extending and reducing services, and the role of the CCAC case manager (now called a care coordinator). New hires must also complete online modules on various topics, including documentation, medication administration, and privacy.

Finally, new registered nurses are required to demonstrate their skills in a classroom setting with respect to certain procedures such as the changing of a peripherally inserted central catheter, commonly known as a PICC line.

The orientation on medication administration and safe medication practices requires nurses to:

- understand and describe the Saint Elizabeth Parenteral Medication Index, including first-dose and high-risk medications;
- effectively use a decision-making tool to decide when to give or not to give a medication;
- understand Saint Elizabeth's independent double-check expectations;
- understand Saint Elizabeth's expectations associated with medication error reporting;
- describe and demonstrate how to appropriately obtain and transcribe a physician's medication order;
- demonstrate accurate medication calculation;
- demonstrate an understanding of medication administration principles and expectations; and
- accurately complete a medication reconciliation.

At the time of the Offence, Saint Elizabeth's policy on administering and monitoring medication specified that before administering medications, nurses were to consider safe medication practices; ensure that the medication was appropriate for the client and the environment; assess the client, medication, and practice supports; and evaluate therapeutic outcomes and adverse effects. At that time, Saint Elizabeth also had an independent double-check policy for such things as initiating or changing / reprogramming an infusion pump, complex medication dose calculations, and high-risk medications. High-risk medications were defined in the policy as medications which "have a high risk of causing serious injury or death to a client if they are misused." For certain situations, such as calculating complex medication doses or administering high-risk medications, the independent double-check required the nurse to contact a clinical resource nurse or clinical educator to independently check the calculation / dosage. If an issue arose, the nurse could also transmit a picture. In other situations, such as when changing an infusion pump, the nurse would transmit a picture of the bag and pump settings to the clinical resource nurse or clinical educator for a double-check of the pump settings.

3. Field Orientation

New nurses at Saint Elizabeth spend their first few days of field orientation shadowing their preceptors on client visits. Gradually, they begin to take over their preceptors' nursing duties. This transfer gives the preceptor the opportunity to observe the new nurses' clinical skills and their comfort in engaging with the clients.

Although preceptors are responsible for evaluating new nurses' performance and providing feedback for improvement, Saint Elizabeth's preceptors in Oxford County are not required to formally document their observations of newly hired nurses during their field orientation. They may choose to make comments on the nurse's PLP or email the nursing service supervisor with comments. This feedback, however, is not necessarily documented.

4. Scheduling Client Visits

Saint Elizabeth's new nurses may begin seeing clients on their own even before successfully completing all aspects of their PLP. For example, if a new nurse cannot yet properly perform a particular treatment, that nurse will not be prevented from caring for clients in the field by providing other nursing treatments. However, nurses are not allowed to administer a treatment until they have demonstrated their knowledge and skill with that treatment.

Before new nurses can go out on their own, they must complete all parts of the in-class orientation, certain online learning modules, and the nursing practice questionnaire. Once the in-class orientation is completed, information from the nursing practice questionnaire on the nurse's skills is inputted into Saint Elizabeth's scheduling program. The scheduler can then review the skill list to see if a new nurse is competent to complete a particular assignment. In addition, the nursing service supervisor may tell the scheduler that a nurse can conduct certain visits, such as those involving wellness checks or wound care, even if not certified on all skills. Nurses are expected to decline any assignments with which they are not comfortable.

Each nurse is assigned to a series of shifts for a certain number of days each week. The Saint Elizabeth service coordinator prepares a schedule of client visits for each nurse the day before the nurse's scheduled shift. At that point, the nurses are expected to call their clients to arrange the approximate time of the visit.

Service providers are expected to assign their staff in a manner that maximizes continuity of care for each client. If a client needs visits every other day, Saint Elizabeth's service coordinator tries to assign a nurse who will be working those days. The organization assigns a primary nurse as well as a partner, who will see the client when the primary nurse is not available. However, there are times when continuity is not possible because of sick days, vacations, and resignations. A change in the client's needs can also affect the organization's ability to maintain the same primary nurse and partner for a client.

D. Saint Elizabeth's Incident Reporting Procedures

All service providers must have a risk management program. These programs are primarily focused on establishing a system for receiving and reporting information about events, triaging that information, and taking steps to prevent problematic events from recurring.

1. Incident Management

Saint Elizabeth has internal procedures to deal with incidents and complaints. The incident management procedure requires employees to notify their immediate supervisor or director when they become aware of an incident or near-miss incident that may affect routine operations or the expected care or safety of the client. If the supervisor or director considers it to be a high-risk event – one that places the client, staff, or organization at risk – the incident is reported to Saint Elizabeth's corporate integrity officer. For instance, a medication error that resulted in a client going to the hospital for treatment would be considered high risk. If the incident is determined to be a low risk – for instance, one which led to no client harm but was out of the usual practice – Saint Elizabeth's advance practice leader in the applicable area would be alerted. For example, the person leading its falls program would get an alert for all client falls.

The incident or near miss must be entered into Saint Elizabeth's internal electronic complaint / incident reporting system (RL6 system) within 24 hours of the event. However, frontline staff cannot access the RL6 system from the tablets they carry in the field. Consequently, frontline staff are not responsible for entering incidents into RL6; rather, that is the responsibility of the supervisor or director to whom they report the incident. When entering the issue into RL6, the supervisor or manager will provide the details of the incident and assign it a risk level on a scale of 1 to 3 to reflect its severity.

A level 1 incident indicates an incident that results in no client harm but is a departure from the usual practice, whereas level 3 incidents are the most serious, such as a medication error that results in hospitalization.

Where possible, Saint Elizabeth prefers that the employee reporting the incident meet with the supervisor or manager personally to have the online form completed. For incidents or near misses that are client-related, the incident must also be charted on the client's record by the time the online form is completed.

All complaints and risk events also needed to be reported to the CCAC, but the RL6 system was not used for this purpose. As mentioned, in the South West CCAC's region, the ETMS system was used for reporting to the CCAC, and only Saint Elizabeth supervisors and managers could enter information into ETMS. In practice, if the incident involved a CCAC client, Saint Elizabeth's procedure was to notify the CCAC within 24 hours of receiving a complaint or incident; fully investigate the incident; have the regional director / manager review and approve any corrective steps within three days for high-risk incidents, and seven days for low-risk incidents; and contact the CCAC about the steps it took and how the issue was resolved within those same time frames. Saint Elizabeth would also provide the CCAC with any necessary documentation relating to the incident.

If the CCAC learned of an issue directly from a client, caregiver, physician, or other interested individual, the CCAC would notify Saint Elizabeth of the incident through ETMS. Saint Elizabeth was then expected to investigate the situation and report its response back to the CCAC through ETMS.

2. Complaints or Compliments

Saint Elizabeth also has a procedure for dealing with complaints and compliments. It requires the staff member who receives the original information to enter it into RL6 within 24 hours or, if that is not possible, to ask the supervisor or manager to do so. In practice, because frontline staff do not have access to the RL6, this information is entered by the supervisor or manager. Once the information is entered, any issues must be investigated within 24 hours.

If a complaint was related to a CCAC client, the CCAC had to be notified within the timelines set out in the services agreement.

E. Performance Evaluation of Frontline Staff

Saint Elizabeth's nursing service supervisors evaluate the performance of the preceptees over the course of their three-month probationary period. They seek feedback about each preceptee's performance and hold probationary meetings with preceptees, after approximately 30 days, 60 days, and 75 days. Because feedback is gathered informally through conversations and emails, records are not always kept of these conversations, particularly since, at the time Wettlaufer worked for Saint Elizabeth, the general practice was to retain emails for just 30 days.

At each probationary meeting, the nursing service supervisor and preceptee review the outstanding competencies the nurse needs to achieve, settle on a learning plan to attain the competency, and set a goal date for doing so. By the final probationary meeting, the preceptee should have learned all the necessary skills, and, in order to assess the preceptee, the nursing service supervisor will have observed one or more of the preceptee's home visits. The preceptee will also finish completing the PLP by the end of the probationary period, at which point it is sent to Saint Elizabeth's human resources office and kept in the nurse's file.

Saint Elizabeth also conducts an observation visit for each nurse's annual performance review.

VII. Saint Elizabeth Hires Wettlaufer

Wettlaufer was hired in Saint Elizabeth's Oxford Service Delivery Centre in 2016. Tamara Condry was the most senior member of Saint Elizabeth at that location, and its regional director was located in London. Approximately 40 nurses, both registered nurses (RNs) and registered practical nurses (RPNs), reported to Ms. Condry in 2016.

Ms. Condry testified that when she began her role as the nursing service supervisor, she was mentored by a more experienced nursing service supervisor but did not receive any formal training about human resources or interviewing skills. Although Saint Elizabeth has a human resources department from which nursing service supervisors can receive advice and support, Ms. Condry said she was not aware of any policy manual related to interviewing skills and techniques.

A. Wettlaufer's 2014 Application Is Rejected

Within days of being dismissed from Caressant Care (Woodstock) in 2014, Wettlaufer applied to Saint Elizabeth. Ms. Condy reviewed Wettlaufer's resumé. As was Wettlaufer's practice, her resumé did not disclose her previous employment with Geraldton District Hospital (see Chapter 3).

Ms. Condy testified that at the time she was reviewing this resumé, one of Saint Elizabeth's RNs became aware of Wettlaufer's application. This nurse had previously worked at Caressant Care (Woodstock) and told Ms. Condy there had been concerns about Wettlaufer at that home. Although she did not specify what the concerns were, she indicated that Wettlaufer did not get along well with others at Caressant Care (Woodstock) and that there were some suspicious circumstances. The nurse indicated that she did not recall what those circumstances were, and she also said that some staff members at Caressant Care (Woodstock) would "make life difficult" for a nurse they didn't like.

Ms. Condy chose not to proceed any further with Wettlaufer's application at that time, chiefly because she had other suitable candidates whose applications she preferred and also because of this discussion about Wettlaufer's departure from Caressant Care (Woodstock).

B. Wettlaufer Submits an Online Application and Resumé in 2016

In 2016, Saint Elizabeth needed registered staff in Oxford County. Ms. Condy asked the human resources department to advertise and send any resumé to her. She received and reviewed an updated resumé submitted online by Wettlaufer, who listed her employment experience as follows:

- agency nurse, Life Guard Healthcare (Brantford, ON), 2015
- charge nurse, Meadow Park Nursing Home (London, ON), 2014
- charge nurse, Caressant Care Nursing Home (Woodstock, ON), 2007–14
- support staff, Christian Horizons (Woodstock, ON), 1996–2007

Ms. Condy directed human resources to proceed with a pre-screening because Saint Elizabeth was still in need of nurses; Wettlaufer remained interested in the position; and proceeding with the pre-screening and a interview would allow her to judge Wettlaufer for herself.

C. Pre-screening Is Successful

On June 2, 2016, Saint Elizabeth conducted a pre-screening of Wettlaufer by phone. Wettlaufer confirmed that she had worked in long-term care as well as with individuals in group homes who were between 3 and 21 years of age and had high medical needs. She said that she believed her current manager would describe her as having “good clinical skills” and as continuing to “strive towards professionalism.”

Saint Elizabeth’s pre-screeners were satisfied with Wettlaufer’s answers, and she moved to the next stage in the hiring process.

D. Wettlaufer’s Interview

Ms. Condry felt that Wettlaufer appeared to be an “excellent candidate on paper.” On June 3, 2016, she interviewed Wettlaufer in person. During the interview, Ms. Condry reviewed Wettlaufer’s 2016 resumé and asked Wettlaufer to describe her experience and skills. Wettlaufer still worked at Life Guard at the time of her interview. She told Ms. Condry that she currently held a community nursing position but was not getting enough hours. Wettlaufer did not offer any information about her reason for leaving Meadow Park (London). She provided no references from Meadow Park (London) or Life Guard, although she did give one from Brierwood Gardens, an LTC home to which she had been assigned by Life Guard (see Chapter 7).

In light of Ms. Condry’s previous conversation with a Saint Elizabeth nurse about Wettlaufer’s departure from Caressant Care (Woodstock), she asked Wettlaufer about this issue. In response, Wettlaufer acknowledged that she had made a medication error during a medication pass and expressed regret for the incident. She told Ms. Condry that a resident’s insulin cartridge had been empty and, when she couldn’t find another cartridge for that resident, she took one from another resident’s supply without carefully checking that it was the correct type of insulin. Wettlaufer indicated that she had administered the incorrect insulin to the resident, and that many nurses after her had continued to use the same cartridge for that resident.

Wettlaufer told Ms. Condry that she had filed a wrongful dismissal case regarding the termination of her employment and that she had won, so Ms. Condry did not ask for any further details. She interpreted Wettlaufer’s comment that she had “won” as evidence that Caressant Care (Woodstock) had not had a good reason to terminate her employment. Ms. Condry

respected Wettlaufer's candour in conveying the details of her termination from the home and testified that she had never had any other interviewee be so forthcoming about a negative incident during an interview.

Overall, Ms. Condry felt that Wettlaufer was polite and friendly, and Wettlaufer told her she was excited about the opportunity to join Saint Elizabeth.

E. The College and Criminal Record Checks

Wettlaufer provided Saint Elizabeth with a clear criminal record and vulnerable sector check dated June 29, 2016. Saint Elizabeth also completed two checks of Wettlaufer's registration on the College website, once at the pre-screening stage and again when she signed her employment contract. Those checks showed that Wettlaufer was registered to practise with no restrictions. At that time, it was not Ms. Condry's practice to ask candidates whether they had any history with the College, so she did not ask Wettlaufer about this during the interview.

The College's Find a Nurse Register on its website did not reveal Caressant Care (Woodstock)'s report to the College because that report had not resulted in a referral to the Discipline Committee or in terms, conditions, or limitations being placed on Wettlaufer's licence. The restrictions that had been imposed on Wettlaufer's licence following the Geraldton District Hospital incident, and the finding of incapacity made at that time, were not on the website either. The restrictions were no longer in place, and, at the time the finding of incapacity was made, the legislation allowed the College to make findings of incapacity publicly available for only six years, and more than six years had elapsed. (Since 2016, no past findings of incapacity have been contained on the public Register. The College's practices with respect to the information posted on the Register are set out in Chapter 13.)

F. Wettlaufer's References Complete Online Questionnaire

Wettlaufer provided Saint Elizabeth with the names of four references. As required, two were managers – Shelly Adkin from Brierwood Gardens, and Sandra Flutters from Caressant Care (Woodstock). The other two references were non-managers – Janette Langford and Robyn Laycock, both from Caressant Care (Woodstock).

Ms. Adkin, Ms. Fluttert, and Ms. Laycock responded to the online reference inquiry. They rated Wettlaufer highly on attributes such as professionalism, interpersonal skills, commitment, problem-solving, and adaptability. Based on her experience, Ms. Condy viewed these ratings as “excellent.”

The references were also asked to provide comments on Wettlaufer’s work-related strengths and areas for improvement. In response, they noted that her strengths included her adaptability, ability to cope with challenging residents, promptness and efficiency, caring nature, ability to deal well with older people, ability to work well with others, compassion, relatability, and her education. For areas for improvement, one reference noted that there may have been an issue with Wettlaufer’s attendance and that she had some medical issues which had since been resolved. Another listed improving her skills at delegation and recognizing the importance of upgrading her skills. All the references identified that they would work with her again.

Based on these comments, Ms. Condy felt that Wettlaufer would be a “great fit” with Saint Elizabeth.

Wettlaufer did not provide any references from Meadow Park (London), where she had most recently been employed full time. As mentioned, Saint Elizabeth did not call a candidate’s past employers if they were not listed as references, although Ms. Condy testified that they would perhaps do so if a red flag were raised either with the recruiter or the interviewer. Similarly, Saint Elizabeth did not usually seek references from staffing agencies because it felt they were not as familiar with nurses’ skills as the facilities in which the nurses were placed. Wettlaufer did not provide Ms. Condy with the reference letter that resulted from the settlement of her grievance with Caressant Care (Woodstock).

G. The Employment Agreement

By letter dated June 27, 2016, Saint Elizabeth offered Wettlaufer employment as a part-time registered nurse effective July 11, 2016. She signed the offer of employment on July 14, 2016. The offer provided that Wettlaufer would be subject to a three-month probationary period.

On hiring, Wettlaufer qualified for a \$1,000 signing bonus, provided she was available to work a minimum of 22.5 hours per week. The bonus was to be paid in two instalments: \$500 after six months, and the remaining \$500 after one year. Wettlaufer resigned before having reached the six-month milestone.

VIII. Wettlaufer's Orientation and Probationary Period

Wettlaufer completed her nursing questionnaire on July 11, 2016. She ranked herself as proficient in three areas of diabetes care and management: monitoring blood glucose with a glucometer; giving insulin injections using a syringe; and giving insulin injections using a pen. Wettlaufer ranked herself as having "moderate experience" in diabetes self-management education, but indicated she had no experience in using insulin pumps or in providing diabetes management in schools. Some Saint Elizabeth nurses provided diabetes management in schools, such as checking students' blood sugars, giving education, administering insulin, and supervising the students who self-administer their insulin.

Wettlaufer also indicated that she had only theoretical knowledge of PICC line care and maintenance. Ms. Condy interpreted this response to mean that Wettlaufer may have read a book or a policy about the procedure but had no hands-on experience. As discussed below, Wettlaufer had difficulty mastering the skill of changing a PICC line dressing.

A. In-Class Orientation

Ms. Condy's recollection is that no one identified any issues with Wettlaufer during the 37 hours of in-class orientation between July 11 and July 19, 2016. She successfully completed all the online modules that formed part of her orientation.

B. Field Orientation

Josephine Wright, who had been a registered nurse with Saint Elizabeth since 2012, was initially assigned as Wettlaufer's preceptor. Wettlaufer accompanied Ms. Wright on client visits on July 14, 20, and 21, 2016. During those visits, one of the skills that Wettlaufer was expected to demonstrate was a PICC line dressing change. To attain this skill, the preceptor was required to sign off to indicate that the preceptee had completed all the requirements.

Ms. Wright reported to Ms. Condy that she had some concerns with Wettlaufer and, in particular, Wettlaufer's ability to perform the PICC line dressing change procedure and to manage a sterile field. Ms. Wright also reported that Wettlaufer would get defensive when Ms. Wright tried to give her feedback. Ms. Wright conveyed this information in a conversation or email, but by the

time the Wettlaufer Offences became known, any email had been purged from the system.

Ms. Wright also spoke to another Saint Elizabeth nurse, Yvette Money, about Wettlaufer's difficulty in mastering this skill. Ms. Money was an experienced nurse who was skilled at the PICC line dressing change. At Ms. Wright's suggestion, Ms. Condy arranged for Ms. Money to take Wettlaufer out in the field to assist Wettlaufer in developing this skill.

Wettlaufer went into the field with Ms. Money on July 22, 26, 27, and August 2, 2016. Based on those visits, Ms. Money did not feel that she could certify Wettlaufer to do the PICC line dressing change. Ms. Wright and Ms. Money told Ms. Condy that Wettlaufer could not do PICC line dressing changes independently until she could demonstrate that she could perform the procedure properly two times in a row. Ms. Money also indicated that Wettlaufer was disorganized, defensive, somewhat argumentative when given feedback, and nervous when she was watched. Based on this information, Ms. Condy concluded that Wettlaufer was resistant to coaching. As nursing service supervisor and a clinical practice coach, Ms. Condy decided to go out with Wettlaufer herself.

By this point, although Wettlaufer was not yet certified in changing the PICC line dressing, she was qualified to give medications such as antibiotics through a PICC line.

C. Wettlaufer Is Scheduled to Commence Client Visits on Her Own

Wettlaufer had completed her in-class orientation by July 19, 2016. Although she was not yet certified to do a PICC line dressing change, she had the skill set to provide other nursing services on her own. As a result, Saint Elizabeth began to assign Wettlaufer her own clients on July 28, 2016.

D. The Observation Visit of August 12, 2016

On August 12, 2016, Ms. Condy accompanied Wettlaufer on four client visits, observed her at work, and completed portions of Saint Elizabeth's "observation visit tool." Those visits included watching Wettlaufer complete a PICC line dressing change and a wound care visit.

Ms. Condy testified that Wettlaufer appeared nervous that she was being observed. In Ms. Condy's experience, it was not unusual for nurses to be

anxious when they were under observation. When changing the PICC line dressing that day, Wettlaufer contaminated her sterile gloves once but immediately recognized the error and changed her gloves. Although it took Wettlaufer a long time to complete the dressing change, Ms. Condy was satisfied that Wettlaufer could perform a PICC line dressing change on her own and certified Wettlaufer in that skill.

During the visit, Ms. Condy identified other issues. She observed that Wettlaufer did not use the Edmonton Symptom Assessment Scale when she was assessing various symptoms palliative clients may display, such as shortness of breath, pain, nausea, or loss of appetite. Ms. Condy also noted that Wettlaufer was not properly updating the care plan, so she suggested that Wettlaufer use the “palliative handbook” – a learning tool for nurses who are less familiar with palliative care. Neither of these concerns raised red flags for Ms. Condy because Wettlaufer was only one month into her three-month probationary period. Ms. Condy hoped that her team could help Wettlaufer improve her skills.

IX. Wettlaufer Commits the Offence

Wettlaufer committed the Offence on August 21, 2016, just two months after she was hired by Saint Elizabeth and less than a month after she began seeing clients on her own.

A. The South West CCAC Refers Beverly Bertram to Saint Elizabeth

The South West CCAC referred Ms. Bertram to Saint Elizabeth on August 19, 2016, for wound care and PICC line maintenance. She was also to be given antibiotics through her PICC line. Ms. Bertram had received services from Saint Elizabeth in the past. Her first nursing visit under this new referral was on August 20, 2016.

Wettlaufer had been certified by Saint Elizabeth to provide all the care that had been ordered for Ms. Bertram, and she completed the admission visit on August 20. She noted on the medication administration record that she gave Ms. Bertram antibiotics through the PICC line during that visit.

Ms. Bertram was diabetic and required insulin injections to manage her diabetes. She self-administered her insulin, and Saint Elizabeth was not contracted to provide nursing services in that regard. On August 20, 2016, Wettlaufer provided Ms. Bertram with education on blood glucose monitoring.

B. Wettlaufer Steals Insulin and Narcotics from Another Client

Wettlaufer did not use Ms. Bertram's insulin when she attempted to kill her on August 21, 2016. Instead, she used insulin she had stolen from another Saint Elizabeth client. Wettlaufer had provided services to that client, also a South West CCAC referral, on August 19, but she returned, unscheduled, to the client's home the following morning, on August 20, at which time she stole the insulin. Saint Elizabeth nurses would access clients' homes in a variety of ways: clients might answer the door, leave the door unlocked, provide a buzzer code, or put a key in a lockbox for the nurses' use. Although it is not clear precisely how Wettlaufer gained access to this client's home, the Agreed Statement of Facts describes her actions as follows:

Uninvited and unexpected, later on August 20, Ms. Wettlaufer attended the residence of another St. Elizabeth home patient. Ms. Wettlaufer entered that residence unannounced while the patient was in the shower. The patient heard something and called out. There was no response. The patient ended her shower and found Ms. Wettlaufer going through that patient's medications on her table. Ms. Wettlaufer claimed to the patient that she was merely looking for an oxygen meter she had forgotten there previously. That patient's insulin was on that table along with her morphine. Ms. Wettlaufer confirmed to police and to staff at CAMH, that what she was actually doing was stealing insulin⁷ from this home because she intended to use it to kill Bertram the next day. Ms. Bertram was a diabetic and had her own insulin. Still, Ms. Wettlaufer chose to steal insulin from a second patient for a specific reason. By obtaining insulin from another patient, should Beverly Bertram die as intended, a later examination of Ms. Bertram's own insulin supply would not appear unusually depleted.

This client reported what had happened to another Saint Elizabeth nurse, Linda Tuinstra, when she came for a scheduled visit later that day. The client said that although Wettlaufer had told her she was looking for an oxygen meter, the client was sure she had seen Wettlaufer put the oxygen meter back in her purse after her visit the previous day. Neither the client nor anyone at Saint Elizabeth was aware that Wettlaufer had stolen some of the client's insulin and hydromorphone that day.⁸

⁷ She also admitted stealing other medication for herself, namely, "hydromorphs."

⁸ Saint Elizabeth has since advised that it did not become aware of those facts until Wettlaufer pled guilty on June 1, 2017, and the Agreed Statement of Facts and Wettlaufer's police interview were made public.

In accordance with Saint Elizabeth's incident management procedure, Ms. Tuinstra emailed Ms. Condy to inform her that Wettlaufer had entered a client's home uninvited. Ms. Tuinstra also emailed another Saint Elizabeth nurse, Patricia Harmer, who provided nursing services to the client, telling her of the incident. Ms. Condy testified that she believes Ms. Harmer also told her about this incident and that the client had told Ms. Harmer that she was "all right."

At the public hearings, Ms. Condy testified that she was not sure when she learned of Wettlaufer's entry into the client's house. She also did not recall what investigation she did, if any, into what had happened. Ms. Condy testified that it was not unusual for a nurse to forget a piece of equipment at a client's home. Her expectation, if that happened, would be that the nurse would call and ask the client if the equipment had been left behind and, if so, make arrangements to return to pick it up.

Ms. Condy acknowledged that it was concerning that Wettlaufer went to the client's home without making prior arrangements and entered without permission. However, Ms. Condy did not have an opportunity to speak to Wettlaufer about the incident because she never saw her again. August 22 ended up being the last day that Wettlaufer worked for Saint Elizabeth; she called in sick for her shifts over the week that followed, and resigned on August 29, 2016. Ms. Condy did not phone the client whose home Wettlaufer had entered, nor did she inform head office of the incident.

Both Ms. Condy and Patricia Malone, Saint Elizabeth's corporate integrity officer, acknowledged that after Ms. Tuinstra and Ms. Harmer had contacted Ms. Condy about this incident, she should have entered it into the RL6 system, in accordance with Saint Elizabeth's incident reporting process. However, she did not do so – and she could not remember the reason. She testified that she may have intended to enter it into the RL6 system but "just sort of didn't get around to it, and then she [Wettlaufer] was gone."

When asked how she would have viewed the severity of the incident had Wettlaufer remained in Saint Elizabeth's employ, Ms. Condy indicated that it was an unusual incident, so she likely would have consulted with Saint Elizabeth's corporate office about how to proceed. Ms. Malone testified that Wettlaufer's entry into the client's home might have been treated as a level 1 or level 2 risk, depending on the feedback received from the client. With no client harm, she believed that it would have been entered as a level 1 risk. The incident also was not reported to the CCAC, although Saint Elizabeth acknowledged that it should have been reported at the time.

C. The Attempted Murder of Beverly Bertram

Wettlaufer visited Ms. Bertram's home on August 21, 2016. During this scheduled visit, she was to administer antibiotics through Ms. Bertram's PICC line. Instead, Wettlaufer admitted that she injected three, 60-unit doses of insulin into Ms. Bertram's PICC line, intending to kill her. She noted in the medication administration record that "antibiotics" had been given via the PICC line.

After Wettlaufer left, Ms. Bertram felt ill and decided not to give herself any insulin. She ultimately recovered without medical intervention.

Ms. Condy was not aware at the time that anything untoward had happened between Wettlaufer and Ms. Bertram. She did not recall anything unusual being reported to her by the Saint Elizabeth nurses who continued to give care to Ms. Bertram.

X. Wettlaufer Resigns from Saint Elizabeth

Wettlaufer never returned to Ms. Bertram's home. She was not scheduled to work August 23 or August 24, called in sick on August 25 and 26, and was not scheduled to work on August 27 and 28, 2016.

On August 29, 2016, Wettlaufer went into the Saint Elizabeth office in Oxford County, where she dropped off the supplies and equipment that Saint Elizabeth had given her as well as some of her own nursing equipment. She left the following handwritten note:

Effective immediately I am resigning my position at Saint Elizabeth.
Please know that I am thankful for all I have learned & done while being an employee here.

In the box are the contents of my trunk kit.

In the backpack is my phone & charger, my tablet & charger & the thermometer & BP cuff issued to me by Saint Elizabeth. My badge is also in there. There is also a good Littman Stethoscope. Hopefully it can be used by the clinic or by the next new nurse who doesn't have their own.

I can no longer work as a registered nurse.

Sincerely Elizabeth Wettlaufer

Wettlaufer left behind her personal stethoscope, pulse oximeter, and a blood pressure cuff. Ms. Condry found it unusual that Wettlaufer was giving away her personal equipment and did not know what Wettlaufer meant when she said that she could no longer work as a registered nurse.

In terms of Wettlaufer's performance, neither Ms. Condry nor Ms. Malone was aware of any client complaints regarding Wettlaufer between July 28 and August 19, 2016. Ms. Condry stated that no one had raised any concerns that Wettlaufer was under the influence of drugs or alcohol or that she had a mental health issue.

After Wettlaufer resigned, Ms. Condry spoke to Ms. Wright, who then phoned Wettlaufer to see if she was all right, given her abrupt resignation. Ms. Wright told Wettlaufer that she was there if Wettlaufer needed to talk. Wettlaufer indicated that she was fine, and Ms. Condry had the impression from Ms. Wright that Wettlaufer was not interested in any help from Saint Elizabeth.

Wettlaufer told the police that she resigned from Saint Elizabeth as a result of a conversation she had with her nursing service supervisor [Ms. Condry]. According to Wettlaufer, Ms. Condry told her that although she had been hired for Woodstock, they needed help with school children in Ingersoll who had diabetes and required assistance with their insulin pumps. Wettlaufer stated that she "panicked" because she did not want to take on that responsibility. She indicated that she quit about a week after that conversation.

Ms. Condry did not recall a specific discussion with Wettlaufer about this subject, but she acknowledged that it might have happened.

XI. Investigations After the Offences Become Known

A. Saint Elizabeth's Internal Investigation

As noted earlier, Ms. Condry did not enter information about Wettlaufer's unauthorized entry into a client's home on August 20, 2016, into Saint Elizabeth's RL6 system. Nor did she contact Ms. Malone, Saint Elizabeth's corporate integrity officer, about the incident. Ms. Malone first became aware of the incident during the police investigation into Wettlaufer's confession. Shortly thereafter, on October 18, 2016, Saint Elizabeth notified the CCAC that one

of its former nurses was under police investigation for attempting to harm a CCAC client. (See Chapter 12 for a description of the investigation that the CCAC conducted into the care Wettlaufer provided to CCAC clients.)

Ms. Malone also called the client whose home had been entered. The client told her what had happened and said she was fine. Ms. Malone left her contact information in case the client needed to reach her.

After speaking to others at Saint Elizabeth, Ms. Malone decided not to reach out to Ms. Bertram because she wanted to avoid causing Ms. Bertram additional stress. Instead, Ms. Malone spoke to the staff members assigned to provide Ms. Bertram with care (who was still receiving services from Saint Elizabeth), to ensure that she was receiving support. In addition, Ms. Malone contacted, or attempted to contact, all clients whom Wettlaufer saw while employed by Saint Elizabeth to find out if they had any concerns about the care she had given them.

Saint Elizabeth also conducted an internal investigation in which it reviewed its hiring processes. Based on this investigation, Saint Elizabeth:

- developed an online module for supervisors on interviewing techniques, including training on identifying red flags and how to seek support when such a flag is identified;
- educated the recruitment team on how to probe into issues such as the reasons for termination of a candidate's previous employment;
- developed a process for handling questions that might arise when reviewing an applicant's file;
- reviewed supervisors' responsibility for documenting complaints in the RL6 system and discussed reporting obligations with Ms. Condy; and
- changed its online reference system to enable Saint Elizabeth to know which comments came from which reference.

RECOMMENDATIONS

Recommendation 14: Service provider organizations that provide publicly funded home care services on behalf of a Local Health Integration Network must ensure that their management and staff receive training in the following areas:

- Management
 - Human resources, including: best practices for screening and selecting candidates; interview techniques; checking references; performing background checks; and obtaining feedback about, and assessing the suitability of, new employees during the probationary period;
 - Investigating risk events; and
 - Policies and procedures for entering risk events and complaints into the relevant events management software.
- Staff
 - Policies and procedures for reporting risk events and complaints to their supervisors.

Rationale for Recommendation 14

- Strengthening the human component of the hiring process should help in detecting patterns of concerning behaviours and work practices.
- Given the importance of prompt reporting by frontline staff, all frontline staff should be trained on the requirement to report unusual incidents – such as Wettlaufer’s unauthorized entry into a client’s home – to their supervisor.

Recommendation 15: Service providers should maintain a permanent personnel file containing an employee’s performance history, along with records of any complaints and concerns.

Rationale for Recommendation 15

- Maintaining complete and accurate records will assist service providers in making informed discipline decisions. If required, the records will also assist the service provider in reporting to the College of Nurses of Ontario.

Recommendation 16: Service providers must establish a process for reporting unusual incidents, including unauthorized entry into a client's home. This process must:

- require such incidents to be promptly reported to the Local Health Integration Network;
- categorize these incidents as high risk;
- clearly set out how frontline staff are to report such events to their supervisors, and within what time frame; and
- designate one individual within the organization to investigate incidents of this nature, and to prepare and maintain records of the investigation.

Rationale for Recommendation 16

- Wettlaufer's unauthorized entry into a client's home was a serious violation of the client's privacy and created a risk of potential harm to the client. As Wettlaufer's actions demonstrate, it also has the potential to lead to harm to others because medications can be stolen and used for wrongdoing. Classifying these events as high risk and investigating them should lead to prompt discovery of things such as the theft of medications.
- Frontline staff at Saint Elizabeth Health Care could not directly link into the internal electronic reporting system. Thus, they either reported verbally or by email to a supervisor. This creates the possibility that the information will not be input into the electronic reporting system – the supervisor could be away or simply not receive the message for any number of reasons. The process for sharing information between staff in the field and the supervisor needs to have checks to ensure both that the supervisor receives the information and that the information is uploaded into the appropriate electronic reporting system.

Recommendation 17: Once the Office of the Chief Coroner and the Office of the Forensic Pathology Service (OCC/OFPS) creates a modified version of the Institutional Patient Death Record (IPDR) for use in deaths occurring in the private homes of those having recently received publicly funded home care (see Chapter 18), service providers should ensure their staff receive training from the OCC/OFPS on its use and encourage frontline workers to review the modified IPDR when they learn of a client's death.

Rationale for Recommendation 17

- A modified Institutional Patient Death Record (IPDR) will increase the likelihood that the Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) will be alerted to deaths in private homes that require its involvement. Frontline workers may have important information about the deceased client that would help the OCC/OFPS to decide whether to investigate the death; they must be properly trained and supported in using the modified IPDR.

Recommendation 18: Service providers are strongly encouraged not to use subcontractors. If subcontractors must be used, service providers must establish formal practices to verify that subcontractors are properly reporting complaints and risk events to them, and conducting rigorous screening and background checks of all staff who will provide services to Local Health Integration Network clients.

Rationale for Recommendation 18

- The Local Health Integration Networks (LHINs) do not have a direct relationship with subcontractors engaged by their service providers. They rely on the service providers to manage approved subcontractors and ensure subcontractors are operating appropriately. Given the important role that hiring and screening plays in ensuring client safety, if subcontractors must be used, service providers should have established practices in place to ensure the subcontractors are following rigorous hiring and screening processes.
- Subcontractors must report complaints, risk events, and other such incidents to the service provider, which in turn must report the incidents to the LHIN. To ensure service providers receive the required reports from subcontractors, they must establish formal reporting practices with subcontractors and ensure the reporting requirements are met.

SECTION I

SECTION II

SECTION III

APPENDICES

Oversight and Regulatory Bodies



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I. Introduction

The Ministry of Health and Long-Term Care (Ministry) is responsible for overseeing Ontario's long-term care (LTC) homes and the provision of publicly funded home care services. Wettlaufer committed all but the last Offence while working in LTC homes. She committed the last Offence in a private home, where she was providing publicly funded nursing services. Given the Ministry's responsibilities, a key question for this Inquiry was how the Ministry failed to detect the Offences when they were committed. To answer that question, it is necessary to understand the Ministry's oversight obligations in respect of LTC homes and publicly funded home care. The Ministry's oversight of LTC homes – and how it discharged these obligations – are the subject matter of this chapter and the two that follow. The Ministry's oversight of publicly funded home care is discussed in Chapter 12.

In the first section of this chapter, I consider three main topics: the Ministry branches that play key roles in the oversight of LTC homes; organizations that assist in the oversight process; and the Ministry's key responsibilities in respect of LTC homes.

The Ministry's oversight of for-profit homes before July 1, 2010, is the subject of the second section of this chapter.¹ On July 1, 2010, the regulatory environment for all Ontario LTC homes was radically changed by the coming into force of the *Long-Term Care Homes Act, 2007* (LTCHA),² and its Regulation³ (Regulation). The Offences were committed between 2007 and 2016 – that is, both before and after the LTCHA came into force. As a result, it is necessary to explore the regulatory schemes that governed LTC homes pre and post July 1, 2010. Prior to July 1, 2010, three different statutes governed LTC homes in Ontario: the *Nursing Homes Act* (NHA),⁴ which governed most for-profit homes; the *Charitable Institutions Act*,⁵ which governed not-for-profit homes; and the *Homes for the Aged and Rest Homes Act*,⁶ which applied to all municipal homes in the province. The LTCHA repealed and replaced all three pieces of legislation.

¹ I focus on the oversight of for-profit homes because, at that time, Wettlaufer was working for Caressant Care Nursing Home (Woodstock), a for-profit nursing home.

² SO 2007, c 8.

³ O Reg 79/10.

⁴ RSO 1990, c N. 7.

⁵ RSO 1990, c C. 9.

⁶ RSO 1990, c H. 13.

Monique Smith's report, *Commitment to Care*,⁷ was the call to action that led to the enactment of the LTCHA. In the third section of this chapter, I discuss that report and how it drove the development of the LTCHA and its regulations, the regulatory framework that continues to govern Ontario's LTC homes today.

In the final section of this chapter, I discuss the Ministry's oversight of LTC homes since the LTCHA came into force, with a particular focus on its inspection regime and mechanisms for enforcement.

My focus in this chapter is on the Ministry's oversight role, in general terms. In Chapter 10, I explore how the Ministry discharged this role with respect to the specific LTC homes in which Wettlaufer committed the Offences – Caressant Care Nursing Home (Woodstock), Meadow Park Nursing Home (London), and Telfer Place. Chapter 10 focuses on the information the Ministry received from, or about, these homes, and the results of the various Ministry inspections conducted in them in the period when Wettlaufer worked in each home.

When the Offences came to light, the Ministry conducted inspections not only in the three LTC homes in which the Offences had been committed, but also in all LTC homes in which Wettlaufer had been placed as an agency registered nurse in 2015–16. The results of those intensive inspections are the subject of Chapter 11.

In Chapter 12, I move away from a focus on LTC homes and consider nursing services provided to individuals in their own homes, which are funded through the Local Health Integration Networks (LHINs)⁸ – that is, the type of nursing services Wettlaufer was providing when she committed her last Offence. At the time, she was employed by a service provider organization that was receiving funding from a LHIN to provide in-home nursing care. Chapter 12 explores the roles of the Ministry, the LHINs, and the service organizations in the provision of publicly funded nursing services in private homes.

⁷ Ontario, Ministry of Health and Long-Term Care, *Commitment to Care: A Plan for Long-Term Care in Ontario*, prepared by Monique Smith, parliamentary assistant to the minister, spring 2004.

⁸ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received Royal Assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC System, including Ontario Health.

II. Ministry Oversight of LTC Homes: An Overview

Ontario currently has 626 LTC homes with close to 79,000 beds.⁹ The Ministry has responsibility for the oversight of these homes. In general terms, it is responsible for licensing, funding, setting standards and requirements, developing policy, and inspecting and ensuring compliance for the homes.

A. Divisions and Branches Involved with LTC Homes

There is no one group within the Ministry with responsibility for overseeing the LTC homes. Rather, the responsibilities are fulfilled by a number of divisions and branches within the Ministry,¹⁰ some of which play indirect roles and others whose sole role is to provide oversight. As well, the Ministry works with external organizations and stakeholders in the LTC sector in performing its oversight role.

The Financial Services Branch, the Health Data Branch, and the Health Analytics and Insights Branch are three Ministry branches with a line of sight into the LTC homes, but whose oversight roles are indirect. The Financial Services Branch (within the Corporate Services Division of the Ministry) is responsible for the reconciliation of funds provided to, and spent by, different healthcare sectors, including LTC homes. The Health Data Branch and the Health Analytics and Insights Branch (both of which are within the Health System and Information Management Division) each play a role in collecting and processing data relating to LTC homes and conducting analyses of those data.

1. Performance Improvement and Compliance Branch

Wettlaufer committed the Offences between 2007 and 2016. From 2007 through 2015, the branch with the most direct oversight over LTC homes was the Performance Improvement and Compliance Branch (PICB), which fell under the Health System and Accountability Division. In 2015, PICB was renamed the Inspections Branch and became part of the newly created Long-Term Care Homes Division. Figure 9.1 outlines the organizational structure of PICB from 2007 through 2015.

⁹ February 2019, Long-Term Care System Report, prepared by Health Data Branch, HSIM Division.

¹⁰ The branch and division names used in this Report are those which were in place in August 2018, when the Ministry evidence was presented during the public hearings. In January 2019, the Ministry was reorganized; some of the branch and division names – and functions assigned thereto – may have changed.

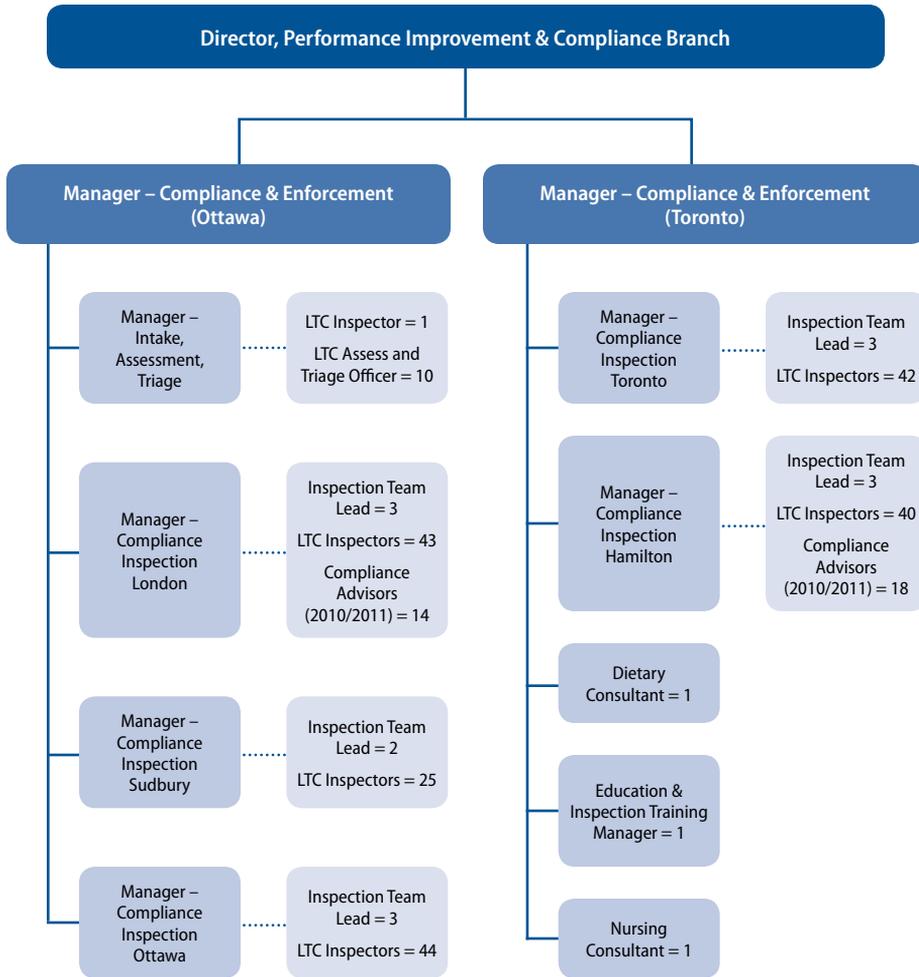


Figure 9.1: Organizational Structure of the Performance Improvement and Compliance Branch, 2007–15

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

From 2007 through 2015, PICB was responsible for the licensing, performance, and regulatory compliance of homes. The compliance and enforcement work in PICB was divided into two teams, one based in Ottawa and the other based in Toronto. Both teams were run by a PICB senior manager. PICB’s responsibilities did not change when the LTCHA came into effect on July 1, 2010.

The PICB's senior managers were responsible for overseeing the work of Service Area Offices (SAOs), each of which also had its own manager. The SAOs were responsible for the compliance and inspection regime. In 2007, five SAOs were established – one in each of Toronto, Ottawa, Hamilton, London, and Sudbury. Each SAO was responsible for the inspection of all LTC homes in a specific geographic area. Typically, each SAO was responsible for between 127 and 140 LTC homes. Compliance advisors (later known as inspectors, under the LTCHA regime) worked from the SAOs. The Ottawa-based PICB senior manager was responsible for the Ottawa, London, and Sudbury SAOs. The Toronto-based PICB senior manager was responsible for the Toronto and Hamilton SAOs.

Before the establishment of the Centralized Intake, Assessment and Triage Team (CIATT) in 2012, each SAO was also responsible for triaging all information received about LTC homes within its jurisdiction and prioritizing the schedule for reviews and inspections in homes in its region.

2. The LTC Homes Division

In 2015, the LTC Homes Division was created. This division includes both the LTC Inspections Branch, and the Licensing and Policy Branch. The LTC Inspections Branch oversees the Long-Term Care Home Quality Inspection Program (LQIP) and is responsible for developing and implementing all operational policies relating to both inspections and inspectors. The Licensing and Policy Branch is responsible for the licensing of LTC homes, as well as general policy work for the LTC homes, including legislative and regulatory development, and the development and implementation of funding and financial policies.

The five SAOs continued to exist under the Inspections Branch of the LTC Division. On March 1, 2018, two new SAOs were created: one in Waterloo and one in Oshawa.

Figure 9.2 outlines the organization of the LTC Homes Division, as at March 1, 2018.

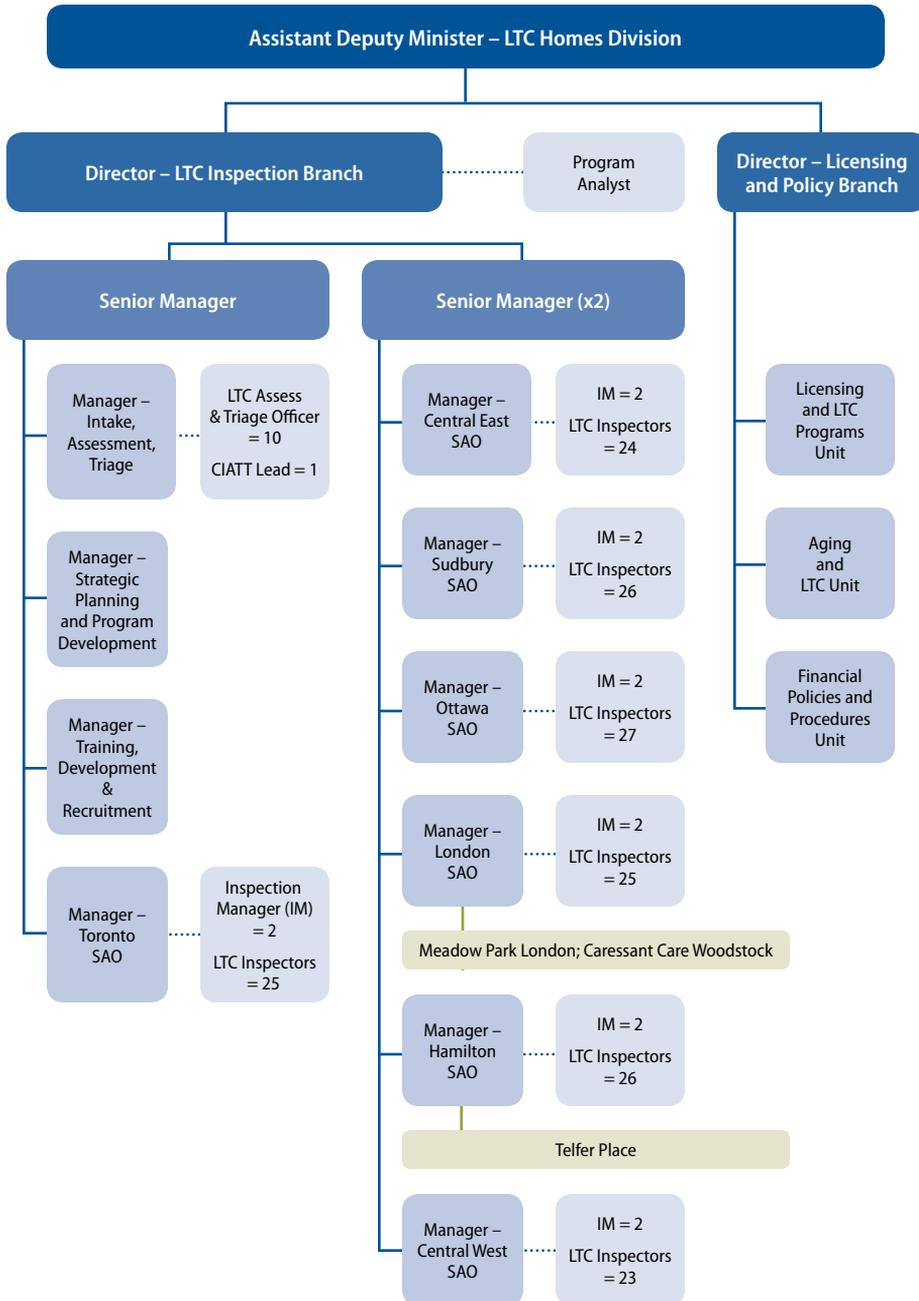


Figure 9.2: Long-Term Care Homes Division, as of March 1, 2018

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

The Offences were committed in three LTC homes: Caressant Care (Woodstock), Meadow Park (London), and Telfer Place. The London SAO was – and continues to be – responsible for conducting inspections and enforcement for both Caressant Care (Woodstock) and Meadow Park (London). The Hamilton SAO was – and continues to be – responsible for conducting inspections and enforcement related to Telfer Place.

In 2007, when Wettlaufer began working at Caressant Care (Woodstock), 15 compliance advisors worked out of the London SAO and conducted inspections and reviews in the homes in its jurisdiction. As of 2016/17, there were 32 full-time-equivalent (FTE) inspector positions in the London SAO.

In 2015, the year Wettlaufer was first placed in Telfer Place as an agency nurse, there were between 25 and 30 FTE inspector positions in the Hamilton SAO.

B. Organizations Assisting the Ministry in the Oversight Process

Other governmental bodies and non-governmental organizations assist the Ministry in its oversight of LTC homes including: the LHINs; the Canadian Institute for Health Information (CIHI); Health Quality Ontario (HQO); and the Centres for Learning, Research and Innovation (CLRIs). Before their abolition, the Ministry also worked with the Community Care Access Centres (CCACs).

Until recently – and throughout the period in which Wettlaufer committed the Offences – CCACs, which were established by the *Community Care Access Corporations Act, 2001*,¹¹ worked at a local community level to help eligible Ontarians access home and community care. The CCACs were considered both “service providers” and “approved agencies” under the *Home Care and Community Services Act, 1994*.¹² Accordingly, CCACs could provide services directly to Ontarians or contract with other organizations to provide services in their region. The CCACs were also responsible for managing the placement and admission of residents into LTC homes, subject to the approval of the home. There were 14 CCACs in the province, each aligned with the LHIN in that area. The South West CCAC was responsible for the placement and admission of residents into Caressant Care (Woodstock) and Meadow Park (London). The Hamilton Niagara Haldimand Brant CCAC was responsible for the placement and admission of residents at Telfer Place.

¹¹ SO 2001, c 33.

¹² SO 1994, c 26.

1. LHINs

In December 2016, the *Patients First Act, 2016*,¹³ received royal assent. The Act resulted in the transfer of CCAC staff, assets, and liabilities to the LHINs, which had been established through the *Local Health System Integration Act, 2006*.¹⁴ Consequently, the LHINs became responsible for managing placements and admissions to LTC homes.

There are 14 LHINs in Ontario; each is responsible for a geographic area. The LHINs are Crown agencies established to plan, coordinate, integrate, and fund health services at the regional level. During the period in which Wettlaufer committed the Offences, each LHIN was responsible for administering funding from the Ministry for the LTC homes in its region. The LHINs were also responsible for providing funding to other health service providers, including the CCACs.

Although the Ministry sets the funding and financial management policies for LTC homes, and determines the amount of funding that homes are to receive, the LHINs administer that funding.¹⁵ To receive funding, an LTC home must enter into a Long-Term Care Home Service Accountability Agreement (LSAA) with the LHIN. That agreement imposes various reporting requirements on the homes, which are different from the home's reporting obligations to the Ministry. The LHINs do not have any direct role in the Ministry's compliance and inspection functions. However, if the Inspections Branch finds significant compliance issues with a licensee of an LTC home, it often invites the relevant LHIN to meetings with the licensee. As Karen Simpson, the former Director (a position created by the LTCHA and filled by a person in the Ministry),¹⁶ explained in her testimony at the public hearings, "We certainly see it as a partnership with the LHIN to move homes forward to ensure the best care for residents."

The South West LHIN, which has an LSAA with each of Caressant Care (Woodstock) and Meadow Park (London), is responsible for administering the funding to those homes. The Hamilton Niagara Haldimand Brant LHIN has an LSAA with Telfer Place and is responsible for administering the funding to that home. Although there are no formal reporting requirements between the LHINs and the Inspections Branch, they have a good working relationship.

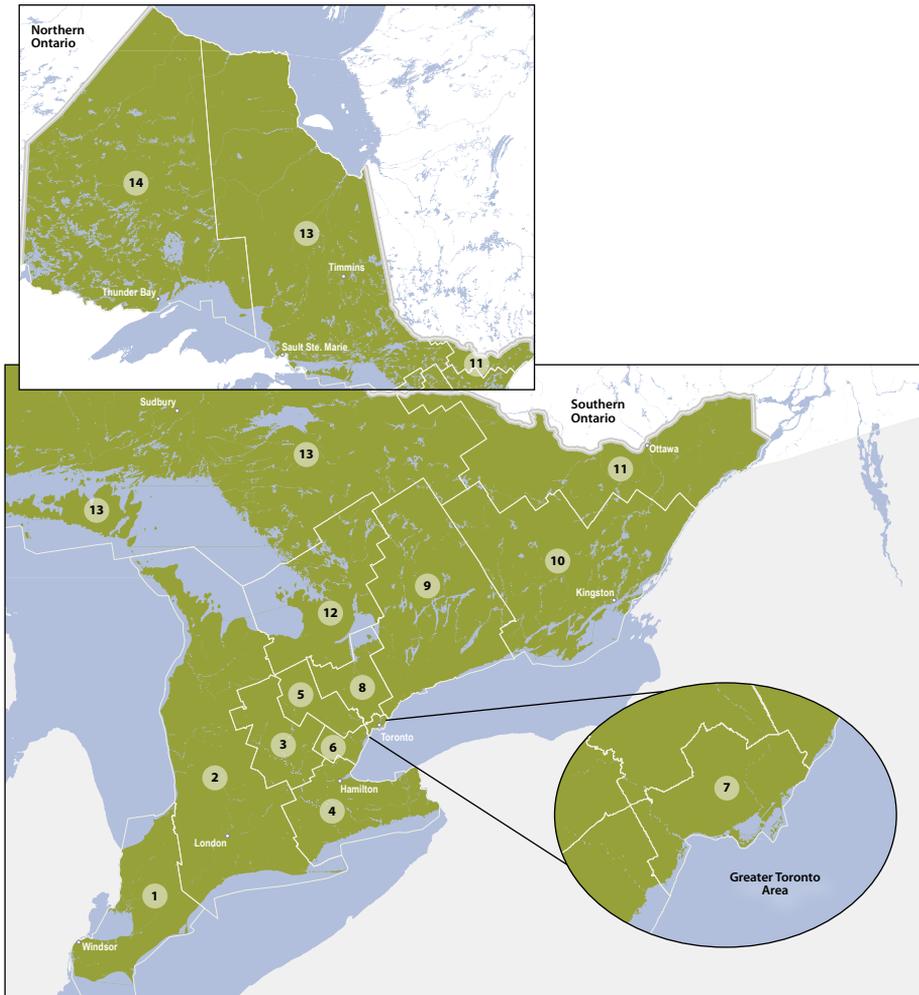
¹³ SO 2016, c 30.

¹⁴ SO 2006, c 4.

¹⁵ Some funding does go directly from the Ministry to LTC homes. Separate agreements exist for this funding.

¹⁶ Karen Simpson became the Director in October 2015. She left the Ministry in July 2018.

The LHINs formally liaise with the Ministry through the LHIN Liaison Branch. Figure 9.3 shows the distribution of the LHINs across the province.



Ontario LHINs

- | | | |
|---------------------------------------|----------------------|-------------------------|
| 1 Erie St. Clair | 6 Mississauga Halton | 11 Champlain |
| 2 South West | 7 Toronto Central | 12 North Simcoe Muskoka |
| 3 Waterloo Wellington | 8 Central | 13 North East |
| 4 Hamilton Niagara
Haldimand Brant | 9 Central East | 14 North West |
| 5 Central West | 10 South East | |

Figure 9.3: Map of Local Health Integration Networks in Ontario, 2017

Source: Health Quality Ontario, *Measuring Up 2017* and Statistics Canada.

2. Canadian Institute for Health Information

The Ministry also works with the Canadian Institute for Health Information (CIHI) in overseeing the LTC homes. CIHI is an independent, not-for-profit organization that provides information on Canadian health systems and the health of Canadians. It collects information from various healthcare sectors in Ontario (including LTC homes), all other provinces, and the territories. CIHI collects, on a quarterly basis, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) data from all Ontario LTC homes. (The RAI-MDS is an interdisciplinary assessment and care-planning tool used in all LTC homes in Ontario. I discuss it further below.) CIHI then processes that information so it can be used by the Ministry (and the homes themselves) to assist in care planning and, generally, in the oversight of the LTC homes sector. The information is also used to help assess how an LTC home performs in relation to others in the province. The RAI-MDS data are sent to, and analyzed by, CIHI to help track the acuity of residents in LTC homes across the province.

3. Health Quality Ontario

Health Quality Ontario (HQO) is the agency mandated to advise government and healthcare providers on evidence to support high-quality care and improvements in quality, and to report publicly on the quality of healthcare provided in the province. To that end, HQO analyzes the RAI-MDS data that the LTC homes provide to CIHI and publicly reports on various indicators of performance for LTC homes. HQO also receives quality improvement plans from LTC homes.

4. Centres for Learning, Research and Innovation

Ontario Centres for Learning, Research and Innovation (CLRIs) also assist the Ministry in overseeing LTC homes in Ontario. The three CLRIs, which were established by the Ministry in 2011,¹⁷ are in Toronto (Baycrest Health Sciences), Ottawa (Bruyère Research Institute), and Waterloo (Schlegel-UW Research Institute for Aging). The CLRIs work with colleges and universities to conduct and support research with the goal of developing evidence-based practices and enhancing LTC quality. They also engage with stakeholders in the LTC

¹⁷ The Ministry provided the CLRIs with funding through March 31, 2016, and additional base funding in August 2017.

sector, including the homes themselves, to share the knowledge they have gained. The CLRIs have developed training programs to help LTC homes meet some of their mandatory training obligations under the LTCHA.

C. Key Responsibilities

The Ministry's role in respect of LTC homes includes:

- funding, both for operations and for redevelopment and renovations;
- setting standards and requirements;
- developing policy;
- issuing and renewing licences;
- collecting and analyzing data from the homes; and
- conducting inspections and seeking to ensure compliance with the governing legislation and regulations.

1. Funding

A number of divisions and branches in the Ministry share responsibility for oversight of funding of LTC homes. For example, the Health Capital Division is responsible for overseeing the redevelopment of or renovations to homes, and the Financial Management Branch is responsible for preparing the reconciliations of the spending in homes against the funding received.

Funding for an LTC home's operating costs comes from three sources: funding envelopes, resident co-payments, and supplemental Ministry funding.

a) Funding Envelopes

The Ministry provides funds to the LHINs, which the LHINs then provide to the LTC homes through four level-of-care funding envelopes. The four envelopes are the nursing and personal care envelope; the program and support services envelope; the raw food envelope; and the other accommodation envelope. These four funding envelopes account for an average of 83% of the total funding provided by the Ontario government to LTC homes. Each envelope provides a set dollar amount per resident, per day. The total level-of-care envelope funding provided to LTC homes has increased from an average of \$142.07 per resident, per day, as of July 1, 2009, to \$176.76 per resident, per day, as of July 1, 2018.

The nursing and personal care envelope, and the program and support services envelope, are for direct resident care needs. The nursing and personal care envelope funds are for direct care staff (including registered staff and personal support workers); nursing and medical equipment; and supplies. The program and support services envelope funds are for program staff; therapy; and recreational equipment and supplies.

The raw food envelope funds are to be used for raw food and nutritional supplements only. Funds from this envelope cannot be used for programs or food preparation.

The other accommodation envelope provides funds for staff wages; equipment; supplies for dietary, laundry, and housekeeping; furnishings; maintenance; and all other operational and administration costs.

As of January 1, 2013, LTC homes may apply any unused funds in their nursing and personal care envelope, and any unused funds in their programs and support services envelope, to their costs of nursing and personal care, program and support services, or raw food. However, surplus funds in the raw food envelope cannot be used for anything else. For-profit LTC homes retain any surplus funds only from the other accommodation envelope.

In 2017/18, Ontario spent \$3.4 billion on level-of-care funding. Table 9.1 sets out the funding provided per resident, per day, in each envelope as of July 1, 2018.

Table 9.1: Amount of Funding Provided Per Resident, Per Day, as of July 1, 2018

LEVEL-OF-CARE FUNDING ENVELOPE	DOLLARS PER RESIDENT, PER DAY
Nursing and personal care	\$100.91
Program and support services	\$9.79
Raw food	\$9.54
Other accommodation	\$56.52
Total	\$176.76

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

Note: As of July 1, 2018, LTC homes can now also receive a quality attainment premium of \$0.36 per diem per bed if they are accredited and have a performance level of 1 or 2 on the Long-Term Care Home Quality Inspection Program (LQIP) Performance Assessment.

The Ministry adjusts the nursing and personal care funding envelope based on the acuity of a home's residents. Acuity is determined by the home's RAI-MDS reporting for each resident.¹⁸ The RAI-MDS data are used to produce a Case Mix Index (CMI) for each home. A home with residents who have more acute or complex health problems compared with other homes in the province has a higher CMI and is thus entitled to more funds from the nursing and personal care envelope.

Between 2013/14 and 2018/19, the CMI for both Caressant Care (Woodstock) and Meadow Park (London) fell slightly below the provincially funded CMI of 1.02. During the same period, the CMI at Telfer Place fluctuated from a low of 0.98 in 2013/14 (below the provincially funded CMI) to a high of 1.06 in 2017/18. Table 9.2 outlines resident acuity in these three homes.

Table 9.2: Resident Acuity – Caressant Care (Woodstock), Meadow Park (London) and Telfer Place, 2013/14–2017/18

RESIDENT ACUITY AS EVIDENT THROUGH CARESSANT CARE WOODSTOCK'S CASE MIX INDEX (CMI) (2013–2018)						
	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Funded CMI (CCW) (Informs the NPC CMI Funding)	0.9862	0.9699	0.9978	1.0111	1.0039	0.9998
Provincial Funded CMI	1.02	1.02	1.02	1.02	1.02	1.02
RESIDENT ACUITY AS EVIDENT THROUGH MEADOW PARK LONDON'S CASE MIX INDEX (CMI) (2013–2018)						
	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Funded CMI (MP) (Informs the NPC CMI Funding)	0.9871	0.9690	0.9610	0.9621	0.9885	1.0070
Provincial Funded CMI	1.02	1.02	1.02	1.02	1.02	1.02

continued

¹⁸ The RAI-MDS assessment must be made by the home on the admission of a new resident and when a resident has a significant change in health status. Assessments must also be updated quarterly for each resident.

**RESIDENT ACUITY AS EVIDENT THROUGH TELFER PLACE'S
CASE MIX INDEX (CMI) (2013–2018)**

	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Funded CMI (TP) (Informs the NPC CMI Funding)	0.9841	0.9981	1.0037	1.0197	1.0608	1.0423
Provincial Funded CMI	1.02	1.02	1.02	1.02	1.02	1.02

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

Notes:

- Base year is 2013 because this is when data quality improvement efforts were implemented by the ministry to enhance data reliability and validity.
- Funded CMI: Represents relative resource use at an LTC home based on RAI-MDS assessments submitted by the home for each resident, over a fiscal year period. This informs the nursing and personal care (NPC) level-of-care funding for LTC homes, which is adjusted for the case mix of a home to reflect resident care needs (i.e., resident acuity) and provided on a per diem basis.

b) Resident Co-payments

All residents must contribute to the cost of their meals and accommodation through a co-payment. The homes collect the resident co-payments directly. Co-payment funds can be used for the same matters covered by the raw food and other accommodation envelopes. They cannot be used to cover the costs of nursing and personal care or programs and support services. The Ministry gives homes additional funding to cover resident co-payments that are not collected. It also provides subsidies for residents who are eligible for a reduction in their co-payment rate.

c) Supplementary Ministry Funding

LTC homes also receive supplementary funding from the Ministry. This funding is typically targeted to achieve specific policy objectives. For example, supplemental funding has been provided for the High Intensity Needs Fund Program; Behavioural Supports Ontario; the placement of registered practical nurses in LTC homes; and to assist with the gathering of RAI-MDS data. Supplemental funding is generally provided on an ad hoc basis and is subject to a home meeting specific conditions, tied to policy objectives. Some

of this funding flows directly to the homes from the Ministry. Other funds go to the LHINs and are then passed along to the homes. Table 9.3 outlines the supplementary funding provided to LTC homes in 2017/18.

Table 9.3: Supplementary Funding to LTC Homes, 2017/18

TYPE OF SUPPLEMENTARY FUNDING	DOLLARS M
Convalescent care additional funding subsidy	\$16.65
Behavioural Supports Ontario staffing resources	\$47.83
LTC home physiotherapy funding	\$65.82
Registered practical nurses in LTC homes	\$60.39
Attending nurse practitioners in LTC homes	\$6.77
Nurse practitioners in LTC homes	\$2.09
RAI-MDS	\$40.48
High Intensity Needs Fund – per diem	\$18.93
High Intensity Needs Fund – claims-based	\$50.69
Accreditation funding	\$8.23
Other	\$414.79
Total	\$732.00

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

Note: The “other” category includes funding from the Municipal Tax and Allowance Fund; construction funding subsidies; structural compliance premium; and capital grants. Funding may be given for a variety of areas including pay equity; CLRIs; laboratory services; personal support workers and palliative care training; Family Council Ontario; Ontario Association of Residents’ Councils; water testing; high wage; and debt services.

2. Setting Standards and Requirements

Through its enforcement of the regulatory regime, the Ministry plays a key role in setting the standards and requirements for LTC homes. This role is discussed later in the chapter.

3. Developing Policy

The Ministry plays a key role in policy development for the LTC homes sector. In some cases, this role can result in significant legislative or regulatory change, as in the case of the LTCHA and its regulations.

The Ministry works with other stakeholders on policy issues. For example, the Ministry worked closely with Shirlee Sharkey to develop staffing and care standards for LTC homes.¹⁹ It also helped to convene the Joint Task Force on Medication Management in LTC, as a follow-up to the Auditor General's 2007 report on medication management in LTC homes.²⁰

As well, the Ministry responds to specific concerns raised about the LTC sector. For example, the Ministry will respond to recommendations made by the Geriatric Long-Term Care Review Committee to determine whether those recommendations require policy changes. (This committee was created by the Office of the Chief Coroner of Ontario. It reviews deaths in LTC homes referred to it by key stakeholders in the death investigation system. Among other things, the committee is to make recommendations aimed at preventing deaths in similar circumstances.)

The Ministry also engages in an internal review of its practices, based on reports prepared about the sector. For example, in May 2012, the Long-Term Care Task Force on Resident Care and Safety released *An Action Plan to Address Abuse and Neglect in Long-Term Care Homes*, which included 18 recommendations for improving the care and safety of residents. PICB then conducted an internal review of its policies and practices – and initiatives that were under way – to determine how they aligned with those recommendations. The Ministry also enacted new policies and procedures specific to its inspections program in response to concerns raised by the Auditor General following her review of the Long-Term Care Home Quality Inspection Program (LQIP).

4. Issuing and Renewing Licences

Under the NHA, a nursing home could be established, operated, or maintained only pursuant to a licence issued by the Director.²¹ Licences were issued to those who met the requirements of the NHA and its regulations and paid the

¹⁹ See Ontario Ministry of Health and Long-Term Care, *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*, Report of the Independent Review of Staffing and Standards for Long-Term Care Homes in Ontario (May 2008). Shirlee Sharkey, the president and CEO of Saint Elizabeth Health Care, began her independent review of staffing and care standards at the request of the minister in 2007. Her review informed the Ministry's work on staffing plan guidelines for LTC Homes, which continued through at least 2011.

²⁰ See the *Joint Task Force on Medication Management – Report* (November 4, 2009), released jointly by the Ontario Long Term Care Association, the Ontario Association of Non-Profit Homes and Services for Seniors, the Ministry, and the Institute for Safe Medication Practices Canada.

²¹ NHA, s 4(1). This licensing scheme did not exist under either the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act*.

fee established by the minister, so long as it was in the public interest and there were no other grounds for refusal.²² Licences expired 12 months after the date of issue (or renewal).²³ The NHA required that the public be notified and given an opportunity to make written or oral submissions before the Director issued a licence, undertook to issue a licence, or renewed a licence.²⁴ The Director was authorized to revoke or refuse to renew a nursing home licence in certain limited circumstances, including where the licensee was in contravention of the Act or regulations that applied to the home.²⁵

Since July 1, 2010, when the LTCHA came into effect, it has been an offence to operate a residential premise for persons requiring nursing care, or in which nursing care is provided to two or more unrelated persons, except under the authority of a licence issued under the LTCHA.²⁶ The minister determines, by considering the public interest, whether there is a need for an LTC home in an area, how many beds there should be, and to whom a licence may be issued.²⁷ Licences are issued for a fixed term, not to exceed 30 years.²⁸ The licence specifies how many beds the licensee is entitled to operate in the home.²⁹

The Ministry is responsible for determining whether a new licence should be issued at the end of the term.³⁰ Currently, the Licensing and Policy Branch in the LTC Homes Division is responsible for licensing. That branch will often seek input from the Inspections Branch about a home's compliance when determining whether to issue, or renew, a licence.

5. Collecting and Analyzing Data

The Ministry plays a role in ensuring that data are collected from residents in LTC homes. The data are analyzed and used by different branches and different organizations for a range of purposes.

LTC homes are required to conduct a RAI-MDS assessment on each resident when first admitted to the home, and then at least quarterly after that. Data, which include information on a wide range of health indicators (e.g., activities

²² NHA, s 5(1)–(7).

²³ NHA, s 5(8).

²⁴ NHA, s 12.

²⁵ NHA, s 13.

²⁶ LTCHA, s 95(1)–(3).

²⁷ LTCHA, ss 96 and 97.

²⁸ LTCHA, s 102.

²⁹ LTCHA, s 104.

³⁰ LTCHA, s 103.

of daily living, cognitive functioning, pressure ulcers, weight, and behavioural issues) are then sent to CIHI for analysis.

The data are made available to the homes to assist in care planning, and to different Ministry branches for a variety of purposes. For example, as discussed earlier, data are used to determine a home's CMI, which affects the amount of funding it will receive in the nursing and personal care envelope. The data are also used in resident quality inspections (RQIs), the comprehensive inspection conducted annually in every LTC home. The RAI-MDS data are key in the Long-Term Care Home Quality Inspection Program (LQIP) Risk and Performance Assessment (LRPA),³¹ discussed later in this chapter. And the Health Analytics Branch used the RAI-MDS data in its work to determine whether excessive mortality rates in LTC homes could be predicted and potentially assist in the detection of intentionally caused harm by healthcare providers. See Chapter 18 in which this work is described more fully.

Other organizations, including Health Quality Ontario and the Centres for Learning, Research and Innovation, use the data collected from LTC homes to study specific indicators of well-being in the LTC homes sector.

6. Conduct Inspections and Seek to Ensure Compliance

Through the inspections regime, the Inspections Branch (formerly PICB) directly oversees Ontario's LTC homes.

Although the LTCHA brought with it significant change – including change relating to compliance and enforcement – core aspects of the inspection regimes remain the same as under the NHA:

- the minister is authorized to appoint inspectors to conduct inspections of LTC homes;³²
- inspectors (known as compliance advisors under the old regime) are granted powers to conduct inspections of premises, records, and so on;³³
- inspectors attend LTC homes to conduct inspections (known as reviews under the NHA) in response to complaints, unusual occurrence reports, and Critical Incident reports received from the homes, as follow-up to outstanding issues, and as part of an annual inspection;

³¹ Now known as the LQIP Performance Assessment.

³² NHA, s 23; LTCHA, s 141.

³³ NHA, s 24; LTCHA, ss 146–47.

- inspections are to determine whether homes are complying with the legislative and regulatory requirements (and, in the old regime, with the standards and criteria imposed under the *Long-Term Care Homes Program Manual*);³⁴
- inspectors are authorized to issue findings of non-compliance³⁵ (unmet standards or criteria under the old regime); and
- inspectors prepare inspection reports following inspections.³⁶

III. Ministry Oversight Before July 1, 2010: The NHA

When Wettlaufer began working in June 2007 at the for-profit nursing home Caressant Care (Woodstock), it was subject to the requirements of the NHA and its regulations, Regulation 832. As well, it was subject to conditions imposed under its Long-Term Care Home Service Accountability Agreement (LSAA) with the South West LHIN. The LSAA required Caressant Care (Woodstock) to comply with the standards and criteria set out in the *Long-Term Care Homes Program Manual* (Program Manual).

As reviewed at the outset of this chapter, the Ministry's compliance advisors, who worked out of the local SAOs, were responsible for conducting inspections of LTC homes to determine whether they were complying with their obligations. They also advised homes on what changes might be needed to achieve compliance. This regime continued until July 1, 2010, when the new regime, imposed by the LTCHA and its regulations, came into effect.

A. Obligations Imposed by the NHA, Regulation 832, and the Program Manual

LTC homes are arguably the most highly regulated part of Ontario's healthcare system. Even under the regime that was in place before July 1, 2010, significant obligations were imposed on nursing homes pursuant to the NHA, Regulation 832, and the Program Manual. In this section, I review those obligations, many of which pertained to the rights of, and care owed to, residents, but some of which covered the physical state of nursing homes. Given the importance of

³⁴ NHA, s 24(2); LTCHA, s 142.

³⁵ LTCHA, s 152. Under the LTCHA, inspectors must document all findings of non-compliance; see LTCHA, s 149(3).

³⁶ NHA, s 24(13); LTCHA, s 149.

medication management and administration to this Inquiry mandate, I also review the requirements – primarily contained in Regulation 832 and the Program Manual – concerning medication management in nursing homes. Finally, I discuss the nature of the inspection regime that existed in the province under the NHA.

1. General Obligations

The NHA, Regulation 832, and the Program Manual imposed a number of responsibilities and obligations on for-profit nursing homes. Section 2(1) of the NHA set out the fundamental principle to be applied in interpreting the NHA and its regulations, saying “a nursing home is primarily the home of its residents and as such is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met.”

a) Bill of Rights

The NHA enshrined a Residents’ Bill of Rights and dictated that licensees ensure that the rights of residents be fully respected and promoted. Section 2(2) required full respect and promotion of the following rights of residents, among others:

- the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s dignity and individuality and to be free from mental and physical abuse;
- the right to give or refuse consent to treatment, including medication, in accordance with the law and to be informed of the consequences of giving or refusing treatment; and
- the right to live in a safe and clean environment.

b) Resident Care, Care Plans, and Quality Management

Under the NHA, licensees were required to develop care plans for residents, based on regular assessments, and to ensure that care was provided to residents as set out in the plan of care.³⁷ They were also obliged to develop and implement quality management programs for “monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the nursing home.”³⁸

³⁷ NHA, s 20.10.

³⁸ NHA, s 20.11.

Regulation 832 imposed specific obligations aimed at the quality of resident care, including:

- requirements relating to physicians and registered nurses;
- the organization of nursing care and shifts, and staff training;
- activity programming;
- nutritional care; and
- resident plans of care.³⁹

c) Residents' Councils

Although the NHA did not require residents' councils in nursing homes, licensees were required to assist in their establishment under certain circumstances, including where at least three residents in the home had asked the administrator to establish a council.⁴⁰

d) Physical State of Nursing Homes

Regulation 832 also imposed specific requirements on the physical property of the home and its maintenance regarding such things as:

- bedrooms and bedroom furnishings;
- nurses' stations;
- privacy area, dining rooms, sitting rooms, and activity area;
- toilet facilities;
- housekeeping programs;
- handling of laundry in the home;
- handling of waste and waste receptacles;
- audio-visual call systems;
- lighting requirements;
- temperature requirements; and
- general safety and fire safety.⁴¹

³⁹ Reg 832, ss 50–54, 56–61.2, 72, 74–77, 126–27.

⁴⁰ NHA, s 29.

⁴¹ Reg 832, ss 10–11, 12, 14–22, 25–27, 28–30, 32–34.

The Program Manual also contained a large number of standards and criteria with which all LTC homes in Ontario were expected to comply. This lengthy manual, which spanned more than 700 pages in its final iteration, required homes to comply with policies, standards, and criteria covering a broad range of matters including resident leaves of absence, CPR and do-not-resuscitate orders, resident care, nursing services, staff education, spiritual and religious programs, and environmental services.

2. Reporting Obligations

The NHA, Regulation 832, and the Program Manual each imposed specific reporting requirements on licensees and, in certain instances, individuals. In some cases, corollary obligations were imposed on those who received the reports.

a) Duty to Report Under the NHA

The NHA imposed a duty on all persons other than residents to report suspected harm or potential harm to residents, whether arising from intentional acts, incompetence, or neglect. Section 25(1) of the NHA stated:

A person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect shall forthwith report the suspicion and the information upon which it is based to the Director. [Emphasis added.]⁴²

None of “reasonable grounds to suspect,” “harm,” “improper or incompetent treatment or care,” or “neglect,” in section 25(1) was defined in the NHA or its regulations.

The NHA explicitly extended this duty to report to medical practitioners and registered staff.⁴³ It also provided that persons making such reports were protected from dismissal, discipline, or penalty, unless they acted “maliciously or without reasonable grounds.”⁴⁴

⁴² No similar obligation was contained in the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act*.

⁴³ NHA, s 25(5).

⁴⁴ NHA, s 25(2), (3).

Licensees were required to forward to the Director any written complaint received concerning the care of a resident or the operation of an LTC home, along with details about what the licensee had done, or proposed to do, to remedy the complaint, or why the licensee believed the complaint was unfounded.⁴⁵

When the Director received a report made under either section 25 (suspected harm) or section 26 of the NHA (forwarded complaints), the Director was obliged to investigate “forthwith.”⁴⁶ The NHA also dictated that, where the Director received a report from any source which gave the Director reasonable grounds to believe that the health, safety, or welfare of a resident might be at risk, the Director was to “cause an investigation to be commenced and the nursing home in which that resident lives to be visited forthwith.”⁴⁷

b) Required Reporting of “Occurrences” Under Regulation 832

Regulation 832 required the immediate reporting⁴⁸ of all resident deaths in a nursing home to (1) a coroner; (2) the resident’s physician; and (3) any registered nurse who attended the resident. If the attending physician or registered nurse was satisfied that the death was from natural causes and the coroner had been informed of the death, the body of the resident could be moved to a private area of the home.⁴⁹

The licensee of a nursing home had to report certain specific occurrences to the Director, including:

- a fire;
- an assault;
- an injury in respect of which a person is taken to hospital;
- a communicable disease outbreak; and
- a death resulting from an accident or undetermined cause.⁵⁰

⁴⁵ NHA, s 26(1)–(2).

⁴⁶ NHA, ss 25(7), 26(3).

⁴⁷ NHA, s 27.

⁴⁸ The regulation did not specify who was required to make the report.

⁴⁹ Reg 832, s 78.

⁵⁰ Reg 832, s 96.

Regulation 832 did not prescribe a timeline for reporting such occurrences, saying only that the report had to be made “promptly” and “in the form provided by the minister.”⁵¹ The Program Manual imposed similar reporting requirements, but with more concrete timelines.

c) Required Reporting of “Unusual Occurrences” Under the Program Manual

The Program Manual also required reporting of certain specific occurrences – known as “unusual occurrences” – but the nature of that obligation differed somewhat from that imposed under Regulation 832. For example, the Program Manual required the administrator (or designate) – not the licensee, as Regulation 832 required – to report “unusual occurrences” to the Ministry. That report was then passed to the SAOs. This requirement also applied to LTC homes governed by the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act*.

An “unusual occurrence” was defined in the Program Manual as an “occurrence which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member, or to the safety and security of the facility, which requires action by staff.” The manual specified which unusual occurrences required reporting immediately, the following day, or within 10 working days.

In particular, the Program Manual required immediate reporting of occurrences “which pose an immediate risk to resident(s) and which involve intervention by an outside agency or agencies, such as police, fire department or medical officer of health.” It specified that immediate reporting was required of:

- reports made to the police concerning occurrences of:
 - abuse and/or assault involving a resident, “including wilful direct infliction of physical pain or injury, as well as sexual assault”;
 - alleged fraud or theft;
 - bomb threats / evacuations;
 - missing persons;
 - unusual / accidental death, including suicide; and
 - missing / misappropriated drugs.

⁵¹ Reg 832, s 96(2).

- reports made to the fire department for occurrences of:
 - fire emergency within the facility requiring partial evacuation of an area or disruption of service.
- reports made to the medical officer of health for occurrences of:
 - infectious disease at the outbreak level;
 - communicable diseases as required by the *Health Protection and Promotion Act*; and
 - contamination of the drinking water supply.

The types of unusual occurrences that administrators were required to report the next working day included events which required the intervention of one or more agency, but which did not “pose an immediate risk to residents”; the implementation of any part of the facility’s emergency plan, including evacuation of residents; and a major equipment or system breakdown, placing residents at risk.

The Program Manual also required the reporting, in writing, within 10 working days of “injury, medication error or treatment error resulting in transfer of a resident to hospital for treatment and/or admission.”

Although unusual occurrences could initially be reported by telephone, the administrator was required to ensure that a copy of the unusual occurrence report form was provided to the Ministry within 10 working days of the occurrence.

The unusual occurrence reports, once received by the SAOs, would be reviewed by compliance advisors and could be the subject of a review conducted at the home.

3. Requirements Concerning Medication Management and Administration

All obligations and requirements relating to medication management and administration in nursing homes were contained in Regulation 832 or the Program Manual.

a) Medication Management as Required by Regulation 832

Regulation 832 placed responsibility for the administration and enforcement of the provisions relating to medications on the administrator of the nursing home.⁵² Sections 63–69 of Regulation 832 established requirements that included the following:

- Residents were to be administered drugs only with an individual prescription.
- No person except a physician, dentist, or registered staff could administer a drug to a resident.
- The administrator could permit no more than a three-month supply of a drug to be stored for a resident.
- Drugs had to be kept locked either in a drug cabinet or storeroom or, if the drugs required refrigeration, in a locked box in the refrigerator.
- The keys to the drug cabinet or storeroom had to be kept locked and under the control of a registered nurse or registered practical nurse on duty, or, in their absence, the administrator.
- Every narcotic and every controlled drug had to be stored in a locked box or cabinet known as the narcotic cabinet.
- Every nursing home had to maintain a drug record book recording the date drugs were ordered, the signature of the person placing the order, the name of the resident for whom the drug was prescribed, the date the drug was received, and the signature of the person receiving the drug on behalf of the home.
- With limited exceptions, only prescription drugs prescribed for a resident could be purchased, kept, or used in a nursing home.
- Drugs prescribed to residents who had been discharged or died, or when the attending physician had ordered their use be discontinued, had to be destroyed by the director of nursing in the presence of an inspector, or by a pharmacist or physician, or removed from the home by an inspector.
- The director of nursing had to record, in the drug record book, when a drug was destroyed or removed from the home.

⁵² S 63(1). No similar obligation was imposed on homes governed by the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act* or the regulations to those Acts.

b) Medication Management Standards Required of Homes Under the Program Manual

The Program Manual also imposed a number of standards and criteria relating to medication management and administration. These standards and criteria applied to all homes in the province, including those governed by the *Charitable Institutions Act* and the *Homes for the Aged and Rest Homes Act*.

The Program Manual imposed eight standards, each having a specific requirement and containing further detailed criteria. Table 9.4 summarizes the standards and their requirements, and includes some details about the related criteria.

Table 9.4: Summary of Standards Required Under the Program Manual

STANDARD	REQUIREMENT	SELECT CRITERIA*
Administration	There shall be an organized program for the provision of pharmacy service to meet the residents' identified needs.	Homes must: <ul style="list-style-type: none"> • have a registered pharmacist to provide clinical pharmacy services to the home; • retain a pharmacy to provide the drugs and drug products to the home; • have a written contract between the home and those responsible for providing pharmacy service, specifying the pharmaceutical service expectations; • have access to pharmacy service available 24 hours a day, seven days a week; and • make available drug-reference materials at each nursing unit.
Organized review process	There shall be an organized interdisciplinary review process for directing the home's pharmacy program and service.	<ul style="list-style-type: none"> • The pharmacist must participate in the interdisciplinary review process. • The review process must include documenting findings of the review and actions on a quarterly basis. • The review process must include a review of the Quality and Risk Management Program as it relates to pharmacy services with a focus on improving residents' pharmacotherapy. • The home must have current written policies and procedures for all aspects of pharmacy service.

continued

STANDARD	REQUIREMENT	SELECT CRITERIA*
Prescription ordering and transmission	Prescription ordering and transmission of orders shall support the safe provision of drugs to residents.	<ul style="list-style-type: none"> • Prescriptions must be written and signed by the physician and include the minimum requirements of resident's name, date, medication name, strength, form, quantity, frequency, route of administration, and physician's signature. • There must be a system for safe, accurate, and timely transmission of all prescription orders. • Written copies of all prescriptions or duplicate prescription orders shall be sent to the pharmacist. • There shall be a review of each resident's medications quarterly (or more frequently if needed), signed by the physician. • The quarterly medication review record must be included in the resident's health record. A copy must be returned to the pharmacy.
Drug dispensing	The pharmacy service shall provide for the accurate, safe dispensing of prescription drugs and biologicals to meet residents' identified medication requirements.	<ul style="list-style-type: none"> • A pharmacist, physician, or dentist must carry out all dispensing, except in exceptional circumstances, where the registered nurse may do so. • All drugs for residents must be labelled with the prescription number, resident's name, and other relevant information.
Recording receipt and disposition of drugs	A system of records for receipt and disposition of all drugs received by the facility shall be maintained in sufficient detail to enable accurate tracking, reconciliation, and auditing, in accordance with applicable legislation.	<ul style="list-style-type: none"> • No additional criteria are included for this requirement in the Program Manual.

STANDARD	REQUIREMENT	SELECT CRITERIA*
Drug storage	All drugs and biologicals shall be stored under proper conditions of sanitation, temperature, light, humidity, and security.	<ul style="list-style-type: none"> • All drugs and biologicals must be stored in conveniently located, locked drug cabinets or storerooms. • Narcotic and controlled drugs must be stored in a separately locked, permanently affixed compartment in the general drug cabinet or storeroom. • Every drug cabinet or room must be kept locked at all times; only the registered nursing staff and pharmacist may have access to keys. • A medication administration system that facilitates monitoring – such as unit dose / blister packs – must be used for all medications.
Drug disposal and destruction	Disposal of drugs shall be in accordance with established Ministry policy.	<ul style="list-style-type: none"> • Discontinued, unused, expired, recalled, deteriorated, and unlabelled drugs should be removed from current medication supplies. • Drugs must be destroyed and removed from the home according to applicable legislation and established Ministry policies and guidelines.
Medication errors / adverse reactions	There shall be a system for immediate reporting of each medication error and adverse drug reaction, with specific follow-up action to be taken.	<ul style="list-style-type: none"> • All medication errors and adverse drug reactions must be reported promptly to the director of nursing, prescriber, and pharmacist, according to established policy and procedure, and specific follow-up action should be taken. • The description of a medication error or adverse drug reaction must be recorded in the resident's clinical record immediately after the report is made. • Any adverse drug reaction must be recorded in the resident's medication profile and reported to the pharmacist, who will report to the Canadian Adverse Reaction Monitoring Program.

Source: Compiled by the Commission.

*The language relating to criteria was mandatory ("shall") and not permissive ("may"), unless otherwise specified.

The Program Manual also set out guidelines relating to pharmacy services, which included possible additional responsibilities of the Pharmacy and Therapeutics Committee in LTC homes. For example, the guidelines suggested that the committee should be assigned a number of different responsibilities, including:

- making recommendations to improve pharmacy programs and monitoring their adequacy in achieving safe, effective, and cost-effective pharmacotherapy, drug distribution, control, and use;
- reviewing all medication error reports and error rates to identify causes and develop policies or procedures to prevent similar occurrences in the future;
- reviewing the audit records of drug storage and distribution; and
- reviewing drug destruction records to identify and make recommendations about any unnecessary waste.

As I explain when discussing the current requirements relating to medication management and administration, many of the standards and criteria from the Program Manual were incorporated into the regulations to the LTCHA.

4. Inspection Regime Under the NHA

Before July 1, 2010, all LTC homes in the province – whether they were charitable institutions, not-for-profit nursing homes, municipal homes, or for-profit nursing homes – were subject to inspection.⁵³ Under the NHA, inspections were “[f]or the purpose of determining whether there is compliance with this Act, the regulations, the terms and conditions of funding ... or a service accountability agreement.”⁵⁴ Inspectors were granted powers to conduct inspections, including the power to inspect the premises of the nursing home and operations on the premises, the power to inspect records, and the right to question persons on matters relevant to the inspection.⁵⁵

Wettlaufer began working at Caressant Care (Woodstock) in 2007. From then until July 1, 2010, inspectors were known as compliance advisors. They worked out of the local Service Area Offices, as part of the Performance Improvement and Compliance Branch (PICB). Most compliance advisors were registered

⁵³ See, e.g., the *Charitable Institutions Act*, s 10.1; the *Homes for the Aged and Rest Homes Act*, s 21; NHA, s 24.

⁵⁴ NHA, s 24(2).

⁵⁵ NHA, s 24(4).

nurses, but some were dietary and environmental health advisors. Between 2007 and 2010, the total number of compliance advisors in the province ranged from 70 to 77. Approximately 15 compliance advisors worked out of the London SAO, which was the office responsible for the oversight of Caressant Care (Woodstock).

Compliance advisors were assigned to specific LTC homes within their SAO region. An advisor, who was typically responsible for between 12 and 15 homes, was the main point of contact between a home and the Ministry. Homes called the advisors directly. Compliance advisors received all reports submitted about the homes – both unusual occurrence reports and complaints. They were responsible for reviewing all the information they received about the homes and determining whether, and when, an inspection should be conducted. One former compliance advisor gave evidence at the hearings that, under the NHA regime, “it was more the exception than the norm that [the Ministry] would review an Unusual Occurrence.”

Compliance advisors conducted all the inspections in the homes, including complaint and unusual occurrence reviews as well as annual reviews. They also conducted more specialized reviews, such as dietary and environmental reviews. Some compliance advisors also conducted reviews before or after a sale of a home, or to follow up on findings of unmet standards or criteria. In conducting a review under the NHA, the advisor was responsible for determining whether the home was in compliance with the NHA, Regulation 832, and the criteria and standards in the Program Manual.

Compliance advisors focused on the Program Manual during their reviews. They examined relevant records, made observations of the home, and then determined whether the home was meeting the standards and criteria set out in the manual.

Following the review, the compliance advisors typically prepared a brief report. Reports did not contain written sanctions. There were two types of reports: a Report of Unmet Standards or Criteria, and an Observations and Discussion Summary. When compliance advisors found a home was not meeting the standards or criteria of the Program Manual, they discussed the findings with the home’s administrator and director of care, sometimes making recommendations or providing advice about successful practices for achieving compliance. In deciding which of the two types of report to issue, advisors considered four factors: scope, severity, compliance history, and the home’s due diligence.

Under the NHA, the Report of Unmet Standards or Criteria – and any notice of non-compliance issued to a home – required the home’s administrator to submit a response, known as a Plan of Corrective Action, to the director within seven days, setting out the proposed steps that would be taken to correct a matter. The Observations and Discussion Summary often provided licensees with suggestions or guidance on how to improve their compliance status. This type of report required no follow-up from the home.

In addition to these reports, compliance advisors under the old regime often provided advice and guidance to homes on how to fulfill the obligations imposed under the NHA, Regulation 832, and the Program Manual. They offered suggestions to a home about how it could achieve compliance and connect with other well-performing homes within the SAO region.

According to testimony at the public hearings, the type of advice given to homes varied significantly, depending on the type of questions asked. One former compliance advisor explained that questions addressed matters ranging from dealing with missing laundry, to getting residents to activities, to accessing resources to help with challenging residents. This advisor often pointed individuals with questions to other homes that were dealing well with that particular issue, or to homes that had developed useful forms or tools. Another former compliance advisor said that if a home was not meeting a particular standard, she would sometimes give advice in the course of a review. She might suggest contacting other homes that had good programs or suggest that the home consider training staff in a particular area.

When asked whether the homes found the advice useful, both former compliance advisors were ambivalent. As one explained, “Sometimes they did. Sometimes we didn’t have information that was helpful or useful to them. It just depended.” The other advisor noted that some homes “really liked” the advisory role, but others were “glad it’s gone because they didn’t feel that it added anything, and it confused them more.”

Almost no enforcement mechanisms were available to compliance advisors (or the Director) under the old inspection regime. Where homes were found to have multiple compliance concerns, they might be subject to “enhanced monitoring,” which was a review process designed to determine if a home was making progress on the identified issue. In cases where the licensee was repeatedly in contravention of the NHA or its regulations, the Director was authorized to revoke or refuse to renew the home’s licence,⁵⁶ or to cease

⁵⁶ NHA, s 13.

admissions to the home.⁵⁷ However, unlike under the LTCHA, neither the compliance advisors nor the Director (a position created by the LTCHA and filled by a person in the Ministry) had the authority to issue a compliance order or to impose a mandatory management order.

IV. *Commitment to Care: A Call to Reform Ontario's Long-Term Care Homes System*

The early 2000s witnessed growing calls for reform of the LTC homes system in Ontario. In 2004, Monique Smith, the parliamentary assistant to the Minister of Health and Long-Term Care, conducted a review of LTC homes in the province. Her final report, *Commitment to Care*, was released in the spring of 2004 and included recommendations for significant change and improvement to the system.⁵⁸ These recommendations, particularly those focused on legislative change and the development of a new inspection and enforcement regime, were the impetus behind the development of both the LTCHA and the Long-Term Care Home Quality Inspection Program (LQIP), both of which continue in force.

In this section, I review the key recommendations from *Commitment to Care*, both generally and with a focus on those specific to the Ministry's oversight of LTC homes. I then examine the Ministry's response to that report, specifically in terms of the work done to develop the LTCHA and its detailed regulations; the Compliance Transformation Project; and the training and education that were prepared and delivered by the Ministry in anticipation of the rollout of the new regime.

A. *Commitment to Care: Its Consultation and Review Process*

During the winter of 2004, Ms. Smith conducted a formal review involving unannounced visits to more than 20 LTC homes in Ontario, including municipal, not-for-profit, for-profit, and charitable homes. Some homes were small (just 22 beds), and others were large (350+ beds).

During her review, Ms. Smith met with numerous stakeholders in the LTC sector, many of which were participants in this Inquiry. They included the Advocacy Centre for the Elderly, the Alzheimer Society, members of family

⁵⁷ NHA, s 20.1(17).

⁵⁸ Ontario, Ministry of Health and Long-Term Care, *Commitment to Care*.

councils, compliance advisors, the Registered Nurses' Association of Ontario, the Registered Practical Nurses Association of Ontario, the Nurse Practitioner Association of Ontario, the Ontario Association of Community Care Access Centres, the Ontario Association of Residents' Councils, the Ontario Nurses' Association, the Ontario Long Term Care Association, the Ontario Association of Non-Profit Homes and Services for Seniors, geriatricians, LTC administrators, medical doctors, and academics with expertise in geriatrics and long-term care.⁵⁹

Ms. Smith characterized her report as "a blueprint for action" and expressed her gratitude for having participated in the "revolution" in LTC. She emphasized that "[t]he government is committed to providing homes where our seniors can live in dignity with the highest possible quality of care." To that end, her recommendations focused on five main areas for government action in the LTC sector:

- improving residents' quality of life;
- ensuring public accountability;
- developing clear enforceable standards with tougher inspection and enforcement;
- improving staffing and administration; and
- amending the legislation and reviewing the funding formula.

1. Quality of Life

Ms. Smith's first set of recommendations targeted the need to improve the quality of life for the more than 70,000 residents then living in LTC homes. In particular, she maintained that the concepts of "home" and "care" had to be reintroduced into the LTC sector. She specifically identified six core areas that required attention: philosophy of care, the role of the administrator, a role for the community, creating a home environment, public education and awareness, and keeping homes safe.

She explained that the philosophy of care in a home is an important indicator of the daily quality of life for residents and that, based on her visits to different homes, the administrator's approach to quality of care was critical. Homes where the administrator's care ethic was missing lacked a dignified, nurturing

⁵⁹ Ontario, Ministry of Health and Long-Term Care, *Commitment to Care*, 3.

home environment, resulting in residents being “warehoused in wheelchairs in front of the television for most of the day or ... lying in bed for long periods of time.”

She made the following recommendations to the Ministry concerning home administrators:

- conduct an internal review of administrators to ascertain qualifications and management expertise, and to identify any required skills training; and
- organize an educational forum with administrators to develop indicators of a well-run home and reinforce best management practices, including philosophy of care and service.

Ms. Smith also emphasized how she had seen families, volunteers, and the community at large play key roles in ensuring that residents in LTC homes were treated with dignity and had a “satisfying and rich life.” She observed how their quality of life was enhanced through family visits and volunteers. At one home, volunteers assisted in a biography-writing project. Another home arranged regular visits with therapy dogs. Ms. Smith also noted the important role played by residents’ councils and family councils in advocating for residents in homes. As she put it, “They play a watchdog role for quality of care.” Based on her observations, Ms. Smith recommended that the Ministry:

- support community and volunteer involvement and outreach by mandating (at a minimum) one dedicated half-time volunteer coordinator in every home;
- facilitate the sharing of best practices province-wide through a manual produced by LTC activities professionals;
- continue to fund the efforts of the residents’ council;
- provide provincial funding to help establish more family councils; and
- issue a directive to homes to establish a family council, which was to remain independent of the home’s administration.

Ms. Smith also emphasized how the physical setting in some LTC homes detracted from the creation of a home environment. She recommended that homes consider new holistic philosophies of care which address quality of life and encourage residents to bring their personal effects to their new homes. She noted that, where appropriate, independent daily routines should be respected so that residents would not be forced to conform to the home’s schedules, and that couples would be kept together in the same home, where

possible. She further recommended that the Ministry consider requiring each home to have at least one palliative care room available to protect the privacy and dignity of dying residents.

Ms. Smith's report maintained that there was a need for greater public education and awareness about the aging process, the continuum of care for seniors, how to navigate the system, and the Ministry's inspection and enforcement system for LTC homes. She recommended that:

- the Ministry develop a strategy with the CCACs to improve public education and awareness, such as exploring whether a section of each CCAC should be devoted to information on all senior services, advocacy groups, and organizations;
- organizations providing public education be encouraged and assisted in circulating their existing materials more broadly, and the Ministry's literature be revised and distributed widely to every community; and
- the Ministry raise awareness about the sanctions at its disposal concerning the oversight of LTC homes.

Finally, Ms. Smith observed that the public needed reassurance that LTC homes had appropriate safety and security measures so that residents with dementia are never placed in harm's way outside of the home, and that the Ministry should review safety and security measures in homes.

2. Public Accountability

Commitment to Care's second set of recommendations focused on the need for public accountability. Most of Ms. Smith's public accountability recommendations were specifically directed at the Ministry, including that it should:

- update the public about the number and nature of calls received at its toll-free action line for complaints, concerns, and questions;
- use the action line information to assist with planning around inspections and compliance;
- institute targeted surprise inspections between annual inspections;
- have family councils, or another third party, administer annual resident satisfaction surveys;
- assist in this initiative by making a generic survey available on its website and by sharing survey results with LTC home administrators;

- move immediately to address all serious non-compliance cases and maintain a record of homes in non-compliance, noting the length of time it takes a home to address issues and return to compliance;
- create an accessible website and make hard copies of reports available to improve public reporting and sharing of information, allowing for informed decisions in the choice of LTC homes;
- improve enforcement of the requirement that homes provide and post information on the complaints process and require that this information be included in the welcome packages for new residents;
- review the Office of the Chief Coroner's policy of reviewing every 10th death in LTC homes or where negligence is reported to ascertain if it was sufficient to ensure public confidence and accountability;
- maintain an internal database with compliance records, complaints, and other relevant data specific to each LTC home which could be monitored daily;
- maintain better records and review staffing levels and staffing mixes at all its homes in order to determine the appropriate staffing level for a particular home; and
- revise the Program Manual to establish clear outcome-based expectations and best practice for all home administrators.

She also recommended that:

- the government provide greater education for LTC staff (including administrators, physicians, nurses, healthcare workers, activation staff, volunteers, and family members) on elder abuse;
- each LTC home have a reporting system in place with public posting of information about whom to call about suspected abuse; and
- new legislation be introduced to encourage all LTC home staff and the general public to report abuse or suspected abuse, with fines to be imposed for not reporting.

3. Standards and Compliance

The third area of recommendations proposed by Ms. Smith addressed standards and compliance. These recommendations targeted the Ministry's oversight of LTC homes most directly, and Ms. Smith emphasized three broad areas in need of work: clear, enforceable standards; tougher inspection and enforcement; and appropriate levels of care.

Ms. Smith maintained that clear, measurable, enforceable, and resident-focused standards were necessary to ensure quality of life for residents of LTC homes. She also noted that LTC homes welcomed greater accountability and transparency but required clear and enforceable standards not subject to differing regional or individual interpretations. Standards must be measurable and include some weighting so that “serious violations are not mixed in with other complaints or violations.”

Ms. Smith noted that the existing Ministry standards were not adequately focused on the quality of care received by residents. She recommended that the Ministry make it a priority to redevelop standards around staff training, abuse prevention, restraints, nurses and personal support workers, and recreation / activities. She also recommended that indicators of quality of care be developed – including in relation to staff and resident satisfaction; number and variety of activities; staff skills and training; and volunteers and hours. She further opined that “[e]nforceability of standards is key” and recommended that the Ministry adopt a risk-based approach to prioritizing inspections, targeting homes with a poor track record or chronic non-compliance.

Ms. Smith noted that the existing compliance system was deficient in two respects: it was not meeting public expectations for ensuring the safety and well-being of residents; and LTC operators found the system unclear and inconsistent. She addressed concerns about what she saw as an apparent conflict in the role of the compliance advisors: working closely with a home to ensure standards were met, but also inspecting the same home and dealing with the subsequent enforcement process. She maintained that there was a need for greater transparency and public reporting of inspection results. To address these concerns, she recommended that the Ministry:

- remove the inspection role from compliance advisors and create a separate inspection function;
- have compliance advisors continue to perform an education function – assisting homes with respect to compliance and becoming more of a presence in homes failing to meet standards;
- design a risk framework identifying graded offences (minor, moderate, serious) with contingent triggers and resulting sanctions, including fines;
- provide better training for both inspectors and compliance advisors;
- move corporate direction for the new inspection regime away from the regional offices to a more central location;

- initiate a separate web board for discussions among compliance advisors and inspectors;
- require that all inspection reports be posted publicly in accessible locations;
- ensure that violations and complaints made against homes be communicated quickly to administrators;
- require inspectors to review the annual inspection reports with both the residents' and family councils and the home's board of directors (where applicable);
- ensure that inspection reports be provided to the CCACs, local MPPs, and other relevant stakeholders, and that they be posted on the public website;
- ensure that any new review process recognized homes with a record of good performance; and
- ensure that a home's financial viability also be reviewed by an auditor on the inspection team.

4. Staffing and Administration

Staffing and administration of LTC homes was the fourth area that Ms. Smith targeted for change. She identified the staffing issues faced by homes that she had observed first-hand, including insufficient numbers of registered staff working on night shifts and the use of agency staff on a short-term basis. These issues, as I heard in the course of the public hearings, continue to pose serious challenges for LTC homes.

Ms. Smith recognized that "funding and staff shortages do affect standards of care," including those involving such basic care needs as bathing, changing of incontinence products, or helping residents have a daily walk. She opined that it would be helpful to review the roles of key staff to determine how they might best be deployed within LTC homes, particularly given the increasingly complex health issues faced by residents.

Ms. Smith issued the following recommendations for this area:

- reinstate the requirement that all residents have at least one bath per week – and double that to two per week;

- provide increased resources for care in LTC homes, specifically in the nursing and personal care envelope, and tie the funding to specific outcomes;
- return to the 24-hour registered nurse standard for all LTC homes;
- develop strategic efforts to promote the desirability of LTC as a career option;
- provide Ministry funding for more nurse practitioners in the LTC sector; and
- consider imposing minimal training requirements for PSWs and administrators.

As well:

- the Ministry should encourage the use of programs offered by the Registered Nurses' Association of Ontario, the College of Nurses of Ontario, the Registered Practical Nurses' Association of Ontario, and others in relation to abuse, communication skills, dementia, and palliative care;
- PSWs and nurses should be trained by the Alzheimer Society; and
- the Ministry should fund bonuses to homes providing dementia care because it was not recognized in the Case Mix Index (CMI).

5. Funding and Legislation

Ms. Smith's final area of recommendations targeted funding and legislation. She indicated that the current funding process required review. She raised concerns about the misuse of the funding envelopes⁶⁰ as well as the CMI system, which she felt failed to provide funding for homes to promote wellness.

In terms of legislation, Ms. Smith recommended consolidating the three then-existing Acts that governed LTC homes (the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*) to ensure uniformity of standards of care, enforcement, and penalties for all homes. She also called for a "uniform ban on abuse with inclusion of whistle-blower protection and a positive obligation to report and penalties for non-reporting."

⁶⁰ As an example of an "unacceptable practice," she cited a home that had paid the legal fees for a wrongful dismissal case from the nursing and personal care envelope.

B. Response to *Commitment to Care* Recommendations

The Ministry moved quickly to respond to *Commitment to Care* and its recommendations, focusing on the development of the new legislation and its regulations; working on the Compliance Transformation Project (explained below); and (ultimately) preparing for the rollout of the new regime with training targeted at both inspectors and LTC homes.

1. The LTCHA and Its Regulation: Development and Passage

The Ministry's Health System Strategy Division took the lead in drafting legislation in response to *Commitment to Care*. By the end of August 2004, the Ministry had prepared a Cabinet submission for the Health and Social Services Policy Committee requesting Cabinet approval to begin developing a new *Long-Term Care Homes Act*, which would replace the existing legislative framework governing LTC homes, and to solicit feedback on the new legislation. The submission specified that the new Act would be aligned with the recommendations from *Commitment to Care*, including the need to strengthen residents' rights and safeguards; standards of care; and the compliance, inspection, and enforcement regime. Less than a month later, Cabinet directed the Ministry to initiate the policy work necessary to develop the new Act.

During the fall of 2005, the Ministry prepared two Cabinet submissions in support of drafting the proposed new legislation. The first, which set out the specific policy recommendations for the Act, focused on five key categories: residents' rights and safeguards; service expectations and care standards; compliance inspection and enforcement; accountability; and asset management. The second Cabinet submission was directed more specifically at the licensing criteria under the proposed new Act. In short order, Cabinet directed the Ministry to take steps to draft a new *Long-Term Care Homes Act*, consistent with the Ministry submission. In June 2006, the Minister of Health and Long-Term Care sought approval from the Legislation and Regulations Committee of Cabinet for the Ministry's draft *Long-Term Care Homes Act, 2006*.

On June 4, 2007, the LTCHA received royal assent but was not yet proclaimed in force.⁶¹ It reflected, in large part, Ms. Smith's recommendations as well as the input from various stakeholders, including residents, families,

⁶¹ Bill 140, *An Act respecting long-term care homes*, 2nd Sess, 38th Leg, Ontario, 2007 (assented to June 4, 2007), SO c 8.

frontline staff, clinical and sector experts, advocacy groups, LTC associations, municipalities, and labour organizations.

Once the LTCHA had passed, significant work lay ahead to develop its regulations. In December 2008 and May 2009, the Ministry prepared Cabinet submissions for the creation of regulations under the LTCHA. Cabinet approved the requests and directed the Ministry to draft regulations.

On March 2, 2010, the Ministry sought approval from the Legislation and Regulations Committee of Cabinet for its draft regulations under the LTCHA. On March 29, 2010, O Reg 79/10 was filed. It was scheduled to come into force on the same day as the LTCHA. On July 1, 2010, the *Nursing Homes Act*, the *Charitable Institutions Act*, and the *Homes for the Aged and Rest Homes Act* were repealed, with the coming into effect of the LTCHA and its regulations.

The new legislative regime was rooted in a number of fundamental principles:

- belief in resident-centred care and enforceable standards for residents' rights, care, and services;
- commitment to the health and well-being of Ontarians living in LTC homes;
- support, collaboration, and mutual respect among residents, families, LTC home providers, community, and government;
- access to LTC homes based on need;
- public accountability and transparency;
- clear and consistent standards of care and services, including required programs for falls prevention and management, skin and wound care, continence care and bowel management, and pain management;
- shifting of responsibility to the licensee (from the administrator or the home) for ensuring compliance with the requirements of the Act and taking action where standards or requirements under the Act are not met, or where the care, safety, security, and rights of residents might be compromised;
- commitment to preserving and promoting quality accommodation that provides a safe, comfortable, homelike environment for residents; and
- delivery of care and services to residents in an environment that supports continual quality improvement.

The LTCHA and its regulations are further discussed below.

2. The Compliance Transformation Project

While the Health System Strategy Division took the lead on the legislative and regulatory drafting, the PICB assumed responsibility for developing a new inspection methodology that would align with the new Act. A small team within PICB was tasked with what came to be known as the Compliance Transformation Project. The goals of this project included building a new evidence-based and resident-centred inspection process; maintaining a focus on residents' quality of care and quality of life; improving objectivity and consistency through structured information-gathering; using technology to better organize inspection findings and enhance documentation and data collection; and targeting inspection resources on homes having the largest number of quality-related concerns.

One of the first tasks undertaken by the Compliance Transformation team was an inter-jurisdictional review of inspection regimes in Canada, the United States, and Australia. The team met with a lead researcher at the US-based Nursing Home Quality, who had worked to develop a methodology to survey (or inspect) nursing homes. The survey methodology, known as the Quality Indicator Survey, was rolled out in US nursing homes in 2006–7, following 15 years of research.

The Compliance Transformation team was drawn to the Quality Indicator Survey methodology – an inspection system that “started with collecting evidence from the residents, staff, and families, and worked outward from there.” Importantly, the care areas within the Quality Indicator Survey also mirrored many of the new requirements contained in the LTCHA and its regulations.

In March 2010, PICB retained Nursing Home Quality to adapt the Quality Indicator Survey methodology to the LTCHA and its regulations so it could become the inspection methodology for the Ministry's annual comprehensive inspection – known as the resident quality inspection (RQI). Nursing Home Quality was also responsible for training individuals who would ultimately become responsible for training all inspectors for RQIs (master trainers). Finally, Nursing Home Quality was retained to develop an information technology system for stage 1 of the RQIs.

One team member was responsible for developing an automated IT software, the Inspector's Quality Solution (IQS), to support stage 2 of the RQIs, as well as other inspections. IQS was designed to allow for "robust data analysis to track inspections and inspection outcomes ... and trending for LTC home compliance."

Between May and November 2010, in a pilot study of the adapted Nursing Home Quality processes, PICB inspectors conducted mock RQIs in about 120 LTC homes across Ontario.

During this period, other members of the Compliance Transformation team were developing the detailed inspection protocols to be used in all inspections – both RQIs and the complaint, critical incident, and follow-up (CCF) inspections. Designed as detailed checklists that align directly with the LTCHA and its regulations, inspection protocols are intended to help focus inspectors on a specific issue and provide guidance on where to look for it in the legislation. The inspection protocols contain instructions, guidelines, and suggested probes and questions that are meant to help inspectors determine whether a home is in compliance with the requirements of the LTCHA and its regulations. The inspection protocols are contained in the IQS software. In the course of an inspection, inspectors can pull them up on their tablets and refer to specific areas under inspection.

The inspection protocols could not be finalized until the work on the regulations had been completed in March 2010. They were tested in LTC homes throughout the province in April, May, and June 2010.

Some changes have been made to the content of the inspection protocols, but not to the overall care areas to which they relate. Although some inspection protocols relate to the programs and procedures of the home, others pertain more directly to residents. Table 9.5 shows the full range of inspection protocols.

Table 9.5: Range of Inspection Protocols

INSPECTION PROTOCOLS			
Home-Related Mandatory	Home-Related Triggered	Resident-Related Triggered	Inspector-Initiated
1. Dining Observation	1. Accommodation Services: Housekeeping	1. Continence Care and Bowel Management	1. Admission and Discharge
2. Family Council Interview	2. Accommodation Services: Laundry	2. Dignity, Choice and Privacy	2. Quality Improvement
3. Infection Prevention and Control	3. Accommodation Services: Maintenance	3. Falls Prevention	3. Resident Charges
4. Medication	4. Critical Incident Response	4. Hospitalization and Change in Condition	4. Training and Orientation
5. Residents' Council Interview	5. Food Quality	5. Minimizing of Restraining	
	6. Reporting and Complaints	6. Nutrition and Hydration	
	7. Safe and Secure Home	7. Pain	
	8. Snack Observation	8. Personal Support Services	
	9. Sufficient Staffing	9. Prevention of Abuse, Neglect, and Retaliation	
	10. Trust Accounts	10. Recreation and Social Activities	
		11. Responsive Behaviours	
		12. Skin and Wound Care	

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

Note: Although any inspection protocol can be used during any inspection, certain inspection protocols are considered “mandatory” during the intensive RQIs. Other inspection protocols may be “triggered,” depending on what the inspectors learn during the first phase of the RQI (discussed below).

3. The New Regime: Training and Education

Before the new regime was rolled out on July 1, 2010, compliance advisors (who became inspectors under the new regime) received training on the new inspection methodology and tools, as well as the various requirements and obligations of the Act. Starting about May 2010, inspectors received training on the role of the inspector; the new inspection process; compliance and enforcement; enforcement mechanisms, including orders, Director referrals and suspensions of admission; Director's reviews and appeal processes; CCF inspections; the judgment matrix policy (discussed below); documentation and note-taking; report writing; and post-inspection activities. Since the rollout of the LTCHA and its regulations, Ministry inspectors have been provided with extensive, ongoing training on conducting inspections and related issues.

Before the LTCHA came into effect, the Ministry also took steps to help prepare licensees, as well as staff and management in LTC homes, for the new Act. The Ministry held seven different "road shows" across the province for the LTC homes – including their administrators, directors of care, and licensees – to educate them about the LTCHA and regulations, and the new inspections regime and methodology. These presentations were videotaped and made available through the Ministry's portal – longtermcarehomes.net – to LTC homes, residents' councils, family councils, associations such as the Ontario Long Term Care Association, and the Ontario Association of Residents' Councils.

V. Ministry Oversight as of July 1, 2010: The LTCHA

On July 1, 2010, after years of planning and preparation, the LTCHA and the Regulation came into effect. At that time, Wettlaufer was still working at Caressant Care (Woodstock), where she had committed the first six of her Offences. She committed the next seven Offences while she was working at it and two other LTC homes, all of which were subject to oversight by the Ministry under the new regulatory regime.

The new regime brought with it significant change to the Ministry's oversight role, its approach to that role, and the obligations on licensees of LTC homes. In this section, I examine some of the key legislative and regulatory changes associated with the new regime. I highlight some specific obligations that the new regulatory framework imposed on licensees with respect to reporting and to medication management and administration. Next, I discuss the changes

to the Ministry's oversight role, highlighting the new inspection regime under the LTCHA; its legislated enforcement mechanisms; the Ministry's approach to managing and triaging information it receives about homes; how the Ministry managed the rollout of the resident quality inspections (RQIs) and the impact on complaint, critical incident and follow-up (CCF) inspections; and the Ministry's approach to assigning risk and performance levels to homes under the new regime.

A. The LTCHA and the Regulation: A New Regime for Ontario's LTC Homes

The new LTCHA brought fundamental change to LTC homes in Ontario. Unlike the previous Acts, the LTCHA begins with a preamble. That preamble, which mirrors many of the recommendations set out in *Commitment to Care*, states:

The people of Ontario and their Government:

Believe in resident-centred care;

Remain committed to the health and well-being of Ontarians living in long-term care homes now and in the future;

Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents;

Recognize the principle of access to long-term care homes that is based on assessed need;

Firmly believe in public accountability and transparency to demonstrate that long-term care homes are governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services to all residents;

Firmly believe in clear and consistent standards of care and services, supported by a strong compliance, inspection and enforcement system;

Recognize the responsibility to take action where standards or requirements under this Act are not being met, or where the care, safety, security and rights of residents might be compromised;

Affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term care homes;

Recognize that long-term care services must respect diversity in communities;

Respect the requirements of the *French Language Services Act* in serving Ontario's Francophone community;

Recognize the importance of fostering the delivery of care and services to residents in an environment that supports continuous quality improvement;

Are committed to the promotion of the delivery of long-term care home services by not-for-profit organizations.

The new regime incorporated, consolidated, and expanded on many of the obligations that had existed under the NHA regime. It imposed those obligations directly on licensees. At the public hearings, I heard evidence that this change was intentional – it was designed to ensure that those in ownership positions in LTC homes were aware of the activities in the home and the consequences of decisions made concerning the home's operation. In contrast, under the earlier Acts and the Program Manual, many of the obligations had been placed on the administrator or the home, not on the licensee.

1. General Obligations Under the LTCHA: An Overview

A primary goal of those developing the LTCHA and the Regulation was to create a regulatory regime that was focused on residents, with enforceable standards for residents' rights, care, and services. This focus on residents is evident in all 10 parts of the LTCHA and the corresponding detailed requirements in the regulations.

Part I of the LTCHA sets out the fundamental principle to be applied in its interpretation and anything required or permitted under it in section 1:

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.

Part II of the LTCHA covers residents' rights, care, and services, beginning with the Residents' Bill of Rights. Section 3 requires every licensee to ensure that a detailed list of residents' rights are "fully respected and promoted." Although many of these rights are similar to those in the NHA, several new ones were added, including the resident's right to be protected from abuse; the right not

to be neglected by the licensee or staff; and the right to participate fully in the development, implementation, review, and revision of his or her plan of care.⁶²

Part II then prescribes the care and services that the licensee must ensure are provided to residents. By way of example, sections 5 through 16 of the LTCHA requires licensees to ensure that:

- the home is a safe and secure environment for its residents;
- there is a written plan of care for each resident setting out the planned care, goals of the care, and clear directions to staff providing the care;
- there is an organized program of nursing and personal support services in the home;
- at least one registered nurse who is both an employee of the home and a member of the regular nursing staff of the home is on duty and present in the home at all times,⁶³ except as provided for in the Regulation; and
- there are organized programs of restorative care; recreational and social activities; nutrition care, dietary services, and hydration; medical services; religious and spiritual practices; housekeeping, laundry, and maintenance services; and volunteers.

Part II of the LTCHA also requires licensees to protect residents from abuse and neglect, have a written policy to promote zero tolerance of abuse and neglect of residents, and ensure compliance with that policy.⁶⁴ Licensees must also have a complaints procedure in the home and are mandated to forward to the Director all written complaints received concerning the care of a resident or the operation of the home,⁶⁵ to investigate, respond, and act on complaints received,⁶⁶ and to forward the results of any investigation to the Director.⁶⁷ Although most of the obligations in Part II are imposed on licensees, section 24 of the LTCHA imposes a duty, on all persons except residents, to report suspected abuse or neglect of a resident, among other things.⁶⁸ The Act also includes whistle-blower protections for those who do report.⁶⁹ The scope of the section 24 duty to report is discussed further, below.

⁶² LTCHA, s 3(1).

⁶³ Known colloquially as the “24/7 RN requirement.”

⁶⁴ LTCHA, ss 19–20.

⁶⁵ LTCHA, ss 21–22.

⁶⁶ LTCHA, s 23(1).

⁶⁷ LTCHA, s 23(2).

⁶⁸ LTCHA, s 24(1)–(5).

⁶⁹ LTCHA, s 26.

Part III of the LTCHA contains detailed rules for the admission of residents to LTC homes.

Part IV governs councils in LTC homes. Unlike the NHA, the LTCHA requires licensees to ensure there is a residents' council in the home.⁷⁰ As well, licensees are required to assist in establishing a family council where one is requested by a family member of a resident.⁷¹ Licensees must also consult regularly – at a minimum, every three months – with the residents' council and, if one exists, the family council.⁷²

Part V addresses some of the requirements related to the operation of homes, including the need for licensees to ensure each home has an administrator, a director of nursing and personal care, and a medical director.⁷³ Licensees must also ensure that all staff working in the home have the proper skills and qualifications to perform their duties and to ensure that screening measures – including police record checks – are conducted on all staff and volunteers.⁷⁴ Part V also restricts the use of agency staff in LTC homes to specified exceptional circumstances and requires licensees to ensure that agency staff are screened, are subject to police record checks, and have received all training before they start to work in the home.⁷⁵ This part of the Act also sets out the training that licensees must ensure all staff, including agency staff, receive before working in the home, including training on:

- the Residents' Bill of Rights;
- the home's mission statement;
- the home's policy to promote zero tolerance of abuse and neglect of residents;
- the duty to make mandatory reports under section 24;
- the policy to minimize restraining of residents;
- fire prevention and safety;
- emergency and evacuation procedures;
- infection prevention and control;

⁷⁰ LTCHA, s 56.

⁷¹ LTCHA, s 59.

⁷² LTCHA, s 67.

⁷³ LTCHA, ss 70–72.

⁷⁴ LTCHA, ss 73–75.

⁷⁵ LTCHA, ss 74–76.

- all Acts, regulations, policies of the Ministry, and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and
- any other area provided for in the regulations.⁷⁶

Part V also requires the homes to provide residents with information, on admission, and to post information in an accessible location in the home on the Residents' Bill of Rights, the home's mission statement, the home's policy to promote zero tolerance of abuse, the duty to make mandatory reports under section 24, and the procedure for initiating complaints to the licensee.⁷⁷ Finally, Part V imposes a number of general management obligations on licensees, including the need to develop and implement a quality improvement and review system, and to conduct an annual satisfaction survey with residents and families.⁷⁸

The funding and licensing of LTC homes are covered by Parts VI and VII, respectively. Part VIII covers municipal homes and First Nations homes.

Part IX pertains most directly to the Ministry's oversight of LTC homes. It contains the LTCHA compliance and enforcement provisions and, thus, is the basis for Ministry's inspection regime, which is discussed further, below.

Finally, Part X of the Act addresses various administrative and transitional issues, such as the replacement of licences issued under the previous Acts.⁷⁹

2. Reporting Obligations

Much like the NHA and its regulations, the LTCHA and the Regulation impose specific reporting requirements on both the licensee and individuals. On receiving certain reports, the Director has corresponding obligations.

Several key reporting obligations are contained directly in the LTCHA. For example, as discussed earlier, licensees are obliged to have a written complaints procedure and to immediately forward to the Director all written complaints received about the care of a resident or the operation of the home.⁸⁰ A licensee who receives a report – or otherwise knows – of an

⁷⁶ LTCHA, s 76(2). Additional training is required of direct care staff, s 76(7).

⁷⁷ LTCHA, ss 78–79.

⁷⁸ LTCHA, ss 84–85.

⁷⁹ LTCHA, s 187.

⁸⁰ LTCHA, ss 21–22.

alleged, suspected, or witnessed incident of abuse or neglect of a resident, must immediately investigate, and take appropriate action. The results of that investigation, along with the actions taken, must then be reported to the Director.⁸¹

a) Duty to Report Suspected Abuse or Neglect – and a Corresponding Duty to Investigate

Section 24(1) of the LTCHA imposes a duty to report, among other things, suspected abuse or neglect. It reads as follows:

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act, 2006*.

Although “abuse” and “neglect” are both defined in the Regulation,⁸² neither “reasonable grounds to suspect” nor “improper or incompetent treatment or care” is defined.

The duty to report extends to any person, except for a resident, who has reasonable grounds to suspect abuse or neglect. Although residents may report suspected abuse or neglect, they are not required to do so.⁸³ The LTCHA creates two offences in relation to this reporting requirement – one for failing to report, and one for suppressing reports.⁸⁴ It also incorporates whistleblower protection for those who report abuse or neglect under section 24.⁸⁵

Where the Director receives information about any of the reportable issues under section 24(1), a failure to comply with a requirement under the Act, or any other matter provided for in the Regulation, the Director must

⁸¹ LTCHA, s 23(1)–(3).

⁸² O Reg 79/10, ss 2, 5.

⁸³ LTCHA, s 24(3).

⁸⁴ LTCHA, s 24(5)–(6).

⁸⁵ LTCHA, s 26.

have an inspector either conduct an inspection or make inquiries for the purpose of ensuring compliance with the Act. Depending on the nature of the information received, the inspector may need to visit the LTC home immediately.⁸⁶

b) Reporting Requirements Under the Regulation

The Regulation also imposes reporting obligations on licensees of LTC homes. Section 107 requires licensees to submit Critical Incident reports to the Director on a range of issues. Certain types of critical incidents must be reported immediately, including:

- an emergency, including a loss of essential services, fire, unplanned evacuation, intake of evacuees, or flooding;
- an unexpected or sudden death,⁸⁷ including a death resulting from an accident or suicide;
- a resident who is missing for three hours or more;
- any missing resident who returns to the home with an injury or adverse change in condition, regardless of the length of time the resident was missing;
- an outbreak of a reportable disease or communicable disease as defined in the *Health Protection and Promotion Act*; or
- contamination of the drinking water.⁸⁸

Other critical incidents must be reported to the Director within one business day of the occurrence, including those involving:

- a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition;
- an environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security, or well-being of residents for a period greater than six hours;
- a missing or unaccounted for controlled substance;

⁸⁶ LTCHA, s 25.

⁸⁷ Note that s 107(1), O Reg 79/10, requires a report to be made where a death is sudden *or* unexpected. This is to be distinguished from s 10 of the *Coroners Act*, which uses the words sudden *and* unexpected.

⁸⁸ O Reg 79/10, s 107(1).

- an injury in respect of which a person is taken to hospital; or
- a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.⁸⁹

Although initial reports to the Director may be made orally, they must be followed, within 10 business days, by a written report setting out further details about the incident.⁹⁰

When the LTCHA first came into effect, the Service Area Offices (SAOs) continued to receive and review all Critical Incident reports related to the homes in their jurisdiction. Each SAO had duty inspectors who were responsible for triaging this information. This process changed in late 2012, when the Centralized Intake, Assessment and Triage Team (CIATT) was established and began to operate. Once CIATT was fully operational, it assumed responsibility for triaging all Critical Incident reports and other information received about homes in the province to determine if an inspection was warranted.

3. Medication Management and Administration

The obligations on LTC homes relating to medication management are expanded in the Regulation from those that had been in place under the regulations to the NHA and the standards and criteria in the Program Manual. The Regulation was drafted with the assistance of the Ministry's Drugs Programs Branch, a group that had identified minimum standards for quarterly evaluations, medication incidents, and adverse drug reactions.

Sections 114–37 of the Regulation place the following obligations, among others, on licensees:

- Develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents;
- Ensure that an interdisciplinary team, including the medical director, the administrator, the director of nursing and personal care, and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system;

⁸⁹ O Reg 79/10, s 107(3).

⁹⁰ O Reg 79/10, s 107(4).

- Retain a pharmacy service provider for the home, to ensure medications are provided to the home on a 24-hour basis, seven days a week, and to perform the responsibilities set out under the Regulation;
- Ensure that the drug supply in the home – both specific to residents and the general emergency supply – is managed in accordance with the Regulation;
- Ensure that there is a monitored dosage system in the home;
- Ensure that drugs are stored safely and securely in accordance with the Regulation, including the need for a monthly audit of daily count sheets to determine if there are any discrepancies; and
- Develop a drug destruction and disposal policy in accordance with the requirements of the Regulation.

The Regulation also imposes specific obligations on licensees relating to the administration of drugs in LTC homes, including obligations to:

- ensure that no drug is used by, or administered to, a resident unless it has been prescribed for that resident;⁹¹
- ensure that the home has a drug record that is maintained and kept for at least two years;⁹²
- ensure that when residents are taking drugs:
 - there is monitoring and documentation of the resident’s response, and of the effectiveness of the drugs;
 - appropriate actions are taken in response to any medication incident or any adverse drug reaction; and
 - there is a documented reassessment of each resident’s drug regime at least quarterly;⁹³ and
- ensure that every medication incident involving a resident and every adverse drug reaction are documented, reviewed, and analyzed, and corrective action taken, and
 - that these incidents are reported to the appropriate persons (including the resident, the director of nursing, the medical director, the prescriber of the drug, and the pharmacy service provider); and

⁹¹ O Reg 79/10, s 131.

⁹² O Reg 79/10, s 133.

⁹³ O Reg 79/10, s 134.

- that a quarterly review is undertaken of all medication incidents and adverse drug reactions to reduce and prevent such occurrences.⁹⁴

As I heard during the public hearings, those responsible for drafting the medication-related regulations sought to expand the role of pharmacy service providers in LTC homes. One witness explained:

We specifically wanted to see more active involvement from pharmacy service providers in LTC homes because pharmacists have specialized knowledge that can contribute to the care of residents, and pharmacists are often on the front line of new medications, treatments and technologies.

Section 120 of the Regulation requires the licensee to ensure that the pharmacy service provider participates in the following activities:

- for each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles;
- evaluation of therapeutic outcomes of drugs for residents;
- risk-management and quality-improvement activities, including the review of medication incidents, adverse drug reactions, and drug utilization;
- development of audit protocols for the pharmacy service provider to evaluate the medication management system;
- educational support to the staff of the home in relation to drugs; and
- drug destruction and disposal (under section 136(3)(a), if required by the licensee's policy).

Although a licensee is required to retain a pharmacy service provider for the home,⁹⁵ there is no requirement that the provider have a pharmacist or pharmacy technician on-site in the home.

B. Inspection Regime Under the LTCHA

With the rollout of the LTCHA, compliance advisors assumed the role of inspectors under the Act. Inspectors, like the compliance advisors before them, are registered nurses, registered dietitians, registered physiotherapists, or environmental inspectors. Since July 1, 2010, inspectors have continued to

⁹⁴ O Reg 79/10, s 135.

⁹⁵ O Reg 79/10, s 119.

work from the SAOs across the province, although they are no longer assigned to particular LTC homes. Although expected to make an inspection of any home in their region, they are no longer expected – or authorized – to provide homes with advice about how to comply with the LTCHA or its regulations.

1. Role of Inspectors

As noted, one of the key changes to the inspection regime under the LTCHA was the elimination of the advisory role from the inspector's functions. This change was significant for both the inspectors and the homes. Karen Simpson, the former Director, explained the rationale for the change and what inspectors are now able to do when asked for help:

Under the new regime, we recognized that an Inspector should not be both giving advice to a home and then inspecting that home. Inspectors can (and do) refer homes to other organizations or other homes to obtain support, but Inspectors should not give advice to a home about what specific actions they need to take to achieve compliance. This is important in order to avoid a situation in which a home has taken an Inspector's advice but is still not in compliance when an Inspector comes to inspect.

Several of the inspectors who testified at the public hearings indicated that, while they no longer give a home advice about how to achieve compliance, they will refer the home to the legislation or to available programs or organizations that may be able to provide support.

Although inspectors shed their advisory responsibility, the new regime gave them a heightened accountability because they are now required to “ensure compliance” with the LTCHA and the Regulation. The LTCHA specifies that “an inspector may conduct inspections for the purpose of *ensuring compliance with requirements under this Act*” [emphasis added].⁹⁶ As I heard during the public hearings, for the Ministry this was the “most significant change” under the new regime. Several inspectors gave evidence that this responsibility informs their approach to inspections. When they go into a home to conduct an inspection, they are looking for compliance.

Under the LTCHA, inspectors are granted various powers and duties. For example, as was the case under the previous regime, they have the authority to enter premises, inspect records, and question persons.⁹⁷ They are also

⁹⁶ LTCHA, ss 141–42.

⁹⁷ LTCHA, s 147.

subject to a number of obligations. For example, they must conduct an inspection or make inquiries if the Director receives information that certain incidents have occurred – such as abuse that resulted in harm to a resident.⁹⁸

The LTCHA requires that every LTC home be inspected at least once a year and that no notice be given of inspections.⁹⁹ Generally, two types of inspections occur under the new regime. Complaint, critical incident, and follow-up (CCF) inspections are the first type. The second type are the comprehensive annual inspections, known as resident quality inspections (RQIs).¹⁰⁰ A CCF inspection tends to be initiated and conducted in an LTC home based on a complaint or Critical Incident report received about a potential issue of non-compliance. Inspectors may also attend a home to conduct a follow-up inspection concerning an order that has previously been issued against the home. The RQI inspection examines a range of care areas. RQIs were not initially conducted annually in all LTC homes; this practice did not start until the latter part of 2013. The rollout of RQIs to all homes – and the impact that had on the inspection regime more generally – is discussed in greater detail below.

2. Enforcement Mechanisms

Although inspectors go into homes looking for compliance, they are obliged to take action if they find non-compliance. They must document any finding of non-compliance in the mandatory inspection reports. Copies of the reports must be given to the licensee, the residents' council, and, if there is one, the family council.¹⁰¹

Section 152 of the LTCHA sets out the possible actions available to an inspector on finding that the licensee has not complied with a requirement of the Act. Where there has been a finding of non-compliance, the inspector must issue one of the following:

- a written notification to the licensee;
- a written request to the licensee to prepare a voluntary plan of correction;
- a compliance order;

⁹⁸ LTCHA, s 25.

⁹⁹ LTCHA, ss 143–44.

¹⁰⁰ While the LTCHA does not specify what type of inspection must be done annually in each home, the RQI has come to be known as the annual inspection.

¹⁰¹ LTCHA, s 149(1)–(3).

- a work and activity order; or
- a written notification and refer the matter to the Director for further action (known as a Director's referral).¹⁰²

Where an inspector has made a Director's referral, the Director has a number of enforcement mechanisms available, including the issuance of a compliance order¹⁰³ (known as a Director's order in these circumstances) or a work and activity order.¹⁰⁴ The Director is also authorized to order that funding be returned or withheld,¹⁰⁵ to issue a mandatory management order requiring the licensee to retain someone to manage or assist in managing the LTC home;¹⁰⁶ to issue an order suspending admissions to the home;¹⁰⁷ and to revoke an LTC home's licence.¹⁰⁸

When deciding which enforcement mechanism to issue with a finding of non-compliance, inspectors use a judgment matrix, based on the Regulation, to guide the exercise of their discretion. The judgment matrix requires inspectors to consider the severity of the non-compliance (or, where there has been harm or risk of harm, the severity of that harm or risk); the scope of the non-compliance (whether it was isolated, a pattern, or widespread); and the licensee's compliance history.¹⁰⁹ Inspectors can depart from the required or "default" action under the judgment matrix, provided the rationale is consistent with the Judgment Matrix Policy and they document their reasons. An inspector (or the Director) may issue an order against a licensee for non-compliance even if the licensee took all reasonable steps to prevent the non-compliance or, at the time of the non-compliance, the licensee has an honest and reasonable belief in a set of facts that, if true, would not have resulted in non-compliance.¹¹⁰ Figure 9.4 summarizes the different enforcement mechanisms available under the Act.

¹⁰² LTCHA, ss 152–54.

¹⁰³ LTCHA, s 153.

¹⁰⁴ LTCHA, s 154.

¹⁰⁵ LTCHA, s 155.

¹⁰⁶ LTCHA, s 156.

¹⁰⁷ LTCHA, s 50. This is known as a cease admissions order.

¹⁰⁸ LTCHA, s 157.

¹⁰⁹ See also O Reg 79/10, s 299.

¹¹⁰ LTCHA, s 159.

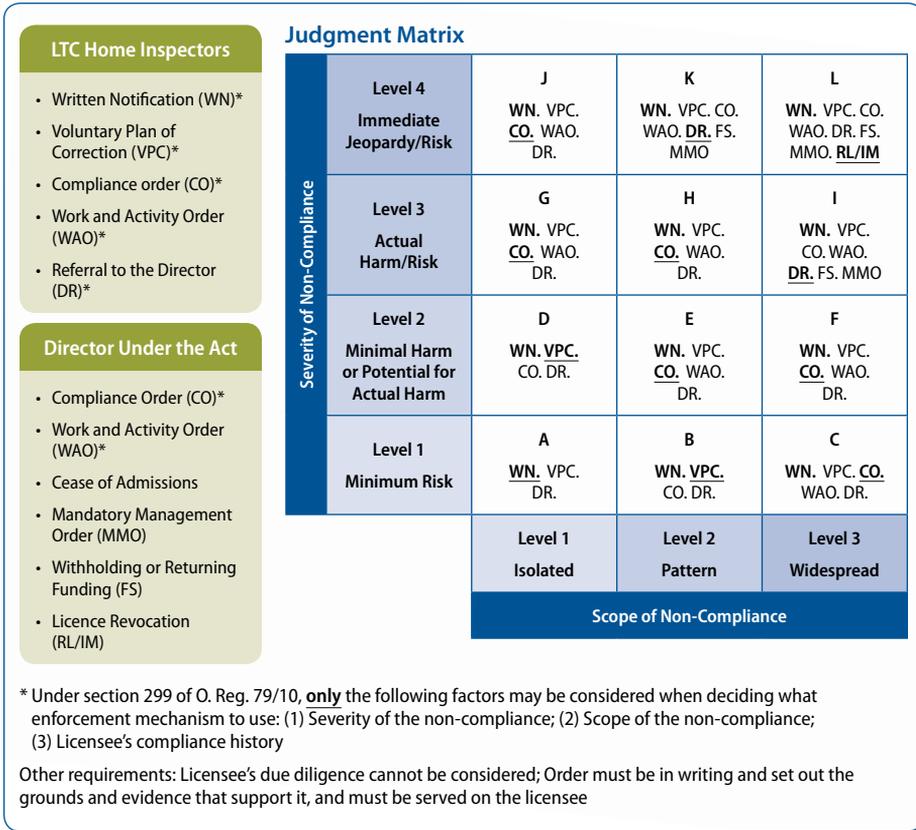


Figure 9.4: Enforcement Mechanisms Under the LTCHA

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

A licensee can request a Director’s review of an inspector’s compliance order or work and action order issued under the LTCHA.¹¹¹ On reviewing an order, the Director may rescind, confirm, or alter the order, and may also substitute his or her own order for that of the inspector.¹¹² A licensee may appeal orders issued by the Director (or decisions of the Director on a requested review) to the Appeal Board.¹¹³

¹¹¹ LTCHA, s 163(1). There is no review option available for a written notification or a voluntary plan of correction issued for a finding of non-compliance.

¹¹² LTCHA, s 163(6).

¹¹³ LTCHA, s 164.

Since the LTCHA has been in force, the most common action taken by inspectors when they have found non-compliance is a written notification. Data provided to the Inquiry by the Ministry's Inspections Branch show that, in almost every year, almost twice as many written notifications as voluntary plans of correction – the second most common action – are issued. Inspectors issue significantly fewer compliance orders (in most years, under a thousand) than either written notifications or voluntary plans of compliance. Director's referrals were extremely rare in the early years of the new regime, with fewer than 10 issued between July 1, 2010, and December 31, 2014. This changed when Ms. Simpson became the Director. Her evidence was that she began to require inspectors to make a Director's referral on the third issuance of a compliance order or where the inspector identified serious risk issues in the home. As a result of this direction, the number of issued Director's referrals increased from 29 in 2015 to 96 in 2016, before dropping to 71 in 2017. Figure 9.5 shows enforcement mechanisms issued for findings of non-compliance between January 1, 2011, and July 31, 2017.

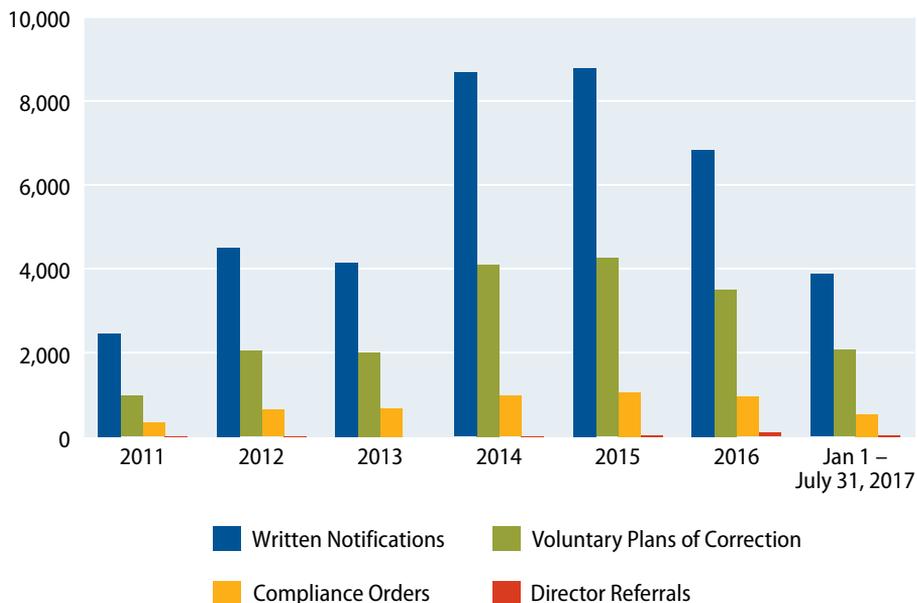


Figure 9.5: Enforcement Mechanisms Issued for Findings of Non-Compliance, January 1, 2011–July 31, 2017

Source: Compiled by the Commission based on tables of data produced by the Ministry.

The other actions taken against homes for non-compliance have been less common. Ms. Simpson testified that, since the LTCHA and the Regulation came into effect, the Inspections Branch has issued cease of admissions orders 17 times, and mandatory management orders just six times. The most significant enforcement mechanism available under the LTCHA – the revocation of a home’s licence – has been used only twice since July 1, 2010.

3. Managing and Triaging Information

When the LTCHA first came into force, each SAO retained responsibility for triaging all information received about the LTC homes within its jurisdiction, including all Critical Incident reports and complaints. Inspectors within each SAO rotated through the position of duty inspector. Duty inspectors in an SAO were responsible for both reviewing the Critical Incident reports and complaints and determining whether an inspection was warranted, based on the information they received.

Sometime in 2011, managers in the Performance Improvement and Compliance Branch became concerned about the lack of consistency in how information was being triaged across the province, in part because of the different inspectors responsible for this process. At the time, no centralized training took place on how to triage information, and those responsible for training had little support. A decision was made to establish a centralized team that would be responsible for triaging all information for the province. This initiative would help ensure that information was triaged consistently, while freeing up inspectors in the SAOs to conduct inspections. This team came to be known as the Centralized Intake, Assessment and Triage Team (CIATT).

Before CIATT began its operations, Karin Fairchild,¹¹⁴ who was then a manager in Quality, Intake and Innovation at PICB, worked with nursing and dietary consultants to develop policies and processes. A decision was made that triage inspectors would need to be, at a minimum, registered practical nurses so that they could assess risk from a clinical perspective to determine how quickly an inspection should be carried out.

¹¹⁴ Ms. Fairchild is currently the manager of the Hamilton SAO.

CIATT began operating in late 2012. The initial opening was “soft,” with draft policies and no equipment. CIATT began to process Critical Incident reports in early 2013 and, in the spring of 2013, its staff included five triage inspectors and a manager. The team has expanded in the past five years and, as of the summer of 2018, included nine triage inspectors, an inspector team lead, and a manager.

Since it began, CIATT has been responsible for receiving, assessing, and triaging all complaints, Critical Incident reports, and the general information received by the Ministry about the care of residents in the province’s LTC homes. Each piece of information received about an LTC home becomes known as an “intake,” to be processed by CIATT. In 2013, CIATT’s first full year of operation, it received and triaged more than 30,000 intakes. By 2017, the number had increased to more than 40,000 intakes, including almost 4,000 complaints received via Service Ontario’s INFOLine.

Triage inspectors are responsible for reviewing all incoming information to determine if there is potential non-compliance with the LTCHA or the Regulation. As part of this process, the inspectors may request additional information from either the LTC home or, where possible, the complainant. If there is no possibility of non-compliance arising out of the intake, or if the intake involved a “non-reportable issue,” the intake will be closed. However, where triage inspectors review an intake that raises an issue with potential non-compliance, they will assign a “risk level” to the intake. The assigned risk level determines whether an inquiry or inspection is warranted, and when the inquiry or inspection should be initiated.

Initially, all intakes were assigned a level 1 through level 4 risk, but this system was changed in December 2016, when a level 3+ was added. Table 9.6 outlines the different risk levels assigned to intakes, definitions of those risk levels, the time frame assigned for initiating inspections, and examples of the types of issues that might be assigned to those risk levels.

Table 9.6: Triaging Information – Risk Levels

RISK LEVEL	DEFINITION	TIME FRAME FOR INSPECTION OR INQUIRY	TYPES OF ISSUES
Level 1 – minimum risk	A situation that has the potential to cause no more than minor negative impacts on residents and poses no (or a nominal) threat of ongoing risk of harm.	An inquiry within 90 days.* An inspection may be required after the inquiry is completed.	A complaint about missing resident clothing or clothing not labelled. Very few critical incidents would be assigned a level 1.
Level 2 – minimal harm or potential for actual harm	A situation that results in minimal discomfort to the resident and/or has the potential (not yet realized) to negatively affect the resident's ability to achieve his or her highest functional status and poses minimal threat of ongoing risk of harm.	An inquiry within 90 days. An inspection may be required after the inquiry is completed.	A complaint about unlabelled dentures or hearing aids. A Critical Incident report of resident-to-resident abuse resulting in minimal bruising.
Level 3 – actual harm / risk	A situation that results in an outcome that has negatively affected one or more residents' health, safety, or well-being, including the resident's ability to achieve his or her highest practical functional status, or where there is a pattern of incidents contributing to the harm / risk.	An inspection within 60 business days.	Intakes involve some type of harm; e.g., lacerations that require suturing, extensive bruising, or large skin tears. This is the most commonly assigned risk level for intakes.

RISK LEVEL	DEFINITION	TIME FRAME FOR INSPECTION OR INQUIRY	TYPES OF ISSUES
Level 3+ – significant actual harm / risk	A situation that results in an outcome that had a serious negative impact on one or more residents' health, quality of life, and/or safety, or that is creating a serious risk of significant actual harm / risk related to one or more residents' health, quality of life, and/or safety.	An inspection within 30 days.	Intakes typically involve more serious injuries, e.g., a previously mobile person has a hip fracture and is now bedbound. They could also involve matters with widespread effect; e.g., a home-wide heating problem leading to temperatures below 22°. Also includes Critical Incident reports of a "sudden or unexpected" death.
Level 4 – Immediate jeopardy / risk	A situation that places a resident or group of residents in immediate jeopardy as it has caused serious injury, harm, impairment, or death to a resident.	Immediate inspection required under s 25(2) of the LTCHA.	Intakes involving reports of a poisoning or a fire where residents had to be evacuated.

Source: Compiled by the Commission.

* As I heard at the public hearings, an inquiry involves gathering information – through contacting either the home or the complainant – to ensure compliance. It does not result in the production of a formal inspection report.

Once the intake has been triaged and assigned a risk level, CIATT emails an end-of-day report to each SAO, listing all intakes that have been triaged. It then becomes the responsibility of the inspection managers in the SAO¹¹⁵ to assign the intake to an inspector to conduct the inspection in the home. The inspection managers may also decide to change the risk level assigned to an intake. Once the intake is assigned, the inspector uses his or her clinical

¹¹⁵ Formerly known as inspector team leads.

judgment and experience to determine what to do about the intake. An inspector may decide that an intake marked for inquiry should be inspected or that an intake marked for inspection warrants only an inquiry. The inspector may also decide that the intake can be closed altogether, perhaps as a result of the receipt of new information about the intake.

Figures 9.6 and 9.7 show the ongoing increase in the number of both complaints and Critical Incident reports that CIATT has received. They also reveal that, although the majority of complaints are assigned for an inspection or inquiry, the opposite is true for Critical Incident reports. Most intakes of critical incidents end up being closed, with the triage inspectors determining that no further action is required.

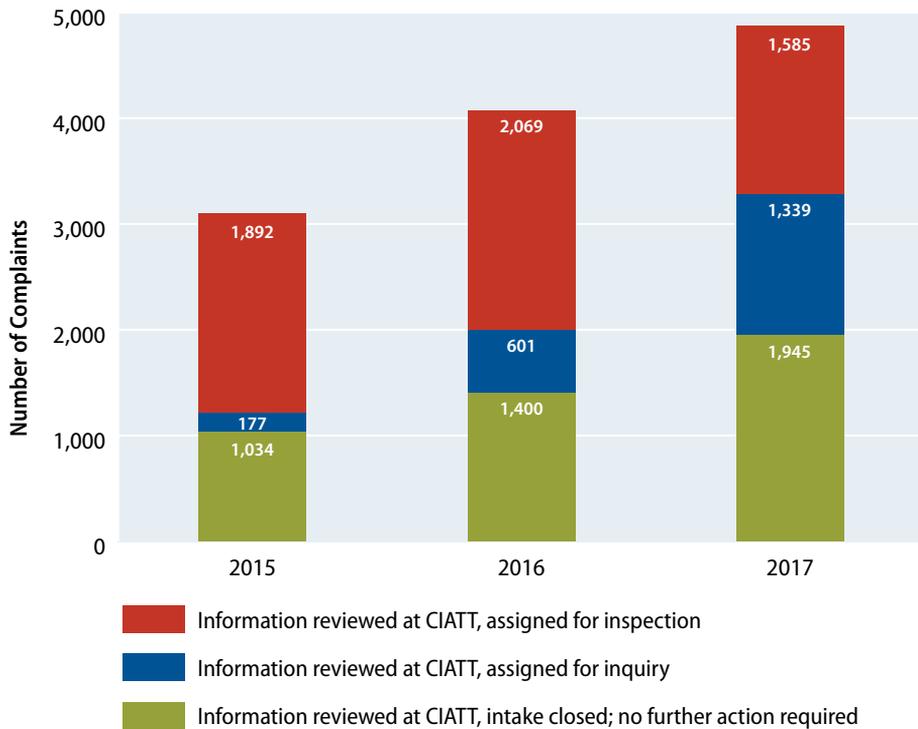


Figure 9.6: Number of Complaints Received at CIATT, 2015–17

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

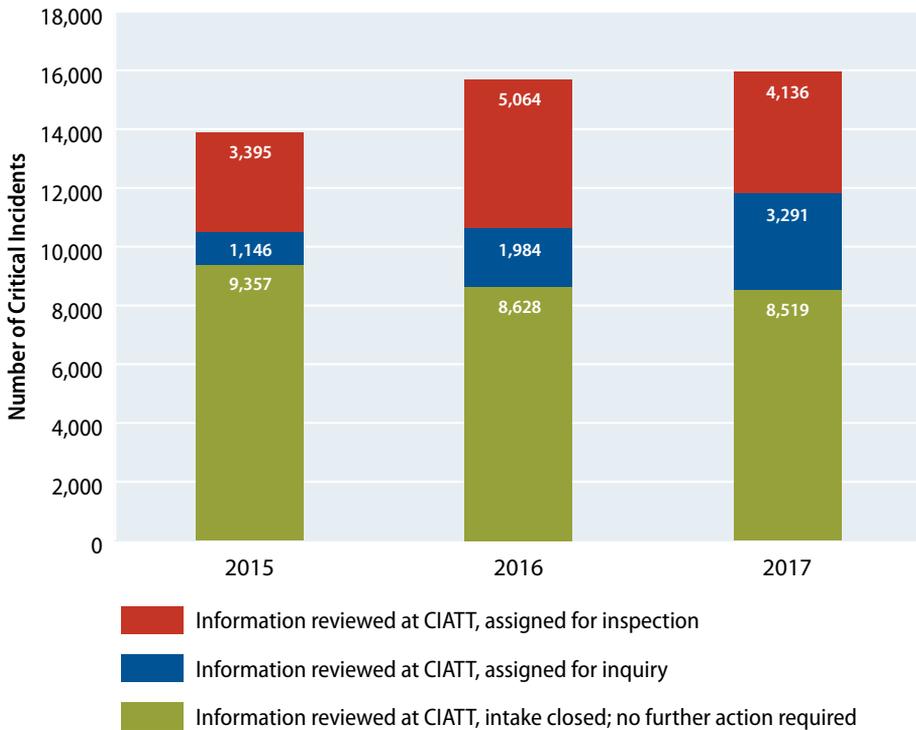


Figure 9.7: Number of Critical Incident Reports Received by CIATT, 2015–17

Source: Compiled by the Ministry for the public hearings, at the request of the Commission.

Along with the addition of the new level 3+ risk level, in 2016 and 2017, CIATT implemented a number of other changes involving policy and procedure, several of which were made in response to concerns raised by the Auditor General in her 2015 report on the Long-Term Care Home Quality Inspection Program (LQIP). For example, since October 2016, triage inspectors have been required to review intakes assigned a low-risk level and look for trends relating to both care issues (involving a review of a resident’s history) and operational issues (a review of the home’s history on a particular issue). Where an inspector identifies a trend – meaning three incidents within six months – the risk level assigned to the intake will be upgraded from the low level (1 or 2) to a level 3, changing it from an inquiry to an inspection. Where a trend is found, all intake numbers relating to it will be listed in the subject line of the intake in order to flag the identified trend for the inspection manager in the Service Area Office (SAO). According to the evidence at the public hearings, CIATT is not currently able to track trends in complaints or Critical Incident reports involving particular staff members.

CIATT began to audit intakes in 2017 to assess the appropriateness of having closed an intake and the rationale for assigning an intake to the SAO (in terms of both the assigned risk level and the identified area of possible non-compliance). Some 5% of all intakes – both those that are closed and those that are assigned for inquiry or inspection – are now audited. The inspector team lead at CIATT is responsible for those audits. If the auditing process reveals that an intake has been closed but should have been inspected, the intake will be reopened and then sent to the SAO for inspection. According to Ms. Simpson, of the intakes audited between January and September 2017, only 2% – or five intakes – were found to have been closed incorrectly.

4. CCF and RQI Inspections

Under the LTCHA inspection regime, there are two main types of inspections: Complaint, critical incident and follow-up (CCF) inspections and resident quality inspections (RQIs). CCF inspections are typically initiated by CIATT's review of an intake for a complaint or Critical Incident report; and RQIs are the comprehensive annual inspections conducted in all LTC homes. While all inspectors conduct both types of inspections, RQIs now account for most of the time spent carrying out inspections. One experienced inspector indicated that at least 80% of her inspection work is made up of RQIs.

RQIs were designed to provide an objective review of the entire operation of an LTC home, with no pre-existing concern about a particular problem. These inspections, which are intended to be proactive, involve examining issues more generally than can be achieved during a CCF inspection. An RQI is intended to identify systemic problems that might not otherwise be found in a CCF inspection. Unlike most stand-alone CCF inspections, RQIs tend to be done by a team of inspectors.

An RQI is a two-stage, resident-focused inspection. During stage 1, inspectors interview 40 randomly selected residents, families, and staff members; draw on RAI-MDS data; make observations of the home; and review clinical records and other documents. Once the stage 1 data collection is complete, the inspectors review the results and, based on the possibility of non-compliance, determine which issues – or care areas – require further inspection in stage 2. During each RQI, inspectors use certain mandatory inspection protocols setting out areas that must be inspected, regardless of whether the particular care area has triggered a need for further inspection. For example, inspectors complete the medication inspection protocol and the residents' council inspection protocol in every RQI. Other inspection protocols are inspected only if the particular issue has been triggered following stage 1. These include

the prevention of abuse, neglect, and retaliation inspection protocols; and the sufficient staffing inspection protocol. Inspectors may also initiate an inspection protocol if they believe there is a risk to residents or they have identified a trend, even if the issue did not trigger from stage 1.

Although the LTCHA came into effect on July 1, 2010, the first RQIs were not conducted until February and March 2011. RQIs were initially not conducted annually in every LTC home; as Ms. Simpson explained, “Given how intensive RQIs were, there was insufficient staff to do so.” In June 2013, the media directed significant attention to the fact that RQIs had not yet been completed in every LTC home in Ontario. On June 10, 2013, the Minister committed that every LTC home in the province would receive the RQI by the end of 2014 and that new inspectors would be hired for that program. This commitment led to the recruitment of a large number of new inspectors in late 2013 and into 2014. In addition to recruiting inspectors, the Performance Improvement and Compliance Branch worked to streamline the RQI process¹¹⁶ without compromising the methodology. Still, the standard RQI required 30 inspector days to complete (three inspectors, 10 inspection days), making the rollout into the more than 600 homes in the province an extremely resource-intensive exercise. RQIs were completed in every LTC home by the end of January 2015.

When inspectors were working to complete RQIs in all homes by the end of 2014, CIATT experienced an increase in the number of Critical Incident reports and complaints it received. The focus on completing RQIs made it difficult for the incidents and complaints to be inspected in a timely manner and led to an increasing backlog. Most of the inspectors who testified during the public hearings agreed that, while they tried to work within the targeted time frames for inspections for the more serious issues, it was not always possible to do so.

In December 2015, when the Auditor General tabled her annual report, including her audit of LQIP, she found that the backlog of complaints and Critical Incident reports had more than doubled in the period that saw the Ministry prioritize the completion of RQIs. The Auditor General recommended that the Ministry take steps to improve the timeliness of CCF inspections; to better track and prioritize them; to attempt to focus on high-risk areas; and to prioritize RQIs according to risk factors such as compliance history, complaints about a home, and critical incidents.

In response to the concerns raised in the Auditor General’s report and the recognized need to address the ever-increasing number of pending

¹¹⁶ The streamlining involved having administrative staff prepare the necessary documentation before the RQI and developing new thresholds for smaller LTC homes.

complaints and critical incidents that had not been inspected, the branch returned to Nursing Home Quality (which had developed the initial RQI methodology) to determine whether it would be possible to conduct more risk-focused RQIs in homes that were performing well – that is, those that had no significant compliance issues. Nursing Home Quality prepared a report for the Inspections Branch and determined that, for homes performing well, the resident sample could be reduced from 40 (the number required in the original RQIs) to 20, and that fewer care areas could be inspected.

As a result of these consultations, in the fall of 2016 the Inspections Branch rolled out a new “risk-focused” RQI for well-performing homes. The new risk-focused RQI is shorter and targets high-risk issues. It begins with a sample of 20 residents in stage 1 and has different thresholds for triggering through to inspections of care areas in stage 2. The risk-focused RQI also has fewer overall mandatory inspection protocols to follow. It requires a total of 10 inspector days (two inspectors, five days) to complete.

A home that the Ministry identifies as “higher risk” continues to receive the original RQI, now known as the intensive RQI. Low-risk homes receive the risk-focused RQI. All low-risk homes are still to receive an intensive RQI once every three years. The risk level of homes is determined according to the Ministry’s LQIP performance assessment, discussed below.

Table 9.7 outlines the key differences between the risk-focused RQI and the original RQI, now known as the intensive RQI.

In an attempt to respond to the Auditor General’s concerns and increase efficiencies in the inspection process, the Inspections Branch has, in recent years, implemented other procedural changes. For example, inspectors are encouraged to “bundle” Critical Incident reports involving similar issues in a home.¹¹⁷ Inspectors also bring with them outstanding Critical Incident reports or complaint intakes when completing an RQI in a home.¹¹⁸ According to Ms. Simpson’s evidence at the public hearings, in 2016, inspectors brought an average of eight intakes to complete during an annual RQI. This means that any findings of non-compliance issued against a home following an RQI may have stemmed from complaints and Critical Incident reports, and not from the other more general issues examined in the RQI. Inspectors do not prepare separate inspection reports for the CCF issues inspected during RQIs.

¹¹⁷ The exception is for reports of suspected abuse; each such report must be inspected separately.

¹¹⁸ The policy change allowing CIATT to assign lower risk intakes for inquiry (as opposed to an inspection) was also targeted at reducing the backlog of intakes in the SAOs.

Table 9.7: Comparison Between Risk-Focused and Original (Now Known as Intensive) RQIs

ORIGINAL (INTENSIVE) RQI	RISK-FOCUSED RQIs
Random sample of 40 residents	Random Sample of 20 residents
5 Mandatory Inspection Protocols <ul style="list-style-type: none"> • Dining observation • Family council interview • Infection prevention and control • Medication • Residents' council interview 	4 Mandatory Inspection Protocols <ul style="list-style-type: none"> • No dining observation
21 Triggered Care Areas <ul style="list-style-type: none"> • Accommodation services – Housekeeping • Accommodation services – Laundry • Accommodation services – Maintenance • Critical incident response • Food quality • Reporting and complaints • Safe and secure home • Snack observation • Trust accounts • Continence care and bowel management • Dignity, choice, and privacy • Falls prevention • Hospitalization and change in condition • Minimizing of restraining • Nutrition and hydration • Pain • Personal support services • Prevention of abuse, neglect, and retaliation • Recreation and social activities • Responsive behaviours • Skin and wound care 	9 Triggered Care Areas <ul style="list-style-type: none"> • Accommodation services – Housekeeping • Continence care and bowel management • Dignity, choice, and privacy • Falls prevention • Minimizing of restraining • Nutrition and hydration • Pain • Prevention of abuse, neglect, and retaliation • Skin and wound care

Source: Compiled by the Commission.

5. Assigning Risk and Performance Levels to LTC Homes

In 2011, not long after the LTCHA came into force, the Director began asking whether it would be possible to develop a methodology, based on existing data, to assess risk in LTC homes. Philip Moorman, PICB's appeals specialist and programs consultant, was responsible for developing the risk assessment framework. He testified at the public hearings that the development of a risk management framework was a key part of the Compliance Transformation Project undertaken by the Director at that time.

Although there had been some consultation with external stakeholders before his involvement, Mr. Moorman did not personally consult with anyone outside the Ministry; his consultations were with internal technical and statistical experts. In developing the risk assessment framework, the Ministry wanted to draw on data that were specific enough to represent an area of risk; reliable, meaning consistently measuring the same thing; and valid, in that the data were actually measuring risk.

a) Data Elements in the LRPA

Ultimately, the risk assessment model chosen was primarily based on an LTC home's compliance history. As Mr. Moorman explained in his evidence, the data were readily available and a home's history of compliance is seen as an indicator of how it will do in the future. The framework also drew on several data elements from RAI-MDS which had previously been identified as valid indicators of risk in LTC homes. When developing the model, Mr. Moorman consulted regularly with members of the Health Analytics Branch – the Ministry's technical experts in statistics and data analysis. This branch helped determine the appropriate data elements, the algorithm for calculating the overall scores for each home, the weighting of certain data, and the appropriate thresholds for various risk levels.

The first version of the risk assessment framework, which was known as the Long-Term Care Homes Quality Inspection Program (LQIP) Risk and Performance Assessment, was produced in November 2013. It drew on four sets of data, including compliance and inspection data, RAI-MDS data, the Long-Term Care Home Service Accountability Agreement (LSAA) compliance report, and qualitative data. Table 9.8, set out below, shows the details of the data elements contained within each data set. All four data sets continue to be used in today's version of the LQIP performance assessment.

A two-step process is used to produce the quarterly LQIP Risk and Performance Assessment reports. As part of the first step, the compliance and RAI-MDS data are converted from raw scores into percentiles, leading to a home's ranking in relation to others in the province. These percentiles are then used to create an overall score for each home, which, in the first version of the model, was the median of the individual percentile scores. The overall score is then used to determine the home's initial risk level under the LQIP Risk and Performance Assessment. In the first version of the model, level 1 homes, which were known as "substantially compliant," were those that fell below the 70th percentile. Level 2 homes, which were "non-compliant – risk level moderate," were those between the 70th and 85th percentiles. Level 3 homes, which were "non-compliant – risk level high," fell above the 85th percentile.¹¹⁹

During the second step, a home's risk level could be manually adjusted based on the information in the next two sets of data: the LSAA compliance report, and qualitative data from the SAOs. For example, a home that was known as a level 1 risk – but where qualitative concerns were raised in the SAO – might see its risk level moved to a level 2 (or even a level 3). Homes that were going to have their licence revoked could be placed in level 4, known as "revocation." In his evidence at the public hearings, Mr. Moorman acknowledged that very few homes had their risk levels changed as a result of the LSAA compliance reports. Only about five or six homes in any given quarter were "chronically non-compliant" on LSAA compliance reports.

According to Mr. Moorman's testimony, the majority of LTC homes – consistently about 85% of homes – fall into level 1. Roughly 10% of homes are level 2, and the remaining 4 to 5% fall into level 3.

The LQIP Risk and Performance Assessment has been modified five times since the first version was produced. The second version, which was produced in September 2015, added two compliance data elements from RQIs. This version also moved from using a median score to produce the overall score, to basing the score on an average. This change was made in consultation with the Health Analytics Branch.

¹¹⁹ Level 3 homes were grouped into two categories until December 2017. Homes were ranked as a level 3, category 1, based on their overall score and/or significant concerns that were raised under qualitative data. If these homes also had a history of not complying with Director's orders, were subject to a mandatory management order, or demonstrated an unwillingness or inability to comply with the LTCHA or its Regulation, they were put into level 3, category 2.

The LQIP Risk and Performance Assessment was next modified in March 2016, when the period from which the compliance data were drawn was expanded from 12 to 18 months. The thresholds for the four risk levels were adjusted in light of the RQI data. Level 1 – substantially compliant homes – were those that fell below the 65th percentile. Level 2 homes were those between the 65th and 80th percentiles. Level 3 homes had a score above the 80th percentile. The June 2016 Risk and Performance Assessment had minor formatting changes only. Starting in September 2016, the risk-focused RQI was conducted in all LTC homes classified as a level 1 risk. Level 2 or 3 homes continued to receive the intensive risk-focused RQI.

The fourth version of the risk assessment model was produced in September 2017. The only change at that time was the model's name. It came to be known as the LQIP Performance Assessment, and what had been known as the "risk levels" became "performance levels" of homes, at the request of management in the Inspections Branch. The fifth (and current) version of the LQIP Performance Assessment was produced in December 2017, when the names associated with each performance level were modified to reflect plain language. This change was made in anticipation of the information being made publicly available, which ultimately took place in the spring of 2018. Level 1 homes are now known as homes "in good standing"; level 2 homes as "improvement required"; and level 3 homes as "significant improvement required." Level 4 homes are known as "licence revoked."

Table 9.8 summarizes the changes that have been made to the LQIP Risk and Performance Assessment since its first incarnation in November 2013.

Since the fall of 2016, homes that are classified as level 1 receive a "risk-focused" RQI. These homes will receive the intensive risk-focused RQI once every three years. Homes that are classified as level 2 or 3 receive the intensive risk-focused RQI.

Table 9.8: Changes to the LQIP Risk and Performance Assessment, November 2013–December 2017

LQIP RISK AND PERFORMANCE ASSESSMENT		
VERSION	DATA ELEMENTS	RISK LEVELS
November 2013	<p>Compliance and Inspection Data – 12-month period</p> <ul style="list-style-type: none"> • Number of inspections • Number of findings of non-compliance • Number of orders • Number of complaint inspections leading to findings of non-compliance • Number of Critical Incident report inspections leading to findings of non-compliance <p>RAI-MDS Data – 3-month period</p> <ul style="list-style-type: none"> • Incidence of worsening pressure ulcers • Incidence of worsening pain • Incidence of worsening behaviour <p>LSAA Compliance Report – 36-month period</p> <p>The LSAA Report identifies homes with two consecutive orders in any of the following high-risk areas as “chronically non-compliant”:</p> <ul style="list-style-type: none"> • Injury that results in transfer or admission to hospital • Medication incidents • Missing resident • Environmental hazards • Infection control • Alleged or actual abuse / assault • Pressure ulcers • Presence of daily restraints • Weight loss management • Continence care and bowel management • Falls • Behavioural symptoms affecting others <p>Qualitative Data</p> <ul style="list-style-type: none"> • Information from SAOs, banks, suppliers, or other creditors that raises concerns about the home’s operations • Could identify high management turnover 	<p>Level 1 – below the 70th percentile – substantially compliant</p> <p>Level 2 – between the 70th and 85th percentiles – non-compliant – risk level moderate</p> <p>Level 3 – Above the 85th percentile – non-compliant – risk level high</p> <p>Level 4 – revocation</p>

continued

LQIP RISK AND PERFORMANCE ASSESSMENT		
VERSION	DATA ELEMENTS	RISK LEVELS
September 2015	As above but with RQI data added to the compliance and inspection data: <ul style="list-style-type: none"> • Number of RQI non-compliances • Number of RQI orders 	No change
March 2016	Data period for compliance and inspection data is increased to previous 18 months	Modified to reflect the addition of RQI data Level 1 – homes below the 65th percentile – “compliant or substantially compliant” Level 2 – Homes between the 65th and 80th percentiles – “compliant – risk level moderate” Level 3 – Homes above the 80th percentile – non-compliant – high-risk level Level 4 – revocation
June 2016	Formatting changes to presentation of data only	No change
September 2017	Change in name to LQIP Performance Assessment	Changed the word “risk” to “performance” when describing the home’s level.
December 2017	No changes	Labels attached to different levels change, but the percentile cut-offs for each “performance” level do not. Level 1 – “in good standing” Level 2 – “improvement required” Level 3 – “significant improvement required” Level 4 – “licence revoked”

Source: Compiled by the Commission.

b) Limitations of the LQIP Risk and Performance Assessment

Despite the many efforts made to improve and refine the Risk and Performance Assessment model, Mr. Moorman agreed that it was not without limitations. He emphasized that he believed the model is sufficiently robust to help distinguish homes that are substantially compliant with the requirements of the LTCHA from those struggling with compliance, but acknowledged there were some limitations, including:

- there may be some double-counting in the model because it includes total number of findings of non-compliance (in both RQI and CCF inspections), as well as the number of non-compliances arising out of complaint inspections and the number of non-compliances arising out of Critical Incident report inspections;
- the model includes all findings of non-compliance and does not distinguish between high- or low-risk areas where there has been non-compliance;
- there is no attempt to weight the data to account for the size of the home (i.e., to account for a greater number of inspections that might be carried out in larger homes);
- the model does not account for the fact that multiple intakes are now being brought along to each inspection, possibly affecting the validity of the data for “number of inspections” or for “non-compliances arising out of RQIs” (when the non-compliance may stem from a complaint intake inspected as part of the RQI);¹²⁰
- there is a data lag of three months before the report is produced; the Risk and Performance Assessment reports provide a snapshot of how an LTC home is doing at a particular point in time; and
- the model is based on reporting of events from a home. If a home is not reporting critical incidents and, thus, there are no inspections done in respect of them, this might impact on the home’s risk assessment.¹²¹

¹²⁰ Mr. Moorman suggested that since this practice is followed in all regions across the province, it should have a similar effect on the risk assessment across all homes.

¹²¹ Although Mr. Moorman acknowledged this limitation was a possibility, he also opined that, given the broad range of data elements in the model, it would not likely have a significant impact on risk assessment.

Mr. Moorman testified that the Inspections Branch remained committed to improving the LQIP Performance Assessment model. In his view, it was useful to consult experts about how they might broaden the data sets they use; as an example, the branch had discussed including more RAI-MDS data and, potentially, financial data. He specifically advised that he hoped the next version would allow for weighting of the compliance data so that high- and low-risk orders could be treated differently. Finally, he suggested that he would like to see greater automation of the report generation so that the branch could engage in more sophisticated trend analysis.

c) Public Sharing of LQIP Performance Assessment Results

Since mid-April 2018, the LQIP Performance Assessment levels for every LTC home in the province have been publicly available on the Ministry's website. The information was not made public earlier because it had been developed for internal use, and homes had not been informed of their risk level or of the methodology underlying the risk levels. Although the Director testified at the hearings that she is in favour of transparency, she has some reservations about publishing LQIP Performance Assessment results that may not reflect the current state of a home. A home's status can change quickly – for better or for worse. Such changes are not immediately reflected in LQIP Performance Assessment ratings based, as they are in part, on the RAI-MDS data that are about four to five months out of date by the time the Ministry receives them.

RECOMMENDATIONS

Note: Most of the recommendations in Chapter 15 are also directed at the Ministry of Health and Long-Term Care.

Recommendation 19: The Ministry of Health and Long-Term Care must expand the funding parameters of the nursing and personal care envelope to permit long-term care homes to use these funds to pay for a broader spectrum of staff, including porters, pharmacists, and pharmacy technicians.

Rationale for Recommendation 19

- Giving long-term care homes the flexibility to use the nursing and personal care envelope for other staff will enable homes to engage the mix of staff best suited to the needs of their residents. It will enable the homes to make better use of their staff, relieving nurses of duties that others can provide (e.g., portering of residents and medication reconciliations).

Recommendation 20: The Ministry of Health and Long-Term Care should encourage, recognize, and financially reward long-term care homes that have demonstrated improvements in the wellness and quality of life of their residents.

Rationale for Recommendation 20

- Under the current funding model, there is no incentive for long-term care (LTC) homes to seek to improve the health status of their residents. Instead, homes that have residents with more acute health problems (as measured through the Case Mix Index), will receive more funding in their nursing and personal care envelopes. Although there are good reasons to provide homes with additional funding to address the complex health needs of more acutely ill residents, there must also be incentives to promote wellness in homes. The Ministry of Health and Long-Term Care (Ministry) should implement incentives for homes to improve resident health and quality of life. Incentives should include public recognition of homes that do this successfully, as well as financial rewards for demonstrated improvements in resident wellness and quality of life.

Recommendation 21: The Ministry of Health and Long-Term Care (Ministry) should create a new, permanent funding envelope for long-term care (LTC) homes to fund training, education, and professional development for all those providing care to residents in LTC homes. The Ministry should permit LTC homes to use the funding envelope for, among other things:

- costs of staffing the shifts of those away on training;
- stipends for staff completing training that requires a leave of absence;
- course fees;
- development of training materials; and
- costs of annual membership fees associated with joining organizations such as the Ontario Long Term Care Association and AdvantAge Ontario.

Details

- The new training funding envelope should be available for a variety of training and educational opportunities, including but not limited to:
 - gerontology and elder care;
 - the legislative and regulatory requirements of the *Long-Term Care Homes Act, 2007* (LTCHA), and the Regulation;
 - mandatory training required by the LTCHA, section 76;
 - the prevention of abuse and neglect;
 - reporting obligations;
 - whistle-blowing protections;
 - residents' councils;
 - the Residents' Bill of Rights;
 - training for medical directors on their responsibilities under the LTCHA and for their attendance at the medical director course offered by the Ontario Long Term Care Clinicians; and
 - developing training materials as needed, including on the healthcare serial killer phenomenon.

- The funding parameters must be sufficiently flexible to allow homes to use the training funding envelope to pay for the costs of training itself (such as course registration fees, expenses associated with bringing in outside speakers, and membership fees for organizations that provide training), and also to cover the costs of replacing staff members who are away on training or providing stipends to staff so they are able to complete the training.

Rationale for Recommendation 21

- Evidence shows there has been insufficient training of management and staff in homes on a range of issues that impact resident safety and security, including the prevention of abuse and neglect, mandatory reporting obligations under the LTCHA, and residents' rights.
- Homes need a permanent and sustained source of funding to ensure that staff and management receive the necessary training.
- Homes should not have to use the existing limited funds in envelopes to cover this training.

Recommendation 22: The Ontario government must repeal that part of section 222(3) of Ontario Regulation 79/10 which exempts licensees from ensuring that medical directors and nurse practitioners (registered nurses in the Extended Class) receive the training required of direct care staff under section 76(7) of the *Long-Term Care Homes Act, 2007* (LTCHA). Section 76(7) of the LTCHA requires that staff providing direct care to residents undergo training on topics such as abuse recognition and prevention, mental health issues, and behaviour management.

Recommendation 23: The Ministry of Health and Long-Term Care must develop a public awareness campaign to educate and raise awareness of those who work, volunteer, or visit family and friends in long-term care homes about their reporting obligations under section 24(1) of the *Long-Term Care Homes Act, 2007* (LTCHA). Section 24(1) of the LTCHA requires that any person who has reasonable grounds to suspect improper or incompetent treatment or care, or the abuse or neglect of residents (among other things), must report his or her suspicion and the information on which it is based to the Director (a position created by the LTCHA and filled by a person in the Ministry) and not simply to management in the home.

Rationale for Recommendation 23

- Although the reporting obligation in section 24(1) of the *Long-Term Care Homes Act, 2007*, applies to all persons, except residents, it is not well understood. A public awareness campaign will raise awareness of this obligation for all who spend time in long-term care homes, including volunteers, and residents' families and friends. This should lead to better reporting about suspected abuse, neglect, and improper or incompetent treatment in the homes.

Recommendation 24: The Minister of Health and Long-Term Care should issue a policy directive to clarify the meaning of "reasonable grounds" and "improper or incompetent treatment" in section 24(1).

Rationale for Recommendation 24

- To fulfill its oversight responsibilities, the Ministry of Health and Long-Term Care (Ministry) depends on LTC homes to make the required section 24 reports about suspected abuse, neglect, and improper and incompetent treatment of residents. To ensure that the Ministry receives these reports, it must educate those who work in the homes about the mandatory reporting obligations under section 24 of the *Long-Term Care Homes Act, 2007*.
- Evidence at the public hearings showed that there is confusion about the meaning of "reasonable grounds" and "incompetent and improper treatment" in subsection 24(1). The meanings of these terms must be clarified so that all persons can properly fulfill their reporting obligations under section 24.

Recommendation 25: The Ministry of Health and Long-Term Care (Ministry)'s Long-Term Care Home Quality Inspection Program (LQIP) has been assigning risk or performance levels to long-term care homes since 2013, based primarily on data from Ministry inspections. The Ministry should refine its LQIP Performance Assessment to better identify homes struggling to provide a safe and secure environment for residents by giving more weight to findings of non-compliance relating to high-risk areas for residents than to findings of non-compliance less likely to impact resident safety or security. For example, a finding of non-compliance for failing to report suspected abuse or neglect is more significant than a finding of non-compliance for failing to ensure that planned menu items are available at each meal and snack.

Rationale for Recommendation 25

- Although the Long-Term Care Home Quality Inspection Program (LQIP) Performance Assessment provides a snapshot of homes with ongoing compliance problems, it fails to differentiate between “high-risk” and relatively “low-risk” non-compliance, making it more difficult to identify those homes where there may be a real risk to resident safety and security that requires immediate intervention. It currently incorporates just three data elements from the Resident Assessment Instrument–Minimum Data Set (RAI-MDS): worsening pressure ulcers, worsening pain, and worsening behaviour. Other RAI-MDS data may help identify resident safety concerns, such as increased use of restraints or increased number of falls. LQIP Performance Assessment reports could be compared with data on the homes – including those homes that have been identified as having higher than expected mortality rates, and trends concerning compliance difficulties in a particular home – both to help prioritize inspections and to identify homes that may need assistance in attaining compliance.

Recommendation 26: Those responsible for coordinating and conducting inspections at the Ministry of Health and Long-Term Care should ensure that all Critical Incident reports and complaints relating to high-risk incidents are given the highest priority and inspected as quickly as possible to ensure that any ongoing risk to residents is immediately remedied.

Recommendation 27: Those responsible for coordinating and conducting inspections at the Ministry of Health and Long-Term Care should draw on the following when establishing inspection priorities:

- the Long-Term Care Home Quality Inspection Program Performance Assessments; and
- data produced by the Information Management, Data and Analytics Branch showing homes with higher than expected mortality rates.

Rationale for Recommendation 27

- Drawing on previous Long-Term Care Home Quality Inspection Program Performance Assessments and data produced by the Information Management, Data and Analytics Branch may help inspectors identify homes that are struggling to achieve compliance with the *Long-Term Care Homes Act, 2007*, or other concerns that require immediate inspection and support.

Recommendation 28: The Ministry of Health and Long-Term Care should review the Long-Term Care Home Quality Inspection Program Performance Assessment results to identify long-term care homes struggling to provide a safe and secure environment for their residents. Where a home has fallen below level 1 performance for two consecutive quarters, the Long-Term Care Homes Division should take action to assist that home in returning to the level 1 classification.

Recommendation 29: When a finding of non-compliance has been issued to a licensee for failing to report as required by section 24(1) of the *Long-Term Care Homes Act, 2007*, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections in long-term care homes should ensure that the next resident quality inspection (RQI) conducted in that home is the intensive RQI, regardless of the performance level assigned to the home.

Rationale for Recommendations 28–29

- The Ministry of Health and Long-Term Care (Ministry) depends on long-term care (LTC) homes to submit mandatory section 24 reports about suspected abuse, neglect, and improper and incompetent treatment of residents. When homes fail to report, the Ministry is not able to fulfill its oversight obligation. If a licensee fails to comply with the section 24 reporting obligation, the Ministry should conduct the most comprehensive annual inspection – the intensive resident quality inspection – in the LTC home during the next such inspection. This inspection will help ensure that resident safety issues are identified.

Recommendation 30: Before beginning an inspection involving either missing narcotics or allegations of staff-to-resident abuse, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections should ensure that the assigned inspector reviews previous Critical Incident reports to determine whether the staff member involved in those incidents is named in earlier reports.

Rationale for Recommendation 30

- This practice should enable inspectors to identify ongoing problems concerning a particular staff member, even if staff move between homes.

Recommendation 31: The Ministry of Health and Long-Term Care should establish a formal communications policy and process to ensure that its inspectors share relevant information with the College of Nurses of Ontario (College) about members of the College who may pose a risk of harm to residents.

Rationale for Recommendation 31

- Informal communication channels between the College of Nurses of Ontario (College) and the Ministry of Health and Long-Term Care (Ministry) exist, but a formal method for sharing information, particularly on matters relating to resident safety, should be established.
- Ministry inspectors (many of whom are registered nurses and thus members of the College) may learn of home staff (or former staff) whose conduct poses a risk of harm to residents. If that staff person is a member of the College, this policy will provide a mechanism for inspectors to share relevant information with the College so that the College can take appropriate steps to protect resident safety.

The Ministry of Health and Long-Term Care's Oversight of Caressant Care (Woodstock), Meadow Park (London), and Telfer Place

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I. Introduction

In this chapter, I explore the oversight of the Ministry of Health and Long-Term Care (Ministry) of the three long-term care (LTC) homes in which Wettlaufer committed 13 of the 14 Offences:¹ Caressant Care Nursing Home (Woodstock); Meadow Park Nursing Home (London); and Telfer Place Long-Term Care Facility. The Ministry had regular interactions with these three homes during the relevant periods – both indirectly (through funding and licensing) and directly (through the regulatory compliance and enforcement requirements governing the homes). Despite the Ministry's various lines of sight into these three homes, it had no information that suggested that Wettlaufer was intentionally harming residents – let alone that she was a serial killer. Indeed, all three homes were known by the Ministry to be performing well, and all demonstrated substantial compliance with their obligations under the governing legislation and funding agreements.

In what follows, I summarize the Ministry's oversight of each home during the periods in which Wettlaufer worked in them. I begin with Caressant Care (Woodstock), where she worked from June 2007 through March 2014. In that period, Wettlaufer committed 11 of the 14 Offences, including the murder of seven residents. During this period, the *Long-Term Care Homes Act, 2007* (LTCHA),² and Ontario Regulation 79/10 (Regulation) came into effect. Under the new regime, fundamental changes were made to the Ministry's oversight of LTC homes, through a new inspection process and new reporting obligations on the part of the homes. Although the Ministry received a few Critical Incident reports from Caressant Care (Woodstock) which involved Wettlaufer, including an incident involving missing narcotics and an allegation that Wettlaufer had abused a resident, none raised red flags about what was happening in the home.

In the following section, I consider the Ministry's oversight of Meadow Park (London) in the brief period that Wettlaufer worked there, from April through October 2014. During this time, the Ministry received a few Critical Incident reports from the home, including one relating to allegations that a staff member (not Wettlaufer) abused Arpad Horvath, one of Wettlaufer's

¹ Wettlaufer committed the last Offence while providing nursing care to an individual in her own home.

² SO 2007, c 8.

victims. The Ministry also received a Critical Incident report from Meadow Park (London) involving missing narcotics, which management at the home believed Wettlaufer had taken. This report resulted in an inspection after Wettlaufer had resigned from the home, but it did not lead to any significant concerns on the part of the Ministry inspector.

In the last section of this chapter, I examine the Ministry's oversight of Telfer Place in the period January 2015 to April 2016, when Wettlaufer worked at the home as an agency nurse. Rather than being employed directly by Telfer Place, Wettlaufer was employed by Life Guard Homecare Inc., an agency that supplied temporary staff to LTC homes and other facilities. During the period that Life Guard assigned Wettlaufer to work at Telfer Place, the Ministry received a few complaints about staffing at Telfer Place, but no concerns specific to Wettlaufer were raised.

II. Ministry Oversight of Caressant Care (Woodstock)

In late June 2007, when Wettlaufer began working at Caressant Care (Woodstock), it was a for-profit nursing home, subject to the requirements of the *Nursing Homes Act* (NHA) and its regulations.³ The Ministry oversaw it both indirectly and directly – through its funding agreement; by virtue of the licence issued to it by the Director under the NHA; and through the reporting requirements imposed by the NHA, its regulations, and the *Long-Term Care Homes Program Manual* (Program Manual).

On July 1, 2010, the LTCHA and the Regulation came into effect. Although this did not alter the funding arrangement for Caressant Care (Woodstock), it changed the nature of the licensing regime,⁴ the obligations imposed on the home (including some of the reporting requirements), and the nature of the inspection regime.

³ RSO 1990, c N 7; RRO 1990, Reg 832.

⁴ The most significant change was that the licence under the LTCHA did not require an annual renewal.

A. Funding Through the Long-Term Care Home Service Accountability Agreement

When Wettlaufer began working at Caressant Care (Woodstock) in June 2007, the South West Local Health Integration Network (LHIN) was responsible for administering the funding for the home's daily operations. The Ministry remained responsible for establishing funding policies, including determining the per diem rate for approved and licensed beds, as well as the rates in each of the four funding envelopes which are identified and discussed in Chapter 9. The relationship between the South West LHIN and Caressant Care (Woodstock) was governed by the Long-Term Care Home Service Accountability Agreement (LSAA), a contract between the home and the LHIN.⁵

The South West LHIN periodically advised the administrator of Caressant Care (Woodstock) about funding the home would receive for specific initiatives, such as creating new registered staff and personal support worker (PSW) positions; or increasing the various level-of-care envelopes that formed the core of the home's funding. On July 22, 2010, shortly after the LTCHA and the Regulation came into effect, the South West LHIN sent a memorandum to all LTC home administrators advising of per diem funding increases, which included funding to assist in the implementation of the LTCHA and the Regulation.

B. Licensing of Caressant Care (Woodstock)

In June 2007, Caressant Care (Woodstock) was licensed to operate 155 beds and four interim beds. In May 2009, the home was approved to operate four additional interim beds, for a total of 163 beds, of which eight were interim. On July 1, 2010, when the LTCHA came into effect, the Director (a position created by the LTCHA and filled by a person in the Ministry) under the Act issued a replacement licence allowing Caressant Care (Woodstock) to continue to operate its 155 beds. At the same time, the Director issued two temporary licences allowing the home to continue to operate its eight interim beds. For the balance of the time that Wettlaufer worked at Caressant Care (Woodstock), the home was licensed to operate a total of 163 beds, including the eight interim beds.

⁵ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received Royal Assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC System, including Ontario Health.

C. Oversight by London SAO Compliance Advisors: June 2007 to June 30, 2010

Caessant Care (Woodstock) fell under the jurisdiction of the Ministry's London Service Area Office (SAO) for the entire time that Wettlaufer worked there. Under the NHA regime (which was in effect until July 1, 2010), compliance advisors in the London SAO were responsible for reviewing all information received about Caessant Care (Woodstock), including unusual occurrence reports and complaints. After reviewing the information, they would determine whether a review was required. If they decided a review was required, they would then conduct the inspection. Compliance advisors would also provide advice to the homes, when asked.

Between 2007 and 2010, there were 15 compliance advisors working out of the London SAO. At that time – and until the LTCHA came into effect – compliance advisors were assigned to specific homes. Each inspector was typically responsible for between 12 and 15 homes.

In what follows, I review the reports and complaints the London SAO received about Caessant Care (Woodstock) during the period Wettlaufer worked in the home. Because the LTCHA came into effect on July 1, 2010, and changed the regulatory regime, I review the periods pre and post July 1, 2010, separately.⁶ The discussion throughout is focused on the reports and complaints most relevant to the Inquiry mandate: those about possible abuse or improper or incompetent treatment; unusual or unexpected deaths; missing or misappropriated drugs; injuries or medication errors that resulted in a resident's transfer to hospital; and concerns about insufficient staffing in the home. I also discuss some of the incidents that we now know happened during this period, which went unreported.

⁶ Reports prepared following reviews under the NHA were not released publicly. All reports relating to reviews at Caessant Care (Woodstock) from before July 1, 2010, are summarized in the *Ministry of Health and Long-Term Care Overview Report*, which was prepared by Commission counsel and filed as an exhibit at the beginning of the public hearings. The source documents (including all inspection materials) for the Overview Report are available at: <https://longtermcareinquiry.ca/en/exhibits/>. Starting July 1, 2010, copies of all inspection reports (and any orders issued) are now posted by the Ministry at <http://publicreporting.ltchomes.net/en-ca> by name of home.

1. Unusual Occurrence Reports and Reviews Conducted: June 2007 to June 30, 2010

Between June 2007 and June 30, 2010, Caressant Care (Woodstock) submitted a total of 10 unusual occurrence reports to the Ministry. Despite being referred to as “unusual occurrences” in the Program Manual, at some point in 2008 these reports became known as Critical Incident reports. The Ministry received five such reports in 2007, three in 2008, and two in 2009. Almost all the reports resulted in a review being conducted at Caressant Care (Woodstock), often within a week of the reports having been sent to the Ministry. The only two incidents not inspected were one that involved stolen medications, and one in which there was resident abuse of a staff member. Wettlaufer was the recipient of the resident abuse.

Although Wettlaufer was mentioned in several of the reports, none raised any red flags about her treatment or care of residents. Nothing in the information that the Ministry received from, or about, the home, or that the compliance advisors learned during their reviews in the home, suggested that any staff member at Caressant Care (Woodstock) was intentionally harming residents.

2007

In July and August 2007, Caressant Care (Woodstock) submitted five separate unusual occurrence reports, each of which involved a resident who had suffered an injury resulting in a transfer to hospital.⁷ The report filed on August 2, 2007, concerned James Silcox, the first resident whom Wettlaufer killed. According to the report, Mr. Silcox had fallen when climbing out of bed. Wettlaufer was not mentioned in this report. The next report, filed August 5, 2007, indicated that a resident had fallen and was found lying next to her bed. The report noted that Wettlaufer was the registered nurse who conducted the post-fall assessment.

On August 9, 2007 – two days after receiving the fifth unusual occurrence report about falls in the July–August period – a compliance advisor attended Caressant Care (Woodstock) to complete an unusual occurrence review. She had trouble matching residents’ progress notes with notes concerning their post-fall assessments and issued a finding of unmet standards for failing to keep all documentation in residents’ health records current, complete, accurate, and legible. The home prepared a plan of corrective action, which the Ministry accepted. Wettlaufer is not mentioned in the notes from the review.

⁷ Most of the injuries were the result of falls. However, in one case, when the resident was being moved in her wheelchair, her foot got caught under the chair, resulting in a fractured femur.

2008

Caessant Care (Woodstock) submitted three Critical Incident reports in 2008. The first incident took place on May 7, 2008. It involved a resident who became verbally aggressive with staff. The police were called, and, ultimately, the resident was held down and subdued with medication. Within a week, a compliance advisor conducted a review in the home. Her notes indicated that the situation had escalated quickly. She made no findings of unmet standards or criteria under the Program Manual, but spoke with the home about putting in place a contingency plan for situations such as this one.

The second Critical Incident report was filed in late August 2008 and involved a resident who was transferred to hospital following a fall, and later died there. Wettlaufer was the registered nurse who was called to assist when the resident was found, not breathing, on the bathroom floor. The resident had also fallen earlier that day. Within days of receiving the report, a compliance advisor went to Caessant Care (Woodstock) to conduct a review. She found that the resident's physician had not been called after the first fall and that the resident had not been receiving care consistent with his plan of care. The compliance advisor's notes indicate no concerns about the care Wettlaufer provided to the resident following his second fall. The compliance advisor issued one finding of unmet standards.

The third Critical Incident report to the Ministry related to an incident in December 2008, in which narcotics had gone missing and were unaccounted for. The report explained that a pharmacy bag containing medications that had been discontinued (or were otherwise not needed) was being returned to the pharmacy but was stolen from the courier's car, which he had left unlocked. The report advised that the police were investigating. A compliance advisor reviewed the Critical Incident report and advised the home to contact the Privacy Commission about a possible breach of privacy related to the personal health information on the stolen medications. Wettlaufer was not mentioned in the report.

2009

Two Critical Incident reports were submitted to the Ministry in 2009, only one of which was relevant to the Inquiry mandate.⁸ In December 2009, Caessant Care (Woodstock) reported an incident of suspected resident-to-staff abuse, in which the resident had apparently jumped out

⁸ The other Critical Incident report was about the heat in the home not working.

of bed in anger when Wettlaufer turned on his roommate's fan. During the incident, he reportedly yelled: "I hate you. I am going to get you." He grabbed Wettlaufer's top, scratched her shoulder, and poked her under the eye. She shoved the resident's arms, then called the police and had the resident taken to hospital for an assessment. A compliance advisor reviewed the report but decided no inspection was required. Although the compliance advisor's notes do not show why she made this decision, evidence at the public hearings indicates that the Ministry did not consider allegations of resident-to-staff abuse "reportable" and, therefore, they were not subject to inspection.

2. Complaints Received and Reviews Conducted: June 2007 to June 30, 2010

Between June 2007 and June 30, 2010, the Ministry received and reviewed 12 complaints about Caressant Care (Woodstock) concerning resident care and insufficient staffing, and its impact on resident care.⁹ Three were received in the latter part of 2007, one in 2008, six in 2009, and two in the first half of 2010. Compliance advisors conducted reviews of all the complaints at the home, shortly after the Ministry received them. Wettlaufer was not mentioned by name in any of these complaints.

2007

The London SAO received the first two complaints for 2007 on July 3, 2007, not long after Wettlaufer began working at Caressant Care (Woodstock). Both complaints came in over the INFOLine, from anonymous callers who advised that the home had run out of incontinence supplies for the residents; that, in their absence, bed pads were being used; and that some residents were refusing to go for breakfast without proper products. Within two days of receiving these complaints, two compliance advisors conducted a review. They spoke with multiple staff members who verified the complaint, and then issued a finding of unmet standards for the provision of continence care products. The home prepared a plan of corrective action, which the Ministry accepted.

The third complaint was received in mid-September, when an anonymous caller advised that LTC homes were using non-registered staff to do the work of registered nurses and registered practical nurses. On October 1, 2007,

⁹ None of the other complaints received about Caressant Care (Woodstock) during this time are relevant to the Inquiry mandate. They relate to such things as complaints about the flooring in the home.

a compliance advisor investigated this complaint at Caressant Care (Woodstock). She met with the administrator and the director of nursing (DON) and reviewed the home's policy concerning certificates of competence for registered staff. She could not verify the complaint and issued no unmet standards or criteria.

2008

In 2008, the Ministry received only one complaint about the care of residents at Caressant Care (Woodstock). A resident's wife complained about multiple issues concerning care in the home: residents being left in dirty clothes for days; dirty laundry carts being left in the hallways on weekends, leading to foul smells and fire hazards; her husband being sent to hospital wearing only a diaper; and her husband being left in bed in his soiled briefs all morning. The day after the complaint was reviewed by the London SAO, a compliance advisor attended the home for a complaint review. She reviewed the charts for incontinent residents, the supply of products, the situation in the halls, and the complainant's husband's medical records. She could not verify any of the concerns raised in the complaint and issued no findings of unmet standards.

2009

The Ministry received six complaints about the care given to residents at Caressant Care (Woodstock) in 2009. The London SAO received the first two complaints in March. A resident's granddaughter raised multiple concerns, including the fact that the resident's clothes and incontinence products were not being changed in the morning, and that the family was not kept updated after the administrator told them that the home was investigating an incident in which the resident had been placed in a small dark room by a male staff member. Less than a week after the complaint was received, two compliance advisors went to Caressant Care (Woodstock) to conduct the review. Their notes showed that they were unable to verify the complaints, either because the staff were unable to recall the events, the particular incident was not documented, or it had happened many years earlier and there were no records to review. They issued no findings of unmet standards or criteria.

Toward the end of March, the Ministry received another complaint from a resident's granddaughter, who was concerned about the care the resident was receiving. She complained that her grandmother had fallen getting out of bed but was not allowed to use bed rails, and that she had become dehydrated from having the flu but was not permitted to go to the hospital. Within the

week, a compliance advisor was back at Caressant Care (Woodstock) for this review. She was not able to verify the complaints and issued no findings of unmet standards or criteria.

The next complaint came in toward the end of June from an employee who was concerned about ongoing nurse shortages, primarily on the weekend and evening shifts, which meant residents were not receiving baths, toileting, or dining assistance. The week after this complaint, two additional complaints raised concern about the care provided to residents suffering from gastrointestinal infections. In the first, a resident had apparently been given laxatives to treat her diarrhea, which led to her hospitalization. In the second, the resident's daughter had spoken to staff several times about her mother's gastrointestinal infection and been advised that she would be fine. Several days later, when she raised the issue with the head nurse, the nurse indicated that she was not aware the resident had been ill. This resident ultimately had to be treated in hospital. Within days of these complaints, a compliance advisor went to the home for a review of all three.

With respect to staffing, the compliance advisor reviewed the daily staff assignment sheets and confirmed that staff were not replaced on certain shifts. She could not find any evidence that baths were missed or care not provided. She did not issue an unmet standard concerning staffing. As for the next complaint, she confirmed that the resident with diarrhea had been given laxatives. She did not issue any findings of unmet standards or criteria, but encouraged the home to review its policy and procedure concerning the administration of laxatives and to ensure registered staff received clear directions about their use.

Finally, the compliance advisor reviewed the records of the resident with the gastrointestinal infection and found that she was experiencing diarrhea from June 21 through to her hospitalization on June 30, 2009, but was not seen by a physician or assessed by a nurse until her daughter requested it on June 27. She also noted that the resident's plan of care had not been updated since June 10. She issued two findings of unmet standards for failing to assess the resident's care when there was a change of condition and for failing to review and revise the plan of care as appropriate. During a follow-up inspection, the same compliance advisor found that Caressant Care (Woodstock) had not done a head-to-toe assessment when the resident returned from hospital. She determined that the previously issued findings of unmet standards remained outstanding.

2010

The Ministry received two complaints about Caressant Care (Woodstock) in the first half of 2010, before the LTCHA came into effect on July 1, 2010. The first was received in early May 2010 and came from a resident who raised multiple concerns about her care, including that she was not being given pain medication when requested; that she had been hit by another resident and the staff had done nothing about it; and that she was being woken every two hours by staff and pulled out of her bed by her sore arm. Within a week of receiving this complaint, a compliance advisor inspected. She spoke with the resident and reviewed her medical records. She determined that none of the complaints were verified. For example, the medical records showed that the resident was being given codeine, at her request. The resident had been struck by another resident, but the home had taken appropriate steps to follow up and mitigate future issues. Finally, the compliance advisor learned that the resident was being woken in the night to ensure that she voided. The compliance advisor found no evidence that the resident was being pulled on her sore arm and issued no findings of unmet standards.

A second complaint came in from a resident's daughter on May 20, 2010, who raised concerns that the home was short staffed, leading to residents being brought late to the dining room and not getting to bed at their usual time. Within two weeks, a compliance advisor went to the home for a complaint review and confirmed both aspects of the complaint. Residents told her they were waiting longer to be toileted and were getting to bed later. She reviewed about a dozen care plans and noted that none included the resident's desired bedtime. She issued a finding of unmet standards for failing to ensure residents' individual bedtimes were encouraged.

3. Other Reviews: June 2007 to June 30, 2010

Between June 2007 and June 30, 2010, compliance advisors visited Caressant Care (Woodstock) on more than 20 separate occasions to conduct reviews other than those related to unusual occurrence reports or complaints. Annual reviews, which lasted three or four days, were conducted in the home in 2007, 2008, and 2009. In both 2007 and 2009, they were completed by two compliance advisors. Compliance advisors also did follow-up reviews where there had been unmet standards issued.

During this period, there were also approximately a dozen environmental reviews at the home, most of which were follow-up reviews to previously issued findings of unmet standards. During the follow-up reviews, the

environmental health advisor repeatedly noted that the unmet standards remained outstanding. In several cases, even reissued findings of unmet standards were still outstanding. In 2009, the environmental health advisor also conducted a review relating to possible new interim beds in the home. She found several outstanding findings of unmet standards, which remained outstanding in a later follow-up review.

Finally, during this period, a dietary advisor attended the home several times to conduct dietary reviews and follow-up reviews where there were previous findings of unmet standards.

4. Incidents Not Reported

During this period, the Ministry received no unusual occurrence reports from Caressant Care (Woodstock) about any medication error or treatment error that resulted in the transfer of a resident to hospital for treatment or admission. In particular, no such report was filed when Clotilde Adriano was sent to hospital in October 2007 after her blood sugar kept “bottoming out” through the night. Ms. Adriano was one of Wettlaufer’s first victims at the home.

No unusual occurrence reports were filed for any death “resulting from an accident or undetermined cause”¹⁰ or for an “unusual or accidental death.”¹¹ In particular, no such report was filed in relation to the death of James Silcox, even though Wettlaufer had marked his death as “sudden and unexpected” when she completed the Institutional Patient Death Record following his death. No unusual occurrence report was filed following the death of Maurice Granat, Wettlaufer’s second murder victim, in December 2007.

D. Oversight by London SAO Inspectors: Post July 1, 2010

On July 1, 2010, the NHA and its regulations were repealed, and the LTCHA and its Regulation came into effect. This heralded a new era in reporting requirements and a new compliance and enforcement regime.

When the LTCHA first came into effect, duty inspectors in the London SAO were responsible for reviewing all information received about Caressant Care (Woodstock), including Critical Incident reports and complaints. They determined whether an inspection was warranted and, if so, how quickly it

¹⁰ As required by Reg 832, s 96.

¹¹ As required by the Program Manual.

should be done. In late 2012, the Centralized Intake Assessment and Triage Team (CIATT) assumed responsibility for reviewing all information received about LTC homes in the province. CIATT's triage inspectors would assign a risk level to the information received, which in turn would generate the time frame for inspection. The higher the risk level, the shorter the time allowed for response.

Inspectors from the London SAO continued to be responsible for conducting all inspections at Caressant Care (Woodstock). However, after the LTCHA came into effect, inspectors no longer had designated homes in the region for which they were responsible. Further, inspectors were no longer permitted to provide advice to the homes, even if requested.

The number of inspectors in the London SAO remained relatively constant between 2010 and 2013, ranging from 13 to 17 full-time-equivalent positions. In 2014, as part of Ontario's commitment to conduct a resident quality inspection (RQI) in every home every year, many new inspectors were hired. In 2014, there were between 31 and 35 full-time inspector positions available and filled in the London SAO.

Although Wettlaufer was named in more Critical Incident reports – and in a few complaints – made during the period from July 2010 to March 2014, when Caressant Care (Woodstock) terminated her employment, the Ministry was not aware of any significant concerns about her performance nor did it have information that suggested she had been intentionally harming residents in the home. Indeed, Caressant Care (Woodstock) was not on the Ministry's radar. Some findings of non-compliance had been made against the home during this period, but only one compliance order was issued between July 1, 2010, and March 2014. In the 2013/14 fiscal year, when the Ministry began to produce Long-Term Care Quality Improvement Program Risk and Performance Assessment (LRPA) reports assigning a "risk level" to all LTC homes in the province, Caressant Care (Woodstock) was classified as a level 1 home, meaning that it was "substantially compliant."

1. Critical Incident Reports Received and Inspections Conducted: July 1, 2010, to March 2014

Between July 1, 2010, and the end of March 2014, when Wettlaufer stopped working at Caressant Care (Woodstock), the home submitted just over 20 Critical Incident reports to the Ministry involving suspected abuse, neglect, or incompetent treatment or care; injury resulting in a resident's transfer to hospital; or missing or unaccounted for narcotics. Although many of these

reports ultimately led to inspections, because of the demands associated with performing annual RQIs for all homes it took inspectors longer to get to the home to conduct those inspections.

2010

Caressant Care (Woodstock) submitted three Critical Incident reports to the Ministry in 2010, after the LTCHA came into effect. The three reports involved suspected verbal abuse (a resident reported that an employee had spoken harshly to her); incompetent treatment or care of a resident resulting in harm or risk of harm (a PSW assisted a resident to the toilet without using the lift and the resident fell while trying to stand on his own); and suspected neglect of a resident (a resident's call bell was unanswered and a staff member told him that she would not help him and he would have to change himself).

The first two reports came in during July and were inspected together, in late August. With respect to the first report, the inspector confirmed that the employee had spoken harshly to the resident. She issued two written notifications of non-compliance accompanied by a voluntary plan of correction to the licensee for failing to ensure both that the resident's right to be treated with courtesy and respect was promoted and that the right to be protected from abuse was respected and promoted.

In the case of the second Critical Incident report, the inspector found that there had been incompetent care in the PSW's use of the lift. She issued two written notifications with voluntary plans of correction for failing to ensure that the resident's plan of care was followed and that staff used safe transferring and positioning techniques.

The final Critical Incident report submitted in 2010 was inspected the same week it was received. An inspector determined that the resident had rung his bell four times and the PSW had refused to assist him. Based on this, the inspector issued a written notification accompanied by a compliance order for failing to ensure that the right of residents not to be neglected was respected. This was the only compliance order issued to Caressant Care (Woodstock) while Wettlaufer was working at the home. She was not involved in this incident.

2011

The Ministry received five Critical Incident reports from the home in 2011. Three involved residents who had fallen, suffered an injury, and been transferred to hospital, with one of the residents later dying in hospital.

Another Critical Incident report was for improper treatment leading to harm: a resident fell during a transfer. The final Critical Incident report was for an “unexpected death”: a resident died in December from choking on a piece of ham. Wettlaufer was not named in any of these reports.

The first Critical Incident report, concerning a fall resulting in a transfer to hospital, was reported in February and inspected in April. The inspector found no compliance concerns. The next three Critical Incident reports involving falls (one of which involved the suspected improper transfer) were assigned for inspection within a 30-day time frame to a different inspector. Although the first two falls took place in September and the third in early November 2011, the inspection did not take place until February 17, 2012. At that time, the assigned inspector determined that the incidents were all properly investigated by the home and appropriate education provided to staff. She issued no findings of non-compliance.

The final Critical Incident report, which involved the unexpected death, was assigned for immediate inspection to yet a different inspector. The inspector learned that the resident had multiple food allergies, including a pork allergy, and that many of the staff did not know which foods contained allergens. The home, which was short-staffed in the dining room on the evening of the incident, did not have a full-time cook. The inspector issued her report on January 24, 2012, with two written notifications accompanied by voluntary plans of correction for failing to ensure food service workers were aware of residents’ diets, special needs, and preferences, and for failing to have a full-time cook in the home.

2012

Caressant Care (Woodstock) submitted six Critical Incident reports to the Ministry in 2012. In three of the reports, Wettlaufer was named as the registered staff member involved in the incidents. After the duty inspectors in the London SAO reviewed each of the reports, the decision was made not to inspect any of the incidents. However, they were reviewed and ultimately inspected as part of the inspection that took place after Wettlaufer confessed to having intentionally harmed residents at the home (Wettlaufer Inspection).

The first Critical Incident report was submitted on January 13, 2012. The incident involved an injury to a resident that resulted in the resident being transferred to hospital. According to the report, the resident had fallen and was found sitting next to her bed in a pool of blood, with lacerations on her leg. Wettlaufer was the registered nurse who tended to the resident. There was some concern that the resident had fractured her hip. The report

did not contain any details about the treatment or care that Wettlaufer had provided. A duty inspector reviewed this Critical Incident report on January 16, 2012, and, based on the information in the report, determined that no inspection was necessary. However, additional information about this incident came to light during the Wettlaufer Inspection. At that time, the inspectors found that Wettlaufer's care during this incident had been the subject of a complaint by another staff member at the home, who felt that it had not been appropriate. This concern about her care had not been reported to the Ministry in the January 13, 2012, Critical Incident report and, therefore, had not been considered by the duty inspector when deciding if an inspection was necessary.

The next two Critical Incident reports involved allegations that Wettlaufer had struck a resident. The first report, which was submitted on January 30, 2012, indicated that on January 12, the resident had gone to the nurses' station shortly after midnight. Wettlaufer asked her to return to her room, and although the resident initially complied, she returned shortly thereafter, signed herself out, and left the building. The resident later told the director of nursing (DON) that Wettlaufer slapped her as she was leaving. The Critical Incident report indicated that the home had investigated immediately and both Wettlaufer and the resident had been interviewed. According to the report, which was filed a couple of weeks after the suspected incident, the resident had come to the office with Wettlaufer on January 16 and told the DON that Wettlaufer had not hit her.

The day the report was submitted, a duty inspector at the London SAO reviewed the report and noted that the resident was now saying the registered nurse "did not hit her." The SAO was already aware of the issue because it had received a complaint from the resident (discussed below), and it had already been assigned for an inspection. The duty inspector noted that the incident was alleged to have occurred on January 12, but the Critical Incident report was not filed until January 30. After consulting with the lead inspector, it was decided that the inspection should proceed as planned.

Just over a week later, on February 8, 2012, the home submitted another Critical Incident report involving another alleged incident of abuse involving Wettlaufer and the same resident. According to this report, earlier that day, Wettlaufer had gone into the resident's room while the resident was sleeping and hit her on the front of her left shoulder to wake her up to measure her blood sugar. The resident reported the incident to the administrator and then met with both the administrator and the DON. In turn, the administrator and DON contacted the resident's sister and the police. The police interviewed the

resident and advised the home that Wettlaufer should no longer provide care to the resident and that the two should be kept separate “for the time being.” A duty inspector reviewed the report and contacted the DON to ask if the resident had been assessed to determine if there was any redness or bruising. The DON said that no injuries were seen, that the resident had a history of disliking Wettlaufer, and that the latter had been told not to provide care to the resident without others present. The duty inspector marked the Critical Incident report as “no action required.”

This Critical Incident report was updated by the DON on February 24, 2012, after the home’s internal investigation of the incident. It indicated that, when the police came to investigate, they told the resident that she could be charged if she was lying. After the police had spoken with her, the resident reportedly went to the DON’s office and inquired if the Ministry could be asked not to come. She explained she was concerned because the police had told her that, if she lied, she could go to jail. The DON told her that, if the Ministry came, she should tell the truth. On March 1, 2012, two inspectors in the London SAO reviewed the materials relating to the two Critical Incident reports and the proposed complaint inspection. Although the notes show that the inspectors were concerned that the home had not reported the incidents within the appropriate time frames, they decided not to do the inspection.

The next Critical Incident report was sent to the Ministry in early August 2012, for an incident resulting in injury and the resident’s transfer to hospital. The report noted that, on August 5, 2012, the resident had thrown herself from her wheelchair onto the floor. Although the registered practical nurse who did the initial assessment listed no injuries, the next morning the resident’s right leg was swollen, firm, and painful. That evening a mobile x-ray was ordered and, two days later, the x-ray results revealed the resident had a fractured femur. She was then sent to hospital. A duty inspector reviewed the report and determined that an inspection was required within 30 days.

The next Critical Incident report involved a report of missing, or unaccounted for, controlled substances. According to the report, on August 28, 2012, when the nurses were completing their narcotic count, they found that one box of Fentanyl patches was missing. The report indicated that the police had been called. The report was amended within the week, to include details from the police investigation. The police had interviewed staff but found insufficient evidence on which to lay a charge. On September 5, 2012, the day after the amended report was submitted, the duty inspector reviewed it and concluded that no inspection was needed. Wettlaufer was not mentioned in this report.

The final Critical Incident report from 2012, submitted on September 4, was a case of suspected staff abuse or neglect of a resident. A resident reportedly had to ring the call bell multiple times before she was provided with her pain medication. The resident's daughter had filed a written complaint with the home, and the home was investigating it. This incident was assigned for an inspection within 30 days, along with the earlier Critical Incident report involving the fractured femur.

This inspection did not take place until mid-November, more than two months later. On November 21, 2012, the inspector issued her inspection report, which included two written notifications of non-compliance, for failing to ensure respect for, and promotion of, the right of residents to be cared for in a manner consistent with their needs, and for lack of compliance with the home's policies concerning post-fall assessments. The latter finding was also issued with a voluntary plan of correction.

2013

During 2013, Caressant Care (Woodstock) sent six Critical Incident reports to the Ministry related to resident care, injuries resulting in a transfer to hospital, or missing narcotics.¹² By this time, CIATT had taken over responsibility for reviewing and triaging all information received by the homes. Three reports involved residents who had suffered an injury resulting in their transfer to hospital. Two involved missing narcotics or controlled substances, including one where Wettlaufer was the registered staff member on shift. The final Critical Incident report involved a case of alleged verbal abuse of a staff member (Wettlaufer) by a resident. Of the six Critical Incident reports submitted in 2013, three were subject to an inspection. Neither of the incidents involving Wettlaufer was inspected.

The two Critical Incident reports concerning missing narcotics were filed by the home in mid-March and mid-April. The first, from March 15, 2013, involved a capsule of Kadian SR 10 mg which was discovered missing during the narcotic count. The police had been called to investigate. The Critical Incident report advised that Wettlaufer believed she may have given the resident a double dose. It was amended on March 28, 2013, to reflect the home's investigation. The notes show that Wettlaufer believed she may have given the resident her medication earlier as she had been complaining of headaches. According to the notes, this was a medication error for two reasons: Wettlaufer

¹² Other reports, such as those relating to outbreaks of illness in the home or a resident who went missing for less than three hours, are not included in this tally.

gave the medication earlier than allowed, and she did not chart it at the time of administration. Wettlaufer was given a one-day suspension for this incident. The amended Critical Incident report was reviewed by the intake inspector, who determined that no action was required. No inspection was conducted.

The second Critical Incident report for missing narcotics was filed with the Ministry on April 16, 2013. On that date, the pharmacy consultant had gone into the home to destroy medications and had discovered that an individual narcotic card of 31 tablets of hydromorphone was missing. It had apparently been placed into the narcotic disposal box by two registered nurses on March 21, 2013. The police had been called. The report was amended the week after it was filed to show that the police had come to investigate, that the narcotic disposal box had been replaced with a more secure option, and that head office had approved the installation of a hidden camera. An intake inspector reviewed the amended Critical Incident report and determined that no action was required. No inspection was conducted into this incident.

On April 1, 2013, the home submitted a Critical Incident report concerning allegations of resident-to-staff abuse. According to the report, a male resident had gone to the DON's office that morning saying he did not trust Wettlaufer to give him the correct medication. He also told her that, if Wettlaufer came near him, he would "kick and punch her in the teeth," and he threatened to kill her. The DON reviewed Wettlaufer's charting and noted that the resident had been laughing at a female resident, which Wettlaufer found to be rude and bullying. When she asked him to stop, the male resident had become angry and threatened to kick Wettlaufer in the stomach. The report showed that the police were called and came to the home to speak with the resident. Wettlaufer was advised not to approach the male resident alone. An intake inspector reviewed this Critical Incident report on April 4; she determined that there was no risk to residents and that no inspection was required.¹³ This decision was consistent with the CIATT policy that such incidents were not reportable and thus did not warrant an inspection.

The remaining three Critical Incident reports filed in 2013 concerned residents who had suffered an injury that required a transfer to hospital. In the first, a resident had fallen after being left unattended in the dining room during a fire drill, had broken two fingers, and been sent to hospital. The second Critical Incident report was filed on September 16, 2013, and involved Maureen Pickering, Wettlaufer's final victim at Caressant Care (Woodstock).

¹³ This incident was later inspected as part of the Wettlaufer Inspection at Caressant Care (Woodstock). It is discussed further in the following chapter.

According to the Critical Incident report, Ms. Pickering and another resident had gotten into an altercation after Ms. Pickering apparently entered the other resident's room. The two were found on the floor and Ms. Pickering, who had a small pool of blood under her head, was sent to hospital to receive a stitch. The final Critical Incident report, submitted on December 20, 2013, was about a resident who was found lying on the floor after falling. During her post-fall assessment, she was crying out in pain. She was later transferred to hospital and passed away just over a week later.

A single intake inspector reviewed all three of these Critical Incident reports. She decided that the first and the last incidents required an inspection. Although she requested that the home file further information concerning the incident with Maureen Pickering, it was not assigned for an inspection. The two inspections conducted in relation to the falls did not result in any findings of non-compliance.

2014

In the three months in 2014 that Wettlaufer worked at Caressant Care (Woodstock), only one Critical Incident report was submitted to the Ministry, on January 21. This report, which was completed by the DON, involved an incident of alleged resident-on-resident abuse. Maureen Pickering was one of the two residents involved. The report noted that Ms. Pickering had been showing "escalating behaviours" since finishing a course of antibiotics for a urinary tract infection. Mid-afternoon on January 20, 2014, Ms. Pickering allegedly punched a PSW in the back. (The PSW reported this to Wettlaufer, as the registered nurse on the evening shift, but not until after 19:00.) Later that afternoon, Ms. Pickering had to be assisted out of a resident's room twice in a very short period of time. Wettlaufer apparently asked Ms. Pickering to stay out of the resident's room, but Ms. Pickering denied having been in it. Wettlaufer charted that she tried to explain to her that she was "forgetful" and needed to trust staff. Ms. Pickering then grabbed Wettlaufer and yelled, "I don't forget." Sometime around 18:20, Ms. Pickering was allegedly verbally aggressive with staff, complaining about feeling nervous and angry, and experiencing pain in her legs. She was given Tylenol, Trazodone, and Risperidone. Around 18:45, a student aide observed Ms. Pickering approach the same resident's room, after which the two residents began speaking loudly and arguing. The student aide then saw Ms. Pickering strike the other resident repeatedly, including in the face. The other resident was left with bruising and a 3 cm laceration on her eye.

Wettlaufer called the doctor shortly after 19:00 to review Ms. Pickering's medications. He ordered that her morning Risperidone be increased and that she be given between 2.5 and 5 mg of Haldol every six hours for agitation. Shortly before 21:00, Ms. Pickering attempted to hit staff and called them liars, at which point she was given 2.5 mg of Haldol. She was given a further 2.5 mg of Haldol an hour later, as the first dose had not been effective. The following morning, Ms. Pickering was reportedly drowsy at breakfast and needed assistance eating.

Although this Critical Incident report was not initially assigned for inspection, it was marked for inspection after a resident's daughter called the INFOLine to address her mother's safety, indicating that two residents – including Maureen Pickering – continued to wander into her mother's room, scaring her.

The inspection occurred on March 5, 2014. The inspection notes showed that Ms. Pickering had been experiencing significant behavioural symptoms related to her Alzheimer's disease and that she had been involved in altercations with other residents. The inspector concluded that the home had used appropriate interventions to address Ms. Pickering's behaviour, and made no findings of non-compliance.

2. Complaints Received and Inspections Conducted: July 1, 2010, to March 2014

Between July 1, 2010, and the termination of Wettlaufer's employment from Caressant Care (Woodstock) in March 2014, the Ministry received 16 complaints about understaffing at the home and the care being provided to residents.¹⁴ With few exceptions, which I discuss below, the complaints were inspected.

2010

The Ministry received four complaints between July 1, 2010, and the end of the year. The complaints were all inspected within a fairly short time.

The first complaint was received on September 29 and concerned the care being provided to a resident. The anonymous complainant advised that the home was "significantly understaffed" and that the resident had fallen from a wheelchair during a fire drill when a PSW failed to put on the chair's brakes.

¹⁴ This does not include complaints that were unrelated to the Inquiry mandate, including issues such as failing to deal with outbreaks of illness, concerns raised by residents that they would be forced to leave the home, and concerns about the disclosure of residents' personal health information.

On October 4, an inspector visited the home. While there, she observed the resident in a wheelchair with the seatbelt – which the resident needed – unfastened. The inspector also noted that the care plan did not reflect the resident's current lift or transfer status. She issued a written notification accompanied by a voluntary plan of correction because of the failure to update the plan of care.

The Ministry received the next complaint on October 18 from the daughter of a former resident, who claimed that she had transferred her mother to a different home because of concerns about the care at Caressant Care (Woodstock). She said that her mother's bedsores had not healed and that she believed the home had been over-sedating her mother. An inspection took place on October 29. While there, the inspector reviewed the resident's medical record and plan of care. She issued two written notifications, both of which were accompanied by voluntary plans of correction, for failing to ensure that a resident with altered skin integrity was reassessed at least weekly by registered staff, and for failing to implement policies and procedures as required by the LTCHA.

On November 1, the Ministry received a complaint from a resident's sister, who was the resident's substitute decision-maker (SDM). The SDM claimed that the resident had fallen on the weekend, and that Caressant Care (Woodstock) had failed to do a proper post-fall assessment or to contact her (as the SDM). Two days after the fall, the SDM took her sister to the hospital herself, and the resident returned to the home with a sling. One week after receiving the complaint, an inspection took place. The inspector determined that the home had failed to address the resident's ongoing pain following her fall. The inspection report, issued on November 15, included two written notifications, both accompanied by voluntary plans of correction, for failing to ensure the resident and the resident's SDM were given an opportunity to help develop the resident's plan of care and to review it when the resident's needs changed.

On November 10, the final complaint of 2010 came in over the INFOLINE from a volunteer in the home's adult day program. The complainant was concerned that a resident was being abused as she had been left on the toilet for several hours and staff had shut off her call bell. An inspector attended the home on December 2 for this complaint inspection but made no findings of non-compliance.

2011

Only one complaint received by the Ministry in 2011 related to resident care.¹⁵ On November 15, an anonymous complaint reported that there had been no registered nurse on duty the previous night. It was assigned for an inspection, which did not take place until March 14–16, 2012. At that time, the inspector concluded that there was no registered nurse in the home from 19:00 to 23:00 on November 14, because the scheduled registered nurse had called in sick. She issued one written notification accompanied by a voluntary plan of correction for failing to ensure that there was a registered nurse on duty and present at all times.

2012

The Ministry received five complaints about the care of residents in 2012. Three came in late January and all were from the resident who claimed that Wettlaufer had hit her, as discussed above. The resident's next two complaints were follow-up calls about the original complaint. Although the resident had also apparently raised this concern with management in the home, no Critical Incident report had been filed. After the London SAO duty inspector called the home to ask about the complaint, the home filed a Critical Incident report, more than two weeks after the incident occurred. As discussed above, although these complaints were initially subject to inspection, the Ministry did not inspect after being advised that the complainant had rescinded her allegations.

In mid-January, the Ministry received another complaint, this one from the daughter of a resident about alleged negligent care of her mother. This complaint was assigned for inspection within 30 days. At the home on February 16, the inspector learned that the resident had ongoing issues related to infections on her hands and, at one point, had been sent to hospital over a possible blood clot. The inspector issued her report on February 21 with no findings of non-compliance.

An anonymous complainant on November 13 made the final complaint received by the Ministry in 2012. The caller advised that a resident had been sent to hospital in extreme pain and had died the following day. The caller further explained that the resident had not voided for 24 hours before being sent to hospital. The duty inspector categorized the complaint as involving an

¹⁵ Other complaints were received about the heat in the home but are not sufficiently relevant to the Inquiry mandate to warrant discussion.

"improper death" and set a 30-day time frame for inspection. After conducting the inspection on November 27, the inspector issued her report the same day, with no findings of non-compliance.

2013

By 2013, CIATT was responsible for reviewing and triaging all complaints received about LTC homes in the province. That year, it received five complaints about resident care and staffing at Caressant Care (Woodstock).¹⁶ Two were about the nature of care being provided to residents, and three addressed understaffing. London SAO inspectors conducted inspections of all these complaints but issued no findings of non-compliance.

The first complaint, on March 15, was sent to the Ministry by a resident's son. In his 18-page letter, the complainant raised multiple concerns about the care being provided to his father, including an incident from August 2012 in which his father had been sent to hospital after being over-sedated with morphine; lengthy delays in responding to call bells; inadequate wound care; and the failure of the home to adequately respond to his complaints. An inspector conducted an inspection on April 16 and 17, 2013. She found no concerns and issued her report with no findings of non-compliance on April 22, 2013.

The next complaint came in to CIATT on June 28, 2013. A part-time staff member at Caressant Care (Woodstock) was concerned about the availability and quality of incontinence products for residents and also thought that the home's understaffing meant that toileting was not always possible. An inspector attended the home on July 15 to investigate the complaint, and ultimately made no findings of non-compliance.

On July 3, 2013, CIATT received an anonymous complaint from a resident's son about his mother's care. He thought that the heat in the home was excessive and that staff did not take it seriously when his mother became ill and could not keep her food down. A week later, an inspection began. The inspector noted that the home had a hot weather plan in place and that the resident in question had been sent to hospital earlier that day, as she was at risk of dehydration. The inspector made no findings of non-compliance.

Finally, in October 2013, CIATT received two complaints related to understaffing in the home – one from a resident's daughter and one from a staff member. On October 22, 2013, an inspector attended the home for

¹⁶ This number does not include complaints about issues such as the housekeeping program in the home.

the inspection of both complaints. She learned that the home had recently changed its bathing policy: it had moved from having two PSWs bathe residents to only one PSW, unless a transfer was required. The inspector made no findings of non-compliance.

2014

Wettlaufer ceased working at Caressant Care (Woodstock) at the end of March 2014. Between January and the end of March, CIATT received only one complaint about the home. This complaint, received on February 10, was made by a resident's daughter, who was concerned about her mother's safety. She indicated that two residents continued to wander into her mother's room, which scared her mother. She noted that one of the two, Maureen Pickering, had recently struck another resident in the face. CIATT assigned this for inspection within 30 days; it was inspected along with the Critical Incident report, discussed above. The inspector made no findings of non-compliance.

3. Other Inspections Conducted: July 1, 2010, to March 2014

In addition to these complaints and critical incident inspections, London SAO inspectors conducted three follow-up inspections at Caressant Care (Woodstock) between July 1, 2010, and March 2014. The first two were completed in the fall of 2010 and were follow-up inspections to the findings of unmet standards that had been issued under the previous regime.

The other follow-up inspection was in November 2011, in relation to the only compliance order issued to the home during this period. That order had been issued following the November 2010 critical incident inspection in relation to the home's failure to ensure the right of residents not to be neglected was fully respected and promoted.

The first comprehensive annual inspection under the LTCHA (RQI) was not completed until December 2014, about eight months after Caressant Care (Woodstock) had terminated Wettlaufer's employment.

4. Critical Incidents Not Reported

In criminal proceedings in June 2017, Wettlaufer was convicted of having killed five residents at Caressant Care (Woodstock) after July 1, 2010: Gladys Millard, Helen Matheson, Mary Zurawinski, Helen Young, and Maureen Pickering. The home was required to report deaths that were "sudden or unexpected" to the Ministry. No one had viewed these deaths as sudden or unexpected, so their deaths had not been reported to the Ministry.

Other than the Critical Incident report about Wettlaufer's alleged abuse of the resident who claimed that Wettlaufer slapped her but who later recanted, the Ministry received no report about suspected abuse or neglect of residents by Wettlaufer. The Ministry also received no reports about alleged improper or incompetent treatment or care by Wettlaufer of any residents, even though staff at the home had raised internal concerns about this. The Ministry reviewed these concerning incidents in its Wettlaufer Inspection at Caressant Care (Woodstock) following Wettlaufer's confession. They are discussed in the following chapter.

III. Ministry Oversight of Meadow Park (London)

Shortly after Wettlaufer left Caressant Care (Woodstock), she began working at Meadow Park Nursing Home in London. She worked there for only a short period, from April to October 2014. Her employment with Meadow Park (London) ended when she resigned, saying in her letter of resignation that she needed to get help with an "illness" that required long-term treatment.¹⁷ In the period that Wettlaufer worked for Meadow Park (London), the home was subject to the regulatory regime imposed by the LTCHA and the Regulation.

A. Funding Through the LSSA

Meadow Park (London) received its funding pursuant to its Long-Term Care Home Service Accountability Agreement (LSAA) with the South West LHIN. Although the Ministry was responsible for setting funding policies, the South West LHIN was responsible for administering the funds. The terms of the relationship between Meadow Park (London) and the South West LHIN were set out in their LSAA.

B. Licensing of Meadow Park (London)

When Wettlaufer began working at Meadow Park (London) in April 2014, it was operating with two different licences. The first, issued on July 1, 2010, was for the operation of 122 beds. The second was a temporary licence, originally issued on July 1, 2010, for the operation of four interim beds in the home.

¹⁷ It later emerged that the long-term illness was her ongoing struggle with addictions.

When this temporary licence expired on March 31, 2013, it was renewed through to March 31, 2015. Thus, when Wettlaufer worked in Meadow Park (London), it was licensed to operate a total of 126 beds.

C. Oversight by London SAO Inspectors

Inspectors at the London SAO were responsible for conducting all inspections at Meadow Park (London), as well as at Caressant Care (Woodstock). When Wettlaufer began working at Meadow Park (London) in 2014, between 31 and 35 inspectors worked out of the London SAO. By that time, CIATT was responsible for reviewing information received about all LTC homes in the province, and determining whether an inspection was required. Seven triage inspectors worked at CIATT.

Nothing was reported to the Ministry during Wettlaufer's brief tenure at Meadow Park (London) which raised red flags about her conduct or what was happening in the home. However, one of the Critical Incident reports filed by the home in 2014 related to missing narcotics which, the inspector was told, the home's management believed had been taken by Wettlaufer.

Meadow Park (London) had an uneven compliance record under the LTCHA, moving from a level 1 "substantially compliant" home, to a level 2 "non-compliant – risk level moderate," and even to a level 3, "non-compliant – risk level high" home. However, nothing in the LRPA assessments in 2014/15 gave cause to suspect that a healthcare serial killer was working there.

1. Critical Incident Reports Received and Inspections Conducted: April–October 2014

Meadow Park (London) submitted three Critical Incident reports to the Ministry in 2014. All three were inspected, and no findings of non-compliance were made.

The first two Critical Incident reports involved allegations of staff-to-resident abuse. The first was sent to the Ministry on July 26, and involved Arpad Horvath, who reportedly had a history of swearing and striking out at staff. According to the report, two PSWs went into his room on July 25 to provide care. Mr. Horvath slapped one of the PSWs on the arm, at which point the PSW slapped Mr. Horvath's arm. Mr. Horvath then spat at the PSW, who spat back. The two PSWs then left the room, and the charge nurse was told what had happened. On July 28, the CIATT triage inspector who reviewed this Critical Incident report set a 30-day time frame for an inspection. The home's

second Critical Incident report for suspected staff-to-resident abuse was sent on September 22. According to it, a PSW had told the charge nurse that she was concerned that another PSW was being rough when caring for a resident, causing the resident to scream and cry out. This Critical Incident report was reviewed by a CIATT triage inspector and assigned for inspection within 30 days.

On October 8–9, an inspector conducted an inspection of both Critical Incident reports at Meadow Park (London). She made no findings of non-compliance.

On October 2, the home submitted its final Critical Incident report for 2014. It related to missing narcotics. According to the report, the co-director of care, Melanie Smith, had been advised, earlier that day, that the home had never received a hydromorphone 1 mg card that had been ordered for a resident on September 26, 2014. The home's investigation revealed that the medication had been delivered to it, along with other medications, but the hydromorphone could not be located. The police had been called to investigate. Two weeks after the report was submitted to the Ministry, it was reviewed by a CIATT triage inspector, who set a 120-day time frame for an inspection.

On November 4 and 5, 2014, Inspector Rhonda Kukoly attended Meadow Park (London) to conduct the inspection. According to her notes, the home's DON and administrator suspected that Wettlaufer had taken the drugs but had no concrete evidence to support their suspicion. In her letter of resignation dated September 25, Wettlaufer stated that she had "an illness which will require long treatment. I will be unable to work during this treatment and also unable to work as an RN following treatment." She gave October 15, 2014, as the effective date of her resignation. Inspector Kukoly's notes indicate that Wettlaufer had told the DON that she had a drug and alcohol problem, some days after she had submitted the resignation letter. According to the inspector's notes, Wettlaufer worked on September 26 – the day the hydromorphone was sent to the home and when it appears to have gone missing. September 26 turned out to be Wettlaufer's last day of work at Meadow Park (London); it treated the two weeks' notice she had given in her resignation letter as sick time. Ms. Kukoly made no findings of non-compliance in relation to this inspection.

At the public hearings, Ms. Kukoly explained that she made no findings of non-compliance because the home had done what was expected of it by investigating the missing narcotics, ensuring that education was provided

to registered staff, and ensuring that appropriate steps had been taken so that the resident did not miss her medication or suffer any harm as a result of the missing narcotics. However, she acknowledged that she might have approached this inspection differently had she known that there had been previous Critical Incident reports to the Ministry from Caressant Care (Woodstock) about missing narcotics involving Wettlaufer. For example, she stated that she might have reviewed Wettlaufer's file to determine whether there were any concerns raised by it, whether Wettlaufer was properly qualified, and whether she had been screened appropriately before starting to work at Meadow Park (London). Ms. Kukoly testified that because Wettlaufer had resigned by the time of the inspection, she did not see any ongoing risk to the home. However, she explained that, if Wettlaufer had still been working there, she might have had further questions and taken steps to interview Wettlaufer herself.¹⁸ Her approach to this inspection was also driven by her understanding of her role as an inspector:

My job is not to determine if she took the narcotics. My job is to determine if the home was compliant with the legislation and the regulations, so was there evidence to support that they did everything they needed to do ...

When asked what she would do if a registered staff member were suffering from addiction issues, Ms. Kukoly advised that she would normally ask the home if it had reported any concerns to the College of Nurses of Ontario (College). However, she did not believe she asked Meadow Park (London) about reporting to the College, since her notes did not indicate that she did so. She acknowledged that, "in hindsight, Lord knows I wish I did." Ms. Kukoly explained that she had personally reported registered staff to the College many times in her previous role as a DON of a home, but not in her role as a Ministry inspector. She stated that, typically, if she asked a home if it had reported someone to the College, it would either say "yes" (in which case she considered it done), or "no" (in which case her question alone would prompt the home to turn its mind to the need to do so). She recognized, however, that it would make sense to clarify the communication lines – and responsibility for reporting to the College – between the Ministry and the homes.

¹⁸ Ms. Kukoly advised that it was not the practice at the time to interview all staff members involved in an incident. She testified that inspectors have now received clear direction that they should interview relevant staff, even if they must call them at home to do so.

2. Complaints Reported and Inspections Conducted

In the six-month period in 2014 that Wettlaufer worked at Meadow Park (London), the Ministry received just two complaints concerning the care being provided in the home. Both were subject to inspections. Wettlaufer was not mentioned in either complaint, nor does her name appear in the inspection notes.

On April 28, the Ministry received a complaint from a resident, who advised that there had been an outbreak of vomiting. The resident indicated that management had not been available when the outbreak started, so the PSWs, who were short-staffed, had to step in to assist. When the complainant was contacted by an inspector, he raised other concerns including the tub chair not working, lack of water in the home, running short on food at meal times, and residents being forced to eat off paper plates when the dishwasher was broken. The complaint was marked for an inspection within 30 days. An inspection took place on May 23, and resulted in one written notice of non-compliance, accompanied by a voluntary plan of correction, for failing to ensure that staff complied with the home's policy to record meal temperatures before serving them.

The second complaint came into the Ministry's INFOline on August 21. A staff member expressed two concerns: that the home was not doing enough to address the behaviour of a violent resident, and that the home had not intervened sufficiently when another resident had been verbally abused by tablemates at dinner. This complaint was reviewed on August 28 and assigned for inspection. On October 8–9, the assigned inspector determined that the home had put in place appropriate interventions for both residents, and she did not issue any findings of non-compliance.

3. Other Inspections: April–October 2014

In early April 2014, three Ministry inspectors attended Meadow Park (London) to conduct a resident quality inspection (RQI). This was the second RQI completed there, the first having taken place in the fall of 2012.¹⁹ The inspectors spent eight days in the home, and issued their inspection report on April 30, 2014. There were 12 written notifications issued for non-compliance with the legislation and regulations, nine of which were accompanied by voluntary plans of correction. No compliance orders were issued. The findings of non-compliance covered a broad range of issues, including failing to ensure

¹⁹ There was no RQI at Meadow Park (London) in 2013.

that residents' rights to be fed, groomed, and cared for in a manner consistent with their needs were respected; the home's furnishings and equipment were maintained in a safe and good condition; residents with altered skin integrity received clinically appropriate skin assessments; direct care staff were provided with training in falls prevention; and drugs were stored in an area or medication cart in compliance with the manufacturer's instructions. The 2014 RQI was a marked improvement over the 2012 RQI, which resulted in 37 findings of non-compliance, 11 accompanied by compliance orders. During that previous inspection, two compliance orders related to the storage of medications.

4. Critical Incidents Not Reported

While working at Meadow Park (London), Wettlaufer killed Arpad Horvath. After she intentionally injected him with an insulin overdose, he became ill and was sent to hospital. Although the Ministry had received a report about possible abuse of Mr. Horvath by a different staff member – which was investigated – the home did not file a Critical Incident report when Mr. Horvath was sent to hospital because it did not associate his failing health with a medication incident.

IV. Oversight of Telfer Place Long-Term Care Facility

In January 2015, shortly after Wettlaufer resigned from Meadow Park (London) to get treatment for her drug and alcohol addictions, she was hired by an agency, Life Guard Homecare. Life Guard placed her as an agency registered nurse in a number of LTC homes throughout southwestern Ontario, including Telfer Place. She worked there, as the registered nurse, on several occasions between January 2015 and April 2016, when Telfer Place instructed Life Guard to stop sending her. Wettlaufer later confessed to having attempted to murder Telfer Place resident Sandra Towler.

When Wettlaufer worked as an agency registered nurse at Telfer Place, the home was subject to the Ministry's indirect and direct oversight, through its funding agreement, and the regulatory regime imposed by the LTCHA and the Regulation. However, the Ministry had no legislative or regulatory oversight over Life Guard.

A. Funding Through the Long-Term Care Home Service Accountability Agreement

Telfer Place is located in Paris, Ontario. At the time Wettlaufer worked in the home, it fell under the jurisdiction of the Hamilton Niagara Halton Brant (HNHB) LHIN. The relationship between the LHIN and Telfer Place was governed by a Long-Term Care Home Service Accountability Agreement between the LHIN and the home's parent company, Revera. Although the LHIN was responsible for administering the funding authority for LTC homes in its jurisdiction, and would provide them with the per diem rates and per diem envelopes for approved or licensed beds, the Ministry was responsible for determining the funding and funding policies.

B. Licensing of Telfer Place

In January 2015, when Wettlaufer was first placed as an agency nurse at Telfer Place, the home was operating with a licence issued on July 1, 2010, by the Director under the LTCHA. The licence authorized the home to operate 45 beds and was effective through June 30, 2025.

C. Oversight Through Hamilton SAO Inspectors: January 2015 to April 2016

Between January 2015 and April 2016, Telfer Place fell under the Hamilton SAO's jurisdiction, and inspectors in that office were responsible for all inspections in the home. In 2015, between 25 and 30 inspectors were working out of the Hamilton SAO. CIATT was responsible for triaging all complaints and Critical Incident reports received about homes and assigning them for inspection. In 2015, there were eight triage inspectors.

Although the Ministry received some complaints and conducted a number of inspections at Telfer Place while Wettlaufer was working in that home, none were made about her. No red flags were raised in the complaints or inspections to suggest that Wettlaufer was intentionally harming residents. Although the risk level assigned to Telfer Place through the Ministry's LRPA fluctuated over time, in the 2015/16 fiscal year it was a level 1 risk or a "substantially compliant home."

1. Inspections Conducted: 2015

During 2015, the Ministry did not receive any Critical Incident reports or complaints about Telfer Place. Hamilton SAO inspectors did, however, conduct two inspections there that year: the resident quality inspection (RQI), in March, and a follow-up inspection in relation to the compliance orders issued as a result of the RQI.

The RQI at Telfer Place was conducted by four inspectors over seven days in March 2015. As a result of the inspection, they issued 12 written notifications of non-compliance, four of which were accompanied by compliance orders. Voluntary plans of correction were also issued for eight of the findings. The non-compliance at the home covered a range of different issues, including the appropriate use of bed rails, the preparation of menu items according to the planned menu, the failure to provide care as set out in a resident's care plan, failure to take actions to meet the needs of residents with responsive behaviours, and failure to keep medications stored in a secured and locked area. The 2015 RQI was the second done at that home. The first was conducted in June 2013 and resulted in 29 written notifications of non-compliance, of which nine were issued with compliance orders and 18 were accompanied by voluntary plans of correction.

Toward the end of July 2015, an inspector attended Telfer Place to conduct a follow-up inspection in relation to the compliance orders issued after the RQI. She determined that most had been brought into compliance, with the exception of the ongoing failure to ensure that residents were appropriately assessed to minimize the risks associated with the use of bed rails. She issued another written notification accompanied by a compliance order for this ongoing non-compliance.

2. Complaints Received and Inspections Conducted: January–April 2016

In the first four months of 2016, when Wettlaufer was still being placed at Telfer Place, the Ministry received two complaints. Both involved staffing and care of residents in the home, and both were inspected.

The Ministry received the first complaint on January 26. An anonymous complainant contacted the Ministry to advise that staff were not being replaced when they called in sick and that residents were not getting out of bed until noon. This complaint was assigned for inspection within a 120-day time frame.

The second complaint was made directly to the inspectors conducting an RQI in another LTC home on March 18. A member of the Telfer Place staff approached the inspector to advise that the staffing concerns in the home had gotten worse since the 2016 RQI was completed. The complaint was assigned for inspection within 30 days.

Both complaints were inspected together, but the inspection did not happen until June 13–15, 2016, close to six months after the first complaint was received and some two months after the home's DON had instructed Life Guard to no longer send Wettlaufer to work in the home. The assigned inspector issued four different written notifications of non-compliance, three of which were accompanied by voluntary plans of correction. She found the licensee had failed to ensure that the home's staffing plan mix was consistent with the residents' care and safety needs; residents were receiving baths at least twice a week; all staff participated in the infection prevention and control program; and residents' linens were changed at least once a week.

3. Other Inspections Conducted: January–April 2016

Hamilton SAO inspectors conducted two other inspections at Telfer Place while Wettlaufer was still being sent to work there: a follow-up inspection about the outstanding compliance order concerning bed rail safety, and the 2016 RQI. The inspector who conducted the follow-up inspection on January 27 determined that the conditions from the compliance order had been met. She issued no further findings of non-compliance.

Three inspectors spent seven days at the home in late January and early February conducting the 2016 RQI. The inspectors found multiple instances of non-compliance in the home and issued 23 written notifications of non-compliance, four with compliance orders, and 10 with voluntary plans of correction. As was true of the 2015 RQI, the non-compliances in 2016 covered a broad range of issues, including failure to ensure that staff provided care for residents as set out in the plan of care; that no person other than a physician, dentist, RN, or RPN administered drugs to a resident;²⁰ that the home's staffing plan provided for a staffing mix consistent with the residents' care and safety needs; that drugs were stored in a secure and locked area; and that at least one registered nurse, who was both an employee and a member of the regular nursing staff of the home, was present in the home at all times, subject to the exceptions provided in the Regulation.

²⁰ This finding was issued because the inspection showed that the executive director, who was not registered with the College of Nurses of Ontario, had done the evening medication pass and administered medications to residents.

Ministry Inspections Following Wettlaufer’s Confessions

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I. Introduction

In the fall of 2016, after the Ministry of Health and Long-Term Care (Ministry) learned that Wettlaufer had confessed to harming, killing, and attempting to kill multiple residents in three long-term care (LTC) homes in southwestern Ontario, it immediately assigned a group of inspectors to inspect these homes. These inspections would arguably become the most intense ever conducted by Ministry inspectors and would lead to multiple findings of non-compliance.

I begin this chapter by discussing how the Ministry learned about Wettlaufer's confessions and what steps the Inspections Branch took to begin inspections at the homes where Wettlaufer admitted to committing offences: Caressant Care (Woodstock), Meadow Park (London), and Telfer Place. I then examine in some detail the intensive inspections that took place in each of those LTC homes. Finally, I discuss the inspections that the Inspections Branch chose to initiate at other LTC homes where Wettlaufer had worked as an agency registered nurse.

II. How the Ministry Learned About Wettlaufer's Confessions

In October 2016, Karen Simpson held the position of Director under the *Long-Term Care Homes Act, 2007* (LTCHA).¹ The Director – a position created by the LTCHA – has significant powers and responsibilities in terms of the oversight of LTC homes.² On the morning of October 5, 2016, Ms. Simpson received an email informing the Ministry that a nurse who had worked in LTC homes in Ontario had confessed to police that she had murdered multiple residents and tried to kill others. The information came through an email from Candace Chartier, the chief executive officer of the Ontario Long-Term Care Association. The email read:

¹ SO 2007, c 8. Ms. Simpson gave evidence at the public hearings in the summer of 2018. By that time, she had left the position of Director.

² See, for example, LTCHA, s 157, which gives the Director the power to revoke a licence to operate a long-term care home in Ontario.

Hi everyone

You may want to sit down for this ...

Jim Lavelle [the president of Caessant Care] just called me. A nurse that worked for him from 2007–2014 (she was fired in 2014 due to medication errors) walked into a Toronto Police station and has admitted to murdering seven residents with insulin injections. She admitted to trying to kill four additional residents but they apparently lived. She admitted to working at another home called Telford Place (can we check and see if a member?) and murdered a resident there with insulin as well and finally went on to admit she worked for Life Care [*sic*] Agency and murdered another resident. At first police thought there was mental illness issues around this confession but apparently she was assessed by a psychologist and they believe it is true. Caessant Care has hired David Golden and a PR firm to help them get through this. They will be notifying ministry as well. We need to be prepared for a lot of media as bodies will have to be exhumed, families notified and a full scale investigation. I am literally sick to my stomach and can't even imagine this horror. On top of it all she has only given police the first names of residents.

Ms. Simpson testified that the news was “shocking ... extremely disturbing and distressing.” She immediately took steps to get inspections started, consistent with her obligations as Director under the LTCHA.³ Because Ms. Chartier had identified the home as Caessant Care (Woodstock) in her email, Ms. Simpson called Peggy Skipper, the manager of the London Service Area Office (SAO), asking her to get an inspector to Caessant Care (Woodstock) that day. When the police informed Ms. Simpson later that same day that Wettlaufer had also confessed to harming residents in both Meadow Park (London) and Telfer Place, Ms. Simpson asked Ms. Skipper to initiate an inspection at Meadow Park (London) too. In addition, Ms. Simpson contacted Karin Fairchild, the manager of the Hamilton SAO, and told her to begin an inspection at Telfer Place.

When Ms. Simpson received Ms. Chartier's email, none of the homes had filed a Critical Incident report on these matters. Ms. Simpson contacted Mr. Lavelle that same day. He told her the police had advised him of Wettlaufer's confession two days earlier, but he had not reported it because he did not know what to do. He told Ms. Simpson that “it was the most upsetting thing in his entire life.”

³ LTCHA, s 25, requires the Director to arrange for an inspector to conduct an inspection if information is received from any source indicating improper or incompetent treatment or care, abuse or neglect of a resident, or unlawful conduct that has resulted in harm or risk of harm to a resident.

By the end of the day on October 5, all three homes had submitted mandatory Critical Incident reports in relation to the Wettlaufer allegations. Each report included different types of information.

Helen Crombez, the director of nursing at Caressant Care (Woodstock), was the first to submit such a report – and she amended it the next day with new information. This report indicated that the police had come to the home and informed management that Wettlaufer, a former registered nurse employed at the home, had confessed to injecting insulin into residents to cause their death. The report named the residents believed to have been involved as Clotilde Adriano, Albina deMedeiros, James Silcox, Maurice Granat, Wayne Hedges, Michael Priddle, Gladys Millard, Helen Matheson, Mary Zurawinski, Helen Young, and Maureen Pickering.⁴ It also noted that Wettlaufer's employment had been terminated in March 2014 and that the College of Nurses of Ontario (College) had been notified.

Ruthanne Foltz, the administrator at Telfer Place, submitted a Critical Incident report for that home late in the afternoon on October 5. It indicated that police had come to the home on October 4, 2016, and advised management that Wettlaufer had confessed to attempting to kill Sandra Towler, one of the residents, by overdosing her with insulin sometime in the winter of 2016. According to the report, management had informed the police that Wettlaufer was not an employee of the home but "an employee of Lifeguard Staffing Services."⁵

The final Critical Incident report filed with the Ministry was for Meadow Park (London). Nicole Ross, administrator of the home, submitted a Critical Incident report early in the evening on October 5. Ms. Ross indicated that police had come to Meadow Park (London) the previous day and informed her they were "currently investigating a registered staff member for abuse of a resident." No resident was named in the report.

⁴ It is not clear if the names were included in the original Critical Incident report, submitted the afternoon of October 5, 2016, or were added the next day when the report was amended.

⁵ This report was amended two days later, on October 7, to include new information indicating that Wettlaufer had said another registered nurse, Dianne Beauregard, had "corrected" what she had done – meaning that she had provided the necessary medical care to Ms. Towler when she found her to have low blood sugar. By that time, the home had also located, in Ms. Towler's health records from September 2015, a documented change in her clinical status.

III. Inspectors Assigned and Inspections Initiated in All Three Homes

Once the London and the Hamilton SAO managers were notified of Wettlaufer's confessions, inspectors Rhonda Kukoly, Natalie Moroney, and Lisa Vink were assigned to initiate inspections in the three homes where Wettlaufer was known to have worked and harmed residents. The three lead inspectors were all witnesses at the hearings.

Unlike most inspections, the inspectors were given very specific instructions about what they could and could not do. These precautions were taken to ensure that the Ministry's inspection did not jeopardize the on-going police investigation.

Ms. Kukoly and Ms. Moroney were told to go to Caressant Care (Woodstock), to speak only to the administrator, to document the entire conversation, and to request documents, including Wettlaufer's shift schedules for the time she worked in the home as well as the death records for all deaths dating back to when Wettlaufer first began working in the home. They were advised not to ask any other questions.

Ms. Vink and the team assigned to the Telfer Place inspection were advised not to discuss information regarding the confessions with anyone, including their colleagues or anyone in the home other than management. Lesley Edwards, who was part of the Telfer Place inspection team, was asked to go to Telfer Place to gather documentation regarding resident hospital transfers, Wettlaufer's shifts, and discharges and deaths.

A. Initial Visits to the Homes

On the afternoon of October 5, 2016, Ms. Kukoly and Ms. Moroney went to Caressant Care (Woodstock) to initiate the inspection and request the necessary documentation. Although they were instructed to speak only to the administrator, on arriving at the home they learned that the administrator had retired the previous Friday. Their manager confirmed they could speak instead with the director of nursing, Ms. Crombez. Both inspectors noted that Ms. Crombez was very upset. As Ms. Kukoly said in her testimony:

She was obviously, reasonably, understandably devastated. She was crying. She just kept saying, "We are a good home. I just can't believe this happened. I can't believe this happened." She was literally in shock.

Ms. Crombez did not give the inspectors the documents they sought that day because the records had been archived. She did, however, track them down and had them ready the following day.

Later on October 5, Ms. Kukoly learned that Wettlaufer had also worked at Meadow Park (London); she and Ms. Moroney were instructed to go to that home the next day. On the morning of October 6, the two inspectors were met by Ms. Ross. She was expecting them and had prepared a number of documents, including Wettlaufer's employment file. She had also copied records for a former resident, Arpad Horvath, and suggested the inspectors might want those too. When they asked why, she told them this resident had been sent to hospital the day after Wettlaufer worked in the home, when he was found with very low blood sugar, and he had died in hospital a few days later. According to Ms. Moroney, Ms. Ross told them the detectives who visited the home had informed management that Mr. Horvath was one of Wettlaufer's victims.

Between October 6 and November 25, 2016, the Hamilton SAO learned that Wettlaufer had worked as an agency registered nurse at several other homes in the area, including Anson Place Care Centre, Dover Cliffs Long Term Care Home, Park Lane Terrace, and Brierwood Gardens. Ms. Fairchild initiated inspections in each of these homes, and inspectors attended to gather initial documentation, including information concerning the shifts that Wettlaufer had worked in the homes.

Once documents had been retrieved, the inspectors were told not to return to any of these homes until further notice, to allow the police to proceed with their criminal investigation. Ms. Simpson worked closely with the officer in charge of the police investigation, Inspector Rob Hagerman of the Ontario Provincial Police, to continue to ensure that the Ministry inspections would not interfere with the police investigation.⁶

⁶ Ms. Simpson explained that if the Ministry inspectors were concerned about any of the information they found during their inspections, they provided it to Inspector Hagerman, so the police could assess its relevance to their investigation.

B. Off-Site Preparation for the Inspections

While the inspectors awaited approval to begin on-site inspections, they reviewed the documents they had retrieved from the homes (including Wettlaufer's employment files) and prepared for the inspections.

Ms. Kukoly and Ms. Vink took the lead in preparing the inspection plans for all three homes, with input from Ms. Simpson and the SAO managers. I was told during the hearings that the plans were similar to what would be prepared for any critical incident inspection, with some important differences. First, for example, inspectors would not typically have access to an employee's human resources file or any resident's healthcare records before beginning the inspection. Second, inspectors would normally have freedom to decide which staff members to interview. Third, it was unusual for the inspectors not to be able to ask the person who was the subject of the Critical Incident reports – in this case, Wettlaufer – about the incidents that had occurred while employed in the home.

All three inspection plans involved consistent approaches. However, Ms. Vink realized that the Telfer Place inspection would be different from the Caressant Care (Woodstock) and Meadow Park (London) inspections because Wettlaufer had been placed at the home as an agency registered nurse and was not an employee of the home. As such, while all three inspections planned to look at the home's entire medication system, the Telfer Place inspection included a review of compliance with the LTCHA requirements relating to agency registered nurse staffing and training for agency staff in the home.⁷

During the time when the inspectors could not go into the homes because of the police investigation, they reviewed inspection reports and Critical Incident reports submitted by the homes, particularly those relating to medication or those involving residents who were known to be victims.

It was unusual for the inspectors to review a staff member's entire employment file as the first step in an inspection. As Ms. Kukoly explained, when she reviewed the Caressant Care (Woodstock) file, she focused on whether the home had complied with the legislative and regulatory requirements concerning the duty to protect residents and whether it had taken corrective action to address medication incidents. In her review of Wettlaufer's employment file, she noted a number of medication errors,

⁷ These issues were also included in the inspection plans for the other homes where Wettlaufer had worked as an agency registered nurse.

complaints made by co-workers, and records of disciplinary actions imposed on her by the home. According to Ms. Kukoly, what she found most significant in her review were co-workers' complaints about Wettlaufer's inappropriate behaviour to her colleagues – and inappropriate behaviour toward, and care of, residents. Much of what Ms. Kukoly found in the employment file helped guide the inspectors' decisions about who to interview and which incidents to inspect.

The inspectors assigned to the Meadow Park (London) inspection, Ms. Moroney and Neil Kikuta, also reviewed Wettlaufer's employment file before their on-site inspection. According to Ms. Moroney, she was surprised to see the positive reference letter from Caressant Care (Woodstock) because she knew "there were issues at CCW regarding EW's performance, absenteeism, difficulty with co-workers, and medication incidents." She confirmed that Meadow Park (London) had complied with the LTCHA requirements with respect to Wettlaufer's mandatory training, confirmation of certificate from the College of Nurses of Ontario, and criminal record check.

As part of the pre-inspection review of documents, the manager and administrative assistants in the London SAO plotted the shifts that Wettlaufer had worked in relation to the deaths in both Caressant Care (Woodstock) and Meadow Park (London). They produced a detailed chart summarizing this information. But, as Ms. Kukoly explained at the hearings, they ultimately decided that "it didn't tell us really anything" because "it didn't pay homage to the fact that not every resident passed away right away. They might have passed away two days later."

Ms. Vink and her team also reviewed the documents that Telfer Place and the other Hamilton homes provided after they learned that Wettlaufer had worked for them as an agency registered nurse. In her testimony at the hearings, Ms. Vink stated that nothing in those records stood out as particularly alarming. She indicated that the most helpful information came from the amended Critical Incident report that provided the name of the alleged victim (Sandra Towler), the time frame for the incident, and the name of the nurse (Dianne Beauregard) who had apparently intervened to help the resident. Ms. Vink and her team also reviewed Telfer Place's compliance history – as they often did before an inspection. She noted several issues concerning medication administration and sufficient staffing, both of which she felt might be relevant to the inspection.

IV. Inspections in the Homes

In late October 2016, the police advised Ms. Simpson that they would hold a news conference to announce the charges against Wettlaufer. Once the charges were public, the police would allow the Ministry to begin its inspections, provided the Ministry did not interview anyone until the police interviews were complete. The on-site inspections at Caessant Care (Woodstock), Meadow Park (London), and Tefler Place began on October 28, 2016 – the day the police announced the charges against Wettlaufer.⁸

A. The Caessant Care (Woodstock) Inspection

On the afternoon of October 28, 2016, inspectors Rhonda Kukoly and Marian Macdonald attended Caessant Care (Woodstock) to begin their inspection. As Ms. Kukoly acknowledged in her evidence at the hearings, this inspection was very different from any other.

First, the inspection was significantly longer than most. The two inspectors remained on-site for the better part of six months. Even after the initial inspection was completed, inspectors had to re-attend for a number of follow-up inspections, meaning that inspectors were in and out of the home fairly regularly (at least every month) until December 2017.

Second, unlike most critical incident inspections, the focus was not on a specific incident or series of issues. Instead, the inspectors were reviewing the home's systems – medication, reporting and complaints, training and orientation, critical incident response – to determine whether these systems posed any current risks to the home's residents.

Third, it was highly unusual for the inspectors to delay their interviews. Although they began their inspection at the home on October 28, 2016, they did not interview anyone until November 9. Moreover, the inspectors were instructed to audiotape the interviews, something they had never done before.

Fourth, the team had much more regular contact with the Director than usual. Ms. Kukoly testified that they connected with Ms. Simpson nearly every day, at

⁸ The charges involving Sandra Towler, the Tefler Place resident, were not announced until January 2017.

least initially, and met with her at least once a week. This contact tapered off as the investigation progressed.

Finally, the team inspected significantly more intakes – other Critical Incident reports or complaints that had been triaged for inspection – during the Wettlaufer inspection at Caressant Care (Woodstock) than in a typical inspection. Altogether they inspected 17 other intakes, two follow-up inspections, and multiple incoming complaints while on-site for this Inspection.

1. First Steps: Review of Systems in the Home

Ms. Kukoly and Ms. Macdonald began their inspection by reviewing the various systems in the home. Although much of their initial focus was on the medication management system, they also reviewed documents concerning training and orientation, screening for new employees, reporting, complaints, and the meeting minutes for both the residents' council and the family council.

Ms. Simpson directed the inspectors to complete the medication inspection protocol⁹ in its entirety.¹⁰ Previously, inspectors were required to complete only part A, which included observations of medication administration, drug storage, and drug destruction records. Inspectors would move on to part B (medication administration and processes) or part C (medication management system) only if there were concerns about non-compliance in part A.

Ms. Kukoly testified that they began the inspection by completing the observations required for the medication inspection protocol. She observed medication passes on different units at different times, as well as how drugs were stored in different medication rooms. At the time, if she found potential compliance concerns, she would point them out and ask, for example, if the expired bottle of medications belonged in the medication cart. She explained that this approach was different from her normal practice because she was not yet able to interview staff. When the inspectors found evidence of non-compliance, they took photos.

⁹ Inspection protocols are designed as detailed checklists that align directly with the LTCHA and the Regulation. They are intended to help focus inspectors on a specific issue and provide guidance on where to look for it in the legislation. The inspection protocols contain instructions, guidelines, and suggested probes and questions that help inspectors determine whether a home is in compliance with the requirements of the LTCHA and the Regulation. They are discussed in more detail in Chapter 9.

¹⁰ See Appendix E for a copy of the medication inspection protocol being used at the time of the writing of this Report.

Ms. Kukoly and Ms. Macdonald also reviewed the home's processes and policies concerning medication incidents and its evaluations and reviews of the medication management system. The inspectors found numerous concerns relating to the administration of medication and to medication management at the home, and these concerns in turn informed their plan for the inspection.

In fact, reviews of the medication inspection protocols at both Caressant Care (Woodstock) and Meadow Park (London) led, in January 2017, to a policy change in the Inspection Branch for all resident quality inspections (RQIs).¹¹ Thereafter, inspectors were required to inspect the medication management system (in relation to medication incidents and adverse drug reactions) as part of the medication inspection protocols in all RQIs in all homes. Previously, this system would have been examined only if the inspectors had found potential non-compliance in these areas during the inspection.

This change in approach to inspecting medication-related issues in homes resulted in many findings of non-compliance relating to medication management systems¹² and medication administration¹³ in the 2017 RQIs in all homes in the province. That year, both made the list of top 10 non-compliances for the first time.¹⁴

The inspectors interviewed other members of management from Caressant Care (Woodstock), including former administrators, regional care coordinators, and the food and nutrition manager. They also interviewed members of Caressant Care's corporate team, including the vice-president of operations, the vice-president of human resources, the corporate communications manager, and a corporate executive assistant.¹⁵

¹¹ Resident quality inspections are the comprehensive inspections conducted annually in each LTC home in Ontario. The nature and scope of these inspections are discussed in more detail in Chapter 9.

¹² O Reg 79/10, s 135.

¹³ O Reg 79/10, s 131.

¹⁴ In 2017, inspectors issued written notifications for non-compliance with section 135 of the Regulation in 42% of all long-term care homes in the province. They also issued written notifications for failing to comply with section 131 in 21% of the homes.

¹⁵ Copies of all inspection reports and orders issued in relation to the Caressant Care (Woodstock) Wettlaufer inspection can be found at: <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2636&tab=1>, under Inspections/Year 2017.

The inspectors interviewed a significant number of the staff at Caressant Care (Woodstock), including all nursing staff, personal support workers, pharmacists, and physicians dating back to the time that Wettlaufer began working in the home in 2007. They also interviewed the chairs of the residents' council and the family council. In addition to asking all staff general questions, they had specific questions for those who had been involved in the incidents and complaints relating to Wettlaufer.

Ms. Kukoly acknowledged that "the interviews weren't as revealing as one might expect them to be, but also looking at the amount of time that we were inspecting on, you can understand why people didn't understand or didn't remember specifics." She recognized that the situation was different at the public hearings, where witnesses (including former staff) were able to review documents before they testified. As she put it, "[W]hen we were asking them at the time ... they didn't have that preparation." She indicated that inspectors would try to read staff progress notes or show them their letters of complaint to help jog their memories, but most of them did not have much to offer.

Ms. Kukoly testified that certain staff members described Wettlaufer's work performance as erratic. Sometimes she did very well at work, and at other times much more poorly. Some staff members told the inspectors that Wettlaufer seemed to know when she was "getting close to the edge" and would then begin to improve. Ms. Kukoly said the most striking thing to emerge from the interviews was that no one had suspected what was happening, even as they worked alongside Wettlaufer:

[N]ot one staff member said they had any idea that ... she could have done this, not one, and they were beside themselves. They were wracked with guilt and sleepless nights that ... she did this while I was working on my shift ... almost every one of them cried ... they get very attached to their residents, and to think they had been murdered.

This theme emerged during the testimony from many witnesses who worked in the LTC homes where Wettlaufer was employed. No one believed they were working alongside someone who would intentionally harm residents. They certainly did not believe there was a serial killer in their midst.

The final step in the Caressant Care (Woodstock) inspection was to interview the families and friends of nine of the 11 victims from that home to see if they had felt any concerns about Wettlaufer or if they had raised any concerns with the home. Ms. Kukoly explained that she found this part of the inspection most difficult.

B. Findings of the Caressant Care (Woodstock) Inspection

Although the Caressant Care (Woodstock) inspection was completed in March 2017, the final inspection report, with findings, was not issued until August of that year.¹⁶ When the report was released, it included 13 written notifications of non-compliance: six were issued just as written notifications, five were accompanied by voluntary plans of correction, and two were issued with compliance orders.¹⁷ There were also three findings of unmet standards under the *Nursing Homes Act*.¹⁸ The two compliance orders arising out of this inspection were issued on January 24, 2017, much earlier than the final report. The day after these orders were issued, Ms. Simpson, in her capacity as Director, issued a “cease admissions order” at Caressant Care (Woodstock).

1. Immediate Compliance Orders

On January 24, 2017, eight immediate compliance orders were issued against Caressant Care (Woodstock) while the inspection was ongoing. Of the eight, six were issued as a result of other complaint, critical incident, and follow-up (CCF) inspections conducted concurrently with the inspection following Wettlaufer’s confessions.¹⁹

¹⁶ The inspectors had been told to delay issuing the reports to avoid interfering with the criminal proceedings against Wettlaufer.

¹⁷ The different enforcement mechanisms available to inspectors (and the Director) are discussed in Chapter 9. They are found in LTCHA, ss 50, 153, 154, 155, 156, 157.

¹⁸ RSO 1990, c N.7. As discussed in Chapter 9, the *Nursing Homes Act* was in effect for the first three years that Wettlaufer worked at Caressant Care (Woodstock). It was repealed and replaced by the LTCHA, effective July 1, 2010.

¹⁹ Of the six immediate compliance orders issued for the complaint, critical incident, and follow-up inspections, four related to concurrent complaint inspections, including orders for (1) failing to ensure that skin and wound assessments had been completed, as required by section 50 of the Regulation; (2) failing to ensure that the residents receive hygiene and grooming on an individual basis, as required by section 32 of the Regulation; (3) failing to investigate allegations of resident neglect, as required by section 23 of the LTCHA; and (4) failing to ensure that direct care staff were aware of resident care needs related to safe feeding and failing to review and revise the care plan as needed, as required by section 6 of the LTCHA. These orders were issued with a compliance date of March 1, 2017.

Two orders were reissued in the follow-up inspection conducted concurrently with the other inspections. The reissued orders were for (1) failing to ensure that the resident’s plan of care was based on an assessment of safety risks with respect to the use of electric wheelchairs, as required by section 26 of the Regulation; and (2) failing to report suspected abuse to the Director, as required by section 24 of the LTCHA. The first order had a compliance date of April 28, 2017, while the second had a compliance date of January 27, 2017.

The two compliance orders issued as a result of the Wettlaufer inspection were for current medication errors and medication management problems that the inspectors identified in the home. Ms. Kukoly and Ms. Macdonald found 41 documented medication errors at the home between August 7 and December 28, 2016. They were concerned about the volume of medication errors and the home's apparent difficulty in managing those incidents. When asked at the hearings whether 41 medication errors in five months was high, Ms. Kukoly acknowledged this number was "a lot" but emphasized that it was "coupled with the way the home was managing or struggling with managing their medication incidents, they really do go together ... That raised concern."

The inspectors were also concerned that some errors had not been reported to the pharmacy and the director of nursing. They found that the home's reporting systems were deficient, in terms of internal reporting and mandatory reporting to the Ministry, when a resident was transferred to hospital following a medication error.

The first immediate compliance order was specifically issued for failing to comply with section 131(2) of the Regulation, requiring the licensee to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. The grounds for the order referenced the 41 medication incidents documented during the period August 7 through December 28, 2016. These incidents included 37 in which the medication was not administered in accordance with the directions for use.

The report noted that the severity of the non-compliance was "actual harm / risk" and that the scope was "widespread." The licensee was ordered to ensure by January 27, 2017, that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The second immediate compliance order was issued for failing to comply with section 135 of the Regulation, concerning the home's system for management of medication incidents and adverse drug reactions. The order specified:

The licensee will ensure that for medication incidents and adverse drug reactions:

- Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health and to prevent reoccurrence.

- Every medication incident and adverse drug reaction will be reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
- Medication incidents and adverse drug reactions will be reviewed and analyzed quarterly and annually in order to reduce and prevent medication incidents and adverse reactions, and a record kept of this.
- Corrective action will be taken as necessary related to the results of the review and analysis of medication incidents and adverse drug reactions in order to reduce and prevent re-occurrence, and a record kept of this.

The grounds listed in support of this compliance order were quite lengthy and included the following:

- Of the 41 medication incidents documented in PointClickCare, all of which were signed by the director of nursing, some showed that steps were not taken to assess or maintain the resident's health. For example, when a resident was not given one of the required doses of Metformin for her diabetes, there was no indication that the resident was assessed or given a blood sugar test.
- In two separate instances in the fall of 2016 when controlled substances were found to be missing, the director of nursing was unable to produce any documentation concerning the interviews she held with registered staff or any follow-up steps taken.
- The consultant pharmacist told the inspectors during interviews that the pharmacy had received reports only of medication incidents that involved pharmacy errors, not of all those that occurred in the home. The pharmacist therefore did not review every medication error in the home and had not been aware of the extent of the medication errors in the fall of 2016.
- Similarly, the medical director told the inspectors during his interview that he had not been advised of all medication errors but only those involving his patients.
- The inspectors reviewed several of the home's internal meeting minutes and documentation, such as the medication management system program evaluations, the Professional Advisory Team meeting minutes, quality improvement / risk quarterly reports, and continuous quality improvement meeting minutes, and found few concrete efforts to decrease the number of medication errors.

The compliance order indicated that the severity of the non-compliance was “minimal harm / risk” or “potential for actual harm / risk,” though the scope was “widespread.” It noted that the home did not have a history of non-compliance. The licensee was given until April 28, 2017, to comply with this order.

2. The Cease Admissions Order

On January 25, 2017, the day after the eight immediate compliance orders were issued to Caressant Care (Woodstock), Ms. Simpson, as the Director, wrote to Mr. Lavelle, the president of Caressant Care, to advise that she had directed the South West Community Care Access Centre to cease authorizing admissions to the home. The cease admissions order was to be effective January 26, 2017, and would last until she issued further notice. As she explained in her letter, “I am directing the ceasing of admissions based on my belief that there is a risk of harm to the health or well-being of residents in the home or persons who might be admitted as residents.” Ms. Simpson testified that she made the cease admissions order because the inspectors “had found evidence of non-compliance reflecting current and serious issues related to the care of residents.” She explained her rationale for issuing the order at some length:

So, we had eight orders, some of which had been ordered before and not complied with. And in addition, with the medication issues, this was a home where we now had charges laid in relation to medication administration causing death and alleged murders ... and this was a home that we also now are finding significant number of medication errors where they are not taking appropriate action to actually investigate and deal with those issues.

So from my perspective, from a risk perspective, there was a huge risk in relation to medication administration just given the alleged offences. And in addition to that, we also had orders that we issued in relation to grooming – like basic grooming and hygiene of residents where residents – this came in through complaints [–] where residents were not being looked after properly.

Of the three homes where Wettlaufer admitted to killing or trying to kill residents, Caressant Care (Woodstock) was the only one that was ordered to cease admissions.

3. Inspection Findings

Although the inspection following Wettlaufer's confessions was completed at Caressant Care (Woodstock) by March 2017, the report was not issued until August 2017. As Ms. Kukoly explained during the hearings, there were ongoing concerns about potentially compromising the police investigation, and the Ministry had been told not to issue its report until the police gave clearance. The Caressant Care (Woodstock) inspection report contained the findings of non-compliance relating to medication administration and medication management systems (outlined above). It also included 11 other findings of non-compliance and three findings of unmet standards under the *Nursing Homes Act* (which was in effect for the time Wettlaufer worked in the home before the LTCHA came into force in 2010). Many of the findings of non-compliance specifically related to Wettlaufer. Table 11.1 summarizes the findings of non-compliance from the Caressant Care (Woodstock) post-confession inspection.

Table 11.1: Summary of Caressant Care (Woodstock) Post-Confession Inspection Findings

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Unmet Standards Issued Under the <i>Nursing Homes Act</i>	
Failing to report an "unusual occurrence" to the Ministry – namely, "unusual or accidental deaths" – as required by the <i>Long-Term Care Homes Program Manual</i> (Program Manual).	Unmet standard issued under the <i>Nursing Homes Act</i> .
Failing to report an "unusual occurrence" – namely, a medication error that resulted in a resident's admission to hospital – as required by the Program Manual.	Unmet standard issued under the <i>Nursing Homes Act</i> .
Failing to ensure that all medication errors and adverse drug reactions are reported promptly to the director of nursing, prescriber, and pharmacist, as required by the Program Manual.	Unmet standard issued under the <i>Nursing Homes Act</i> .

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Non-compliance Relating to Reporting of Medication Incidents, Medication Management, and Administration	
Failing to file a Critical Incident report for a missing or unaccounted for controlled substance or medication or for a medication incident or adverse drug reaction that results in a resident's transfer to hospital, as required by O Reg 79/10, s 107(3).	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to hold quarterly interdisciplinary team evaluations of the home's medication management system, as required by O Reg 79/10, s 115.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to hold annual interdisciplinary team evaluations of the home's medication management system, as required by O Reg 79/10, s 116.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that drugs remain in original labelled container or package until administered to a resident or destroyed, as required by O Reg 79/10, s 126.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that monthly audits are undertaken of the daily count sheets of controlled substances, as required by O Reg 79/10, s 130.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure compliance with the home's policy relating to drug destruction and disposal, as required by O Reg 79/10, s 8.	Written notification only (LTCHA). A compliance order was issued for non-compliance with this provision in a concurrently completed critical incident inspection.
Failing to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, as required by O Reg 79/10, s 131.	Issued as an immediate compliance order (LTCHA) on January 25, 2017, with this inspection (before the final report was issued).
Failing to ensure that all appropriate steps are taken following a medication incident or adverse drug reaction involving a resident, including documenting actions taken to assess and maintain the resident's health and reporting to the resident, his or her substitute decision-maker (if any), and all relevant healthcare professionals, as required by O Reg 79/10, s 135.	Issued as an immediate compliance order (LTCHA) on January 25, 2017, with this inspection (before the final report was issued).

continued

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Non-compliance with Requirements Relating to Allegations of Abuse or Neglect of Residents	
Failing to ensure compliance with the home's written policy promoting zero tolerance of abuse and neglect of residents, as required by LTCHA, s 20.	Written notification only (LTCHA). A compliance order was issued for non-compliance with this provision in a concurrently completed critical incident inspection.
Failing to ensure that every alleged, suspected, or witnessed incident of abuse of a resident which the licensee knew of, or which was reported, was immediately investigated and appropriate action taken, as required by LTCHA, s 23.	Written notification only (LTCHA). A compliance order was issued for non-compliance with this provision in a concurrently completed critical incident inspection.
Failing to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, or incompetent or improper treatment or care of a resident which resulted in harm or risk of harm to the resident, had reported that suspicion to the Director immediately, as required by LTCHA, s 24.	Written notification only (LTCHA). A compliance order was issued for non-compliance with this provision in a critical incident inspection conducted during the same time frame.
Non-compliance Relating to Screening Checks	
Failing to ensure that criminal record checks were completed, as required by LTCHA, s 75.	Written notification only (LTCHA).
Non-compliance Relating to the Home's Record-Keeping	
Failing to ensure that a documented record was kept in the home of each written and verbal complaint received, along with other relevant information.	Written notification only (LTCHA). A compliance order had been issued during an earlier resident quality inspection at the home and, later, it was found that it had been brought into compliance.

Source: Compiled by the Commission.

The three findings of unmet standards under the *Nursing Homes Act* all involved failures to report to the Ministry. The first unmet standard was issued to Caressant Care (Woodstock) for failing to report "unusual occurrences according to Ministry Policy," including "unusual or accidental deaths" as required by the standards and criteria set out in the *Long-Term Care Homes Program Manual* (Program Manual). This finding was issued in relation to

James Silcox, Wettlaufer's first murder victim at the home. The report noted that Wettlaufer had completed the Institutional Patient Death Record on August 12, 2007 (see Chapter 14) and had checked "yes" next to the questions "Accidental death?" and "Is the death both sudden and unexpected?" Despite the death having been marked as accidental and as sudden and unexpected on this form, no unusual occurrence report was filed with the Ministry, as required by the Program Manual.²⁰

The second unmet standard was issued for failing to file an unusual occurrence report for a medication or treatment error that resulted in a resident's admission to hospital, as required by the Program Manual. The inspectors found a resident incident report in PointClickCare from October 7, 2007, for Clotilde Adriano. That incident related to a medication error that resulted in a resident's blood sugar bottoming out several times during the night. When the registered nurse on duty contacted the physician on call about orders for treatment, she was told that a nurse had called that evening "about an insulin overdose." The incident report was signed by the resident's physician, the director of nursing, and the administrator. The next day, the resident's progress notes showed that her family wanted her checked, and the doctor agreed she could be sent to hospital. She was admitted to hospital on the evening of October 7 and was not discharged back to the home until October 15. Although the Program Manual required the home to submit an unusual occurrence report when a medication or treatment error required a transfer to hospital, no report had been sent to the Ministry.

The final unmet standard issued under the *Nursing Homes Act* also related to the medication error involving Ms. Adriano. It was issued for failing to ensure that "all medication errors and adverse drug reactions shall be reported promptly to the director of nursing, prescriber, and pharmacist according to established policy and procedure and specific follow-up action shall be taken." When the inspectors interviewed Ms. Crombez about this incident from October 2007, she was not able to recall if any follow-up action had been taken and could not produce any documentation to show it had. The inspectors also spoke with the consultant pharmacist who had provided services to the home from 2007 to 2013. He told them that the home did not report all medication errors to the pharmacy but limited its reports to pharmacy errors.

²⁰ Reporting requirements under the Program Manual are discussed in Chapter 9.

The remaining findings of non-compliance in the Caressant Care (Woodstock) inspection report were made under the LTCHA regime, which meant they involved incidents from July 1, 2010, through to the time of inspection.

The first six findings of non-compliance issued under the LTCHA related to problems with medication management in the home – from reporting of critical incidents, to evaluations of the medication management system, to drug storage and audits of drug counts. Inspectors issued a written notification for failing to comply with section 107(3) of the Regulation, requiring the licensee to file a Critical Incident report for a missing or unaccounted-for controlled substance or for a medication incident or adverse drug reaction that resulted in a resident being taken to hospital. The inspectors found two internal Caressant Care (Woodstock) medication incident reports completed in the fall of 2016 for controlled substances that had gone missing, but no Critical Incident reports had been filed with the Ministry.²¹ Inspectors also found that the home had failed to file a Critical Incident report for a medication incident from the fall of 2016 that resulted in the resident's transfer to hospital. The written notification for failing to report was issued with a voluntary plan of correction.

The next two findings of non-compliance pertained to the quarterly and annual evaluations of the effectiveness of the medication management systems in the home, as required by sections 115 and 116 of the Regulation. The inspectors issued this finding because the home was not able to produce documentation to show that it had been holding quarterly (or annual) evaluations of the home's medication management system with all required members of the interdisciplinary team. In the course of their interviews, the inspectors found that not all required members of the team had participated in medication management program evaluations. These two written notifications of non-compliance were also issued with voluntary plans of correction.

The next written notification was for failing to comply with section 126 of the Regulation, requiring the licensee to ensure that drugs remain in the original labelled container or packaging provided by the pharmacy service provider or the Government of Ontario until they are administered or destroyed. In the fall of 2016, the inspectors observed that drugs had been removed from their original packaging and placed directly on the medication carts in

²¹ Although the report noted that the last Critical Incident report for missing or unaccounted-for controlled substances was from August 2012, Ms. Kukoly acknowledged in her testimony that this statement was a mistake. In preparing for the Inquiry, they discovered some Critical Incident reports filed by Caressant Care (Woodstock) in 2013 and 2014 for missing controlled substances.

individual bins for residents. This notification was issued with a voluntary plan of correction.

The next written notification was for failing to comply with section 130 of the Regulation, which requires that steps be taken to ensure the security of the drug supply – for example, by doing a monthly audit of daily count sheets of controlled substances. The director of nursing told the inspectors that they had never done audits of daily count sheets of controlled substances, and she was not aware it was required. This notification was also issued with a voluntary plan of correction.

The final written notification was issued for failing to comply with section 8 of the Regulation, requiring the licensee to ensure compliance with all policies as required by the Act and the Regulation. This finding was based on evidence that there had been no compliance with the home's drug destruction and disposal policy, both by keeping medications waiting to be disposed of in urine collection bottles and for failing to comply with the policy on expiry and dating of medications. The Caressant Care (Woodstock) inspection report noted that there was a history in the home of non-compliance with this section of the legislation. A finding of non-compliance with this same section was issued as a compliance order in a critical incident inspection completed concurrently with the Wettlaufer inspection. That compliance order had a compliance date of May 26, 2017.

The next three written notifications involved findings of non-compliance with the requirements relating to allegations of abuse or neglect of residents in the home (LTCHA, sections 20, 23, and 24). The first written notification was for failing to ensure compliance with the home's policy that promoted zero tolerance of abuse and neglect of residents. Inspectors found the licensee had not ensured that staff submitted immediate reports in writing of all cases of suspected abuse. In reviewing Wettlaufer's file, inspectors found a handwritten letter of complaint from a personal support worker (PSW) outlining three different concerns about the care Wettlaufer was providing to residents in the home, including waiting several days to conduct an assessment on a resident with breathing difficulties and delays in responding to two different residents' call bells requesting medication. Although some of the PSW's concerns dated back to early December 2011, they were not shared with the director of nursing until mid-January 2012. The report noted that there was a history of non-compliance with this provision at the home. A compliance order was issued in a concurrently completed critical incident inspection, with a compliance date of May 26, 2017.

Inspectors also issued a written notification for failing to comply with section 23 of the LTCHA, requiring the licensee to ensure that every alleged incident of abuse or neglect was immediately investigated and that appropriate action was taken. This finding was issued with regard to the inspection done into Wettlaufer's alleged verbal abuse of a resident when she had reportedly asked him, "Do you need a psych evaluation?" and "Do you need a Haldol?" Inspectors found that two staff members had complained about her conduct toward a resident. The director of nursing could not recall if any action was taken and could find no documentation to suggest it had. The report noted that this matter was issued as a compliance order in another concurrently completed critical incident inspection, with a compliance date of March 1, 2017.²²

The next related written notification was issued for failing to comply with section 24 of the LTCHA, which requires immediate reporting to the Director by anyone with reasonable grounds to suspect that abuse, neglect, incompetent, or improper treatment of a resident has occurred or may occur. Several incidents of this nature involving Wettlaufer had never been reported, including:

- disparaging comments Wettlaufer made to a resident (as mentioned above);
- various comments Wettlaufer made to Maureen Pickering about her confusion and how she couldn't remember things; and
- the incident where Wettlaufer independently transferred a resident with a suspected hip fracture and then lanced the hematoma on the resident's shin with non-sterile scissors.

The inspectors found that no Critical Incident reports had been submitted to the Ministry in relation to these incidents. The report noted that Caressant Care (Woodstock) had a history of non-compliance with section 24 of the LTCHA. A compliance order had been issued to the home in a different follow-up inspection, with a compliance date of January 27, 2017.

The next written notification was for failing to comply with section 75 of the LTCHA, which requires licensees to ensure that screening measures, including criminal record checks, are conducted before hiring staff. The inspectors issued this finding when they discovered that at least two staff members had worked

²² Ms. Kukoly explained at the hearings that because they were not sure when the Caressant Care (Woodstock) inspection report could be made public, they had issued a number of compliance orders on related matters in the concurrent inspections so they could go out before the report.

at the home before their criminal reference checks had been completed.²³ The report indicated that the home did not have a history of non-compliance with this section.

The last written notification of non-compliance (other than for medication administration and medication management, which were part of the immediate compliance orders discussed above) was issued for failing to comply with section 101 of the Regulation, which requires the licensee to keep documented records for each verbal or written complaint received, along with other relevant information such as the date it was received, action taken, final resolution, and when the response was communicated to the complainant. The inspectors issued this finding based on the evidence that before 2015, Caressant Care (Woodstock) had no formal process for documenting complaints and had been unable to locate complaint documentation for the 2010–14 period. The home had a history of non-compliance with section 101. It had been issued as a compliance order during the 2015 RQI, though it was found to be in compliance in 2016. Ms. Kukoly explained that because the finding related to a past problem that had been corrected, the written notification was not issued with a voluntary plan of correction or any other enforcement mechanism.

4. Follow-Up Inspections and the Mandatory Management Order

Ms. Kukoly was involved in all the follow-up inspections at Caressant Care (Woodstock) with the exception of the last one. The first follow-up inspection, conducted in early May 2017 by Ms. Kukoly, Ms. Macdonald, and Sharon Perry, related to seven of the compliance orders issued in January. At that time, some of the orders had been satisfied, but others had not. Seven written notifications were issued; four were accompanied by voluntary plans of correction, and three were accompanied by reissued compliance orders. These reissued compliance orders related to section 50 of the Regulation (failing to ensure that residents are given skin assessments when required); section 23 of the LTCHA (failing to investigate, respond to, and act in response to suspected, alleged, or witnessed abuse or neglect of a resident); and section 131 of the Regulation (failing to ensure that residents receive medication as prescribed). As Ms. Kukoly explained, the compliance order was reissued in relation to medication administration because the number of medication incidents had not declined.

²³ Wettlaufer was not one of these employees. As Ms. Kukoly explained in her evidence, the requirement for criminal reference checks first arose when the LTCHA came into effect in 2010, several years after Wettlaufer had been hired by Caressant Care (Woodstock).

On May 24, 2017, two other compliance orders were issued to Caressant Care (Woodstock) arising from some of the critical incidents that were inspected concurrently with the Wettlaufer inspection. The orders were for failing to ensure compliance with the home's medication reconciliation policy (section 8 of the Regulation) and for failing to comply with the home's zero tolerance and abuse policy.

Ms. Kukoly and another inspector, Ali Nasser, returned to Caressant Care (Woodstock) on July 1, 2017, for a further follow-up inspection. This follow-up inspection related to three compliance orders: one issued in January for medication management,²⁴ one reissued in early May regarding medication administration,²⁵ and another issued later in May concerning compliance with the home's medication reconciliation policy.²⁶ During that visit, the inspectors also conducted two concurrent complaint inspections relating to staffing and medication management concerns.

The inspectors found evidence of ongoing non-compliance with the Regulation and reissued compliance orders for concerns relating to medication management, medication administration, and failing to ensure the implementation of written policies and protocols regarding the medication management system. As Ms. Kukoly explained at the hearings, the inspectors tried to provide more detail in this order about what they were looking for, including:

- for all registered staff, conduct training related to medication administration and the practices, policies, and procedures of the home and pharmacy provider;
- develop and implement a system for tracking the training of staff for medication administration; and
- develop and implement a quality improvement plan for medication administration and for reducing medication incidents in the home.

Despite this clarification, when the inspectors re-attended the home in late July for another follow-up inspection, they were concerned that Caressant Care (Woodstock) still did not have a quality improvement plan and did not have a tracking tool to show that their staff had all received the required

²⁴ O Reg 79/10, s 135.

²⁵ O Reg 79/10, s 131.

²⁶ LTCHA, s 8.

training. After that inspection, they reissued the compliance orders and, in addition, issued a Director's referral²⁷ for sections 131 and 135 of the Regulation (medication administration and medication management).

On September 1, 2017, Ms. Simpson issued a mandatory management order²⁸ based on her belief that "the licensee cannot properly manage the long-term care home." As she explained in her order, her belief was based on the "ongoing and persistent non-compliance" of the licensee. In her testimony, she expanded:

We had been in that home repeatedly over the past ... nine, ten months doing inspections and had had to reissue orders multiple times. So when you look at page 5 [of the mandatory management order], you'll see that medication administration, so section 131, had now been issued at that point three times ...

When we look at medication incidents, that had been issued twice, with the first issue being on January 25th.

Policies related to medication reconciliation, that order had been issued three times. Skin and wound care had been issued twice.

We had an order related to zero tolerance of abuse, and then we also had an order related to immediate investigation that we issued twice.

This home had gone through a lot of management instability which, you know, one can understand given some of the issues that happened; however, there was still instability happening.

And the other concern that I had was that I did not have the confidence at that point in time that the licensee actually had the ability to correct the non-compliance in this home.

²⁷ Under the LTCHA, s 153, inspectors may refer a matter to the Director for further action. Where a Director's referral is made, the Director is then able either to issue a compliance order (which is known as a Director's order in these circumstances), a work or activity order, or an order requiring that funding be returned or withheld. The Director can also issue a mandatory management order or revoke a long-term care home's licence.

²⁸ LTCHA, s 156, authorizes the Director to issue a mandatory management order requiring the licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the LTC home. The Director can issue a mandatory management order where there has been non-compliance with the LTCHA or the Regulation and there are reasonable grounds to believe the licensee cannot or will not properly manage the LTC home or cannot do so without assistance.

Once the new management team was in place at Caressant Care (Woodstock), as required by the mandatory management order, the inspectors began to see improved compliance in their follow-up inspections. In October 2017, Ms. Kukoly, Ms. Nasser, and Ms. Northey returned for a follow-up inspection on the six outstanding compliance orders. They found that most of the requirements of the orders had been met. The home had put in place a quality improvement plan for medication incidents which had led to real improvement. The medication incidents they found all related to agency staff who had not been trained by the home. As a result of this issue, the orders relating to sections 131 and 135 were still not satisfied.

In late November 2017, Ms. Northey returned to Caressant Care (Woodstock) for one more follow-up inspection and found that the two outstanding compliance orders had been satisfied. Less than a week after this inspection report was issued, the cease admissions order at the home was lifted. As of August 2018 (during the public hearings), the mandatory management order remained in effect. Ms. Simpson testified that she has never lifted any of the mandatory management orders she has issued.

C. The Meadow Park (London) Inspection

On October 28, 2016, inspectors Natalie Moroney and Neil Kikuta attended Meadow Park (London) to begin their on-site critical incident inspection following Wettlaufer's confessions. Ms. Moroney stated that she and Mr. Kikuta approached this inspection as they would any other: "We went into the Inspection looking for compliance. We would only have findings of non-compliance if we had facts to support those findings under the LTCHA." As was true of the inspection at Caressant Care (Woodstock), however, some aspects of this inspection were unique.

The Meadow Park (London) inspection spanned many months – the inspectors were there more often than not through to the end of February 2017. During this period they completed concurrent inspections for 14 other critical incident and complaint intakes, significantly more than would be done in a typical inspection.²⁹

As at Caressant Care (Woodstock), the inspectors were not able to start interviewing staff immediately. Ms. Simpson coordinated the approvals for

²⁹ Two of these intakes had been received shortly before they began the inspection following Wettlaufer's confessions. The remainder came in while the inspectors were conducting that inspection.

staff interviews so they would not interfere with the police investigation. According to Ms. Moroney, the interviews at Meadow Park (London) took longer than usual because they had to coordinate with legal counsel for the home, who attended many of the staff interviews.³⁰ It was unusual for the inspectors to audiotape the interviews with the staff. The police were conducting their investigation during this same period and, on occasion, were also in the home to collect documents and interview staff. Ms. Moroney accepted that “this was a stressful and overwhelming process” for both the inspectors and the staff at the home.

Finally, it was unusual for the inspectors to be asked to complete the medication inspection protocol in its entirety as they were instructed to do.

1. First Steps: Gathering Materials and Completing the Medication Inspection Protocol

When the inspectors first arrived at Meadow Park (London), Ms. Simpson directed them to speak only with the administrator, Nicole Ross. According to Ms. Moroney, they asked the administrator for a variety of materials, including the home’s investigation notes for the Critical Incident reports they brought with them, their complaints binder, the home’s abuse policy, records of any medication incidents, and their medication policy. They were also given access to the home’s PointClickCare system, which included the digital medical records for Arpad Horvath.

The initial focus of the Meadow Park (London) inspection was the completion of the medication inspection protocol. On the first day, the inspectors began by observing two of the home’s four medication rooms, where the medication carts were stored. The other medication rooms were observed later in the inspection. They noticed several problems with the way drugs were stored. They found opened ampules of hydromorphone on the top shelf of the medication cart as well as medications in Dixie cups, rather than in the original packaging with resident identifiers attached as required.

Their initial observations also revealed deficiencies in some of the home’s medication record-keeping. For example, the daily narcotics count sheets and the pharmacy order book were not completed properly. In another room, they observed medication, including insulin pens, either with no labels or with labels in illegible writing, meaning there was no (legible) resident personal health information. They observed problems in the home’s drug destruction

³⁰ Counsel was not present during the interviews with the physicians, the pharmacists, or officials from the corporate head office.

process, including full containers with no lids that contained ampules, needles, and other medications that required de-naturing (to make them irretrievable in the waste chain).

As Ms. Moroney explained, they would normally have spoken directly to the registered staff responsible for those medication carts and medication management issues, but, because they were not yet able to interview staff, that was impossible. Instead, they spoke with Ms. Ross.

When asked at the hearings whether she found the extent of the medication management issues unusual or surprising, Ms. Moroney was somewhat non-committal in her reply. She acknowledged that medication concerns were a “widespread issue . . . in all areas of the home,” but also noted that, because they were completing the medication inspection protocol in its entirety, they were looking into areas they had not inspected before, so she couldn’t “necessarily say it was surprising.”

During the inspection, the inspectors also reviewed other documents, including resident health records, plans of care, and the home’s written policies and procedures.

2. Interviews Conducted

The inspectors were initially told they could speak only with the administrator at Meadow Park (London). Staff interviews began later – on November 3, 2016. Shortly after starting the interviews, they were asked to stop because they were told that legal counsel would be attending interviews with the home’s staff, particularly if the interviews were to be about anything related to the home in 2014.

As a result, the interviews with the staff were delayed until counsel could be present. Ms. Moroney explained that the inspectors eventually interviewed a significant number of staff in the home, including both the previous and the acting administrator, the director of care (current and previous), three registered nurses, 11 registered practical nurses, and 18 personal support workers, members of the corporate head office, physicians, and the pharmacy consultant.³¹ Some staff were interviewed more than once. They also interviewed residents and one family.

³¹ All the inspections and orders reports relating to the Meadow Park (London) Wettlaufer inspections are available at: <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2643&tab=1>, under Inspections, Year 2017.

D. Findings of the Meadow Park (London) Inspection

Although the inspection was completed in late February 2017, the Meadow Park (London) inspection report was not issued until August 15, 2017.

The report included eight written notifications of non-compliance; seven were issued with voluntary plans of correction, and one was issued with a compliance order.

1. The February 2017 Compliance Order

On February 6, 2017, a compliance order was issued to Meadow Park (London) relating to deficiencies that the inspectors found with the home's medication management system. As Ms. Moroney explained during the hearings, "[g]iven the extent of [their] concerns," they issued the order during the course of their inspection. The order was issued for failing to comply with section 114(1) of the Regulation, which requires licensees to develop an interdisciplinary system that provides safe medication management and effective drug treatments for residents. The order obliged the licensee to fulfill 14 different requirements to comply with the Regulation. Many of them involved educating and training staff on the regulatory requirements relating to medication management, drug safety, medication administration, drug storage, and similar matters. For example, the licensee was ordered to educate and train staff on various regulatory requirements, including most of sections 126–36 of the Regulation:

- to store controlled substances safely in double-locked storage areas or in a separate locked area within the locked medication cart;
- to keep drugs in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed;
- to respect the policy and procedures for (1) unused or wasted medication for storage, (2) maintaining a drug record, (3) recording daily count sheets for controlled substances, (4) ordering, reordering, and receiving all medication for residents;
- to ensure that only staff who are authorized to administer medications fulfill that function;
- to respect the licensee's policy and the legislative requirements for destruction of a controlled substance; and
- to follow the medication incident reporting system.

The licensee was also ordered to develop the policies, procedures, and systems required by sections 133, 135, and 136 of the Regulation. For example, the order specified that the licensee must develop:

- a procedure to ensure that expired medications are removed from medication carts;
- a system for establishing accurate and up-to-date drug records; and
- a system to ensure that an evaluation is conducted of all medication incidents and that appropriate actions are taken when concerns are identified.

Finally, the licensee was ordered to fulfill sections 130 and 133 of the Regulation:

- to maintain and keep a drug record for every drug ordered and received in the home for at least two years; and
- to conduct monthly audits of the daily count sheets for controlled substances.

Meadow Park (London) was given two months to comply with the order. All changes were to be implemented by April 6, 2017.

In setting out the grounds for the compliance order, the report explained that the inspectors had found that the licensee had failed to comply with 10 different regulatory and legislative provisions relating to medications in the home.³² The inspectors explained, in some detail, the evidence of non-compliance they found:

- the policies and procedures related to the management of the medication program were not clearly understood by the staff, nor were they implemented in a consistent manner by all the staff;
- medications were stored in bottles without appropriate labels or in medication cups with no identifying information linking the medications to specific residents;
- controlled substances were stored improperly outside the locked area in the medication cart;
- monthly audits of the daily count sheets for controlled substances had not been completed between August 2016 and January 2017;

³² The inspectors had identified non-compliance with ss 8(1)(b), 114(3)(a), 122, 126, 129(1)(b), 130(3), 131(1), 131(3), 133, and 134 of the Regulation.

- on multiple days in October and November 2016, the daily count sheets of controlled substances had not been counted and verified by two registered staff on every shift;
- registered staff had, on several occasions, borrowed hydromorphone from one resident and administered it to another resident whose supply had run out;
- a registered practical nurse had been observed pouring a prescribed medication for a resident and then giving it to a personal support worker to administer to the resident;
- the drug record book had not been completed in its entirety for 116 of 122 drug reorders during the month of October 2016; and
- when a resident did not receive a dosage of prescribed hydromorphone, no action was taken, no incident report prepared, and no pain assessment done.

Although the inspectors found non-compliance with many different sections of the Regulation, they did not issue multiple findings of non-compliance. Instead, they used those findings as the grounds to support the compliance order issued under the umbrella of section 114 of the Regulation. As Ms. Moroney explained, they took this action at the direction of Ms. Simpson, the Director, who advised them on “how to draft the Order to cover the wide range of issues and to make it understandable to the LTC home licensees so that they could comply with it.” Under cross-examination, Ms. Moroney agreed that their decision to issue one compliance order, as opposed to multiple orders or multiple written notifications accompanied by voluntary plans of correction, could affect the public’s perception of the home when the report was made available. She was not aware that this decision could also affect the Long-Term Care Home Quality Inspection Program Risk and Performance Assessment score for Meadow Park (London).³³

The structure of the compliance order was markedly different from those issued to Caressant Care (Woodstock). For Caressant Care (Woodstock), the inspectors issued two separate compliance orders (and several other written

³³ As discussed in Chapter 9, the Long-Term Care Home Quality Inspection Program Risk and Performance Assessment (LRPA) is a risk assessment model that draws on different data elements to assign a risk or performance level to all long-term care homes in the province. Among the data elements included in the model used to assign a score to each home are compliance and inspection data, such as the number of findings of non-compliance.

notifications accompanied by voluntary plans of correction as outlined above) for the different areas of non-compliance with the regulations related to medication. Ms. Simpson explained why the two different approaches were taken:

[D]ifferent approaches were taken with respect to the non-compliance relating to medication management because of what was found in each of the Inspections. For example, we determined that, given the wide breadth of the issues identified at [Meadow Park (London)], it made the most sense to issue one order in relation to s. 114 of the Regulation even though the findings referenced non-compliance with other medication-related provisions of the Regulation. We determined that s. 114 was the most applicable section. The goal was compliance and by putting all of the areas of non-compliance together in one Order, the Order was easier for the licensee to understand. The Inspection had uncovered multiple areas of non-compliance but all were linked to the medication administration system in the home. Rather than confuse the issue with multiple orders in multiple areas, I wanted to make clear that the home had significant issues with their medication management system and the entire system had to be looked at by the licensee to come into compliance ...

In contrast, [Caessant Care (Woodstock)] was issued multiple Orders because the non-compliance in that home was not related to the medication management system as a whole, as with [Meadow Park (London)]. Inspectors found 40 medication errors in six weeks at [Caessant Care (Woodstock)]; it was not appropriate in the circumstances to issue one broad order in relation to s. 114 of the Regulation. Instead, an Order was issued specific to s. 131 of the Regulation related to administering medication as per the prescriber's direction.

Ms. Simpson did not order that admissions be ceased at Meadow Park (London), as she had at Caessant Care (Woodstock). When she was asked by Commission counsel why, given the scope of the medication management issues, she did not cease admissions at Meadow Park (London), she replied, "[W]e didn't have the number of compliance orders in the multiple different areas that we had at Caessant Care (Woodstock)."

2. Inspection Findings

The final Meadow Park (London) inspection report was not issued until August 15, 2017, almost six months after the inspection was completed.³⁴ This final report included the findings of non-compliance relating to the

³⁴ At Ms. Simpson's direction, inspectors delayed issuing it until the police had completed their criminal investigation.

medication management system that had been issued in the compliance order of February 2017. It also detailed seven other written notifications of non-compliance, all accompanied by voluntary plans of correction. Although the “default action” based on the inspectors’ judgment matrix³⁵ was that six of the eight findings of non-compliance should be issued with a compliance order, the inspectors varied five of the six to a voluntary plan of correction. The Meadow Park (London) post-confession inspection findings are summarized in Table 11.2.

Table 11.2: Meadow Park (London) Post-Confession Inspection Findings

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Non-compliance Relating to Allegations of Abuse, Complaints, and Reporting	
Failing to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, as required by LTCHA, s 19.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone which results in harm or risk of harm to a resident immediately reports the suspicion and the information on which it is based to the Director, as required by LTCHA, s 24.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that a resident whose pain is not relieved by initial interventions is assessed using a clinically appropriate assessment instrument, as required by O Reg 79/10, s 52(2).	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that every complaint made to the licensee – or a staff member – is properly investigated, resolved, and the response provided within a set time frame, as required by O Reg 79/10, s 101.	Written notification issued with a voluntary plan of correction (LTCHA).

continued

³⁵ Inspectors use a judgment matrix to guide their exercise of discretion with respect to which enforcement mechanism they should issue with a finding of non-compliance. The judgment matrix requires inspectors to consider the severity of non-compliance (or, where there has been harm or risk of harm, the severity of that harm or risk of harm); the scope of the non-compliance (whether it was isolated, a pattern, or widespread); and the licensee’s compliance history. Inspectors can depart from the default action suggested by the judgment matrix as long as the rationale is consistent with the judgment matrix policy and they document their reasons.

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Non-compliance Relating to Medication Management and Administration	
Failing to ensure that the annual evaluation of the medication management system has been completed, as required by O Reg 79/5, s 116.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that a written policy is in place to address the location of the emergency drug supply, and that the emergency drug supply is evaluated at least annually, as required by O Reg 79/10, s 123.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that appropriate actions are taken when a resident is taking a drug, or a combination of drugs, to monitor and document the resident's response and the effectiveness of the drugs, as required by O Reg 79/10, s 134.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that the home develops an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, as required by } O Reg 79/10, s 114.	Issued as an immediate compliance order (LTCHA) on February 6, 2017, with this inspection (before the final report was issued).

Source: Compiled by the Commission.

The first written notification of non-compliance was issued for failing to comply with section 19 of the LTCHA – the duty to protect. This section requires the licensee to protect residents from abuse and neglect. It was issued based on the inspectors' review of progress notes from the summer of 2014 (when Wettlaufer was working at the home) relating to the care of a resident with an in-dwelling catheter. The inspectors found that staff had failed to keep adequate records of the resident's output, follow the recommended treatment for the resident, follow up with the physician to clarify the size of the catheter required, and do pain assessments despite the resident's obvious signs of pain. The inspectors' notes showed that this resident had spent the last 10 days of his life, from July 20 to July 30, 2014, in considerable pain – moaning, groaning, crying out, and screaming. As the report noted, there was "a pattern of inaction that jeopardized the health and well-being of the resident." The inspectors rated the severity of this non-compliance as "actual harm," and the scope, "isolated." Meadow Park (London) had no history of non-compliance with this legislative provision, and although the default action suggested by the judgment matrix for

this non-compliance was a compliance order, the inspectors varied it to a voluntary plan of correction. Ms. Moroney testified that they chose to do so because the events had occurred in 2014, they had not found similar issues in relation to the 2016 inspections, and the home had no history of non-compliance with this section of the Act.

The second written notification was issued for failing to report alleged abuse or neglect to the Director, as required by section 24 of the LTCHA. In their review of records from the summer of 2014, the inspectors found three incidents of alleged abuse that had not been reported to the Director. Wettlaufer documented the alleged abuse in each of the resident's progress notes and, in each case, indicated that management had been told about the incident. The first, from July 2014, involved an incident where a resident's visitor had pushed and yelled at another resident in the home. The second incident took place in August 2014, when Wettlaufer observed that Mr. Horvath had been tied to his bed rail by the string in his jogging pants. The final incident was from September 2014, when a resident was observed sexually touching another resident. The Ministry had not received any Critical Incident reports about these events. The administrator and the director and co-director of care were apparently not aware of the first two incidents. The director of care said they were aware of the sexual touching and believed that a Critical Incident report had been submitted. The report noted that the severity of this non-compliance was "minimal harm," and the scope, "widespread." Meadow Park (London) had a history of non-compliance with this section of the legislation. The default action suggested by the judgment matrix was a compliance order, but again this finding was issued with a voluntary plan of correction.

Ms. Moroney acknowledged that reporting is important to both the Inspections Branch and to the inspectors, but did not seem concerned about downgrading the default action from a compliance order to a voluntary plan of correction. When asked why they had done so, she again emphasized that these incidents had occurred in 2014 and they were not seeing these same issues in the home in 2016.

The third written notification was issued for failing to ensure that residents experiencing pain were assessed using a clinically appropriate assessment instrument, as required by section 52(2) of the Regulation. Unlike the first two written notifications, the evidence to support this finding did not date back to the summer of 2014 but involved a resident who had been admitted to the home in June 2016 with a variety of chronic conditions, including chronic obstructive pulmonary disease (COPD). During the period leading

up to the resident's death on November 7, 2016, no pain assessment was carried out. The inspectors noted in their report that the resident's COPD was not identified in the plan of care, that the severity of non-compliance was "minimal harm or potential for actual harm," and the scope, "isolated." Because the home had a history of non-compliance with this section of the regulation, they issued a written notification with a voluntary plan of correction in their February 2016 RQI. This notification was issued again with a voluntary plan – the default action from the judgment matrix. Ms. Moroney explained that the severity was "potential for harm," and not "actual harm," because the resident was receiving some pain medication. The resident simply had not had the proper pain assessment done.

The fourth written notification was issued for failing to comply with section 101 of the Regulation, which imposes obligations on licensees with respect to handling complaints. The inspectors found that the home failed to investigate or respond to a complaint received from a substitute decision-maker in February 2015 relating to the care given to a resident who had died in the fall of 2014. They also found that the home failed to keep a record of written and verbal complaints from 2014 and 2015 and was unable to show that management were completing quarterly reviews of complaints during that period. The report noted that the severity of the non-compliance was "minimum risk," and the scope, "widespread." The home had a history of non-compliance with this regulation, and it had been issued as a voluntary plan of correction in a 2016 complaint inspection. Although the default action for the non-compliance was a compliance order, the inspectors varied it to a voluntary plan of correction. As Ms. Moroney explained, they did so because their main concern – the lack of records for 2014 complaints – had already been addressed.

The next three written notifications were issued in relation to problems found in the home's medication management and medication administration system – problems that were not addressed in the immediate compliance orders. The first was issued for failing to ensure that there was an annual evaluation of the medication management system in the home, as required by section 116 of the Regulation. The inspectors found that the licensee had not completed an annual review in 2014 or 2015. The report noted that the severity of non-compliance was "minimal harm," and the scope, "widespread." The home did not have a history of non-compliance with this regulation. Though the default action was a compliance order, the inspectors varied it to a voluntary plan of correction. Ms. Moroney explained that they had issued the compliance order in relation to section 114 during the inspection in February.

In the circumstances, even though they felt there was potential harm associated with not having the annual evaluation, they were comfortable with this written notification being issued without a compliance order.

The next written notification related to medication was issued for failing to comply with section 123 of the Regulation, requiring the home to have a written policy in place for its emergency drug supply, which was to be evaluated at least once a year by an interdisciplinary team. The inspectors again found no records of any annual evaluation of the emergency drug supply in 2014 or 2015. They evaluated the severity of the non-compliance as "minimal harm," and the scope, "widespread." The home did not have a history of non-compliance with the legislation, so, although the default action was a compliance order, they varied it to a voluntary plan of correction.

The final written notification related to medication was issued for failing to comply with section 134 of the Regulation, which requires licensees to ensure that appropriate actions are taken when residents are prescribed drugs or combinations of drugs (including psychotropic drugs) to monitor and document both their responses to the drugs and the effectiveness of the drugs. The inspectors found that Wettlaufer had given psychotropic medications to a resident in May 2014 but had failed to document why this "as needed" medication was given or the effects it had on the resident. The progress notes showed that the resident was transferred to hospital later that same morning. The administrator, director of care, and co-director of care all told the inspectors that they did not know about the care that the resident received before her transfer to hospital. At the hearings, Ms. Moroney agreed that no Critical Incident report had been submitted to the Ministry. The report rated the severity of the non-compliance as "minimal harm," and the scope, "isolated." The home did not have a history of non-compliance with this regulation. The inspectors issued a voluntary plan of correction – the default action under the judgment matrix.

3. Follow-Up Inspection

In July 2017, Ms. Northey, Mr. Kikuta, Amie Gibbs-Ward, and Nancy Sinclair returned to Meadow Park (London) to conduct the home's annual RQI. While there, they conducted a concurrent follow-up inspection in relation to both the compliance order issued in February concerning medication management and a second compliance order, which had been issued to the home on May 25, 2017, following a complaint inspection for failing to ensure that

residents were given skin assessments using a clinically appropriate tool. During that visit, the inspectors determined that the two compliance orders had not yet been satisfied. The orders were reissued on October 6, 2017, with a new compliance date of November 30, 2017.

The order for medication management was again grouped under the umbrella of section 114 of the Regulation, although the inspectors indicated that they found ongoing non-compliance with other sections of the Regulation, including:

- section 126 – drugs to remain in the original labelled container or packaging provided by the pharmacy service provider or the Government of Ontario until they were administered or destroyed;
- section 129(1)(b) – controlled substances to be stored in a separate double-locked stationary cupboard or in a separate locked area within the locked medication cart;
- section 130(3) – a monthly audit to be done of the daily count sheets for controlled substances;
- section 133 – a drug record to be maintained in the home for at least two years;
- section 135 – every medication incident and adverse drug reaction to be documented, reported to the appropriate people, reviewed, analyzed, and corrective action taken as necessary; and
- section 8(1)(b) – compliance with a plan, policy, protocol, procedure, strategy, or system to be maintained.

In May 2018, Meadow Park (London) satisfied the compliance order relating to medication management.

E. The Telfer Place Inspection

Like the Caressant Care (Woodstock) and the Meadow Park (London) inspections, the Telfer Place inspection began on October 28, 2016. On that date, inspectors Lesley Edwards and Phyllis Hiltz-Bontje went to the home. Ms. Vink did not join them until November 9, 2016.

The inspectors faced unique constraints in the Telfer Place inspection. First, like the inspections at Caressant Care (Woodstock) and Meadow Park (London), the inspectors could not immediately begin to interview staff at the home. Karin Fairchild, the manager of the Hamilton SAO, helped to vet

the list of proposed interviewees to ensure that the interviews would not interfere with the police investigation. Second, the inspectors had to complete the medication inspection protocol in its entirety, something they had not previously done.

Unlike the inspections at the other two homes, the Telfer Place inspection was different because the police had not yet laid charges for the attempted murder of resident Sandra Towler when the inspectors began their work at the home. Wettlaufer was not charged with this offence until January 2017. As Ms. Vink explained, “[A]lthough staff in the home knew they had worked with the nurse and were aware she was in the media, it was not related to their home at that time.” Unlike the inspections at the other two homes, the victim was still alive and living in the home. The inspectors could not reveal what they knew about the allegations or the Offence against Ms. Towler during their interviews with staff. They were told not to use any information that Telfer Place had received from the police about Wettlaufer’s confession to support findings of non-compliance during the inspection.

Although the inspection took longer than most critical incident inspections, the inspectors spent significantly less time at Telfer Place than did the inspectors in the other two homes. They returned to the home on several occasions in the winter of 2017, but, in total, the inspection lasted just under 15 days.³⁶

1. Initial Steps: Document Review and the Medication Inspection Protocol

When Ms. Edwards and Ms. Hiltz-Bontje first attended Telfer Place, they met with the acting director of nursing, who provided them with a number of documents they had requested, including policies, procedures, and copies of Ms. Towler’s clinical records and progress notes. As Ms. Vink explained, the inspection focused on whether there had been complaints about Wettlaufer, the training she received from the home, and information about any medication errors she made.

By the time Ms. Vink arrived at the home, Ms. Edwards and Ms. Hiltz-Bontje had completed many of the observations and record reviews required to complete the medication inspection protocol. They observed several medication passes, including those for residents needing insulin and those

³⁶ The report relating to the Telfer Place Wettlaufer inspection is available at: <http://publicreporting.ltc homes.net/en-ca/homeprofile.aspx?Home=2742&tab=1>, Inspections, Year 2017.

carried out by agency staff. They also observed medication rooms and drug storage, but had not yet conducted any staff interviews. In that first week, they began reviewing the home's records with respect to reporting, complaints, and the training provided to staff before they began working in the home. Once Ms. Vink arrived, she took over from Ms. Hiltz-Bontje.

Ms. Vink and Ms. Edwards reviewed portions of the health records for Ms. Towler as well as residents who had passed away around the time Wettlaufer worked in the home. They reviewed diagnoses, causes of death, and progress notes. Ms. Vink testified that the inspectors did not issue any findings of non-compliance in relation to those chart reviews.

2. Interviews Conducted

The inspectors began their interviews with staff at Telfer Place in the second week in November 2016. They interviewed approximately 30 people, including both current and former management in the home, the medical director, an attending physician, the restorative care coordinator, registered staff, personal support workers, and residents.

The inspectors tried to interview Ms. Towler, but her health made that impossible. They did speak with her family later in the inspection, by phone.

F. Findings of the Telfer Place Inspection

The final Telfer Place inspection report was issued on May 24, 2017, several months before the reports for Caressant Care (Woodstock) and Meadow Park (London) were issued. At the public hearings, Ms. Vink testified that she was directed by her manager to release the report on that day, and she did not know why the other reports were held back for a longer period. She noted that the Telfer Place report was prepared long before the May date, but she had been directed to delay its release. The report included six written notifications of non-compliance, all of which were accompanied by voluntary plans of correction. No compliance orders were issued following the inspection – and none were issued as immediate orders, as was the case for Caressant Care (Woodstock) and Meadow Park (London).

The non-compliance found in the Telfer Place inspection was of a somewhat different nature than that found in the other two homes. At Telfer Place, many of the compliance problems stemmed from the use of agency staff in that home – and from the policies the home followed in regard to the screening

and training of agency staff before they began working in the home (see Chapter 7). The findings from the Telfer Place post-confession inspection are summarized in Table 11.3.

Table 11.3: Telfer Place Post-Confession Inspection Findings

FINDING OF NON-COMPLIANCE	ENFORCEMENT MECHANISM
Non-Compliance Relating to Use of Agency Nurses	
Failing to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present in the home at all times, except as provided for in the regulations, as required by LTCHA, s 8(3).	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that screening measures, including criminal record and vulnerable sector checks, are conducted before staff begin working in the home, as required by LTCHA, s 75(2).	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that all staff have received the training required by LTCHA, s 76.	Written notification issued with a voluntary plan of correction (LTCHA).
Failing to ensure that for each staff member a record is kept which includes verification of the member's current registration with the college of the regulated health profession of which he or she is a member, as required by O Reg 79/10, s 234.	Written notification issued with a voluntary plan of correction (LTCHA).
Non-compliance Relating to Documenting Complaints	
Failing to ensure that a documented record is kept of all complaints received by the home, including the date the complaint is received, actions taken to resolve the complaint, and any follow-up action, as required by O Reg 79/10, s 101.	Written notification issued with a voluntary plan of correction (LTCHA).
Non-compliance Relating to Medication Incidents	
Failing to ensure that every medication incident that involves a resident is reported to the resident's substitute decision-maker and pharmacy service provider, as required by O Reg 79/10, s 135.	Written notification issued with a voluntary plan of correction (LTCHA).

Source: Compiled by the Commission.

The first finding of non-compliance was issued for failing to comply with section 8(3) of the LTCHA, which requires the licensee to ensure that at least one registered nurse – an employee of the licensee and a member of the regular nursing staff – is on duty and present in the home at all times, subject to the limited exceptions set out in the regulations. As Ms. Vink explained during her evidence, Telfer Place is a smaller home, with just 45 beds. Because of its size, the home typically had just one registered nurse on each shift, 24 hours a day, seven days a week. At times, the home had difficulty meeting this requirement. The inspectors reviewed the registered nurse staffing schedule for the period June 25 to December 9, 2016, and found that on 25 occasions the only registered nurse in the home was an agency nurse, and on seven occasions the only registered staff had been a registered practical nurse (RPN), with a registered nurse (RN) on call. The inspectors determined that the severity of this non-compliance was “minimum risk,” and the scope, a “pattern.” Because the home had a previous related history of non-compliance, the written notification was issued with a voluntary plan of correction.

The next written notification was issued for not complying with section 75 of the LTCHA, which requires licensees, before they hire staff, to ensure that screening measures, including criminal reference checks, have been conducted in accordance with the regulatory requirements. These screening measures apply also to agency staff; they are considered “hired” when they first work in the home. The inspectors found Telfer Place had not obtained verification of a completed criminal record check for three different agency registered nurses, one of whom was Wettlaufer, before they began working at the home.³⁷ Management had also not checked that the employment agency had done the requisite criminal record checks. The inspectors ranked the severity of the non-compliance as “minimum risk,” and the scope, “widespread.” The home did not have any history of non-compliance with this part of the Act.

Although the default action of the judgment matrix was a compliance order, the inspectors varied it to a voluntary plan of correction. When asked why, Ms. Vink explained they did so because the home had believed the agency was doing the checks. The home had been ensuring that criminal record checks were completed for their own staff. She also noted that the home had changed its approach to this issue as a result of the inspection. Although

³⁷ Had a criminal record check been conducted for Wettlaufer, it would have come back “clean” because she had no record at that time.

Ms. Vink indicated that they had tried to confirm with the employment agency that those criminal record checks had been done, they were not able to do so. Ms. Vink acknowledged that, because the LTCHA applies to LTC homes, not to agencies, the employment agency was not subject to any legislative requirement to complete the criminal record checks.

The third written notification was issued for failing to comply with section 76 of the LTCHA, which requires that all staff receive certain mandatory training before working in the home. In reviewing the home's training records, the inspectors found that agency registered nurses working in the home, including Wettlaufer, had not received all the required training, including that in relation to the Residents' Bill of Rights, the policy to promote zero tolerance of abuse and neglect of residents, and the duty to report. The inspectors rated the severity of this non-compliance as "minimal harm or potential for actual harm," and the scope as a "pattern," though there was no related compliance history. The default action according to the judgment matrix was a compliance order, but the inspectors varied it to a voluntary plan of correction because they found that the home had identified the problem with the training of agency staff and had implemented a new plan to ensure that training was provided.

The fourth written notification was issued for failing to comply with section 101 of the Regulation, which requires licensees to ensure that a documented record is kept in the home for complaints, including the date the complaint was received, the action taken to resolve the complaint, and the final resolution, if any. This finding was issued in relation to various deficiencies the inspectors found with the home's complaints records, and the home's failure to review and analyze trends in complaints at least quarterly. They found the severity associated with this non-compliance to be a "minimum risk," and the scope, a "pattern." There was a previous history of non-compliance, so the inspectors issued a voluntary plan of correction – the default action set out in the judgment matrix.

The fifth written notification was the only one issued in the Telfer Place inspection in relation to the home's medication management system. This notification was for failing to comply with section 135 of the Regulation, which requires proper documentation and appropriate reporting of medication incidents and adverse drug reactions. The inspectors identified five medication incidents on one day in February 2016 which were documented as medication omissions. Although reports were created for each incident, they did not

indicate whether the incidents had been reported to the residents' substitute decision-makers or to the pharmacist. The pharmacist, when interviewed, said that the home consistently reported only those incidents that involved a pharmacy error or an adverse event; it did not report all medication incidents.

When Commission counsel asked Ms. Vink whether five medication incidents on one day in a home with just 45 residents was a high number, she was non-committal, in part because it was her colleague who inspected these incidents. When asked if any thought had been given to issuing a non-compliance with section 131 – requiring residents to receive their medications as prescribed – she replied there had not. Her colleagues had observed a number of medication passes and had no concerns.

The inspectors rated this non-compliance as “minimum risk.” Ms. Vink explained that Ms. Edwards had reviewed the clinical records for the residents and found that there were no negative outcomes. They determined that the failure to document information did not necessarily put the residents at risk. They found the scope of the non-compliance to be a “pattern” and, because there had been previous non-compliance with this section of the Regulation, they issued a voluntary plan of correction.

The final written notification issued in the Telfer Place inspection was for failing to comply with section 234(1) of the Regulation, which requires the licensee to ensure that a record is kept for each staff member which includes, where applicable, verification of the staff member's current registration with the college or regulated health profession of which he or she is a member. The inspectors found that the home had not required proof of agency nurses' registration or licence from the agency that employed them or, in the case of two of three different nurses, one of whom was Wettlaufer, directly from the agency nurses themselves. Telfer Place had also not taken any steps to verify the agency nurses' standing with the College of Nurses of Ontario (College) for these two nurses. The inspectors found the severity of this non-compliance to be “minimum risk,” and the scope followed a “pattern.” Because the home had no history of non-compliance with this particular part of the Regulation, they issued a voluntary plan of correction. As Ms. Vink explained, she thought this non-compliance was a minimal risk because, when she searched the Find a Nurse Register on the College website, she found that, with the exception of Wettlaufer, the other nurses were “registrants in good standing with the College.”

Because the inspectors issued no compliance orders as part of this inspection, there was no need for any follow-up inspections at Telfer Place.

G. Inspections Conducted in Other Homes

In the fall of 2016, because the Hamilton SAO learned that Wettlaufer had been placed as an agency registered nurse in a number of other LTC homes in its jurisdiction, inspections were initiated at Anson Place Care Centre, Park Lane Terrace, Brierwood Gardens, and Dover Cliffs Long Term Care Home.

On October 6, 2016, intake inspector Aislinn McNally was advised that Wettlaufer had worked at Dover Cliffs and Brierwood Gardens. She assigned inspections for those homes that same day. On October 28, 2016, the administrator of Anson Place called the Hamilton SAO to say that the registered nurse who had been criminally charged had worked in its home. Anson Place was also assigned for an inspection that same day. Finally, in late November, the manager of the Hamilton SAO, Ms. Fairchild, learned that Wettlaufer had worked four shifts at Park Lane. The home was then assigned for inspection.

The team assigned to the Telfer Place inspection was also tasked with conducting the inspections at Anson Place, Park Lane, Brierwood Gardens, and Dover Cliffs. Ms. Vink and Ms. Edwards were involved in inspections at all four homes. Ms. Hiltz-Bontje assisted with the inspections at Anson Place and Brierwood Gardens.

The inspections in these four homes took place primarily in November and December 2016. The inspections took much less time than those conducted at Telfer Place, Meadow Park (London), or Caessant Care (Woodstock). Inspectors spent six days at Anson Place, five days at Park Lane, and eight days at Dover Cliffs. The longest inspection (and the one resulting in the most findings of non-compliance) was at Brierwood Gardens, which lasted for 12 days.

The homes where Wettlaufer had been placed as an agency registered nurse ranged in size. The smallest was Anson Place, which was licensed for 61 beds, followed by Dover Cliffs (70 beds), and Brierwood Gardens (79 beds). Park Lane was the largest of the four homes, with 132 beds. All these homes used agency registered nurses to fill in when they were short staffed. The inspection plan used in all four inspections was similar to that used at Telfer Place: the inspectors examined issues specific to the use of agency staff in the homes as well as to medication management.

1. Inspection Findings

The inspection reports for each home were issued separately and, for three of the four homes, on different days,³⁸ but they shared similar compliance problems, most of which related to their use of agency nurses. The main compliance issues involved failing to comply with the requirements for a registered nurse to be on duty at all times (as required by section 8(3) of the LTCHA); failing to conduct appropriate screening checks for agency staff – both for criminal records (as required by section 75(2) of the LTCHA) and for registration with the College (as required by section 46 of the Regulation); and failing to ensure that agency staff received all the required training before beginning to work in the home (as required by section 76 of the LTCHA). All four homes were issued written notifications for failing to comply with the “24/7 RN requirement” and the required criminal reference check.

Only Dover Cliffs was issued a voluntary plan of correction with the written notification for non-compliance with the “24/7 RN requirement”; the other three homes were given only a written notification. The inspection reports for Anson Place, Park Lane, and Brierwood Gardens indicated that each of these homes had between eight and 12 shifts during a five- to seven-month period where the only registered nurse in the home was an agency registered nurse (in circumstances that did not legislatively permit their use). Dover Cliffs had failed in this regard significantly more often than the other homes, having an agency registered nurse as the only registered nurse in the home about 80 times in a six-month period.

All the homes were issued a voluntary plan of correction along with a written notification for failing to take steps to ensure that agency staff in the home had their criminal record checks completed before they started to work in

³⁸ The first reports issued were those for Park Lane and Dover Cliffs, on May 24, 2017. The Anson Place inspection report was released on May 29, 2017. The Brierwood Gardens inspection report was initially released on August 14, 2017. An amended version was issued on August 31, 2017, with a slight change made to the date by which the training of staff was required by the compliance order.

Copies of these inspection reports are available at: Park Lane, Inspections, Year 2017 <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2779&tab=1>; Dover Cliffs, Inspections, Year 2017 <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=1056&tab=1>; Anson Place, Inspections, Year 2017 <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2786&tab=1>; and Brierwood Gardens, Inspections, Year 2017 <http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2678&tab=1>.

the home. The only exception was for Anson Place, which was issued only a written notification. According to the Anson Place inspection report, the home had "immediately put in place a plan to ensure compliance" during the inspection.

All four homes were found not in compliance with the Regulation requiring licensees to ensure that nurses were currently registered with the College. More specifically, Anson Place and Brierwood Garden were issued written notifications for failing to comply with section 46 of the Regulation, which requires licensees to ensure that every staff member who performs duties in the capacity of registered nurse or registered practical nurse has the appropriate current certificate of registration with the College. Although the inspectors found that this issue applied to agency staff in both homes, it was also a problem with at least one new employee at Brierwood Gardens. In fact, according to the Brierwood Gardens report, the inspectors found that a registered practical nurse had been hired to work at the home and had been performing her duties over a six-month period, though she did not hold a certificate of registration with the College. The inspectors issued a written notification along with a voluntary plan of correction.

The inspectors also issued written notifications along with voluntary plans of correction to Dover Cliffs and Park Lane for failing to comply with a different, but related, part of the Regulation – section 234 – which requires licensees to ensure that a record is kept for each staff member's current registration with the College. Both homes had assumed that the agency was screening staff, as per the terms of their contract, but they acknowledged that they did not consistently request proof of an agency nurse's registration status with the College from the agency.

All the homes except Dover Cliffs were issued with written notifications for failing to ensure that agency staff received training as required by section 76 of the LTCHA before they began to work in the homes. In particular, the inspectors found that the homes had not trained agency staff in areas such as the Residents' Bill of Rights, the duty to report under section 24 of the LTCHA, and the home's policy of zero tolerance of abuse. The written notifications were accompanied by voluntary plans of correction at both Brierwood Gardens and Park Lane.

Inspectors issued four other findings of non-compliance to Brierwood Gardens as a result of this inspection, including:³⁹

- failing to comply with subsections 131(2)–(3) of the Regulation, requiring both that drugs be administered to residents in accordance with the directions of the prescriber and that no person administer drugs to a resident in the home unless that person is a physician, dentist, RN, or RPN; this finding was issued with both a voluntary plan of correction and a compliance order;
- failing to ensure that all staff in the home had the proper skills and qualifications to perform their duties, as required by section 73 of the LTCHA; this finding was issued with a voluntary plan of correction;
- failing to ensure that resident care plans be reviewed and revised when care needs change, as required by section 6 of the LTCHA; this finding was issued with a voluntary plan of correction; and
- failing to submit a Critical Incident report to the Director for an unexpected or sudden death of a resident as required by section 107(1) of the Regulation; this finding was issued solely as a written notification of non-compliance.

2. Impact of the Inspections

During the hearings, I heard from many of Wettlaufer's former colleagues about how devastating it was for them to learn they had been working alongside a nurse while she was surreptitiously harming those she was supposed to be caring for. Although there is more awareness today about the vicarious trauma suffered by first responders, we do not always consider the effect on those who must investigate the horrors that humans can inflict on others.

³⁹ Eight findings of non-compliance were issued to Brierwood Gardens, four to Anson Place and Park Lane, and three to Dover Cliffs.

All the inspectors and managers from the Ministry Inspections Branch who gave evidence testified about how difficult it was to be involved in the inspections that followed Wettlaufer's confessions. All three of the lead inspectors broke down in tears when asked by Commission counsel how they had been affected by this work. Ms. Kukoly described the impact on her – and her concerns about the impact on the nursing profession and the long-term care sector more generally:

So when I first learned of EW's [Wettlaufer's] confessions, facing the obvious magnitude ... of these confessions and the charges laid was daunting.

Being assigned to this inspection was stressful to say the least. Reading the actual Progress Notes of a resident who we now knew was murdered was truly overwhelming. It was surreal. It wasn't what I went into nursing for.

Also, in the inspection, it was the first time we had done audiotaped interviews. Talking to the staff in the home was awful. Most cried. Some sobbed. They were still in the shock of the announcement of the charges and were continuing to care for residents.

There were times when we stopped recording to allow them to collect themselves. The strain and guilt of working with someone who did this was absolutely palpable.

I cannot stop thinking about how horrible it must be for the residents and their families living in the home at the time to watch the news and hear of this happening in the home where they lived. This is their home.

Talking to the families during this inspection was the most difficult part. To call someone who we knew their loved one had been murdered in long-term care and to ... ask them to tell us about it was more than awful. They cried, and I can tell you we cried during those interviews.

...

I am a nurse. I have always wanted to be a nurse. It's super corny. I've had many different roles in nursing, but the premise is always that you want to – you want to help people. And regardless of whether I'm in the home as an inspector or whether I'm administering medications, when I see someone that's in distress, the urge to want to help them doesn't disappear because I'm wearing an inspector badge.

The pressure to perform as an inspector and to represent the Ministry of Health, the inspection process, for the residents, and the public was and is truly enormous.

I can sincerely say that this inspection and the Public Inquiry process has changed me forever.

But worst of all, this has tainted long-term care, and it's tainted nursing. The trust in long-term care and nursing has been absolutely battered.

I believe that the impact of this on the sector is going to be vast beyond imagination.

We talked about the nursing shortage, and after this, who's going to want to work in long-term care as a nurse? I fear for long-term care, and I fear for nursing.

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I. Introduction

A. Importance of Ontario's Home Care Sector

Publicly funded home care plays a vital role in Ontario's healthcare system. Many Ontarians would rather have medical care at home and, when they are approaching the end of their life, would prefer to die at home instead of in an institutional setting. The effective and safe provision of publicly funded home care services is necessary to keep Ontarians in their homes longer. Such services are also crucial to alleviating pressure on hospitals: by allowing patients to return home sooner, home care services free up hospital beds for those who are more seriously ill. For that reason, there has been a concerted government effort in recent years to provide increased in-home healthcare supports.¹

The term "home care services" is not defined by statute, but for the purposes of this chapter, I use the term to refer to the publicly funded personal support services, nursing services, and therapy services² that were provided for or arranged by Ontario's 14 Community Care Access Centres (CCACs) at the time Wettlaufer committed the Offences – responsibilities that were later assumed by the 14 Local Health Integration Networks (LHINs).

The need for publicly funded home care services is growing, and the acuity of home care patients is increasing. In the 2016/17 fiscal year, 58% of home care patients were over the age of 65.³ The complexity of the medical and personal support needs of these patients has markedly increased over the last decade, with the percentage of adult long-stay home care patients with "high care needs" more than doubling between the 2007/08 and 2015/16 fiscal years.⁴ As Donna Ladouceur, the vice-president of home and community care at the South West LHIN, explained at the public hearings:

¹ See, e.g., Expert Group on Home and Community Care, *Bringing Care Home: Report of the Expert Group on Home and Community Care* (March 2015); and Ministry of Health and Long-Term Care, *Patients First: A Roadmap to Strengthen Home and Community Care*, 2015.

² These services include but are not limited to physiotherapy, occupational therapy, speech language pathology, dietetics, social work, and pharmacy services.

³ Data compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the Inquiry's public hearings.

⁴ Data compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the Inquiry's public hearings.

[P]atients who are on ventilators used to have to remain in hospital, but we are now able to support ventilated patients at home. In my view, hospital nursing jobs are no longer more challenging than nursing jobs in home care, in terms of the care issues nurses are faced with.

In the 2016/17 fiscal year, 561,380 Ontarians received publicly funded home care services.⁵ Nursing services are by far the most common type of care provided, with over 320,000 Ontarians receiving in-home nursing visits in the 2016/17 fiscal year, and another 10,248 receiving in-home nursing “shifts.”⁶ This equates to 7.28 million in-home nursing visits in addition to 2.19 million shift nursing hours.⁷

As the statistics indicate, these services are in high demand and play an important role in caring for Ontarians – particularly older Ontarians. However, as in long-term care, the recruitment and retention of qualified healthcare workers is an ongoing challenge in the home care sector. Many qualified staff leave home care to work in a hospital setting. Witnesses at the public hearings indicated that hospital nursing jobs are often seen as more desirable for a number of reasons:

- there is no need to drive from home to home;
- hospital staff are paid for a shift of a certain number of hours, whereas home care staff are usually paid per visit, and they may not occur in one solid block;
- hospitals pay considerably more;
- some homes may have poor, unsafe, or unsavoury conditions; and
- co-workers in the hospital can provide in-person support.

As a result, maintaining sufficient staff to meet the demand for home care is often difficult. This reality strains the home care system and creates challenges in ensuring that patients receive the services they need.

⁵ Data compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the Inquiry’s public hearings.

⁶ Data compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the Inquiry’s public hearings. Shift nursing involves a nurse attending a patient’s home for a fixed block of hours to provide care. Visiting nursing services typically involve shorter visits with nurses providing specified nursing interventions and then leaving after the specified task(s) are complete.

⁷ Data compiled by Health Shared Services Ontario and provided to the South West LHIN in preparation for the Inquiry’s public hearings.

B. Overview of Available Home Care Services

One of the most significant differences between the provision of healthcare services in the home as opposed to in a long-term care (LTC) home or another institutional setting is that, in his or her home, the patient retains full autonomy over the setting and day-to-day activities. Unlike an institutional environment, where all aspects of the patient's medication and care are managed by someone else, in the home care setting healthcare workers have less control over the environment. In addition, unlike in institutional settings, there is generally only one worker going into the home at a time, meaning there is typically no direct on-site supervision of the manner in which in-home healthcare services are provided.

Patients who require in-home healthcare services have two options. They can choose to pay an organization privately, or, assuming they are eligible, they can avail themselves of the publicly funded system. As mentioned, the CCACs were responsible for providing or arranging for the provision of publicly funded home care services at the time Wettlaufer committed the Offences. The CCACs could either provide services themselves or contract with another agency, known as a service provider, to deliver the services. These contracts, known as services agreements, were assumed by the LHINs when they took over the responsibilities of the CCACs.

The Inquiry's public hearings focused on the practices in the South West CCAC, since that is the region in which Wettlaufer committed the offence involving a home care patient (Offence). The South West CCAC's staff provided a few specialized types of nursing services directly to patients; however, they were only a small fraction of the in-home nursing services provided through the publicly funded home care system. The vast majority of services were provided by service providers – whose workers the CCAC did not employ and therefore did not directly supervise or oversee. This continued to hold true when the LHINs assumed the CCACs' responsibilities.

This reality creates a potential vulnerability in the home care system. The delivery of safe and effective home care services depends heavily on service providers properly screening, supervising, and overseeing their healthcare workers. It also relies on the service provider's staff and managers properly reporting problems that arise, including medication errors and signs of abuse. If service providers did not ensure their staff reported these issues, or if the management failed to do so, the CCAC might never learn of them, unless the patient or someone else in the home reported the issue to the CCAC directly.

In discussing Ontario's publicly funded home care system, this chapter will address these vulnerabilities in more detail. I begin by providing an overview of the role of the CCACs and LHINs in the home care sector, as well as the legislative and contractual framework governing publicly funded home care services. I then discuss how patient care is provided, including the referral and assessment process, the oversight of staff, the approach to medication management, and the processes in place to detect and prevent abuse. I then look at the processes in place for managing complaints and other events that pose a risk to patients, and the CCAC's management of performance issues with service providers. Finally, I discuss the services the victim in the home care setting was receiving and the investigation the South West CCAC conducted after Wettlaufer's confession came to light.

Three introductory comments are in order. First, this chapter focuses on the provision of home care by CCACs, since the CCACs were responsible for providing or arranging for publicly funded home care services at the time of the Offences. However, as mentioned, not long after the Offences came to light, the CCACs were dissolved and the 14 Local Health Integration Networks (LHINs) took over their responsibilities – including the responsibility for providing or arranging for the provision of publicly funded home care.⁸ Unless otherwise noted, the CCAC practices discussed in this chapter remained the same in all material respects when the LHINs took over the CCACs' responsibilities, except that they were carried out by the LHINs, not the CCACs. Subsequently, while the writing of this Report was in progress, on February 26, 2019, the Ontario government introduced Bill 74⁹ which, among other things, would reorganize the 14 LHINs. All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC system.

⁸ The *Patients First Act, 2016*, SO 2016, c 30, received royal assent on December 8, 2016, after the period during which Wettlaufer committed the Offences. That Act amended the *Local Health System Integration Act, 2006*, SO 2006, c 4 (LHSIA), enabling the minister to transfer CCAC staff, assets, and liabilities to the LHINs. The minister approved the LHINs to provide certain community services under the *Home Care and Community Services Act, 1994*, SO 1994, c 26 (HCCSA), and designated the LHINs as placement coordinators under the *Long-Term Care Homes Act, 2007*, SO 2007, c 8. These approvals and designations took effect on the same date as the transfer orders so that all responsibilities formerly carried out by the CCACs were then performed by the LHINs. Each CCAC ceased to exist as of the date of its transfer in 2017.

⁹ On April 18, 2019, *The People's Health Care Act, 2019*, SO 2019, c 5, received royal assent. When the relevant provisions are proclaimed in force, this statute will, among other things, create a new agency known as Ontario Health and allow for the reorganization or dissolution of the 14 Local Health Integration Networks (LHINs). All recommendations in this Report directed to the LHINs should be considered by any successor body with responsibilities relating to the LTC System, including Ontario Health.

Second, this chapter focuses on the practices of the South West CCAC, since that was the region in which the Offence was committed. However, each CCAC is permitted to establish its own policies or procedures. To the extent the discussion in this chapter relates to CCAC policies and procedures – as opposed to legislative or contractual requirements – the procedures in other CCACs were not necessarily precisely the same.

Finally, as mentioned, patients may make private arrangements and pay an organization to provide home care services directly. In fact, many service providers provide both publicly funded home care services to CCAC patients and privately paid home care services to other patients. However, the legislative and contractual framework governing publicly funded home care services does not apply to privately funded home care. A discussion of privately paid home care services is beyond the scope of the Inquiry mandate, given that the Offence in the home care setting was committed against a CCAC patient.

II. Overview of the CCACs and LHINs

The CCACs were established by the *Community Care Access Corporations Act, 2001*,¹⁰ and were responsible for providing access to home and community care. Until the CCACs were dissolved in 2017 and the LHINs took over their responsibilities, the CCACs would, among other things, assess patients to determine their eligibility to receive services, and provide or arrange for the provision of home care services (including nursing, personal support, and therapy services) to people in their homes, schools, and communities. The LHINs provided the CCACs with funding from the Ministry of Health and Long-Term Care (Ministry) for the provision of home care services, and the CCACs could use this funding either to provide the services themselves or to pay a service provider to do so.

The LHINs were established by the *Local Health System Integration Act, 2006* (LHSIA).¹¹ They are Crown agencies established to plan, coordinate, integrate, and fund health services at a regional level, based on the principle that community-based planning of health services is best able to respond to the needs of the local population. Each of the province's 14 LHINs is responsible for its own geographic area and, at the time the Offences were committed, there was a CCAC corresponding to the geographic area of each LHIN. At that

¹⁰ SO 2001, c 33.

¹¹ SO 2006, c 4.

time, the LHINs were responsible for setting local priorities for healthcare, among other things. Before they took over the CCACs' responsibilities in 2017, the LHINs did not provide any services directly; rather, they funded other organizations – such as the CCACs – to do so.

III. Legal Framework Governing Home Care Services at the Time of the Offence

A. The *Home Care and Community Services Act*

The *Home Care and Community Services Act, 1994* (HCCSA),¹² governed – and continues to govern – the provision of publicly funded home care services by the CCACs and later the LHINs. It imposes limited obligations on CCACs (later the LHINs) and service providers.

1. Obligations the HCCSA Imposed on CCACs

When a person applied to the CCAC for publicly funded home care services, the HCCSA required the CCAC to assess the patient's requirements; determine the patient's eligibility for services; and, if the patient was eligible, develop a plan of care.¹³ It also required the CCAC to review the patient's requirements as appropriate and to evaluate and revise the plan of service as necessary.¹⁴ The CCAC had to consider the patient's preferences in developing, evaluating, and revising the plan, and had to allow the patient, the substitute decision-maker, and the patient's or substitute decision-maker's designate to participate in developing the plan.¹⁵

The CCAC was required to respect and promote the Bill of Rights, found in section 3(1) of the HCCSA. Under the HCCSA, the CCAC also had to provide patients with a written notice containing certain information, including, but not limited to, a list of the rights contained in the Bill of Rights, a statement that CCAC and service provider staff were required to respect and promote those rights, and an explanation of the procedure for making complaints and suggestions regarding the CCAC and its service providers.¹⁶

¹² SO 1994, c 26.

¹³ HCCSA, s 22(1).

¹⁴ HCCSA, s 22(2).

¹⁵ HCCSA, ss 22(4), (6).

¹⁶ HCCSA, s 25(2).

The HCCSA also required the CCAC to develop a plan for preventing, recognizing, and addressing abuse, including educating and training staff on this issue; develop a quality management system to monitor, evaluate, and improve the quality of services provided; and establish a procedure for reviewing and responding to certain types of complaints.¹⁷ However, the HCCSA gave little guidance on how the CCACs had to carry out these requirements. Later in this chapter, I address in detail the South West CCAC's approach to these obligations.

The HCCSA is not overly prescriptive about how services were provided on a day-to-day basis. As discussed below, most of the obligations related to the provision of these services were contained in the agreements between the CCACs and the service providers.

2. Obligations the HCCSA Imposes on Service Providers

The HCCSA imposes fewer obligations on service providers than it did on the CCACs. The most significant obligation is the requirement that service providers respect and promote the HCCSA's Bill of Rights. The Bill of Rights provides protection and support for patients to ensure that they are free from abuse, their needs and wishes for their care are respected, and they are treated with dignity, respect, and in a culturally sensitive manner.¹⁸

In addition, the HCCSA requires service providers to post certain information in their offices, including a copy of the Bill of Rights.¹⁹ It also contains rules governing the confidentiality and disclosure of personal health information and access to health records.²⁰

B. The Services Agreements Between the CCACs and Service Providers

The services agreements between the CCAC and its service providers outlined the requirements related to the day-to-day provision of home care services. These contracts were hundreds of pages long and contained detailed requirements related to reporting; the qualifications, supervision, and screening of staff; and various other issues. These requirements are discussed later in this chapter.

¹⁷ HCCSA, ss 26, 27, 39.

¹⁸ HCCSA, s 3(1).

¹⁹ HCCSA, s 31.

²⁰ HCCSA, ss 32–36.

The services agreements were based on a common provincial template used by all CCACs, and automatically renewed every year. Although each CCAC could tailor its services agreements to some extent by adding certain requirements, the basic obligations the contracts imposed on service providers were the same across the province. When the CCACs were dissolved, the LHINs assumed the services agreements with the service providers.

Each services agreement specified the particular services the service provider would offer, the region of the CCAC within which it would provide those services, and the amount the CCAC would pay for those services. Each agreement also set out the market share the service provider would receive. For example, if three service providers had contracts for nursing services in one part of the South West CCAC's territory, one might have a contract that guaranteed it 50% of the market share, and the other two might each be guaranteed 25% of the market share.

In many cases, a service provider delivered only one or two services. Thus, if a patient was receiving several different home care services – for example, personal support services, nursing, and physiotherapy – the patient might deal with three different service providers. This situation was not uncommon, but it could be confusing for patients. When a patient had multiple organizations providing services, the patient's CCAC care coordinator helped the patient understand who the assigned providers were and whom to speak to if there was a problem.

IV. The Provision of Patient Care

A. CCAC Intake and Initial Assessments

A patient could be referred to the CCAC by physicians, other care providers, family members, and friends. Patients could also self-refer to the CCAC. In the South West region, hospitals were the largest source of referrals – an estimated 35–40%.

Once a patient was referred to the CCAC, an initial intake assessment was typically done over the phone by a care coordinator on the access team (an access coordinator). If the patient was in hospital, a care coordinator based in the hospital would conduct the assessment in person. The initial assessment was designed to determine the patient's eligibility for CCAC services and to

assess the patient's needs, including their nature and urgency.²¹ Although the eligibility requirements varied depending on the service, all patients had to demonstrate a need for the services and had to be insured under Ontario's public health plan, the Ontario Health Insurance Plan (OHIP).²²

Assuming the patient was eligible to receive CCAC services and could be adequately supported at home, the CCAC staff member who conducted the initial assessment prepared a plan of care, which would then be sent to the assigned service provider, as I discuss in greater detail below.

At the same time, the patient was also assigned to one of the CCAC's community teams. Within the South West CCAC, the patients were assigned to one of four teams:

- **Short stay** – someone receiving services for a short time and likely to be discharged within a few months. A large portion of the South West CCAC's patients were short-stay patients, the majority of whom required services for three months or less;
- **Chronic / community independent** – someone requiring longer-term assistance or whose condition was deteriorating;
- **Complex** – someone with higher, more complex needs, or palliative patients; and
- **Children** – someone under the age of 18.

A care coordinator from the patient's assigned team then became responsible for the patient, and became the patient's main point of contact with the CCAC. The care coordinator also spoke to the patient's service provider if there were problems. All care coordinators were regulated health professionals, although not all of them were nurses.

After a care coordinator was assigned, he or she would visit the patient's home and conduct a more detailed face-to-face assessment.²³ This assessment was supposed to be completed within 10 days, although this was not always feasible and, in practice, it might be conducted either before or after the service provider began delivering services to the patient. The care coordinator used this assessment to determine if the plan of care that was established

²¹ This initial assessment was done using the Resident Assessment Instrument – Contact Assessment (RAI-CA).

²² *Provision of Community Services*, O Reg 386/99.

²³ The care coordinator would use the Resident Assessment Instrument – Home Care (RAI-HC) to complete the more detailed face-to-face assessment.

upon intake needed to be modified by adding or changing services, adjusting the frequency of visits, or changing the length of time for which services were to be provided. Figure 12.1 depicts the provision of patient care.

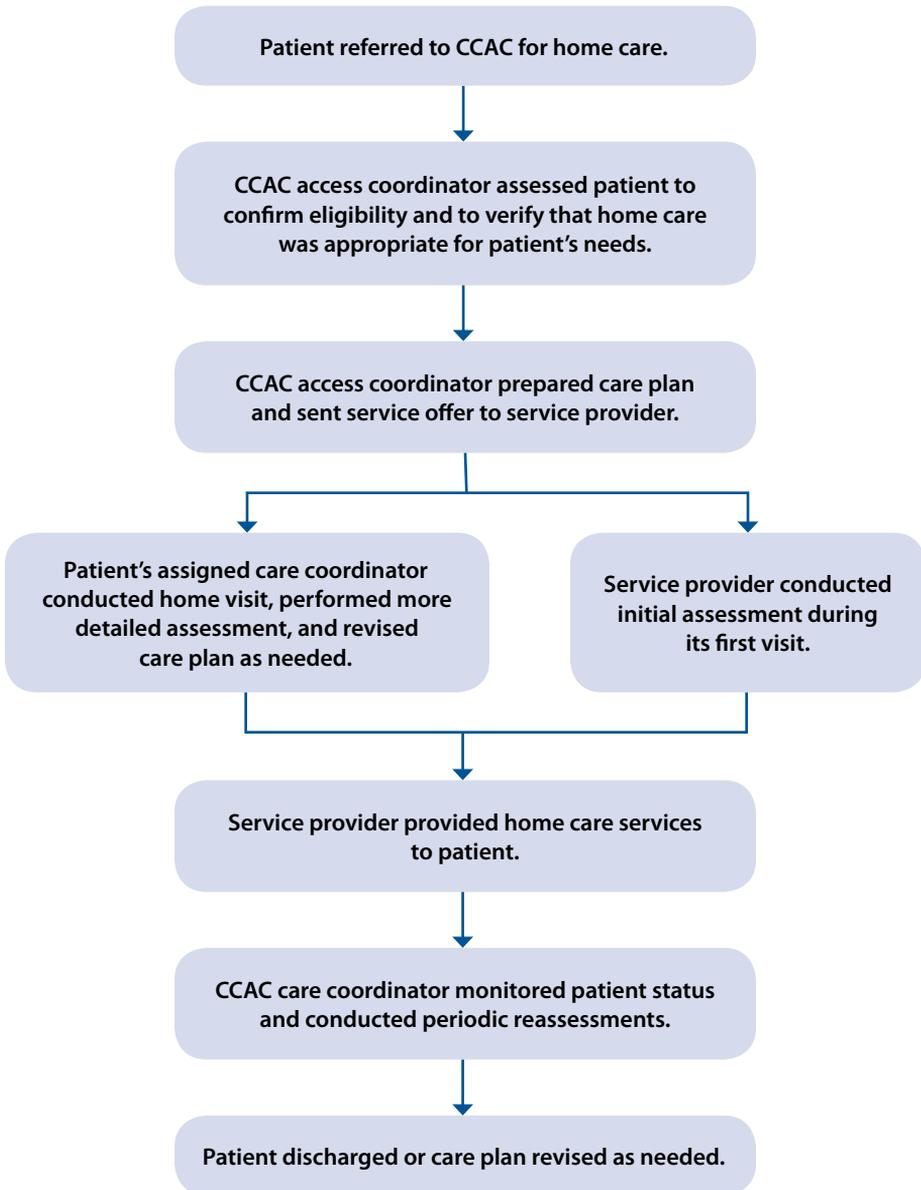


Figure 12.1: Provision of Patient Care

Source: Adapted from Office of the Auditor General of Ontario, *Annual Report 2015*, 75.

B. Assigning a Service Provider

After the access coordinator or hospital-based care coordinator completed the initial assessment and developed the plan of care, the CCAC's system automatically assigned a service provider to the patient. Service providers were assigned automatically in an attempt to ensure that each organization received the market share set out in its services agreement (because the CCAC was required to pay a higher rate if the service provider did not receive its promised market share). However, in rare cases, care coordinators would manually assign a service provider to promote continuity of care. This might happen if a CCAC patient had been recently discharged and needed to be brought back on the same service. It could also occur if the patient's service provider indicated that a healthcare worker with special skills was needed (for example, a wound care specialist) – in which case, the care coordinator might assign the same service provider to supply this specialized worker.

After the service provider was assigned, the care coordinator sent it a service offer, setting out the details of the required services. The service provider had to accept or decline the service offer in a relatively short time. Nursing referrals were usually accepted or declined within 30 minutes, and personal support worker (PSW) referrals within 45 minutes. After a service provider accepted the service offer, the CCAC sent it the patient's information electronically, along with a complete referral package.

C. Service Provider Assessments and Provision of Services

Service provider nursing staff maintained a paper chart in the patient's home so that each nurse who provided services could update it. For home care services other than nursing, service providers typically maintained electronic charts. The CCAC maintained its own electronic record for each patient, which was not available to the service provider. This included information such as:

- a client notes report outlining any contact with the patient or conversation with the patient's family members, members of the care team, physicians, and service providers;
- consents;
- contact information for the patient's physician;

- details of the CCAC services for which the patient had been referred;
- details of the patient's plan of care;
- patient updates sent by the CCAC to the service provider;
- copies of communications about the patient sent between the physician and service provider staff;
- physician orders;
- documentation outlining changes in service frequency;
- reports submitted by the service provider; and
- discharge reports.

The CCAC also maintained a separate electronic file for each patient that could be accessed by the service provider. This file contained copies of assessments performed by care coordinators and a list of the patient's medications. The CCAC could also allow the service provider to see certain entries in the client notes report.

When the service provider's healthcare workers first visited the patient, they conducted their own assessment to ensure that the plan of care was appropriate. Under the terms of the services agreement, the service provider was required to complete and send the CCAC an electronic report after this initial patient visit. That report would indicate any changes the service provider workers thought were needed to the plan of care. The care coordinator would then approve or reject the requested changes.

Service providers were also required to send other updates to the care coordinator about the patient's status. Reports had to be sent if there was a significant change in the patient's condition, if the care coordinator requested a report outlining the patient's progress, and when the patient's services ended. Service provider healthcare workers also had informal contact with the care coordinator when patients' needs changed. In addition, nurses would contact the patient's primary care physician as needed, both to obtain updated orders and to keep the physician apprised of developments.

Finally, service providers were required to report to the CCAC when there was a complaint or other event that posed a risk to the patient, an area I discuss later in the chapter.

D. Reassessments by the Care Coordinator

In addition to the initial face-to-face assessment, care coordinators periodically reassessed each of their assigned patients, with the frequency depending on the patient's needs. Within the chronic / community independent team at the South West CCAC, lower-needs patients were reassessed every 12 months, those with higher needs every six months, and those who were waiting for admission to long-term care (LTC) homes every three months. A reassessment could also be conducted if the patient was admitted to hospital or the patient's condition changed.

E. Discharge of a CCAC Patient

In some cases, a patient receiving CCAC services from a service provider would be discharged earlier than scheduled. If a home care patient was hospitalized for 14 days or more, that patient was automatically discharged from existing CCAC services. If the patient needed CCAC services upon discharge, another intake assessment and referral had to be obtained. This assessment would be done by a hospital-based care coordinator when the patient was preparing for discharge. When the patient returned home, the assigned community-based care coordinator would conduct an initial face-to-face assessment, as would be done for any new referral.

V. Oversight and Qualifications of Service Provider Staff

A. Requirements for Nurses' Qualifications and Training

Under the services agreements, healthcare workers assigned by the service provider to CCAC patients had to have the skills required to provide the services the patient needed. Nurses had to have the clinical expertise to provide a broad range of nursing services, including managing hyper- and hypoglycemia; monitoring blood glucose levels; and administering a range of medications, including those administered by injection or IV. The service provider was required to assign workers in a manner that maximized the continuity of care as much as possible. In reality, however, if a patient needed services on a daily basis or multiple times a day, he or she would not always be served by the same healthcare workers.

The services agreements required service provider nurses to be qualified and registered to practise nursing in Ontario; have a certificate of registration with the College of Nurses of Ontario and be a member of the College in good standing; be in compliance with all laws relevant to the practice of nursing in Ontario; and be qualified in standard level first aid and cardiopulmonary resuscitation.

The services agreements also required service providers to verify the qualifications of their nurses on a continuing basis, although the contracts did not specify how this should be done or how often. In addition, service providers had to manage any restrictions the College had placed on a staff member's certificate of registration. Finally, they were required to implement appropriate screening measures and verify that each nurse had obtained a police record check and provided an annual offence declaration.²⁴

Under the services agreements, service providers had to comply with education and training requirements for their staff, including:

- education to ensure staff were familiar with, and followed, the Bill of Rights in section 3 of the HCCSA;
- anti-discrimination and anti-harassment education; and
- orientation programs for new staff, which had to include education on both CCAC and service provider policies and procedures. The required training on CCAC policies included training on the reporting requirements under the services agreements.

The CCAC did not require service providers to send proof of compliance with the obligations related to staff qualifications and education, although the CCAC could perform audits if it wished to verify compliance.

B. Assignment and Oversight of Healthcare Workers

The CCAC did not directly oversee the service provider staff who provided healthcare services to CCAC patients. It did not have a list of the healthcare workers employed by service providers, nor did it receive a list of the workers

²⁴ This is a declaration that the nurse either has no criminal convictions under the Criminal Code for which a pardon has not been issued or lists any convictions since his or her last criminal record check or annual offence declaration.

assigned to provide services to any given patient. The responsibility for hiring, screening, training, scheduling, and supervising the frontline healthcare workers rested with the service provider.

Service providers were responsible for the day-to-day supervision of their healthcare workers and for overseeing the care provided in a patient's home. The services agreements imposed certain supervision requirements on service providers, although they were fairly general in nature. For example, although the services agreements required service providers to evaluate the performance and competency of their staff regularly, they did not specify when or how this had to be done. In practice, service providers tended to have managers or supervisors who supported and oversaw their nurses. These supervisors would sometimes do "ride-alongs" or home visits with new nursing staff or with nurses moving into work with specialized populations, to ensure they had the necessary skills.

The services agreements also required service providers to have nursing service supervisors, who were regulated health professionals with the management qualifications and experience to supervise registered nurses (RNs) and registered practical nurses (RPNs). Their role was to assist with the delivery of nursing services; provide clinical advice and clinical reference resources; and monitor and supervise the delivery of nursing services. The services agreements did not specify how the nursing service supervisors had to carry out these tasks. In particular, the contracts did not require nursing service supervisors to monitor and supervise the delivery of nursing services in person.

There are practical challenges associated with requiring regular ride-alongs or in-home spot checks of the services nurses are providing. The South West CCAC's patients were spread throughout thousands of homes across a widespread geographic area and, since the South West CCAC had anywhere from 18,000 to 20,000 patients on its roster at any given time, the demands of requiring routine ride-alongs or supervised in-home visits would be significant. However, the South West LHIN has been exploring the use of remote support for nursing staff via FaceTime, and it is possible that digital technology could be used to provide remote supervision.

VI. Medication Management in Home Care

Most home care patients administer their own medications and are responsible for storing them properly and taking them as prescribed. Although CCAC and service provider staff could recommend how medication should be managed, those decisions were ultimately up to the patient. Nonetheless, CCAC care coordinators still played a role in medication management. During assessments, they would often review medications with patients to ensure patients knew what medications they were on and why, the proper dosage and timing, and how to remember to take them. As part of the medication review, the care coordinator would compare the pharmacy's list of the patient's medications with those found in the patient's home. If there were discrepancies, the care coordinator would suggest that the patient follow up with the doctor or pharmacist.

Service provider nurses also play a role in managing medications. Like care coordinators, they conduct medication reviews with patients. The nurses might also remind patients to take their medications at the correct time, or educate a patient or informal caregiver about how to administer a new medication. When a patient is prescribed insulin for the first time, the service provider nurse might teach the patient how to inject insulin properly. However, unlike nurses who work in long-term care homes, service provider nurses are not typically responsible for the administration of insulin to home care patients. Rather, they play a teaching role.

In some cases, the service provider nurse continues to have some responsibility for overseeing medication administration, even when the patient or informal caregiver takes over the actual administration. For example, when a patient's informal caregiver learns how to change an IV medication bag or flush the line, the nurse continues to have oversight responsibility.

There are also situations in which a service provider nurse must administer medication, although they occur only in a small number of cases. For example, nurses might have full responsibility for administering IV antibiotics or managing narcotic injections for pain management in palliative patients. In addition, if the patient has physical or cognitive limitations that preclude self-administration and has no informal caregiver who can administer medications, service provider nurses are responsible for administering the patient's medications.

When service provider nurses are responsible for administering medications, the nurse ensures the patient receives the right medication, in the right dose, and at the right time. In those cases, the service provider – not the CCAC – was responsible for oversight. The CCAC did not specify how the service provider had to monitor the administration of medications in the home care setting, and it did not perform spot checks or audits to ensure nurses were administering medications correctly.

Because service provider nurses are typically in the home alone, their managers do not become aware of problems with the administration of medications unless a patient or family member complains, or a nurse who later visits the home notices an issue and reports it. Given the large geographic territory covered by the South West CCAC (and many other CCACs), and the number of patients on their rosters, in-person supervision of the administration of injectable medications by nurses was not feasible. However, new technologies, such as FaceTime, are being explored to support nurses in the field and may allow the remote supervision of injectable medications.

During the public hearings, the South West LHIN's vice-president of home and community care, Donna Ladouceur, indicated that, at present, it would not be feasible to require all injectable medications to be administered by LHIN nurses, as opposed to service provider nurses. In the South West region, the LHIN had fewer than 50 nurses providing clinical services at the time of the public hearings. Although many care coordinators are RNs who could theoretically administer medications, they may already be responsible for overseeing the services of approximately 100 patients each. In addition, the large geographic region covered by the South West LHIN – and many other LHINs – makes this impractical.

VII. Detecting and Preventing Abuse

Detecting abuse and neglect in the home care setting is challenging because patients are often alone with a service provider healthcare worker. If a worker abuses a patient – or observes signs of abuse but fails to report it – the abuse can easily go undetected. The patient, family members, and others who provide services to the patient are therefore an important safety net.

The HCCSA required each CCAC to have a program for preventing, recognizing, and addressing the abuse of patients.²⁵ The South West CCAC

²⁵ HCCSA, s 26.

used multiple approaches to ensure that staff were aware of, and intervened in, cases of suspected or actual abuse. It trained all care coordinators on how to identify instances of elder abuse and neglect, and about the need to report such cases. Care coordinators would draw on this training to assess what was occurring in a patient's home when they visited for assessments and reassessments, and during those visits care coordinators would typically ask the patients if they had any concerns about the care they were receiving. Through these conversations and observations, care coordinators might see signs of financial, mental, or physical abuse. However, these assessments and reassessments were infrequent (in most cases, no more than a few times per year). Apart from these visits, care coordinators had little face-to-face contact with patients, since service provider staff provided the vast majority of direct care.

The CCAC also encouraged patients to report issues to it. However, if patients were not aware that services were not being properly provided, they might not express concerns. In addition, there would not always be physical signs of abuse that care coordinators could observe during home visits – and such visits did not happen frequently – so these home visits were not the primary way in which the CCAC learned of abuse and neglect. Rather, its primary sources of information were calls, complaints, and reports from others, including caregivers and physicians or para-medicine providers who were going into the patient's home. The CCAC also conducted quarterly patient satisfaction surveys, which could alert the CCAC to problems.

The South West CCAC had an events management framework that required both CCAC and service provider staff to report incidents of suspected or actual abuse of patients. All care coordinators were trained to enter such incidents into the electronic events management system so they could be addressed by the appropriate person within the CCAC. Service provider staff were similarly trained on the requirement to report suspected or actual abuse and neglect to the CCAC.

The services agreements required all service providers to establish a risk management program. As part of that program, service providers had to train and prepare staff and establish procedures to follow when an incident occurred involving patient abuse, accident, or injury. At the public hearings, Ms. Ladouceur reported that many service providers trained their staff annually on abuse or neglect, although the CCAC did not require annual training on these issues.

VIII. Dealing with Complaints and Risk Events

A. How the CCAC Learned of Complaints and Risk Events

The services agreements required service providers to report both “risk events” and “adverse events” to the CCAC. The agreements defined a risk event as an “unforeseen event that has given rise to or may reasonably be expected to give rise to danger, loss or injury relating to the delivery of the Nursing Services, including danger, loss or injury to the Patient, Caregiver, Service Provider Personnel or loss or damage to the CCAC or the Service Provider.” Examples include a patient injury or fall, a medication error, an improper procedure or intervention, a failure to follow medical orders, the actual or potential abuse of a patient, an actual or alleged theft in the home, and the unexpected death of a patient.

In turn, “adverse events” were a subset of risk events. They included any risk event that:

- was related to a patient;
- caused an unintended injury to the patient or a complication that resulted in disability, death, or increased use of healthcare resources; and
- was caused by healthcare management, including any care or treatment provided as part of a formal care plan by healthcare workers, formal or informal caregivers, or as self-care by the patient.

Because care coordinators were patients’ main point of contact with the CCAC, patients could raise concerns directly with them. The CCAC would sometimes also learn of a patient complaint or risk event through a report from the service provider, from other healthcare professionals who treated the patient, through the long-term care action line,²⁶ through an MPP’s office, or through the patient ombudsman’s office.

²⁶ The action line received complaints about both long-term care homes and publicly funded home care services.

B. Reporting and Responding to Complaints and Risk Events at the Time of the Offence

1. Under the HCCSA

The HCCSA did not require the CCAC to have a general process for reviewing all complaints and made no reference to risk events. It required only that the CCAC establish a process to review complaints about:

- a decision that a patient was not eligible to receive a service;
- a decision to exclude a particular service from the patient's plan of care;
- a decision respecting the amount of any particular service to be included in the patient's plan of care;
- a decision to terminate the provision of a particular service to the patient;
- the quality of the services provided to the patient by the CCAC or by the service provider the CCAC assigned to do the work; and
- an alleged violation of the Bill of Rights in section 3 of the HCCSA.²⁷

The HCCSA required the CCAC to review these complaints and provide the complainant with a response or decision within 60 days.²⁸

For the most part, there was no formal appeals process patients could use if they were dissatisfied with how a complaint was resolved. However, there were a few exceptions. The HCCSA permitted patients to appeal to the Health Services Appeal and Review Board in relation to decisions on four types of complaints:

- the patient's eligibility for services;
- the exclusion of a service from the plan of care;
- the amount of services; and
- the termination of services.²⁹

In effect, patients could not appeal decisions regarding complaints about such things as the quality of care, violations of the Bill of the Rights, service providers, or service provider staff members.

²⁷ HCCSA, s 39.

²⁸ HCCSA, s 39(2), (3).

²⁹ HCCSA, s 40.

The HCCSA imposed no obligations on service providers in relation to complaints or risk events. It did not require them to have a process for dealing with complaints, nor did it establish an appeal process for complaints they received. Given the limited obligations imposed on CCACs and service providers by the HCCSA, the CCACs' policies and procedures were the primary source of obligations related to complaints and risk events.

2. Under the Services Agreements

Under the services agreements, service providers were required to immediately notify a patient's care coordinator of risk events involving patient safety, as well as adverse events, and to provide a written report within three days. They also had to immediately notify the patient's care coordinator if a CCAC patient was unexpectedly admitted to a hospital or healthcare facility. In addition, service providers had to report quarterly on the rate of adverse events attributable to or contributed to by the service provider, and the rate and type of patient and caregiver complaints they had received. Finally, service providers had to abide by the CCAC's policies about reporting complaints and risk events, which are outlined below.

3. The South West CCAC's Policies and Procedures

a) Reporting of Complaints and Risk Events

The South West CCAC's policies and procedures required both CCAC and service provider staff to document and report on a wide range of complaints and risk events based on an events management framework, developed for use in CCACs across the province in 2009. Although the South West CCAC adopted this framework, not all CCACs necessarily used it as the basis for their policies and procedures. At the time of the public hearings, the South West LHIN was developing a revised patient relations framework to replace the events management framework.

Under the events management framework in use at the time of the Offences and the public hearings, CCAC and service provider staff were required to report various categories of events, including, but not limited to:

- violations of patients' rights under the HCCSA's Bill of Rights, human rights legislation, or otherwise;
- a variety of events related to patient and caregiver safety, including:
 - an improper procedure or intervention;

- a failure to follow medical orders;
 - a patient injury or fall;
 - a medication error;
 - actual or potential abuse of a patient;
 - an alleged theft;
 - an unexpected death;
- a missed visit; and
 - an adverse event.

b) Documenting Complaints and Risk Events

The South West CCAC's procedures required all reportable complaints and risk events to be documented in the CCAC's events tracking management system (ETMS). ETMS was an electronic system maintained by the South West CCAC and accessible to its service providers. However, because other CCACs may have used different software, the details below cannot be generalized to all CCACs.

The information recorded in the South West CCAC's ETMS included the source of the complaint or risk event; the patient's name; the region within the CCAC where the event occurred; the patient's service provider; the applicable category from the events management framework; and a notes section to document additional information gathered, the actions taken in response, and the resolution. The person entering the event – either at the CCAC or the service provider – also had to assign and enter a risk level: low, medium, or high.

The risk level was primarily determined by the impact the issue had on the patient, the service provider, or the CCAC. This meant that a single type of error (such as a medication error) could be classified as low, medium, or high risk, depending on how it affected the patient. Low-risk events were those that had actual or potential for minimal harm, medium-risk events had actual or potential for some injury or harm, and high-risk events had actual or potential for significant harm. All adverse events were considered high risk. The service provider was required to provide a written response to all medium- and high-risk events within five calendar days. There was no required timeline within which service providers had to respond to low-risk events.

Regardless of risk level, the patient's care coordinator and the care coordinator's direct supervisor were notified of the event. In addition, all adverse events and high-risk events were reviewed by a designated, more senior person within the CCAC's quality team. The purpose of this review was to ensure that appropriate actions were taken to address the issue, provide expertise and advice on how best to address it, recommend any necessary changes to CCAC practices, and support any related quality improvement initiatives.

Both at the time of the Offences and the time of the public hearings, ETMS did not have a designated field to enter and track the name of the staff member who was the subject of a complaint, although this information could be entered in the field where the details of the event were documented. This omission had implications for the South West CCAC's ability to monitor trends and complaints related to a specific staff member, as I discuss later in this chapter. However, Steven Carswell, the South West LHIN's director of quality, indicated that service providers are still able to identify and follow up with the staff member involved. Even if the complainant does not report the staff member's name, the service provider can determine who the staff member is by cross-referencing the patient's name and the date and time of the visit at issue with its own internal scheduling system or the patient's electronic medical record.

c) Responsibility for Documenting and Reporting Complaints and Risk Events

A CCAC staff member who learned of a complaint or risk event was required to enter the event into ETMS. The patient's care coordinator and the care coordinator's direct supervisor would be automatically notified, as would the service provider if the issue was related to the service provider or one of its staff.

If it was the service provider that first learned of a complaint or risk event, a supervisor or manager was responsible for documenting the event in ETMS. Because service providers' frontline staff could not enter events into ETMS, they were required to report issues to their supervisors so the concerns could be entered into ETMS. When a service provider created an ETMS entry, CCAC administrative staff would receive an automatic notification, and they would then alert the patient's care coordinator and the care coordinator's direct supervisor.

Given the large number of people who would enter events in ETMS, they were not always documented in a consistent manner, particularly in the assignment of risk levels. However, the assigned risk level could be changed at any point in the process if additional information came to light or if someone more senior concluded that the risk level was not appropriately assigned. At the time of the public hearings, the South West LHIN was considering whether all risk levels should be assigned or reviewed by a designated team within the LHIN to ensure consistency.

In addition, although the South West CCAC's procedures required all events to be recorded, minor issues that did not affect patient safety – such as a patient complaint about a personality conflict with a service provider worker – were sometimes dealt with in the moment. Although these issues would be entered into the patient's electronic record maintained by the CCAC, they were not necessarily recorded in ETMS. Although this reality had some impact on the tracking of trends, the CCAC primarily focused on trends related to patient safety and quality of care, which Mr. Carswell testified were typically properly reported and entered into ETMS.

The CCAC's complaints process relied heavily on service provider frontline staff reporting issues to their managers, and those managers then reporting to the CCAC by entering issues into ETMS. However, if frontline staff did not report an issue, or supervisors failed to document it in ETMS, the CCAC would not learn of it unless the patient or someone else in the home made a complaint. At the public hearings, the South West LHIN's vice-president of home and community care stated that she believed that, for the most part, service providers properly reported issues to the CCAC, with the exception of some inconsistent reporting around missed care by PSWs. However, on occasion, a patient would tell the CCAC about an ongoing issue that had not been reported by the service provider. Ms. Ladouceur's view was that, in such cases, it was typically the service provider's frontline workers who were not reporting the issue to management, not management that was failing to pass such reports on to the CCAC.

Nonetheless, this vulnerability in the system can lead to serious issues going unnoticed, as became evident during the public hearings. In late August 2016, two nurses from Saint Elizabeth Health Care (Saint Elizabeth) learned from a CCAC patient that Wettlaufer had entered her home uninvited and unannounced. They reported this unauthorized entry to their supervisor at Saint Elizabeth; however, the supervisor did not report it to the CCAC. Saint Elizabeth subsequently learned, through Wettlaufer's criminal

proceedings, that during the unauthorized entry Wettlaufer stole the insulin that she ultimately used to attempt to murder Beverly Bertram, the victim of the Offence. Saint Elizabeth managers did not report Wettlaufer's theft to the CCAC when they learned of it. Ms. Ladouceur and Mr. Carswell testified that the first time they learned that Wettlaufer's unauthorized entry and theft involved a South West CCAC patient was during the testimony of the Saint Elizabeth witnesses at the Inquiry's public hearings.

As discussed earlier in this chapter, theft from a patient's home was considered a risk event and had to be reported. As for Wettlaufer's unauthorized entry, both Ms. Ladouceur and Mr. Carswell testified that they would have expected it to be reported, although Mr. Carswell noted that it did not fit neatly into any of the CCAC's reporting categories. They indicated that as a result of this incident, the South West LHIN was working to clarify its reporting requirements and train all its service providers about the need to report such an incident.

4. Resolving Complaints and Risk Events

For issues that did not relate to a service provider or its staff, the CCAC would conduct its own review of the concern. However, for issues that related to service providers or service provider staff, the CCAC would address the issue collaboratively with the service provider. Within the CCAC, the care coordinators and their direct supervisors had the primary responsibility for working with service providers to address complaints and risk events. More senior individuals within the CCAC would also be informed as needed. For example, the South West CCAC's director of quality was typically informed of events that had a significant impact on patient safety or risk, or if the event was part of a broader trend.

For issues related to a service provider or its staff, the CCAC would review the incident, gather information by speaking to the relevant people or by reviewing documents, and work with the service provider to resolve the issue. The CCAC also required the service provider to respond formally through ETMS to outline the steps it had taken or planned to take. The CCAC might require the service provider to take particular steps in response – for example, by reviewing a particular policy or procedure with its staff, or performing an in-depth analysis to determine what caused the issue.

At the time of the public hearings, the South West LHIN was updating its patient relations framework to govern the reporting of complaints and risk events, and was working on clarifying its expectations and providing clearer

guidance about how different types of issues should be addressed. It was also in the process of formalizing a “duty to report process” for LHIN and service provider staff about their reporting obligations to the colleges that regulate healthcare professionals (such as the College), the Retirement Homes Regulatory Authority, and the long-term care action line.

If an issue was related to the skills or professionalism of a service provider staff member, the CCAC had no power to require the service provider to discipline or terminate the staff member’s employment. However, the services agreements allowed the CCAC to require that a service provider not send a particular staff member to care for CCAC patients. Under the agreements, the CCAC could make this request if it concluded that the staff member had committed serious misconduct or been charged with a criminal offence, or if the CCAC had reasonable cause to be dissatisfied with the staff member’s performance. The CCAC could make the request on either a temporary basis – for example, until the staff member received additional training – or on a permanent basis.

IX. Use of Data About Complaints and Risk Events

A. Data That Were Tracked and Examined for Trends

The services agreements contained performance indicators that were used to monitor service providers’ performance. Service providers who delivered nursing services had to report on several indicators related to nursing including, but not limited to, the rate of missed care; the rate at which patients received their first visit within the targeted five-day period; and various patient satisfaction measures relating to overall satisfaction, continuity of care, and patient-centred appointments.

In addition to these performance indicators, service providers had to provide the CCAC with annual summaries of the results of any client and caregiver satisfaction surveys completed. As mentioned, service providers also had to report quarterly on, among other things, the rate of adverse events and the rate and type of patient and caregiver complaints.

Apart from receiving these reports, the South West CCAC monitored the safety and quality of home care services by looking at trends related to complaints, risk events, and adverse events. Using the data entered into ETMS, the South

West CCAC could compile reports outlining trends by month, by region, by event category, by risk level, and by service provider. CCAC frontline staff looked at these trends primarily to determine if issues reported to them reflected a broader trend in the community. The director of the quality team also reviewed these trends at a high level on a weekly basis, primarily with a view to identifying areas where a service provider's performance was weak or where additional resources were needed to improve quality.

In preparation for the Inquiry's public hearings, the South West LHIN compiled data on the types of complaints and risk events the CCAC (and later the LHIN) received related to home care from January 1, 2005, to July 31, 2017. The most common issues related to the quality of services and the safety of staff entering the home. Quality of service issues ranged from minor complaints about a worker arriving late or a personality conflict, to complaints that the patient's health was being compromised by inadequate treatment. Staff safety concerns could range from unsecured animals in the home to violence from a patient or someone else in the home.

As mentioned above, ETMS did not have a dedicated field to track the names of staff members who were the subject of a complaint or risk event. As a result, it was difficult for the CCAC to see patterns related to a particular staff member, since there was no systematic way to view a history of complaints related to that staff member. In addition, each CCAC could monitor trends only within its geographic area. This meant it would generally not be aware of complaints and risk events related to a staff member's work in another CCAC's region. Although the CCAC would sometimes become aware of issues anecdotally, these challenges made it more difficult to determine when the CCAC should ask a service provider to stop sending a particular staff member to care for CCAC patients.

B. Use of Trends to Monitor and Address Systemic Issues

When reviewing trends, the South West CCAC (and later the LHIN) looked at whether there seemed to be a systemic issue across service providers. If it seemed there was, the information was used to discuss possible improvements with service providers and other stakeholders. For example, at one point, a trend related to issues with palliative care arose, which led to discussions with physicians and service providers aiming to improve patient safety.

The South West CCAC (and later the LHIN) also participated in various committees that worked to address system-wide issues. It participated in provider operations meetings (POMs), which were committees composed of leaders from each service provider and from the South West CCAC. There were three POMs: (1) nursing and medical supplies; (2) therapies and medical equipment; and (3) personal support services. POMs were designed to address delivery of care within each discipline, to allow the South West CCAC and its service providers to work collaboratively to resolve systemic issues, and to implement new quality improvements. For example, when there was a trend in complaints and risk events regarding electronic pain pumps, the nursing and medical supplies POM created a subcommittee to determine the causes and ultimately recommended changes to be implemented by all service providers.

Systemic trends could also be addressed through the Inter-Agency Leadership Partnership (IALP), which was made up of the most senior regional leader from each service provider, as well as the South West CCAC's director of quality and its regional manager, contracts. The IALP meetings were used to discuss broad system-related issues and performance metrics. A recent issue that was dealt with through the IALP was the difficulty meeting the demand for personal support services in the South West region.

C. Use of Trends to Monitor and Address the Performance of Service Providers

The South West CCAC monitored patient satisfaction by conducting quarterly surveys of its patients. It would discuss these results, as well as trends related to complaints and risk events, during its quarterly performance meetings with each service provider. The CCAC used its reports on trends to determine if a performance issue with a particular service provider needed to be addressed. For example, Mr. Carswell testified that a recent review of trends revealed that one service provider was not responding adequately to complaints and risk events. As a result, the South West LHIN conducted a formal audit of all complaints and events related to the service provider and then dealt with the issue through a formal performance management process.

X. How the CCAC Managed Performance Issues with a Service Provider

The CCACs had various tools available to address issues that arose with a service provider's performance. In most cases, the CCAC would try to resolve the issue collaboratively before taking more serious steps. However, for serious or ongoing unresolved issues, the CCAC would use more formal tools at its disposal.

A. Informal Conversations

The CCAC would typically first try to address issues by having informal discussions with the service provider. They would discuss the area of concern and agree on a plan for improvement. However, if the service provider did not make or sustain an improvement, the CCAC would use its formal performance management process to address the issue.

B. Quality Improvement Notices

One option under the performance management process was the issuing of a quality improvement notice – a written notice of a performance issue. It required the service provider to conduct an investigation and follow an action plan that set out milestones, deliverables, and timelines to resolve the issue. The CCAC and the service provider typically agreed on the action plan together. The CCAC would monitor the service provider's performance through regular meetings, attended by the leadership of the service provider and senior members of the CCAC. The meetings would typically continue until the issue was resolved, and the quality improvement notice remained open until the CCAC was satisfied that the improvements had been sustained over a period of time.

C. Contract Management Meetings

The CCAC also had the option of requiring a formal contract meeting or series of meetings. Those meetings were intended to allow the CCAC and service provider to discuss concerns and, where appropriate, to agree on a plan for correcting those issues. Contract management meetings were designed to impress upon the service provider the severity of the issue, allow it a chance to respond to the concern, and enable the CCAC and service provider to prepare and agree upon an enhanced action plan.

D. Withholding Payment

If the tools outlined above did not correct the situation, or if the problem was so serious that more aggressive action was needed, the CCAC could withhold payment under the services agreement. If the CCAC took this step, the service provider had 30 days to remedy the issue, after which the CCAC was required to pay the amounts withheld. Mr. Carswell testified that during his tenure with the CCAC (now the LHIN), this tool had not been used because the other available remedial options were considered more effective.

E. Reducing Market Share

Short of terminating the contract, the most aggressive tool available to the CCAC was the option of reducing the service provider's market share, on either a temporary or a permanent basis. The South West CCAC reduced the market share of underperforming service providers on numerous occasions.

Although the reduction of market share was a powerful tool, it had challenges. The CCAC first had to ensure that another service provider could take on the additional volume of work. If there was not a second suitable service provider in the region, or if the other service providers could not take on extra work, the CCAC would not reduce the market share of an underperforming organization. The CCAC would first have to recruit another service provider to ensure that there was no disruption to CCAC patients' ongoing services. Thus, reduction in market share was not necessarily a tool that could be deployed by the CCAC immediately: it often required advance planning and, at times, a gradual transition of the service volume.

F. Terminating the Services Agreement

The most serious option available to the CCAC was the termination of the services agreement. This step would be taken very cautiously and only in extreme cases, as it could put the care of patients at risk. If an agreement was terminated, the CCAC had to find another agency to provide a significant volume of services – and that could be challenging. For that reason, the CCAC considered termination only if there were very serious or ongoing issues with a service provider's performance.

G. Minister's Power to Suspend

Section 56 of the HCCSA gives the minister of health and long-term care the power to order a service provider to suspend or stop an activity that the minister has reasonable grounds to believe is causing, or is likely to cause, harm to a person's health, safety, or well-being. However, the South West LHIN's director of quality indicated that, to his knowledge, this power has never been used.

Given that it was the CCAC (later the LHIN), and not the minister, who monitored the day-to-day performance of service providers, it is not clear to what extent the minister would be in a position to make such an order. There was no evidence suggesting that the minister was routinely informed about performance issues with the many service providers in the province. Practically speaking, it was the CCAC that intervened if there was a problem with the quality of services.

H. CCAC Power to Inspect, Survey, or Review

Under the services agreements, the CCAC had the power to inspect, survey, or otherwise review the services performed by the service provider, and to visit the service provider's office for that purpose. However, this was not a formalized inspection program like the one in place for long-term care homes. Rather, it was a general power the CCAC could use to gather information about specific issues that arose, and was used only on an ad hoc basis.

Because home care services are delivered in thousands of homes over a wide geographical area, it would have been difficult and impractical for the CCAC to conduct routine audits or inspections in patients' homes. Such an approach would also be highly invasive, given that it would involve entering patients' private dwellings. For those reasons, the power to inspect, survey, or review is not well-suited for general monitoring of the provision of home care. Rather, the CCAC (later the LHIN) saw the other performance management tools as better suited to that task.

However, this power was used by the CCAC to perform larger, global audits – for example, to examine the human resources practices or the rate of missed care across its service providers. It was also used when the CCAC was reviewing a known issue, either as part of a quality improvement process or otherwise. For example, it may be used to request a patient's chart or to audit the records of an electronic pain pump that has been the subject of complaints.

XI. Use of Subcontractors

A. The Service Provider’s Ability to Engage Subcontractors

Under the terms of the services agreements, a service provider could engage other agencies to provide services to CCAC patients on its behalf. These other agencies were known as “subcontractors” under the services agreements. For example, Life Guard Homecare, which provided temporary nursing staff to long-term care homes, was also subcontracted by various service providers to provide home care services to CCAC patients.³⁰

A service provider that wished to use a subcontractor required the prior written approval of the CCAC. When evaluating a request to approve a subcontractor, the CCAC looked at various factors, including the subcontractor’s past performance, its history of working in the home and community care sector, any legal claims or concerns relating to the subcontractor, and the service provider’s process for ensuring the subcontractor properly performs its obligations. This final point is particularly important because the service provider remained fully accountable for the delivery of the services covered by its services agreement – including those carried out by the subcontractor.

B. The CCAC and a Service Provider’s Subcontractors

The CCAC did not have a direct, formal relationship with a service provider’s subcontractors. Although a subcontractor’s nursing staff or scheduler might speak to a CCAC care coordinator directly about a patient, the CCAC did not regularly speak with subcontractors about performance issues. Rather, if the CCAC had concerns about a subcontractor’s performance, it typically discussed those issues with the service provider, which was then expected to address the issue with the subcontractor. However, if the CCAC was performing a review or holding a meeting related to an issue, it might involve both the service provider and the subcontractor’s leadership.

³⁰ In the South West CCAC’s territory, Life Guard was a subcontractor for CarePartners and ParaMed Health Services at the relevant time. It was also a subcontractor for three service providers in the Hamilton Niagara Haldimand Brant CCAC’s region.

The reporting of complaints and risk events to the CCAC also followed a different process when a subcontractor was involved in that the service provider was responsible for reporting to the CCAC on behalf of the subcontractor. In the South West CCAC's territory, subcontractors did not have access to the CCAC's electronic events reporting system (ETMS). For that reason, subcontractors were expected to report complaints and risk events to the service provider, which, in turn, would enter them into ETMS to report them to the CCAC.

This process could result in an information gap between the CCAC and the subcontractor. Although the CCAC would learn of issues with a subcontractor if a patient complained directly to the CCAC, it relied heavily on the service provider to inform it about issues with subcontractors. In turn, the service provider's ability to inform the CCAC about concerns with a subcontractor depended on the latter properly reporting issues to it. However, the CCAC did not have any formal process in place to ensure service providers were appropriately overseeing their subcontractors or monitoring the way in which they were reporting issues. As a result, if a service provider did not ensure subcontractors were reporting issues properly, the CCAC might not learn about certain concerns at all.

C. Removal of Subcontractors

The services agreement allowed the CCAC to require a service provider to stop using a subcontractor to care for CCAC patients. The CCAC could make such a request if it concluded that the subcontractor had committed serious misconduct or been charged with a criminal offence, or if the CCAC had reasonable cause to be dissatisfied with the subcontractor's performance. Of course, the CCAC's ability to make such a request depended on its learning of a performance issue with the subcontractor. This fact made the service provider's oversight particularly important.

The power to ask the service provider to stop using a particular subcontractor has rarely been used in recent years in the South West LHIN's region. The South West LHIN's director of quality indicated that neither the South West CCAC nor the South West LHIN had taken action under this provision since 2015, when he joined the South West CCAC.

XII. The Care Provided to the Victim of the Offence and the South West CCAC's Investigation After Wettlaufer's Confession

A. The Care Provided to Wettlaufer's Victim in the Home Care Setting

Wettlaufer's victim in the home care setting, Beverly Bertram, had intermittently received CCAC services for a number of years. In early 2016, she was assigned to the CCAC's chronic / community independent team and was receiving personal support and nursing services, the last of which was provided by Saint Elizabeth. In early July 2016, Ms. Bertram was admitted to hospital and, because she was hospitalized for more than 14 days, she was discharged from all these services, in accordance with CCAC policy.

Ms. Bertram was released from hospital on August 19. Before her discharge, she was assessed by a hospital-based care coordinator and given a new referral so she could resume receiving home care. The hospital-based care coordinator established a plan of care, and Saint Elizabeth was assigned to provide nursing services related to the administration of intravenous antibiotics, PICC line (peripherally inserted central catheter) maintenance, and wound care.

Because Saint Elizabeth – not the CCAC – decided which particular healthcare workers were assigned to a patient, the CCAC was not aware, at the time, of which nurses were sent to provide services to Ms. Bertram. Saint Elizabeth assigned Wettlaufer to provide Ms. Bertram with services on August 20 and 21, 2016. As she later confessed, on August 21, Wettlaufer attempted to murder Ms. Bertram by administering large doses of insulin through the PICC line. Fortunately, Ms. Bertram survived Wettlaufer's attack.

By early September, when Ms. Bertram's assigned community-based care coordinator visited her home to conduct the more detailed face-to-face assessment, Wettlaufer's attack had already occurred, although she had not yet confessed to it or the other Offences. Ms. Bertram's care coordinator gave evidence that she did not see anything during the assessment that caused her to be concerned, and neither Ms. Bertram nor anyone in her household complained about the services she had received to that point. Similarly, the CCAC had not received any complaints about the services Wettlaufer had provided to Ms. Bertram in August 2016. In short, there was nothing to alert the CCAC to the Offence against Ms. Bertram.

Wettlaufer later confessed that she stole the insulin she used in her attempt on Ms. Bertram's life from another CCAC home care patient. Wettlaufer had entered that patient's home, without invitation, for the express purpose of stealing insulin. As discussed earlier in this chapter, Saint Elizabeth supervisors did not report Wettlaufer's unauthorized entry into this patient's home to the CCAC. Later, when Saint Elizabeth learned that Wettlaufer had stolen insulin from this patient, it did not report the theft to the CCAC, either.

B. The South West CCAC Learns of Wettlaufer's Confessions

The South West CCAC first learned of Wettlaufer's confessions on October 18, 2016. On that date, Saint Elizabeth contacted Ms. Ladouceur, who was then the vice-president, patient care, at the South West CCAC, to inform her that an unidentified nurse had confessed to attempting to harm multiple patients. The email mentioned only one South West CCAC patient, Ms. Bertram, and indicated that the nurse had confessed to injecting insulin into Ms. Bertram's PICC line. The email confirmed that Ms. Bertram was "alive and well" and that the police investigation was ongoing.

After Wettlaufer's confessions came to light, Ms. Bertram's care coordinator contacted Ms. Bertram to ask how she was coping and if she needed additional supports. The South West CCAC's patient relations coordinator also created an ETMS entry to document the incident and the steps taken in response. Two days later, the South West CCAC's senior leadership team was provided with a briefing note outlining the information the CCAC knew at that point.

On October 25, the Ontario Provincial Police and the Woodstock Police held a press conference about Wettlaufer's Offences. They indicated that she had been charged with several counts of murder and attempted murder, and released the names of eight of her victims.

Upon learning the names of Wettlaufer's victims, the South West CCAC determined that, apart from Ms. Bertram, who was a home care patient, several of Wettlaufer's victims had been placed into long-term care homes by the South West CCAC. It therefore searched for the records of any victims who had been South West CCAC patients, and, to protect the privacy of those records, restricted access to a small number of senior CCAC staff.³¹

³¹ Because Ms. Bertram was still actively receiving home care services, access to her file was not restricted, as it needed to remain accessible to CCAC staff.

C. Discussions with Saint Elizabeth

On October 21, 2016, the South West CCAC's patient relations coordinator and its regional manager, quality, spoke with Saint Elizabeth management by phone to discuss the steps that needed to be taken to ensure patient safety. During that call, the South West CCAC stated that it expected Saint Elizabeth to follow up individually with each patient to whom Wettlaufer had been assigned to ensure that there were no unreported quality of care issues. The South West CCAC also told Saint Elizabeth to speak with Wettlaufer's fellow nurses to determine if they had any concerns about the quality of care she had provided. Following this call, the South West CCAC's regional manager, quality, and Saint Elizabeth were in frequent contact as the investigation unfolded.

D. Communications with Service Providers

On October 25, 2016, as part of the South West CCAC's investigation after the Offences came to light, the South West CCAC's regional manager, contract management, contacted all of its service providers to ask if Wettlaufer had ever worked for them, either under her current surname or her birth name. Apart from Saint Elizabeth, all the service providers indicated that she had not.

The same day, a local newspaper reported that Wettlaufer had worked for Life Guard Homecare. The South West CCAC had approved Life Guard as a subcontractor for two service providers, ParaMed Health Services and CarePartners. Accordingly, the regional manager, contract management, reached out to both service providers to inform them that Wettlaufer had worked for Life Guard and to ask them to identify any South West CCAC patients to whom Wettlaufer had provided services in that capacity.

ParaMed found that Wettlaufer had provided services to seven South West CCAC patients while working as a personal support worker (PSW) through Life Guard, and CarePartners indicated that she had provided PSW services to one South West CCAC patient during an eight-hour e-shift through Life Guard.³²

³² An e-shift is a program through which a PSW provides services in a patient's home and receives direction and communication from a nurse via a smartphone.

The South West CCAC asked both ParaMed and CarePartners to investigate the care Wettlaufer provided to those patients to determine if there were any issues with the services she had provided. Both ParaMed and CarePartners reported back that their respective investigations did not reveal any concerns.

These communications highlight the extent to which the CCAC relied on service providers to manage their frontline staff and subcontractors. As revealed by the communications with the service providers in the wake of the Offences, the CCAC did not know what staff worked for each service provider. In addition, neither the CCAC nor the service providers knew the names of the staff working for subcontractors. It was not until the media reported that Wettlaufer worked for Life Guard that the CCAC was able to alert ParaMed and CarePartners to the need to follow up with some of their patients. This underscores that the work done by service providers and subcontractors to screen and train staff and monitor the quality of services is critical for ensuring the safety of patients.

E. Communications with Hamilton Niagara Haldimand Brant CCAC

After learning that Wettlaufer had worked for Life Guard, the South West CCAC also contacted the Hamilton Niagara Haldimand Brant (HNHB) CCAC, as Life Guard also worked in that region. The HNHB CCAC then asked all its service providers if Wettlaufer had ever worked for them. All indicated that she had not; however, three service providers had subcontracts with Life Guard. The HNHB CCAC asked them to determine if Wettlaufer had provided services to any CCAC patients through Life Guard, and all three found that she had. The HNHB CCAC obtained a list of those patients and confirmed that there were no unexpected deaths involving any of them.

F. South West CCAC Audit of Patient Files

After communicating with its service providers and alerting the HNHB CCAC to Wettlaufer's work for Life Guard, the South West CCAC audited the files of all the South West CCAC patients to whom Wettlaufer had been assigned. Thus, they reviewed the files of patients:

- whom the police identified as victims of the Offences, including the victims who were residing in long-term care homes and were no longer receiving home care services at the time of their deaths;
- whom Saint Elizabeth identified as having received one or more visits from Wettlaufer;
- whom ParaMed identified as having received one or more visits from Wettlaufer when she was working as a PSW for Life Guard; and
- whom CarePartners identified as having received one or more visits from Wettlaufer while working as an e-shift PSW for Life Guard.

The South West CCAC's regional manager, quality, who was a registered nurse, reviewed the patient records, including all documentation and patient notes, to identify if any quality of care issues had not been entered into ETMS or escalated to the quality team. Based on this review, the South West CCAC did not identify any unexpected deaths, complaints, or quality of care issues, apart from those related to Ms. Bertram. In addition, the regional manager, quality, reviewed all of the electronic patient reports authored by Wettlaufer, and did not find any quality of care issues. To ensure she had reviewed the files of all patients to whom Wettlaufer had been assigned, the regional manager, quality, also cross-referenced the electronic reports with the list of patients the South West CCAC already knew Wettlaufer had seen. No new patients were identified through her review.

After conducting this review, the South West CCAC determined that the issue with the care Wettlaufer had provided to CCAC patients appeared to be limited to her attempt to kill Ms. Bertram.

RECOMMENDATIONS

The following recommendations are directed at the Local Health Integration Networks (LHINs) since, at the time of the writing of this Report, they are carrying out the Community Care Access Centres' former responsibilities for providing or arranging for the provision of publicly funded home care. In light of *The People's Health Care Act, 2019*, which, when the relevant provisions come into force, would allow for the reorganization or dissolution of the LHINs, these recommendations are intended to apply to any successor organization that is responsible for publicly funded home care services.

Recommendation 32: All Local Health Integration Networks (LHINs) should adopt the same electronic events reporting system. The system should:

- be set up in a manner that allows all data to be accessed and searched by all LHINs; and
- contain a dedicated, searchable field for the name of the staff member involved in reported incidents.

Rationale for Recommendation 32

- Not all Local Health Integration Networks (LHINs) use the same electronic events management systems; thus, each one can search only the complaints and reports within its own territory. The result is that a LHIN has no easy way to determine if a caregiver has been involved in incidents in another LHIN's jurisdiction.
- The events tracking management system used by the South West Community Care Access Centre (CCAC) (later, the South West LHIN) did not have a dedicated field to record the name of the staff member(s) involved in an incident. This meant the CCAC could not easily search a history of complaints and reports involving a particular staff member to determine if there were any patterns.

Recommendation 33: Local Health Integration Networks should modify or clarify their reporting requirements for service providers on unusual incidents, including unauthorized entry into a patient's home by:

- clarifying that all such events must be reported;
- clarifying that all such events are considered high risk; and
- requiring service providers to immediately notify the patient's care coordinator when such an incident occurs, and to follow up with a written report setting out the steps the service provider took to investigate the incident.

Rationale for Recommendation 33

- Wettlaufer's unauthorized entry into a patient's home was not reported by the service provider to the South West Community Care Access Centre. Clarification of the types of events that are reportable would ensure that the Local Health Integration Network (LHIN) is informed of incidents of this nature.
- Unauthorized entry into a patient's home is a serious invasion of privacy and, as Wettlaufer's actions demonstrate, can be for nefarious purposes. Treating such events as high risk will ensure that they are investigated promptly. Requiring service providers to immediately notify the care coordinator of such events will ensure the LHIN is aware of the incident and can address it immediately.

Recommendation 34: Local Health Integration Networks (LHINs) should provide additional training for both service providers and LHIN staff, as follows:

- For service providers: on using the LHIN's electronic events reporting system and reporting requirements.
- For LHIN staff: on using the LHIN's electronic events reporting system and reporting requirements, and the steps to take when a complaint or risk event is reported.

Rationale for Recommendation 34

- The service provider did not report Wettlaufer's unauthorized entry into a patient's home nor did it report that, during this unauthorized entry, Wettlaufer stole the patient's insulin. The Local Health Integration Network's (LHINs) ability to oversee home care services and ensure patient safety depends on reliable and consistent reporting; therefore, LHIN staff and service providers must have a common understanding of what must be reported, how it must be reported, and when it must be reported. LHIN staff must also know how to follow up on unusual incidents such as an unauthorized entry.

Recommendation 35: Local Health Integration Networks (LHINs) should prepare written information about:

- the signs and symptoms of toxicity;
- the steps to take if toxicity is suspected; and
- information on the safe storage and disposal of medications.

As a standard practice, LHIN care coordinators should distribute this information to all home care patients who receive injectable medications and should discuss this information when conducting medication reviews with them.

Rationale for Recommendation 35

- Home care patients largely control their own medications. If they are receiving injectable medications, having information on the signs and symptoms of toxicity will help protect their safety.
- Some care coordinators review safe storage and disposal of medications with patients. This review should be a standard practice for all care coordinators.

Recommendation 36: Local Health Integration Networks should inform home care patients of MedsCheck at Home, a program through which a community pharmacist goes into a patient's home and reviews medications the patient is taking and how they are being stored. The pharmacist will safely remove expired medications or those the patient no longer uses.

Rationale for Recommendation 36

- Through the MedsCheck at Home program the pharmacist learns about the patient, the patient's medications, and any risks or challenges the patient faces with safe storage. Promotion of the MedsCheck at Home program may result in safer medication storage. The program is funded by the provincial government, and anyone regularly taking more than three prescribed medications is eligible to participate in it.

Recommendation 37: Local Health Integration Networks should conduct regular audits to ensure that all service providers are:

- carrying out their obligations related to hiring, screening, education, and training of staff; and
- reporting all incidents.

Rationale for Recommendation 37

- Robust screening and training of staff at the time of hiring is essential for client safety. Although the services agreements include obligations related to screening and training, the Local Health Integration Networks (LHINs) do not routinely ask service providers to demonstrate that they are complying with these requirements. LHINs should verify on a regular basis that all service providers are complying with these requirements.
- It is important for LHINs to confirm that service providers understand their reporting obligations and are, in fact, reporting as required.

Recommendation 38: Local Health Integration Networks should amend their services agreements to require, as a condition of approving a service provider's proposed subcontractor, that:

- the service provider ensure the subcontractor is conducting rigorous screening and background checks of all staff; and
- the service provider establish a process to verify, on an ongoing basis, that the subcontractor is properly reporting all complaints, risk events, and other incidents to it.

Rationale for Recommendation 38

- The Local Health Integration Networks (LHINs) do not have a direct relationship with subcontractors. They rely on the service providers to manage and oversee approved subcontractors, as well as to report complaints and risk events to it, on behalf of those subcontractors. Given the importance of screening and reporting, the LHINs should explicitly require that service providers who use subcontractors provide the necessary oversight of the subcontractor's screening processes and its reporting.

Recommendation 39: Once the Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) creates a modified version of the Institutional Patient Death Record (IPDR) for use in deaths occurring in the private homes of those having recently received publicly funded home care (see Chapter 18), the Local Health Integration Networks (LHINs) should:

- require care coordinators and other appropriate LHIN staff to take training from the OCC/OFPS on the use of the modified IPDR;
- encourage care coordinators to review the IPDR when a client dies and, if that review triggers concerns, to contact the OCC/OFPS; and
- encourage service providers to train frontline workers on the modified IPDR and its use.

Rationale for Recommendation 39

- A modified Institutional Patient Death Record (IPDR) will increase the likelihood that the Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) will be alerted to deaths in private homes that require its involvement. Frontline workers may have important information about the deceased client that will help the OCC/OFPS to decide whether to investigate the death. They must be properly trained and supported in using the modified IPDR.

The College of Nurses of Ontario

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I. Introduction

Elizabeth Wettlaufer's crimes were committed while she was working as a registered nurse. Wettlaufer began practising nursing in 1995, after completing a three-year nursing program at Conestoga College in Stratford, Ontario. The Offences were committed between 2007 and 2016 while she was employed as a nurse in various practice settings.

From her initial registration as a nurse in 1995 and throughout the time she committed the Offences, Wettlaufer was a member of the College of Nurses of Ontario (College). It is therefore important to understand both the College's role in governing nurses in Ontario and Wettlaufer's interactions with the College throughout the time she was a nurse.

Much of the information in this chapter comes from the evidence that Anne Coghlan, executive director of the College, provided at the public hearings. The legislation establishing the College provides a framework within which the College operates, but information on how the College has operationalized that framework comes largely from Ms. Coghlan's testimony. Where information comes from other sources, that is indicated.

II. Role and Structure of the College

A. Self-Governance and the College's Responsibility

Nursing in Ontario is a self-governing profession. A profession is self-governing when, in recognition of the profession's specialized expertise, it has been granted the legal authority to govern and regulate its members. The concept of self-governance is premised on the belief that the profession is best placed to determine its requirements for entry and standards of practice.

In Ontario, the College has served as the regulatory body for the nursing profession since its establishment in 1963. To practise nursing in Ontario, a nurse must be a member of the College and, therefore, subject to the College's regulation.

The primary purpose of the College is to regulate, in the public interest, its 175,000 nurse members. To carry out its regulatory function, the College establishes requirements for admission to membership, articulates and promotes the profession's standards of practice, administers a quality assurance program, and enforces its standards of practice and nursing conduct through education, remediation, and discipline.

In 2016, the College had an annual budget of \$33.7 million and a staff of 208. The College has the largest membership of any regulated health college in Ontario.

The nursing profession is divided into two categories recognized by the College: registered nurses (RNs) and registered practical nurses (RPNs). Registered nurses can also be members of the Extended Class, known as nurse practitioners (NPs). Later in this chapter, I describe the differences between RNs (including NPs) and RPNs.

B. Legislative Framework

The *Regulated Health Professions Act, 1991* (RHPA),¹ is umbrella legislation for 26 self-governing health professions in Ontario, including nursing. Schedule 2 of the RHPA is the *Health Professions Procedural Code* (Code). The Code includes a comprehensive set of rules that all health regulatory colleges, including the College of Nurses of Ontario, must follow.

Each health profession also has its specific governing legislation. I will refer to these pieces of legislation collectively as the health profession Acts. For nurses, this legislation is the *Nursing Act, 1991* (*Nursing Act*).² By operation of the RHPA, the Code is deemed to be part of each of the health profession Acts, including the *Nursing Act*.³

Collectively, the RHPA, the Code, and the *Nursing Act* and its regulations set out the regulatory scope of the College.

¹ SO 1991, c 18.

² SO 1991, c 32.

³ RHPA, s 4, and the *Nursing Act*, s 2(1).

1. The RHPA

The RHPA provides that the minister of health and long-term care is responsible for its administration. The Act provides that the minister's duties are to ensure that:

- the health professions are regulated and coordinated in the public interest;
- appropriate standards of practice are developed and maintained;
- individuals have access to services provided by the health professions of their choice; and
- individuals are treated with sensitivity and respect in their dealings with health professionals, the colleges, and the Health Professions Appeal and Review Board (a board responsible for conducting complaint and registration reviews and hearings of certain decisions of health regulatory colleges).

The RHPA also provides for the creation of the Health Professions Regulatory Advisory Council. The advisory council's role is to advise the minister, where requested in writing, on the following: whether unregulated professions should be regulated (or whether regulated professions should no longer be regulated); possible amendments to the RHPA or any of the health professions Acts; matters concerning quality assurance programs undertaken by colleges; colleges' patient relations programs and their effectiveness; or any other matter the minister considers desirable to refer to the advisory council relating to the regulation of the health professions.

Each college and the advisory council are required to report their activities and financial affairs to the minister annually. A college's report must include an audited financial statement. The College's annual reports are publicly available.

The RHPA includes a list of 14 "controlled acts." Under section 27 of the RHPA, controlled acts cannot be performed by a person in the course of providing healthcare services unless (1) the person is a member authorized by a health profession Act to perform the controlled act; or (2) the performance of the controlled act was delegated to the person by a member properly authorized. Delegation of a controlled act by a member must be in accordance with regulations under the health profession Act governing that member's profession.⁴

⁴ RHPA, s 28.

Section 29 of the RHPA provides certain exceptions to the section 27 restriction on the performance of controlled acts. For example, there is an exception for acts performed to assist a person with his or her routine activities of daily living.

Schedule 1 to the RHPA includes a table of the 26 self-governing health professions and the corresponding health profession Acts. Schedule 2 to the RHPA is the Code, which I review below.

2. The Code

The Code establishes the duties, objects, and governance framework for each of the regulated health colleges. It provides that the duty of each college is to work with the minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled, and competent regulated health professionals.⁵ The Code also lists the objects of all the colleges, which include, among others:

- regulating the practice of the profession and governing the members (in accordance with the health profession Act, the RHPA, and the Code);
- developing, establishing, and maintaining standards of qualification for persons to be issued certificates of registration;
- developing, establishing, and maintaining programs and standards of practice to ensure the quality of the practice of the profession; and
- developing, establishing, and maintaining standards of knowledge and skills and programs to promote continuing evaluation, competence, and improvement among members.

In carrying out these objects, the colleges are required to serve and protect the public interest.

The Code requires the creation of seven statutory committees within each college. Below, I review the structure and organization of the College of Nurses. The statutory committees address issues including the registration and discipline of nurses.

⁵ Code, s 2.1.

The Code then establishes the practices and procedures each college must follow for these areas, among others:

- registration of new members;
- addressing complaints and reports by the public and other stakeholders about members of the college;
- powers of investigation;
- disciplining members of the profession;
- addressing concerns regarding its members' capacity to practise safely; and
- the creation and maintenance of quality assurance programming.

The Code also imposes mandatory reporting obligations by setting out instances where employers, facility operators, and members are required to report to the College information about a member or about that member's ability to practise safely.

3. The *Nursing Act*

The *Nursing Act* is the health profession Act that applies to nurses in Ontario. It sets out the scope of nursing practice as well as those controlled acts that each class of member may be authorized to perform. I elaborate further on those controlled acts later in this chapter.

Only members of the College may hold themselves out as nurses or use certain restricted titles ("nurse," "nurse practitioner," "registered nurse," or "registered practical nurse"). To practise nursing in Ontario, a nurse must be a member of the College and therefore subject to the College's regulation.

The *Nursing Act* also sets out the corporate structure of the College and provides that its Council (board of directors) may make regulations further to the regulation of the profession.

4. Regulations Under the *Nursing Act*

There are currently two regulations under the *Nursing Act*: the *Professional Misconduct* regulation;⁶ and the *General regulation*.⁷

The *Professional Misconduct* regulation sets out 37 acts of professional misconduct for nurses. Acts of professional misconduct by nurses include, among others:

- contravening a standard of practice of the profession or failing to meet the standard of practice of the profession;
- practising the profession while the member's ability to do so is impaired by any substance;
- abusing a patient verbally, physically, or emotionally;
- contravening a term, condition, or limitation on the member's certificate of registration; and
- engaging in conduct or performing an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

The *General* regulation sets out additional requirements about registration, controlled acts, the delegation of controlled acts, and quality assurance.

C. Governance Structure

The College is overseen by the executive director and chief executive officer (executive director), who performs the functions of the registrar under the RHPA and Code. The current executive director of the College, Anne Coghlan, has held this position since 2000.

Figure 13.1 outlines the College's corporate structure.

⁶ O Reg 799/93.

⁷ O Reg 275/94.

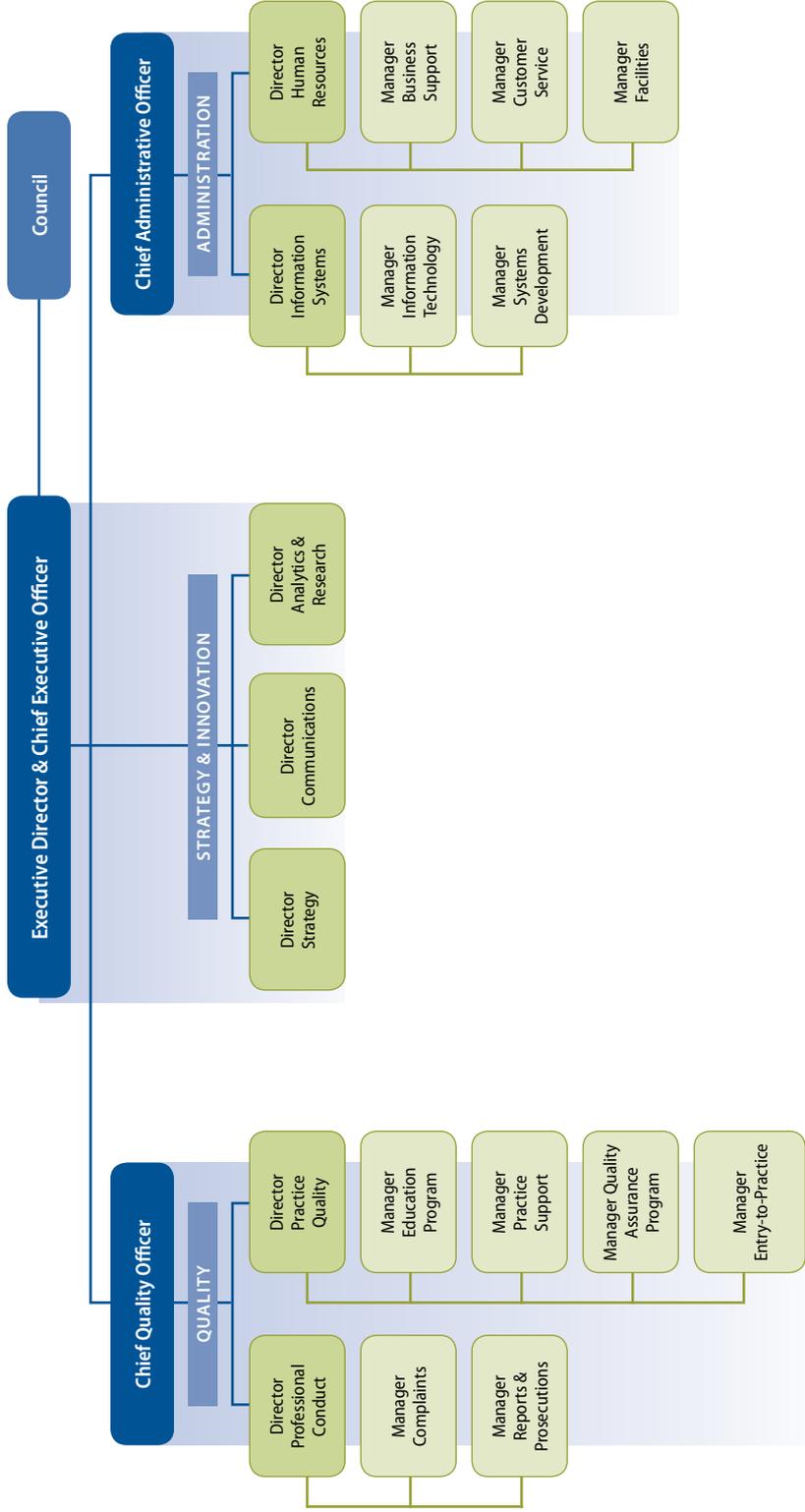


Figure 13.1: Organizational Structure of the College of Nurses of Ontario.

Source: College of Nurses of Ontario, March 2018.

As required by the RHPA, the affairs of the College are governed by a board of directors known as Council. The *Nursing Act* provides for up to 39 members of Council. The executive director, although not a Council member, attends Council meetings.

Council's mandate is to represent the public and make decisions in the public interest. Its role includes passing bylaws, approving practice standards for the profession, overseeing the College's financial matters, appointing members to the College's statutory committees, and providing governance oversight.

In 2018, the College's Council consisted of 21 members of the College who were elected by their peers throughout Ontario, and 15 persons appointed by the lieutenant-governor in council who are not members of any regulated health profession college or council.

In her testimony, Ms. Coghlan said that accountability to the public is promoted by this direct collaboration between nurses and members of the public on Council and the College's statutory committees.

The College's statutory committees are made up of a combination of members of Council (both public and nurses) and non-Council nurses.⁸ Since 2009, the College's seven statutory committees as required by the Code have been the:

- **Executive Committee**, which, between Council meetings, has all the powers of the Council in any matters that require immediate attention (other than the power to make, amend, or revoke a regulation or bylaw). For example, if a vacancy exists on a statutory committee, the Executive Committee may appoint a new member. That appointment would then be ratified by Council at its next meeting.
- **Registration Committee**, which receives referrals from the executive director where applications for certificates of registration do not meet the registration requirements. The committee reviews the applications as well as any additional submissions by the applicant and will direct the executive director to issue a certificate of registration; to require additional examination or training before issuing a certificate; to require the certificate to include terms, conditions, or limitations; or to refuse the issuance of a certificate.

⁸ Code, s 10(3), which provides that committee composition is to be determined by each college's bylaws.

- **Inquiry, Complaints and Reports Committee (ICRC)**, which is a screening body that considers the results of inquiries into a nurse's health (as described later in this chapter), the executive director's reports resulting from investigations of reports, as well as public complaints. The ICRC may take no further action regarding a matter, issue advice or other educational dispositions, or issue cautions to members. For more serious matters that require adjudication, the ICRC may make referrals to the Discipline Committee or the Fitness to Practise Committee.
- **Discipline Committee**, which considers referrals from the ICRC of specified allegations of professional misconduct by members. Where agreement is not reached between the member and the College, disciplinary matters proceed through contested hearings. If the panel of the Discipline Committee finds that the member engaged in professional misconduct, a number of penalty orders can follow. These orders could include imposition of terms, limitations, and conditions on a nurse's certificate of registration; a reprimand; suspension of a nurse's certificate for a specified period; or revocation of a nurse's certificate of registration.
- **Fitness to Practise Committee**, which holds hearings to determine if members are "incapacitated" owing to chemical dependence or mental or physical health problems, such that their practice should be restricted in whole or in part. Where the member and the College have resolved a matter by way of agreement, the committee will endorse the agreement by way of consent orders, without the need for a formal hearing. This committee also considers matters where members are seeking to return to practice, as well as allegations of breaches of terms, conditions, or limitations on a member's certificate of registration.
- **Quality Assurance Committee**, which is responsible for administering the College's mandated quality assurance program. Each member is required, once a year, to complete a learning plan. About 800 to 1,000 members are randomly selected annually for an audit of their learning plan and completion of examinations to measure knowledge of specific practice standards. Members assessed as unsatisfactory are directed to complete remedial activities before being reassessed.
- **Patient Relations Committee**, which advises Council on the College's patient relations program. This mandated program addresses different kinds of abuse of patients (physical, verbal, emotional, sexual) and, as part of the College's abuse prevention program, addresses boundary violations as well.

Figure 13.2 outlines the framework of the College's statutory committees.

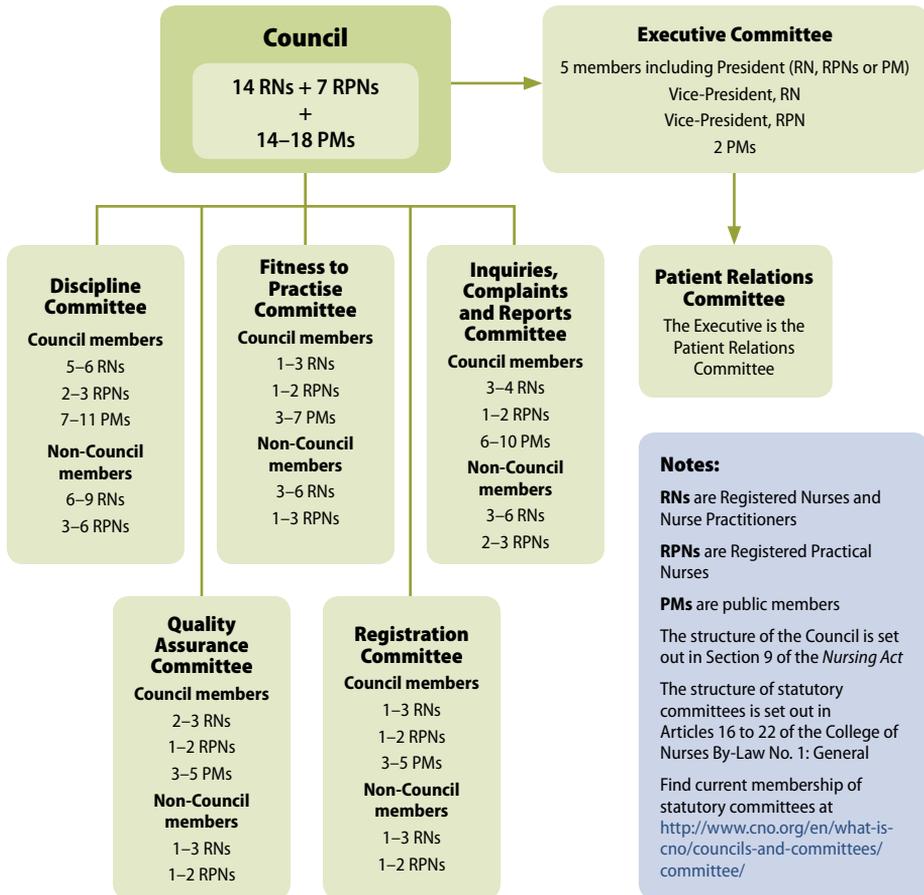


Figure 13.2: College of Nurses of Ontario Structure of Council and Statutory Committees.

Source: College of Nurses of Ontario, Exhibit 21, Tab C, at the public hearings.

In 2014, the College began a governance review that looked at global governance trends, best practices, and expert advice in nursing regulation. This review culminated in the College's *Final Report: A Vision for the Future*, commonly referred to as Vision 2020. Council approved Vision 2020 at its December 2016 meeting. The report recommends several changes to Council to reflect current evidence on effective governance. Recommendations include reducing Council's size and ensuring that Council membership is based on competencies. The College is in the process of implementing Vision 2020.

D. Practice Standards and Practice Guidelines

1. Practice Standards

The College publishes a number of practice standards (Standards), which are authoritative statements setting out the legal and professional bases of nursing practice. Council approves the Standards, using the mandate in the legislation to set nursing standards. The Standards inform nurses of their obligations and advise the public of what to expect of the profession. The Standards apply to all nurses regardless of their role, job description, or area of practice.

The College's *Professional Standards, Revised 2002*, provide a framework for the practice of nursing and a link with other Standards, guidelines, and competencies that the College has developed for all nurses in Ontario. Most recently updated in August 2018, the *Professional Standards* identify and describe the following standards of practice for all nurses in Ontario:

- **Accountability.** Each nurse is accountable to the public and responsible for ensuring that his or her practice and conduct meet legislative requirements and the standards of the profession.
- **Continuing competence.** Each nurse maintains and continually improves his or her competence by participating in the College's quality assurance program.
- **Ethics.** Each nurse understands, upholds, and promotes the values and beliefs described in the College's *Ethics Standard*.
- **Knowledge.** Each nurse possesses, through basic education and continuing learning, knowledge relevant to her or his professional practice.
- **Knowledge application.** Each nurse continually improves the application of professional knowledge.
- **Leadership.** Each nurse demonstrates his or her leadership by providing, facilitating, and promoting the best possible care and/or service to the public.
- **Relationships.** Each nurse establishes and maintains respectful, collaborative, therapeutic, and professional relationships.
- **Professional relationships.** Professional relationships are based on trust and respect, and result in improved client care.

The College's other current published Standards include, among others, *Confidentiality and Privacy: Personal Health Information; Documentation; Decisions About Procedures and Authority; Ethics; Medication; and Therapeutic Nurse-Client Relationship*.

Under the *Professional Misconduct* regulation, it is an act of professional misconduct for a nurse to contravene or to fail to meet a standard of practice of the profession.

That said, not every contravention of a Standard is brought to the attention of the College. In her evidence at the public hearings, Ms. Coghlan testified that most breaches of practice standards are addressed in the practice setting. In those instances, the incidents would not even come to the College's attention. However, the College's expectation is that workplaces use the College's resources to ensure everyone in the practice setting is aware of the Standards. As well, the College expects workplaces to create mechanisms that support nursing practice according to the Standards.

When breaches or potential breaches of Standards are brought to the College's attention, however, the College must decide on its regulatory response. Regulatory responses can range from taking no further action to referring the nurse to the Discipline Committee for a hearing. I describe this process later in this chapter.

2. Practice Guidelines

Practice guidelines, which often address specific practice-related issues, help nurses understand their responsibilities and how to make safe and ethical decisions in their practice.

The College's current published guidelines include, among others, *Authorizing Mechanisms; Conflict Prevention and Management; Consent; Working in Different Roles; RN and RPN Practice: The Client, the Nurse and the Environment; and Working with Unregulated Care Providers*. The primary purpose of the guidelines is to help members apply the Standards to their practice.

The College does not specifically consider the guidelines in prosecuting cases of professional misconduct before the Discipline Committee. Rather, the Standard that the guideline refers to would be the basis of the prosecution.

3. Practice Standards and Guidelines Pertaining to Medication

The College's *Medication* Standard describes the standards nurses are held to when engaging in medication practices, such as administration, dispensing, medication storage, inventory management, and disposal. The *Medication Administration Standards* (as it was formerly named), first published in November 1996, has been revised several times.

The current *Medication* Standard, published in 2017, reflects the standards that apply to all nurses. (In addition, NPs are accountable for the medication practices outlined in the *Nurse Practitioner Standard*.) It identifies three principles that outline the College's expectations relating to medication practices:

- **Authority.** Nurses must have the necessary authority to perform medication practices.
- **Competence.** Nurses ensure they have the knowledge, skill, and judgment needed to perform medication practices safely.
- **Safety.** Nurses promote safe care and, when involved in medication practice, contribute to a culture of safety within their practice environments.

The current *Medication* Standard was intended to reflect a "principle-based approach," which was designed to provide nurses with broad guidance concerning their medication practices rather than detailed, prescriptive standards.

For example, the current *Medication* Standard requires that nurses accept medication orders which are "clear, complete, and appropriate." If a nurse accepts an order that is not clear, complete, and appropriate, it is a breach of the *Medication* Standard. The previous *Medication* Standard, in contrast, included a prescriptive list of items to verify before an order could be accepted and implemented, including order date, client name, medication name, dose in units, route, frequency purpose, and prescriber's name, signature, and designation.

According to evidence given by Ms. Coghlan, the change to a principle-based approach was made following consultation with nurses and other stakeholders and a review of the current research on best practices in medication. The intention of the revised, principle-based approach was to provide guidance that was more adaptable to diverse, rapidly changing healthcare settings, as well as to allow for flexibility and adaptation to the

myriad different contexts in which medication is administered. This approach also acknowledged the professional accountability that nurses have for exercising their knowledge, skill, and judgment whenever they are practising.

In addition to the *Medication Standard*, the College publishes a number of decision tools to help members apply the Standard.

Making a medication error is a breach of the *Medication Standard*. The Standard defines a medication error as “any preventable event that may cause or lead to inappropriate use or patient harm while the medication is in the control of the health care professional, patient, or customer.” The Standard expresses the College’s expectation that all errors, “near misses,” and adverse reactions are reported in a timely manner. The current *Medication Standard* does not identify the expected recipient of that report, but Ms. Coghlan testified that such reporting should be done through formal practice-setting communication.

While all medication errors are breaches of the *Medication Standard*, Ms. Coghlan and former College intake investigator Karen Yee gave evidence at the public hearings that the College is aware that medication errors are very common in the healthcare system. Studies suggest that up to a third of a nurse’s time providing care to patients may be involved in medication administration, and medication administration errors are a well-studied phenomenon.

By way of example, Ms. Coghlan cited a study that systematically examined the empirical evidence on the prevalence and nature of medication administration errors in healthcare. The most common types of these errors were found to be wrong time of medication administration, omission, and wrong dosage. The researchers concluded that the median medication administration error rate was 19.6%, and, where timing-related medication administration errors were excluded, the median rate was 8.0%. The study also concluded that the error rate was higher in long-term care homes than in hospitals.

Ms. Coghlan further testified that her understanding, from the literature, is that patient safety is enhanced when medication errors are openly discussed and reporting is supported and encouraged, without a health professional risking blame or punishment for errors. Ms. Coghlan explained that the College’s *Medication Standard* reflects what she termed the “patient safety movement”: medication errors can be prevented when health professionals have a safe environment in which to identify and report errors – their own

errors, and those of others. The whole healthcare team can then be aware of, and identify, measures to potentially prevent future errors.

Medication errors are among the more common practice concerns brought to the College's attention. Of the complaints and reports the College receives about its members from the public and stakeholders, about 20 to 30% annually involve, at least in part, medication errors.

III. Membership in the College

A. RNs, RPNs, and Classes of Registration

As noted, there are two categories of nurses in Ontario: registered nurses (RNs) and registered practical nurses (RPNs). RNs can also be members of the Extended Class, known as nurse practitioners (NPs).

In 2017, there were approximately 175,000 nurses in Ontario, made up of about 119,200 RNs (3,340 of them NPs) and 55,760 RPNs. About 13,000 members are in the Non-Practising Class, described below.

The College's database suggests that Ontario has more than 13,000 individual employers of nurses, ranging from large facilities to employers of individual nurses. In 2017, the majority of RNs worked in hospitals (61%) while the greatest number of NPs worked in the community (49%). Most RPNs work either in long-term care homes (38%) or in hospitals (36%).

RNs and RPNs have different entry-level requirements but study from the same body of knowledge. RNs acquire greater foundational knowledge in clinical and theoretical practice through a longer period of entry education. Since January 1, 2005, an applicant for a general certificate of registration as an RN must have a baccalaureate degree in nursing.⁹

The *General* regulation establishes the classes of certificates of registration for registered nurses and registered practical nurses:

- **General Class.** This class includes RNs or RPNs who are registered with the College and are eligible to practise nursing in Ontario. Most nurses registered with the College belong to the General Class.

⁹ With a few exceptions during the initial transition, where the applicant graduated before January 1, 2005, or where the applicant's nursing education took place in other jurisdictions.

- **Extended Class.** This class is for those RNs who have additional education (i.e., successful completion of a nurse practitioner program) and clinical experience that allows them to provide an expanded scope of practice with the authority to diagnose, prescribe medication, perform procedures, and order and interpret diagnostic tests. Members in the Extended Class are NPs.
- **Temporary Class.** Where candidates have completed all registration requirements other than the registration examination, they can be granted temporary registration. Conditions placed on the temporary registration include that the nurse practises with an authorized employer. If the nurse fails the registration examination, the temporary registration is revoked. On successful completion of the examination, a Temporary Class member may become a member of the General Class.
- **Special Assignment Class.** This class is a time-limited registration for nurses who have an appointment as an RN or RPN with an approved facility in Ontario. Members in this class can practise only within the scope of their appointment and only under defined terms and conditions.
- **Emergency Assignment Class.** This class comes into force when the provincial government declares an emergency and asks the College to issue emergency assignment certificates of registration to qualified nurses.
- **Non-Practising Class.** Since January 1, 2013, the *General* regulation has provided for a Non-Practising Class. Members in this class are former members of the College's General or Extended Class who are not currently practising nursing. These nurses remain subject to the College's regulatory jurisdiction.

Before 2013, a nurse could remain a member of the College in a Practising Class (as opposed to the then-existing Retired Class), even if he or she were not practising nursing – provided the nurse complied with all other registration requirements, including mandatory participation in the College's quality assurance program.

Since the introduction of the Non-Practising Class (and elimination of the Retired Class) in 2013, the College has required that nurses renewing their registration in a Practising Class confirm in their annual membership renewal forms that they have practised nursing in the previous three years. Members who have not done so are asked to transfer to the Non-Practising Class or to resign their membership. According to Ms. Coghlan, to practise as a nurse,

members must be using their nursing knowledge, skill, and judgment in their work to influence the care of, or to care for, a patient or resident; or performing controlled acts (whether or not they are called “nurses” at work). A nurse may be practising, even when he or she acts in a volunteer role. Regardless of whether the nurse is paid for his or her work, if practising, the nurse is accountable to the College.

Members of the Non-Practising Class can apply for reinstatement to the General or Extended Class by submitting a completed reinstatement application to the executive director. They will be required to demonstrate, among other things, evidence of nursing practice experience within the three years prior to the date on which they satisfy all other requirements for reinstatement; and successful completion of the examination in nursing jurisprudence within five years of that date. If members of the Non-Practising Class are not eligible for reinstatement (e.g., have not practised nursing in the past three years), they need to submit to the College a new application for a certificate of registration in a Practising Class.

B. Scope of Nursing Practice

The *Nursing Act* defines the scope of nursing as “the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.”

All nurses (RNs, RPNs, and NPs) are accountable to the same Standards. RNs and RPNs study from the same body of nursing knowledge, although RNs study for a greater length of time. As a result, their levels of autonomous practice differ: RNs would have acquired greater foundational knowledge in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization, and resource management.

In determining whether an RN or an RPN should care for a patient, a nurse is expected to assess the patient’s complexity, the predictability of patient outcomes, and the risk of negative outcomes as a result of the patient’s health conditions or as a response to treatment. The more complex the patient’s care requirements, the greater the need for consultation with an RN rather than an RPN, and the need for an RN to provide the full spectrum of care.

Section 4 of the *Nursing Act* provides that all nurses are authorized to perform the following controlled acts:

- performing a prescribed procedure below the dermis or a mucous membrane;
- administering a substance by injection or inhalation;
- putting an instrument, hand, or finger beyond the external ear canal, the point in the nasal passages where they normally narrow, the larynx, the opening of the urethra, the labia majora, or the anal verge, or into an artificial opening into the body;
- treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception, or memory that may seriously impair the individual's judgment, insight, behaviour, communication, or social functioning; and
- dispensing a drug.

RNs and RPNs are authorized to perform these controlled acts under the following two conditions:

- if permitted by, and performed in accordance with, the regulations; and
- if ordered by a physician, dentist, chiroprapist, midwife, or NP authorized to perform the act.

NPs are authorized to perform more controlled acts, and with fewer conditions, than those authorized for RNs and RPNs. Those acts include, among others, allowing NPs to diagnose diseases or disorders and to prescribe medication.

The *General* regulation establishes the differences between an RN's and an RPN's authority to initiate controlled acts. Initiation is when a nurse independently decides that a specific procedure within a controlled act is required and performs that procedure in the absence of an order or directive from an authorizing professional. The *General* regulation and the *Decisions About Procedures and Authority* Standard set out distinctions where an RN may initiate or provide an order for an RN or RPN to perform certain acts, as opposed to more limited circumstances in which an RPN may initiate but cannot order another nurse to perform certain acts. As an example, both RNs and RPNs can provide wound care, but RPNs require an order to do the more complex activities of debriding, irrigating, probing, or packing of a wound.

In contrast, both RNs and RPNs require an order for a medication practice when a controlled act is involved (e.g., administering by injection or inhalation); when a prescription medication is administered; or when required by legislation that applies to a practice setting. Orders for medication can be:

- *Direct orders*, which are client specific and are written or verbal orders for a procedure, treatment, drug, or intervention for an individual client. Direct orders are made by another health professional who has the authority to order the specific intervention (e.g., a physician, midwife, dentist, chiroprapist, NP, or RN initiating a controlled act), to be administered at a specific time; or
- *Directives*, which are orders that apply to a number of patients when specific conditions are met and specific circumstances exist. A directive is always written by a regulated health professional who has the legislative authority to perform the procedure.¹⁰

IV. Registration and Renewal

A. Legislative Requirements for Registration

To practise nursing in Ontario, a nurse needs to register with the College and be given a certificate of registration. Registration requirements are set out in the *General* regulation and include requirements that, in addition to paying fees and confirming citizenship, residency, or immigration criteria:

- the applicant disclose certain information to the executive director, including:
 - any findings of guilt for any criminal offence, any offence relating to the use, possession or sale of drugs, any offence under the *Controlled Drugs and Substances Act*, or any other offence in relation to the practice of nursing or another profession in any jurisdiction;
 - any findings of professional misconduct, incompetence, incapacity, professional negligence, or malpractice, or any similar finding against the applicant in relation to the practice of nursing or another profession in any jurisdiction;

¹⁰ Affidavit of Anne Coghlan, para 35; *Medication Practice Standard*, p 3. Note that orders for controlled substances must be direct orders. See also *Directives Practice Guideline*, p 3.

- any current investigation, inquiry, or proceeding for professional misconduct, incompetence, or incapacity, or any similar investigation or proceeding in relation to the practice of nursing or another profession in any jurisdiction;
 - a current proceeding involving any offence in any jurisdiction; and
 - a refusal to register the applicant to practise as a nurse or another profession in any jurisdiction; and,
- the executive director or a panel of the Registration Committee, based on the applicant's past and present conduct, has reasonable grounds for the belief that the applicant:
 - does not suffer from any physical or mental condition or disorder that could affect his or her ability to practise nursing in a safe manner;
 - will practise nursing with decency, honesty, and integrity and in keeping with the law;
 - has sufficient knowledge, skills, and judgment to competently engage in the practice of nursing authorized by the certificate of registration; and
 - will display an appropriately professional attitude.

B. Applications for Registration

In 2017, the College received 13,528 applications for registration, a number consistent with historical trends. In total, 10,165 new nurses were registered with the College that year.

Applicants must complete a registration application form designed to assess whether they meet the registration requirements set out in the *General* regulation.

The specific questions contained on the registration form have changed over the years. The current form requires applicants to identify the name of their nursing educational institution / school and to authorize the release of information to the College – including examination results and all information that the educational institution possesses relating to their nursing education.

The form also requires applicants to disclose, among other things:

- if they have been found guilty of a criminal offence; any offence relating to the use, possession, or sale of a drug; any offence under the *Controlled Drugs and Substances Act*; or any other offence in relation to the practice of nursing or another profession in any jurisdiction;

- if they have been the subject of a finding of professional misconduct, incompetence, incapacity, professional negligence, or malpractice in any jurisdiction;
- if they are the subject of a current investigation, inquiry, proceeding for professional misconduct, incompetence, or incapacity, or any similar investigation or proceeding in any jurisdiction;
- if they have been refused registration as a nurse or in another profession in any jurisdiction; and
- if anything in their past or present would provide reasonable grounds for the belief that they
 - suffer from any physical or mental condition or disorder that could affect their ability to safely practise nursing;
 - will not practise nursing with decency, honesty, and integrity and in accordance with the law;
 - do not have sufficient knowledge, skill, and judgment to competently engage in the practice of nursing authorized by the certificate of registration; or
 - will not display an appropriate professional attitude.

The registration application form requires applicants to certify that all the statements in it are true and complete. Applicants must also confirm their understanding that falsification, misrepresentation, or providing misleading information knowingly may result in the cancellation of their application for registration, or cancellation of any certificate that may be issued. If a member is later found to have submitted false information in an application, the registration would be nullified.

The process also requires applicants to complete the proper educational program and a jurisprudence exam, confirm fluency in English or French, pay the application fee, submit to a criminal records check, and acknowledge that they obtained liability protection insurance.

Registration applications are initially reviewed by the College's customer service team. Applications requiring assessment of conduct or health issues are reviewed by the entry to practice team before being referred to the executive director for review and consideration for referral to the Registration Committee.

If an applicant answers in the affirmative to any of the questions listed above, the College's process is to follow up to obtain further information, in order to determine whether the applicant might require terms, conditions, or limitations on his or her certificate of registration. Terms, conditions, or limitations are restrictions placed on a member's certificate of registration that restrict a member's practice or require a member to take certain steps to ensure he or she is practising safely. Examples include requiring a nurse to wear hearing aids while practising, a restriction on a nurse administering narcotics while practising, or a requirement that a nurse practise in the company of other health professionals (i.e., prohibiting the nurse from practising independently).

The College does not independently verify the accuracy of most self-reporting on an application, unless it has information indicating that verification is needed. Such information could include notifications from a regulator in another jurisdiction or media reports of findings of guilt in criminal proceedings. Ms. Coghlan believes that it would not be logistically possible, at present, for the College to independently verify the additional information provided by each applicant to the College.

The College does, however, verify that the applicant graduated from an approved educational program. One of the College's roles is to approve nursing education programs, and that involves specifying the competencies that a curriculum must include for program approval. In Ontario, any applicant seeking registration must have graduated from a program approved by the College's Council. Once the institution has been approved, the College will accept the education of a nurse from that program at the time of registration.¹¹

The College's Registration Committee considers referrals from the executive director for applicants who do not meet the registration requirements. The Registration Committee also determines if it should impose, modify, or remove any registration terms, conditions, or limitations in relation to a certificate of registration. Applicants also have the right to request a review of their applications by the Health Professions Appeal and Review Board.

¹¹ The College has also published *Entry-to-Practice Competencies* documents for each of NPs, RNs, and RPNs, setting out their expected competencies, as well as a fact sheet setting out the requisite skills and abilities for nursing practice in the province.

In 2017, the Registration Committee reviewed 629 matters emerging from 613 applications where those applicants had not met one or more of the requirements for registration (e.g., nursing education, evidence of practice, registration examination, language proficiency, immigration authorization, conduct, or health). Of these matters, 16 were related to health.

The College is now collaborating with the College of Registered Nurses of British Columbia and the US National Council of State Boards of Nursing to create a database in Canada that would give all regulators access to the registration and discipline history of any individual who has been registered or licensed. Ms. Coghlan testified that the intention is to replicate a database that now exists in the United States, with the goal of eventually connecting the Canadian database to the American one. Her expectation is that a prototype database connecting Ontario and British Columbia will exist by early 2020, with other Canadian jurisdictions subsequently joining. Ms. Coghlan testified that this database will allow regulators to have immediate access to information about anyone applying for membership. The goal is to ensure and enhance public safety by providing regulators with information and data that help them make decisions on whether to accept individuals as members of the profession. This access may also help regulators determine if an applicant's certificate of registration should be restricted in some manner by terms, conditions, or limitations.

C. Annual Membership Renewal

Once a year, members of the College must renew their membership to continue practising as nurses in Ontario. Members need to answer questions about their employment status and areas of practice and education, as well as pay an annual fee. Those who fail to complete the annual membership renewal form (which has at times been called the annual payment form) and pay the renewal fee risk having their memberships suspended and, ultimately, expire.

The annual membership renewal form is generally updated yearly either to reflect changing statutory requirements or the College's experience from previous years. For example, the 2016 form required members to provide demographic information, detail any nursing or non-nursing education completed since the last renewal, and set out employment information (including if they were practising nursing in some capacity, and demographic information about the employer and patients), and practice information (including the average time spent practising and the division of that

time among, for example, direct professional services, clinical teaching, and research).

According to Ms. Coghlan's evidence, the College considers the renewal process to be an administrative one. The College does not verify the information on a renewal form unless it receives information indicating the information requires verification. The purpose of the renewal process is to obtain data as well as fees from members – the College contributes information about its members to the provincial health human resources database. If a member is subsequently found to have submitted false information in a renewal, this matter would be reviewed by the College's professional conduct team and could lead to an investigation for professional misconduct.

V. The College's Register

Under the Code, the registrar of each regulated health profession is obliged to maintain a register containing information available to the public, including on its website. The required contents of the Register have changed and become more extensive over time. Currently, the Code provides that the Register must contain, among other information:

- each member's name, business address, and business telephone number;
- each member's class of registration and specialist status;
- the terms, conditions, and limitations in effect on each certificate of registration;
- a notation of every caution that a member has received from a panel of the Inquiry, Complaints and Reports Committee, and any specified continuing education or remedial program required by a panel of the ICRC;
- a notation of every matter that has been referred by the ICRC to the Discipline Committee that has not been finally resolved, including a copy of the specified allegations that were referred;
- the result of a disciplinary or incapacity proceeding; and
- a notation of every revocation or suspension of a certificate of registration.

Additional information must be included on the Register where prescribed by regulations made under the RHPA or in accordance with a college's bylaws.

The Code provides that all the information that must be on the Register shall be made available to an individual during normal business hours and be posted to the College's website within a reasonable amount of time of its being received by the executive director. However, sections 23(6)–(11.1) of the Code prescribe certain circumstances where information on the Register may or shall be withheld from the public, including:

- an address or telephone number, or other information as designated in the bylaws, may be withheld if the executive director has reasonable grounds to believe
 - that disclosure may jeopardize the safety of an individual; or
 - that the information is obsolete and no longer relevant to the member's suitability to practise;
- personal health information shall be withheld, unless it is the personal health information of the member and its disclosure is in the public interest, and then the registrar shall post no more information than is reasonably necessary;
- where a member has made an application for the removal of certain information from public access and enumerated conditions are met, the information shall be withheld from the public Register; and
- where there is no finding of misconduct or incompetence from a Discipline Committee proceeding, and more than 90 days have passed, unless the member asks that the information be maintained.

Since 2009, the information on the Register has been publicly available on the College's Find a Nurse Register on its website. (Between 1995 and 2009, if the public requested information, the College provided it by email or telephone.)

The College does not provide additional information (i.e., information not on the public Register) about a member to the public or to employers or prospective employers.¹² Nor does the College maintain on the Register information about a nurse's past employers. Subject to the above, in relation to disciplinary (as opposed to health) matters:

¹² Affidavit of Anne Coghlan, para 60. However, in certain circumstances an employer may obtain more information about a nurse than is publicly available. For instance, an order of the Fitness to Practise Committee may require a nurse to notify an employer of the committee's findings as well as any restrictions ordered be placed on the member's registration, and the employer will often be involved in any of the monitoring terms imposed on the member. In addition, the order may require a member to post any restrictions on access and administration of controlled substances at the member's practice location(s). See Affidavit of Anne Coghlan, para 57.

- decisions of the Discipline Committee since 2009 are permanently maintained on the Register. Decisions with respect to a specific member are available under the member's "Practice Information" tab, under the heading "Results of Past CNO Hearings";
- terms, conditions, or limitations imposed on a member's certificate by the Discipline Committee are permanently maintained on the Register. A summary of the terms, conditions, or limitations are available under the member's "Practice Information" tab. While the terms, conditions, or limitations are in effect, they are recorded in full under "Current Practice Restriction," and a summary is posted under "Results of Past CNO Hearings." When they expire, the fact that they were one time in effect is recorded under "Results of Past CNO Hearings" along with a summary of those terms, conditions, or limitations;
- matters that are under investigation are not placed on the public Register. If an interim order is imposed by the ICRC prior to referral to the Discipline Committee, it will be posted on the Register; and
- the fact of a referral to the Discipline Committee is placed on the Register.

Where the matter relates to health, as opposed to discipline, the information available on the Register is as follows:

- decisions and reasons of the Fitness to Practise Committee are not publicly available on the Register;
- the Fitness to Practise Committee is not listed as a source of an outcome on the Register, unless the member was suspended by that committee. Even after the suspension is complete, a record of it will remain on the Register under the Registration History tab;
- past and current findings of incapacity have not been on the Register since 2016;
- if the Fitness to Practise Committee imposes terms, conditions, or limitations on a member's certificate, those that involve workplace restrictions (e.g., a requirement for supervision) will generally be posted on the Register, while those that involve personal health information (e.g., a requirement for urine screening) will generally not be posted. The workplace restrictions are posted without reference to the Fitness to Practise Committee, and are under the "Practice Information" tab. Once the terms, conditions, or limitations expire, they are removed from the Register;

- where health concerns are resolved by way of a voluntary undertaking after a referral to the Fitness to Practise Committee, a memorandum of understanding between the member and the College sets out what restrictions will be posted on the Register. In general, workplace restrictions will be posted, while restrictions involving personal health information will not. In the College's view, restrictions agreed to by way of undertaking are not terms, conditions, or limitations on a member's certificate of registration; and
- where health concerns are resolved by way of a voluntary undertaking while the matter is still before the ICRC, the undertaking may not be publicly available.

VI. Mandatory Reporting Requirements

Employers, facility operators, and nurses each have legal obligations under the Code to report concerns about a nurse to the College in defined circumstances. Such reports are known as the mandatory reports. The College does not have the ability or authority to impose additional mandatory reporting obligations on employers or facility operators.

A. The Mandatory Reporting Guide

The College publishes a process guide to explain mandatory reporting obligations to employers, facility operators, and members. Available on the College's website, *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses* is revised periodically. The version in use at the time of the public hearings was dated 2017. It was developed after consultation with employers to obtain their views on the guide's clarity and usefulness.

In addition to this guide, the College developed a template report form, available online, to help employers and facility operators in filing a mandatory report about a nurse. The College requests employers and facility operators to complete this form and mail or fax it back.

The mandatory reporting obligations of stakeholders are reviewed below, along with the College's guidance on those obligations.

B. Reporting by Employers

Under section 85.5 of the Code, an employer who terminates the employment or revokes, suspends, or imposes restrictions on the privileges of a member for reasons of professional misconduct, incompetence, or incapacity is required to make a report setting out the reasons. Most nurses do not have “privileges,” and the College interprets this legislative requirement as requiring mandatory reporting only of termination (as opposed to suspension or restrictions) for reasons relating to a member’s conduct, competence, or capacity.

The report must be made within 30 days of termination or filed immediately if there is a concern the nurse poses a continued risk. Members cannot avoid a mandatory report to the College simply by resigning their employment. The Code requires employers to report a voluntary resignation where the resignation is related to the member’s professional misconduct, incompetence, or incapacity.

The term “incompetence” is not expressly defined in the legislation, although section 52 of the Code does direct that a panel shall find a member to be incompetent if the member’s professional care of a patient displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates the member is unfit to continue to practise or that the member’s practice should be restricted.

In *Mandatory Reporting*, the College defines incompetence to include three key components:

- it must relate to the nurse’s professional care of a client;
- the nurse must display a lack of knowledge, skill, or judgment; and
- any deficiencies must demonstrate that the nurse is unfit to continue to practise, or that his or her practice should be restricted.

The term “incapacitated” is defined in section 1.1 of the Code as where a “member is suffering from a physical or mental condition or disorder that makes 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 practise.” I elaborate on this term below.

In *Mandatory Reporting*, the College states that incapacity consists of two components:

- the member must have a physical or mental condition; and
- the condition must warrant that the member not be permitted to practise, or that the member's practice be restricted.

The guide further directs that a nurse is incapacitated where he or she has a health condition that impairs the nurse's ability to provide care, and that the impairment must be of such a degree that, to protect patients, the employer or facility operator finds it necessary to restrict the nurse's practice or remove the nurse from practice. In the following section, I review the distinct mandatory reporting obligations of a facility operator regarding incapacity.

Ms. Coghlan testified that, in the College's view, those closest to the care setting are in the best position to identify whether there are concerns about a nurse's practice that are having an impact on patient care. The expectation is not that the employer or facility operator (who may or may not be a healthcare provider or expert) would make a determination of incapacity. Rather, that individual is in a position to identify that a nurse's health condition may be interfering with safe practice. According to Ms. Coghlan, identifying this situation triggers the individual's obligation to contact the College, the entity with the legislative authority and structures to determine if the nurse was incapacitated according to the definition in the Code.

C. Reporting by Facility Operators

The person who operates a facility where one or more members practise is required to report to the College where there are reasonable grounds to believe that a member who practises there is incompetent, incapacitated, or has sexually abused a patient. In contrast to an employer's reporting obligations, there is no requirement that the nurse be terminated before these reporting obligations kick in.

The facility operator's report must be made within 30 days, unless the person has reasonable grounds to believe the member exposes patients to harm or injury or that intervention is urgently needed, in which case the report must be immediate.

Although the Code does not include a definition, the College defines a facility operator as the individual who operates a facility where one or more nurses practise. In the College's view, the obligation to deliver a report resides with

the person who operates the facility, rather than staff members. The College encourages facilities to develop procedures and guidelines so staff can support the facility in meeting its reporting obligations.

Since most organizations employ nurses directly, a facility operator and an employer are typically the same person. However, where, for example, a nurse is employed by an agency and practises in a long-term care facility, the nurse's employer would be the agency, and the facility operator would be the long-term care facility.

Mandatory Reporting provides additional guidance to facility operators about their reporting obligations where a nurse is incapacitated. The guide states that the "College expects a facility operator to make a report only when a current health condition is accompanied by concerns about unsafe practice or the need for ongoing monitoring," even if the health condition did not rise to the level of requiring the nurse to be removed from practice to protect patients.

D. Reporting by Members

All regulated healthcare professionals, including nurses, are obliged to report the sexual abuse of a patient by a healthcare professional to that member's regulatory college. Members have no other mandatory reporting obligations under the Code.

E. Self-Reporting by Nurses

A nurse is obliged to self-report to the College on an ongoing basis if he or she:

- has been found guilty of any offence in any jurisdiction;
- has been charged with any offence, including information about every bail condition or other restriction imposed or agreed on in relation to the charge;
- has been subject to a finding of professional negligence and/or malpractice; or
- has been subject to a finding of professional misconduct or incompetence by another body that governs a profession inside or outside Ontario.

To help nurses self-report, the College developed a self-reporting form, which it asks nurses to use.

VII. Other Communications

The College receives information about members through various sources. In addition to mandatory reports, described above, nurses, employers, and members of the public communicate concerns to the College about the conduct or capacity of a nurse, even where no mandatory reporting obligation under the Code is triggered.

In some cases, the College expects that such voluntary (as opposed to mandatory reporting) communications will be made to it or another authority.

One source of the College's expectation is the *Professional Misconduct* regulation. That regulation provides that it is an act of professional misconduct for a nurse to fail to report an incident of unsafe practice or unethical conduct of a healthcare provider to (1) the employer or other authority responsible for the healthcare provider, or (2) the College.

Further, certain Standards set out the College's expectations for members. For example, the College's *Professional Standards* provide that nurses demonstrate they meet the Standard by "reporting to the appropriate authority any healthcare team member or colleague whose actions or behaviour toward clients is unsafe or unprofessional, or indicate physical, verbal and emotional abuse" and by "taking action to stop abuse and reporting it appropriately." In addition, the *Therapeutic Nurse-Client Relationship* Standard directs that nurses are to protect clients from harm by ensuring that abuse is prevented, or stopped and reported, and that nurses meet this Standard by:

- intervening and reporting, where appropriate, incidents of verbal and non-verbal behaviours that demonstrate disrespect for patients;
- intervening and reporting behaviours toward a client that may be perceived by the client or others to be violent, threatening, or intended by the nurse to inflict physical harm; and
- intervening and reporting a healthcare provider's behaviours or remarks toward a client that may reasonably be perceived by the nurse and/or others to be romantic, sexually suggestive, exploitive, and/or abusive.

These Standards do not specify to whom these concerns should be reported. However, Ms. Coghlan testified that the College would want to have information where a nurse poses a continued immediate risk to patient safety, even where no mandatory reporting obligation is triggered.

Ms. Coghlan also testified that, where nurses are in leadership roles at their place of employment (e.g., directors of care at hospitals or long-term care homes), these Standards would inform and potentially extend the circumstances in which the College expects those nurses to report information about a fellow nurse's practice.

In terms of capacity issues, on applying for registration, applicants are asked whether they suffer from a health condition that may have an impact on their ability to practise safely. Beyond responding to that question, a nurse does not have an ongoing obligation to self-report health conditions to the College. However, it is currently a term, condition, and limitation of every certificate of registration that nurses report to the executive director if they have been the subject of a finding of incapacity in relation to the practice of nursing or another profession in any jurisdiction, or if they are the subject of an investigation, inquiry, or proceeding in relation to incapacity.¹³

In addition, the Standards direct nurses to remove themselves from practice if their health interferes with their ability to practise safely. Ms. Coghlan testified that the ethical obligations articulated in the College's Standards require nurses to be self-reflective about their health and take appropriate action where they recognize their physical or mental limitations affect their ability to provide safe, effective, and ethical care.

Ms. Coghlan was asked about the College's expectations where an employer became aware that a nurse was a "recovered alcoholic and drinking again" but the employer did not feel it necessary to place restrictions on the nurse's practice. She confirmed that this situation would not oblige the employer to make a mandatory report, but that it was nevertheless information the College needed to carry out its mandate to protect the public. She explained: "[I]f anyone has information that would suggest that clients could potentially be at risk ... we all need to be part of the safety net in the healthcare system, and that is information that the College would want to have." Ms. Coghlan noted that, with respect to the example of a nurse with a substance-use disorder who had resumed drinking, the nature of the disease includes clouded judgment. Because this information would be a "huge red flag and a warning sign," the College hopes that an employer or facility operator would share that information with it.

¹³ O Reg 275/94, ss 1.5(1)1(iii)–(iv). Note that the same term, condition, and limitation exists for nurses to self-report where a finding of professional misconduct or incompetence has been made, or a current investigation, inquiry, or proceeding for professional misconduct or incompetence is ongoing, or a charge or finding of guilt in any jurisdiction relating to any offence has occurred.

VIII. Complaints and Reports to the College

A. Receipt of Information About a Member

The College also receives information about members through formal complaints, which must be written or otherwise recorded.

The Code sets out different processes for handling “reports” and “complaints.” These terms are not defined in the legislation, however, so regulators have developed their own practices for characterizing information that comes into their possession.

Historically, the College permitted reporters to choose whether the information they provided would be treated as a report or a complaint. The College no longer permits this choice. Information received from a member of the public – including a patient or a patient’s family – that poses concerns about a member’s practice is treated as a complaint while information from an employer, facility operator, other health professional, or the member is treated as a report.

In 2017, the College received 323 complaints and 810 reports about nursing conduct. The number of complaints received has remained generally consistent over the past 14 years, ranging between 225 and 323. The number of reports the College has received has risen because the matters that must be reported to the College have increased.

Ms. Coghlan testified that, in 2018, the College received an average of about 40 reports weekly, double the amount received in 2017. She speculated that the increase was due to the attention this Inquiry placed on the healthcare sector.

I summarize below the different processes for consideration of information received by way of complaint and by way of report, as provided for by the Code.

B. Process for Considering and Addressing Complaints

The College reviews all new complaints at its weekly complaints intake meeting, attended by the manager, complaints; the complaints intake coordinator; investigators; and an intake associate.

At this meeting, College staff determine whether the complaint is an abuse of process, appropriate for alternative dispute resolution (ADR), not suitable for ADR and thus requiring investigation, or otherwise not properly within the College's jurisdiction (for instance, complaints that do not raise nursing issues).

Since amendments were made to the RHPA in 2009, the College has pursued ADR of a complaint where permitted by the statutory scheme (which, among other things, requires the parties to consent to participate in the process) and where the College determines the complaint is appropriate for dispute resolution. A trained investigator attempts to help the complainant, the member, and the College reach a resolution. If the parties agree to engage in the ADR process, the outcome is confidential and will not be included on the public Register. In 2017, 38.7% of the complaints the College received were resolved through ADR.

When a complaint is not dealt with through the ADR program (and is within the College's jurisdiction and is not an abuse of process), the College is mandated by the Code to investigate the complaint. College investigators interview witnesses, gather relevant documentation, and, where appropriate, conduct site visits. During the investigation, the Inquiry, Complaints and Reports Committee can request that the executive director appoint an investigator with the powers under section 75 of the Code to compel evidence and documents in the investigation. The investigator's powers include the ability to summons witnesses or compel production of evidence; make reasonable inquiries of any person (including the member) on relevant matters; enter into the member's place of practice and examine anything found there; and obtain a warrant for search and seizure.

A member is given notice of the complaint and the opportunity to respond.

The results of the investigation are ultimately considered by a panel of the ICRC, which may order that:

- no further action be taken with respect to the complaint;
- the member undertake remediation (e.g., continuing education);
- the member appear before a panel of the ICRC to be cautioned;
- the member be referred to another panel of the ICRC for incapacity proceedings; or
- specified allegations of the member's professional misconduct or incompetence be referred to the Discipline Committee.

Importantly, subject to the exceptions noted above, every complaint is investigated and is considered by the ICRC. Once the ICRC disposes of a complaint, both the complainant and the nurse have the right to request a review of the decision by the Health Professions Appeal and Review Board.

C. Process for Considering and Addressing Reports

Where information is received by way of a report, an investigation into that information is not mandatory.

Within 24 hours of receiving a report, an intake associate at the College creates a file and reviews the information in it to identify if the matter is high risk and needs to be addressed urgently. If a matter is identified as high risk, it will also be reviewed by the intake coordinator (or, in the past, a manager), who will confirm if it warrants priority.

Ms. Coghlan described high-risk reports that require urgent attention as including physical, mental, or sexual abuse; reckless conduct by a nurse; or issues involving unauthorized access of health records or breaches of confidentiality and privacy. High-risk or serious matters are immediately allocated to an intake investigator by the intake coordinator. Other matters would be assessed and assigned to an intake investigator, who is directed to continually triage the caseload so that matters which require more urgent attention are addressed first.

Matters assessed as high risk are addressed through the intake process within days, depending on the availability of verifiable information. Matters assessed as low to moderate risk are moved through the intake process, generally within six months.

Once a report has been allocated to an intake investigator, the intake investigator reviews the information, makes inquiries to gather further relevant information, and assesses the reliability and accuracy of the information. The role of an intake investigator is different from that of an investigator. The intake investigator does not carry out a formal investigation but, rather, exercises discretion and judgment in assessing risk and recommending an appropriate regulatory response to the information.

Typically, an intake investigator begins by reviewing the report and the member's history, if there is any, with the College. The intake investigator then contacts the individual who submitted the report and, based on that interview

and other available information, determines what, if any, further follow-up is required. Since the intake investigator has no formal powers under the RHPA, all the information the College obtains at this stage is provided voluntarily.

The intake investigator's main function is to identify any nursing issues raised by the member's conduct and assess the potential risk in order to make a recommendation to the executive director about the appropriate regulatory response.

In conducting the risk assessment, intake investigators are directed to consider a risk assessment tool, which directs consideration of the following questions:

- Are the sources of information and the information itself reliable?
- Does the history (or lack of it) of reports and complaints regarding the member indicate greater or lesser risk?
- Is the work setting a contributing factor?
- Is the experience of the member mismatched with the job requirements, and did the employer realize this and provide adequate supervision?
- Is violence involved?
- Was significant physical or emotional harm reported?
- Were the actions performed with intent?
- Was recklessness a prime factor?
- Was the member dishonest or fraudulent?
- Was chemical or substance abuse a factor?
- Does the member express positive awareness about the incident that would lead him or her to be accountable?

The current practice is for the intake investigator either to meet weekly with the reports intake coordinator to review files and recommendations or to attend a weekly group intake meeting. The original report to the College, the member's history with the College (if any), summaries of interviews conducted (if any), and the intake investigator's summary of his or her inquiries and his or her ultimate recommendation are provided to the executive director for consideration and determination of the appropriate regulatory outcome.

Regulatory outcomes of a report include:

- **Bank without notice.** The information is retained by the College, but not disclosed to the member. This outcome is appropriate only if the information reported is not supported by the evidence obtained by the intake investigator or no regulatory issues are identified.
- **Bank with notice.** Members are provided with a copy of the report, reminded of their accountability as members of the College, and directed to review Standards relevant to the issues identified in the report. Members are advised that the information will be kept on file and considered should further concerns come to the College's attention.
- **Meet with College representative.** Members are invited to the College to discuss their reflections on the reported concerns and what they have learned. In advance of the meeting, a member is asked to review certain Standards or other documents relevant to the reported concerns and to complete activities that will be discussed at the meeting.
- **Meet with executive director.** Members are invited to the College to meet with the executive director and to provide assurances about future practice. In advance of the meeting, the member is asked to review certain Standards or other documents relevant to the reported concerns and to complete activities that will be discussed at the meeting. The executive director uses further information gleaned from the member during the meeting to determine whether an appointment of an investigator is warranted.
- **Section 75 investigation.** If the executive director has reasonable and probable grounds to believe a member has committed an act of professional misconduct or is incompetent, he or she may request that the ICRC appoint an investigator.
- **Health inquiry.** This process is described later in this chapter.

By way of illustration of the College's regulatory responses, Table 13.1 describes the outcomes of the 258 mandatory reports that the College received in 2017.

Table 13.1: Outcomes of Mandatory Reports Received by the College of Nurses of Ontario, 2017

YEAR RECEIVED	OUTCOME	NUMBER
2017	Close	8
	Complaint investigation 75(1)(c)	17
	Meet with CNO rep	8
	Meet with executive director	7
	Met with CNO rep – notice	3
	Met with executive director – notice	5
	Notice & direction	35
	Reports – Health inquiry	39
	Reports – Health inquiry and 75(1)(a)	4
	Reports – Health inquiry and hold s 75(1)(a)	33
	Reports investigation – 75(1)(a)	99

Source: Compiled by the Commission.

Ms. Coghlan's evidence was that the Standards play a role in evaluating the proper regulatory response, ensuring that the College's resources are applied proportionately. Ms. Coghlan testified that where gaps in practice exist, and where a nurse has demonstrated insight and a willingness to review the Standards and improve his or her practice, the College's view is that, in the majority of cases, the appropriate regulatory action is remediation. This action might include directing members to review applicable Standards and guidelines or requiring members to meet with a College representative to review their reflections on identified documents and related improvements to their practice.

If the ICRC approves the appointment of an investigator, an investigator is appointed with powers to compel evidence and documents under section 75 of the Code, including the power to summons witnesses or compel production of evidence; make reasonable inquiries of any person (including the member) on matters relevant to the investigation; enter into the member's place of practice and examine anything found there; and obtain a warrant for search and seizure. An intake investigator does not have these statutory powers.

When an investigation under section 75 is complete, the results are compiled in a case report that is provided to the ICRC for its review and decision on the appropriate action. The ICRC then has the power to take the actions described above in relation to complaints. In contrast to the appeal route for complaints (a request for a review by the Health Professions Appeal and Review Board), a nurse who intends to challenge the ICRC's disposition of a report must bring an application for judicial review to the Divisional Court.

IX. Emergency and Interim Orders

Since 2009, the Code has provided that, in emergencies, the executive director may appoint an investigator immediately, without the Inquiry, Complaints and Reports Committee's approval, if the executive director believes on reasonable and probable grounds that the member's conduct may expose patients to harm or injury.

Since 2009, the Code has also provided the ICRC with the power to suspend a member's registration on an interim basis, or to impose terms, conditions, or limitations on an interim basis, once an allegation is referred to the Discipline Committee or the Fitness to Practise Committee and the ICRC believes the member's conduct exposes, or is likely to expose, patients to harm or injury. Since May 2017, the ICRC may make an interim order suspending a member or imposing terms, conditions, or limitations on a member's certificate of registration prior to a referral to the Discipline Committee or the Fitness to Practise Committee if the ICRC believes the member's conduct exposes, or is likely to expose, patients to harm or injury.

X. Discipline Proceedings

As set out above, one of the options available to the Inquiry, Complaints and Reports Committee, after considering the information obtained in the investigation of either a complaint or a report, is to refer specified allegations of a member's professional misconduct or incompetence to the Discipline Committee.

The Discipline Committee is an adjudicative body that may make findings of professional misconduct or incompetence after a hearing. Matters are referred to that committee when there is the highest risk of harm to patients. This risk is evaluated according to the Standard(s) breached as well as considerations

such as intentional behaviour, reckless behaviour, and blatant abuse, among other high-risk behaviours that put patients at risk.

If a matter is referred to the Discipline Committee, the committee considers the Standards in determining whether a nurse has fallen below the standards of practice and, therefore, committed an act of professional misconduct.

If the panel of the Discipline Committee finds that a member committed an act of professional misconduct or is incompetent, it may make an order including revocation or suspension of the member's certificate of registration, or placing specific terms, conditions, and limitations on the certificate of registration for a specified or indefinite period. The Discipline Committee may also order the member to appear before the panel to be reprimanded or to pay a fine to the minister of finance. The Code requires the panel to make certain orders where the member was found to have committed an act of professional misconduct by sexually abusing a patient.

If the panel of the Discipline Committee finds a member to be incompetent, it can similarly make an order requiring the revocation or suspension of a member's certificate of registration or imposing specified terms, conditions, and limitations on the member's certificate of registration.

XI. Fitness to Practise Proceedings

A. Legislative Framework for Health Inquiries

The legislation prescribes a procedure for colleges to follow when there are concerns that a member's health may impact his or her ability to practise safely, or at all. Members are considered "incapacitated" when they have a health condition that requires they not practise or that terms, conditions, or limitations be placed on their practice.

As I noted earlier, the Code defines "incapacitated" as where a member:

is suffering from a physical or mental condition or disorder that makes 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 practise.¹⁴

¹⁴ Code, s 1(1).

The Code directs that, where the executive director believes a member may be incapacitated, he or she shall make inquiries considered appropriate and shall report the results of those inquiries to the Inquiry, Complaints and Reports Committee. When it receives such a report from the executive director, or when a referral is made from another panel of the ICRC (through the process described earlier), the ICRC shall, in turn, appoint a panel to inquire into whether the member is incapacitated.

The overarching objective of the College's health inquiry process is to allow members to receive treatment for conditions that affect their ability to practise, while at the same time ensuring public safety. Members can obtain necessary treatment and be monitored and/or supervised in a manner that permits them to practise, if possible, without compromising the protection and safety of the public.

B. Sources of Information About a Member's Health

Through reports from employers, facility operators, members of the public, patients, colleagues, the police, or the media, the College may become aware of a concern relating to a member's health that affects his or her ability to practise safely. Some of these reports are mandatory and others are not.

In the past several years, the College has received annually, through its intake process, an average of between 100 and 120 matters that relate to incapacity. Since the amendments to the Code in 2009 that require facility operators to report a member's incapacity, "incapacity" has been cited in about 10% of the mandatory reports received by the College.

Ms. Coghlan testified that, where the College receives information about a member's health, it has the discretion to treat the matter as a health issue, a discipline issue, or both. The College considers whether there are reasonable grounds to suspect the nurse has a health condition affecting his or her practice, or any admissions by the nurse of a health issue that caused the behaviour in question.

In deciding whether an incident related to a member's health condition should also be considered a discipline issue, the College considers whether and to what extent the member's behaviour affected patients. For example, where a nurse is diverting drugs for personal use by withholding them from patients, that reflects not only a health condition but also a serious risk of harm to patients.

C. Process for Considering a Member's Capacity

When the College receives information by way of a report that a member may be incapacitated, the executive director reviews the information received by the intake investigator and the intake investigator's recommendation. If the executive director decides to direct a health inquiry, the member is notified and given 30 days to respond. After any follow-up inquiries, the executive director presents the results of the health inquiry to the ICRC.

In contrast, where the College receives information by way of a complaint that a member may be incapacitated, the ICRC may refer the matter to another panel of this committee directly for incapacity proceedings.

Once the matter is before the ICRC, by way of either a report or a complaint, the committee can direct that the member submit to an independent medical examination with an independent assessor if the ICRC determines there are reasonable and probable grounds to believe the member is incapacitated. Physicians perform these examinations.

In many cases, to perform the assessment the physician independent assessor will request that the member provide his or her medical records. The College cannot otherwise compel the production of a member's medical records. If the independent assessor requests the records, however, and is not able to complete the assessment without them, the ICRC has the power to suspend the member's registration for failure to comply with an order to undergo a health assessment.

Ms. Coghlan testified about the role that medical assessment reports play in the College's assessment of incapacity, characterizing these reports as the expert evidence on which the ICRC makes a determination about the appropriate regulatory action. She explained that the ICRC requires this expert evidence before determining whether terms, conditions, or limitations should be placed on a member's certificate of registration.

The ICRC provides the member with a report that includes the results of the health inquiries and the independent medical examination (if ordered) and requests the member's response. The committee then considers all the information it has gathered, along with the member's response, to determine whether to refer the matter to the Fitness to Practise Committee and/or to suspend – or impose terms, conditions, or limitations on – a member's certificate on an interim basis.

Figure 13.3 outlines this process.

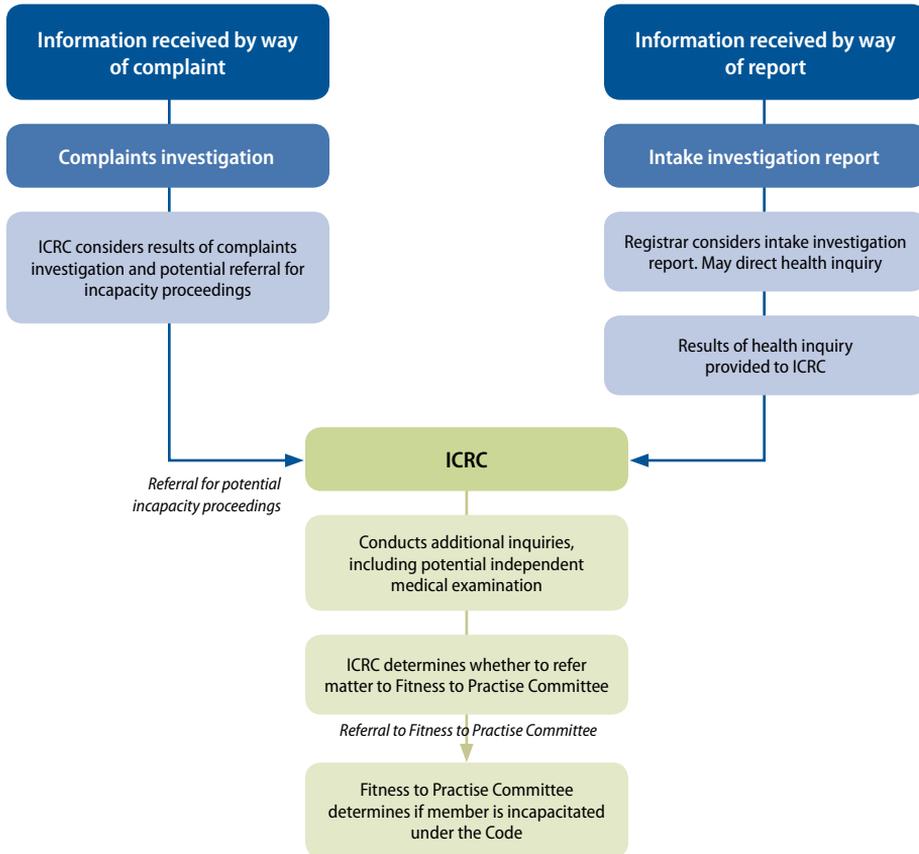


Figure 13.3: Intake of Information About Potential Incapacity (Current at the Time of the Public Hearings)

Source: Compiled by the Commission.

D. Fitness to Practise Hearings

The Fitness to Practise Committee holds hearings to determine if a member is incapacitated. If the nurse is found to be incapacitated, his or her certificate may be surrendered or suspended, or have specified terms, conditions, and limitations – directed at ensuring the member is able to practise safely – attached to it for a certain period. Examples include restrictions on the member’s ability to access narcotics, or requirements that the member undergo ongoing monitoring (e.g., in-person assessments at scheduled intervals, urine monitoring) by a treating physician as recommended by the medical experts.

In certain circumstances, the College negotiates an agreement with a member that restrictions be placed on his or her certificate in lieu of a full fitness to practise hearing.

E. Undertakings

In 2015, the ICRC adopted a new process for accepting undertakings from members, in lieu of a referral to the Fitness to Practise Committee for a hearing. The ICRC may agree to an undertaking where the member poses a low risk of relapse, is in a stable condition, and has healthcare professionals who have agreed to monitor the member and communicate with the College.

All undertakings set out the treatment and monitoring the member will continue to receive, the identity of the healthcare professionals who provide the treatment and monitoring, an agreement that the member's healthcare professionals can communicate with the College, and an acknowledgment that the College can begin an inquiry into whether there has been a breach of the undertaking. Where the ICRC has accepted an undertaking from a member, that information is not contained on the Register. However, workplace restrictions contained in the undertaking might be placed on the Register, provided those conditions do not themselves contain personal health information.

Ms. Coghlan testified that the undertaking process acknowledges that the label of "incapacity," as defined by the Code, is associated with significant stigma. Where a member poses a low risk of relapse, is stable, and is in treatment with a healthcare professional who has agreed to monitor the individual and communicate with the College if concerns exist, the ICRC may enter into the undertaking to ensure that all appropriate monitoring takes place. However, there would not be a finding of incapacity.

Undertakings can also be accepted by the College after a referral to the Fitness to Practise Committee.

Between 2015 and 2017, 18% of health inquiries were resolved by way of an undertaking, and 45% resulted in an order by the Fitness to Practise Committee.

F. Monitoring

Where the Fitness to Practise Committee imposes terms, conditions, and limitations on the member's certificate, or the College accepts a voluntary undertaking from the member, the College monitors the member's compliance with the order or undertaking during a fixed period, known as the monitoring term. At this time, monitoring terms remain in effect, typically for three to five years.

Both orders of the Fitness to Practise Committee and undertakings generally require members to secure the participation of their healthcare team and employer, if applicable. The College's monitoring team relies on members, workplace monitors, employers, and healthcare professionals to advise the College of concerns regarding the member's ability to practise safely or to comply with the restrictions for the duration of the monitoring term.

If at any time during the monitoring term a member fails to comply with the terms of an order, the College can either use the process set out in the order (e.g., to revise conditions on agreement, or to require an independent assessment) or return the matter to the Fitness to Practise Committee. That committee may impose additional or different terms on a member's certificate of registration, or it may suspend or revoke the member's certificate.

G. Anticipated Nurses' Health Program

The College is currently implementing a program to divert eligible nurses who would otherwise be found to be "incapacitated" out of the formal Fitness to Practise proceedings, provided those members receive the requisite restrictions on and monitoring of their practice.

The program, called the Nurses' Health Program (NHP), is similar to the Physician Health Program developed and financed by the Ontario Medical Association and recognized by the College of Physicians and Surgeons of Ontario. The NHP is based on the US National Council of State Boards of Nursing guidelines for substance disorder and alternatives to discipline programs. To encourage nurses to seek treatment for mental health or substance-use disorders, the program is voluntary and confidential.

The NHP includes the following elements:

- flexibility, to allow for tailoring to the variety of workplaces, work arrangements, and supervisory arrangements of participant members;

- monitoring by experienced case managers, along with active communication, input, and participation from the member's healthcare team and employer. These supports will allow case managers to become aware of behaviour that suggests potential relapse, to increase monitoring in the face of a risk of relapse (e.g., increasing urine screens, check-ins with the employer or healthcare team), and to manage any potential relapse within the confines of the program agreement;
- evidence-based practices for treatment and monitoring;
- a referral network for members to obtain treatment and care from appropriate healthcare providers;
- an education and outreach component for healthcare providers, colleagues, and employers;
- confirmation that any breach of the program will result in a report to the College and/or the deployment of the incapacity process; and
- confirmation to the College of who is participating in the program, and structured report and audit mechanisms to enable the College to be sure that the program is in compliance with its guidelines and procedures.

The Fitness to Practise process remains in place for those members unable (or unwilling) to stay within the parameters set by the NHP.

XII. Quality Assurance Program

All health colleges in Ontario are required to have a quality assurance program. The College's program is intended to support nurses in their ongoing learning and their commitment to continuing growth in their professional knowledge, skills, and judgment.

The College's current quality assurance program requires members to develop annual learning goals based on learning needs and to connect those goals to the College's Standards and guidelines. Members are expected to develop and maintain their learning plan for two years. The College can request submission of the learning plan at any time.

The College's program does not specify the number of hours of continuing education that members are required to complete annually. Rather, it is premised on "reflective practice." Ms. Coghlan testified to her understanding of the literature, indicating that professionals are best able to continue to develop and maintain their competence when they reflect on their practice

and seek peer feedback and other programs that support their development of additional competence.

In addition, certain employers or practice settings may have requirements for nurses to complete courses or training either before caring for the patient population or on an ongoing basis.

The College also randomly selects nurses to undergo a practice review. That process includes completion of practice tests, to test a nurse's ability to apply standards. If a test identifies deficiencies, the Quality Assurance Committee may specify continuing education.

A certain portion of those nurses selected for a practice review is entirely random. As well, the College selects nurses from two groups identified as potentially high risk to undergo a practice review: (1) nurses working in the long-term care sector; and (2) nurses who had prior involvement in the "executive director action process" – meaning they had previously been reported to the College and were required to meet with a College staff member, or the executive director, to review and reflect on reported incidents.

In 2017, 801 nurses underwent a practice review, a number consistent with a typical year. Council is currently reviewing the quality assurance program, and the College remains in the process of identifying changes to increase its ability to engage annually with more nurses and in a more robust way.

XIII. The College's Involvement with Elizabeth Wettlaufer

A. Initial Registration: 1995

1. Wettlaufer's Registration Process

After completing her nursing education at Conestoga College in May 1995, Elizabeth Wettlaufer (then known as Beth Parker) submitted an application for a certificate of registration with the College. Since she had not yet passed her nursing examination, Wettlaufer initially submitted an application for assessment to determine eligibility for registration in order to work at Geraldton District Hospital, where she had been offered a position as a casual, part-time graduate nurse subject to her obtaining registration with the College. Wettlaufer's application was received by the College on May 10, 1995.

At that time, the College required applicants for temporary registration to have an employer provide an Offer of Employment for Temporary Registration form. Applicants also had to complete the application for assessment to determine eligibility for registration, in which they were asked several questions including, among others, the following:

- Have you ever been denied registration / licensure by a registration / licensing authority for nursing (RN/RPN) in any province, territory, state, or country?
- Have you ever had your nursing registration encumbered in any way (revoked, suspended, surrendered, restricted, subjected to individual terms and conditions) by a registration / licensing authority for nursing (RN/RPN) in any province, territory, state, or country?
- Have you ever been convicted of a criminal offence or an offence under the *Narcotic Control Act* (Canada) or the *Food and Drugs Act* (Canada)?
- Are you affected by a physical or mental condition / illness which might affect your ability to practise nursing?

Wettlaufer answered no to each question and certified that all statements in the application were true and complete in every respect. She also provided the Offer of Employment for Temporary Registration form, completed by the director of nursing (DON) at Geraldton District Hospital.

On May 30, 1995, the College notified Wettlaufer in writing that she met the requirements for temporary registration and that a temporary certificate of registration would be issued on receipt by the College of a signed copy of an undertaking, the completed initial registration form, and payment of the registration fee.

On June 5, 1995, Wettlaufer completed and signed the application for a certificate of registration as a registered nurse – temporary class and again answered the above-noted questions in the negative. She also executed an undertaking on June 5, 1995, in which she agreed that her temporary registration included the restrictions, conditions, and limitations that she practise nursing only at Geraldton District Hospital and that she had to provide a copy of the undertaking to anyone who offered her employment.

A temporary certificate of registration was granted to Wettlaufer on June 8, 1995.

In June 1995, Wettlaufer wrote and passed the nurse registration examination. On August 8, 1995, she completed an application for a certificate of registration as a registered nurse – General Class, on which she again answered the above-noted questions in the negative and certified that her statements were true and complete in every respect. The College granted Wettlaufer a general certificate of registration on August 11, 1995.

In 1995, as today, the College would not have independently verified the accuracy of Wettlaufer’s answers to the questions on her application forms. In 1995, criminal records checks were not required by applicants to the College.

2. Changes in Registration Since 1995

The College’s registration requirements have changed to reflect changes in the regulations since 1995. By way of example, there were fewer and different classes of certificates of registration for nurses in 1995 and correspondingly different registration requirements.¹⁵

The specific questions on the College’s application forms have also changed to mirror changes in the terminology in the *General* regulation. For example, in 1995 applicants had to answer on their application form the question, “Are you affected by a physical or mental condition / illness which may affect your ability to practise nursing?”¹⁶ Today, the question is, “Is there anything in your past or present that would provide reasonable grounds for the belief that you suffer from any physical or mental condition or disorder that could affect your ability to practise nursing in a safe manner?”¹⁷

The requirements for applicants have also changed in certain respects. In 1995, to become an RN, an applicant had to have graduated from a specified nursing program, but not necessarily a baccalaureate program. Today, the applicant must have graduated from a baccalaureate nursing program (or the equivalent in another jurisdiction).

¹⁵ In 1995, for example, the classes of certificates of registration were limited to General, Temporary, Special Assignment, and Provisional (O Reg 275/94 (1994), ss 1 and 1.1). At present, the classes of certificates of registration are General, Extended, Temporary, Special Assignment, Emergency Assignment, and Non-Practising (O Reg 275/94, ss 1 and 1.1).

¹⁶ Application for a Certificate of Registration, signed by Wettlaufer on August 8, 1995 (stamped by CNO with an issuance date of August 11, 1995); reflecting O Reg 275/94 (1995) s 5 requirement that an applicant is not suffering from a physical or mental condition or disorder that “makes it desirable in the public interest that he or she not practise nursing.”

¹⁷ Affidavit of Anne Coghlan, Ex. L, – reflecting O Reg 275/94 (present) s 1.4(1) 2i determination as to whether an applicant “suffer[s] from any physical or mental condition or disorder that could affect his or her ability to practise nursing in a safe manner.”

An additional change is that the College now requires applicants to provide criminal records checks.

B. Incapacity Proceedings: 1996–98

1. Information Received from Geraldton District Hospital

On September 14, 1995, just a month after Wettlaufer was given her general certificate of registration, the Geraldton DON called the College to discuss an incident. The DON told the College representative that Wettlaufer had collapsed while working a night shift at the hospital and had admitted to having removed and consumed Lorazepam from the hospital supply. The DON said that the hospital was considering whether to terminate Wettlaufer's employment.

The College representative reminded the DON that there were mandatory reporting obligations to the College if Wettlaufer's employment was terminated and was assured that either a report or a complaint about Wettlaufer would be made, with Wettlaufer being suspended from work by the hospital in the interim.

The College representative called back the Geraldton DON on October 25, 1995, and was told that Wettlaufer's employment had been terminated and she had grieved the termination. The DON advised the representative that a formal report would be made to the College in the following two weeks and that Wettlaufer was working elsewhere. The notes from that telephone call do not indicate if the College was notified of where else Wettlaufer was working at that time.

On November 7, 1995, the College received a letter from the Geraldton DON reporting Wettlaufer's termination of employment on October 13, 1995. The letter listed Wettlaufer's current employment as "Geraldton District Association for Community Living (GDACL)" and contained the following description of the incident resulting in her termination:

Member was completing a 12 hour night tour at 0730 hours. Two oncoming RN's reported that the member, who was coming out of the staff bathroom, appeared dazed, was grossly unsteady on her feet and had difficulty communicating verbally. Subsequently, it was ascertained from the member that she had removed Lorazepam (2 mg) from the ward medication stock without authorization and had ingested them during her working hours. The history given by the member changed several times over the 24 hour period (September 13 to September 14/95).

In terms of the statement that Wettlaufer's account of the incident "changed several times," Ms. Coghlan testified that, in her experience with incapacity matters, it is not uncommon. Ms. Coghlan explained that "it is often a reflection of the disease process that clouds judgment."

No formal investigation was launched by the College before it received the termination report on November 7, 1995. In her testimony, Ms. Coghlan stated that the College required written information about the incident before initiating an investigation of the matter so it could verify that the information was credible and reliable. The College did make a further inquiry of the Geraldton DON on October 25, 1995, however, to request information on a voluntary basis, as described above. Although the Code requires that a complaint to a health college be made in writing, or be recorded on a tape, film, disk, or other medium, the legislation does not include this same requirement for a report. Such a requirement appears to be a College policy.

2. The College's Investigation and Assessments

On receiving the report from the Geraldton District Hospital on November 7, 1995, a staff member at the College requested approval from the Executive Committee to appoint an investigator, on the basis that the report provided reasonable and probable grounds for believing Wettlaufer had committed an act of professional misconduct or was incompetent.

On November 9, 1995, the Executive Committee approved the appointment of an investigator under section 75(a) of the Code. At that time, Ms. Coghlan was the president of Council and the chair of the Executive Committee. In the latter role, she signed the approval. The College started its investigation. On November 24, 1995, the investigator interviewed the Geraldton DON and was given more information about Wettlaufer's training and experience, and about the incident. The DON also told the investigator that she had suggested to Wettlaufer before this incident that she might wish to seek employment at the Geraldton District Association for Community Living, because her position at Geraldton District Hospital constituted casual employment with limited shifts.

Ms. Coghlan testified that the College's practice was to ask if an employer knew if a nurse was working anywhere else, and then to make inquiries of any other employers to determine if there were any concerns in those workplaces. To her knowledge, this practice was also in effect in 1995, although there was no evidence at the public hearings about whether such inquiries were made of Wettlaufer's possible other employer(s) at that time.

During the call with the investigator, the Geraldton Hospital DON indicated that she would like her report of termination to be considered a letter of complaint. She subsequently sent a letter to the College reiterating that request. At that time, the College permitted a reporter to elect whether to categorize a matter as a report or a complaint. In contrast to a report, a complaint (then and now) enables the complainant to have ongoing involvement in the investigation and notice of the disposition of the complaint. As I outlined above, the College now considers information received from members of the public as a complaint. Information from employers, facility operators, self-reports, and other members is considered a report, and the College does not allow the reporter to make this election.

Because the matter was thereafter characterized as a complaint, the College was statutorily required to investigate, although a section 75 investigation had already begun and was ongoing at that time in any event.

The College's investigation included:

- requesting Wettlaufer's medical records pertaining to her September 13, 1995, admission to Geraldton District Hospital, which were received; and
- requesting additional documentation relating to the incident from Geraldton District Hospital, as well as staff schedules, background information on the procedures of the unit, and contact information for witnesses to the incident. The Geraldton DON provided a list of 10 witnesses and notes from nine of those witnesses describing what they had observed. The notes referred to
 - one witness who had observed Wettlaufer walk out of the staff washroom at about 07:35 the morning of September 13, "staggering forwards and backwards" and noting that she "had no balance";
 - a witness who observed Wettlaufer at about 07:25 the same morning, "reaching into her pockets for the narcotics keys but she started to lose her balance & began to fall backwards" ... and that "her gait was very unsteady, speech was heavy & slurred & she was groggy";
 - a witness who observed a physician speaking to Wettlaufer on September 13, and heard Wettlaufer state that she "took 2 Lorazepam at 2200 hrs to take the edge off." That witness reported that, later that day, she spoke to Wettlaufer and at that time Wettlaufer reported she had taken "2 Lorazepam at 2200 one at 0400 and then again after 7 o'clock";

- a witness who, at approximately 11:00 on September 14, spoke to Wettlaufer. Wettlaufer, the witness said, “verbalized how embarrassed she was and also worried about her job” and “that in the morning she took 25 mg of Ativan.” The witness also reported that on September 7, while working a night shift with Wettlaufer, “she had told me that she was feeling depressed about personal and financial difficulties”; and
- a witness who was advised by Wettlaufer’s physician that she told him on September 14 “she had lied to him yesterday” and that “she had taken 25 Lorazepam tabs at approximately 0715 on Sept 13 as a suicide attempt.”

The College provided Wettlaufer with notice of the complaint and gave her the opportunity to provide a written response. An investigator was not appointed under section 75(c) of the Code (the appointment power relevant to complaints), and Wettlaufer was advised that her provision of a response to the complaint was voluntary, as was the completion of health release forms to enable the College to obtain information from her healthcare providers.

Wettlaufer retained a lawyer, who confirmed that she had advised Wettlaufer not to execute the health release forms at that time. Counsel gave the College a response to the complaint, which included the following:

Ms Parker advises that she took 25 mg of Lorazepam from the hospital supply on a one-time only basis. The medication was taken in furtherance of a suicide attempt brought on by an acute episode of depression. The incident arose as a result of Ms Parker’s depression and not as a result of drug addiction. She has no history of drug addiction or of drug usage; this was a one-time only occurrence.

On March 1, 1996, Wettlaufer’s counsel also provided the College with a letter attaching two reports from practitioners at the North of Superior Counselling Programs, a non-profit community-based mental health and addictions agency.

The first report, completed by a mental health worker, indicated that the writer had been involved with Wettlaufer for the previous five months. The writer referenced Wettlaufer’s self-report of isolation in Geraldton and her reported difficulties sleeping and eating, her lack of energy, and her overwhelming feelings of loneliness and rejection in the two months before the incident. The writer said that Wettlaufer had made “a lot of progress” since the incident in September and had “made a lot of positive changes in her life.”

The second report, completed by a substance abuse worker, indicated that “[b]ased on the information Ms. Parker provided or her response to questions it would not appear that there is a problem with drugs, other than those recently experienced during her suicide attempt and several past incidents of experimental cannabis use. However, her intake of alcohol was definitely an area of concern and put her at high risk for potential physical damage.” The writer cited Wettlaufer’s report that she had “apparently become very deeply involved in her church and is using this as her support system, as well as her means of controlling her intake of alcohol. She believes her alcohol intake is now in total control and intends to continue using the Church as the guiding force in her life.”

In the March 1, 1996, letter, Wettlaufer’s lawyer also made further written submissions, attributing Wettlaufer’s depression to her isolation and loneliness from being in the Geraldton area and asking that the Complaints Committee refer the matter to the Executive Committee for investigation of incapacity. The Complaints Committee was, at the time, the committee that considered complaints matters. This role is now played by the ICRC.

On March 20, 1996, the Complaints Committee considered the results of the College’s investigation. The committee concluded that the allegations and information obtained during the investigation “point to the member suffering from health-related problems that may be affecting her capacity to practise safely and effectively,” and referred the matter to the Executive Committee for incapacity proceedings. The Executive Committee no longer plays this role, which has also been subsumed into the role of the ICRC.

Wettlaufer and the Geraldton Hospital DON were both notified of this result by way of a letter dated March 22, 1996.

Figure 13.4 provides an illustration of the College’s process, as described above, for addressing information about a member’s potential incapacity in 1995–98.

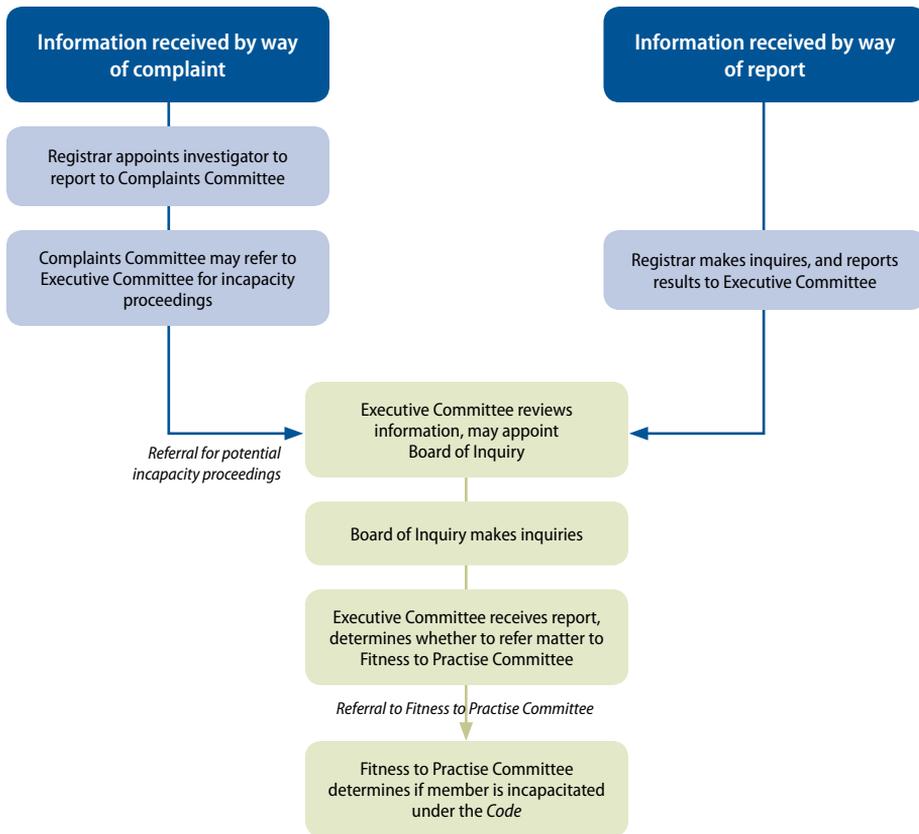


Figure 13.4: Intake of Information About Potential Incapacity (1995–98)

Source: Compiled by the Commission.

3. Referral for Incapacity Proceedings

On April 25, 1996, the Executive Committee met and considered the referral from the Complaints Committee. The Executive Committee decided to appoint a Board of Inquiry pursuant to section 58(2) of the Code to inquire into whether Wettlaufer was incapacitated. This appointment was formalized by the execution of a directive for an inquiry by the executive director on the same date, pursuant to section 57 of the Code.

At that time, the Code defined “incapacitated” as meaning that a member was “suffering from a physical or mental condition that makes it desirable in the interests of the public that the member no longer be permitted to practise, or that the member’s practice be restricted.”

The Board of Inquiry¹⁸ met on May 15, 1996, and ordered that an examination of Wettlaufer's health status be carried out by a physician specializing in addiction medicine at the Homewood Health Centre, selected by the College, under section 59(2) of the Code. Wettlaufer was advised that her failure to attend the examination could result in the Board of Inquiry directing the executive director to suspend her certificate of registration until she submitted to the examination. Wettlaufer was also directed to complete release forms so that the College could obtain information from certain of her healthcare practitioners. There was no evidence during the public hearings that these releases were completed and returned to the College by Wettlaufer at that time.

a) Assessment by Addiction Physician

The College asked an addiction physician to assess whether Wettlaufer was suffering from any physical or mental condition or disorder and, if she was, the nature and extent of the disorder. The physician was also asked what effect, if any, the condition or disorder might have on Wettlaufer's ability to practise nursing and to provide his opinion on any recommendations for continuing treatment or monitoring by healthcare professionals, and on restrictions in the workplace.

Wettlaufer underwent the examination by the addiction specialist on June 14, 1996. According to his report, Wettlaufer told him she had had recurrent thoughts of suicide since the age of 13, and at the age of 15 she was raped. Wettlaufer reported receiving counselling from a Christian counsellor at age 21 for her abuse issues, and that she continued to see a counsellor in the Woodstock area primarily for her mood. She also reported a history of alcohol abuse, though she stated she had not had a drink since December 1995. Wettlaufer confirmed that she began to see an addiction medicine specialist in London two months earlier, continued to be closely followed by him, and attended his health professional support group. The assessor contacted Wettlaufer's treating physician, who confirmed aspects of her account and reported that he "felt that Beth was demonstrating healthy recovering behaviours."

¹⁸ The Code in force at that time provided that a board of inquiry may be appointed by the Executive Committee to inquire whether a member was incapacitated (s 58). The board of inquiry was empowered to "make inquiries it considers appropriate" (s 59(1)), and could require a member to submit to physical or mental examinations where it had reasonable and probable grounds to believe the member was incapacitated. The board of inquiry was to report to the Executive Committee (s 60), after which that committee could refer the matter to the Fitness to Practise Committee (s 61).

In his report for the College, the addiction specialist concluded:

I think this lady is an incapacitated nurse under the Act, who since December of 1995 has made significant changes in her lifestyle and is demonstrably in recovery. I feel that she requires no further assessment or treatment at this time, rather she should continue with the Health Professional Support Group with reports going back to the College from [her addiction medicine specialist] on a regular basis and I would encourage her to attend one meeting of A.A. per week with support from her Health Professional Group. I am impressed that she demonstrates a strong spiritual program connected with her profound Christian beliefs and I have seen many individuals recover using this method of recovery as opposed to attending A.A. I am also impressed with her forthrightness and honesty with her place of work and with her family and I do not think she requires further definitive treatment whether it be based in the community or in a residential setting ... With regard to narcotics I have no concerns regarding her narcotic history and I don't feel that, other than urine monitoring, further assessment or management from this perspective needs to be entertained.

b) Assessment by Psychiatrist

The Board of Inquiry directed an additional assessment of Wettlaufer by a psychiatrist, which included a review of the materials that had prompted the Executive Committee to appoint the Board of Inquiry (including the Geraldton District Hospital admission records and the witness notes outlined above) as well as an interview with Wettlaufer on August 13, 1996.

In his report dated September 12, 1996, the psychiatrist noted Wettlaufer's reported and documented history of social isolation, alcohol use, and depression, and that she was no longer isolated and was abstinent. The psychiatrist concluded that Wettlaufer had suffered from "Major Depressive Disorder, Single Episode (DSM-IV 296.22) of Moderate severity," and that there was no current indication of mood disorder and no need for treatment. He concluded that Wettlaufer's "occupational difficulties arose in the context of a mental disorder which interfered with her function," and that "Ms Parker is no longer ill from a psychiatric standpoint. No active treatment is required. Return to work is realistic and safe in my view."

The Board of Inquiry met again on September 30, 1996, and considered the four specialist reports (from the addiction specialist, the psychiatrist, and the two North of Superior Counselling Programs reports provided by Wettlaufer's counsel). The Board of Inquiry report to the Executive Committee summarized

the view of the addiction specialist (that Wettlaufer was an incapacitated nurse who did not require any further assessment or treatment at that time) as well as that of the psychiatrist (that Wettlaufer was no longer ill from a psychiatric standpoint).

c) Submissions of Counsel and Further Inquiries by the College

On October 22, 1996, Wettlaufer's counsel wrote to the College and advised that Wettlaufer would be prepared to negotiate terms and conditions on her certificate of registration, consistent with the addiction specialist's recommendation for minimal conditions and continued treatment programs. Counsel noted the psychiatrist's opinion that Wettlaufer suffered from a single episode of depressive disorder and submitted that "there is no case to be made under the legislation for her current incapacity on her mental health."

The College sought an update on Wettlaufer's condition from her counsel in early 1997. During a telephone conversation on February 6, 1997, counsel reported to the investigator that Wettlaufer was doing extremely well, remained abstinent from substances, and was working at a Christian organization. Counsel reported that Wettlaufer had previously worked as a charge nurse at Victoria Rest Home but left "because it wasn't a very well run place." In a letter of the same date, counsel wrote to confirm that Wettlaufer was doing "extremely well in her recovery and has been abstinent from alcohol for over one year." The letter detailed Wettlaufer's ongoing treatment and monitoring by addiction specialists and her employment as a residential counsellor at Christian Horizons, a group home for developmentally challenged persons in Woodstock, since the previous October. The correspondence confirmed Wettlaufer's authorization for the College to speak to her supervisor at Christian Horizons about her current performance. Counsel advised that health release forms had been sent to Wettlaufer's treating physicians so that the College could also contact those practitioners. The following day, a letter confirmed Wettlaufer's authorization for the College to contact her former employer, Victoria Rest Home, but indicated that "she has some concerns about her employment with this facility." The College contacted Wettlaufer's former supervisor at Victoria Rest Home, who confirmed that Wettlaufer had worked there as an RPN from April 18, 1996, to November 17, 1996, and that she left voluntarily. The former supervisor reported that Wettlaufer "was a good nurse" but felt "she was a little quick to make a decision on her own."

The College contacted Wettlaufer's treating physicians in March 1997 to obtain further information on her progress. During a telephone call with her addiction specialist on March 18, 1997, the investigator was advised that the specialist had not seen Wettlaufer since the prior August because of his own illness, but that she had continued to have random urine screens (for both alcohol and drugs) completed weekly and they had all been negative. He confirmed that Wettlaufer had attended the weekly Health Professional Group meetings "fairly regularly" until August, though he could not comment on her attendance since that time. On March 26, 1997, the investigator spoke to the physician who had covered the addiction specialist's practice while he was ill. She advised that Wettlaufer had seen her individually in her office on two occasions in October 1996 and had attended one Health Professional Group meeting in October 1996.

d) Reassessment

On March 26, 1997, the College wrote to Wettlaufer's counsel to advise that it was concerned, based on the information received from the physicians, that "Ms Parker has not been fully engaged in a program of recovery," and that it could not agree to terms and conditions at that time. The College proposed that Wettlaufer be reassessed by the addiction specialist to determine if, based on her current program, his earlier recommendations remained the same.

Wettlaufer agreed to undergo the reassessment, which took place on April 4, 1997.

After the reassessment, the addiction specialist reported to the College that he was "struck by [Wettlaufer's] honesty and her willingness to share her issues with key people in her life." He noted that her "recovery life [was] getting out of balance," which he attributed to more focus placed on work rather than attendance at support groups. The addiction specialist recommended that Wettlaufer attend a minimum of three support groups each week (including the Health Professional Group and church attendance) and wrote a letter to her employer asking for modified work to allow that attendance. He also recommended that urine monitoring continue and that the College consider asking Wettlaufer's pastor for reports on her attendance at church activities.

Based on this subsequent report, the College indicated that it was prepared to enter into an agreement with Wettlaufer to impose conditions on her certificate of registration.

4. Order by the Fitness to Practise Committee

On May 9, 1997, the College and Wettlaufer entered into a memorandum of agreement in which Wettlaufer acknowledged that she was “incapacitated” within the meaning of section 1(1) of the Code and agreed to a Decision on Consent of the Fitness to Practise Committee (Decision), without the need for a hearing.

In the Decision, the committee found that Wettlaufer was incapacitated as a result of alcohol dependence, and ordered that terms, conditions, and limitations be placed on her certificate of registration for one year, including, among other things, that she:

- not abuse any substances and remain alcohol free and free of any mood-altering drugs, except for those prescribed by her family physician or addiction specialist;
- advise her current employer, Christian Horizons, that her certificate was subject to conditions and confirm that her supervisor would co-operate with the College in providing information it required to ensure she was complying with the conditions;
- continue to obtain treatment and monitoring from her addiction specialist, including individual counselling, attendance at the Health Professional Group, and provision of random, supervised urine samples for analysis; and
- obtain agreement from her family physician and addiction specialist to co-operate with the College in providing the information required to ensure she was complying with the conditions and to immediately notify the College if, in their opinion, her chemical dependency might interfere with her ability to practise nursing or if she had failed to comply with any of the conditions.

The Decision included confirmation that, if the College was of the view that any of the conditions had been breached, it could return the matter to the Fitness to Practise Committee, which could revoke, suspend, or impose additional terms, conditions, and limitations on Wettlaufer’s certificate of registration.

5. The College's Monitoring: May 1997–May 1998

Wettlaufer's employer, family physician, and addiction specialist each agreed to comply with the monitoring conditions of the Decision. The incapacity coordinator at the College wrote to all three to advise that, throughout the one-year monitoring period, she would be contacting them by telephone about four times.

Between December 1 and 3, 1997, the College placed telephone calls to Wettlaufer, her family physician, her addiction specialist, and her employer. Each one indicated she was doing well.

On March 9, 1998, the College placed a telephone call to Wettlaufer's family physician, who confirmed that Wettlaufer was doing well. In May 1998, the College contacted him again, and he reported that Wettlaufer was in good health, and that he had "no concerns regarding overusage of meds / alcohol" and "no concerns regarding possible relapse."

There is no evidence that the College made any other inquiries of Wettlaufer, her employer, or her addiction specialist during the monitoring period. In her testimony, Ms. Coghlan speculated that by the time the notices were provided and the agreements executed by the practitioner and employer, a length of time had passed into the monitoring period.

On May 29, 1998, the College notified Wettlaufer that, to the College's knowledge, she had fully complied with the conditions on her certificate of registration, and "[t]herefore the College of Nurses [would] no longer monitor compliance with recommended treatment or aftercare, and [her] certificate no longer ha[d] any conditions attached to it."

After the completion of the monitoring period and following the removal of the terms, conditions, and limitations from Wettlaufer's certificate of registration, Wettlaufer was permitted to practise nursing without any restrictions or monitoring.

For the next 16 years, until May 2014, when the College received the Caressant Care (Woodstock) termination report of Wettlaufer's employment (dated March 31, 2014, and submitted on April 17, 2014), its only contact with Wettlaufer was the receipt of her annual payment forms (described later in this chapter). No other complaint, report, or information came to the College's attention regarding Wettlaufer or her practice over this period.

6. Information on Register Resulting from Incapacity Concerns

In 1997, when Wettlaufer was found to be incapacitated, the Code required that each college's Register include:

- each member's name, business address, and business telephone number;
- each member's class of registration and specialist status;
- the terms, conditions, and limitations imposed on each certificate of registration;
- a notation of every revocation and suspension of a certificate of registration;
- the result of every disciplinary and incapacity proceeding;
- where findings of the Discipline Committee were appealed, a notation that they were under appeal (until the appeal was finally disposed of, after which time the notation would be removed);
- information that a panel of the Registration, Discipline, or Fitness to Practise Committee specified be included; and
- information that the regulations prescribed be kept on it.

Under the Code in force at that time, not all information on the Register was accessible to the public. The Code provided that the public could access, among other things:

- the notation of a suspension of a certificate while the suspension was in effect; and
- the results of disciplinary and incapacity proceeding completed within the six years before the time the Register was prepared or last updated, in which the member's certificate of registration was revoked, suspended, or had terms, conditions, and limitations placed on it, or the member had been required to pay a fine or attend to be reprimanded, or if an order was suspended, if the results of the proceeding were directed to be included in the Register by a panel of the Discipline or Fitness to Practise Committee.

The Code required that this information be available to a person during "normal business hours." From 1995 to 2009 (prior to the College's Find a Nurse Register on its website), the College would provide this information, if requested to do so, by either email or telephone.

Regarding Wettlaufer's incident at Geraldton District Hospital, the following information on the College's Register would have been publicly available:

- *before May 9, 1997*: only the standard information available for all nurses. More specifically, no reference to the information received from the Geraldton District Hospital director of nursing, or the existence of an ongoing section 75 investigation or Board of Inquiry proceeding, would have been publicly available;
- *from May 9, 1997 to May 9, 1998*: that terms, conditions, and limitations were imposed on her certificate of registration, and what those were; and
- *from May 9, 1997 to May 9, 2003*: the finding of incapacity. The Fitness to Practise Committee's Decision would not have been available because the committee's hearings are closed and deal with personal health information.

7. Changes in the Incapacity Process Since 1996–98

As a result of legislative amendments and changes in the College's practice, the process by which the College addresses information about a member's potential incapacity has changed since 1996–98.

As of June 4, 2009, the Inquiry, Complaints and Reports Committee has the combined functions of the former Complaints Committee and Executive Committee, as described above. As a result, the current regime requires that a panel of the ICRC be appointed to review complaints and executive director-initiated health inquiries that suggest a member may be incapacitated. Earlier I outlined the current process for addressing complaints or reports regarding a member's health.

Additional changes include the College's use of undertakings and the introduction of the Nurses' Health Program (both described above).

Although the terms of a Fitness to Practise Order are case-specific, Ms. Coghlan testified that at this time a major difference is the length of a typical monitoring period, which would now generally extend for three to five years. Ms. Coghlan explained that the science has changed since Wettlaufer's monitoring period of one year was accepted, and that the expert advice of addiction specialists is now generally for a longer monitoring period. There may, however, still be circumstances where a period of a year would be recommended.

C. Wettlaufer's Annual Membership Renewals

Wettlaufer submitted annual payment forms (later called annual membership renewal forms) to the College, although she was often late in sending them in.

The format and content of the forms have changed over those years, to reflect either changes in statutory requirements or the College's experience from previous years.

Beginning on the 1997 form, until and including the 2007 form, Wettlaufer listed Christian Horizons as her business address. On these forms, Wettlaufer indicated she was "employed in other than nursing" and/or was an "unregulated care provider." In seven of these years, Wettlaufer submitted her form late after the College had issued a Notice of Intent to Suspend due to her failure to complete and submit the form.

In 2002, the annual payment form was changed to include the following question, under the member's self-reporting obligations: "Since your initial registration with CNO has there been a finding of professional misconduct, incompetence or incapacity against you in relation to the nursing profession or to any other health profession, whether in Ontario or any other jurisdiction." Wettlaufer answered "no," which was false.

This inaccuracy was not identified by the College, which did not have a practice of verifying the accuracy of self-reporting obligations.

In 2003, the format of the annual payment form was changed, and members were asked to respond to: "According to the Guide ... I have one or more reporting requirements to CNO." Wettlaufer left her answer blank. The following year, in 2004, the form asked: "I have been involved in a disciplinary or incapacity proceeding, or have been found guilty of a criminal offence since my last reporting to the CNO." Wettlaufer also left a blank response.

The questions about self-reporting obligations have now been removed from annual payment forms. Ms. Coghlan explained in her testimony that the legislation was amended to impose ongoing obligations on members to self-report if they have been charged with or found guilty of an offence; if there have been findings of professional negligence or malpractice against them; or if findings of professional misconduct or incompetence have been made against them by another body that governs a profession. The legislation does not, however, require members to self-report incapacity or health issues to their regulators.

On her annual payment forms between 2009 and 2014, Wettlaufer listed Caressant Care Woodstock Nursing & Retirement Home as her business address and indicated her employment type as “Nursing.” The 2013 form was submitted late, after the College issued a Notice of Intent to Suspend due to her failure to complete and submit the form.

Wettlaufer’s 2015 and 2016 annual membership renewal forms listed Meadow Park (London) Inc. and Life Guard Homecare, respectively, as her employers and indicated that she was practising nursing.

D. 2014 Termination Report from Caressant Care (Woodstock)

1. The Termination Report

Between 1998 and 2014, the College was not notified of any issues relating to Wettlaufer.

On May 1, 2014, however, according to the College, it received a letter and report of Wettlaufer’s termination of employment from Caressant Care (Woodstock). The letter and termination report can be found as Appendix F to this volume.

The report was dated March 31, 2014, and was submitted under a cover letter from Brenda Van Quaethem, the administrator of Caressant Care (Woodstock), dated April 17, 2014. The administrator testified that she believes she must have started preparing the report on March 31, 2014, and completed it in April. She cannot recall if she submitted the report by mail or by fax, but agreed that if the College received the letter on May 1, 2014, this would support the view that she sent it by mail.¹⁹

¹⁹ Testimony of Brenda Van Quaethem, Transcript, pp 418 (June 6, 2018), 477 (June 7, 2018), 586 (June 7, 2018); Testimony of Anne Coghlan, Transcript, July 25, 2018, pp 5523–24, 5386.

The cover letter read as follows:

Enclosed please find the Report Form for Facility Operators and Employers. We are reporting the termination of [Elizabeth Wettlaufer] to the College of Nurses. She was terminated due to a medication error which resulted in putting a resident at risk.

If you have any questions feel free to contact myself or Helen Crombez, Director of Nursing at Caressant Care Woodstock at the number listed below.

Caressant Care (Woodstock) reported Wettlaufer's termination of employment using the template form that the College created to assist employers and facility operators in fulfilling their mandatory reporting obligation (see the above section on Mandatory Reporting Requirements).

On its face, the template form stated:

Please review the College's Collection of Personal Information statement in the Mandatory Reporting: A process guide for employers, facility operators and nurses to understand how the College uses your information. [The website address for the guide followed.]

The following statement appeared at the top of the fourth page of the template form, just above a chart:

Describe the event(s) that led to this report (who, what, where, when, and why) in chronological order starting with the most recent.

Below this statement there was the chart with five headings: Date; Incident / event; Consequences to client / other; Member response / explanation; Employer action. At that time, the template form limited the number of incidents that could be reported to 10.

The report showed that Caressant Care (Woodstock) terminated Wettlaufer's employment on March 31, 2014, and that Wettlaufer worked the evening shift, with a nurse : client ratio of 32:1.

The report summarized 10 incidents involving Wettlaufer, beginning with the termination event on March 20, 2014, and going back to August 29, 2012. The 10 incidents showed that Caressant Care (Woodstock) had taken escalating disciplinary action in respect of Wettlaufer, giving her two five-day suspensions and one one-day suspension, as well as written warnings and counselling.

The report described the terminating event as follows:

Administered insulin to a resident belonging to another resident. The insulin was not the same insulin. Beth had come on shift at 15:00 hour to work the 15:00 to 23:00 hour shift. The Day nurse had reported to Beth at change of shift that the insulin was ordered and would be coming in with the medication delivery between 17:00 and 18:00 hour. Beth said she did not remember hearing this. She said she went to the refrigerator and substituted the insulin from another resident as it was the same. It was not.

The insulin pen was left opened on the medication cart by the day nurse as a reminder to Beth that the refill was needed. The day nurse in her report said she had reviewed this with Beth during shift report a couple of times.

The consequence to the client was stated as “resident had an episode of hypoglycemia.”

Two matters were listed under the column heading “Member’s response / explanation.” First, Wettlaufer was upset when she heard about the incident and said she thought she had loaded the cartridge with the same insulin as the one prescribed for the resident. Second, Wettlaufer admitted she had taken another resident’s insulin when she knew she “was not to borrow.”

The other incidents summarized in the termination report can be grouped into two categories: (1) errors in medication administration, and (2) other nursing or work-performance issues.

Incidents in the first category include administering eye drops incorrectly; charting medications as having been given to a resident when she had failed to give four medications to this resident over two medication passes; failing to sign for a narcotic given to a resident; failing to follow proper procedure by leaving medications on a dining room table; and, not properly counting narcotics with the oncoming shift.

Incidents in the second category include one in which Wettlaufer upset a resident by speaking to the individual in an inappropriate manner. The report shows that Wettlaufer failed to document the interventions she said she had used to calm the resident. As well, to calm the individual, she administered medication outside the allowable time frame. The incident in which Wettlaufer incorrectly administered eye drops is another example within the second category. It was a medication error to give the two types of eye drops at

the same time, one that could adversely affect the resident's eyesight over time. The reason this incident falls into the second category is that a family member told Wettlaufer that the way she had administered the eye drops was incorrect, to which Wettlaufer replied, "I know."

Another example in the second category was incorrect treatment of a hypoglycemic episode, in which proper food and drink were not given, late charting was done, and neither the physician nor the dietitian was informed. Another incident falling into the second category was Wettlaufer's failure to have a urine sample tested. The sample was obtained from a "difficult resident" with help from the resident's wife. The sample was given to a PSW, who gave it to Wettlaufer because it was Wettlaufer's responsibility to have it tested. Wettlaufer did not get the sample tested, and it had to be discarded because it was stale. Failing to have the sample tested was significant because it created the possibility of late identification of a urinary tract infection. In the column for "employer action" for this incident, several other examples of substandard work performance were identified, including failing to do assessments, and failing to process and follow up on doctors' orders. Other incidents in the second category were Wettlaufer's failure to take the temperatures of the medication refrigerator and her failure to assess a resident when required.

The report concluded with the following statement:

There were other reports from staff that did not lead to discipline but were considered at time of termination. These reports had to do with attendance, professional behaviour.

2. The College's Initial Response to the Report

By letter dated July 18, 2014, to Caressant Care (Woodstock), the College acknowledged that it had received the termination report. The letter stated:

Since all of the information pertaining to this matter is confidential, we are unable to inform you of the proceedings or outcome in relation to any investigation which may ensue. If further information is required, an investigator of the College will contact you at a later date.

Karen Yee, the College intake investigator to whom the report was allocated (but who is no longer a College employee), gave evidence to explain the delay in the College's response to the report. She testified that, on receiving the report and cover letter from Caressant Care (Woodstock), a College intake associate would have reviewed them to identify the nature of the report –

whether it was about termination, incompetency, incapacity, or abuse. As well, the reports manager would have reviewed it to confirm the associate's assessment. If a report was assessed as not urgent, it would not immediately have been allocated to an intake investigator.

3. The Intake Investigator's Treatment of the Report

The termination report was allocated to Ms. Yee on July 23, 2014. Ms. Yee, an RN and a lawyer, was in clinical practice as a mental health nurse for six years before working at the College from 2006 to 2015. She originally worked as an investigator in the College's Professional Conduct Department, investigating complaints for two years and then investigating reports for six years. She moved into the intake investigator role in January 2014.

Ms. Yee testified that she had no independent memory of considering the report. The evidence she gave was based on her standard practice and experience as an intake investigator.

As set out above, the function of the intake investigator is to conduct a risk assessment to determine the appropriate regulatory response to the information received by the College. Intake investigators do not have the power to compel evidence at the intake stage. Any information that employers and facility operators provide to an intake investigator is provided voluntarily.

According to Ms. Yee, as an intake investigator she was trained to undertake the intake process to determine, as best as possible and without exhaustive investigation:

- What are the outstanding nursing issues?
- What is the risk to the public?
- What response would be the most appropriate?

Her general practice was first to review the report and make notes about what information appeared to be missing, questions she would want to ask, and whom she should contact at the member's place of employment for additional information. She would then review the College's internal database, called FLO. FLO contains the member's current and former employers as well as the member's past history with the College. If the member had a history with the College, Ms. Yee would review the College's file of that history to see what the issues and outcomes had been.

Ms. Yee would then telephone the contact person identified on the report (the reporter) to obtain more information about the member and any concerns not expressed in the report form, and to gain additional context for the reporter's concerns about the member's practice.

Finally, Ms. Yee would review the College's FLO database to see if the member had any other current or past employers. If other current employers were listed (other than the reporting employer), Ms. Yee would call and use a general inquiry approach to see if there were any concerns about the member's practice or conduct. If past employers were listed, Ms. Yee would assess whether to call, depending on the passage of time since the member last worked at that facility and based on the likelihood of that employer having relevant information. If no other employers were listed in FLO, Ms. Yee would generally ask if the reporter was aware of the member working elsewhere.

In assessing risk, Ms. Yee testified that she was initially trained to use the College's WebART tool, through which she answered a series of questions directed at assessing risk. This tool generates a number, based on the intake investigator's answers to the questions, to be used to help assess the level of risk. In March 2014, however, intake investigators stopped inputting information into the WebART tool directly but continued to consider the same factors in assessing risk. These factors and the resulting analysis would then be recorded in a memo to the executive director.

Ms. Yee testified that this change did not have any impact on how she conducted risk assessments – it simply changed the format in which the information was presented to the executive director. In undertaking a risk assessment, Ms. Yee would refer to the questions and considerations contained in the WebART tool and supplement them according to the information in the report or obtained directly from the reporter during the telephone conversation.

Ms. Yee indicated that she relied on employers being accurate and providing as much information as they believed relevant and concerning. She agreed that she could not perform her job properly if she did not receive accurate information on an employer report form.

Ms. Yee reviewed the covering letter and the report form received from Caressant Care (Woodstock). At the public hearings, she identified what issue or issues were raised by each incident reported, and which College Standard or Standards were implicated. She testified that she considered each incident's

level of risk based on her own clinical nursing practice and the inquiries and investigations she had conducted previously. Ms. Yee confirmed that a risk of harm to a patient from medication errors always exists. However, she also considered how common that type of an error would be in the practice setting and also Wettlaufer's response to each incident and her reported remorse, insight, or willingness to learn, as included in the report form. Although several medication errors were reported, Ms. Yee explained that it was significant to her risk assessment that they were different types of medication errors, rather than the same error being repeated.

The report form included, under "other comments," that "[t]here were other reports from staff that did not lead to discipline but were considered at time of termination. These reports had to do with attendance, professional behaviour." Ms. Yee's impression from this statement was that the most significant items that had been identified by the employer were contained in the form. She believed that all the incidents which were concerning to the employer had been included, except for those that did not lead to discipline but related to attendance and professional behaviour.

Ms. Yee's overall impression, based on the information contained in the report form, was that Wettlaufer was not providing "the greatest care" and that "her practice was not the greatest, but my view at that time would have been that she was still practising within the range of acceptable nursing practice, the low range, but still within the range that is acceptable." Ms. Yee believes she would have noted that, in certain of the incidents reported, Wettlaufer was stated to have taken responsibility for her errors, but in other cases she had not. Because Wettlaufer's level of insight was not reported to be consistent with each incident, Ms. Yee would have followed up with the employer to gain a sense of Wettlaufer's insight and accountability.

Ms. Yee would have also reviewed information about Wettlaufer's prior incapacity finding contained in the file. She would have wanted to ascertain the outcome of that proceeding, and the terms, conditions, and limitations imposed at that time, to try to determine if it may be connected to the issue(s) in the report form. Ms. Yee testified that she would have understood that Wettlaufer had a prior health issue and that she would not have focused on whether that health issue related to drug addiction, alcohol use, or a mood disorder. Because the nature of health issues can evolve, Ms. Yee would not have limited her consideration to whether Wettlaufer at this time had the same prior health issue (alcohol misuse or depression).

4. Interview of Helen Crombez

On July 28, 2014, Ms. Yee tried to contact the DON of Caressant Care (Woodstock), Helen Crombez, and left a telephone message with reception requesting that her call be returned. Ms. Yee testified that when leaving a message, if she reached the contact person's voicemail, her practice was to identify herself and indicate that the College had received the report and she was calling about that information. However, if the message was left with another person answering the phone, she would not indicate the purpose for her call and would simply request that the contact person return her call.

On July 30, 2014, Ms. Yee and Ms. Crombez spoke on the telephone. Ms. Yee's practice was to handwrite notes during a telephone interview and, immediately afterward, while the discussion was fresh in her mind, type an interview summary. Ms. Yee has no recollection of the discussion with Ms. Crombez, but she provided evidence based on her practice in terms of the questions she would have asked and the information in her notes from her interview with Ms. Crombez.

Ms. Yee would have had prepared a list of questions in advance for Ms. Crombez. During the telephone call, Ms. Crombez confirmed that Wettlaufer had worked at Caressant Care (Woodstock) full time since 2007 and had not worked elsewhere during that period.

According to Ms. Yee's notes, Ms. Crombez reported that she was not aware of whether Wettlaufer had any stressors going on in her personal life that may have affected her practice, and that there was no underlying issue or concern with the member. Ms. Crombez reported that one time, "a while back, the member mentioned that she was on medication for some mood related / anxiety condition," and that Wettlaufer had stated that "she recently had her medication changed and was having difficulty adjusting to it and that was the reason for an error she did."

Ms. Yee believes she would have noted that Wettlaufer had been employed starting in 2007, and that the reported incidents began only in 2012, and would have asked why there were not any incidents reported before that year. The notes reflect that Ms. Crombez stated that, before 2012, Wettlaufer had worked in another section and worked evening and night shifts, and her practice had become more visible when she began working evening shifts (instead of nights) because she was no longer the only registered staff member working a particular shift.

Ms. Yee testified that she believes she would also have sought clarification about the employer's views on Wettlaufer's insight, in light of the inconsistencies contained in the report form (i.e., at some points the report suggested Wettlaufer showed insight and accountability for her errors, and at others she did not display the same qualities). Ms. Crombez told Ms. Yee that Wettlaufer was upfront about her errors when asked, accepted she made a mistake, but "just never changed her practice."

Ms. Yee testified that she would have understood from her conversation with Ms. Crombez that Wettlaufer had a level of insight and accountability over the errors that were included in the report form. The employer's report that Wettlaufer "just never changed her practice" gave Ms. Yee the impression that the employer stopped being tolerant of the member's low level of practice. Ms. Yee was also advised by Ms. Crombez that "there was no sustained harm to the residents involved in the incidents."

5. Intake Investigator's Recommendation for Regulatory Response

After reviewing the termination report, interviewing the Caressant Care (Woodstock) DON, and reviewing the College's file on Wettlaufer's prior incapacity proceedings, Ms. Yee prepared a memo to file summarizing that information and giving her recommendation for regulatory action. She concluded that Wettlaufer's health was not in issue and that it was Wettlaufer's nursing practice that was of concern. She made this assessment clear in her memo to file, which read:

Nursing issues mainly concern member's medication administration skills and to a lesser degree the member's TNCR [therapeutic nurse-client relationship] skills. From February 2013 to March 2014, the member made seven med errors, examples are: leaving meds on a dining room table, administering narcotic without signing for it, forgetting to administer meds, giving med outside of time frame (too early), and most recently administering the wrong insulin to a resident and using another resident's insulin pen to administer it ... There was no sustained harm to the residents ...

The member's prior occurred 17 years ago and although the member's prior is related to health, the information in this current report does not indicate that the member's health is a current issue.

At the public hearings, Ms. Yee testified that she viewed Wettlaufer as having made seven medication errors over a 13-month period and, although that was "not a very good practice ... it's still within the acceptable range of nursing practice." The fact that there was no sustained harm to residents was a factor

in Ms. Yee's analysis, but she said she would also have considered whether the incidents posed any serious potential harm to the residents. Ms. Yee's evidence was that she was not given the impression that Wettlaufer's actions were a danger to residents' welfare. On questioning during the hearings, however, Ms. Yee agreed that failing to properly treat hypoglycemia could be a very serious issue for a resident, and that administering the wrong insulin could result in serious issues, including death. It was also suggested to Ms. Yee that leaving medications on a dining room table, where they could be consumed by other residents, could have resulted in a resident being sent to hospital or even dying. Ms. Yee testified that this consideration would apply to all medication errors.

Ms. Yee recommended to the executive director that the matter "be banked with notice,"²⁰ with the direction that Wettlaufer review the *Professional Standards* and the *Medication Standard*. Her recommendation was based on her view that a health matter was not in issue, it was the first time the College had been made aware of concerns about Wettlaufer's practice, and the overall risk was low.

Ms. Yee's recommendation was reviewed at an intake review meeting, which would have been attended by two intake associates and the other intake investigators. Ms. Yee would have presented her memo to file, along with her recommendation, for the purpose of discussing whether there was consensus on the recommendation and, if there wasn't, what other options would best address the risk. The intake team agreed with Ms. Yee's recommendation to bank with notice.

6. Registrar's Regulatory Response

On October 14, 2014, Anne Coghlan reviewed Ms. Yee's assessment and accepted her recommendation.

Ms. Coghlan did not have an independent recollection of undertaking this review but, based on her practice, she believes she would have reviewed Ms. Yee's memo to file, the termination report, Ms. Yee's summary of her interview with the Caressant Care (Woodstock) DON, and the earlier decision of the Fitness to Practise Committee.

²⁰ As discussed above, this recommendation means that the College would give Wettlaufer a copy of the Report, remind her of her accountability as a member of the College, and direct her to review the Standards relevant to the issues identified in the Report. Wettlaufer would also be told that the information would be kept on file and considered if further concerns came to the College's attention.

In her evidence, Ms. Coghlan testified that her assessment at that time was that Wettlaufer was a nurse who, over a period, had a number of “low-risk incidents that suggest sloppy practice” and that, “for whatever reason, the nurse is not responding to the employer’s expectation and direction,” such that she needed to be reminded of her professional accountability and the College’s expectations. Ms. Coghlan considered the report to contain examples of sloppy behaviour, poor communication, and medication errors. However, she testified she would not have had a concern about Wettlaufer’s ability to administer medication safely, because the medication errors viewed in total were “typical of medication errors that are low-risk and are amenable to remediation, review of standards, and attention to one’s professional accountability.” Based on the information in the interview summary with the Caressant Care (Woodstock) DON, Ms. Coghlan did not form the belief that Wettlaufer suffered from a health concern at that time. The DON had no underlying issue or concern with Wettlaufer, and the fact that it was reported on one occasion, “a while back,” that Wettlaufer reported difficulties adjusting to a medication did not cause her concern that Wettlaufer had a current health condition. Ms. Coghlan testified that many nurses are on medication and it has no impact on their ability to practise.

The College then sent Wettlaufer a letter, under Ms. Coghlan’s name, enclosing a copy of the report and cover letter, as well as a copy of the memorandum of agreement dated May 9, 1997, from her prior Fitness to Practise proceeding. The letter told Wettlaufer that the governing legislation gave the executive director the discretion to appoint an investigator to investigate her conduct if the executive director believed, on reasonable and probable grounds, that Wettlaufer had committed an act of professional misconduct or was incompetent. However, it went on to state, “I have determined that the appointment of an investigator is not currently warranted.”

Wettlaufer was told that the information the College had received implied she had failed to maintain the standards of practice of the profession, and that the College expected nurses to reflect on the practice issues giving rise to a report and to review the applicable standards of practice. She was specifically directed to review *Professional Standards* and the *Medication Standard*, and to continue with her professional development.

The College’s disposition of the report was confidential and not shared with any employers (prior, current, or potential) or the public. The College retained the information on file for future consideration, if further information about Wettlaufer came to its attention.

7. Changes in the Process Since 2014

Ms. Coghlan testified that the College's initial intake process for assigning files to intake investigators has not changed since it received the report in 2014. However, to address the significant increase in reports received in recent years, the College has added more resources to the intake process. Further, the intake coordinator is now instructed to continually assess the reports received and their relative priorities. Intake investigators are also required to continually assess the relative priority of the cases assigned to them. Ms. Coghlan explained that the volume of reports received is unpredictable and additional resources can be added to accommodate for volume, but the College's first priority is to address those matters that pose the most serious risk of harm to patients.

Ms. Coghlan also testified that, as a result of the Offences, the College undertook a literature review on the healthcare serial killer phenomenon. The review led to the production of a memo, "Identifying risks: learnings from the literature on health care serial killers." Ms. Coghlan testified to her understanding that, although the literature did not disclose a methodology or algorithm for identifying healthcare serial killers, it did identify risk factors that might assist in the College's intake assessment process.

The memo was circulated to the College's professional conduct team, with the goal of ensuring that staff were aware of the phenomenon when doing their work and that they understood it within the context of potential risk factors. As a result of the review, a revised risk assessment tool was created for intake investigators.

The College has indicated that it intends to share the research it has conducted on the healthcare serial killer phenomenon with other health regulators in Canada, the United States, and internationally. Its long-term goal is to explore an algorithmic approach that would use predictive analytics to identify members who might pose a serious risk to the public. In her testimony, Professor Beatrice Crofts Yorker, an American expert on healthcare serial killers, testified that she was not aware of any licensing bodies currently using such a tool and hoped that the College's efforts and the results of this Inquiry could be used by regulators in the United States in the future. Professor Crofts Yorker's expert testimony and report are discussed in Chapter 16.

E. Information Received from CAMH and Revocation of Wettlaufer's Nursing Licence

1. Information Received from CAMH on September 29, 2016

On September 29, 2016, Dr. Alan Kahn, a psychiatrist at the Centre for Addiction and Mental Health (CAMH) in Toronto, left a voicemail on the College's reports on-call line, indicating that he wanted to report a nurse for professional misconduct. The voicemail included Wettlaufer's name and date of birth, that she resided in the Woodstock area, and that the physician was calling the College with her consent.

When a College investigator returned Dr. Kahn's call, Dr. Kahn told her that Wettlaufer was a patient at CAMH and had been there for 12 days. He reported that on the previous day, Wettlaufer gave him a handwritten four-page self-report in which she confessed that over the past nine years, while working in nursing homes, she overdosed patients with insulin with the intent to kill them. Dr. Kahn provided details of the confession and of Wettlaufer's past work history, and he said that Wettlaufer told him she had been stealing Dilaudid and other controlled substances.

Dr. Kahn advised the College investigator that the Toronto Police Service was investigating and asked if a College representative could go to CAMH and speak with Wettlaufer. The College investigator said that certain statutory processes had to be followed before the College investigated or met with the member. Dr. Kahn agreed to send a letter to the College's executive director and enclose with it a copy of the confession.

2. The College's Early Inquiries and Contact with Wettlaufer

Later on September 29, 2016, the College investigator contacted Wettlaufer's then-employer, as identified in the College's records. She spoke to Heidi Wilmot-Smith, the president of Life Guard Homecare. Ms. Wilmot-Smith reported that Wettlaufer had resigned her employment with Life Guard as of September 7, 2016, and that there had been no issues or concerns with her clinical practice or competence. She also told the College investigator that Wettlaufer had an additional employer and had been providing community nursing.

On September 30, 2016, at 09:13, Wettlaufer emailed Investigations – Intake at the College, writing: "I, Elizabeth T Wettlaufer am no longer fit to practice

as a nurse. I have deliberately harmed patients in my care and am now being investigated by the police for same.”

Also on September 30, 2016, Dr. Kahn spoke again with the College investigator. He told her that he was speaking with legal counsel to confirm if he could disclose the confession. He also told her that he had provided a copy of the confession to the police, and that the police were to question Wettlaufer later that day. He reported his view that there was no reason not to believe the information that Wettlaufer had shared about her practice and conduct.

Wettlaufer telephoned the College investigator on September 30, 2016, stating that she understood that the College wanted information from her. Wettlaufer was advised that she was under no obligation to provide information to the College, and that she had the right to retain and instruct legal counsel. Wettlaufer stated that she had deliberately given insulin overdoses to patients between 2007 and 2016 on about 14 occasions.

The College investigator told Wettlaufer that if she had no intention of continuing to practise nursing, she could consider resigning her certificate of registration or moving to the Non-Practising Class. The investigator asked if Wettlaufer would be willing to enter into an undertaking with the College not to practise while police were following up on the information she had provided. The notes of the call indicated that Wettlaufer agreed she would “definitely sign an undertaking because she does not want to continue practising.”

Also on September 30, the College investigator contacted a Toronto Police Service detective and indicated that the College was aware there had been police involvement with the matter, and to advise that it was the College’s intention also to follow up on the information provided. The detective confirmed the police service’s intention to co-operate with the College and that the police would advise if charges were laid against Wettlaufer.

That same day, the College investigator contacted Wettlaufer’s other employer, as identified by Ms. Wilmot-Smith. The investigator spoke to Tamara Condry, the supervisor of nursing and clinical practice coach at Saint Elizabeth Health Care (Oxford County). Ms. Condry advised that Wettlaufer had worked for Saint Elizabeth Health Care from July 11, 2016, to August 22, 2016, at which point she called in sick and then left a resignation note. Ms. Condry reported that Wettlaufer was “a bit rusty on some technical skills,” but no issues or concerns had been reported to her by any clients, and Wettlaufer’s practice was otherwise fine.

The investigator had further discussions with the police on September 30, 2016, because the police had asked the College to suspend Wettlaufer's certificate of registration. The police were concerned that, if there were a "gap" between the time Wettlaufer was released from CAMH and later taken into police custody, she would be able to practise nursing and, potentially, put the lives of patients in jeopardy. The College investigator told the police that the College could not impose a suspension without statutory authority, which was possible only after certain steps had taken place.

3. Emergency Appointment of Investigator

On September 30, 2016, the College investigator recommended the emergency appointment of an investigator under section 75(2) of the Code.

Later that day, the executive director made the appointment. She also made a report to the Inquiry, Complaints and Reports Committee (ICRC) that same day, advising that an investigator had been appointed on the basis of her belief on reasonable and probable grounds that Wettlaufer's conduct exposed or was likely to expose patients to harm or injury, that an investigator should be appointed immediately, and that there was no time to seek approval from the ICRC.

No terms, conditions, or limitations were placed on Wettlaufer's certificate of registration at that time, because there was no statutory authority to do that until there had been a referral to either the Discipline Committee or the Fitness to Practise Committee. However, the College believed that Wettlaufer was not in a position to practise nursing, owing to her hospitalization at CAMH and the police involvement in her case.

4. Investigation

The College investigator was in contact with the Woodstock Police Department during the police investigation. On October 5, 2016, the police notified the College that Wettlaufer was to be released from CAMH the following day or so and would be escorted to a police station for an interview.

The College also received a report from Revera Inc. on behalf of Telfer Place on October 5, 2016. It identified the nature of the report as "incapacity" and explained that the police had attended at Telfer Place the day before and advised that Wettlaufer had admitted to overdosing a patient of Telfer Place with insulin. The College acknowledged receipt of the report the same day.

The College investigator attempted to contact Wettlaufer on October 7, 2016, with the intention of asking her to execute an undertaking not to practise nursing. The investigator also wished to obtain a copy of the confession. A woman answered the cell phone number that the College had on file for Wettlaufer but declined to provide her name to the investigator and stated, before hanging up, that she did not know who Wettlaufer was. The investigator then called Wettlaufer's home phone number, and the woman who answered confirmed she was Wettlaufer but hung up once the investigator introduced herself.

The College's investigation included issuing a summons to obtain Wettlaufer's medical records from CAMH, which were provided.

On October 14, 2016, the College's Register was updated to reflect that Wettlaufer was not entitled to practise and that her registration status was "resigned."

On October 18, 2016, the College received a letter (dated October 14, 2016) from Carol Hepting, the vice-president of operations at corporate Caressant Care. The letter stated that it was written further to its 2014 termination report about Wettlaufer and that:

Based on information that has recently come to our attention we wish to restate our position that the [Wettlaufer] is unfit to safely practice. We have serious concerns regarding this nurse's ability to practice with an unrestricted license, which she continues to hold according to information on the College's Find a Nurse web page.

The College remained informed of the status of the criminal investigation in October 2016, leading to charges of first-degree murder being laid on October 25, 2016. The College co-operated with the ongoing police investigation, delivering documents in response to a production order.

On November 14, 2016, the College investigator spoke with Crown counsel involved in Wettlaufer's criminal proceedings. The Crown asked the College to stop its investigation while the police investigations were under way. He assured the College that Wettlaufer had not applied for bail, and, if bail were to be granted, it would include, among other things, a condition that she not provide any medical or personal support care to anyone.

In December 2016, the College requested documentation from Caressant Care (Woodstock), Meadow Park Nursing Home (London), Saint Elizabeth Health Care, and Telfer Place, including the medical records of victims, nursing schedules, and the policies and procedures of the facilities. The requested documents were provided to the College.

On March 7 and April 12, 2017, Ms. Coghlan signed executive director's reports to the ICRC and enclosed the results of the investigation.

On May 30, 2017, the College investigator wrote to Wettlaufer's criminal counsel. Counsel had agreed to facilitate disclosure to Wettlaufer so Wettlaufer could determine whether she would respond to the College's investigation. The College received no response from Wettlaufer.

5. Referral to Discipline Committee

On June 22, 2017, the ICRC considered the results of the College investigation and elected to refer specified allegations of professional misconduct to a panel of the Discipline Committee. The specified allegations included that Wettlaufer abused clients verbally, physically, or emotionally by administering overdoses of insulin to 14 patients with the intent to harm and/or cause their death. That same conduct was also alleged to constitute conduct that would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

The College notified both Wettlaufer and her counsel of the referral to the Discipline Committee.

6. Revocation: July 25, 2017

On July 25, 2017, a panel of the Discipline Committee considered whether to revoke Wettlaufer's certificate of registration. Wettlaufer did not attend and did not have a representative in attendance. However, the panel was satisfied that she had received adequate notice of the proceeding and continued with it.

The panel considered that the Ontario Superior Court of Justice had found Wettlaufer guilty of eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault. The College also presented extensive documentary evidence of Wettlaufer's deliberate conduct and admissions of guilt to Dr. Kahn, the police, the College investigator, and the court.

The Discipline Committee retained continuing jurisdiction over Wettlaufer for acts committed while a member of the College, even though she had resigned her membership the prior September. The panel found that Wettlaufer had committed the acts of professional misconduct alleged, concluding:

This matter is shameful and unprecedented. It is the most egregious example of abuse and disgraceful conduct that this Panel has ever had to consider ... There can be no doubt that Ms. Wettlaufer's actions constitute professional misconduct in the most egregious manner possible. Ms. Wettlaufer preyed on her victims, knowing that they were vulnerable and wholly unable to defend themselves against her murderous actions. This conduct is unprofessional, dishonourable and disgraceful. Ms. Wettlaufer has brought shame to her former profession.

At the panel's direction, the executive director immediately revoked Wettlaufer's certificate of registration.

7. Changes in the Process Since 2016–17

As I outlined above, because of legislative amendments in force since May 2017,²¹ the College now has the ability to impose an interim suspension on a member's certificate of registration on an emergency basis prior to a referral to the Discipline Committee or the Fitness to Practise Committee, where the Inquiry, Complaints and Reports Committee believes the member's conduct exposes or is likely to expose his or her patient to harm or injury. The College would make this information publicly available on the Register.

²¹ *Protecting Patients Act, 2017, SO 2017, c 11.*

RECOMMENDATIONS

Recommendation 40: The College of Nurses of Ontario must educate its membership and staff on the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care.

Rationale for Recommendation 40

- For the reasons given in Chapter 16, the College of Nurses of Ontario must assume responsibility for educating its members on the healthcare serial killer phenomenon. This education should not be delivered as “stand-alone” information but, rather, as a component of topics such as professional responsibility and patient risk management.

Recommendation 41: The College of Nurses of Ontario should strengthen its intake investigation process, following receipt of termination and other reports, by training intake investigators:

- on the healthcare serial killer phenomenon and how to conduct their inquiries in light of it;
- to explain the purpose of their inquiries to those they interview;
- to identify and interview not only the contact person listed in the report but also other relevant people at the member’s place of employment; and
- to identify, in advance of an interview, the information that the interviewee should review before speaking to the investigator, to ask the interviewee to review that information before the interview, and to ask the interviewee to have the information with him or her during the interview.

Rationale for Recommendation 41

- The College of Nurses of Ontario (College) did not review Wettlaufer's full personnel file at Caressant Care (Woodstock) at the time it investigated the termination report. College witnesses said that a number of incidents in the personnel file (but not in the termination report) would have triggered further investigation on their part. This recommendation should assist employers / facility owners in preparing for interviews with intake investigators.

Recommendation 42: The College of Nurses of Ontario must review its policies and procedures and revise them, as necessary, to reflect the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care.

Recommendation 43: The College of Nurses of Ontario (College) told the Inquiry that it intends to share the research it has conducted on the healthcare serial killer phenomenon with other health regulators in Canada, the United States, and internationally. The College should pursue this initiative with the goal of leading a larger discussion among regulators about how to prevent, deter, and detect healthcare professionals who may seek to intentionally harm those in their care.

Recommendation 44: The College of Nurses of Ontario should regularly review its approved nursing programs to ensure that they include adequate education and training on nursing care for an aging population, and the possibility that a healthcare provider might intentionally harm patients / residents.

Recommendation 45: The College of Nurses of Ontario should use its influence with post-secondary institutions offering approved nursing programs to:

- promote the inclusion of information on the healthcare serial killer phenomenon in their curricula, in courses such as professional responsibility and patient risk management;
- ensure that they are providing adequate education and training on nursing care for an aging population;
- promote the discussion of nursing in long-term care (LTC) homes – including the career opportunities it provides – in a balanced way; and,
- promote student placements in LTC homes.

Rationale for Recommendations 42–45

- Given Ontario’s demographics, nurses need training in, and exposure to, providing nursing services to an aging population. Education in these areas should begin at the undergraduate and college level.
- Exposure to the long-term care (LTC) home environment – particularly early exposure – makes nurses more likely to value it as a workplace and career option. This result can be seen in the case of registered practical nurses who have a mandatory placement in LTC homes and are much more likely than registered nurses to seek work in LTC homes and stay there.
- A perception remains that work in LTC homes is less desirable than that in acute care settings. Nurses working in LTC homes told the Inquiry how meaningful their work was and questioned whether students in nursing programs are given sufficient information about the challenges and the benefits of work in the LTC sector.

Recommendation 46: The College of Nurses of Ontario (College) should take steps to improve reporting by long-term care home employers and facility operators by educating them on their mandatory reporting obligations to the College under sections 85.1–85.6 of Schedule 2 (Health Professions Procedural Code) to the *Regulated Health Professions Act*, particularly reports on terminating a member’s employment and reports where there are reasonable grounds to believe that a member is incompetent or incapacitated. This education should clarify the relationship between the employer and facility operator’s mandatory reporting obligation to the Director (a position created by the *Long-Term Care Homes Act, 2007* (LTCHA), and filled by a person in the Ministry) under section 24(1) of the LTCHA, and their reporting obligation (if any) to the College in respect of the same matter.

Rationale for Recommendation 46

- The evidence shows that employers / facility operators do not fully understand their mandatory reporting obligations to the College of Nurses of Ontario (College).
- Employers and facility operators must understand that making a section 24(1) report to the Director (at the Ministry of Health and Long-Term Care) which involves a nurse does not relieve them of their reporting obligations to the College. Because their section 24(1) reporting obligations and their reporting obligations to the College overlap but are not identical, employers and facility operators need to be educated about which incidents that lead to section 24(1) reports must also be reported to the College.
- Improved mandatory reporting should enhance the College’s ability to triage and investigate the reports.

Recommendation 47: The College of Nurses of Ontario (College) should revise its publication entitled *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses* so that it clearly explains employer and facility operator mandatory reporting obligations under the *Regulated Health Professions Act*, the types of information to be included in the reports, and how the College will use the information provided in those reports.

Rationale for Recommendation 47

- The College of Nurses of Ontario (College) has indicated that it wants employers and facility operators to include all “relevant” incidents when they complete mandatory reports. However, those completing the report need clear guidance from the College on how relevance is to be determined.
- For the College to obtain the information it requires to properly assess risk, its guide must be clarified so that those using it better understand what type of information the College wishes them to provide. However, the obligation to assess the risks associated with the reported incidents must remain with the College.

Recommendation 48: The College of Nurses of Ontario (College) should revise its template form for mandatory reports and the process for submitting those reports to the College. The revised template form should:

- include a declaration by the person completing the report that (1) the person understands and has complied with his or her reporting obligations; and (2) the contact person identified in the report is familiar with the nurse member's practice and is the appropriate person for the College to contact;
- contain clear instructions on its face requiring the reporter to provide all relevant information relating to the member. In cases of a termination report, this may include some or all of the member's discipline history but will always include a copy of the letter of termination from the employer to the member;
- ensure that the "Incidents" section in the revised template report form expands automatically to allow the reporter to fill in all relevant information and incidents;
- provide a plain-language explanation of the words "incapacitated" and "incompetent"; and
- enable the report, once completed, to be submitted to the College by email.

Rationale for Recommendation 48

- Witnesses for Caressant Care (Woodstock) testified that they were unable to set out all incidents involving Wettlaufer on the termination report because the College of Nurses of Ontario (College) template form limited the number of incidents that could be listed and described. The recommendations will remedy this situation.
- Enabling reports to be sent to the College electronically will underline the need for employers and facility operators to provide them promptly to the College and eliminate the delays attendant on sending the reports by mail.
- These recommended changes to the template form should result in the College receiving more complete and better information in reports and assist it in triaging those reports.

Recommendation 49: The College of Nurses of Ontario (College) should institute a program to educate members on their reporting obligations to the College arising from the *Regulated Health Professions Act*, the College's Practice Standards, and the Professional Misconduct Regulation to the *Nursing Act*. This program should expressly address when members must report, to the College, suspected abuse and neglect of patients and residents by other nurses.

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I. Introduction

The Offences Elizabeth Wettlaufer committed would almost certainly have remained concealed had she not confessed in September 2016. Although Ontario has a death investigation system, it did not detect her serial homicides. In three instances, local coroners were contacted about the death of one of her victims. None of these contacts, however, led to a suspicion that the deaths were the result of intentional wrongdoing.

In this chapter, I describe the death investigation system in Ontario, how deaths in long-term care (LTC) homes are reported to the Office of the Chief Coroner (OCC), the steps that are taken in death investigations of residents in LTC homes, and the intersections of the death investigation system with the Wettlaufer victims. This examination of the system as a whole explains the challenges it faces when attempting to detect concealed homicides. In the final section of this chapter, I set out a series of recommendations, based on a two-pronged approach to reforming the death investigation process as it relates to residents in LTC homes. The first prong focuses on the redesign of the Institutional Patient Death Record (IPDR) which is the form that LTC homes use to report deaths to the OCC. The second prong focuses on changes to the death investigation process itself, for residents who die while in long-term care.

Much of the discussion in this chapter comes from the evidence of Dr. Dirk Huyer, chief coroner for Ontario, and Dr. Michael Pollanen, chief forensic pathologist for Ontario, provided at this Inquiry's public hearings. The *Coroners Act*¹ establishes the OCC and the Ontario Forensic Pathology Service (OFPS) and provides a framework within which the OCC/OFPS operates. However, information on how the OCC/OFPS has operated within that framework comes largely from the evidence of Dr. Huyer and Dr. Pollanen.

¹ RSO 1990, c C-37.

II. Role and Structure of the OCC/OFPS

A. Ontario's Death Investigation System

1. The Coroner's System in Ontario

In Ontario's death investigation system, physicians are appointed to act as coroners and to conduct death investigations under the *Coroners Act*. In the "coroner's system," coroners are responsible for:

- investigating deaths as directed by the *Coroners Act*;
- informing the public about investigative findings that may prevent similar deaths;
- requesting autopsies for medico-legal reasons;
- conducting coroner's inquests; and
- completing certificates for cremation and for shipment of bodies out of Ontario.

This system differs from the "medical examiner" system in many jurisdictions in the United States and certain provinces in Canada, including Alberta, Nova Scotia, Manitoba, and Newfoundland. In these systems, forensic pathologists oversee death investigations and certify deaths in addition to performing autopsies (post mortem examinations).

Most deaths in Ontario are caused by natural diseases and are not investigated by coroners. However, as discussed more fully below, section 10(1) of the *Coroners Act* requires that every person notify a coroner or a police officer of a death that appears to be the result of violence, suicide, accident, or other specified circumstances. As well, deaths that take place in particular locations, such as group homes and psychiatric facilities, must be investigated. If a death investigation is performed, a coroner is responsible for conducting it and for certifying the death.

In death investigations, coroners apply their medical knowledge to answer five questions: who died, when did the death occur, where did the death occur, what was the medical cause of death, and how (or by what means) did the individual die? If they determine that additional examination is required to answer any of these questions, they can involve a pathologist or a forensic pathologist to conduct an autopsy. Pathologists are medical doctors with

expertise in the study of disease. Forensic pathologists have additional subspecialty training in interpreting the mechanism and pathway to death.

Coroners also play a public safety role. They are responsible for identifying concerns or issues and making recommendations to help inform strategies to improve the health and safety of Ontarians.

The death investigation system in Ontario is jointly led by the OCC and the OFPS. The mission of the OCC/OFPS is to provide high-quality death investigations for a safer Ontario and to support the administration of justice. The OCC, led by the chief coroner for Ontario (chief coroner), is responsible for overseeing regional supervising coroners (RSCs) and coroners who conduct death investigations in the province (local coroners). The OFPS, led by the chief forensic pathologist for Ontario (chief forensic pathologist), is responsible for supervising pathologists and forensic pathologists who perform autopsies ordered by coroners.

2. The Goudge Inquiry and the Creation of the OFPS

The current structure of the OCC and the OFPS has been in place since 2009. That year, significant legislative and structural changes to Ontario's death investigation system were implemented, largely as a result of the Inquiry into Pediatric Forensic Pathology in Ontario (Goudge Inquiry).²

The Goudge Inquiry addressed the practice and oversight of pediatric forensic pathology following an independent review that challenged the opinions and conclusions of a formerly renowned pediatric pathologist. The work of that pathologist had been relied on in numerous criminal cases that resulted in criminal convictions of parents and caregivers. Some of those convictions were overturned because of questions about the validity of the pathologist's work. The Goudge Inquiry was established to make recommendations to help restore and enhance public confidence in pediatric forensic pathology.

Before the Goudge Inquiry and the resulting legislative changes in 2009, the Forensic Pathology Branch (FPB), as it was called, was part of the OCC (see Figure 14.1). Historically, the chief forensic pathologist was autonomous, but in the mid-1990s this role was subsumed under the OCC. From that point on, the chief forensic pathologist reported to the chief coroner, though between approximately 2001 and 2006 no one held that role. Ontario had no formal

² Ontario, *Inquiry into Pediatric Forensic Pathology in Ontario: Report* (4 vols., Toronto: Ontario Ministry of the Attorney General, 2008) (Commissioner Stephen T. Goudge).

accreditation of “forensic pathology,” and physicians with pathology training (and not necessarily subspecialty forensic pathology training) were retained to do autopsies in death investigations on a fee-for-service basis. There was little oversight of pathologists’ training, expertise, and performance of autopsies in death investigations.

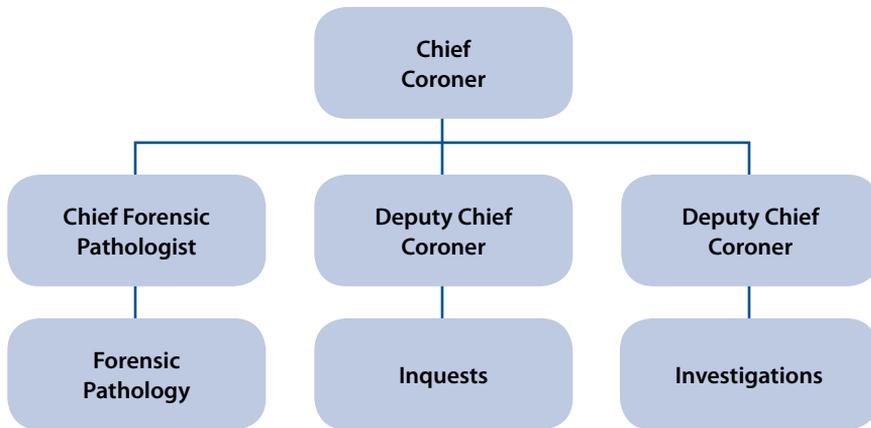


Figure 14.1: Structure of the OCC and the Forensic Pathology Service Before 2009

Source: Compiled by the Commission.

The Gouge Inquiry concluded that the legislative framework in the *Coroners Act* for death investigations in Ontario created “no foundation for effective oversight of forensic pathology,” noting that the Act did not contain any mention of forensic pathology or who should be responsible for it. It concluded that the institutional arrangements for forensic pathology, and responsibility for oversight, were ill defined. There were no tools for effective oversight, such as best-practice guidelines. The Inquiry recommended that all forensic pathology be professionalized by:

- making legislative changes to recognize forensic pathology in death investigations and establish the foundation for a proper organization of the forensic pathology system;
- establishing forensic pathology education, training, and certification in Canada; and
- committing to recruit and retain qualified forensic pathologists.

The *Coroners Act* was amended in 2009 to create the OFPS.³ The OFPS is tasked with ensuring that pathologists and forensic pathologists who participate in death investigations under the *Coroners Act* are trained and that autopsies in death investigations are completed properly. Since these amendments, only pathologists whom the chief forensic pathologist has authorized to provide services under the *Coroners Act* and has listed on a publicly available register can be involved in death investigations under the legislation.⁴

As a result of the legislative amendments, the chief forensic pathologist no longer reports to the chief coroner. In the current system, these officers work in tandem under the oversight of a Death Investigation Oversight Council (Figure 14.2).

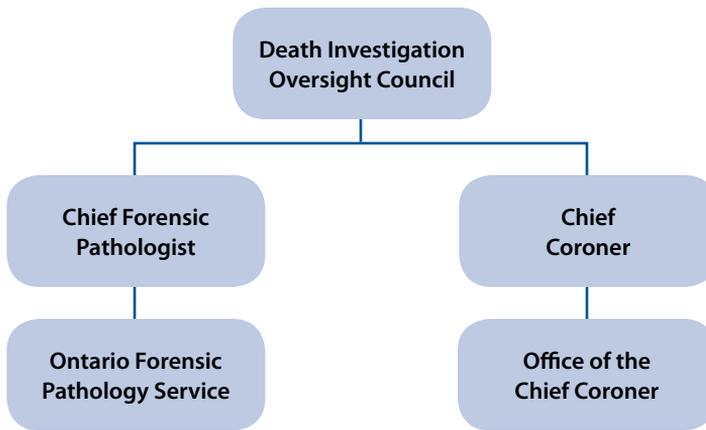


Figure 14.2: Structure of the OCC/OFPS After 2009

Source: Compiled by the Commission.

B. Structure of the Death Investigation System in Ontario

1. The Death Investigation Oversight Council

The 2009 amendments also created the Death Investigation Oversight Council (DIOC), whose members are appointed by the lieutenant-governor of Ontario. As an independent council, the DIOC is designed to ensure that death investigation services are provided in a transparent, effective, and accountable manner. The DIOC oversees the OCC and the OFPS by advising and making recommendations on matters such as financial resource management,

³ *Coroners Amendment Act, 2009*, SO 2009, c 15.

⁴ *Coroners Act*, s 7.1.

strategic planning, quality assurance, appointment and dismissal of senior personnel, and compliance with the Act and the regulations.

The DIOC, through its complaints committee, is also responsible for reviewing complaints about coroners and pathologists involved in death investigations. Complaints about coroners or pathologists are referred, respectively, to the chief coroner or the chief forensic pathologist, and the chiefs report their findings to the complaints committee. The committee reviews every complaint made about either the chief coroner or the chief forensic pathologist.

2. The Coroners

a) Chief Coroner

The role of the chief coroner is set out in section 3 of the *Coroners Act*. *The chief coroner is to:*

- (a) administer the *Coroners Act* and the regulations;
- (b) supervise, direct and control all coroners in Ontario in the performance of their duties;
- (c) conduct programs for the instruction of coroners in their duties;
- (d) bring the findings and recommendations of coroners' investigations and inquest juries to the attention of appropriate persons, agencies and ministries of government;
- (e) prepare, publish and distribute a code of ethics for the guidance of coroners;
- (f) perform such other duties as are assigned to him or her by or under the *Coroners Act* or any other Act or by the Lieutenant Governor in Council.

The chief coroner works out of the Forensic Services and Coroner's Complex in Toronto and is supported by three deputy chief coroners, 11 regional supervising coroners, and approximately 350 local coroners.

The current chief coroner, Dr. Dirk Huyer, was appointed in April 2014, after acting as interim chief coroner from July 2013 on. He had previously worked as a local coroner in the Peel Region beginning in 1992, first alongside his work as a staff physician at the Hospital for Sick Children (SickKids) as part of the Suspected Child Abuse and Neglect (SCAN) Program and later on a

full-time basis. In 2008, Dr. Huyer became the regional supervising coroner for the Central West Office in the Central Region (covering Peel, Halton, and the County of Simcoe).

b) Regional Supervising Coroners

Ontario has 11 regional supervising coroners (RSCs). One of them oversees coroner's inquests, and the other 10 are assigned to individual regional offices, where they are responsible for the oversight of local coroners in their designated geographical area. This oversight requires them to:

- mentor new investigating coroners;
- respond to inquiries from investigating coroners about particular death investigations or coroner practice issues;
- review and finalize the Coroner's Investigation Statements (Form 3s) completed by coroners at the end of each death investigation (a process described below); and
- on request, conduct educational sessions in the community.

The current West Region London Office (London Office) is the regional office covering the jurisdiction where the majority of the Offences were committed. It covers Bruce, Chatham-Kent, Elgin, Essex, Grey, Huron, Lambton, Middlesex, Oxford, and Perth counties. In 2018, approximately 55 coroners worked in the London Office region, supervised by Dr. G. Richard Mann, who has held the position since 2008. Dr. Mann testified during the public hearings.

c) Local Coroners

Ontario has approximately 350 local coroners. They are all licensed physicians and, because the majority have medical practices, most of them do their coroner work on a part-time basis.

Dr. Huyer testified that the quality of death investigations varies across Ontario. Coroners differ in their availability for death investigation service and their competency, as defined by training, expertise, experience, and the number of investigations they complete each year.

(i) Appointment and Remuneration

Historically, coroners in Ontario were appointed by the Lieutenant-Governor in Council through an order in council. Though it was a lifetime appointment, coroners held office only during the time they were legally qualified medical practitioners.

The coroner system in Ontario is a fee-for-service model. Local coroners are paid for each death investigation they complete (currently \$450) and for mileage. The fee is based on an estimated three hours of work per death investigation, though actual times vary considerably. Coroners can apply to their RSC for additional payment if a particular investigation requires significant time, but such applications are rare.

Legislative amendments that came into force on April 30, 2018, enable the chief coroner to appoint coroners directly.⁵ Dr. Huyer testified that he is working toward a service delivery model in which a cadre of trained healthcare professionals dedicate a portion, if not all, of their career to death investigation. He anticipates that these appointments will be for periods of three to five years, with reappointment linked to performance and education as outlined in a contract.

(ii) Training and Oversight

In Ontario, a coroner must be a licensed physician, but no other specific medical training or formal certificate program is required. The OCC insists that physicians attend the Course for New Coroners before they begin their work. This course is held annually and is currently of five days' duration (previously three, then four days).

The Course for New Coroners teaches coroners how to approach death investigations as well as their component parts, including: attendance at scenes; communication with families; investigations in different contexts (including natural scenes, accident scenes, suicides, homicides, and undetermined manners of death); forensic pathology; maternal / pediatric deaths; toxicology; and death certification. These segments of the course are generally taught by RSCs, forensic pathologists, the chief coroner, and the chief forensic pathologist. The course also includes case studies for the various topics reviewed, so the new coroners can practise applying their knowledge in real-world scenarios.

Dr. Huyer testified that, between 2011 and 2013, death investigations in LTC homes formed a specific module in the course. He could not confirm if this module was included in other or subsequent years but noted that the investigation of deaths in LTC homes is integrated throughout the course.

⁵ *Safer Ontario Act, 2018, SO 2018, c 3.*

After completing the Course for New Coroners, appointees are mentored by their RSCs for a number of cases. New coroners are expected to call their RSCs at the beginning of each death investigation to develop an investigative plan. They then implement the plan and receive feedback throughout the death investigation, as well as when the investigation is completed. In addition, their Coroner's Investigation Statements are audited over their first six to 12 months of work as coroners.

The OCC and the OFPS hold a course for coroners and pathologists in Toronto each fall. The topics vary from year to year, but they are intended to address areas in the death investigation system that might benefit from additional insight or learning. It is not mandatory that all coroners attend this annual event, but attendance is strongly encouraged.

Performance expectations for local coroners are defined in policy. The OCC develops and circulates memoranda and *Best-Practice Guidelines* to coroners for performing death investigations. Since 2011, these documents have been consolidated in the *Coroner's Investigation Manual* (see below).

The OCC does not engage in regular or formal performance reviews of local coroners, though at the regional office level, RSCs may implement their own performance review procedures. Dr. Mann testified that for the first four years of his tenure as RSC, he reviewed the coroners under his jurisdiction every two years. This process involved auditing a sample of their investigation statements, followed by one-on-one meetings with them. He also completed performance evaluation forms that included consideration of each coroner's acceptance of cases for death investigation, communication with pathologists, discretion when ordering autopsies, completion of Coroner's Investigation Statements, communication skills, and attendance at continuing education.

Dr. Mann did not continue with this evaluation process because of the heavy workload at the London Office. He testified that in the 23 years he worked as a local coroner, he could recall only one individual performance evaluation from his RSC.

When there are significant performance concerns about a particular coroner, the chief coroner can initiate a review process and take any corrective actions necessary. Dr. Huyer testified that, since 2006, this process has resulted in the removal of two coroners (and a third review was active but not yet completed when he gave his evidence). He stated that other coroners may have chosen to resign after their RSC initiated review processes, but he did not know how many would fit into this category.

3. The Forensic Pathologists

Like the Office of the Chief Coroner, the central office for the Ontario Forensic Pathology Service is housed at the Forensic Services and Coroner's Complex in Toronto, along with the Provincial Forensic Pathology Unit (PFPU) and the Centre of Forensic Sciences. The PFPU performs autopsies on deceased persons in the Greater Toronto Area and, in addition, is the central referral facility for complex autopsies from across the province. The Centre of Forensic Sciences conducts scientific investigations, such as toxicology, chemical analysis, and biological testing, to support death investigations and in cases where there are potential crimes against persons and property.

The OFPS Directorate is staffed by the chief forensic pathologist, the deputy chief forensic pathologist, and the executive assistant for the chief forensic pathologist.

a) Chief Forensic Pathologist

The role of the chief forensic pathologist is to supervise and direct pathologists performing autopsies under the *Coroners Act* and to be responsible for the administration and operation of the OFPS. Section 7(1) of the Act sets out the responsibilities of the chief forensic pathologist to:

- (a) be responsible for the administration and operation of the Ontario Forensic Pathology Service;
- (b) supervise and direct pathologists in the provision of services under this Act;
- (c) conduct programs for the instruction of pathologists who provide services under this Act;
- (d) prepare, publish and distribute a code of ethics for the guidance of pathologists in the provision of services under this Act;
- (e) perform such other duties as are assigned to him or her by or under this or any other Act or by the Lieutenant Governor in Council.

To perform autopsies under the *Coroners Act*, pathologists and forensic pathologists must be listed on the Register (see below). The chief forensic pathologist does not have any authority over autopsies performed by pathologists outside the *Coroners Act* regime, such as autopsies done in hospitals at the request of next of kin.

The current chief forensic pathologist, Dr. Pollanen, explained in his testimony that he was appointed in 2006, after having worked full time as a forensic pathologist for the PFPU since 2003. He was named one of the Founders of the subspecialty of forensic pathology in Canada, an honorary designation from the Royal College of Physicians and Surgeons of Canada. In 2015, he was appointed a deputy chief coroner.

Dr. Pollanen plays an important supervisory role over the work of pathologists on the Register. Each morning, through the Pathology Information Management System, he receives a list of autopsies that were conducted the day before. Pathologists generate entries on that system as they complete each autopsy. The information Dr. Pollanen reviews includes the deceased's name, age, and location, the pathologist assigned, a brief history, the initial autopsy findings, and, if determined, the cause of death.

In addition, cases that are assigned as "high profile" by the RSC are managed as they unfold by email communications to all senior staff, including the forensic pathologist on call and Dr. Pollanen. Examples of high-profile cases include homicides, pediatric cases, cases involving organ donation, complex cases, or cases with significant media attention. Dr. Pollanen will receive a notification email initiated by the RSC that sets out the deceased's name, age, and location, the local coroner, a brief description of the circumstances surrounding death, and the intended facility where the autopsy will be performed. He may intercede and direct that the body be transferred to a different location.

For all autopsies, the chief forensic pathologist's office receives and reviews a copy of the Report of Post Mortem Examination (PME Report; see below). In Ontario, approximately 7,000 PME reports are completed annually.

b) Forensic Pathologists

(i) Training and Accreditation

Since 2009, the Royal College of Physicians and Surgeons of Canada (RCPSC) has recognized forensic pathology as a formal medical subspecialty of anatomical pathology and general pathology. To obtain an RCPSC certification in forensic pathology, a physician must:

- obtain an RCPSC certification in anatomical pathology or general pathology after completing a five-year residency program;
- successfully complete the RCPSC examination in forensic pathology; and
- successfully complete the forensic pathology portfolio – a log of case work and the main points to be learned from the cases.

To maintain their specialist competency, forensic pathologists are required to participate in professional development activities and continuing medical education in forensic pathology. The OFPS collaborates with the OCC and the Centre for Forensic Science and Medicine at the University of Toronto to provide educational activities in forensic pathology.

(ii) Appointment and the Register

Section 7.1 of the *Coroners Act* requires the chief forensic pathologist to maintain a register of pathologists whom he has authorized to provide services under the Act. When a coroner issues a warrant for a pathologist to perform a post mortem examination under the *Coroners Act*, only pathologists who are listed on the Register are eligible to conduct such examinations (also referred to as “medico-legal autopsies”). As of May 30, 2018, there were 113 pathologists and forensic pathologists on the Register.

Every pathologist in Ontario can apply to be on the Register. A credentialing committee of senior forensic pathologists at the OFPS advises the chief forensic pathologist on appointments, continuing professional development, renewals, reclassifications, suspensions, and removal from the Register. The chief forensic pathologist may take into account educational standards, including successful completion of the RCPSC forensic pathology examination or its equivalent, relevant experience, and other factors deemed appropriate.

Based on their qualifications, all pathologists on the Register are assigned to one of three categories authorizing them to perform specified tasks:

- Category A: all medico-legal autopsies, including homicide and criminally suspicious cases. These pathologists are recognized as having additional experience, training, and/or certification in forensic pathology. As of 2016, there were 39 Category A forensic pathologists on the Register.
- Category B: all medico-legal autopsies except for homicide and criminally suspicious cases and cases of infants and children aged under five years. As of 2016, there were 65 Category B pathologists and forensic pathologists on the Register.
- Category C: only autopsies of infants and children aged under five years, excluding homicide and criminally suspicious cases. As of 2016, there were seven Category C pathologists and forensic pathologists on the Register.

For each medico-legal autopsy, a pathologist or forensic pathologist from the appropriate category will be assigned. In practice, the local coroner contacts the centralized Provincial Dispatch in Toronto to advise where the body needs

to be transported so that the appropriate category of pathologist can be involved. The RSC may be involved in this determination.

(iii) Practice Locations

Pathologists listed on the Register operate in one of three settings: the PFPU, the regional Forensic Pathology Units (regional FPU), and community hospitals.

The PFPU is a forensic pathology unit responsible for:

- performing autopsies, at the request of coroners, for deceased persons in the Greater Toronto Area;
- acting as the central referral facility for complex autopsies from across the province (including homicides, skeletal remains, and the violent deaths of children); and
- operating the University of Toronto's forensic pathology residency training program.

The medical director of the PFPU reports to the chief forensic pathologist. The PFPU is staffed by forensic pathologists (currently 13, all of whom have completed subspecialty forensic pathology training and work full time for the PFPU), forensic anthropologists, pathologist assistants, technologists, and imaging specialists as well as administrative and management personnel. In total, the PFPU performs approximately 2,700 autopsies annually.

The regional FPU's perform forensic pathology services outside the Greater Toronto Area. They operate out of university teaching hospitals in Hamilton, Kingston, London, Ottawa, Sault Ste. Marie, and Sudbury. Each regional FPU is managed by a medical director, a senior forensic pathologist who works on a full-time or nearly full-time basis (depending on the size of the unit). The FPU's provide regional expertise in forensic pathology for approximately 2,600 routine and complex autopsies annually, including homicides and pediatric cases. The majority of pathologists working at the regional FPU's have completed training in subspecialty forensic pathology. Many work at the larger regional FPU's on a full-time basis.

Pathologists working in 22 community hospitals may also conduct routine autopsies pursuant to the *Coroners Act* on a fee-for-service basis (provided they are listed on the Register). The pathologists working in the community hospitals may or may not have completed subspecialty forensic pathology training.

The OFPS operates a call schedule, so any registered pathologist can seek advice or clarification from the on-call forensic pathologist at any time, even in the midst of an autopsy. This service can be accessed by calling the Provincial Dispatch. The on-call forensic pathologist also assists in managing the high-profile case notification system.

(iv) Reviews and Oversight

Since 2009, oversight of forensic pathology in Ontario has been provided in several ways. The Register was created and maintained to ensure that those performing medico-legal autopsies are properly trained and accredited to do so. Written guidelines have been created and circulated, including the 2014 *Practice Manual for Pathologists* and a code of conduct that emphasize the impartiality and independence of forensic pathology and the importance of evidence-based investigations.

Further, a quality assurance system was established, with two essential elements. The first is a formal peer review of the PME Report for all cases relating to homicides, criminally suspicious deaths, pediatric deaths, and Special Investigations Unit (SIU) cases. This substantive review determines whether the conclusions in the PME Report are reasonable. The second is an audit process, where PME Reports in routine cases are audited for administrative and technical accuracy (see below).

In addition, the chief forensic pathologist and other senior staff oversee autopsies in death investigations and can provide substantive input on where the autopsy should be performed, any special considerations that might apply, or other related case-management issues. In addition to the email communications on high-profile cases, the chief forensic pathologist also receives a daily list of autopsies performed. As chief, Dr. Pollanen reviews this list and raises any questions he may have with the pathologist who performed the autopsy. He can make directions he considers necessary, including that a second autopsy be performed.

Ultimately, however, the chief forensic pathologist cannot direct pathologists to change their opinions as to the cause of death. Dr. Pollanen testified that his legislative mandate is to “supervise and direct” but not “control” pathologists who perform autopsies in death investigations. He explained that, in his view, the chief forensic pathologist should not “have ultimate authority to trump another pathologist.” Rather, all pathologists should exercise their own professional expertise and judgment in forming their opinions as to the cause

of death. If Dr. Pollanen (or another senior staff) disagrees with the opinion provided, the case may be referred to peer review, and different opinions may then be put forward.

4. Current Statistics on Death Investigations in Ontario

Coroners investigate approximately 17–18% of the approximately 100,000 deaths each year in Ontario. The number of death investigations has remained relatively stable over the last decade, but the number of autopsies has risen in recent years. Dr. Huyer attributed this increase to the higher proportion of non-natural deaths being investigated, such as opioid-related deaths. These figures are summarized in Table 14.1.

Table 14.1: Death Investigations and Autopsies in Ontario, 2007–17

YEAR	TOTAL DEATHS INVESTIGATED	AUTOPSIES PERFORMED	% OF INVESTIGATIONS INCLUDING AUTOPSIES
2007	18,308	6,949	37.97
2008	17,528	6,591	37.60
2009	16,926	6,392	37.77
2010	16,415	6,112	37.23
2011	16,298	5,703	34.99
2012	16,576	5,708	34.43
2013	16,815	5,955	35.41
2014	15,115	5,874	38.86
2015	15,023	6,138	40.86
2016	15,899	6,858	43.13
2017	17,154	7,635	44.51

Source: Compiled by the Commission.

While the overall number of death investigations in Ontario has remained relatively stable, the number of death investigations in long-term care homes has decreased significantly over the last few years. The reasons for this decrease are discussed later in this chapter.

C. Legislative Framework

The *Coroners Act* provides the legislative authority for death investigations in Ontario. It requires every person who has reason to believe that a person died in certain circumstances, outlined in section 10 of that Act, to immediately notify a coroner (or, in some cases a police officer or a coroner) of the death. Where police officers are notified, they must immediately notify the coroner of the facts and circumstances of the death. Based on the information provided to the coroner, the coroner determines whether the death meets the statutory requirement for investigation (the section 10 criteria). Once this determination is made, section 15 of the *Coroners Act* gives the coroner authority to examine the body and conduct a death investigation. Section 15(1) reads as follows:

Where a coroner is informed that there is in his or her jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 10, the coroner shall issue a warrant to take possession of the body and shall examine the body and make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner,

- (a) to determine the answers to the questions set out in subsection 31(1);
- (b) to determine whether or not an inquest is necessary; and
- (c) to collect and analyze information about the death in order to prevent further deaths.

Dr. Huyer testified that he understands the reference in section 15(1) to the public interest to mean that, when coroners are determining whether to undertake death investigations, they must consider the public interest. In other words, Dr. Huyer's understanding is that where a death is reported and the coroner is of the opinion that the death meets the section 10 criteria, the coroner should investigate that death to the extent that it is in the public interest to do so.

1. Duty Under the *Coroners Act* to Give Information

The *Coroners Act* sets out when coroners must be notified of deaths. Section 10(1) places a duty on every person to immediately notify a coroner or a police officer if the person has reason to believe that a deceased person died

- (a) as a result of,
 - (i) violence,
 - (ii) misadventure,
 - (iii) negligence,

- (iv) misconduct, or
- (v) malpractice;
- (b) by unfair means;
- (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
- (d) suddenly and unexpectedly;
- (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
- (f) from any cause other than disease; or
- (g) under such circumstances as may require investigation.

Dr. Huyer testified that section 10(1) is intended to capture deaths that are not natural. He noted that the largest reported category of such deaths is those that occurred “suddenly and unexpectedly.” The legislation does not define this phrase and, particularly in LTC home settings, the criterion can be challenging to apply (see below).

Other provisions in section 10 of the *Coroners Act* create the obligation to give notice, to a coroner, of deaths that take place in particular settings or locations. Examples include when a person dies:

- while residing in an LTC home (section 10(2.1));
- while committed to and on the premises of a place or facility designated as a place of secure custody under the *Young Offenders Act* (section 10(4.2));
- while committed to and on the premises of a correctional institution, or off the premises but in the custody of a person employed by the institution (section 10(4.3), (4.5));
- while restrained and while detained in a psychiatric facility (section 10(4.7)); and
- where a worker dies as a result of accidents occurring in the course of employment at or in a construction project, mining plant, or mine (section 10(5)).

Dr. Huyer explained that these circumstances generally involve potentially vulnerable sectors of society or where the state exerts its authority over an individual.

Where coroners have reason to believe that a deceased person died in any of the circumstances in section 10, they must (or in relation to certain subsections, are authorized to) make whatever investigations as are, in the opinion of the coroner, necessary in the public interest to fulfill paragraphs a, b, and c of section 15(1). If the death does not meet section 10 criteria, coroners do not have the legal authority to investigate it. That said, it is important to note the breadth of subsection 10(1)(g), which empowers coroners to investigate deaths occurring “under such circumstances as may require investigation.”

2. Duty Under the *Coroners Act* to Give Information Relating to LTC Homes

Before 1995, the *Coroners Act* required that notice should be given to a coroner of every death that occurred in what were then called homes for the aged, rest homes, and nursing homes, and that the coroner should investigate every death. Amendments to the legislation in 1995 removed the requirement that all such deaths be investigated, although notice of the deaths still had to be given to a coroner who would decide whether the death ought to be investigated. It also became the policy of the OCC to investigate threshold deaths – that is, every 10th death in a long-term care home.

Section 10(2.1) of the *Coroners Act* was amended by the *Long-Term Care Homes Act, 2007*.⁶ Section 10(2.1) continues to govern and provides:

Deaths in long-term care homes

Where a person dies while resident in a long-term care home to which the *Long-Term Care Homes Act, 2007* applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

LTC homes fulfill their obligation to give notice of deaths to a coroner by sending the OCC an Institutional Patient Death Record.

⁶ SO 2007, c 8, s 201(2).

III. Notifying the Office of the Chief Coroner of Deaths in LTC Homes

A. The Purpose of IPDRs

Section 10(2.1) requires LTC homes to immediately give notice of the death of a resident to a coroner. The OCC developed the Institutional Patient Death Record (IPDR) form to help LTC homes fulfill this requirement (see Appendix D for the version in use at the time of the Inquiry). Each time a resident dies in an LTC home, someone at the home (the reporter) must complete the IPDR and submit it to the OCC. Dr. Huyer explained that the IPDR also acts as a screening tool to identify care, compliance, and infection concerns or concerns expressed by family members on the death of a loved one in an LTC home.

The IPDR requires the LTC home to answer a series of questions that will help to determine whether the death requires investigation under the *Coroners Act* – for example, whether the death was an accident, suicide, homicide, undetermined, sudden and unexpected, or if the family or care providers had raised any concerns about the care provided to the deceased. If any of the questions on the IPDR are answered “yes,” the reporter must immediately notify a local coroner of the death, with the assistance of Provincial Dispatch. The local coroner will speak with the reporter and others as deemed necessary to determine whether to accept the case for a death investigation. If all the questions on the IPDR form are answered “no,” the IPDR is simply submitted to the OCC, and no further action is required by the LTC home.

Dr. Huyer testified that he expects LTC homes to complete IPDRs immediately after the death of one of their residents. The OCC has directed LTC homes that IPDRs must be submitted within 48 hours of death.

B. The IPDR Questions

The questions on the IPDR largely reflect the section 10 criteria and the OCC’s policies regarding death reporting. The current version of the IPDR requires LTC homes to check “yes” or “no” to the following eight questions:

1. Accidental Death? (An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads

to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner).

2. Suicide? (Death due to an external factor initiated by the deceased).
3. Homicide? (Death due to an external factor initiated by someone other than the deceased).
4. Undetermined? (The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide).
5. Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable).
6. Has the family or any of the care providers raised concerns about the care provided to the deceased?
7. Has there been a recent increase in the number of deaths in your Long-Term Care Home?
8. Has there been a recent increase in the number of transfers to hospital?

The first five questions summarize circumstances in the section 10 criteria. Those criteria include the requirement that notification of a death be given to a coroner where a person has reason to believe that someone died as a result of violence, misadventure, negligence, misconduct or malpractice, or suddenly and unexpectedly. Dr. Huyer testified that while the terms accidental death, suicide, and homicide are not specifically identified in the section 10 criteria, they are examples of the types of deaths that would be investigated under that provision. In addition, he explained that question 6, relating to any care concerns expressed by the family or care providers, gives coroners important information with which to determine whether to conduct a death investigation, particularly in light of the OCC mandate to make recommendations to improve public safety and prevent similar deaths. Dr. Huyer stated that the last two questions are intended to uncover any pattern of increased illness or death because trends of this kind could lead to involvement by a coroner.

In 1995, the OCC directed LTC homes to maintain a registry of deaths (death registry), and in 2004 the OCC circulated a resident death or transfer record as a model for the homes to follow. It includes, at the top of each page, headings for “average numbers of deaths per month in this facility” and “average numbers of transfers per month in this facility,” with space left for staff to indicate the range of lowest to highest numbers. Several of the coroners testified that these figures were frequently not completed in the death registries they reviewed during death investigations. In addition, the death

registry form has no information on how these figures are to be calculated or tracked. Dr. Huyer testified that the OCC had released written memoranda over the years on these matters, but there had been no systematic approach to educate LTC home staff on them.

1. Meaning of “Sudden and Unexpected”

Since at least 2004, each version of the IPDR has included a requirement that the reporter indicate if a death was both “sudden and unexpected.” The evidence at the public hearings revealed that different individuals, and even different coroners, have varying interpretations of what constitutes a sudden and unexpected death, particularly in the context of the death of a resident in an LTC home.

The OCC has not provided written guidance on how to interpret sudden and unexpected in the LTC home context. The only direction on the IPDR form is that a death was sudden and unexpected if it was “not reasonably foreseeable.”

Dr. Huyer testified that, in his view, whether a death in an LTC home is sudden and unexpected must be determined contextually and that each case must be evaluated on its own merits. The death of an older person with several co-morbidities would generally not be sudden and unexpected, though it would depend on the circumstances of the case. He explained that the person completing the IPDR and coroners should take into account the condition of each resident and the condition or manner of death to determine if it was sudden and unexpected.

In his testimony, Dr. Mann explained the challenges of identifying when a death is sudden and unexpected in an LTC home. He stated that staff in the homes commonly ask him questions about this matter. He tells them that death is usually a sudden event, but whether it was unexpected requires examining each individual’s medical history. Dr. Mann testified that he believes this question is not easy for LTC home staff to answer.

Two local coroners testified about their interpretation of the term “sudden and unexpected.” Dr. Elizabeth Urbantke said that she understood “sudden” to refer to timing, and “unexpected” to refer to whether the death was reasonably foreseeable, based on the circumstances and the deceased’s medical history. Dr. William George testified that, in his opinion, “sudden and unexpected” was not an appropriate term in the LTC home context. He explained that resident deaths may be sudden but may also have been foreseeable or expected, owing to the resident’s co-morbid conditions. In his view, a better question is

whether the death was reasonably foreseeable, and whether the cause flowed logically from natural disease.

Dr. Huyer testified that he does not believe the term “sudden and unexpected” is helpful to many individuals working in the LTC home sector or to the general public, and he agreed that it is not a straightforward question to answer. In his view, it is appropriate for LTC home staff to contact coroners when they are not sure if a death is sudden and unexpected, so that the coroner can make that assessment.

In any event, when deaths are reported to coroners as sudden and unexpected, the coroners must apply their medical knowledge and exercise their clinical judgment to determine whether these deaths do in fact fit this description. If they deem that a death is sudden and unexpected, they should conduct a death investigation.

C. Who Completes IPDRs?

The *Coroners Act*, section 10(2.1), provides that when a resident in an LTC home dies, “the person in charge of the home shall immediately give notice of the death to a coroner.” The IPDR form stipulates that “[p]ersons in charge of such institutions” are to report such deaths to the OCC by completing and submitting the form. The OCC does not otherwise mandate or direct who at an LTC home should complete and submit IPDRs.

Dr. Huyer testified that LTC homes have each developed their own approach regarding who is to complete and submit the forms.

D. Review of IPDRs

Between approximately 2004 and the introduction of a system for electronic submission of IPDRs in 2011, LTC homes faxed the IPDRs to the OCC. Dr. Huyer testified that, to his knowledge, the administrative staff at the OCC reviewed the faxed IPDRs and forwarded those containing “yes” answers on any of the questions to the appropriate regional office for filing. If all the questions were answered “no,” the staff at the OCC simply placed the forms in a box. Dr. Huyer could not confirm whether this process of review was systematic because it predated his tenure as chief coroner.

In 2011, the OCC introduced a new electronic submission process for IPDRs, via the Service Ontario website, and notified LTC homes of the change. A few LTC homes continue to submit the forms by fax, so compliance with electronic

submission has not yet reached 100%. Dr. Huyer's best estimate is that, as of 2017, 8% of IPDRs were still being submitted by fax. If the IPDR is faxed, the data contained in the IPDR are not stored electronically.

The current electronic submission process for IPDRs requires that, if the form contains a "yes" answer, it must include the name of the coroner to whom the case was reported (via the centralized Provincial Dispatch). When an IPDR is submitted electronically, the data are stored on a SharePoint site, but it is not reviewed even if it contains a "yes" answer.

E. Changes in the IPDR Process, 2007–18

1. Reporting of Hospital Deaths

Until 2011, if a resident in an LTC home died in hospital within 30 days of being transferred to it from the home, the OCC required the hospital to submit the IPDR. The policy changed in 2011. At that time, the OCC directed that if a resident died on or off the premises of the home, so long as the resident was in the care of the home, the LTC home was responsible for completing and submitting the IPDR. Neither a home nor a hospital was required to complete an IPDR when a resident died in hospital while not under the care of staff from the home.

Dr. Huyer testified that the 2011 policy change pre-dated his tenure as chief coroner. He understands that it was made because section 10(2.1) applied to residents who died in long-term care homes. Dr. Huyer expressed some concern with this policy change because, to analyze potential trends or patterns in the rates or manner of death, complete data sets are needed. He noted that epidemiological research and data analytics should be considered in determining the appropriate cut-off date for reporting deaths after the transfer of a long-term care home resident to hospital.

2. Elimination of Threshold Death and Disease Outbreak Questions

Before 2013, LTC homes were required to answer "yes" or "no" to the following two additional questions on the IPDR:

9. If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?
10. Is this a threshold case? [The threshold was the 10th death in the LTC home, whether or not a local coroner investigated any of the previous nine deaths.]

In September 2013, these questions were removed from the IPDR form. Coroners no longer routinely investigate “threshold deaths” or deaths that occur during an infectious outbreak. The LTC home is still required to report outbreaks and outbreak deaths to the local public health unit, and a coroner will investigate an outbreak death if requested by Public Health.

Threshold death investigations were regarded as a quality assurance mechanism to fill the gap left by the elimination of mandatory death investigations in LTC homes. Analysis by the OCC showed that, as of 2013, approximately 12% of death investigations in Ontario were threshold death investigations, at an annual cost of \$900,000.

Dr. Huyer agreed with the elimination of threshold death investigations because, while no research or statistical analysis had been done regarding their efficacy, anecdotal evidence suggested they did not significantly enhance public safety. He emphasized the potential role for data analytics in increasing the presence of coroners in LTC homes. Dr. Mann testified that he had been “a bit uncomfortable” with the elimination of threshold death investigations because they had provided a coroner’s presence in LTC homes and ensured that coroners would periodically review each home’s death registry to see if it showed anything unusual.

IV. Determining Whether to Conduct a Death Investigation in an LTC Home

A. When a Coroner Must Be Contacted

LTC homes must speak directly with a local coroner if the reporter answers “yes” to any of the questions on the IPDR form.

B. How Local Coroners Are Contacted: Provincial Dispatch System

Since approximately 2011, homes have followed a particular process when they need to speak directly with a local coroner. The reporter calls the Provincial Dispatch System in Toronto, using the single number designated for this purpose. This call is the entry point to the death investigation system in Ontario. The dispatcher obtains basic demographic information from the reporter, including the deceased’s name, address, and date of birth, the person who pronounced the death, any police involvement, and the name

and contact information of the reporter. That information is recorded, and the dispatcher advises the reporter that a coroner will contact him or her directly. The dispatcher then locates a local coroner and relays the reported information. Depending on the region, Provincial Dispatch contacts the next coroner on a list on a rotating basis (often in less densely populated regions) or on a call schedule basis. If the coroner is able and available to consider the case, the dispatcher gives the coroner the reported information. If not, the dispatcher calls the next coroner on the list or call schedule. Once a coroner agrees to accept the case, the coroner is responsible for case decisions and management. Provincial Dispatch does not receive a copy of the IPDR, so the dispatcher cannot relay any information from it to the coroner.

Before the rollout of the Provincial Dispatch System, each region had a different way of contacting coroners to notify them of a death. Some regional offices, including the London Office, had their own answering services to take calls about death investigations. In creating Provincial Dispatch, the OCC used a dispatch software called Intergraph Computer Aided Dispatch (I/CAD), which had been used by the Ontario Provincial Police. The software includes the regional address of every coroner in the province, so the dispatcher simply enters the location of the deceased and identifies which coroner should be contacted.

C. A Coroner's Determination of Whether to Conduct a Death Investigation

1. The Test

After accepting a case, the local coroner conducts a preliminary consultation, described below, to determine whether the case meets the section 10 criteria in the *Coroners Act*. If it does not, typically no death investigation is undertaken. However, even if the death does not fit within the section 10(1) criteria, the coroner has the discretion to investigate the death under section 10(2.1). That section provides the coroner with authority to investigate a death in an LTC home "if the coroner is of the opinion that the death ought to be investigated."

Provincial Dispatch receives approximately 26,000 death reports annually from all sources, including LTC homes. The OCC's best estimate is that of those reported, 9,000 (or 35%) do not result in an investigation after consideration by local coroners.

2. The Process

Before deciding whether a death should be investigated, the coroner must make inquiries to determine if the section 10 criteria are met. These inquiries can include interviews with the reporter and other relevant people, including healthcare professionals, police, and/or family members. Normally, during this preliminary consultation stage, the coroner does not have access to a copy of the IPDR, though he or she is free to ask the reporter about the questions answered in the affirmative and on what basis. Nor did the coroner have the legal authority to require production of the deceased's medical records, though he or she can obtain medical information directly by asking questions of a healthcare provider or a family member.⁷ Dr. Huyer testified that, in his view, coroners need to be able to obtain enough information at the preliminary consultation stage to thoughtfully determine whether a death investigation is warranted and to be able to provide a rationale for that decision.

The *Coroner's Investigation Manual* includes the Guidelines for Death Investigation, which the OCC developed for local coroners and regional supervising coroners. The Guidelines were intended to ensure quality and consistency in death investigations by articulating the underlying principles of death investigations. The Guidelines offer the following directions to coroners as they determine whether to accept a case for death investigation:

- if the circumstances of death are clearly non-natural (accident, homicide, suicide, suspicious), the investigation must be accepted;
- where the circumstances of death have been specified under sections 10(2)–(5) (i.e., in-patient in a psychiatric facility, custody or detention, construction site or mine), the investigation must be accepted;
- where the death is apparently due to natural causes and is not subject to the above, appropriate inquiries must be made to determine if the investigation should be accepted in accordance with the section 10 criteria. Coroners should use the Natural Death Case Selection Criteria in determining whether an investigation is necessary (as described further below); and

⁷ On March 26, 2019, amendments to the *Coroners Act* came into force as part of the *Comprehensive Ontario Police Services Act, 2019*, SO 2019, c 1. One amendment added a new subsection to the *Coroners Act* – s 15(1.1) – that allows a coroner to seek information and review records about a deceased person prior to the commencement of an investigation to assist in determining whether an investigation is warranted.

- in circumstances where an investigation is not warranted pursuant to the section 10 criteria (e.g., sudden but not unexpected, medically anticipated or expected, no medico-legal concerns), the investigating coroner should not accept the case.

Beginning in September 2010, the OCC began compensating coroners for the time it takes to decide whether an apparently natural death should be investigated. To receive this payment, they have to complete and submit the Case Selection Data Form and Case Selection Invoice to their regional office, for approval by the RSC.

The Case Selection Data Form provides additional guidance for coroners as they determine whether a case requires a death investigation. It creates a framework for them to apply as they make this decision – one that also promotes consistency among coroners provincially. Dr. Huyer testified that the questions on the form are intended to help coroners collect information and apply it to the case at hand. When the forms are submitted, the RSC reviews them, both for the administrative purpose of approving payment and also as an oversight mechanism of the coroner's decision to decline to conduct a death investigation (see below).

The questions on the Case Selection Data Form (also described as the Natural Death Case Selection Criteria) are as follows:

- Was the death all natural? (i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event)
- Was the death reasonably foreseeable and does the cause flow logically from a natural disease process? [emphasis in original]
- Is there a designated healthcare practitioner to complete the medical certificate of death?
- Is the case free of significant care related concerns from either family or care providers?
- Are OCC policy and/or Section 10(2)(3) statutory obligations excluded? (Includes: child with CAS involvement (direct service in the past 12 months); threshold case for a long-term care facility ...).

The Case Selection Data Form directs that if any of these questions are answered in the negative, the coroner should investigate the death. In his testimony, Dr. Huyer agreed with this requirement.

Dr. Huyer stated that coroners are not required to use this Case Selection Data Form and submit an invoice when they decline a case, although it is a best practice to do so. He testified that coroners and the Ontario Coroners

Association had expressed concern to him about this form, explaining that the time needed to complete it was onerous and the decision whether to conduct a death investigation could be quickly made in many cases. Some coroners have told him that the time required to complete the form and submit it, along with the invoice, was not worth the payment of \$30 (for a daytime call) or \$60 (for a night-time call). In his opinion, however, coroners should submit the forms. If they fail to submit them, the OCC and the RSC are unaware of, and unable to review, coroners' decisions not to investigate deaths reported to Provincial Dispatch.

After determining whether to conduct a death investigation, the coroner is required to call Provincial Dispatch and report whether the case has been accepted. The decision will be recorded in the system, though not necessarily the rationale for the decision. Before the Provincial Dispatch System was in place, local coroners in the London Office region were not required to call the answering service back to advise of their decision.

3. Recording of Notes

Although coroners are not required to complete Case Selection Data forms when they decide against conducting a death investigation, the OCC expects them to keep notes of their preliminary consultation so that, if asked, they can articulate the reasons for their decision. This documentation should set out the date, name of the deceased, name of the reporting person, and sufficient information to identify the case and indicate why it did not require a coroner's death investigation. If they do complete and submit a Case Selection Data Form, this obligation is satisfied. This expectation is set out in the *Coroner's Investigation Manual*.

Dr. Huyer testified that he believed most coroners did not maintain this documentation for deaths they decided not to investigate. In her testimony, however, Dr. Urbantke confirmed that in her coroner's work she makes handwritten notes when she speaks to Provincial Dispatch and to the contact person(s) about a death, and that she retains those notes. She also stated that, for a period of time, she completed and submitted Case Selection Data forms because she understood that the purpose of the form was to track when coroners had been contacted but declined to investigate a death. However, once the centralized Provincial Dispatch was created, she thought that the information was being recorded, so she was no longer consistent in submitting the forms.

Dr. George testified that he, too, made notes as he spoke to the dispatcher and the contact person. However, when he decided not to accept a case for death investigation, he no longer kept the notes. He did not realize that the OCC considered it mandatory for notes to be maintained, even where a case was not accepted for death investigation. Dr. George explained that he referred to the Case Selection Data Form when he was evaluating whether to accept a case for death investigation, but he did not complete or submit the form to the RSC. He understood that submission of the form was recommended in the OCC's guidelines, but thought that its purpose was to reimburse coroners for undertaking this assessment.

4. Oversight

Neither the OCC nor the RSCs receives notification from Provincial Dispatch about the calls it makes to local coroners or the decisions the coroners make on death investigations. As a result, unless coroners submit Case Selection Data forms, the OCC and the RSC are not aware of, and do not review or provide oversight over, the decisions coroners make against investigating deaths.

Dr. Mann testified that, when a Case Selection Data Form is submitted to the London Office, he reviews the form and contacts the submitting coroner if he has any questions or requires further information. This review process has, in some instances, led him to direct a coroner to conduct a death investigation that the coroner had initially declined. He confirmed, however, that this intervention did not happen often. In some cases, local coroners ask their RSCs for advice on whether to take a case, but Dr. Huyer said these requests are rare. Dr. Mann testified that he has provided such advice to coroners and that he regarded it as part of an RSC's supervisory role.

D. Changes to the Notification System

Dr. Huyer testified that the OCC is in the process of implementing a new IT system, which will be web based and integrated with the I/CAD software. The new IT system will allow coroners to access and enter information at the scene. It will also require coroners to select a case type and, in due course, complete the corresponding template specific to that case. Over the long term, these forms will facilitate the systematic collection of information.

At the case selection phase, the new IT system will require coroners to document why they accepted, or did not accept, each case for death investigation. Dr. Huyer testified that this requirement should address current

concerns about coroners not submitting Case Selection Data forms when they decide against carrying out death investigations. With a full set of case templates generated through the new IT system, it should be possible to analyze the metrics for individual coroners and, if needed, to evaluate each coroner's process for acceptance of cases.

V. The Steps in Death Investigations in LTC Homes

The OCC created the *Coroner's Investigation Manual* to inform and assist coroners as they carry out death investigations. An electronic document, it contains several chapters that provide insight into how investigations should be conducted and incorporates policies and procedures established by the OCC.

Chapter 11 of the Manual focuses on the conduct of death investigations in LTC homes. It directs coroners to consider residents in LTC homes as a vulnerable population, and while "the vast majority of their deaths are uncomplicated, the coroner needs to be open to the possibility of injury, abuse and neglect, in the same way as one would when investigating the death of a child or other vulnerable member of society."

Dr. Huyer referred in his testimony to many reasons why individuals living in LTC homes should be considered a vulnerable population: they may have limited physical ability or cognitive impairments that limit their ability to communicate, or they may experience a higher risk of harm due to isolation. He confirmed that the ordinary approach to a death investigation in an LTC home includes attending at the home, examining the body of the deceased, reviewing the deceased's medical records, and speaking to the family and, potentially, the health practitioners working at the home. The expectation is that coroners will satisfy themselves that they have a full understanding of the circumstances of the death.

A. Attendance at LTC Homes

Once a death at an LTC home is accepted for death investigation, the coroner is expected to attend at the home within a reasonable period of time to examine the body. The Guidelines for Death Investigation provide that the coroner should complete a Warrant to Take Possession of the Body of a Deceased Person at the beginning of the investigation or as soon as practicable. This warrant establishes the coroner's authority to conduct the death investigation and to have exclusive jurisdiction to investigate the death.

B. Review of Records and Discussion with the Family

Coroners are expected to review the deceased's medical records while at the LTC home. According to Dr. Huyer, the records reviewed would be tailored to the circumstances of death; there is no standard set of records that coroners are instructed to review in all cases. In his own practice as a local coroner, Dr. Huyer reviewed, at minimum, the deceased's two most recent quarterly reviews, requirements for assistance, medications, and the records from the days before death. In some cases, he would seek clarification from family or caregivers about those pieces of information.

The *Coroner's Investigation Manual* directs coroners to identify the following points when conducting a death investigation in an LTC home:

- the date the deceased was admitted to the LTC home;
- if the death was the result of injury (e.g., complications following a hip fracture), the date and circumstances of the injury (including whether it was a fall, the deceased was pushed, and the fall was witnessed);
- any relevant incident reports (noting that they may be kept separate from the medical chart, and reminding the coroner to ask the nurse or the administrator for such reports);
- whether the deceased was managed with physical restraints and, if so, the details of this restraint (type, timing, relationship to events leading to the death, etc.); and
- whether the family has any concerns surrounding the death, or specifically regarding the care provided as it relates to the death. The *Coroner's Investigation Manual* includes in bold type: "talk to the family!"

Dr. Huyer reiterated the importance of coroners speaking to family members about the deceased, both for the purpose of explaining their involvement and to obtain information from the family that could affect the death investigation.

C. Review of the Death Registry

LTC homes are required to maintain an up-to-date death registry. It should include the death of every resident, regardless of where the death occurred, and note whether an IPDR has been sent to the OCC. The OCC circulated a memorandum to LTC homes explaining this requirement. It also created the "resident death" or "transfer record" document that LTC homes can use as their death registry. However, no particular form is compulsory for this purpose.

Coroners are directed in the *Coroner's Investigation Manual* to review the death registry during each death investigation at an LTC home. They are expected to record that they have investigated the death in the registry, so that subsequent coroners will be aware of the deaths that have been investigated by a coroner. The purpose of this review is to identify any "clustering" of deaths, such as an increase in the number of deaths per month or an increase in deaths of a specific type. Another purpose is to identify any previous deaths that should have been reported for investigation by coroners but were not, such as a death following an injury.

Dr. Huyer explained the limitations of this review: questions about the accuracy and completeness of the death registry made it difficult to identify trends and patterns. He also noted that coroners throughout the province applied different standards to the registry: some required gaps they identified to be rectified by the LTC home staff, but others did not apply this level of scrutiny and thoroughness. Further, both the local coroners who testified explained that, in their experience, staff at LTC homes did not generally complete the part of the document that references "average numbers of deaths per month in this facility" and "average numbers of transfers per month in this facility" (see below).

D. Examination of the Deceased

Dr. Huyer explained that the local coroner should conduct a head-to-toe examination of the deceased's body. The purpose of this examination is to look at the body's general status, including consideration of appearance, any injuries, signs that there may have been challenges with care, the level of hygiene, and the general environment within the room. The goal of this review is to gather as full an understanding as possible about the deceased's circumstances of living.

When examining a deceased's body in an LTC home, the *Coroner's Investigation Manual* instructs coroners to pay special attention to unique features relating to the elderly:

- hydration and nutritional status (noting that signs of dehydration and wasting have a different interpretation in a deceased who had refused intake of food and water during the terminal days);
- presence, location, and depth of decubitus ulcers (and, if present, review of the chart to determine whether they were recognized and managed appropriately);

- presence and location of flexion contractures;
- signs of injury;
- bruising (and whether it is consistent with falls as distinct from inflicted injury); and
- evidence of restraint use.

E. Determining Whether to Order an Autopsy

Section 28 of the *Coroners Act* provides the legislative authority for coroners to issue a warrant for a pathologist to perform an autopsy. Not all death investigations involve an autopsy, and autopsies are rare for deaths of residents in LTC homes. Only 8–9% of death investigations in LTC homes involve an autopsy, compared to 40% generally.

Coroners will always consider whether an autopsy should be part of a death investigation. First, the coroner will judge whether an autopsy is required; for instance, when the apparent manner or circumstances of death are homicide or criminally suspicious.⁸ If the death does not appear to be of a sort for which an autopsy is mandatory, the coroner should consider whether an autopsy would assist in understanding the circumstances of death, particularly if there are questions that can be answered only through an autopsy, such as the identity of the deceased or the cause or manner of death.

The OCC created the *Best Practice Guidelines* to assist coroners in deciding whether to order an autopsy. The *Guidelines* provide that:

- in the majority of death investigations, an autopsy is unnecessary. A thorough gathering of the facts and examination of the body are all that is required;
- it is usually sufficient for local coroners to exercise their best clinical judgment as to the cause of death, based on a balance of probabilities; and
- each case is unique, the guidelines are not a substitute for clinical judgment, and local coroners should discuss complex or problematic cases with their RSCs.

⁸ The Post Mortem Examination Ordering Decision Tool directs that autopsies of adults are mandatory for homicide, criminally suspicious deaths, SIU investigations, and cases where an inquest is likely.

The OCC has also created the Post Mortem Examination Ordering Decision Tool – a framework to help coroners decide whether an autopsy is required. Dr. Huyer explained that it is another piece of guidance for coroners to use in order to think through that decision.

When coroners order an autopsy, the *Guidelines* provide that they are required to complete the Warrant for Post Mortem Examination. This warrant gives the pathologist the legal authorization to perform the autopsy.

F. Additional Investigative Steps Coroners May Take

If coroners form the belief that records, writing, or access to a location are necessary for their death investigation, section 16 of the *Coroners Act* grants them additional investigative powers. Specifically, they may inspect and extract information from any records or writings relating to the deceased and seize anything they have reasonable grounds to believe is material to the investigation. Furthermore, coroners may issue an Authority to Enter and Inspect to gain access to any place where the body is lying or has been removed, or any place the deceased was before death.

G. Arriving at the Cause and Manner of Death, and Documenting the Coroner’s Investigation Statement

Coroners are statutorily required to determine the cause and manner of death, but their decisions may be informed by the results of an autopsy (if undertaken). The ultimate determination lies in each case with the coroner. In making this determination, coroners apply the “balance of probabilities.” Dr. Huyer described this standard as each coroner forming a reasonable belief as to the most likely cause of death, based on the investigative findings. Dr. Mann described “balance of probabilities” as being where “one interpretation or answer is more likely than another.”

The cause of death includes the direct cause and any intervening or underlying antecedent causes, as well as any other significant conditions that contributed to the death but were not related to the condition causing it.

As to the manner of death, there are only five potential categories:

- natural: from a disease process of some sort or a complication of that disease;
- accident: death from an external event that was not recognized as potentially leading to death (e.g., motor-vehicle crash, fall, drug toxicity);
- suicide: an intentional act by a person who knew that the likely consequence was death;
- homicide: the death of a person from the actions of another person; and
- undetermined: cases where the coroner, on a balance of probabilities, cannot identify one of the other categories as the manner of death.

At the conclusion of death investigations, every coroner must complete a Coroner's Investigation Statement (Form 3) – the permanent summary and official record of the death investigation, including the cause and manner of death. This statement (which may be preliminary or final) should be submitted within 30 days of death, and must be submitted within 60 days. If the first report is preliminary because information is outstanding, the final report should be submitted within 30 days of receipt of all necessary subsidiary reports (autopsy report, toxicology report, etc.). The Coroner's Investigation Statement is classified as final once the medical cause and the manner of death have been established from the investigation and no further testing or investigation is required.

Each Coroner's Investigation Statement should include a narrative that summarizes the steps the coroner has undertaken in the death investigation as well as an analysis. Dr. Huyer explained that the narrative should include the coroner's understanding of the case, the individual's medical history, the events that led to the investigation, any concerns the family may have had, and the findings of the investigation.

Oversight by RSCs includes reviewing and signing off on all Coroner's Investigation Statements prepared by coroners in their geographic jurisdiction. Dr. Mann described the steps he followed in the London Office:

- Review the Coroner's Investigation Statement and all other information submitted (possibly a PME Report; police, fire marshal, or Ministry of Labour reports; and medical records). He confirmed that IPDRs are not reviewed as part of this process.

- Consider whether the Coroner's Investigation Statement conforms with internal standards (e.g., editing the document, as necessary, to correct typos or remove extraneous information) and whether the cause of death on the statement accords with the international classification of death employed by the Office of the Registrar General for medical certificates of death. This check is important because the cause of death on the Coroner's Investigation Statement will be the same as on the medical certificate of death (Form 16). After completing a death investigation, coroners are expected to fill out the deceased's medical certificate of death, which identifies the cause of death.⁹
- Consider whether the Coroner's Investigation Statement "makes sense" – both in a medical sense and in common sense – in light of the information collected as part of the death investigation. Dr. Mann explained that he asks himself whether the cause of death logically flows from the information provided and whether it appears correct on a balance of probabilities. He will sometimes call the local coroner if he has any questions as a result of this review.
- Finalize some administrative steps: stamping a hard copy of the Coroner's Investigation Statement containing his handwritten edits and providing that copy to an assistant, who inputs the edit into the electronic system and closes the file.

The Quality and Information section of the Operational Services Branch (the support service to the OCC/OFPS) also completes some random audits of Coroner's Investigation Statements to ensure quality control. These audits are generally procedural rather than substantive – they review form and content rather than perform an independent verification of accuracy.

⁹ Affidavit of Dr. Dirk Huyer, para 83. Completion of Form 16 is also to fulfill the legislative requirement in section 18(1) of the *Coroners Act* that, where coroners determine that an inquest is unnecessary, they "shall also forthwith transmit to the division registrar a notice of death in the form prescribed by the *Vital Statistics Act*."

H. Statistics Pertaining to Death Investigations in LTC Homes

Table 14.2 sets out the number of death investigations conducted in LTC homes since 2007, and the number that involved autopsies.

Table 14.2: Death Investigations in LTC Homes in Ontario, 2007–17

YEAR	DEATH INVESTIGATIONS	AUTOPSIES
2007	3,326	160
2008	3,117	111
2009	2,907	111
2010	3,045	84
2011	2,971	77
2012	2,665	81
2013	2,031	77
2014	905	67
2015	927	81
2016*	943	91
2017*	886	86

*The years 2016 and 2017 contain preliminary figures that are subject to change once the statistical year has been completed.

Source: Compiled by the Commission.

Dr. Huyer and Dr. Mann attributed the significant decrease in death investigations in LTC homes since 2013 primarily to the elimination of threshold death investigations. Dr. Huyer agreed that this change had resulted in a significant decrease in the physical presence of coroners in LTC homes. However, he does not believe that threshold death investigations were effective or promoted public safety.

Table 14.3 sets out the number of death investigations in LTC homes in the London Office region. As a percentage of overall death investigations, death investigations in LTC homes have decreased significantly.

Table 14.3: Death Investigations in LTC Homes in the London Office Region, 2007–16

YEAR	DEATHS INVESTIGATED	LTC HOME DEATHS INVESTIGATED	% OF DEATH INVESTIGATIONS COMING FROM LTC HOMES
2007	2,831	585	20.66
2008	2,458	505	20.55
2009	2,323	427	18.38
2010	2,429	457	18.81
2011	2,259	507	22.44
2012	2,380	450	18.91
2013	2,350	302	12.85
2014	2,027	137	6.76
2015	2,056	129	6.27
2016	2,187	151	6.90

Source: Compiled by the Commission.

As Table 14.2 shows, death investigations in LTC homes are rare, and very few include an autopsy. Overall, approximately 40% of death investigations include an autopsy, whereas only about 8–9% of death investigations of residents in LTC homes include one. Dr. Pollanen attributed this underrepresentation of LTC home residents to two factors: first, the barriers to access experienced by the elderly in many ways, in both life and death; and, second, the age of residents in LTC homes and the frequency of age-related diseases skew their deaths into the “natural” death category. That means they are less likely to attract attention by the death investigation system and proceed to an autopsy.

Table 14.4 sets out the number of death investigations and autopsies conducted in the LTC homes in which Wettlaufer committed the Offences.

Table 14.4: Death Investigations and Autopsies Conducted in LTC Homes Where Wettlaufer Worked, 2007–17

	CARESSANT CARE (WOODSTOCK)		MEADOW PARK (LONDON)		TELFER PLACE	
	Death investigations	Autopsies	Death investigations	Autopsies	Death investigations	Autopsies
2007	23	2	5	0	3	0
2008	9	0	13	0	2	0
2009	8	2	7	0	3	0
2010	7	0	4	0	1	0
2011	12	1	6	0	3	0
2012	9	0	4	0	1	0
2013	8	0	3	0	1	0
2014	3	0	4	2	0	0
2015	0	0	0	0	0	0
2016	2	2	1	0	4	0
2017	0	0	1	0	1	0

Source: Compiled by the Commission.

VI. When a Death Investigation Includes an Autopsy

If, after their investigations, coroners are unable to determine the cause of death, they bring in a forensic pathologist to perform a medico-legal autopsy. The purpose of the autopsy is to provide an expert opinion of the cause of death. The 2014 *Practice Manual for Pathologists*, which includes the Practice Guidelines for Medicolegal Post Mortem Examinations, sets out a pathologist's tasks in conducting a medico-legal autopsy:

- attend or assess scenes as required before or after the autopsy;
- perform the medico-legal autopsy as directed by the Warrant for Post Mortem Examination;
- obtain assistance from any needed person in performing the autopsy and conducting other examinations and analyses;

- conduct or direct any person (other than a coroner) to conduct examinations and analyses considered appropriate;
- provide a professionally independent and impartial opinion on the cause and mechanism of death and other medico-legally relevant issues within the scope of forensic and general pathology;
- report preliminary findings to the chief forensic pathologist, the coroner, and investigators as appropriate;
- provide a final report of the autopsy and any other examinations or analyses to the coroner, the regional coroner, and the chief forensic pathologist; and
- provide expertise to the coroner's or legal system.

While the *Coroners Act* states that both coroners and pathologists may request toxicology testing in the course of a death investigation, Dr. Pollanen explained that, in his view, best practices would be for the coroner to involve a pathologist to assist in determining what (if any) toxicology testing is appropriate. One of the coroners who testified, Dr. Elizabeth Urbantke, said that she normally called a pathologist to discuss the case once she had decided to order an autopsy, and that in some instances she had called a pathologist for advice before making that decision. In these situations, she usually called the RSC first.

A. Determining the Scope of the Autopsy

When pathologists are involved in death investigations, they must first determine the scope and method of the autopsy to conduct. Depending on the case, they may consider internal and external examinations, toxicology results, additional laboratory tests, medical records, and any other relevant data. In determining the scope of the autopsy, the pathologist will consider whether:

- a complete autopsy should be undertaken or if a limited autopsy would be appropriate;
- to collect and/or submit toxicology samples; and
- to undertake any additional testing.

Complete autopsies include both external and internal examination of the deceased, while limited autopsies consist of an external examination only. Pathologists have the discretion to conduct limited autopsies, after discussion with the coroner and the RSC, when the cause of death is readily apparent by

external examination or history and the external examination did not reveal any unexpected findings.¹⁰ Dr. Pollanen testified that very few autopsies involve external examinations only.¹¹

External examinations include review and documentation of clothing and personal effects, length and weight of the body, and identifying features (e.g., colour of hair, scars and tattoos, presence or absence of teeth). In addition, pathologists examine the head, neck, torso, extremities, hands, fingers, external genitalia, and perineum in a systematic matter and record any positive findings (including evidence of natural disease).

Internal examinations involve dissection and examination of the head, brain, thoraco-abdominal organs, neck organs, and all major organs and tissues. The precise technique is left to the discretion of the pathologist.¹²

Dr. Pollanen explained that, in determining the scope of the autopsy, pathologists should obtain “as much information as they can get” – normally from the coroner and the police. Pathologists may also need access to relevant medical records, which can be obtained through the coroner.

B. Collection and Submission of Samples

The *Practice Guidelines* for Medicolegal Post Mortem Examinations set out the routine samples that must be collected by pathologists or forensic pathologists in all medico-legal autopsies, including heart blood, peripheral (femoral) blood, and urine, where available. Other samples may be collected at the discretion of the pathologist; for example, vitreous fluid (the fluid that keeps the eyeball round), and certain pieces of tissue and hair for special testing.

¹⁰ Affidavit of Dr. Michael Pollanen, para 65. Also see Affidavit of Dr. Michael Pollanen, para 66, which provides that the applicable *Practice Guidelines* also direct forensic pathologists that a limited examination should not be done when the purpose is to differentiate between natural disease and toxicological cause of death. Those cases require complete autopsies with internal examinations by dissection.

¹¹ Testimony of Dr. Michael Pollanen, Transcript, July 23, 2018, p 4992. In Toronto, the PFPU has access to advanced imaging techniques, including CT and MRI scanning, so in some cases the imaging technology can be used to limit or forgo dissection of the body.

¹² Affidavit of Dr. Michael Pollanen, para 63. The *Practice Guidelines* provide a list of cases that almost always require an internal examination, including all sudden and unexpected deaths in infants, children, and young adults (defined as mostly under 40 years of age); all homicides and criminally suspicious deaths; deaths likely due to drug or alcohol intoxication, including unexpected death in the context of chronic alcoholism; and all unexpected deaths that are likely related to complications of a therapeutic intervention or with coronial concerns about the quality of healthcare. See Affidavit of Dr. Michael Pollanen, para 64.

These samples may be submitted for toxicology testing. If they are not, the samples are stored at the Provincial Forensic Pathology Unit for up to two years.¹³ While the collection of certain samples is mandatory, their submission for toxicology testing is mandatory only for certain cases (homicide, sudden or unexpected death in a child under age five, fatal motor vehicle collision, aviation death, or fire-related deaths), and is otherwise left to each pathologist's discretion. The *Practice Guidelines* for Medicolegal Post Mortem Examinations state that toxicology analysis is not required in all autopsies and should be requested only if required for determining the cause of death or a pertinent medico-legal issue. Dr. Pollanen testified that the decision whether to submit a sample for analysis is based on the history of the case and the autopsy findings.

Pathologists request toxicology analysis in approximately 3,600 death investigations annually – some 50% of the autopsies performed by OFPS pathologists. The analysis is performed by the Centre of Forensic Sciences, a branch in the Public Safety Division within the Ministry of Community Safety and Correctional Services. The Centre of Forensic Sciences operates out of the same location as the PFPU and OCC in Toronto, although, as a distinct entity, it does not report to the chief forensic pathologist.

When pathologists submit toxicology samples to the Centre of Forensic Sciences, they must provide sufficient information about the case to permit the forensic toxicologist to decide on the type or scope of testing to be conducted. The OFPS has developed test menus, from which pathologists may select to request that specific testing be conducted by the toxicologist based on the known circumstances of death. Examples of test menus include suspected drug overdose, fire or carbon monoxide-related death, criminally suspicious death, and death in custody or at a workplace. Pathologists are directed to select all the tests that may apply to the death. In addition, pathologists may consult with the toxicologist directly to determine the appropriate testing to request.

Dr. Pollanen was asked if resources played a role in determining whether to order toxicology tests. He explained that, as in most medical practice, diagnosis relies on professional judgment, training, and expertise rather

¹³ Affidavit of Dr. Michael Pollanen, para 68. Toxicology analysis is required in all homicides, sudden and unexpected deaths in infants and children under five, workplace deaths subject to mandatory inquest, fatal motor vehicle collisions, aviation deaths, and fire-related deaths (see para 74). See also O Reg 180 under the *Coroners Act*, s 9, which sets out the retention periods for tissue samples and body fluids.

than resources alone. In his words: “You don’t want to be doing a number of irrelevant tests when the information you have indicates that the yield will be so low.”

C. Histology and Additional Laboratory Testing

Pathologists also have discretion to order histology testing (microscopic study of tissues) during an autopsy. The Practice Guidelines for Medicolegal Post Mortem Examinations state that, in deaths resulting from natural conditions, histology should be used to provide reviewable documentation of lethal diseases or lesions.

In specific cases, laboratory testing beyond histology and toxicology can also be ordered. The most common tests include microbiology, biochemistry of vitreous fluid (e.g., diabetic ketoacidosis), and genetic testing (e.g., suspected familial arrhythmic disorders in young people or genetic thrombophilias in young people with pulmonary thromboembolism).

From a pathologist’s perspective, testing for insulin is considered a laboratory test rather than a toxicology test because insulin is a naturally occurring substance in the body, not a toxin. Dr. Pollanen explained that insulin has not been included in the test menus developed by the OFPS for several reasons, as discussed further below.

D. Determining Cause of Death

When forensic pathologists are involved in death investigations, they give their opinion on the cause of death to the coroner. The coroner is ultimately responsible for determining the cause of death, which is then certified on the Coroner’s Investigation Statement and the medical certificate of death.

Dr. Pollanen explained that, because pathologists are rooted in the science and medicine of a case, their evidence in determining the cause of death differs from the coroner’s or the court’s evidence. For forensic pathologists, the cause of death must not be speculative; rather, it must be based on tested or testable evidence that can be independently validated or corroborated. Pathologists would not consider confessions, circumstantial information, or hearsay evidence. If the cause of death cannot be objectively determined based on the individual’s history and the findings on autopsy, pathologists should report the cause of death as undetermined.

Coroners, in contrast, perform a quasi-judicial function in determining the cause of death for death certification. As such, they are not limited to considering only scientific and medical evidence in making that certification.

E. Report of the Post Mortem Examination

A Report of Post Mortem Examination (PME Report) is prepared at the end of every medico-legal autopsy. To ensure consistency, the OFPS developed standardized headings for these reports. They must include all test results as well as the Warrant for Post Mortem Examination. After completion, copies of the reports are sent to the coroner, the RSC's office, and the chief forensic pathologist.

All PME reports on homicide, criminally suspicious, pediatric, and Special Investigations Unit (SIU) cases are subjected to peer review before they are released to the coroner and other entities. Some reports in routine cases are audited for administrative and technical accuracy by the medical directors of regional Forensic Pathology Units (routine cases in their units) or the chief forensic pathologist or designate (routine cases in community hospitals). An administrative audit reviews completeness and adherence to guidelines for all community hospital PME reports and 10% of routine regional FPU PME reports. A technical audit reviews the content of the report to ensure that the approach, conclusions, and opinions are appropriate and derive from the evidence. In general, 10% of routine PME reports undergo a technical audit, including every PME Report that falls into three categories: cases with an undetermined cause of death; non-traumatic and non-toxicologic deaths of individuals younger than age 40; and reports from pathologists performing fewer than 20 autopsies per year.

F. Post Mortem Examinations in LTC Home Death Investigations

As a practical matter, very few death investigations of LTC home residents involve an autopsy. In 2015, the most recent year with finalized statistics, of the 927 death investigations conducted on LTC home residents, 81 included autopsies. In that year, a total of 15,023 death investigations were conducted, of which 6,138 included autopsies. Accordingly, about 1% of the medico-legal autopsies that year were in the LTC home context.

Dr. Pollanen estimated that these figures are within the range of the autopsy rate for older people dying under similar circumstances in the community.

VII. Challenges in the Post Mortem Detection of Hypoglycemia

After death, it is challenging to identify hypoglycemia through laboratory testing. Hypoglycemia occurs when a person's blood glucose levels go too low. Blood glucose is a simple sugar that bodies need for fuel. Humans naturally produce two substances that stabilize glucose levels: glucagon and insulin.

Insulin is a hormone that lowers the level of glucose in the blood, whereas glucagon is a hormone that increases the level of glucose in the blood. Synthetic insulin is prescribed to individuals, such as diabetics, who do not naturally produce sufficient insulin to properly regulate glucose levels.

The brain is vulnerable to a drop in blood glucose levels. Hypoglycemia can be caused by many factors, including eating too little food or exercising more than normal, or by more significant clinical causes such as certain types of tumours or the administration of excess insulin. Symptoms of mild hypoglycemia include confusion, shakiness, anxiety, increased heart rate, weakness, and reduced levels of consciousness. Severe hypoglycemia can result in hypoglycemic encephalopathy – irreversible brain damage, followed by coma and death. No mechanism exists at present to diagnose hypoglycemia by using samples from a dead body. Blood glucose levels drop rapidly after death (though, depending on where the blood sample is taken, blood glucose may actually appear higher after death). As a result, blood glucose is not normally tested during autopsies. Even if blood glucose testing were done within an hour of death, no meaningful information could be obtained.

In addition, the Centre of Forensic Sciences does not currently have the instruments or process to perform insulin testing. Dr. Pollanen explained that if insulin testing is requested, the Centre has to send the sample to an off-site laboratory. To his knowledge, that happens only rarely – perhaps once every few years.

Even if the Centre were to develop a method and acquire the instruments needed for insulin testing, insulin and its analogues are susceptible to degradation, both in the body after death and in stored samples. Samples would need to be recovered from a body as soon as possible following death and immediately frozen for storage. Post-mortem blood samples also

contain products or artifacts that can affect the results of this testing. In short, the results of any testing might not meet the forensic requirements for reproducibility and reliability.

Dr. Pollanen testified that there are other practical challenges to identifying hypoglycemia, caused by insulin administration, through laboratory testing in Ontario. Pathologists order toxicology and laboratory testing only when they have reasons to do so, and they would have to find significant indicators in a deceased's medical history before they would consider insulin testing as part of a death investigation. Moreover, as happened for victims of the Offences, deaths from insulin administration can occur days after the administration of insulin, and that passage of time can make detecting insulin virtually impossible. Finally, insulin is a naturally occurring substance in the body. Although it is possible to distinguish between natural and synthetic insulin, changes that occur after death can make that distinction challenging.

Dr. Pollanen explained that a diagnosis of hypoglycemia could possibly be corroborated or inferred through an autopsy if the deceased suffered from hypoglycemic encephalopathy – a condition that may result in distinct but subtle brain tissue damage. Dr. Pollanen stated, however, that this diagnosis can only be detected through careful dissection and analysis, usually by sending the brain to a neuropathologist.

Overall, Dr. Pollanen concluded, it was very unlikely, without other information to trigger an investigation, that a pathologist would detect a death caused by hypoglycemia due to insulin injection. Even if 100% of death investigations in LTC homes resulted in autopsies, unless a particular death presented as a potential insulin-related death, it is unlikely that the autopsies would produce any evidence that would lead to further toxicology or laboratory testing. Most residents in LTC homes have chronic and potentially fatal medical conditions that could explain their deaths, and the investigating coroners and pathologist would probably not request further investigations to ascertain the cause of death.

VIII. The OCC's Contemporaneous Involvement with the Wettlaufer Victims

A. Receipt of the Victims' IPDRs

The OCC's involvement with Wettlaufer victims was limited to receiving Institutional Patient Death records (IPDRs) for the victims who died in LTC homes. The OCC also received Coroner's Investigation statements for two of the victims who were the subject of death investigations, discussed below. Those documents would have been handled by the OCC in the usual way. Because none of the Wettlaufer victims were the subject of an autopsy, neither the OFPS nor any forensic pathologist was involved at the time of their deaths.

For the eight murder victims, seven IPDRs were submitted to the OCC, although one of those forms cannot at present be located. It appears that no IPDR was submitted for Arpad Horvath, who died in hospital in 2014, three years after the OCC stopped asking that hospitals submit IPDR forms.

Local coroners were contacted in relation to three of the victims: James Silcox (August 2007), Wayne Hedges (January 2009), and Maureen Pickering (March 2014). Two of these deaths resulted in death investigations.

B. James Silcox

1. The IPDR

Mr. Silcox died at Caressant Care (Woodstock) on August 12, 2007, following what we now know was Wettlaufer's fatal administration of insulin on the evening of August 11, 2007. In the spring of that year, Mr. Silcox had suffered a stroke, which led to a four-month stay in hospital. Shortly after his admission to Caressant Care (Woodstock) on July 25, 2007, he fell and fractured his right hip, and he underwent repair surgery at the Woodstock General Hospital on August 4, 2007. He returned to Caressant Care (Woodstock) on August 10, 2007, and passed away two days later.

In the IPDR Wettlaufer completed on the day Mr. Silcox died, she answered "yes" to two of the questions on the form: "Accidental Death?" and "Is the death both sudden and unexpected?" Handwriting on the IPDR states that the form was faxed to the OCC on August 12, 2007. The IPDR indicates that the local coroner who was contacted in respect of Mr. Silcox's death was Dr. William George.

2. Dr. George's Death Investigation

Early on the morning of August 12, 2007, at 05:15, Dr. George was notified of Mr. Silcox's death by the coroners' answering service in place at that time.

Dr. George practises family medicine and has additional training in anesthesia and dermatology. Since his appointment as coroner in 2004, he has performed coroner work part time along with his medical practice. Dr. George testified that he had no independent recollection of his death investigation of Mr. Silcox. He gave evidence based on his general practice and his review of the records.

Dr. George stated that when Provincial Dispatch (or, before 2011, the coroners' answering service) contacted him about a death, the dispatcher gave him the name and birth date of the deceased as well as contact information for the person who reported the death. He might then consult hospital or family health team records, if he could access them electronically through his medical practice, but he would not have access to records in LTC homes. I note that during the preliminary consultation phase, coroners do not have the legal authority to access the deceased's medical records, but both the local coroners who testified at the public hearings said they did, when the records were available electronically, to help inform their decision-making. Dr. Huyer testified that it would be helpful for coroners, the regional supervising coroners, and the OCC to have access to these records to assist with the investigative system, provided this access was within the parameters of privacy protection. Since the March 26, 2019, amendments to the *Coroners Act*, this access has been permitted.

Dr. George stated that he then contacted the IPDR reporter to obtain a summary of the circumstances of the death as well as the deceased's medical history, medications, and previous level of functioning. When a resident in an LTC home died, Dr. George would ask about the final illness or final days, to get a sense of what had happened and to try to determine if the death was expected. Dr. George would also ask the reporter which questions on the IPDR had been answered in the affirmative.

Dr. George determined that a death investigation was warranted because Mr. Silcox's death may have been accidental, given the history of the fall and the subsequent fracture. Dr. George accepted the case for investigation, and he arrived at Caessant Care (Woodstock) at 06:45.

Dr. George explained that his general practice was to go to the ward within the LTC home where the death occurred and, if death had not already been

pronounced, to do so. He would then conduct an examination of the body, noting how the individual was positioned and clothed as well as its general nutritional status, lividity (colour), rigor (stiffness), and body temperature, assessing whether there were any marks of external violence. He also surveyed the room to see if there was anything of concern. In his Coroner's Investigation Statement, Dr. George noted that Mr. Silcox was lying supine in bed, with no marks of external violence, that rigor was absent, and there was blanching.

After completing the physical examination, Dr. George would proceed to the nursing station to review the deceased's medical chart (including the progress notes for the last period of illness, medication profile, and consultation reports) and the LTC home's death registry. In his Coroner's Investigation Statement, Dr. George noted that Mr. Silcox had been recently admitted to the LTC home and had co-morbid conditions, including several that made him prone to falls. Dr. George documented Mr. Silcox's history of a fall and surgical repair in hospital before being transferred back to Caressant Care (Woodstock) on August 10, 2007.

Finally, Dr. George would speak to the family, if present, or he would phone the family contact person, to find out additional information and determine if they had any concerns.¹⁴ Sometimes he also spoke to the attending physician or the nursing staff to see if they had any additional information to provide.¹⁵ In Mr. Silcox's case, Dr. George documented: "His death was discussed with family; they had no concerns."¹⁶

At the public inquiry, evidence from Mr. Silcox's daughter and power of attorney was filed. It stated: "At no time did I, or my mother [Mr. Silcox's wife], or other members of our family have discussions with the Coroner on August 12, 2017 [sic] about my father's death."¹⁷ Dr. George testified that there may have been instances where he would have asked a caregiver, rather than

¹⁴ Testimony of Dr. William George, Transcript, July 18, 2018, pp 4697–99, 4721–22.

¹⁵ Testimony of Dr. William George, Transcript, July 18, 2018, pp 4701–02.

¹⁶ This was documented in the Coroner's Investigation Statement (Form 3) completed by Dr. George in respect of Mr. Silcox's death. It is contained as a source document in the *Overview Report – Office of the Chief Coroner and the Ontario Forensic Pathology Service*, which was prepared by Commission Counsel and filed as an exhibit at the beginning of the public hearings. The source documents for the Overview Report are available at <https://longtermcareinquiry.ca/en/exhibits/>. During testimony, Dr. George noted that he has no specific recollection of the Silcox case, but testified that it was his usual practice to speak with the family: see Testimony of Dr. William George, Transcript, July 18, 2018, pp 4721–22.

¹⁷ Affidavit of Dianne Crawford, para 10.

speaking to a family directly, to determine if the family had any concerns. He agreed that it was always best practice to attempt to speak with the family directly.¹⁸

According to the evidence of Mr. Silcox's daughter, she spoke with Wettlaufer at Caressant Care (Woodstock) the morning of her father's death and asked whether the coroner would perform an autopsy. She explained she was concerned that he had passed away only nine days after surgery. She indicated that, in response, Wettlaufer said the coroner was unlikely to perform an autopsy in the case and suggested she contact the coroner in four to six weeks to request his report. When she did follow up within that time frame, she found the coroner to be dismissive of her concerns. (The evidence did not confirm which coroner she may have spoken to, whether Dr. George, the RSC at the London Office before Dr. Mann's appointment, or someone else.)¹⁹

Dr. George identified the medical cause of death on the Coroner's Investigation Statement for Mr. Silcox as "complications of fractured right hip," with Alzheimer's, diabetes, and cerebrovascular disease each listed as contributing factors. This cause of death was also included by Dr. George on the completed medical certificate of death. Dr. George determined that the primary event was the fall and the hip fracture. Based on the medical history and co-morbid conditions, Dr. George was satisfied that it was "very likely" that Mr. Silcox's death resulted from complications following the fall in which his hip was fractured. He did not consider ordering an autopsy because he did not believe that anything would be gained by it.

C. Wayne Hedges

1. The IPDR

Mr. Hedges died at Caressant Care (Woodstock) on January 24, 2009. We now know that Wettlaufer intentionally overdosed Mr. Hedges with insulin in October 2008 and, after he became hypoglycemic, administered medication to restore his glucose levels. He subsequently died of unrelated causes approximately three months later.

¹⁸ Testimony of Dr. William George, Transcript, July 18, 2018, pp 4721–22.

¹⁹ Dr. Mann was not the RSC at the time of Mr. Silcox's death and, as such, he had no involvement in the death investigation and did not review and finalize Dr. George's Form 3. See Affidavit of Dr. G. Richard Mann, para 52.

An RN at Caressant Care (Woodstock) completed an IPDR on the day of Mr. Hedges's death and answered "yes" to two of the questions on the form: "Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution?" and "Is this a threshold case (threshold is every 10th death [for most institutions] whether or not a local coroner investigated any of the previous nine deaths)?"

As a result of the affirmative responses on the IPDR, staff at Caressant Care (Woodstock) phoned the coroners' answering service at or around 01:05 on January 24, 2009, to report Mr. Hedges's death. Given that it was a threshold investigation case, the coroner would have had no discretion in whether to accept it for death investigation. The OCC policy in place at that time required that all threshold deaths be investigated. The IPDR confirms that Dr. Elizabeth Urbantke was the local coroner who was contacted about this death.

2. Dr. Urbantke's Death Investigation

Dr. Urbantke is an emergency room physician at the Woodstock General Hospital. She was appointed a coroner in 2004 and performs her coroner work part time along with her medical practice. After she was contacted about Mr. Hedges's death, she phoned Caressant Care (Woodstock) at approximately 01:56 on January 24, 2009. Dr. Urbantke testified that she did not have any recollection of her involvement in this investigation and gave evidence based on her usual practice and her review of the records.

When she spoke to the reporter at Caressant Care (Woodstock) in that initial call, Dr. Urbantke told her that she would not be able to attend to pronounce the death until the morning at the earliest, but likely not until early afternoon. She requested that the reporter contact the on-call physician to pronounce the death. When she arrived at the home, she said, she would need Mr. Hedges's chart and the death register to review.

The on-call physician attended and pronounced Mr. Hedges's death at or around 08:15 on January 24, 2009, and his body was released to the funeral home at or around 09:20 that same morning. The time of Dr. Urbantke's attendance at the home is not noted on the Coroner's Investigation Statement or in the medical records, and Dr. Urbantke could not confirm when she arrived at Caressant Care (Woodstock) to conduct the death investigation. She testified, however, that her general practice was to attend as soon as possible and not to complete a death investigation without undertaking a physical examination of the body.

Dr. Urbantke completed a Warrant to Take Possession of the Body of a Deceased Person. On arrival at an LTC home, she normally went first to the deceased's room to examine the body. Her examination included a head-to-toe examination and a quick inspection of the room. Her second stop would be at the nursing station – to review the medical records, the resident's medical history, medications, and any incidents potentially related to the death.

Dr. Urbantke made handwritten notes during the course of her death investigation. In Mr. Hedges's case, she documented physical findings pertaining to skin ulcers, which she believed she observed during her physical examination of the body, as well as his past medical history and medications. She did not document contacting any health practitioners to discuss Mr. Hedges, but it is possible she did so.

On the Coroner's Investigation Statement for Mr. Hedges, Dr. Urbantke certified the medical cause of death as cerebrovascular accident (more commonly known as a stroke), with diabetes as a contributing factor. She made this determination based on Mr. Hedges's previous medical history of a stroke and the symptoms he exhibited in the two days before his death, including a decreased level of consciousness, inability to swallow, and unilateral (one-sided) drooling. Dr. Urbantke explained that these symptoms are consistent with a stroke, while diabetes is a risk factor for hardening or narrowing of the arteries. She reported on the Coroner's Investigation Statement that the family had no concerns – information she would have ascertained after speaking to the family.

Dr. Urbantke testified that she would not have considered ordering an autopsy in this case. On a balance of probabilities, she would have felt that the cause of death was a stroke. The on-call physician who pronounced Mr. Hedges's death completed his medical certificate of death. Dr. Urbantke could not confirm why she had not filled it out, but she said that she would have reviewed the certificate in the course of her investigation and would have redone it if she had disagreed with the cause of death identified by the on-call physician.

Dr. Mann, as the RSC for the London Office, would normally have reviewed and finalized Dr. Urbantke's Coroner's Investigation Statement. However, in this case, another RSC undertook the review process. Dr. Mann did not recall the circumstances but testified that colleagues assist one another with closing cases at times.

D. Maureen Pickering

1. Ms. Pickering's Hospitalization and Dr. Urbantke's Concerns

On March 23, 2014, at 10:50, an RN at Caessant Care (Woodstock) found Ms. Pickering to be unresponsive, diaphoretic (sweaty), and cold and clammy. Earlier that morning, Ms. Pickering had been responsive to questions but drowsy, and the RN was unable to determine when her status had deteriorated. Staff called an ambulance, which arrived at 11:15 to transfer Ms. Pickering to the Woodstock General Hospital. We now know that Wettlaufer administered two insulin injections to Ms. Pickering about two-and-a-half hours apart on the evening of March 22, 2014.

Dr. Urbantke was the emergency room physician who provided care to Ms. Pickering on her arrival at the hospital at approximately 11:46 on March 23, 2014. At the public hearings, Dr. Urbantke had no recollection of her involvement in Ms. Pickering's care, but she provided evidence based on her normal practice and Ms. Pickering's medical records.

When she arrived at the hospital, Ms. Pickering was taken to a trauma (resuscitation) room – the usual procedure when a patient is very sick. Dr. Urbantke obtained Ms. Pickering's medical history: that she was a resident in an LTC home, aged 78, who that morning had been found by staff to be unresponsive and with a blood glucose level of 0.4. The paramedics had injected Ms. Pickering intravenously with 1 amp of D50W (sugar water) to bring up her blood sugar, and her blood glucose level had risen to 4.6. The paramedics gave Ms. Pickering a second dose of D50W before her arrival at the hospital.

Dr. Urbantke explained that she would have examined Ms. Pickering and ordered laboratory investigations and a CT scan of the head. The CT scan revealed a possible infarct of pons – a stroke.

At approximately 17:00, Dr. Urbantke contacted Caessant Care (Woodstock) to provide an update on Ms. Pickering's status. After speaking to Wettlaufer, she documented Ms. Pickering's status in the hospital record: Ms. Pickering was to receive comfort measures and had a DNR (do not resuscitate) order. Because Ms. Pickering remained unresponsive and was in poor condition, Dr. Urbantke also gave orders to the LTC home to hold oral medications and to administer certain medications by injection – a palliative approach to ensure that comfort measures were taken.

Dr. Urbantke testified that she had a second reason to contact Caressant Care (Woodstock): she could not explain Ms. Pickering's low blood sugar, and she asked the home to contact a coroner if Ms. Pickering passed away. Dr. Urbantke testified that she believed she was concerned that the unexplained low blood sugar could have resulted from a medication error, but not from any suspicion of intentional harm.²⁰

Dr. Urbantke could not recall whether she had one or two separate discussions, but she presumed there was only one. Wettlaufer documented two entries regarding this discussion with Dr. Urbantke in Ms. Pickering's progress notes at the home:

17:11: Call received from Dr. Urbantke from Woodstock Hospital at 17:00. Maureen continues to be unresponsive and tests show the possibility of a "mid brain" stroke. Maureen will be coming back to us this evening in a palliative state. Orders received for comfort measures only, hold all p.o. meds, ativan sub q prn and hydromoph sub q prn.

17:21: Dr. Urbantke mentioned that Maureen's blood sugar was extremely low when she arrived at the hospital and the cause is unknown. She stated that if Maureen passes it "might be a good idea to call the coroner on this one."

Ms. Pickering was discharged from hospital later that evening and returned to Caressant Care (Woodstock). Dr. Urbantke's diagnosis on discharge was severe hypoglycemia due to Ms. Pickering's "very low blood sugar of 0.4." Dr. Urbantke testified that a normal blood sugar in a non-diabetic patient would be about 4 to 6. Ms. Pickering subsequently died at Caressant Care (Woodstock) five days later, on March 28, 2014.

2. The Involvement of Provincial Dispatch

On March 28, 2014, at 8:28, Provincial Dispatch received a call from Karen Routledge, an RN at Caressant Care (Woodstock), reporting that Ms. Pickering had died. The I/CAD records show that the dispatcher spoke with Ms. Routledge and was advised that Ms. Pickering had gone to hospital, where she was found to have low blood sugar. The records also state: "Dr. Urbantke (one of our coroners) advised the nursing home to call this case in once she dies not sure if there is more to it or not."

²⁰ Testimony of Dr. Elizabeth Urbantke, Transcript, July 19, 2018, pp 4864, 4878.

The dispatcher contacted Dr. Urbantke to assign her the case. The records indicate that they spoke at 08:37. Dr. Urbantke confirmed that Ms. Pickering's blood sugar was "less than 1 and was unexplained," but that she could not accept the case because she had provided care to Ms. Pickering. The record stated that Dr. Urbantke "will speak to the coroner to give more background information."²¹ At the public hearings, Dr. Urbantke stated that she had no recollection of being contacted by Provincial Dispatch about Ms. Pickering's case. She confirmed that she would have declined the case because, given her recent involvement with Ms. Pickering as a treating physician, it would have been a conflict of interest for her to investigate the death.²²

The I/CAD software generated the next coroner for the dispatcher to contact, which in this case was Dr. William George. The dispatcher immediately contacted Dr. George. There is no record of what information Dr. George received, but the dispatcher gave evidence by affidavit at the public hearings that she normally provided the coroner with all the information she had regarding the circumstances of death. Dr. George accepted the case.

Dr. George testified that he had no recollection of receiving a call about Ms. Pickering from Provincial Dispatch or of his involvement in her case. He did not maintain any records of his discussion with the dispatcher. He testified that he normally made notes on a pad of paper as he spoke to the dispatcher and the reporter, but he did not keep those records for longer than a couple of weeks if he decided to not accept a case for a death investigation. He did not realize that the OCC considered maintenance of notes to be mandatory, even when a case was not accepted for death investigation.

Dr. George accepted that he would have been advised by the dispatcher that Ms. Pickering was found to have low blood sugar and that Dr. Urbantke thought a coroner should be called if she died.

Neither Dr. Urbantke nor Dr. George can recall whether they spoke to each other on March 28, 2014, about Ms. Pickering's death.

3. The IPDR

The IPDR for Ms. Pickering's death was completed by Ms. Routledge. Each of the eight questions on the form was answered in the negative.

²¹ Affidavit of Noelle Kelly, para 5c.

²² Testimony of Dr. Elizabeth Urbantke, Transcript, July 19, 2018, pp 4865–66.

Ms. Routledge testified that she answered “no” to the question whether the death was sudden and unexpected because of her understanding, from the hospital, that Ms. Pickering had suffered a stroke. She said she completed the IPDR after speaking to Dr. George, and the fact that he, as coroner, was not alarmed by the information she reported influenced her decision to answer that question in the negative. Ms. Routledge agreed that it made sense to her that further investigation was not warranted. The documentary evidence suggests that, on March 28, 2014, Ms. Routledge submitted the IPDR at or around 09:35 and spoke to Dr. George at 09:50. The timing suggests it is possible that Ms. Routledge submitted the IPDR before she spoke to Dr. George. Alternatively, they may have spoken twice.

4. Dr. George’s Decision to Not Perform a Death Investigation

Ms. Routledge testified that she informed Dr. George that Ms. Pickering had been seen in hospital five days previously and that medical staff there had concerns about her unexplained extremely low blood sugar. Ms. Routledge also discussed with Dr. George Ms. Pickering’s medical history and co-morbidities and the possibility that she may have suffered a stroke. Although he did not recall the discussion, Dr. George agreed that it would have been his practice to obtain a patient history from the reporter.

The medical records indicate that, at 09:50, Dr. George contacted Caressant Care (Woodstock) and relayed to Ms. Routledge that, in his opinion, this death was not a coroner’s case. Dr. George testified that he normally called a reporter to speak about a death almost immediately after he hung up with Provincial Dispatch (which, in this case, would have been at or around 08:37). For this reason, he believed that he may have initially contacted Ms. Routledge, then gathered more information about Ms. Pickering’s admission to the hospital (by contacting the hospital, either the emergency department or the medical records department), before calling Ms. Routledge again at 09:50 to report that he would decline the case.²³

Dr. George now believes that, based on Ms. Pickering’s medical history, including the fact that she had been in palliative care and had experienced a stroke evidenced on a CT scan, he did not feel this death was a coroner’s

²³ Testimony of Dr. William George, Transcript, July 18, 2018, pp 4732–33. The I/CAD software automatically notified dispatchers to follow up on a case where it had been left open for five hours. At 13:44, the dispatcher was alerted by that I/CAD alarm to follow up with Dr. George. She extended the alarm by 100 minutes. At 15:19, the I/CAD records indicate that the dispatcher spoke to Dr. George. The record of that discussion states: “Has determined that no coroner is required.” Immediately thereafter, the dispatcher closed the case. See Affidavit of Noelle Kelly, para 5g.

case. He would have been aware that she had a single low blood sugar result, though, in his understanding, an individual would need to have a prolonged period of low blood sugar to experience hypoglycemic encephalopathy. As such, he would not have been concerned that the apparent stroke on the CT scan had been caused by hypoglycemic encephalopathy.

Dr. George also testified that he would have considered why Ms. Pickering's blood sugar had been extremely low on March 23. The possibilities included a medication error or a side effect of Ms. Pickering's medications (several of which could accentuate hypoglycemia). However, Dr. George agreed that, if an individual's death could have been precipitated by a medication error, it should have been investigated by a coroner. It would appear, then, that he did not think at the time that Ms. Pickering's death was related to a potential medication error.²⁴

Dr. George was asked at the public hearings whether, in retrospect, he believes he should have investigated Ms. Pickering's death. He testified that he did not believe a death investigation was warranted as her death was foreseeable and expected, given her palliative status and the fact that he understood she had suffered a stroke.²⁵ Because no Case Selection Data Form was submitted, there was no review of Dr. George's decision not to investigate Ms. Pickering's death. The RSC would not have been aware that the case was considered and declined for death investigation.

5. Was This Case a Missed Opportunity?

At the public hearings, Dr. Pollanen expressed his belief that Ms. Pickering's case was a "missed opportunity."²⁶ He explained that it was known she went into a coma after profound hypoglycemia. This was an indication to explore the cause and to determine if the hypoglycemia and coma were related. An autopsy to look for evidence of hypoglycemic encephalopathy would have been the appropriate mechanism to determine if those two events were related. If the death could be explained on the basis of brain damage caused by hypoglycemia, it could have been the first step to getting to the correct answer of how the hypoglycemia occurred.²⁷

²⁴ Testimony of Dr. William George, Transcript, July 18, 2018, pp 4738–39. Dr. George testified that if an individual experiences a solitary event of unexplained severe hypoglycemia which is corrected, he does not believe the case should be investigated further (pp 4765–66).

²⁵ Testimony of Dr. William George, Transcript, July 18, 2018, p 4739.

²⁶ Testimony of Dr. Michael Pollanen, Transcript, July 23, 2018, p 5108.

²⁷ Testimony of Dr. Michael Pollanen, Transcript, July 23, 2018, pp 5109–10.

IX. The OCC/OFPS's Retrospective Involvement with the Wettlaufer Victims

A. Initial Involvement and Dr. Pollanen's First Report

The Office of the Chief Coroner first became aware of the Offences when Dr. William George was contacted by the local police in September 2016. Dr. George notified Dr. G. Richard Mann, regional supervising coroner of the London Office, of the police investigation.

Based on the information provided to him about Wettlaufer's confession, Dr. Mann concluded that the section 10 criteria in the *Coroners Act* had been met in respect of the eight murder victims. He issued a Coroner's Authority to Seize During an Investigation to both Caressant Care (Woodstock) and Meadow Park (London) long-term care homes requesting relevant medical records. Dr. Mann also created Preliminary Coroner's Investigation statements on the Coroner's Information System (the current provincial database accessible by the OCC and regional offices, which will be replaced by a new web-based IT system) for each of the murder victims for whom no Coroner's Investigation Statement yet existed.

Dr. Huyer, the chief coroner, subsequently became aware of the police investigation. He decided to centralize the involvement of the OCC and the Ontario Forensic Pathology Service to ensure that the appropriate expertise was used. He consulted with Dr. Pollanen, the chief forensic pathologist, and they agreed that Dr. Pollanen should take the lead on the retrospective investigations to determine cause of death.

At the request of the Crown attorney involved in Wettlaufer's criminal prosecution, Dr. Pollanen reviewed the medical records of the eight (then alleged) murder victims and recommended that the bodies of Arpad Horvath and Helen Matheson undergo exhumation and autopsy. Dr. Pollanen hoped that the embalming would have been of a sufficiently high quality that these autopsies would reveal clinically significant information – namely, evidence of hypoglycemic brain damage.

Each of the other murder victims had been cremated, so their remains were not available for further autopsy investigations. Dr. Pollanen prepared an initial report based on his review of the medical records and before the exhumations. In that report, he concluded:

- In the case of Ms. Pickering, the underlying cause of death was hypoglycemic brain damage.
- In the cases of Mr. Granat, Ms. Millard, and Ms. Young, the cause of death was unknown. He had not been able to decide whether insulin played any role in causing the deaths. He noted that each case had non-specific signs and symptoms of hypoglycemia, but the reliability of inferring hypoglycemia from that evidence was not known.
- In the cases of Mr. Silcox and Ms. Zurawinski, the cause of death was unknown. He was undecided as to the role of insulin in causing the deaths, and there was no clear medical evidence of hypoglycemia.
- In the cases of Mr. Horvath and Ms. Matheson, exhumation and autopsy were required to determine if hypoglycemic encephalopathy was present.

B. Post Mortem Examinations and Reports

In response to Dr. Pollanen's recommendation that the remains of Mr. Horvath and Ms. Matheson be exhumed, Dr. Mann issued warrants for the autopsies. They took place in January 2017, and Dr. Pollanen completed his Post Mortem Examination (PME) reports in May 2017.

In both cases, Dr. Pollanen could not arrive at a definite cause of death based on scientific principles. He did not rely on the confession evidence in his analysis. Owing to the limits of the available scientific evidence, he ultimately stated that, in his opinion, the cause of death was undetermined.

With Mr. Horvath, Dr. Pollanen found that his body was moderately well preserved. Toxicology testing could not be done because of the embalming. The autopsy consisted of a detailed examination of the body, macroscopically and microscopically. The heart and brain were examined by a cardiac pathologist and a neuropathologist, respectively. In his medico-legal report, Dr. Pollanen gave this analysis of Mr. Horvath's case.

- The sequence of events leading to death began with hypoglycemia. Death occurred seven days later, following a coma.
- The hypoglycemia could have caused the coma and could corroborate the putative administration of insulin. Another possible explanation was hypoglycemia from oral hypoglycemic medication.
- Hypoglycemic encephalopathy was a possible cause of death. However, the neuropathologic evidence was only suggestive, not definitive.

- Overall, based on the limitation of the autopsy and the lack of insulin testing at the time of the initial hypoglycemic episode, the cause of death was undetermined.

With Ms. Matheson, her body was too decomposed to determine cause of death. The autopsy similarly consisted of a detailed examination of the body, and the brain and heart were examined by a cardiac pathologist and a neuropathologist, respectively. In Dr. Pollanen's opinion, death could have been due to endometrial carcinoma and Alzheimer's disease. He noted that the body was too decomposed to determine if any findings were present that could corroborate the history of non-therapeutic insulin administration. Again, he assigned the cause of death as undetermined.

Dr. Huyer ultimately completed the Coroner's Investigation statements for the murder victims based on the information contained in the Agreed Statement of Facts, following the criminal proceedings, and on Dr. Pollanen's PME reports for Mr. Horvath and Ms. Matheson. He explained that the Coroner's Investigation statements were not representative of detailed investigations but, rather, were a summary of information so that the case management system had full documentation of the findings related to the deaths. As the RSC in the region where the deaths occurred, Dr. Mann reviewed and signed off on the Coroner's Investigation statements.²⁸

Dr. Huyer certified the cause of death of each of the murder victims as follows:

- Maurice Granat: hypoglycemia due to or as a consequence of the intentional administration of exogenous insulin.
- Arpad Horvath: complications of hypoglycemia due to or as a consequence of the administration of exogenous insulin, with a contributing factor of diabetes.
- Helen Matheson: complications of hypoglycemia due to or as a consequence of the administration of exogenous insulin, with a contributing factor of endometrial carcinoma.
- Gladys Millard: hypoglycemia due to or as a consequence of the intentional administration of exogenous insulin.
- Maureen Pickering: complications of hypoglycemia due to or as a consequence of the administration of exogenous insulin.

²⁸ Affidavit of Dr. G. Richard Mann, para 59. Dr. Mann stated that to finalize the Form 3s, he reviewed the PME reports and Agreed Statement of Facts from the criminal proceedings. He did not undertake any independent investigation beyond these steps, and he signed off on the Coroner's Investigation statements without any significant edits (para 60).

- James Silcox: hypoglycemia due to or as a consequence of the intentional administration of exogenous insulin, with contributing factors of dementia, diabetes, and cerebrovascular disease.
- Helen Young: hypoglycemia due to or as a consequence of the administration of exogenous insulin.
- Mary Zurawinski: hypoglycemia due to or as a consequence of the intentional administration of exogenous insulin.

C. Dr. Pollanen's Review of the Clinical Cases

Dr. Pollanen also reviewed the medical records of the six victims of attempted murder or aggravated assault, but he was not able to reach a definitive medical conclusion on whether hypoglycemic episodes in these patients were caused by the administration of insulin. Dr. Pollanen could not ultimately assess if there was a forensic medical link between Wettlaufer's confession and any episode of hypoglycemia in those cases.

X. The OCC/OFPS Initiatives

A. Office of the Chief Coroner Initiatives

1. Structural Changes to the Coroner Model

Dr. Huyer testified that he intends to make two key structural changes to the coroner component of the death investigation system. First, he hopes to hire a cadre of coroners with a defined contractual relationship with the OCC, rather than the fee-for-service model that currently exists. The goal of this approach would be to increase the quality and effectiveness of death investigations across the province by having a smaller cadre of highly trained coroners who devote a larger portion of their medical practice to coroner work.²⁹

The second change focuses on the training for coroners. Dr. Huyer is currently working with Queen's University to review and revise the Course for New Coroners, so that it becomes a competency-based, evidence-informed training course. Dr. Huyer explained that he would like to use the model of forensic pathology, where pathologists undergo a fellowship program

²⁹ Since Dr. Huyer gave his evidence in the public hearings, he has begun to build this cadre of coroners.

designed to teach them the practical skills they will need to be involved in the death investigation system. He said that his ultimate goal is to have a formal certificate program for coroners in Ontario, one he anticipates could be associated with the Canadian College of Family Physicians.

2. Revisions to the IPDR

As a result of the Wettlaufer Offences, the OCC is currently in the process of revising the Institutional Patient Death Record. The goal is to create a new IPDR that, at the time of death, better captures information about a resident's death. The process for revising the IPDR is ongoing. At the time of writing this Report, the OCC had conducted a literature review and consulted with experts. The current draft IPDR contains revised questions and requires a healthcare professional (physician, registered nurse, or nurse practitioner) with direct knowledge of the resident to complete the form. Dr. Huyer expects that, based on their knowledge of the patient's medical history and condition, these healthcare professionals will be better positioned to answer whether the death was "reasonably foreseeable" or "sudden or unexpected." He also confirmed that the introduction of the new IPDR must be accompanied by thorough training for LTC homes and their staff.³⁰

Dr. Huyer noted that the overall goal is to create a robust system in which information contained in the new IPDR can be reviewed in a systematic manner by the OCC. He is contemplating methods by which this data (along with the mass of existing information about LTC home residents held by the Ministry of Health and Long-Term Care) could be assembled and analyzed to try to identify trends or patterns that would inform and direct further investigations as required.

For example, if an increase in the number of deaths in an LTC home is identified, there could be an interdisciplinary review or investigation that involves coroners, forensic pathologists, police, and public health specialists.³¹

³⁰ It is unclear whether such training has been provided to date. Registered nurses from both Caressant Care (Woodstock) and Meadow Park (London) testified that they had received no training on how to complete the IPDR.

³¹ If legislative authority would be required to authorize the coroner to call for such an interdisciplinary review, recent amendments to the *Coroners Act* appear to provide it. As of March 26, 2019, s 25.1 now authorizes the chief coroner to "exercise the powers in subsection 25(1) in respect of a death that has previously been investigated or subject to an inquest by a coroner which may include causing an investigation into one or more deaths to be conducted only for the purpose set out in clause 15(1)(c)."

Together, they would try to determine the reason for the spike in deaths in the home. Dr. Huyer has communicated with the Information Management, Data and Analytics Division in the Ministry of Health and Long-Term Care about potential analytics models that could be created to further this work.

3. Use of Data Analytics

Dr. Huyer testified that, after the Offences became known, he attended a meeting with Ministry officials to discuss whether the Offences could have been detected earlier and what, if anything, could be done to allow for earlier detection of concealed homicides. That meeting led to the creation of a data analytics project within the Ministry to try to answer the questions raised and to develop models for predicting mortality rates in LTC homes. The project and its results are discussed in Chapter 18.

B. Ontario Forensic Pathology Service Initiatives

Dr. Pollanen testified that, since the Offences came to light, he and the OFPS have launched two initiatives. The first initiative is to create a specific protocol for conducting medico-legal autopsies among the older population, one that is similar to the protocol that currently exists for conducting autopsies on children under the age of five. Dr. Pollanen explained that the benefits of developing this protocol include increasing uniformity in the way data are collected and examinations are performed. Though still under development, Dr. Pollanen expects that the protocol will include ensuring that the OCC/OFPS have more historical and circumstantial information about the death, with photographs of the body at the scene and at the autopsy, standardized laboratory testing, and standardized radiologic examinations.

The second initiative is Dr. Pollanen's review of historical concealed homicides in Ontario. Dr. Pollanen undertook this review to attempt to determine how concealed homicides are detected, in order to ascertain relevant patterns or themes that may assist this Public Inquiry and the death investigation systems. After reviewing 15 concealed homicides and two probable concealed homicides that occurred in Ontario, he concluded that the involvement of forensic pathologists in the death investigation was an important tool to detect homicides that would otherwise have remained hidden.

RECOMMENDATIONS

Note: Most of the recommendations in Chapters 16 and 18 are also directed at the Office of the Chief Coroner and the Ontario Forensic Pathology Service.

Recommendation 50: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should replace the Institutional Patient Death Record (IPDR) with a redesigned evidence-based resident death record, following consultation with stakeholders. The redesigned IPDR should require the long-term care home registered staff member completing it to:

- answer a series of evidence-based questions that will prompt the registered staff member to provide clinical observations and other information about the resident's death;
- indicate if there are aspects of the resident's decline or death that were inconsistent with the expected medical trajectory of death;
- indicate if the family or other care providers, such as personal support workers, raised concerns about the resident's care in the period leading up to and including the death; and
- indicate if the person completing the redesigned IPDR is uncertain as to the answer to any question, and to explain the reason for the uncertainty on the form itself.

Rationale for Recommendation 50

- The Office of the Chief Coroner and Ontario Forensic Pathology Service (OCC/OFPS) created the Institutional Patient Death Record (IPDR) for the use of long-term care homes. When a resident dies, the home is required to complete the IPDR and send it to the OCC/OFPS. The information in the IPDR is intended to assist both the home and the OCC/OFPS to decide whether a local coroner should be contacted. If any of the questions on the IPDR are answered "yes," a local coroner must be consulted. The redesigned IPDR will provide the OCC/OFPS with better information to decide whether to involve a coroner.
- Other stakeholders will bring important insight and perspective to the redesign of the IPDR.

- At present, there is no space on the IPDR for the person completing it to include clinical observations and assessments. Nor is there space to set out information from, or concerns of, family members and other staff. Such information, however, can provide crucial context when deciding whether a coroner should be asked to do a preliminary consultation.
- The questions on the current IPDR are largely a reflection of the section 10 criteria in the *Coroners Act*. These questions need to be supplemented with standardized questions and prompts relating to clinical observations and assessments of the resident's death.
- The current IPDR contains a series of "yes" or "no" questions, with no option to indicate any uncertainty. Nurses may feel unsure how to answer questions falling outside their clinical expertise and training. One example of such a question on the current IPDR is whether the death is "sudden and unexpected." The form must allow the person completing it to respond "yes," "no," or "uncertain."
- The current IPDR does not provide space in which the person completing it can include an explanation, including clinical observations, for that uncertainty.

Recommendation 51: The redesigned Institutional Patient Death Record (IPDR) should clearly state on its face that:

- it is to be completed by the registered staff person in the long-term care home who was providing the resident with the most direct care at the time of death, following consultation with the personal support workers caring for the resident in the period leading up to death;
- the person completing the redesigned IPDR should promptly submit it to the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) and, at the same time, send copies to the long-term care home's medical director, director of nursing, and pharmacist, as well as to the resident's treating physician(s) or nurse practitioner (if any); and
- those receiving a copy of the redesigned IPDR must review it and promptly contact the OCC/OFPS if they have any concerns about the resident's death or the accuracy of the information set out in the IPDR.

Rationale for Recommendation 51

- Nurses working with the residents should complete the form because they have the most knowledge of the resident's day-to-day care and the trajectory of a particular resident's death. The resident's physician or nurse practitioner may rarely be at the home or may see the resident only infrequently.
- Because of the amount of time personal support workers spend with residents, attending to their needs, they will often have important additional information about the resident in the period leading up to the death.
- Requiring a copy of the redesigned Institutional Patient Death Record (IPDR) to be sent to other healthcare professionals involved in the resident's care will accomplish three objectives:
 - ensure that at least one other healthcare professional with knowledge of the resident is made aware promptly of the resident's death and the circumstances of that death;
 - ensure that the healthcare professionals will have additional current and relevant medical information (from the redesigned IPDR) to use when considering the resident's death; and
 - prompt the healthcare professionals to consider whether anything about the resident's death should be brought to the attention of the Office of the Chief Coroner and Ontario Forensic Pathology Service.

Recommendation 52: The Office of the Chief Coroner and the Ontario Forensic Pathology Service must take steps to ensure that licensees of long-term care homes have their staff submit the completed redesigned Institutional Patient Death Record to it electronically.

Rationale for Recommendation 52

- Despite the Office of the Chief Coroner and Ontario Forensic Pathology Service (OCC/OFPS) directive that Institutional Patient Death Records (IPDRs) be submitted electronically, some homes still submit them by fax. As a result, the OCC/OFPS is unable to aggregate the data contained in the IPDRs and use them to look for trends, spikes, and clusters of deaths. Ensuring that all redesigned IPDRs are submitted electronically will give the OCC/OFPS a complete data set with which to do that work.

Recommendation 53: The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should require that, where a resident dies in hospital within 30 days of being transferred to the hospital from a long-term care (LTC) home, a redesigned Institutional Patient Death Record (IPDR) be submitted to it for that death. The OCC/OFPS should work with LTC homes and hospitals to work out a process for the submission of the redesigned IPDR, including who is to submit the form and how necessary medical records will be shared.

Rationale for Recommendation 53

- The longer a resident remains in hospital before death, the greater the number of opportunities for intervening events to contribute to the death. Nonetheless, to ensure that residents in long-term care homes have their deaths appropriately considered and investigated, such deaths must be reported to the Office of the Chief Coroner and Ontario Forensic Pathology Service.

Recommendation 54: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should provide training for all registered staff in long-term care homes who may be called on to complete the redesigned Institutional Patient Death Record. The training should include education on:

- the expected trajectory of death and how to assess whether a resident's death departs from that expected trajectory; and
- the meaning of a "sudden and unexpected" death.

Details

- Training should also address who is the most appropriate person to complete the redesigned Institutional Patient Death Record (IPDR). For example, homes should be trained on who should complete the redesigned IPDR when the registered staff person providing the resident with the most direct care at the time of death is not familiar with the resident, such as a new nurse or an agency nurse.

Rationale for Recommendation 54

- The redesigned IPDR will only be as good as the information it contains. Those who may be required to complete it must be given appropriate training so that they understand the rationale behind the form and how they can best include in it the information the Office of the Chief Coroner and Ontario Forensic Pathology Service (OCC/OFPS) needs.
- Individuals have different interpretations of what constitutes a “sudden and unexpected” death, particularly in the context of a death in a long-term care home. The OCC/OFPS needs to provide guidance and training on how to interpret “sudden and unexpected” in the context of resident deaths.
- The OCC/OFPS should use its cadre of coroners to provide the requisite training to homes’ management and registered staff. The cadre will have specialized training and expertise on the long-term care home resident population and on the redesigned IPDR. Thus, the cadre will be able to ensure consistency and high standards in the training.
- Using the cadre to provide the training will also establish a coroner’s presence in the homes. Such a presence is currently lacking. It will enable the coroners to develop relationships with the homes. Those relationships should facilitate the coroner’s involvement when called to perform a preliminary consultation and, as well, improve lines of communication between the OCC/OFPS and the homes.

Recommendation 55: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should establish as a best practice that, at the preliminary consultation stage, coroners should:

- speak with the deceased’s family or the person who had the decision-making power for the deceased; and
- advise the deceased’s family or decision-maker that, if the coroner decides that no death investigation will be undertaken, the family or decision-maker can contact the regional supervising coroner with their questions.

Rationale for Recommendation 55

- Communication by the coroner with the deceased's family or decision-maker is important for many reasons, including their knowledge of the resident's health and death trajectory. This communication will also give the family or decision-maker the assurance that the coroner knows of their concerns about the resident's treatment or changes in health and that such information has been considered in the death investigation process.

Recommendation 56: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should prepare written materials about the death reporting and investigation process and provide those materials to long-term care homes for distribution, at appropriate times, to the families of residents.

Recommendation 57: The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should mandate that if, after conducting a preliminary consultation, a coroner decides not to perform a death investigation, the coroner must complete a standard document (e.g., a revised version of the case selection data form) setting out the reasons for the decision and submit that document electronically to both the regional supervising coroner and the OCC/OFPS within specified timelines.

Rationale for Recommendation 57

- At present, local coroners do not always complete the case selection data form. If not completed, the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) has no documentation on why a death investigation was not carried out for a particular resident's death.
- When the current case selection data form is completed, the information provided is not consistent.

- Requiring completion of a document outlining why a death investigation was not carried out and requiring copies to be sent to both the regional supervising coroner (RSC) and the OCC/OFPS will ensure that both can review these decisions.
 - The RSC can use the information to determine if a death investigation is needed.
 - The OCC/OFPS can use the information as part of its general supervisory power. It can determine if there are variations in the rates of investigations undertaken by coroners and consider that information when reviewing decisions not to conduct a death investigation. As well, if the OCC/OFPS is aware that the local coroner has decided not to conduct a death investigation but data analytics suggest an investigation may be appropriate (see Chapter 18), receipt of the form will give the OCC/OFPS the opportunity to require that a death investigation be undertaken.
- Requiring coroners to file the document electronically will allow the OCC/OFPS to run reports and gather data on the cases in which a local coroner is consulted but a death investigation is not carried out. This information will contribute to consistency in decision-making.
- If the family asks the RSC for additional information about the decision not to conduct a death investigation, the RSC will have a suitable source of information on which to draw. Transparency in the death investigation process is important.

Recommendation 58: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should develop protocols and policies on the involvement of forensic pathologists in the death investigation process of residents in long-term care homes.

Rationale for Recommendations 58

- The early involvement of forensic pathologists in the death investigation process has been a factor in detecting concealed homicides (i.e., homicides that would otherwise be undetected).

Recommendation 59: The Office of the Chief Coroner and the Ontario Forensic Pathology Service should develop a standardized protocol for autopsies performed on the elderly and should train forensic pathologists on this protocol.

Rationale for Recommendation 59

- Autopsies provide more information as to the cause of death, allowing for a more accurate determination of the cause of death. They are also helpful in detecting deaths that result from intentional harm.
- Developing a standard protocol for autopsies on this population and providing training to forensic pathologists on this protocol will increase the likelihood of detecting intentionally caused deaths. The use of the protocol will also increase knowledge about geriatric care, which in turn will inform future care and understanding of disease, mortality, and morbidity.

Recommendation 60: The Government of Ontario should continue to support the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) financially in establishing and maintaining a cadre of specially trained coroners who:

- agree to dedicate a portion of their practice to coroner work, to be specified in a contract with the OCC/OFPS.
- receive specialized training on long-term care homes, their resident populations, and best practices in conducting preliminary consultations and death investigations of residents.

Recommendation 61: The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should ensure that the work of coroners in long-term care (LTC) homes be performed as much as possible by the cadre of coroners. If local coroners continue to perform death investigations of residents in LTC homes, the OCC/OFPS should require that they take ongoing training on performing death investigations in LTC homes.

Rationale for Recommendations 60–61

- The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) is establishing a cadre of coroners who will dedicate a portion of their practice to providing services to the OCC/OFPS and will be appropriately paid for their work. The OCC/OFPS can require the cadre to take ongoing mandatory, standardized training, thereby leading to more consistent and higher quality resident death investigations.
- Because the cadre will be adequately compensated for their work, there will be no financial disincentive to performing quality death investigations.
- Through mandatory education and training, the OCC/OFPS can ensure that the cadre are educated about long-term care (LTC) homes and their resident populations, and that deaths of residents are not assumed to be natural – they can be sudden and unexpected.
- The cadre will be well positioned to provide education and training to long-term care home staff on the redesigned Institutional Patient Death Record.
- The OCC/OFPS can use a cyclical review and reappointment process for those coroners in the cadre, enabling it to enforce rules, standard protocols, and standard procedures.
- Specialized training relating to LTC homes and the resident population will help to achieve consistency and high standards in the work of coroners. If local coroners continue to be involved in the death investigation process for residents, they should be required to take that training.

SECTION I

SECTION II

SECTION III

APPENDICES

Volume 2 Appendices



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Appendix A – Order in Council



Ontario

Executive Council of Ontario Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

WHEREAS under the *Public Inquiries Act, 2009*, the Lieutenant Governor in Council may appoint a person to inquire into any matter of public interest;

AND WHEREAS on June 1, 2017, Elizabeth Wettlaufer pled guilty to and was convicted of eight counts of first degree murder, four counts of attempted murder and two counts of aggravated assault (the "Offences"), these Offences having been committed while working as a registered nurse in southwestern Ontario;

AND WHEREAS it is desirable to ensure that Ontario's long-term care homes system meets the objectives of the *Long-Term Care Homes Act, 2007* to ensure the safety and well-being of residents of long-term care homes in Ontario;

AND WHEREAS it is considered desirable and in the public interest for the Ontario Government to appoint a person to identify and make recommendations to address systemic failings in Ontario's long-term care homes system that may have occurred in connection with the Offences;

AND WHEREAS it is considered advisable to set out the terms of reference for such process and recommendations;

THEREFORE, pursuant to the *Public Inquiries Act, 2009* it is ordered as follows:

Commission

1. A Commission is established and the Honourable Justice Eileen E. Gillese is appointed as a commissioner under section 3 of the *Public Inquiries Act, 2009*, (the "Commissioner"), effective as of August 1, 2017.

Mandate

2. Having regard to section 5 of the *Public Inquiries Act, 2009*, the Commission shall inquire into:
 - a. the events which led to the Offences;
 - b. the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices, and accountability and oversight mechanisms; and

O.C./Décret: 1549 / 2017

Conseil exécutif de l'Ontario Décret

Sur la recommandation de la personne soussignée, la lieutenant-gouverneure de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit:

WHEREAS under the *Public Inquiries Act, 2009*, the Lieutenant Governor in Council may appoint a person to inquire into any matter of public interest;

AND WHEREAS on June 1, 2017, Elizabeth Wettlaufer pled guilty to and was convicted of eight counts of first degree murder, four counts of attempted murder and two counts of aggravated assault (the "Offences"), these Offences having been committed while working as a registered nurse in southwestern Ontario;

AND WHEREAS it is desirable to ensure that Ontario's long-term care homes system meets the objectives of the *Long-Term Care Homes Act, 2007* to ensure the safety and well-being of residents of long-term care homes in Ontario;

AND WHEREAS it is considered desirable and in the public interest for the Ontario Government to appoint a person to identify and make recommendations to address systemic failings in Ontario's long-term care homes system that may have occurred in connection with the Offences;

AND WHEREAS it is considered advisable to set out the terms of reference for such process and recommendations;

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2. Having regard to section 5 of the *Public Inquiries Act, 2009*, the Commission shall inquire into:
 - a. the events which led to the Offences;
 - b. the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices, and accountability and oversight mechanisms; and

O.C./Décret: 1549 / 2017

- c. other relevant matters that the Commissioner considers necessary to avoid similar tragedies.
- 3. The Commissioner shall perform her duties without expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization. The Commissioner shall further ensure that the conduct of the inquiry does not in any way interfere or conflict with any ongoing investigation or legal proceeding related to these matters.
- 4. Where the Commissioner considers it essential and at her discretion, she may engage in any activity appropriate to fulfilling her duties, including:
 - a. Conducting research and collecting information, including conducting interviews and undertaking surveys;
 - b. Conducting inter-jurisdictional research to identify practices in other jurisdictions that are relevant to this inquiry;
 - c. Consulting with, or seeking submissions from, key stakeholders and sector experts;
 - d. Consulting with the general public, including consulting prior to making its rules or determining who may participate in the public inquiry; and
 - e. Receiving oral and written submissions.
- 5. The Commission shall, as much as practicable and appropriate, refer to and rely on the matters set out in section 9 of the *Public Inquiries Act, 2009*. In particular, the Commission shall review and consider any existing records or reports relevant to its mandate, including the court records of the Wettlaufer criminal proceedings, and other medical, professional and business records. Further, the Commission shall rely wherever possible on overview reports submitted to or created or written by the inquiry. The Commission may consider such reports and records in lieu of calling witnesses.
- 6. Pursuant to section 14 of the *Public Inquiries Act, 2009*, the Commission may hold public hearings as necessary to fulfill its mandate.
- 7. The Commission may exercise the powers provided for in section 13 of the *Public Inquiries Act, 2009*.
- 8. The Commission shall, wherever practicable, rely on representative witnesses on behalf of institutions and may convene and/or consult with panels of representative witnesses in order to fulfill its mandate in a timely manner.
- 9. In accordance with the *Public Inquiries Act, 2009*, the Commissioner shall obtain all records necessary to perform her duties and, for that purpose, may require the production of information that is confidential or inadmissible under any Act or regulation.
- 10. Where the Commissioner considers it necessary, she may impose conditions on the disclosure of information in order to protect the confidentiality of that information. In so far as practicable, the Commissioner shall work to maintain and ensure the confidentiality of personal health information.

O.C./Décret:

11. The Commissioner shall follow Management Board of Cabinet directives and guidelines and other applicable government policies unless, in the Commissioner's view and having regard to her mandate, it is not possible to follow them.
12. The Commission shall promote accessibility and transparency to the public through the use of technology, including by establishing and maintaining a website.

Funding

13. The Commissioner may make recommendations to the Attorney General regarding funding to participants in the inquiry to the extent of that participant's interest where, in the Commissioner's view, the participants would not otherwise be able to participate in the inquiry without such funding. Such funding shall be in accordance with applicable Management Board of Cabinet directives and guidelines.

Report

14. The Commissioner shall endeavor to conclude her mandate and deliver a final report to the Attorney General summarizing her activities and including any recommendations no later than 24 months after the establishment of the Commission.
15. In delivering her final report to the Attorney General, the Commissioner shall ensure, in so far as practicable, that it is in a form appropriate for public release, consistent with the requirements of the *Freedom of Information and Protection of Privacy Act* and other applicable legislation.
16. The Commissioner shall be responsible for translation and printing and shall ensure that her final report is delivered in English and in French, at the same time, in electronic and printed versions.

Financial and Administrative Matters

17. The financial and administrative support necessary to enable the Commission to fulfill its mandate shall be provided in accordance with sections 25, 26 and 27 of the *Public Inquiries Act, 2009*.
18. All ministries and all boards, agencies and commissions of the Government of Ontario shall, subject to any privilege or other legal restrictions, assist the Commission to the fullest extent possible, including producing documents in a timely manner, so that the Commission may carry out its duties.
19. The Attorney General shall make the Commissioner's final report available to the public as soon as practicable after receiving it.

ATTENDU QU'en vertu de la *Loi de 2009 sur les enquêtes publiques*, la lieutenant-gouverneure en conseil peut nommer une personne pour effectuer une enquête sur toute question d'intérêt public;

ATTENDU QUE le 1^{er} juin 2017, Elizabeth Wettlaufer a plaidé coupable à huit chefs d'accusation de meurtre au premier degré, à quatre chefs d'accusation de tentative de meurtre et à deux chefs d'accusation de voies de fait graves (les « infractions »), ces infractions ayant été commises tandis qu'elle exerçait en tant qu'infirmière autorisée dans le Sud-Ouest de l'Ontario, et qu'elle a été déclarée coupable de tous les chefs;

O.C./Décret:

ATTENDU QU'il est souhaitable que le réseau ontarien des foyers de soins de longue durée respecte les objectifs de la *Loi de 2007 sur les foyers de soins de longue durée* de façon à garantir la sécurité et le bien-être des résidents des foyers de soins de longue durée en Ontario;

ATTENDU QU'il est jugé souhaitable et dans l'intérêt public que le gouvernement de l'Ontario nomme une personne pour cerner les défaillances systématiques du réseau ontarien des foyers de soins de longue durée susceptibles d'être associées à la perpétration des infractions, et pour formuler des recommandations afin d'y remédier;

ATTENDU QU'il est jugé utile d'énoncer le cadre de référence de ce processus et de ces recommandations;

EN CONSÉQUENCE, en vertu de la *Loi de 2009 sur les enquêtes publiques*, il est décrété ce qui suit :

Commission

1. Une commission est constituée et l'honorable juge Eileen E. Gillese est nommée commissaire en vertu de l'article 3 de la *Loi de 2009 sur les enquêtes publiques* (la « commissaire »), le tout prenant effet le 1^{er} août 2017.

Mandat

2. Compte tenu de l'article 5 de la *Loi de 2009 sur les enquêtes publiques*, la commission a pour mandat d'effectuer une enquête :
 - a. sur les événements qui ont conduit aux infractions;
 - b. sur les circonstances et les facteurs contributifs ayant permis que ces événements surviennent, notamment sur l'effet, le cas échéant, des politiques, procédures et des pratiques pertinentes et sur les mécanismes de responsabilisation et de surveillance;
 - c. sur les autres éléments pertinents que la commissaire juge nécessaires afin d'éviter des tragédies similaires.
3. La commissaire s'acquittera de ses fonctions sans formuler de conclusions ou de recommandations quant à la responsabilité civile ou criminelle de toute personne ou de tout organisme. La commissaire veillera à ce que la conduite de l'examen n'entrave aucunement toute autre enquête ou instance judiciaire en cours liée aux mêmes questions.
4. La commissaire peut, à sa discrétion et si elle l'estime essentiel, exercer les activités qui lui permettent de s'acquitter de ses fonctions, notamment :
 - a. effectuer des recherches et recueillir des renseignements, y compris mener des entrevues et entreprendre des sondages;
 - b. effectuer des recherches auprès d'autres territoires pour y repérer des pratiques pertinentes dans le cadre de cette enquête;
 - c. consulter des intervenants clés et des spécialistes du domaine ou les inviter à lui faire part de leurs observations;

O.C./Décret:

- d. consulter le grand public, y compris engager des consultations avant d'établir ses règles ou de décider des participants à l'enquête publique;
 - e. recevoir des observations orales et écrites.
5. La commission se reporte aux documents énoncés à l'article 9 de la *Loi de 2009 sur les enquêtes publiques* et se fonde sur eux lorsqu'il est possible et approprié de le faire. En particulier, la commission examine et étudie les dossiers ou les rapports existants qui se rapportent à son mandat, y compris les archives judiciaires de l'instance pénale dans l'affaire Wettlaufer, ainsi que les autres documents médicaux, professionnels et opérationnels. En outre, la commission se fonde, dans la mesure du possible, sur les rapports sommaires soumis à l'enquête ou créés ou rédigés dans le cadre de l'enquête. La commission peut étudier ces rapports et ces dossiers plutôt que d'entendre des témoins.
 6. Conformément à l'article 14 de la *Loi de 2009 sur les enquêtes publiques*, la commission peut tenir les audiences publiques qu'elle estime nécessaires dans l'exercice de son mandat.
 7. La commission peut exercer les pouvoirs prévus à l'article 13 de la *Loi de 2009 sur les enquêtes publiques*.
 8. La commission s'appuie, dans la mesure du possible, sur des personnes représentatives qui témoignent au nom d'institutions et peut convier ou consulter des groupes de témoins représentatifs afin d'exécuter son mandat en temps opportun.
 9. Conformément à la *Loi de 2009 sur les enquêtes publiques*, la commissaire obtiendra tous les dossiers nécessaires à l'exécution de ses fonctions et, à cette fin, elle peut demander la production de renseignements qui sont considérés comme confidentiels ou non admissibles en preuve en vertu d'une loi ou d'un règlement.
 10. Si elle l'estime nécessaire, la commissaire peut assortir de conditions la divulgation de renseignements, afin de protéger le caractère confidentiel de ces renseignements. Dans toute la mesure du possible, la commissaire veille à la protection de la confidentialité des renseignements médicaux personnels.
 11. La commissaire suit les directives et lignes directrices du Conseil de gestion du gouvernement ainsi que les autres politiques gouvernementales applicables, sauf si elle estime, eu égard à son mandat, qu'il n'est pas possible de les suivre.
 12. La commission favorise l'accessibilité et la transparence en ayant recours à la technologie, notamment en créant un site Web et en le mettant à jour.

Financement

13. La commissaire peut présenter des recommandations au procureur général en ce qui concerne le versement de fonds à des participants à l'enquête, dans la mesure de leur intérêt, si la commissaire est d'avis que ces participants ne seraient par ailleurs pas en mesure de participer à l'enquête sans ces fonds. Un tel financement doit être conforme aux directives et lignes directrices applicables du Conseil de gestion du gouvernement.

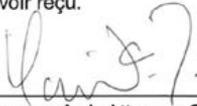
O.C./Décret:

Rapport

14. La commissaire s'efforcera de mener à bien son mandat et de remettre son rapport final résumant ses activités et présentant ses recommandations au procureur général dans les 24 mois qui suivent l'établissement de la commission.
15. Dans la mesure du possible, la commissaire veillera à remettre son rapport final au procureur général sous une forme appropriée pour sa diffusion publique, conformément aux exigences de la *Loi sur l'accès à l'information et la protection de la vie privée* et de toute autre loi applicable.
16. La commissaire assumera la responsabilité de la traduction et de l'impression de son rapport final et veillera à ce que ses versions française et anglaise soient présentées en même temps, en format électronique et sur papier.

Questions financières et administratives

17. Le soutien financier et administratif nécessaires pour permettre à la commission de s'acquitter de son mandat sera prévu conformément aux articles 25, 26 et 27 de la *Loi de 2009 sur les enquêtes publiques*.
18. Sous réserve de tout privilège ou de toute autre restriction légale, tous les ministères, ainsi que tous les organismes, conseils et commissions du gouvernement de l'Ontario, prêteront leur concours à la commission dans leur pleine mesure de façon que cette dernière puisse s'acquitter de ses fonctions.
19. Le procureur général rendra public le rapport final de la commissaire dès que possible après l'avoir reçu.



Recommended: Attorney General

Recommandé par: Le procureur général

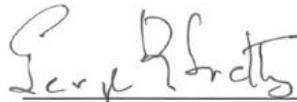


Concurred: Chair of Cabinet

Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered:
Approuvé et décrété le:

JUL 26 2017



Administrator of the Government
L'administrateur du gouvernement

O.C./Décret:

Appendix B – Reasons for Sentence

CITATION: HMQ v. WETTLAUFER, 2017 ONSC 4347
Court File No. CR-17-00000005-0000

5 SUPERIOR COURT OF JUSTICE

10 HER MAJESTY THE QUEEN

15 v.

ELIZABETH TRACEY MAE WETTLAUFER

20 P R O C E E D I N G S

BEFORE THE HONOURABLE JUSTICE B. THOMAS
on June 26, 2017, at WOODSTOCK, Ontario

25
30 APPEARANCES:

F. Kelly / A. Rajna

Counsel for the Crown

B. Burgess

Counsel for Elizabeth Wettlaufer

(i)
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SUPERIOR COURT OF JUSTICE

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4 CD of victim impact statements collectively	52
Sentence	61

Legend
<i>[sic]</i> - Indicates preceding word has been reproduced verbatim and is not a transcription error.
(ph) - Indicates preceding word has been spelled Phonetically.

Transcript Ordered: February 6, 2018
 Transcript Completed: February 6, 2018
 Ordering Party Notified: February 6, 2018

1.
Sentence
Thomas, J.

MONDAY, JUNE 26, 2017

S E N T E N C E

THOMAS, J. (Orally):

5 In a brief review of the facts surrounding these
13 counts, let me try to capture a few of the
important features of the serial actions of the
offender before me.

10 Elizabeth Wettlaufer was a registered nurse. She
is now 50 years of age. Her marriage dissolved
about the time her first offences, the aggravated
assaults of Clotilda Adriano and Albina Demedeiros
and her murder of James Silcox. From 2007 to
15 2016, Elizabeth Wettlaufer went on a nine year
spree of killing and attempting to kill. Some of
her victims managed to survive because they were
successfully treated by others. All of her
victims were administered nontherapeutic doses of
20 insulin to drive down their blood sugar levels and
put them into shock and eventually cause their
death.

25 At first it seems Elizabeth Wettlaufer
experimented with her victims to find a killing
combination. She said in her confession, "it was
kinda hit and miss." Finally, she settled on
doses of long acting and short acting insulin
given at the same time. Obviously, to her it
30 seemed effective.

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Thomas, J.

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She was the RN in charge of the shifts. She controlled the medication, she controlled the staff and the paperwork. It seemed she had a free run. Most of her victims were residents at Caressant Care in Woodstock. They were there exhibiting different conditions and different levels of awareness of their surroundings and their circumstances. They all, however, were exceedingly vulnerable to the abuse of Elizabeth Wettlaufer. One of the victim impact statements describes her as a "predator stalking the weak and those easily overwhelmed."

The attempts at killing continued after Ms. Wettlaufer was terminated from Caressant Care, successful at Meadow Park in London, in the circumstances of Mr. Horvath, unsuccessful in Paris with Sandra Towler and at the home of Beverly Bertram in Ingersoll.

The effect upon the victims of the killing doses of insulin have been described by Elizabeth Wettlaufer in her confession. It was a painful and contorting experience on the mind and body of all the victims both the deceased and those who survived.

It was perhaps best expressed in the victim impact statement of Beverly Bertram, the 68 year old sole survivor who was able to assist with the circumstances of these crimes. She has provided this Court with a chilling description of her

3.

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Thomas, J.

pain, suffering and hallucinations experienced while she should have been peacefully recovering in her own home from what was leg surgery.

We are led irresistibly to one question, why? It is a question that resonates throughout the victim impact statements. It is a question we had in our minds as we watched the matter of fact, almost clinical way Elizabeth Wettlaufer described her killing spree to Detective Hergott.

Elizabeth Wettlaufer spent 19 days with psychiatrists at the Centre of Addiction and Mental Health, CAMH in Toronto. The Agreed Statement of Facts says the following about their observations of their patient. In part, psychiatrists determine there was no evidence of psychosis. She did not suffer from hallucinations. She had full insight into her actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behaviour, borderline personality disorder, mild alcohol and opiate use disorders and major depressive disorder.

She self describes as being overwhelmed, angry about her career, her responsibilities and her life in general. She describes almost a euphoria after killing when the pressure seemed to lift from her. Perhaps too simplistic a view, but it seems she sought the control she lacked in her own

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Thomas, J.

life through determining the lives of those entrusted to her care.

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10
One thing seems certain, had Elizabeth Wettlauffer not chosen to walk into CAMH on September the 16th, 2016, none of us would be here today. The families of those victimized would be none the wiser regarding the abuse of their loved ones and perhaps the offender would still be in business.

15
I want to speak now to the victims, the families and the friends who are assembled here and those who are not, those who chose to provide victim impact statements and those simply could not withstand the experience.

20
25
A civilized society protects its most vulnerable, its young, its infirmed, its aged; those who can no longer care for themselves. As families of the sick and elderly, you must at some point, pass off the task of the day to day care to those who are trained and better able to provide a safe and secure environment. That is especially true as an increasing percentage of our population ages and lives are extended by modern medicine.

30
It is a complete betrayal of your trust when a caregiver does not prolong life but rather terminates it. But you simply cannot blame yourselves. The value of the lives of your loved ones is not diminished by their age or condition, nor does the law recognize a sliding scale of

5.

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Thomas, J.

penalties for murders of this nature. Your losses are just as unbearable.

I have read each of your victim impact statements. I have heard each of you here today. The statements of wives and husbands, daughters and sons, grandchildren, nieces and nephews, long time friends, victims, all. I know that each of you has a unique reaction to these events but in your words, I do find some common descriptions. Betrayal. Betrayal by those who you entrusted with the care of those who could no longer care for themselves. Anger. How could this have happened for so long to so many? Guilt. Why couldn't you have done more to protect them? Why didn't you see this happening? At least in one instance, guilt leading to a breach in a family bond itself. Distrust. For those that you now see as caring professionals attempting to work with you, your family and friends. Grief. Grief experienced all over again, years perhaps after your initial loss and the reality now of having to grieve so publicly. Depression. Withdrawal from social events, time off work and away from family, an inability to sleep, a lack of motivation, physical maladies driven by the stress of what you're going through, medication, counselling and therapy. All aptly described by one victim as "a nightmare that doesn't seem to end."

I can offer you so very little beyond what the law provides. The criminal justice system is not a

6.
Sentence
Thomas, J.

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place where I can direct a sentence somehow
thought to be equivalent to the value of the lives
of your loved ones. That would be impossible and
it is simply not my role. I cannot provide your
loved ones back to you which is what you really
crave. I can only prescribe a sentence based on
the law and determined by the principles I must
apply. I am truly sorry for your losses. No one
should have to endure your pain.

15
20
Section 745(a) of the *Criminal Code* directs a
sentence for 1st degree murder of life imprisonment
without eligibility for parole until 25 years of
the sentence has been served. The sentences for
the counts of aggravated assault and attempted
murder, in law must be concurrent to the life
sentences for murder. Section 745.51 considers
ineligibility for parole where there are multiple
murders. The section states the following,

25
30
At the time of the sentencing under Section
745 of an offender who is convicted of murder
and who has already been convicted of one or
more other murders, the judge who presided
over the trial, having regard to the
character of the offender, the nature of the
offence and the circumstances surrounding
it's commission, may by order decide that the
periods without eligibility for parole for
each murder convictions are to be served
consecutively.

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Thomas, J.

5 It goes on to direct that I must give reasons for my decision on this issue. In summary, Section 745.5.1 directs that I consider making the 25 parole and eligibility periods consecutive to each other, that is running one after another for the offences of 1st degree murder that took place after that section came into force on December the 2nd, 2011.

10 In this case, there are three such offences that fall into that consideration. They are those set out in counts 10, 11 and 12. Section 745.51 requires that I consider the character of the offender, the nature of the offence, the 15 circumstances of the commission of the offences. As part of the overall assessment of sentence, I must consider the purposes of sentencing set out in Section 718. Here I see my primary purposes as set out in section 718(a), (b) and (c), to 20 denounce, to deter and to separate Elizabeth Wettlaufer from society.

25 Section 718.1 requires that the sentence be proportionate to these gravest of all offences and the degree of responsibility of Elizabeth Wettlaufer which of course is substantial.

30 My consideration of mitigating and aggravating factors I believe is captured by the statutory considerations in Section 745.51. Let me know consider the parole and eligibility periods for the offences of murder.

8.
Sentence
Thomas, J.

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Firstly, the character of the offender.
I have touched on this in earlier information in my reasons. Elizabeth Wettlaufer is 50 years of age. She has no previous criminal record. She was born in Woodstock. Her parents remain alive. She was educated at Conestoga College, obtained her registered nursing certification and obtained regular employment in nursing related to long term care. She was married from 1997 to 2007. She has no children. She developed an addiction to hydromorphone and described herself as a binge user of drugs. Her psychiatric profile has been previously revisited from the description set out in the discharge summary of CAMH.

20
25
The nature of the offences.
Again, as described previously, Elizabeth Wettlaufer murdered eight patients under her care by administering massive doses of insulin that sent them into hypoglycemic shock. They were vulnerable persons often elderly, often suffering from dementia or other progressive diseases. Their deaths were painful and often protracted.

30
The circumstances surrounding the commission of the murders.
All victims were accessible to Ms. Wettlaufer in facilities where she worked. As the on-shift RN, they were under her control. She was overwhelmed, angry and depressed. She saw some of them as troublesome residents. Some she simply felt it

9.

Sentence

Thomas, J.

was their time to die. She was far from an angel of mercy for terminal patients. Rather she was the shadow of death that passed over them on the nightshift where she supervised.

I consider part of the circumstances surrounding these offences to be the circumstances that occurred at the hand of Ms. Wettlaufer post offence. Those circumstances normally found to be mitigating factors in my sentencing analysis.

In late summer 2016, Elizabeth Wettlaufer found herself assigned to assist school children with their insulin once school was ready to commence again that year. It is her uncontradicted evidence that she could not trust herself not to turn her focus to the killing of children. She quit her job. She voluntarily checked herself into CAMH in Toronto because she said it was the only mental health facility she found with an emergency department. That happened on September the 16th, 2016.

Ms. Wettlaufer almost immediately began confessing to anyone who would listen. Despite urging, she declined to speak to a lawyer. She provided a statement to the College of Nurses. She resigned from nursing on September the 30th, 2016. She confessed to Toronto Police and then again in the lengthy video tape interview we saw conducted by Detective Constable Hergott.

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On October the 6th, 2016, she voluntarily entered into a recognizance directed by the *Criminal Code* as the investigation into these matters continued.

5 On October the 24th, 2016, she turned herself in to police for her arrest. She has been in custody since. She has never applied for bail. She has always wanted, it seems to resolve these matters by guilty plea. She has been guided through that process by her counsel, Mr. Burgess who needed to fulfill his professional responsibilities to his client before that could happen.

10 She has signed the Agreed Statement of Facts that was made Exhibit 1 in this proceeding. It is clear from that document and from her comments to me in this courtroom, that she acknowledges what she has done and the legal consequences of her pleas of guilt to all counts. She has expressed remorse.

15 Without her confessions, I am convinced this offender would never have been brought to justice. I have a joint submission before me from experienced Crown and defence counsel. Counsel who have acquainted themselves with all the details of these offences and the evidence that can be brought to bear against this accused. They request concurrent periods of parole ineligibility. The law requires that I should depart from a joint submission only if it is contrary to the public interest and secondly, if

11.
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it would bring the administration of justice into disrepute.

I have reviewed a number of decisions that have considered Section 745.51 and the proposed consecutive periods of parole ineligibility. *R. v. Bourque* [2014] a decision of the New Brunswick Queen's Bench, NBQB at page 237. *R. v. Baumgartner* [2013] ABQB 761, a decision of the Alberta Queen's Bench. *R. v. Husbands* [2015] OJ 2674, a decision of this Court, the Ontario Superior Court. *R. v. Beauzeaux* [2015] Prince Edward Island Supreme Court, page 14. And finally, two decisions from Justice Masonville of the British Columbia Supreme Court in *R. v. Bains* [2015] BCSC 2145 and *R. v. Koopmans* [2015] BCSC 2120.

In the matter before me, Elizabeth Wettlaufer murdered eight people for whom she had a responsibility of care. She left a trail of broken lives in her wake. She tarnished her profession. She exposed the weaknesses in care at the long term care facilities where she worked. But she surrendered herself, she confessed, she plead guilty to all offences and by those actions she has exposed the real story of how those eight lives ended. She has spared the families the pain of months of trial.

It must also be remembered that while she is eligible to apply for parole in late 2041, she may

12.
Sentence
Thomas, J.

in fact never be paroled. Considering the number and nature of her crimes, that in fact, seems likely.

5 Just stand up please, Ms. Wettlaufer.
I accept the joint submission of counsel. It is in fact, in accordance with the public interest in my view and I endorse that conclusion. While considering the position of counsel, let me say that at all times, while being staunch advocates for the interests they protect, counsel were professional, civil and recognized the deep emotions evoked by this prosecution.

10
15 Crown counsel was incredibly prepared, always with their view to the proper administration of justice and seeing that justice was served. Mr. Burgess, the measure of you as defence counsel does not come from your representation of the rich and sympathetic but rather from your support for the poor and most reviled.

20
25 As to sentence.
On all counts of 1st degree murder, counts 3, 4 and 7 to 12, the murders of James Silcox, Maurice Granat, Gladys Millard, Helen Matheson, Mary Zurawinski, Helen Young, Maureen Pickering and Arpad Horvath, there will be a sentence of life imprisonment without eligibility for parole for 25
30 years all sentences to run concurrently.

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Thomas, J.

5 On all counts of attempted murder, counts 5, 6, 13 and 14, the attempted murder of Wayne Hedges, Michael Priddle, Sandra Towler and Beverly Bertram, a sentence of 10 years on each count to run concurrently to each other and to all other sentences.

10 On all counts of aggravated assault, counts 1 and 2, the aggravated assault upon Clotilda Adriano and Albina Demedeiros, 7 years on each count concurrent to each other and concurrent to all other sentences.

15 On all counts, there will be a DNA data banking order in form 5.03. All offences are primary designated offences. All counts, there will be weapons prohibition orders pursuant to Section 109 prohibiting the possession of any weapons for the lifetime of Ms. Wettlaufer.

20 Is there anything else counsel?

MR. BURGESS: Not from my perspective, no.

25 MR. KELLY: Can you please endorse that the arrest date there, sir because the - the correctional authorities are going to be looking for that.

THE COURT: I will do that, thank you.

MR. KELLY: I have a little bit of housekeeping matters related to tomorrow...

30 THE COURT: Yes, that's fine.

MR. KELLY: ...however, I'll allow you to make your endorsement.

14.
Sentence
Thomas, J.

5 THE COURT: Right, so I can make my endorsement at
some point. You can sit, ma'am. I can make my
endorsement when I leave and I'll do that. What
would you like to tell be about further
proceedings?

10 MR. KELLY: There was a, as you know an
application brought last date that relates to a
slight tinkering essentially with the Justice
Heeney's order in the post media application.
That is currently scheduled for tomorrow at two
o'clock and I'd like to keep that date.

15 THE COURT: Yes.

MR. KELLY: There's been ongoing communications
between post media and myself. That actually
isn't part of the trial, proper. That's a
separate proceeding. Ms. Wettlaufer has the right
to attend but not, I don't think, the obligation
to be there. Likewise counsel on her behalf,
could attend with or without her being present.

20 On that score, I've spoken with Mr. Burgess, it's
my position - it's optional on the part of the
defence as to whether they show up there but I do
want to keep that time tomorrow afternoon. I'm
going to need that time.

25 As well, it may be advisable at this stage if Mr.
Burgess could put on the record, the position on
behalf of Ms. Wettlaufer on that application.

30 THE COURT: Thank you. Mr. Burgess.

MR. BURGESS: Yes, thank you Your Honour. Ms.
Wettlaufer is going to waive her right to attend

15.
Sentence
Thomas, J.

5
the hearing of that application tomorrow. I can
put on the record now that I joined with the Crown
in their position on that application. However, I
- I no further input or argument to make on it and
neither myself or Ms. Wettlaufer will be present
tomorrow.

10
THE COURT: That's fine. It is - I - I agree it
is a separate application. It deals simply with
Justice Heeney's order related to the production
of the ITO now that this proceeding has concluded
and what form that may take. And so, I appreciate
the fact that - that now understanding your
client's position as stated by you, that it's not
necessary for you to attend.

15
MR. BURGESS: Thank you very much, Your Honour.

THE COURT: Thank you. Is there anything else
counsel?

MR. KELLY: No, sir. I believe that completes
this matter.

20
THE COURT: Thank you.

MR. KELLY: I appreciate the Court's
consideration.

THE COURT: Yes, you're welcome.

25
... MATTER COMPLETED

30

16.
Certification

FORM 2
CERTIFICATE OF TRANSCRIPT (SUBSECTION 5(2))

Evidence Act

I, Linda A. Lebeau, certify that this document is a true and accurate transcript of the recording of Regina v. Elizabeth Wettlaufer in the Superior Court of Justice, held at 415 Hunter Street, Woodstock, Ontario taken from Recording No. 2911_CR1_20170626_091123__30_THOMASBRU which has been certified by Shelby Middaugh in Form 1.

Date

Linda A. Lebeau



Lebeau
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*This certification does not apply to the Reasons for Sentence, which were judicially edited on July 17, 2017.

Appendix C – Agreed Statement of Facts

Court File 05/17

SUPERIOR COURT OF JUSTICE
(Southwest Region at Woodstock)

B E T W E E N:

HER MAJESTY THE QUEEN

AND

ELIZABETH TRACY MAE WETTLAUFER

AGREED STATEMENT OF FACTS ON GUILTY PLEA

Overview

1. Elizabeth Tracy Mae Wettlaufer is charged on a fourteen-count indictment. She is charged with eight counts of first degree murder, four counts of attempted murder and two counts of aggravated assault. She pleads guilty to all counts. The counts are summarized in this chart.

Count #	Charge	Victim name	Dates alleged	Venue
1	Agg asslt	Clotilde Adriano	2007 (June 25 to Dec 31)	Woodstock (Caressant Care)
2	Agg asslt	Albina DeMedeiros	2007 (June 25 to Dec 31)	As above
3	1 st d. murder	James Silcox	2007 (Aug 11)	As above
4	1 st d. murder	Maurice Grant	2007 (Dec 22-23)	As above
5	Att. murder	Wayne Hedges	2008 (Sept 1 to Dec 31)	As above
6	Att. murder	Michael Priddle	2008-2009 (Jan. 1, 2008 to Dec. 31, 2009)	As above
7	1 st d. murder	Helen Matheson	2011 (Oct 25-26)	As above
8	1 st d. murder	Gladys Millard	2011 (Oct 13-14)	As above
9	1 st d. murder	Mary Zurawinski	2011 (Nov. 6-7)	As above
10	1 st d. murder	Helen Young	2013 (July 13-14)	As above
11	1 st d. murder	Maureen Pickering	2014 (March 22-28)	As above
12	1 st d. murder	Arpad Horvath	2014 (August 23-31)	London (Meadow Park)
13	Att. murder	Sandra Towler	2015 (Sept 1-30)	Paris (Telfer Place)
14	Att. murder	Beverly Bertram	2016 (Aug 1-30)	Ingersoll (in a private home)

2. The facts in this document are admitted by the parties and form the basis for the plea. This document is to be tendered as evidence and, subject to the direction of the Court, will then be public. Victim Impact Statements will be filed in on sentencing.

3. It is understood there are no agreements outside those set out in this document.

4. Of the counts involving fatalities, there were no autopsies except upon the two deceased who were disinterred in 2017 (Helen Matheson and Arpad Horvath). All other deceased had been cremated so disinterment was not possible.

Background

5. The accused, Elizabeth "Bethe" Tracy Mae Wettlaufer, was born June 10th, 1967. She has one sibling and both her parents are still alive. Wettlaufer was raised in the Woodstock area where she attended school and church.

6. Following secondary school, Ms. Wettlaufer enrolled in various schools, including Conestoga College where she obtained her diploma as a Registered Nurse in 1995. She completed the 3 year course in nursing which involved palliative and seniors care, medication administration and client health care.

7. From 1995 until 2007, Ms. Wettlaufer was employed by a number of institutions and agencies in the health care field - eventually as a registered nurse. She married in 1997, but the marriage dissolved in 2007. She does not have children. She is divorced. Ms. Wettlaufer later explained that she eventually found herself feeling immense pressure.

Caressant Care

8. On June 25, 2007 Ms. Wettlaufer began her employment as a registered nurse (RN) with the Caressant Care Nursing Home located at 81 Fyfe Avenue, in the City of Woodstock. This establishment included both rehabilitation/physiotherapy facilities as well as end of life palliative care.

9. As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising the registered practical nurses (RPNs) as well as the personal support workers (PSWs). Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

Insulin and Hypoglycemia

10. All of the matters before this court involve the injection of insulin. It is essential, therefore, to understand certain basic facts about insulin, glucose and how insulin can impact health. Glucose, sometimes called *blood sugar*, is a simple sugar which our bodies need for fuel. Normally, we get glucose from the foods we eat and some fluids. Our bodies function best when glucose levels stay within a normal range.

11. Humans naturally produce two substances that stabilize glucose levels – glucagon and insulin. Should glucose levels get too low, a condition called *hypoglycemia*, glucagon is secreted to elevate blood sugar level. Should one's glucose level get too high, a condition called *hyperglycemia*, naturally-produced insulin is secreted to lower blood sugar level. Normally, the body is able to keep glucose levels within the normal range.

12. Diabetics do not stabilize their blood sugar levels properly so they take measures to ensure blood sugar remains within the normal range. To that end, some diabetics take synthetic insulin by injection. Some diabetics control blood sugar by a hypoglycaemic agent in a pill form which is not insulin. (It is a different drug, the specifics of which are unimportant in this case). Insulin, again, lowers blood sugar levels. Many elderly people have diabetes to varying degrees so synthetic insulin is commonly administered in facilities that care for the elderly. Synthetic insulin has various brand names but there are two broad classes that matter in this case. There is "long acting" and "short acting" insulin which, as the names suggest, are intended to be effective in lowering blood sugar levels more immediately or more slowly over a longer period of time. Both are commonly available in long term care facilities that tend to the needs of the elderly. How synthetic insulin is used - its form, its timing and its quantity - is individualized to a patient's needs and metabolism. Injection of insulin is normally accomplished by inserting cartridges of insulin inside an insulin "pen" - a simple pen-like device with a needle on one end and a dial and button on the other. Models vary somewhat but they work the same way more or less. They allow users to turn a dial (or "dial up") to set the desired amount of insulin to be injected from the cartridge then to use the needle end to inject the set amount of insulin into the person who needs it.

13. Insulin injected into a person with high blood sugar helps to lower their blood sugar to a normal range. Insulin can save the lives of those who need it. If injected into a person who does not need it, insulin will still have an impact. Depending on quantity, it may drop their blood sugar levels below the normal range. If blood sugar level drops too low, they will suffer from hypoglycemia, or become hypoglycemic.

14. Hypoglycemia, low blood sugar, can be mild or quite serious. The spectrum of symptoms is wide and non-specific. That is, the observable symptoms of hypoglycemia are the same symptoms one might observe in relation to many other medical conditions. Persons suffering hypoglycemia may experience confusion, paleness, diaphoresis (the medical term for *sweating*), shakiness, irritability, hunger, anxiety, tachycardia (the medical term for an abnormally rapid heart rate), dizziness, headache and/or weakness. Again, it is noteworthy that many of these symptoms are commonly observed and experienced in relation to many other medical conditions, not merely hypoglycemia. When hypoglycemia becomes severe enough, a person may experience a reduced level of consciousness, coma or death. The full impact of injected insulin often takes hours. It is not usually an "instant" killer. When it is severe enough, hypoglycemia can damage brain tissue in a particular way. For that reason, even after blood chemistry has deteriorated, it may be possible to find evidence corroborating hypoglycemia by examining the tissue of the brain.

15. As will be explained later, Ms. Wettlaufer gave a number of lengthy statements in which she provided significant detail about her criminal activities. In relation to some of the counts before this court, medical records obtained after she confessed, revealed some symptoms associated with hypoglycemia and confirmed that Ms. Wettlaufer was on duty overseeing the care of certain victims at the relevant times (thereby providing some circumstantial confirmation of her actions). The medical records do not show precisely what she was injecting into victims because Ms. Wettlaufer was not making notes about injecting victims with insulin beyond the medically prescribed amount. She

deliberately refrained from recording her criminal actions to avoid raising suspicions. Ms. Wettlaufer explained to police, however, that as a registered nurse she knew “if your blood sugar goes low enough, you can die.” She explained that she never knew how much insulin was required to cause death. She believed there was “no set amount” – “it was kinda hit and miss.”

Specific Counts

Count 1: Clotilde Adriano

16. Clotilde Adriano passed away in 2008. Ms. Wettlaufer admits committing aggravated assault by injecting Mrs. Adriano with insulin in 2007 thereby endangering her life.

17. Clotilde Adriano was born October 25, 1920 and resided in the Woodstock area where she married and raised her family. Clotilda Adriano and her husband, (deceased in 1997) had two children. Mrs. Adriano had many siblings, including a sister-in-law, Albina DeMedeiros, who was also a resident of Caressant Care and is the alleged victim in the next count.



18. On March 5, 2007, Mrs. Adriano moved into Caessant Care and had a number of ailments including diabetes which was controlled with injected insulin. She also had dementia. In the initial months of moving into the facility, Adriano's insulin medication required adjustment.

19. In June 2007, Ms. Wettlaufer had started working at Caessant Care. In July 2007 Mrs. Adriano was experiencing hypoglycemic incidents which tend to occur in the evening. Ms. Wettlaufer eventually told police that she had little interaction with Mrs. Adriano and felt no ill-will towards her, however, Ms. Wettlaufer said, she felt overwhelmingly angry about her career, responsibilities, and her life in general.

20. Ms. Wettlaufer told police that she recalled working a night shift when she attended Mrs. Adriano's room. Ms. Wettlaufer deliberately injected Mrs. Adriano with an *additional* dose of insulin (additional to the prescribed amount). The insulin was part of Mrs. Adriano's own supply of long-acting insulin. Ms. Wettlaufer said she believed it was anywhere from 30 to 40 units. Ms. Wettlaufer told police that she thought to herself, "I didn't really want her to die I just I don't know I was just angry and um had this sense inside me that she might be a person that God wanted back with him. I honestly felt that God wanted to use me." When asked, Ms. Wettlaufer explained that she did not feel like she was doing the right thing for any of the victims.

21. Ms. Wettlaufer told police that she selected Mrs. Adriano simply because Mrs. Adriano was already diabetic and insulin-dependent so insulin was readily available.

Ms. Wettlaufer admitted that she gave Mrs. Adriano additional insulin on more than one occasion, the first time being prior to the time when her third victim, Mr. Silcox, died.

22. Ms. Wettlaufer told police that when Mrs. Adriano experienced low blood sugar due to "extra" insulin injections, she was successfully treated by other nursing staff.

Count 2: Albina DeMedeiros

23. Albina DeMedeiros passed away in 2010. Ms. Wettlaufer admits committing aggravated assault by injecting Mrs. DeMedeiros with insulin in 2007 thereby endangering her life.

24. Albina DeMedeiros was born February 25, 1919 in Portugal and moved to Canada to join her brothers and family. She married and worked alongside her husband growing tobacco in the Woodstock area. Although they did not have any children of their own, her husband had children from a previous marriage.

25. When the DeMedeiros' were living in the Woodstock area, Mrs. DeMedeiros' cognition declined so home safety became a real concern. On April 12, 2006 she was admitted to Caressant Care where she was placed in a room beside her sister-in-law, Clotilda Adriano, where Ms. Wettlaufer worked. Mrs. DeMedeiros medical history included diabetes which required insulin injections.



26. Between June 25, 2007 (the day Ms. Wettlaufer started working at Caressant Care) and December 31, 2007, Ms. Wettlaufer, gave Mrs. DeMedeiros a non-medically prescribed dose of 30 to 40 units of long lasting insulin.

27. Ms. Wettlaufer told police that she overdosed Mrs. DeMedeiros on more than one occasion and opted not to offer any medical assistance to help Mrs. DeMedeiros following the injections. Ms. Wettlaufer explained that other nurses found her with low blood sugar and treated Mrs. DeMedeiros to elevate and stabilize her blood sugar levels.

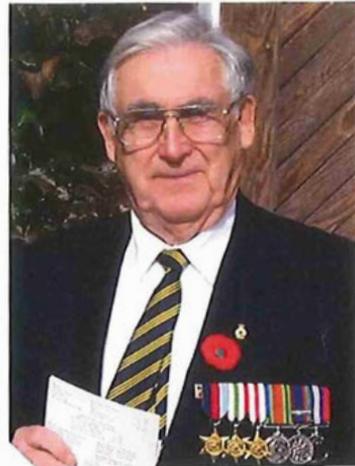
28. Ms. Wettlaufer maintains the first time she injected Mrs. DeMedeiros was prior to injecting her third victim, James Silcox. Ms. Wettlaufer added that Mrs. DeMedeiros had not done anything wrong nor had she provoked Ms. Wettlaufer but she was selected because she was diabetic and that made easier to use her own available insulin. Ms. Wettlaufer also estimated to police that she overdosed Mrs. DeMedeiros in October, 2007.

29. Medical records in October and November 2007 show that Ms. Wettlaufer attended to Mrs. DeMedeiros and that Mrs. DeMedeiros had a number of events that resulted in symptoms consistent with low blood sugar. Ms. Wettlaufer told police that she survived because her low blood sugar was always successfully treated by other nursing staff.

Count 3: James Silcox

30. Ms. Wettlaufer admits fatally injecting James Silcox with insulin in August 2007. She admits the injections were made unlawfully with intent to end his life after she considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

31. James Lancing Silcox was born on February 17th, 1923 and settled for most of his life in the City of Woodstock. He was a World War II veteran and had been married for 63 years. He was the father of six children, a grandfather and a great grandfather. He had worked in the Woodstock area at Standard Tube Inc. for over thirty years.



32. In the spring of 2007 Mr. Silcox had a stroke which resulted in a four and a half month stay in hospital. The stroke affected his right side and this left him prone to falling which he did while in the hospital resulting in a broken pelvis. On July 25th, 2007, Mr. Silcox was first admitted to the Caressant Care Nursing Home with many diagnoses including Alzheimer's disease and diabetes controlled with insulin injection. [In her

police statement, Ms. Wettlaufer told police that Mr. Silcox was not diabetic. Medical records make clear that on this issue, she was mistaken].

33. On August 4, 2007 Mr. Silcox had surgery on his right hip at Woodstock General Hospital. The surgery reportedly went well allowing Mr. Silcox to return to Caressant Care on August 10th, 2007.

34. Mr. Silcox was often confused while at Caressant Care, and frequently called out for his wife Agnes, particularly at night. Nursing notes (not merely those made by Ms. Wettlaufer) show that nurses occasionally experienced inappropriate behaviour and heard inappropriate comments from Mr. Silcox when assessing and treating him.

35. On August 11, 2007 Mr. Silcox was notably confused and could not recall his whereabouts, recognize himself or family in photographs in his room. At 4:00 p.m. a nurse documented his status noting that his incision from his surgery appeared well. On August 11, 2007 Ms. Wettlaufer began her "double shift" which included caring for Mr. Silcox.

36. Ms. Wettlaufer explained to police that anger and pressure was building inside her at this time. It related generally to her job, life and relationship. She said she was particularly "angry at him" this evening due to Mr. Silcox's conduct and described her feelings as an "urge to kill him" and "wanted him to die". Ms. Wettlaufer said she felt it was "his time to go" because of the way he acted.

37. At approximately 9:30 p.m. Ms. Wettlaufer attended the medical storage room and located a spare insulin needle that she prepared with a dose of 50 units of short acting insulin which was kept in the medical storage fridge. At approximately 10:30 p.m. Ms. Wettlaufer attended Mr. Silcox's room and injected him "hoping he would die". To police she explained that she gave Mr. Silcox more insulin than the previous two victims because they did not die. Further, while she could not be sure of the exact site of the injection, it would have been "somewhere I'd hoped wouldn't show". She said she knew that the amount injected "would harm him".¹

38. Ms. Wettlaufer's written statement explained that after he was overdosed, Mr. Silcox called out "I'm sorry" and "I love you". Ms. Wettlaufer told police she felt "absolutely awful"; and "so ashamed" about this and felt even worse when his family came in after he died and praised her for being a good nurse. She also told police that after overdosing Mr. Silcox "it felt like a pressure had been relieved from me just over all....like a pressure lifted from my emotions."²

39. At approximately 3:00 a.m., now August 12, 2007, a Personal Support Worker (PSW) found Mr. Silcox without vital signs. Being the supervisor, Ms. Wettlaufer attended the room to confirm he was without vital signs and subsequently contacted the attending physician as well as Mr. Silcox's family.

40. He was pronounced dead with a listed cause being complications from his hip surgery.

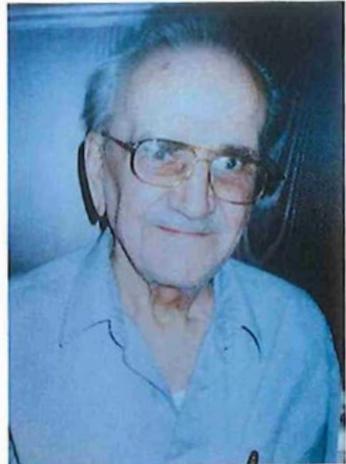
¹ September 29, 2016 statement to Metropolitan Toronto Police Service

² September 29, 2016 statement to Metropolitan Toronto Police Service

Count 4: Maurice Granat

41. Ms. Wettlaufer admits fatally injecting Maurice Granat with insulin in December 2007. She admits the injections were made unlawfully with intent to end his life after she considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

42. Maurice Granat was born February 7th, 1923 and lived the majority of his life in the Town of Tillsonburg. He was a tinsmith by trade and ran a small shop in Tillsonburg where he would fix devices. He had extensive family and friends in the Tillsonburg area.



43. On December 4, 2006, Mr. Granat was admitted into the Caressant Care Nursing Home. While there, he was battling cancer, had a number of other physical ailments and by late 2007, he had become frail. By late 2007, his eating was irregular and he was not particularly energetic some days choosing to stay in bed. He was not however diabetic and had no medical need for synthetic insulin. While he was noted to be confused on just a few days, he was not diagnosed with dementia or any similar illness.

44. On December 22, 2007 Ms. Wettlaufer was working the night shift, from 11:00 p.m. until the following morning at 7:00 a.m., in Mr. Granat's area. He was under Ms. Wettlaufer's care. For example, at 2:05 a.m. Ms. Wettlaufer noted that he had been scratching himself and she applied cream.

45. Ms. Wettlaufer told police that Mr. Granat had grabbed her breast on one occasion and when she ordered him to stop he removed his hand and laughed.³ Ms. Wettlaufer told police that she again felt an overall sense of anger and pressure on December 23, 2007 and that she felt the strong urge to end Mr. Granat's life to relieve these emotions. She explained that she was "just angry in general...at my job...at my life...at my partner". She attended the medical storage room and retrieved an insulin pen from the allocated drawer and insulin from the medical refrigerator before attending Mr. Granat's room.

46. Ms. Wettlaufer advised Mr. Granat that she needed to give him a vitamin shot and recalls needing to inject the insulin into his leg since he had very little body fat at that time. Insulin is normally injected into fatty tissue. Ms. Wettlaufer injected between 40 units – 60 units of short acting insulin into Mr. Granat knowing he was not a diabetic. This injection of insulin was not documented.

47. At 3:55 a.m. he was noted by a PSW to be very confused. At 7:08 a.m. Ms. Wettlaufer notated in her reports - "At 05:00, resident was found diaphoretic and

³ This may be true. Documentation from a number medical staff (not Ms. Wettlaufer) noted Mr. Granat sometimes inappropriately touched nursing staff.

struggling to breathe. Pulse was 120, resps were 16 and labored. Family was called at this time. At this writing, family is bedside. Resident is unconscious but rouses to sound. Resident appears comfortable." Indeed, police confirmed Ms. Wettlaufer did phone two close friends of Mr. Granat who attended immediately.

48. Ms. Wettlaufer made no attempts to save Mr. Granat, but instead completed her shift then went home. Shortly thereafter, Mr. Granat was reportedly unresponsive.

49. At 11:45 a.m. that day, Mr. Granat passed away.

Count 5: Wayne Hedges

50. Wayne Hedges passed away in January 2009. Ms. Wettlaufer admits unlawfully injecting Mr. Hedges with insulin in the fall of 2008 intending to end his life.

51. Wayne Douglas Hedges was born April 23, 1951. His parents, sisters and family were largely based in Western Ontario. Mr. Hedges had lived in Caressant Care since 2000. He had diabetes, schizophrenia and mental disabilities. Mr. Hedges' diabetes was normally treated with insulin injections.



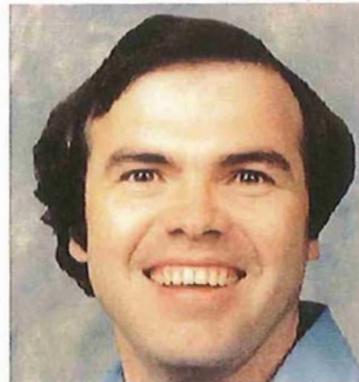
52. Ms. Wettlaufer told police Mr. Hedges was "developmentally challenged, diabetic and a handful", adding that he could be "uncooperative" at times.

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53. Ms. Wettlaufer told police she intentionally overdosed Mr. Hedges with insulin in October 2008 with a "large overdose" because she believed "it was his turn to go". Ms. Wettlaufer reached this conclusion because, she said, he would occasionally say that he wanted to die. Other nursing notes document that Mr. Hedges made his wants known with some regularity, sometimes quite strongly, but there are no nursing notes about him stating that he wanted to die. Ms. Wettlaufer said to police that on one particular night, she felt a "surge" and injected him with additional insulin; however, in her words "He didn't die". Medical records in October 2008 confirm he had a hypoglycemic event while under Ms. Wettlaufer's care. Records indicate that after Mr. Hedges became hypoglycemic, Ms. Wettlaufer administered medication to restore his glucose levels. She has no recollection of doing so or what prompted her to do this.

Count 6: Michael Priddle

54. Michael Priddle passed away in January 2012. Ms. Wettlaufer admits unlawfully injecting Mr. Priddle with insulin in 2008 or 2009 intending to end his life.



55. Michael Stephen Priddle was born June 1, 1949. He grew up in Ingersoll where he met his wife. Married in 1971, they had one

son. He was a butcher by trade and worked until his diagnosis with Huntington's disease (an inherited brain disorder that causes parts of the brain to die). He was an ardent hockey fan. His Huntington's diagnosis eventually resulted in him needing 24 hour care and he was admitted into Caressant Care on October 20, 2006.

56. Mr. Priddle, due to his conditions, was unable to voice the presence of pain, but was placed on a pain management regime. He was at a high risk for injuries and falls which required staff to check on him every half hour, even throughout the night. Mr. Priddle was also at constant risk for choking, as he had great difficulty swallowing. To police Ms. Wettlaufer described Mr. Priddle's disease as one that "robs you of your body and you still have your mind". She referred to it as a "horrible disease".

57. Ms. Wettlaufer explained to police that one night in 2009 she decided to intentionally overdose Mr. Priddle with insulin. She explained that Mr. Priddle had never done anything to harm her. He was not a diabetic and had no medical need for synthetic insulin. She described feeling a "surging" and thought "now this must be God because this man is not enjoying his life at all". Ms. Wettlaufer remembers giving him what she considered a "large amount of insulin" and believed it was 90 units total.

58. Medical records confirmed that in July 2008 Ms. Wettlaufer was attending to Mr. Priddle and he experienced an incident that appeared to be hypoglycemic in nature. Ms. Wettlaufer advised police that Mr. Priddle "just survived" the overdose without any staff interjection or treatment.

Count 7: Gladys Millard

59. Ms. Wettlaufer admits fatally injecting Gladys Millard with insulin in October 2011. She admits the injections were made unlawfully with intent to end Mrs. Millard's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

60. Gladys Jean Millard was born October 11, 1924 in New Glasgow, Nova Scotia then settled in the City of Woodstock along with her husband (deceased in 1997). She was the mother of two children and was active in her church, charities and service clubs.



61. On September 11, 2006 Mrs. Millard was admitted to the Caressant Care Nursing Home with diagnoses of Alzheimer's disease and other conditions. She was not diabetic and had no medical need for synthetic insulin.

62. To police Ms. Wettlaufer described Mrs. Millard as spunky and spirited when she first cared for her but later, with worsening dementia, she became very stubborn and difficult to administer medication to. Medical records confirm that Mrs. Millard had some aggression issues while at Caressant Care.

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63. On October 13, 2011 Ms. Wettlaufer was working the night shift from 11:00 p.m. to the following morning at 7:00 a.m. She oversaw Mrs. Millard's care during that shift. Ms. Wettlaufer explained that Mrs. Millard's stubbornness may have played a part of why she was targeted. Ms. Wettlaufer explained that she got that "red surging feeling that she was going to be the one" and that the red surge is what Ms. Wettlaufer identified as God telling me "*this is the one*". Ms. Wettlaufer decided Mrs. Millard was the next one she would overdose with insulin intending to cause death.

64. At approximately 5:00 a.m. Ms. Wettlaufer attended the medical room where Ms. Wettlaufer took both long and short acting insulin from the medical refrigerator. Ms. Wettlaufer's accounts of the quantity of insulin given are inconsistent. In her handwritten statement she said she injected Mrs. Millard with 40 units of long acting and 60 units of short acting insulin. In her police statement she noted with some hesitation "I think" it was 80/60. Ms. Wettlaufer told police Mrs. Millard "fought a little bit"; she "struggled" with Ms. Wettlaufer. Ms. Wettlaufer found a spot to successfully inject her on a location that Ms. Millard could not reach or grab her.

65. On October 14, 2011 by 7:00 a.m. (the end of Ms. Wettlaufer's shift) medical records showed that Mrs. Millard was unresponsive and diaphoretic (sweaty).

66. At the end of her shift, Ms. Wettlaufer notated in Mrs. Millard's patient notes "...Gladys had been awake all night, was crying out and had a very tense look on her face. She fell asleep and is currently still sleeping. Staff instructed to leave her in bed asleep...".

67. Wettlaufer recalled to police that she had to help move Mrs. Millard into the palliative care room with the day shift nurse at the end of her shift because day shift staff noted that Mrs. Millard was red, sweating and incoherent with vital signs low. Ms. Wettlaufer told police that she was terrified that someone might conclude that Mrs. Millard's decline was due to something Ms. Wettlaufer had done. That fear was not realized.

68. At 09:45 a.m. Mrs. Millard was found to be diaphoretic, cold, clammy, foaming at the mouth, very pale and her body and extremities were twitching. Over the course of the day various medications were given in an attempt to assist Mrs. Millard. By 4:05 p.m. she had passed away.

Count 8: Helen Matheson

69. Ms. Wettlaufer admits fatally injecting Helen Matheson with insulin in October 2011. She admits the injections were made unlawfully with intent to end Helen Matheson's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.



70. Helen Muriel Matheson was born June 4, 1916

and settled in the Village of Innerkip. Her husband passed away in 1998. They had two sons, grand-children and great grandchildren. She had been active in her church for many years.

71. On January 20th, 2010, Helen Matheson was admitted into Caessant Care Nursing Home from the adjoining Caessant Care Retirement Home at 93 years of age. Her diagnoses included dementia but not diabetes. Helen Matheson had no medical need for synthetic insulin.

72. On October 25th, 2011, Ms. Wettlaufer was working the afternoon shift from 3:00 p.m. to 11:00 p.m. Helen Matheson's double room was in Ms. Wettlaufer's area near the nurse's station. Ms. Wettlaufer recalled "making a bit of a fuss about her that night" because she was very lucid at that time. They discussed Helen Matheson's fondness of blueberry pie and ice cream, and how Helen Matheson used to bake such pies.

73. Ms. Wettlaufer's nursing notes indicated that "*a staff member went on their break and got blueberry pie for Helen.*" Ms. Wettlaufer returned to Helen Matheson's room where she gave Helen Matheson some pie and ice cream. Her nursing notes read:

She ate 4 bites with ice cream then smiled and said "That's enough dear, but the crust is lovely."

74. Ms. Wettlaufer explained to police that she then felt that Helen Matheson was to be the next person to go, that it was her time. Ms. Wettlaufer told police Helen Matheson was "very quiet, very determined and just seemed to be waiting to die".

75. The evening of October 25, 2011 Ms. Wettlaufer attended the medical supply room once again, located a spare insulin needle from the allocated drawer, as well as insulin from the medical refrigerator. Ms. Wettlaufer "dialed up" a dose of *approximately* 50 to 60 units of short acting insulin. Ms. Wettlaufer injected Helen Matheson with the insulin. There was no struggle or resistance. Helen Matheson was not a diabetic. Ms. Wettlaufer explained to police that she got a feeling "in my chest area and after I did it, I got that laughter" while injecting insulin and thereafter.

76. On October 26, 2011, Ms. Wettlaufer was again working the afternoon shift in Section B, which included overseeing Helen Matheson's deteriorating condition. Ms. Wettlaufer recalls Helen Matheson ceased to eat or drink after she gave the insulin injection.

77. At 8:15 p.m. Ms. Wettlaufer recorded in Helen Matheson's patient notes the following: "Helen appears very pale and listless. She responds to voice occasionally. The inside of her mouth appears dry and sticky and her skin is displaying tenting. At 8:00 p.m. she appeared to be in pain and was given 10 mg of morphine. She has been moved to room 15 and her son has been called."

78. Helen Matheson was moved to palliative care. On October 26, 2011 at 10:28 p.m. Ms. Wettlaufer wrote her last notation for Helen Matheson where she requested morphine every two hours or as needed and the following: "Helen was flinching and appeared uncomfortable so 10 mg was given. She now appears to be resting comfortably".

79. On October 27, 2011 at 1:00 a.m. Helen Matheson's son Jon notified staff that his mother had stopped breathing while he had been sitting at her bedside.

80. In January 2017, Helen Matheson's body was exhumed by search warrant for an autopsy. The scientific results were inconclusive. Due to the state of decomposition pathologists were unable to corroborate or negate Ms. Wettlaufer's description of events. There is no dispute, however, that based on *all* the evidence (including but not limited to scientific evidence), Ms. Wettlaufer's actions were a significant contributing cause of Helen Matheson's death.

Count 9: Mary Zurawinski

81. Ms. Wettlaufer admits fatally injecting Mary Zurawinski with insulin in November 2011. She admits the injections were made unlawfully with intent to end Mary Zurawinski's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.



82. Mary Zurawinski was born in April 7, 1915 and spent much of her youth in Sudbury. She had worked as a waitress, was married and had four sons. Her husband and three of her sons pre-deceased her. Prior to her admission to Caressant Care on May 6, 2011, she was described as a very independent woman.

83. Mary Zurawinski had a number of conditions including dementia but not diabetes. She had no medical need for synthetic insulin.

84. On November 6, 2011, Ms. Wettlaufer was scheduled to work the afternoon shift from 3:00 to 11:00 p.m. It was Ms. Wettlaufer's last shift before scheduled holidays.

85. Ms. Wettlaufer told police that she was tending to Mary Zurawinski when she asked Ms. Wettlaufer to place her into the "deathbed" as Mary Zurawinski believed she was going to die. Mary Zurawinski's health had been declining and she assured Ms. Wettlaufer she believed she was going to die and requested a palliative care room.

86. Ms. Wettlaufer with help from another staff member moved Mary Zurawinski into the palliative care room. Ms. Wettlaufer decided Mary Zurawinski was the next one that needed to die, however, according to Ms. Wettlaufer; there were no signs she was going to die that day. Ms. Wettlaufer again turned to overdose with insulin.

87. At approximately 4:30 p.m., Ms. Wettlaufer retrieved an insulin pen and medication from the medication room, once again both short acting and long acting insulin. Ms. Wettlaufer once again felt angry in general, not particularly with Mary Zurawinski, although Ms. Wettlaufer described her as being feisty, outspoken and "she was fun".

88. Ms. Wettlaufer told Mary Zurawinski the needles were for pain as she injected Mary Zurawinski in the arm with 50 units of short acting insulin and 30 units of long acting insulin. Upon doing so Ms. Wettlaufer told police that she got "that feeling inside and the laughter."

89. At 5:23 p.m. Ms. Wettlaufer entered an "End of Life Care Note" into Mary Zurawinski's medical chart. It read:

Mary was sitting at the dining room table at 16:55 and was very pale. She started breathing in soft gasps, 30 per minute. She asked staff to put her back to bed "so I can die there". She was taken to the palliative room and put to bed. She then asked for someone to pray with her. PSW O.R. said "Hail Mary" with her and Mary visibly relaxed. Son has been called.

90. On November 7, 2011 at 2:15 a.m. Mary Zurawinski was found by staff without vital signs and family was notified.

Count 10: Helen Young

91. Ms. Wettlaufer admits fatally injecting Helen Young with insulin in July 2013. She admits the injections were made unlawfully with intent to end Mrs. Young's life after Ms. Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

92. Helen Whitelaw Marshall Young was born on June 29, 1923 in Edinburgh, Scotland. She served in World War II in several locations which is how she met her husband. Together they moved to Canada in 1948 settling in the Woodstock area in 1971. Her husband passed away in 1988 and they had no children. Always outspoken, she loved animals and travelling.



93. On December 12, 2009, Helen Young was admitted to Caressant Care. She had a number of medical issues including dementia but not diabetes. She had no medical need for synthetic insulin. [In her police statement Ms. Wettlaufer says she recalled that Helen had type 2 diabetes. Medical records confirm that Ms. Wettlaufer's recollection on this issue is mistaken.]

94. Nursing notes confirm that Helen Young had an initial aversion to Caressant Care but, over time, grew more accepting of her new living situation. To police Ms. Wettlaufer described Helen Young as feisty, outspoken, miserable, and unhappy with her life. Ms. Wettlaufer was annoyed by Helen Young constantly crying out "help me nurse." From Ms. Wettlaufer's perspective, she was "very difficult to deal with". Ms. Wettlaufer told police that she frequently stated "I want to die." Nursing notes, not merely those made by Ms. Wettlaufer, confirmed this kind of behavior had occurred before.

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95. On July 13, 2013, Ms. Wettlaufer was working the afternoon shift from 3:00 to 11:00 p.m. That afternoon, after 3:00 p.m., Ms. Wettlaufer told police that Young was again asking for help and repeating that she wanted to die. Ms. Wettlaufer told police it was like something "snapped inside" and the "red surge" came back and she thought to herself, "Okay, you *will* die."

96. Just prior to dinner, Ms. Wettlaufer prepared two insulin injections and attended Helen Young's single room. Ms. Wettlaufer injected Helen Young with one shot 60 units of short acting insulin. Just after dinner, Ms. Wettlaufer injected Helen Young a further 60 units of long acting insulin. Ms. Wettlaufer misled Young by saying that the insulin injections were needles were to help with pain.

97. At 7:27 p.m. Ms. Wettlaufer recorded in the patients Vital Signs Assessment the following: "Helen was diaphoretic after supper and was slurring her words..."

98. Records show that at approximately 9:00 p.m. Ms. Wettlaufer was summoned to Helen Young's room by a PSW because Helen Young's face was red, her arms and legs were bent inward, her eyes were bulging and she was moaning loudly. Helen Young was having an apparent seizure as a result of the insulin.

99. At the end of Ms. Wettlaufer's shift, she noted the incident in nursing notes and added "When writer asked if she was in pain, she nodded".

100. At 8:40 a.m. the following morning Helen Young passed away and her family was notified. Ms. Wettlaufer was not working at that time. Ms. Wettlaufer was working later

however, when Mrs. Young's niece attended to retrieve her belongings. Ms. Wettlaufer hugged Mrs. Young's niece as she cried on her shoulder. Ms. Wettlaufer expressed how sorry she was over the loss.

Count 11: Maureen Pickering

101. Ms. Wettlaufer admits fatally injecting Maureen Pickering with insulin in March 2014. She admits the injections were made unlawfully with intent to put Mrs. Pickering into a coma and to cause permanent brain damage – bodily harm that she knew was so serious that it would likely kill Maureen Pickering and proceeded to inject her despite knowing Ms. Pickering would likely die as a result of that grievous bodily harm. The injection was administered only after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

102. Maureen (O'Neil) Pickering was born on June 9, 1935 and resided in the town of Tillsonburg. She resided with her husband in the Greater Toronto area in the 1980's before moving to the Tillsonburg area. They did not have children. After her husband passed away, Mrs. Pickering regularly spent time in Florida before her health declined.



103. On September 9, 2013, Mrs. Pickering was admitted to Caressant Care from Tillsonburg Hospital where she had been since August 21, 2013.

104. Her diagnoses included dementia and Alzheimer's disease but not diabetes. She had no medical need for synthetic insulin. Medical records reveal that, over time, Mrs. Pickering's cognitive health began to further deteriorate, often rendering her confused and aggressive. Due to the wandering and aggressive tendencies, Mrs. Pickering often needed 1 to 1 care which was not always possible due to staff shortage and other duties. As a result, a privately paid Personal Support Worker was arranged for to supplement the nursing staff as well as to keep her company. When no PSW was available, Ms. Pickering's care was the duty of the charge nurse – like Ms. Wettlaufer – who often had other duties. Ms. Wettlaufer explained that Mrs. Pickering could be "a handful".

105. On March 22, 2014, Ms. Wettlaufer was working the afternoon shift from 3:00 to 11:00 p.m. At 3:32 p.m. shortly after Ms. Wettlaufer began her shift, she recorded on Mrs. Pickering's behavior notes: "Received Maureen in a highly agitated state. She has been pacing in and out of her room and back and forth in front of the nurses station. She also went into room 108 and yelled at that resident. She has been stating she will go home and is complaining of feeling nervous and scared"

106. Ms. Wettlaufer notes were that Mrs. Pickering had been given a Haldol at 1:40 p.m. by the previous nurse, however, Ms. Wettlaufer gave her an additional Haldol shot in an attempt to calm her down.

107. Ms. Wettlaufer explained to police that she was irritated that she had to focus so much time on Mrs. Pickering while also being responsible for 32 other residents' medication, paper work, and treatments. Ms. Wettlaufer described feeling frustrated and angry as Mrs. Pickering continued her disruptive behavior.

108. Ms. Wettlaufer told police that she once again felt that "urge" but told herself, "No, I don't want her to die but if I could somehow give her enough of a dose to give her a coma, something to change her brainwaves maybe make her less mobile and less hard to handle." And that she "really wanted to make sure that she, her mind would change a bit before she came back". At approximately 8:00 p.m. Ms. Wettlaufer attended the unit's medical storage room and located an insulin pen and the insulin itself from the medical refrigerator, then prepared two insulin needles intended for Mrs. Pickering.

109. Ms. Wettlaufer gave Mrs. Pickering two insulin injections about 2 1/2 hours apart - first 80 units of long acting insulin followed by 60 units of short-acting insulin. Ms. Wettlaufer made clear it was "a lot" because she "really wanted to make sure that she, her mind would change". Initially, Ms. Wettlaufer gave her a sedative to calm her down before giving the first insulin injection which was misrepresented as a vitamin injection.

110. At 11:27 p.m. Ms. Wettlaufer noted:

Maureen started to settle down at 16:30 Hrs. She stopped complaining and feeling nervous. She requested to go to bed at 19:00 but got back up again. Staff had her assist with folding towels and she resettled to bed at 19:30 and has been asleep each time she was checked on. Maureen has called out "help help" twice since 22:00 but both times she was asleep.

111. The following morning March 23, 2014, another nurse noted that Mrs. Pickering was drowsy and did not want to come down for breakfast at 8:00 a.m. That nurse then checked on Mrs. Pickering every half hour.

112. At 10:50 a.m. Mrs. Pickering was found unresponsive, diaphoretic, cold, and clammy with deep snoring sounding respirations and mucous. An ambulance was immediately called and Mrs. Pickering was transferred to Woodstock General Hospital.

113. On March 23, 2014, Ms. Wettlaufer was again working the afternoon shift from 3:00 to 11:00 p.m. At 5:00 p.m. Ms. Wettlaufer received a phone call from a doctor at Woodstock General Hospital with an update on Mrs. Pickering. Ms. Wettlaufer made notes of that call. She learned that Mrs. Pickering had suffered a stroke, was unresponsive and was to be returned to Caressant Care in a palliative state.

114. Once returned, for the first 24 hours, Mrs. Pickering was described in nursing notes as being responsive to voice and touch by moaning and moving her eyes. Thereafter, for the next four days, she was documented as completely unresponsive. On March 28, 2014 at 9:23 a.m., another nurse, not Ms. Wettlaufer found Mrs. Pickering had passed away. By then, Wettlaufer was no longer at Caressant Care. She had been terminated as a result of a non-criminal medicine administration error.

Count 12: Arpad Horvath

115. In April 2014, Ms. Wettlaufer was hired as an RN at the Meadow Park Nursing Home located in the City of London. It is at Meadow Park that she had dealings with Arpad Horvath.

116. Ms. Wettlaufer admits fatally injecting Arpad Horvath with insulin in August 2014. She admits the injections were made unlawfully with intent to end Mr. Horvath's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

117. Arpad Alajos Horvath was born November 14, 1938. He had resided most of his life in Straffordville. He was married with two children and three grand-children. He was an avid hunter, proud of his Hungarian heritage and had run his own tool& die business for 50 years.



118. Mr. Horvath was admitted into Meadow Park Nursing Home on August 29, 2013. He had a number of conditions including dementia and diabetes.

119. Patient *Progress Notes* made by a number of staff (not merely Ms. Wettlaufer) show that Mr. Horvath was sometimes inappropriate and explicit with the staff.

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120. On August 21, 2014, Ms. Wettlaufer noted observations that Mr. Horvath had been hitting and kicking at staff. On August 23, 2014 Ms. Wettlaufer was working the afternoon shift. Mr. Horvath was one of the residents under her care.

121. On her shift Ms. Wettlaufer twice made nursing notes about Mr. Horvath yelling, spitting, and swinging his fist when she approached him for his required care.

122. Ms. Wettlaufer told police she felt angry, frustrated and vindictive. She decided "enough was enough" with Mr. Horvath. She attended Meadow Park's medical storage room in which she had access to insulin. Ms. Wettlaufer prepared two insulin pens to inject Mr. Horvath.

123. At approximately 8:00 p.m. Ms. Wettlaufer attended Mr. Horvath's room and injected him with 80 units of short acting insulin and 60 units of long acting insulin. He attempted to fight it but he was unsuccessful. She explained that "eventually I got it into him." There was no immediate effect. When Ms. Wettlaufer finished her shift, Mr. Horvath was fine but his condition changed thereafter.

124. Just over 8 hours later, a PSW found Mr. Horvath unresponsive, diaphoretic, cold and clammy and unconscious. An ambulance was called and transported him to London Health Science Centre. There, he was determined to be hypoglycemic upon admission. Testing to determine insulin levels was not done. Mr. Horvath was treated at the hospital but he remained there because he was comatose and was having seizures.

During his time at London Health Sciences, Ms. Wettlaufer contacted the hospital twice requesting an update on Mr. Horvath's condition. Ms. Wettlaufer made related notes as to his condition in his patient records.

125. Mr. Horvath passed away seven days later - on August 31, 2014. No autopsy was conducted at that time.

126. In January 2017, Mr. Horvath's body was exhumed by search warrant for autopsy. The scientific results are inconclusive relating to cause of death. The medical records are clear that that Mr. Horvath's condition started with hypoglycemia. Evidence of tissue damage in the brain was suggestive of the death caused by hypoglycemia but it is not definitive. There is no dispute, however, that based on all the evidence (including but not limited to scientific evidence), Ms. Wettlaufer's actions were a significant contributing cause of Arpad Horvath's death.

Count 13: Sandra Towler

127. On October 1, 2014 Ms. Wettlaufer resigned from Meadow Park to get help with drug/alcohol dependency issues. Later Ms. Wettlaufer admitted to police she had been stealing and taking the medication.

128. Life Guard Homecare of Brantford, Ontario, is an assisted living company offering nursing assistance and services within patients' homes, as well as contracting

RN and PSW's out to facilities in the Brant, Oxford and Haldimond-Norfolk area. Life Guard employs 60 – 75 employees at any given time.

129. In January 2015 Ms. Wettlaufer commenced her employment with Life Guard where she attended individual residents, as well as long-term care facilities including Telfer Place Long Term Care Facility (Telfer Place), in the town of Paris. It is at Telfer Place that Ms. Wettlaufer came in contact with Sandra Towler.

130. Ms. Wettlaufer admits unlawfully injecting Sandra Towler with insulin in the September 2015 intending to end Sandra Towler's life.

131. Sandra Towler was born April 6, 1939 and resided in Brant County where she raised her daughter and son. Sandra Towler is still alive. She has dementia.

132. On February 12, 2014 Sandra Towler was admitted to Telfer Place. At the time of her admission she was diagnosed with a number of conditions including "dementia in Alzheimer's disease" and diabetes that was controlled by oral medication (which was not insulin). Accordingly, Sandra Towler did not normally receive insulin injections and had no medical need for them.

133. Ms. Wettlaufer told police she injected Sandra Towler with insulin sometime around September 6, 2015. Indeed, records confirm that on September 6, 2015 Ms. Wettlaufer was working and caring for Ms. Towler.

134. Ms. Wettlaufer told police that sometime during that shift, she attended Sandra Towler's room which she shared with three roommates. Ms. Wettlaufer told police that she felt frustrated again with her job and "sensed" Sandra Towler did not want to be there anymore. As a result, Ms. Wettlaufer explained, she injected Sandra Towler with what Ms. Wettlaufer recalls to be 80 long acting insulin and 60 short acting. Sandra Towler had never had a hypoglycemic event before that date. Medical records confirm Ms. Towler became hypoglycemic beginning just after Ms. Wettlaufer's shift ended. It was significant enough that Sandra Towler was removed from Telfer Place and hospitalized (and successfully treated) thereafter. Ms. Wettlaufer explained to police that nobody raised any concerns or suspicions about Ms. Wettlaufer's care of Ms. Towler.

Count 14: Beverly Bertram

135. Saint Elizabeth is the largest health care provider in Ontario with more than 8,000 staff delivering approximately 5 million health care visits annually. RNs and RPNs attend to client's needs in their homes alone where they provide various types of nursing and home services.

136. Ms. Wettlaufer was offered employment with Saint Elizabeth Health Care starting in July 2016. She provided nursing care to patients at their homes within Oxford County. Through Saint Elizabeth, she cared for a woman by the name of Beverly Bertram.

137. Beverly Bertram is alive. Ms. Wettlaufer admits unlawfully injecting Beverly Bertram with insulin in August 2016 intending to end Beverly Bertram's life.

138. Beverly Bertram, age 68, resided in Ingersoll. Beverly Bertram has a number of health issues and suffers from diabetes which is controlled through injectable insulin. She does not suffer from dementia. In the summer of 2016, Beverly Bertram had surgery on her left leg. On August 19, 2016 Beverly Bertram returned home from the hospital. St Elizabeth Health Care nurses then attended periodically to assist with an infection. Specifically, part of the nurses' help was administering intravenous antibiotics to Beverly Bertram at her home through a tube inserted into a vein called a "picc line".

139. On August 20, 2016 Ms. Wettlaufer attended at the home of Beverly Bertram. On that date, Ms. Wettlaufer administered intravenous antibiotics to Beverly Bertram through the use of Beverly Bertram's picc line.

140. Uninvited and unexpected, later on August 20, Ms. Wettlaufer attended the residence of another St. Elizabeth home patient. Ms. Wettlaufer entered that residence unannounced while the patient was in the shower. The patient heard something and called out. There was no response. The patient ended her shower and found Ms. Wettlaufer going through that patient's medications on her table. Ms. Wettlaufer claimed to the patient that she was merely looking for an oxygen meter she had forgotten there previously. That patient's insulin was on that table along with her morphine. Ms. Wettlaufer confirmed to police and to staff at CAMH, that what she was actually doing was stealing insulin⁴ from this home because she intended to use it to kill Bertram the next day. Ms. Bertram was a diabetic and had her own insulin. Still, Ms.

⁴ She also admitted stealing other medication for herself, namely, "hydromorphs".

Wettlaufer chose to steal insulin from a second patient for a specific reason. By obtaining insulin from another patient, should Beverly Bertram die as intended, a later examination of Ms. Bertram's own insulin supply would not appear unusually depleted.

141. The next day, August 21, 2016, Ms. Wettlaufer re-attended Beverly Bertram's residence and once again administered intravenous antibiotics to Beverly Bertram. Beverly Bertram recalled Ms. Wettlaufer taking a long time in the kitchen while obtaining her antibiotics from the fridge. After receiving what she thought were merely the antibiotics, Beverly Bertram described herself as feeling unusually nauseous and dizzy. Concerned, Beverly Bertram decided not to inject herself with her insulin that day and was able to recover from that state without medical help.

142. Ms. Wettlaufer told police about that day. She described herself as feeling frustrated and angry with her job and all the people she had to care for that weekend. Ms. Wettlaufer felt the same "surge" that evokes her urge to overdose people and that injecting Beverly Bertram with insulin with intent to kill her was pre-planned. Ms. Wettlaufer said she gave Beverly Bertram "a huge amount"- 180 units of insulin via the picc line. Ms. Wettlaufer further explained that she gave three separate doses of 60 units through her picc line.

143. On August 22, 2016 Ms. Wettlaufer said she accessed the patient records for Saint Elizabeth Health Care using her assigned tablet thereafter to check on the status of Beverly Bertram. Ms. Wettlaufer noticed that she had been seen by another nurses the following days and assumed she had survived and was fine.

144. Ms. Wettlaufer did not return to Beverly Bertram's home again.

Police Became Involved

145. On August 29, 2016 Ms. Wettlaufer resigned from Saint Elizabeth Health Care after she was told she would be working with diabetic children within a school. Ms. Wettlaufer panicked. She later explained to police that she did not trust herself not to harm children so she resigned.

146. On September 16, 2016 Ms. Wettlaufer voluntarily admitted herself to the Centre for Addiction and Mental Health (CAMH) located on College Avenue, in Toronto for fear she would harm others or herself. She remained at CAMH for about three weeks – until October 5, 2016. Even though she walked in on her own Ms. Wettlaufer was held there by law as an involuntary patient on a Form 1 under the *Mental Health Act*.

147. At the time of her admission there was no ongoing criminal investigation relating to any victim or in relation to Ms. Wettlaufer. Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients. While CAMH came to consult legal counsel and professional bodies to determine their legal duties in these unusual circumstances, they took measures to be fair to Ms. Wettlaufer very early on. That is, CAMH invited Ms. Wettlaufer to discuss the matter with a lawyer before discussing her conduct further. She declined. CAMH told her that they may have a legal obligation to report what she was saying both to the College of Nurses and

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to police. It did not matter. Over the course of 20 days, she continued to confess to CAMH repeatedly and in detail even after CAMH told her that police and the college had been contacted. She insisted she wanted to be taken seriously.

148. Ms. Wettlaufer was treated by the Women's Inpatient Psychiatrist, Dr. Allan KAHN, who suggested she organize her thoughts and admissions *on paper* for therapeutic purposes. After considering that suggestion for a few days, on September 24 and 25th, 2016 Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She later told police that writing it out "was my decision, I was under no duress when I wrote them out" and that she was "very very careful when I wrote that". Still, she explained that she wrote it from memory without any other records available to her, that some of the dates and insulin dosages were approximated. A photocopy of the handwritten document is marked as **Appendix A**. Ms. Wettlaufer eventually consented to Dr. KAHN providing her hand-written admissions to police and furthermore to facilitate her speaking with police. It was arranged.

149. On September 29, 2016, Woodstock Police Criminal Investigations Branch was notified of the allegations because the majority of the offences occurred in Woodstock. It was agreed that detectives with Toronto Police Service would conduct an initial interview with Ms. Wettlaufer.

150. With her consent, Elizabeth Wettlaufer agreed to go with Toronto Police Service officers to be interviewed on September 29th, 2016. She was *temporarily* released from

CAMH for this purpose. She declined an opportunity to speak with counsel and spoke voluntarily for about 40 minutes before explaining that she had become fatigued and asked to return to CAMH. With that, police terminated the interview and returned her to CAMH. Woodstock police were advised as to the content of this interview.

151. On October 3, 2016, Woodstock Police commenced their own investigation which resulted in a joint investigation by Woodstock Police Service, the Ontario Provincial Police and London Police Service because the allegations involved multiple Ontario jurisdictions - Woodstock, London, Paris and Ingersoll.

152. The second interview, given on October 5, 2016, is more detailed than the first⁵ and will be played in court. As edited (removing times when there is no discussion and some personal details of others etc.), this video recorded statement is about 2 ½ hours long but, in all, she was at Woodstock police station for about 3 hours 40 minutes. This edited video recorded statement and related transcript will be marked **Exhibits B and C** respectively to this agreed statement of fact. One part of the October 5th, 2016 interview requires clarification. In it, police confront Ms. Wettlaufer with a proposition that police had come across *other* "suspicious deaths" at that time. That was untrue. Police had not come across other suspicious deaths. It was said to gauge her reaction. She denied any further victims.

153. On October 5, 2016, Ms. Wettlaufer was discharged from CAMH and agreed to go with police to Woodstock for a second interview. At Woodstock Police

⁵ The substantive details that appear *only* in her first police interview are in this document. They are embedded into the description of the individual offences.

Headquarters, Ms. Wettlaufer provided a cautioned statement with D/Cst. HERGOTT where she confessed in detail.

154. On October 6, 2016, Ms. Wettlaufer appeared before a judge where she voluntarily entered into an 810.2 recognizance with numerous conditions while police conducted a more in-depth investigation.

155. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Computer Search

156. Police seized and examined Ms. Wettlaufer's personal computer by search warrant. On September 8th, 2016, a week before going to CAMH, Elizabeth Wettlaufer performed *google* searches for the names of five victims (Beverly Bertram, Sandra Towler, James Silcox, Helen Matheson and Helen Young) and reviewed the obituaries for three others (Gladys Millard, Maureen Pickering and Arpad Horvath). On September 14th, the day before attending CAMH, there was other computer activity noted:

- She searched a website "Yahoo answers" for answers to two questions: "*How long and how painful is insulin over dose death? What Happens to the person in this case?*"
- She viewed an article entitled "*5 Killer Nurses Who Preyed on Their Helpless Patients*".

- She viewed another article entitled "*When Nurses Kill*", apparently published by Psychology Today.

CAMH Records

157. Police obtained all Ms. Wettlaufer's psychiatric records, from CAMH and elsewhere.⁶ There is no evidence she told any other mental health professionals about harming patients. The most detailed and meaningful records are from CAMH. The CAMH discharge data summary (9 pages) will be appended to this agreed statement of fact as **Appendix D**. There is no dispute as to its accuracy. In part, psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

158. Criminal Responsibility and Intoxication. None of her mental health diagnoses are a defence under section 16 of the *Criminal Code* (not criminally responsible on account of mental disorder). Further, while Ms. Wettlaufer did use prescription drugs on occasion while working, she does not claim to have been intoxicated by drugs or alcohol while committing the crimes to which she has pleaded guilty.

⁶ Psychiatric records were seized by production orders sealed pending a claim of privilege or a consent to unseal and disclose. Ms. Wettlaufer was co-operative with this investigation. With her consent, privilege over these records was not claimed and the records were unsealed and disclosed to her.

Confessions to others

159. In her October 5, 2016 video statement (and to CAMH), Elizabeth Wettlaufer explained that she had disclosed that she had harmed patients to others. Police investigated and were able to confirm much of what she said but none of the confessions to others were as detailed as what she said to police or to CAMH staff. Police interviews are summarized below. In some respects, Ms. Wettlaufer remembers some specifics differently than the witnesses disclosed but it is agreed that this is a fair summary of what occurred:

- a. **Pastor and his wife.** On October 18, 2013 Ms. Wettlaufer met with her then pastor and his wife. During the meeting she told them, among other things, that she had killed some of her (unnamed) patients. The pastor's wife recalls Ms. Wettlaufer mentioning the use of a drug and she believes the drug that was mentioned was insulin. The couple told police they could not grasp what they were being told. The pastor told police he was unsure about whether to believe Ms. Wettlaufer. His wife told police that she did not believe it. Ms. Wettlaufer asked that they pray with her and that is what they did. There was no follow up. They decided to never speak to Ms. Wettlaufer about it again. The confession went unreported.

- b. **Student nurse's aide.** Sometime in the period 2009 to 2011 a young woman worked as a nurse's aide at Caressant Care. She was between 16 and 18 years of age at the time. She befriended Ms. Wettlaufer and

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on either her 16th or 17th birthday Ms. Wettlaufer took this young woman out to dinner in Toronto. This young woman explained that she and Ms. Wettlaufer came to discuss a number of people dying during Ms. Wettlaufer's shifts. In the course of those discussions, Ms. Wettlaufer admitted harming some patients; she had overdosed them on insulin. The young woman told police that she thought Ms. Wettlaufer appeared remorseful. A couple of days later the young woman told Ms. Wettlaufer that she felt the need to report this to either staff or police. Ms. Wettlaufer told her that no one would believe her since there was no proof and Ms. Wettlaufer would simply deny it. Ms. Wettlaufer also told her that she had found God and He had directed Ms. Wettlaufer to do it and had forgiven her. The confession went unreported.

- c. **Former NA Sponsor.** Ms. Wettlaufer's former sponsor in Narcotics Anonymous explained to police that she recalls discussions with Ms. Wettlaufer in Step 4 of their work which deals with admissions. She approximated that these conversations occurred in 2014 but could not be certain of the year. Ms. Wettlaufer insinuated, but did not actually say, that she had committed murders by drawing circled letter "M"s. She indicated that 8 people were harmed though no names or specifics were used. Although this former sponsor believed that Ms. Wettlaufer was capable of such acts, she told police that she thought Ms. Wettlaufer was a pathological liar and was manipulative. She did not believe it. In

sessions Ms. Wettlaufer talked about power, control, obsession and rush when discussing her feelings including having homicidal thoughts. These admissions went unreported.

- d. **Former boyfriend.** Ms. Wettlaufer had sporadic social media contact with a friend from bible college. Sometime in 2015 she confessed to him that she had killed two of her patients using insulin and told him that to the best of her knowledge there was no evidence. This person did not report the confession to police. He explained to police that he had no timeline and thought that the confession could be attributed to Ms. Wettlaufer having a psychiatric event of some sort. On August 26, 2016 she messaged him by text that on the past Sunday (August 21) she had tried to kill one of her patients. [We now know this was Beverly Bertram but no name was provided.] This admission went unreported. His last electronic (text) message from her indicated that she was in the back of a police car heading back to Woodstock.

- e. **Former Roommate.** In the fall of 2014 Ms. Wettlaufer told her roommate/ girlfriend that she had stolen drugs from her employer and that she was going to get some help for her drug issues. She also said that while at work she "had been suicidal over the years and at times she sometimes feels like she wants to kill somebody" in the nursing homes. By then, Ms. Wettlaufer had been terminated at Caressant Care

so the roommate was “freaked out” but not “too concerned with it” assuming that she would get some help. The roommate did not tell anyone about this conversation until approached by police in October 2016.

- f. **Cousin.** In September of 2016, just prior to going to CAMH, Ms. Wettlaufer contacted a cousin. She told her cousin that she was checking herself in to a mental health facility. She said something was very wrong and she could be responsible for the deaths of some patients at work. When asked if these people could simply have passed away on her shift, Ms. Wettlaufer explained by text, that she felt that she had given them too much insulin and that she was responsible. The admissions to this cousin went unreported.
- g. **AA friend.** Ms. Wettlaufer and a former AA friend kept in touch over the years. In early September 2016, about a week prior to going to CAMH, Ms. Wettlaufer told this person that she had been overdosing patients on insulin since 2007 and that some patients died because of it. She also indicated that she quit her job because she was asked to work with diabetic children. This person told Ms. Wettlaufer that she was prepared to call the police if Ms. Wettlaufer had not followed through. This person later confirmed that Ms. Wettlaufer went to CAMH and spoke to police.

They stayed in touch by text message while Ms. Wettlaufer went to CAMH. While there, Ms. Wettlaufer identified this friend.

- h. **Acquaintance from NA.** The night before she went in to CAMH Ms. Wettlaufer reached out to an acquaintance from Narcotics Anonymous. She texted that person that she had been overdosing patients, that she was going to be sent to work with children and she couldn't do that. Ms. Wettlaufer told her that she was checking herself in to CAMH and continued to check in with that person during her stay there. This person explained that she was prepared to contact police if Ms. Wettlaufer did not seek help and explain what she had done to CAMH and police.
- i. **Acquaintance from drug counselling program.** In 2016, while in CAMH, Ms. Wettlaufer reached out by text to a former acquaintance she knew from a drug counselling group a couple years prior. In that text conversation Ms. Wettlaufer asked questions about jail. She went on to explain that she might be going to jail as soon as the upcoming weekend. When asked why, she admitted that it was regarding deaths for which she was responsible that had occurred between 2007 and 2016, and "Yes, I am guilty". In her last text message, Ms. Wettlaufer indicated that she was in a car with police driving back to Woodstock.

- j. **Facebook Friend.** In late September 2016, while at CAMH Ms. Wettlaufer was online on Facebook Messenger. An old friend connected with her to see how she was doing since he knew she was in CAMH. She confided in him that she had been responsible for the deaths of several people while on duty in her professional capacity. She told him that these were not accidental, that she deliberately administered insulin overdoses to them. She acknowledged that she was currently an involuntary patient at CAMH and that she expected to be arrested upon her release. This person called police.
- k. **College of Nurses.** On September 30, 2016, while at CAMH, Ms. Wettlaufer sent an email to the College of Nurses from CAMH. It read in its entirety: "I Elizabeth T. Wettlaufer am no longer fit to practice as a nurse. I have deliberately harmed patients in my care and am now being investigated by the police for same." She also telephoned an investigator from the College of Nurses from CAMH the same day. In that telephone call Ms. Wettlaufer explained that she had been giving insulin overdoses between 2007 and 2016, explaining she had done this about 14 times in all. Further, she described the various locations where these events occurred – essentially what she told police in an abbreviated form. In that call she told the College of Nurses she would have CAMH fax the four-page confession she had written [Appendix A]. CAMH provided it and many of their other records to the College of Nurses.

- i. **Bible College Friend.** On October 10, 2016, shortly after her release from CAMH, Ms. Wettlaufer contacted an old friend from bible college with whom she had stayed in contact. During the conversation she admitted that she had given insulin overdoses to patients who didn't need insulin. No detailed information was given. She also explained that police were gathering a case against her and asked if this friend had been contacted by them. This friend later told police that he/she was in shock, that Ms. Wettlaufer was capable of doing this, and that he/she could not see her fabricating it.
- m. **Lawyer.** In her statement to police and to CAMH, Elizabeth Wettlaufer said she had consulted a lawyer (not Mr. Burgess) years earlier. Ms. Wettlaufer told them that the lawyer explained it would be in her interest to remain silent. To CAMH, Ms. Wettlaufer explained further that the lawyer urged her to pursue professional help from a mental health professional.

ADMISSION OF LIABILITY AND SIGNIFICANCE OF THIS DOCUMENT

160. Elizabeth Wettlaufer has been in custody since she turned herself in for arrest on October 24, 2016. She has never applied for bail. She has no prior findings of guilt or convictions. There are no outstanding charges other than those before this court. She is currently not entitled to practice nursing having resigned on September 30, 2016. The

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College of Nurses is currently investigating this matter and in due course there will be a disciplinary hearing. While the parties do not speak for the College of Nurses, it can be reasonably assumed that this guilty plea will effectively ensure she loses her nursing status permanently.

161. Elizabeth Wettlaufer admits she committed first degree murder in relation to eight people – James Silcox, Maurice Granat, Gladys Millard, Helen Matheson, Mary Zurawinski, Helen Young, Maureen Pickering and Arpad Horvath. Specifically, she acknowledges and understands that:

- a. In the periods alleged she intentionally applied force to each of them by injecting each of them with insulin.
- b. When injecting insulin into each, she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.
- c. When injecting insulin into each of them, she knew she did not have consent to do so from any of them or from their powers of attorney.
- d. She intended to murder each of them. Specifically,
 - i. In relation to James Silcox, Maurice Granat, Gladys Millard, Helen Matheson, Mary Zurawinski, Helen Young, and Arpad Horvath, Elizabeth Wettlaufer intended to kill each of them, and
 - ii. In relation to Maureen Pickering, Elizabeth Wettlaufer intended to cause bodily harm that she knew was so serious that it would likely kill Maureen Pickering and proceeded to inject Maureen Pickering despite

knowing Maureen Pickering would likely die as a result of the bodily harm she intended to cause.

- e. The injections of insulin were significant contributing causes of each of their deaths;
- f. That before injecting each of them she considered the consequences of giving the injections. Further, before injecting each of them, she formulated a scheme or design after weighing the advantages and disadvantages of giving the insulin injections. Once the scheme or design was formed, she then executed each scheme or design immediately.

162. Elizabeth Wettlaufer admits she is guilty of four counts of attempted murder in relation to four people – Wayne Hedges, Michael Priddle Sandra Towler and Beverly Bertram. Specifically, she acknowledges and understands that:

- a. In the periods alleged she intentionally applied force to each of them by injecting each with insulin.
- b. When injecting insulin into each, she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.
- c. When injecting insulin into each of them, she knew she did not have consent to do so from any of them or from their powers of attorney.
- d. When she injected each of them, she intended to kill each of them.

163. Elizabeth Wettlaufer admits she is guilty of two counts of aggravated assault.

Specifically, she understands and acknowledges that:

- a. In the periods alleged she intentionally applied force to each Clotilde Adriano and Albina DeMedeiros by injecting each with insulin.
- b. When injecting insulin into each Clotilde Adriano and Albina DeMedeiros, she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.
- c. When injecting insulin into each Clotilde Adriano and Albina DeMedeiros, she knew she did not have consent to do so from either of them or from their powers of attorney.
- d. When injecting insulin into each Clotilde Adriano and Albina DeMedeiros, she knew then that an overdose of insulin could be fatal.
- e. By injecting insulin into each Clotilde Adriano and Albina DeMedeiros, she endangered each of their lives.

164. Elizabeth Tracy May Wettlaufer confirms that she has received independent legal advice regarding the case against her, her available defences, the implication and significance of entering guilty pleas and her signing this document. By entering guilty pleas and signing this document, Elizabeth Wettlaufer acknowledges her understanding that she waives her right to a trial at which the Crown would be obliged to prove all essential elements of the charges before the Court beyond a reasonable doubt.

165. Elizabeth Wettlaufer understands that first degree murder involves a minimum sentence of life imprisonment without eligibility for parole for 25 years and section 745.6(2) of the *Criminal Code* bars an application for a reduction of parole. The Crown acknowledges that pursuant to section 746 of the *Criminal Code*, parole calculations are to be based on the date of arrest, October 24, 2016. Further, Elizabeth Wettlaufer acknowledges understanding that the Crown and her counsel will jointly propose a sentence as follows:

- a. On all counts of first degree murder (counts 3, 4, 7 to 12 inclusive), life imprisonment without eligibility for parole for 25 years, all sentences to run concurrently.
- b. On all counts of attempted murder (counts 5, 6, 13 and 14), 10 years to run concurrently to each other and to all other sentences.
- c. On all counts of aggravated assault (counts 1 and 2), 7 years concurrent to each other and concurrent to all other sentences.

166. Elizabeth Wettlaufer and the Crown agree that nothing in this document bars an appeal of the sentence imposed.

167. The Crown and Elizabeth Wettlaufer confirm that notwithstanding any submission made regarding the length of sentence to be imposed for the non-fatal charges, the final decision as to sentence remains with the Court.

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168. It is agreed that the Court is obliged to make two mandatory ancillary orders as part of the sentence imposed⁷:

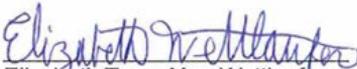
- (a) DNA databank order in Form 5.03
- (b) Weapons prohibition for life under section 109

169. Elizabeth Wettlaufer also confirms her understanding that, if this guilty plea is struck or later overturned on appeal, the Crown may seek to use this document as a voluntary confession in any resulting proceeding.

170. Elizabeth Wettlaufer confirms that she speaks and reads English, that she has read this document and that all the facts in this document are true and correct.

ALL OF WHICH IS AGREED,

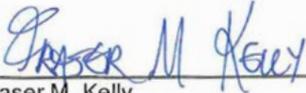
SIGNED by Elizabeth Tracy Mae Wettlaufer and Brad Burgess at Woodstock
Ontario on the 1st day of July, 2017.


Elizabeth Tracy Mae Wettlaufer

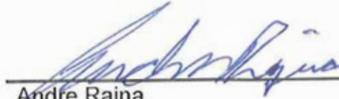

Brad Burgess
Counsel for Ms. Wettlaufer

⁷Murder, attempted murder and aggravated assault are all *primary designated offences* under section 487.04 of the *Criminal Code* and the DNA order is therefore mandatory pursuant to section 487.051(1). A ten-year weapons prohibition is mandatory pursuant to section 109(3).

SIGNED on behalf of the Ministry of the Attorney General, Province of Ontario at
Woodstock, Ontario on the 1 day of JUNE, 2017.



Fraser M. Kelly
General Crown Counsel



Andre Rajna
Crown Attorney

Appendix A to the Agreed Statement of Fact – Handwritten confession

Appendix A to the Agreed Statement of Fact Handwritten Confession

Sept 2007 CareSant Care Not a diabetic, had dementia

Written Sept 24 -
Elizabeth [unclear] off

① James Silcox - I was working a double shift. 3pm - 7am.

James was known for inappropriately touching the staff. [redacted]

[redacted] James was not diabetic.

That evening I got the urge to overdose James. I was angry that he was so inappropriate. At approximately 7:30pm I decided to overdose him with insulin, hoping he would die. I felt it was his time to go because of the way he acted. I remember feeling angry at him.

I went into the med room & used a spare insulin meddle to prepare a dose of 50 units of short acting insulin. I gave it to him at app. 10:30 p.m.

Throughout the night, after I overdosed him, James called out "I'm sorry" and "I love you". At app. 3:00 a.m., the P&W's found James vital signs absent. I called the attending physician and the James family to inform them of James' death. The physician ruled his cause of death to be a post surgery embolism.

Sept or Oct 2007

② Maurice Granat CareSant Care Not a diabetic, cancer patient

I was told by one of the nurses that Maurice had a bad habit of grabbing the staff's breasts and asses. One afternoon I was working and I felt angry. I gave Maurice app. 40 units of short acting

Maurice Granat (cont'd)

Page 2 of 4

insulin at around 8 pm. By the next morning he was in a coma. He died some time that afternoon.

October 2011

Helen Matheson Not a diabetic, Carersant Care, Dementia

Helen was very quiet & reserved. One afternoon I gave her an overdose of insulin. I am not sure why I chose her. I was feeling angry and frustrated about my job. After the overdose she stopped talking and eating. The Doctor declared her to be palliative. She died 2 days later.

October November 2011

Mary Zerwinski - Not a diabetic, Carersant Care, dementia

Mary was spunky, thin and outspoken. One afternoon, around 4 pm, I gave her 50 units of short acting insulin and 30 units of long acting insulin. She begged me because she was outspoken & resistant to care. I was feeling very angry in general. She died the next afternoon.

November 2011

Gladys Millard - type 2 diabetic, Carersant Care, dementia

Gladys had severe dementia & no longer talked. She was very stubborn & horribly difficult to give pills to.

I was working 7-5:11 pm - 7 am. At around 5 am I gave her 40 units of long acting insulin and 60 units of short acting insulin. At app. 7 am she became unresponsive and diaphoretic. She died that evening.

Eizabeth Wattleup

October 2013

pg 3 of 4

Helen Young - Caressant Care - type 2 diabetic, - dementia

Helen was feisty and outspoken. She was constantly saying "help me nurse". She frequently yelled out "I want to die". One afternoon I felt like something snapped inside me. She kept yelling out she wanted to die. I thought angrily "fine. I'll help you die." I gave her 60 units ~~of~~^{of} short acting insulin just before supper. After supper I gave her 60 units of long acting insulin. At app 8pm the PSWs called me to her room. Helen was having a seizure. She was not epileptic. I took all her vital signs and pretended to take her blood sugar. She died 2 days later.

March 2014th March 2014

Maureen Pickering - Caressant Care - dementia, diabetic

Maureen had a lot of behaviours. She would hit other residents or pull their hair. She was on one to one care. We didn't always have the needed staff for this. Sometimes I had to be with her 1 on 1 as well as give pills to 32 people, do paperwork and do treatments. One afternoon shift we did not have her 1 to 1 staff. I was angry, frustrated and irritated. She kept yelling out random^{or} things. I gave her a Haldol shot to calm her down. Then I got the idea that if I could cause her some brain damage she wouldn't be such a handful.

At app. 8pm I gave her 80 units of long acting insulin. That night she went ^{to} had a stroke.

E. [Signature]

March 2014^{8th} March 2014^{8th}

Pg 4/14

Maureen Pickering (cont'd)

She was sent to hospital where she became comatose. She died app. 5 days later.

August 2014^{8th} Meadow Park Nursing Home

Arpad "Art" Horvath Dementia, Not diabetic

Art was physically abusive to the staff. He would pinch & hit. One evening I decided enough was enough I felt angry, frustrated, vindictive, & energized. I gave Art 80u of short acting insulin & 60u of long acting insulin at app 8pm. During the night he had a stroke, ~~and~~ died 4-5 days later.

People who didn't die

Clotilda Adriano - dementia - diabetic - Caressant Care
September 2007

Robina Demidenov - diabetic - Caressant Care
October 2007

Wayne - dementia diabetic - Caressant Care
October 2008

Mike - Huntington's disease
2009

Sandra Fowler Telfer Place Paris Winter 2016 Gave her 80u long acting insulin, 60u short acting
Survived.

Beverly ~~(?)~~ ^{Sk} (?) diabetic

August 2016 Saint Elizabeth, Ingersoll, homecare
Gave 180u long acting insulin via Picc line
Survived -

Elizabeth Wettkamp

Appendix C to the Agreed Statement of Fact – Transcript of police statement

Appendix C to the Agreed Statement of Fact

Transcript of Elizabeth Wettlaufer's Police Statement

Date: October 5, 2016



TRANSCRIPT OF TAPED INTERVIEW

RMS #:	955-10-2016-110
Audio Recorded Interview:	<input checked="" type="checkbox"/>
Video Recorded Interview:	<input checked="" type="checkbox"/>
Name:	Elizabeth WETTLAUFER
Residence:	
Date of Birth:	
Telephone: <i>Residence:</i>	
<i>Business:</i>	
<i>Cell:</i>	
Date of Interview:	October 5, 2016
Location of Interview:	Woodstock Police Service
Interviewed By:	D/C Nathan HERGOTT
Time Interview Commenced:	1714 hrs
Time Interview Concluded:	1923 hrs
Others Present:	D/C Karen OVERBAUGH U/I Male
Transcribed By:	J.P. #399935 (00:00:00 to 01:59:59) L.K. #335196 (02:00:00 to 03:48:23)
Reviewed By:	M.R. #449963 Nathan HERGOTT #704
(ph) phonetic spelling	



[On Oct. 5, 2016, Woodstock Police attended CAMH in Toronto. Ms. Wettlaufer was discharged that day but agreed to go with police for an interview. Take-out food was purchased en route to Woodstock. Ms. Wettlaufer was then escorted into an interview room and left alone to eat. Thereafter, the interview starts...]

[Personal information of 3rd parties has been deleted]

(D/C HERGOTT enters room at 00:32:15

dur) HERGOTT: there you are

WETTLAUFER: thank you

HERGOTT: I'll just be one more quick second okay

WETTLAUFER: yup

HERGOTT: okay thanks Beth

(D/C HERGOTT exits room 00:32:20 dur; no conversation heard from
00:32:20 to 00:34:30 dur)

(D/C HERGOTT enters room at 00:34:30 dur)

HERGOTT: sorry about that

VIDEO STARTS HERE

WETTLAUFER: that's okay



HERGOTT: too many people movin and shaking around here and you can't

WETTLAUFER: (laughs)

HERGOTT: really keep track of who's doing what so um so yeah like I said um I'm I'm just gonna go through for everything in this room is audio and video recorded first off

WETTLAUFER: right

HERGOTT: you okay with that

WETTLAUFER: okay oh yeah

HERGOTT: okay

WETTLAUFER: of course

HERGOTT: so I just wanna go through like I said a couple formalities cover a few little things off things that I have to do on my end that I I need to do

WETTLAUFER: right

HERGOTT: and uh things that I just wanna tell you an make sure that we're all on the same page before we uh before we get goin

WETTLAUFER: okay

(00:35:00 dur)

HERGOTT: okay so first off um today is Wednesday October the 5th 2016 and on my phone right now I'll just use as a a time reference is five fourteen (5:14)

WETTLAUFER: okay

HERGOTT: so seventeen fourteen (17:14) we'll just use as a start time of our conversation here today um again my name's Nathan HERGOTT with the Woodstock Police Service

WETTLAUFER: mm hmm

HERGOTT: I currently work in our crime unit

WETTLAUFER: okay

HERGOTT: and uh we met a short time ago in downtown Toronto correct

WETTLAUFER: yup

HERGOTT: alright

WETTLAUFER: yup

HERGOTT: so um we came to a facility where you've spend the last uh few weeks from what I understand

WETTLAUFER: yeah

HERGOTT: and uh we met with doctor KAHN and

WETTLAUFER: yeah

HERGOTT: and his team of uh associates an

17:14:04.



WETTLAUFER: yeah

HERGOTT: uh I believe you're under his care for the last little while correct

WETTLAUFER: yup the last three (3) weeks

HERGOTT: okay and uh the process how how we got here basically is um we kinda offered you a ride back and and so we could have this conversation an and you gracefully accepted an uh off we went down uh the 401 or the well the the gardner the Q E

WETTLAUFER: yeah

HERGOTT: and the 403 an an

WETTLAUFER: the 403 an

HERGOTT: and here we are right

WETTLAUFER: mm hmm

HERGOTT: um so just to make it clear for whoever might watch in the future um we didn't force you to come with us we didn't uh you know shove you in the car and off we went kinda thing

WETTLAUFER: no

HERGOTT: you did it on your own free will and you accepted it on your own uh on your own decision making

WETTLAUFER: yup no

HERGOTT: is that correct

WETTLAUFER: yup I had enough and you even let me try to give money to the homeless people so

HERGOTT: there you go I remember all that

WETTLAUFER: (unintelligible)

HERGOTT: I remember all that so I I know I read ya a few things before um as we were kinda just cruising down Spadina there um and I know you've been read this many times but it's just things that we need to just reiterate and and make sure that you're clear and comfortable with

WETTLAUFER: okay

HERGOTT: with having this conversation today

WETTLAUFER: okay

HERGOTT: okay um like I said um based on our investigation there could be some some pretty serious criminal charges that result of

WETTLAUFER: yeah

HERGOTT: of our investigation okay

WETTLAUFER: yeah

17:15:1



HERGOTT: so having said that if if you wish to speak to a lawyer at any time

WETTLAUFER: okay

HERGOTT: I don't want ya to hesitate uh we can make it happen whenever you like

WETTLAUFER: okay

HERGOTT: so whether it's now five (5) minutes from now an hour from now or three (3) days from now whatever the case may be you just let

WETTLAUFER: we're not gonna be asking questions for three (3) days are we

HERGOTT: I hope not I hope

WETTLAUFER: (laughs) okay

HERGOTT: I'm just use I'm just saying that anytime that you wanna speak to a lawyer that you're kind of in our company or whatever the case may be you let us know an and we can make that accommodation for you

WETTLAUFER: okay okay

HERGOTT: does that make sense

WETTLAUFER: yup

HERGOTT: okay because you uh in your position uh as a Canadian citizen you're uh you're entitled to have free legal advice from a legal aid

WETTLAUFER: okay

HERGOTT: uh duty counsel lawyer a lawyer of your choice whoever you like

WETTLAUFER: okay

HERGOTT: make sense

WETTLAUFER: yeah

HERGOTT: okay um an an like I said because there could be some criminal charges that that result of of our investigation

WETTLAUFER: right

HERGOTT: okay um also an an I know you've been read this many times before that and you may be charged uh with many criminal offenses um and you don't have to say anything in answer to the charges that you face but if you wish to do so um we're gonna do that today um but whatever you do say could be used in in court and I know we had that conversation in the car on the way on the way uh

WETTLAUFER: yeah

HERGOTT: back to Woodstock

17:16:32



WETTLAUFER: yup

HERGOTT: an I asked you to repeat it in your own words and you kinda gave us a few uh a few (unintelligible) of of describing it in your own vocabulary as think you said something like not Vegas what happens in the car on the way back doesn't necessarily stay in the car right

WETTLAUFER: yes no

HERGOTT: so same thing same thing in this room anything that you say

WETTLAUFER: okay

HERGOTT: and everything that we talk about can be used as evidence

WETTLAUFER: can come out

HERGOTT: at court

WETTLAUFER: yup

HERGOTT: okay

WETTLAUFER: okay

HERGOTT: so kind of to put it easily the same rules apply

WETTLAUFER: okay

HERGOTT: okay um and if you've spoken to any other police officers I know that you've dealt with uh the Toronto police officers

WETTLAUFER: with Toronto yeah

HERGOTT: uh there was uh a couple officers in the car on our trip back here um if anyone's persuaded you or tried to push you into making a statement whatever they've said I don't want that to influence you

WETTLAUFER: no

HERGOTT: in any way okay

WETTLAUFER: no what I'm about to say

HERGOTT: I want ya to

WETTLAUFER: uh uh I'm doing of my own free will

HERGOTT: okay alright and I appreciate that um and we'll get moving forward for an another few things and I know that because it's in the car you are not under arrest right now

WETTLAUFER: okay

HERGOTT: okay I wanna make that very clear to you

WETTLAUFER: okay

HERGOTT: okay you're not under arrest the door is unlocked okay I'm not impeding your way to the door if you wanna leave

17:17:40



at any time if you wanna stop talking to me at any time you just let me know and uh

WETTLAUFER: okay

HERGOTT: and we'll just carry on from there

WETTLAUFER: okay

HERGOTT: okay but you're not being held here against your will uh

WETTLAUFER: yeah

HERGOTT: we're not forcing you to speak to us um we just have some follow up some uh some follow up questions from the investigation that kinda

WETTLAUFER: okay

HERGOTT: Got going while you were in Toronto

WETTLAUFER: yeah being interviewed is hard cuz it takes so long

HERGOTT: it does

WETTLAUFER: um so I'll do my best like if like I said if I have to get up and pace around a bit or whatever

HERGOTT: if you wanna take a break at any time you let us know if you wanna get up and pace around I'll just kinda hang tight here and

WETTLAUFER: yeah

HERGOTT: and we'll just keep conversing as long as uh as long as you're comfortable

WETTLAUFER: I'll I'll go as long as I can

HERGOTT: okay alright sounds good um that's kind of all the formalities but but like I said uh those are the the things that I just wanted to make sure that were were clear to you and if you have any questions for me before we get started

(00:40:02 dur)

WETTLAUFER: (clears throat)

HERGOTT: the floor is yours if if there's anything

WETTLAUFER: no

HERGOTT: or any concerns that ya have

WETTLAUFER: no I just I wanna get through this and find out what happened to my mom and dad cuz I know they're upset cuz someone went to visit them today

HERGOTT: okay and

WETTLAUFER: they visited them today and they said you know they're here we're concerned what's goin on

HERGOTT: yeah yeah oh I can imagine I can imagine I and I honestly don't have those answers for you

17:18:50



WETTLAUFER: okay

HERGOTT: but I can get them for you um

WETTLAUFER: okay

HERGOTT: my role in this investigation so far has been not as in depth as some of the other officers um but

WETTLAUFER: okay

HERGOTT: my my task today obviously was to travel to Toronto an an and meet with you with with my fellow coworkers

WETTLAUFER: yeah

HERGOTT: and uh and come back here an and have a conversation so that's kinda where where I'm at right now but I can definitely get those answers for ya

WETTLAUFER: okay

HERGOTT: an and uh I don't wanna upset any more people that need to be uh especially your mom and dad

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: and you shoulda bought blue It blue jay tickets while you were there

HERGOTT: you know what if I could afford them for the playoff I probably would've yeah I that was exciting last night um so just just for the record uh and I know you you prefer to go by Beth is what you told us

WETTLAUFER: yeah

HERGOTT: is that correct

WETTLAUFER: yeah

HERGOTT: can you just state your full name for me

WETTLAUFER: Elizabeth Tracy Mae WETTLAUFER

HERGOTT: uh Tracy Mae

WETTLAUFER: yup

HERGOTT: okay and just spell your last name for the record

WETTLAUFER: W E T T L A U F E R

HERGOTT: okay perfect um and Beth the reason why we're here today is because uh we've received some information uh back at the end of last week um with regards to uh some information that was provided to the Toronto Police service

WETTLAUFER: mm hmm

HERGOTT: um which is led us into uh quite a bit of work an an leads us here today to speak to you with regards to kinda how this all started an and follow up

17:20:11



WETTLAUFER: yeah

HERGOTT: but basically um I I watched your statement that you provided to Toronto

WETTLAUFER: okay

HERGOTT: okay and we've been provided uh this document here does that look familiar to you

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: (unintelligible)

HERGOTT: alright and from what I can see here there's four (4) pages of uh a handwritten document is that your handwriting

WETTLAUFER: yes it is

HERGOTT: okay and it just kinda goes through um some people that you've encountered in in your career uh from 2007 through to

WETTLAUFER: 2016

HERGOTT: 2016 of August

WETTLAUFER: yeah

HERGOTT: uh August of 2016 okay so so that's kinda the the focus of our investigation right now

WETTLAUFER: right

HERGOTT: is the the information that you you've put on these four (4) pieces of paper

WETTLAUFER: yes

HERGOTT: okay um but but before we get into that I just wanna kinda get an idea of your career an and where you've kinda where you've been in your career

WETTLAUFER: um

HERGOTT: and kinda how you got into things an

WETTLAUFER: registered nurse. I started from call I started from wood from uh Huron Park uh secondary school I um (clears throat)

HERGOTT: let's move that out of your way

WETTLAUFER: I graduated grade thirteen (13) went for a year of law school not law school sorry journalism school

HERGOTT: okay

WETTLAUFER: and uh then uh went to uh Bible College

HERGOTT: yup

17:21:30



WETTLAUFER: at London Baptist Bible College in London graduated with a degree in uh counselling just a bachelor's degree in counselling

HERGOTT: mm hmm

WETTLAUFER: and then um discovered that that's not gonna be wasn't really gonna get me a lot far as work wise an career wise an so I went back to uh Huron Park high school for a year and I took a year of math and sciences and went on to um Conestoga College in in uh they have it's in Kitchener but they have Stratford campus so I went there for the three (3) years

HERGOTT: okay

WETTLAUFER: and then when I graduated there I worked in a place called Geraldton

HERGOTT: okay

WETTLAUFER: which is sixteen (16) hours West of sun of uh Toronto

HERGOTT: I was gonna say that's quite a bit North isn't it

WETTLAUFER: three (3) hours North of Thunder Bay

HERGOTT: yeah that's a ways up there

WETTLAUFER: yeah um worked there couldn't stand the isolation moved back worked for um an organization called uh Christian Horizons here in town in one of their group homes till 2007 um at which time um my marriage fell apart in February 2007 an uh I met a woman online

HERGOTT: okay

WETTLAUFER: and she decided to move to be with me

HERGOTT: okay

WETTLAUFER: so um I ended up quitting the job I was at and going to Caressant Care to make a little bit more money cuz I was the only breadwin earner

HERGOTT: mm hmm

WETTLAUFER: so I started working at Caressant Care um believe it was June 2007

HERGOTT: okay and how long did you work there for

WETTLAUFER: until um 2014

HERGOTT: okay

(00:45:00 dur)

WETTLAUFER: yeah till uh like I think it was March 2014

HERGOTT: and were you always in the same role or

WETTLAUFER: as a as a reg

HERGOTT: did you do different roles at Caressant Care or

17 : 23 : 36



WETTLAUFER: as a reregistered nurse
 HERGOTT: yeah
 WETTLAUFER: as a registered nurse's role is always the same
 HERGOTT: yeah
 WETTLAUFER: but um I worked in different areas of the home
 HERGOTT: okay
 WETTLAUFER: there's five (5) wings to Caressant Care so I worked in
 different areas
 HERGOTT: right okay all throughout the the seven (7) or so years
 that you were there
 WETTLAUFER: yes
 HERGOTT: okay and at that point did ya have different supervisors
 from unit to unit or uh
 WETTLAUFER: no there was
 HERGOTT: uh did you always report to the same person or
 WETTLAUFER: there was one supervisor Helen Crombez she was the
 head nurse
 HERGOTT: okay
 WETTLAUFER: and then there was like two (2) people under her um
 Shelly uh Jeannette um I don't remember the rest of
 them
 HERGOTT: okay
 WETTLAUFER: but there was like an uh an administrative head I think for
 most of that time it was Brenda
 HERGOTT: right oh okay um and then from Caressant Care I know
 you've you've had a few other
 WETTLAUFER: yeah I went from Caressant Care was fired from
 Caressant Care
 HERGOTT: okay
 WETTLAUFER: for a a medication area aira
 HERGOTT: okay
 WETTLAUFER: error error
 HERGOTT: yup
 WETTLAUFER: then from there I went to um Meadow Park nursing home
 HERGOTT: okay
 WETTLAUFER: and uh left there to get help with an addiction issue
 HERGOTT: okay
 WETTLAUFER: hoping that it would get help with that as well
 HERGOTT: mm hmm
 WETTLAUFER: and then when I came back I started working again in
 January I left I left Meadow Park in uh September of

17:25:04



2014 and I started working for a um nursing agency called uh Life Guard in 2015 and I worked with them for over a year and then in July 2016 I started working for Saint Elizabeth's health care

- HERGOTT: okay
- WETTLAUFER: as well I was still working for um Life Guard
- HERGOTT: oh okay and how did that work did you just split your time between the two (2)
- WETTLAUFER: um
- HERGOTT: or was it just kind of a part time position at both organizations
- WETTLAUFER: Elizabeth Saint Elizabeth's was my priority
- HERGOTT: okay
- WETTLAUFER: so and Life Guard is very much you pick up the shifts as they come there's very few scheduled shifts so
- HERGOTT: gotcha
- WETTLAUFER: I'd say yes and no to them an an book around Saint Elizabeth's
- HERGOTT: okay and wero and were those roles where you would do like in home care with different homes
- WETTLAUFER: um with uh Life Guard it's an agency so you go into nursing homes you go into people's homes you go into um you go into uh like retirement homes um you did a lot of different things a lotta one on one's with people
- HERGOTT: mm hmm
- WETTLAUFER: like in their own homies
- HERGOTT: mm hmm
- WETTLAUFER: twelve (12) hour shifts eight (8) hour shifts
- HERGOTT: okay
- WETTLAUFER: sitting with them
- HERGOTT: okay
- WETTLAUFER: a lotta stuff I did was sitting with palliative patients
- HERGOTT: right okay that would be tough
- WETTLAUFER: I it was okay
- HERGOTT: yeah
- WETTLAUFER: like cuz I knew they were gonna die
- HERGOTT: yup
- WETTLAUFER: and it was just an opportunity to give the family a rest
- HERGOTT: yeah absolutely
- WETTLAUFER: so



HERGOTT: yeah it's an important role think a lotta people wouldn't see it that way an would even notice the care that these people are giving from people like yourself right um

WETTLAUFER: yeah

HERGOTT: so to give the families a bit of a break an and to take take that role is is important then

WETTLAUFER: yeah

HERGOTT: which a lotta people don't see right so

WETTLAUFER: cuz when some when someone's dying in the house

HERGOTT: mm hmm

WETTLAUFER: families don't want evryone to be asleep at once right and that can be very hard

HERGOTT: that's right

WETTLAUFER: if you're not able to do that

HERGOTT: that's right

WETTLAUFER: but if you have a nurse there that says no it's okay I've got this I know the medications they get it's gonna be alright then

HERGOTT: oh and kinda rest easy

WETTLAUFER: yeah

HERGOTT: yeah good um back at Meadow Park oh what were ya what was your addiction

WETTLAUFER: uh hydromorph

HERGOTT: okay alright

WETTLAUFER: hydromorphone

HERGOTT: okay and what like how much were you using an

WETTLAUFER: I was a binge user

HERGOTT: okay

WETTLAUFER: so I would use what I could get a hold of

HERGOTT: okay

WETTLAUFER: by stealing it from the patients

HERGOTT: okay alright and how would that work like would it would it just be in their in their allotted medications or would you have access to a cart or

WETTLAUFER: uh

HERGOTT: (unintelligible) or

WETTLAUFER: there's a (unintelligible) (clears throat) there's some in their allotted medications some of them had um confusion so they couldn't tell the difference between what pills you were giving them I could give them a laxative instead of their hydromorph

17:28:00



HERGOTT: okay

WETTLAUFER: um there was uh lotta of them had as needed so it would be in a big card

HERGOTT: mm hmm

WETTLAUFER: and then they'd say I would just punch out the oh Barney needed two (2) of those today you know Billy needed three (3) of those today when they really didn't

HERGOTT: okay

WETTLAUFER: and that's how I would get a hold of it

HERGOTT: okay

WETTLAUFER: every once in a while there was also a um drug well uh a dru big drug uh holder like a safe almost that we would put the drugs in

(00:50:05 dur)

HERGOTT: okay

WETTLAUFER: once uh like if somebody died

HERGOTT: yup

WETTLAUFER: and there were like twenty-three (23) hydromorph's left would (unintelligible) the whole card in the drug holder

HERGOTT: mm hmm

WETTLAUFER: well if you picked it up and turned it upside down and shook it you'd get drugs back out of it

HERGOTT: okay alright

WETTLAUFER: um

HERGOTT: so you had your ways

WETTLAUFER: yes

HERGOTT: yeah okay an an was that ever uh an issue with with staff were were you ever confronted or or would that

WETTLAUFER: I would

HERGOTT: did did that go totally undetected for the the time you were there

WETTLAUFER: there was a time when um hydromorph was delivered to the home and they do get put away right away

HERGOTT: mm hmm

WETTLAUFER: by the person that should have

HERGOTT: mm hmm

WETTLAUFER: and so I took the hydromorph

HERGOTT: mm hmm

WETTLAUFER: and put it in my bag and took it home

HERGOTT: okay

WETTLAUFER: and it wasn't discovered for months

17:29:17



HERGOTT: okay
WETTLAUFER: and uh so I just played dumb
HERGOTT: okay
WETTLAUFER: when the police phoned about it I played dumb
HERGOTT: yeah and that was that
WETTLAUFER: yeah
HERGOTT: okay alright so as a bingy a binge user then like how much would you would you be using on a I mean obviously you wouldn't use it on a daily basis if you're if you were binge using but
WETTLAUFER: yeah
HERGOTT: like how long did the addiction last for
WETTLAUFER: oh the addiction lasted from I think it started in 2008
HERGOTT: okay
WETTLAUFER: so to 2014 at which time I went away and got treatment at a treatment center
HERGOTT: okay
WETTLAUFER: but then uh I started using again probably about January 2015 I started using again
HERGOTT: okay and are you still using when ya get your hands on them or
WETTLAUFER: no
HERGOTT: no
WETTLAUFER: no I'm not I'm going to I stopped using alcohol as well I'm going to the I have friends in A A and I'm I've got a very clear plan to get if I'm able to be out and about
HERGOTT: right
WETTLAUFER: I have a very clear plan
HERGOTT: okay
WETTLAUFER: and I also know if I'm not able to be out and about that A A and narcolics anonymous do have some programs where they come into prisons
HERGOTT: absolutely
WETTLAUFER: so
HERGOTT: yeah
WETTLAUFER: that's my plan
HERGOTT: well that's that's good that you have a plan um wa what do you think what do you think the reason is that you slipped into the addiction back in '08 like what what
WETTLAUFER: um

17:30:37



HERGOTT: do think it was just the stresses of the job that you were facing or

WETTLAUFER: yeah

HERGOTT: dealing with

WETTLAUFER: yeah just

HERGOTT: your personal life as well an

WETTLAUFER: just always feeling like I had to be the best possible person an very very stressful job giving medications to thirty-two (32) people um making sure treatments were done on thirty-two (32) people

HERGOTT: right

WETTLAUFER: charting for thir thirty-two (32) people supervising four (4) P S W's who sometimes didn't always get along and sometimes always didn't always get along with me

HERGOTT: yeah

WETTLAUFER: um it's a hard job any nurse will tell ya

HERGOTT: I believe it

WETTLAUFER: it's a hard job

HERGOTT: I believe it a hundred percent

WETTLAUFER: and uh then they would add different things like oh you have to do this and that to say who's here an counting the medications at the end of the shift an it's a hard job and I did

HERGOTT: and I get

WETTLAUFER: I always was putting this pressure on myself to be a really good nurse and to do everything perfectly

HERGOTT: mm hmm

WETTLAUFER: and every once in a while when I could get a hold of a hydromorph or two (2) and take it then that pressure was gone

HERGOTT: Right, right oh okay and um the treatment uh that uh that you went away to where was that

WETTLAUFER: (sighs) I cannot remember

HERGOTT: okay

WETTLAUFER: I've tried tried to remember

HERGOTT: yeah

WETTLAUFER: um

HERGOTT: was it local or out of town

WETTLAUFER: no it was a it was out of town it was like two (2) a good two (2) hour drive

HERGOTT: okay

17:31:59



WETTLAUFER: you know where the locks are

HERGOTT: yeah

WETTLAUFER: near Niagara Falls

HERGOTT: Welland

WETTLAUFER: Welland

HERGOTT: yeah

WETTLAUFER: it's a little town outside of Welland

HERGOTT: okay

WETTLAUFER: and it's they have a it's an eighteen (18) day treatment that they have an I I was successful I went to the whole thing

HERGOTT: nice so all eighteen (18) days

WETTLAUFER: yes

HERGOTT: okay and it helped

WETTLAUFER: yes yeah

HERGOTT: okay good good what about family I you were born and raised Woodstock

WETTLAUFER: yeah born and raised in Woodstock um married from 2000 and er from '97 to 2007

HERGOTT: okay

WETTLAUFER: we broke up um February 2007 no children I wanted them he never did

HERGOTT: okay

WETTLAUFER: my mom and dad are in their seventy's (70)

HERGOTT: mm hmm

WETTLAUFER: seventy-five (75) and seventy-six (76) they live [REDACTED]

HERGOTT: mm hmm

WETTLAUFER: I have cousins all over the area

HERGOTT: do ya

WETTLAUFER: um and uh my brother and his wife and four (4) kids they live in uh [REDACTED]

HERGOTT: okay

WETTLAUFER: and their um well they're they're quite active the oldest one is twenty-six (26) and he's got a a wife and two (2) kids

HERGOTT: (unintelligible)

WETTLAUFER: he lives with his parents they all live with the parents except for my nephew [REDACTED]

HERGOTT: oh is that right

WETTLAUFER: yeah just one big house (unintelligible)

17:33:14



HERGOTT: yeah
WETTLAUFER: crazy
HERGOTT: gonna say big happy family huh have ya been out to visit at all or been out East or
WETTLAUFER: um I've been to see their house the once
HERGOTT: yeah
WETTLAUFER: they've been here a few times
HERGOTT: nice

(00:55:00 dur)
WETTLAUFER: they came in 2013 for my parents uh fiftieth (50) wedding anniversary
HERGOTT: nice
WETTLAUFER: and um my nephew and his wife stayed behind and lived with my parents for a few months while my nephew tried to go to Bible College
HERGOTT: okay
WETTLAUFER: but he wasn't successful so
HERGOTT: okay
WETTLAUFER: they went back
HERGOTT: yeah so your brother older or younger than you
WETTLAUFER: older
HERGOTT: older
WETTLAUFER: he's three (3) years older than me
HERGOTT: okay
WETTLAUFER: so he's fifty (50) fifty-two (52)
HERGOTT: right on good good um so as far as your latest position at um Saint Elizabeth's
WETTLAUFER: yup
HERGOTT: that was your position as an RN
WETTLAUFER: yes it was
HERGOTT: is that correct okay and you said you resigned from there
WETTLAUFER: yeah
HERGOTT: okay what what brought you to that
WETTLAUFER: (sighs) that's that that's where things get a little crazy
HERGOTT: okay
WETTLAUFER: this is part that I haven't told the doctors
HERGOTT: okay
WETTLAUFER: um cuz it seems so stupid now
HERGOTT: okay



- WETTLAUFER: when my ex and I broke up in 2007 I was already taking the medication for my for my borderline personality disorder
- HERGOTT: okay
- WETTLAUFER: and I was so angry and it was like a voice said inside me I'll use you don't worry about it and the different times that I have caused peoples deaths or caused them discomfort through the um through the influence
- HERGOTT: mm hmm
- WETTLAUFER: I believe it was the influence of that volcé or whatever it was it wasn't a voice in my head it was a voice in here
- HERGOTT: okay
- WETTLAUFER: and when I would do it afterwards I would hear like a laughter in my tummy
- HERGOTT: okay
- WETTLAUFER: so started working for Saint Elizabeth's and I was doing well but it was a lot of pressure
- HERGOTT: mm hmm
- WETTLAUFER: and the way that you know that I helped people to die has been through insulin and uh after my first my thirty (30) day evaluation my uh my uh supervisor came to me and said you know I'm really sorry we wanted you for Woodstock but we have so many kids in schools in Ingersoll
- HERGOTT: mm hmm
- WETTLAUFER: that need help with their insulin pumps that you're gonna start working in Ingersoll
- HERGOTT: okay
- WETTLAUFER: and I panicked I panicked I didn't wanna do that
- HERGOTT: okay
- WETTLAUFER: cuz I felt you know what if those are kids so about think it was about a week after that that I quit
- HERGOTT: okay
- WETTLAUFER: yeah and then I uh packed my stuff in the car
- HERGOTT: mm hmm
- WETTLAUFER: and I drove two (2) days into co I drove into Quebec
- HERGOTT: mm hmm
- WETTLAUFER: thinking like I would just sorta run away sorta thing
- HERGOTT: mm hmm



WETTLAUFER: and then I thought no that's just stupid I came back and uh but couldn't tell my parents what was going on but they had visitors from Scotland

HERGOTT: okay

WETTLAUFER: so I didn't tell them I just (laughs) I'm sorry

HERGOTT: okay

WETTLAUFER: spent two (2) weeks pretending to go to work

HERGOTT: okay

WETTLAUFER: (laughs) (unintelligible)

HERGOTT: right

WETTLAUFER: Scotland were here

HERGOTT: okay

WETTLAUFER: it's funny but it's not funny (laughs) and then um once they left I de I decided I didn't wanna nurse anymore I didn't want to hurt anybody anymore so I also quit my other job and then I decided um well whatever Friday that was

HERGOTT: mm hmm

WETTLAUFER: that like I did a lot of looking into how I could get help cuz I realized I needed help with whatever this was

HERGOTT: right

WETTLAUFER: cuz part of me had started to believe that it was the devil

HERGOTT: mm hmm

WETTLAUFER: and part of me thought it might be God that (unintelligible) purpose through my life

HERGOTT: okay

WETTLAUFER: and uh I know the doctor asked me those questions but I didn't answer him because I was so ashamed but I just uh I didn't want this to keep going on so I quit both jobs looked into where I could get help doctor FERNANDO is my uh psychiatrist and he's not a very nice man

HERGOTT: okay

WETTLAUFER: so I went an online uh support group and was talking on to people on there and they were saying you know get some help so then I started researching some uh psych boards and stuff and I saw CAMH

HERGOTT: okay

WETTLAUFER: and they are the only um mental health facility in Ontario that has an emergency department

HERGOTT: okay



WETTLAUFER: so I made a decision and I went I went there on Friday morning I took the train and off I went

HERGOTT: okay and wa

WETTLAUFER: and before I went I had told um two (2) I had told three (3) people what was going on my my cousin [REDACTED] my uh friend from AA

(01:00:03 dur)

HERGOTT: okay

WETTLAUFER: and um my uh friend uh [REDACTED] I told them all what's going on they said yes go and get help and my friend [REDACTED] even drove me to the train station.

HERGOTT: okay and and when you say you told them what was going on did you get into details of why

WETTLAUFER: I told them that

HERGOTT: you were going to seek help or

WETTLAUFER: I told them that I have been killing people using an insulin overdose

HERGOTT: okay

WETTLAUFER: and they all said yes you better go get help so off I went

HERGOTT: okay and who is [REDACTED]

WETTLAUFER: she's friends from uh when I used to work at [REDACTED] [REDACTED]

HERGOTT: okay alright what did ya have ja last name

WETTLAUFER: um the mm [REDACTED]

HERGOTT: [REDACTED] okay and she drove you to the train station on uh

WETTLAUFER: on the Friday

HERGOTT: on the Friday morning

WETTLAUFER: yeah

HERGOTT: uh the Woodstock train station

WETTLAUFER: yup

HERGOTT: okay um and then your other friend was it [REDACTED] that you said

WETTLAUFER: [REDACTED] is my cousin

HERGOTT: okay

WETTLAUFER: [REDACTED]

HERGOTT: okay and she's a cousin of yours

WETTLAUFER: yeah she lives in BC

HERGOTT: okay an an I an an if you don't wanna tell me uh that's fine based on the reason why this person may or may not be a friend but your AA friend

17:39:41



WETTLAUFER: my AA friend yup

HERGOTT: okay

WETTLAUFER: she's her her I can tell you her first name [REDACTED] but

HERGOTT: okay

WETTLAUFER: otherwise it's confidentiality

HERGOTT: an uh and I don't wanna dig into that uh at this point that's that's not a problem at all um so did you disclose the same thing to all those three (3) people

WETTLAUFER: that I had been giving uh insulin overdoses I didn't say why cuz at that point I felt so stupid

HERGOTT: yeah

WETTLAUFER: eh I just felt so stupid

HERGOTT: kay yeah an and Beth to be honest with you I uh I admire your the way that you're conducting yourself an an telling us and having this conversation with me I thank you for that um and I'm not here to judge in anyway

WETTLAUFER: I know

HERGOTT: so I don't want you to know that and

WETTLAUFER: (unintelligible)

HERGOTT: and I'm not a doctor I know you spent a lot of time at at CAMH the last three (3) weeks right

WETTLAUFER: yup

HERGOTT: um and I'm far from a doctor uh but I do appreciate ya ya telling me uh the truth an an telling me uh the way that these things happened and played out

WETTLAUFER: yeah

HERGOTT: and uh and I admire you for that

WETTLAUFER: and it's you know it's been a while because I've been staying about like (sighs) do I give the names of the people

HERGOTT: right

WETTLAUFER: that I killed

HERGOTT: right

WETTLAUFER: because then here is eight families that thought that their family member died peacefully

HERGOTT: mm hnm

WETTLAUFER: and normally

HERGOTT: mm hnm

WETTLAUFER: and they didn't an an what's that gonna do to those families

HERGOTT: right

17:41:02



WETTLAUFER: and even up to uh going to the going to the hospital I decided I was just gonna give the first names and um my cousin ██████ said listen they know what years you worked there if you don't tell them the exact names

HERGOTT: mm hmm

WETTLAUFER: they're gonna go in there and go over every single file

HERGOTT: mm hmm

WETTLAUFER: and that's gonna be even worse for the families there

HERGOTT: right

WETTLAUFER: so that she was the one that gave me that advice to give the names

HERGOTT: okay and as far as you know have have these people reached out to any of the police agencies where they may reside to to notify that you have told them this or

WETTLAUFER: no

HERGOTT: did you tell them in in kind of confidence and said said (simultaneously talking)

WETTLAUFER: I told them with confidence and they said

HERGOTT: that they would keep that to themselves

WETTLAUFER: they promised me they wouldn't tell anyone

HERGOTT: okay but

WETTLAUFER: but basically the in the inpliance was if i didn't get help

HERGOTT: right

WETTLAUFER: then they'd be on the phone the next day

HERGOTT: okay I gotcha so did you tell them basically then on

WETTLAUFER: I told them i

HERGOTT: the Thursday

WETTLAUFER: I told them the night before I went

HERGOTT: okay so

WETTLAUFER: yeah

HERGOTT: Thursday night

WETTLAUFER: yeah

HERGOTT: and you took off Friday morning

WETTLAUFER: yeah

HERGOTT: okay okay

WETTLAUFER: but that's basically what they said was you know if you haven't gotten help Friday then we're calling the police we love you but we're calling the police

HERGOTT: right well they just probably felt that they had obligation right

WETTLAUFER: yeah yeah

17:42:14



HERGOTT: maybe a moral obligation or however they saw it right

WETTLAUFER: yeah

HERGOTT: what medications are you on right now

WETTLAUFER: I'm taking um fluvoxamine it's called Luvox two hundred (200) milligrams it's a anti-obsessional and then antidepressant

HERGOTT: okay

WETTLAUFER: I'm taking three hundred (300) milligrams of Seroquel which is um an anti-psychotic

HERGOTT: mm hmm

WETTLAUFER: and they up'ed that when I was at CAMH

HERGOTT: okay

WETTLAUFER: which has really helped clear my thinking

HERGOTT: has it good

WETTLAUFER: and then I'm taking a couple blood pressure medications and then I've got some (unintelligible) for when I get really agitated

HERGOTT: okay and when we left the hospital you had taken I believe some Ativan is that right

WETTLAUFER: I took two (2) milligrams of Ativan when we left the hospital

HERGOTT: right okay

WETTLAUFER: which was you guys noted the time one forty (1:40)

HERGOTT: yeah

WETTLAUFER: or something like that

HERGOTT: that's about right yeah

WETTLAUFER: yeah

HERGOTT: exactly (unintelligible)

WETTLAUFER: and I've had nothing since

HERGOTT: yeah okay and I know that the doctor doctor KAHN provided with with a prescription that (unintelligible)

WETTLAUFER: yeah and he also gave me two (2) Loxapine

HERGOTT: yup

WETTLAUFER: and was very strict I am not to take those till all these interviews are over

HERGOTT: okay

WETTLAUFER: because they will start to interfere with my thinking

HERGOTT: okay

(01:05:00 dur)

WETTLAUFER: and then let's (unintelligible)

17:43:29



HERGOTT: yeah exactly and do you feel that you're of a a clear sound mind right now

WETTLAUFER: yes I do

HERGOTT: conversing with me in this in this room

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: (unintelligible)

HERGOTT: an and everything that you're telling me is is the truth and to the best that you can remember

WETTLAUFER: yes

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: okay um I could I could appreciate where you're coming from as far as the work that ya you went through um obviously I've never been a nurse and I've never worked in in a profession that you that you did but I coulda imagine how overwhelming it is

WETTLAUFER: yeah

HERGOTT: um having a lot of responsibility um maybe not having the support of of the administration or or your supervisors you know just kinda go out and get it done right

WETTLAUFER: yeah

HERGOTT: and uh and that could be I could see how that could be stressful and I could see how that would drive ya maybe into your addiction an into other things but um I wanna just go over this document if that's okay

WETTLAUFER: okay

HERGOTT: with you

WETTLAUFER: yup

HERGOTT: okay would you be willing to do that with me

WETTLAUFER: yup yeah

HERGOTT: okay and you you

WETTLAUFER: give me that

HERGOTT: you do your thing

WETTLAUFER: sorry

HERGOTT: no no don't be sorry absolutely not

WETTLAUFER: this is pretty

HERGOTT: yeah

WETTLAUFER: pretty may major I've only ever had parking tickets I've never been arrested for anything

HERGOTT: well like I said you're not under arrest right now

17:44:41



WETTLAUFER: oh i know

HERGOTT: but it is uh it is a very significant investigation you're in

WETTLAUFER: I understand

HERGOTT: okay and like I said before Beth I I do appreciate you uh speaking with us an can imagine that uh does it feel like a weight off your shoulders

WETTLAUFER: yes

HERGOTT: does it

WETTLAUFER: yes and no

HERGOTT: you've been carrying a burden for quite some time

WETTLAUFER: and I've tried to get help a couple times

HERGOTT: yeah yeah well sometimes it takes a few attempts to finally commit to it right the

WETTLAUFER: yeah I had a pastor that I told and he prayed over me and told me I'd be fine and that was God's grace and then

HERGOTT: when was that

WETTLAUFER: that was uh Halloween 2013

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: okay and you had you kinda divulged to him what had happened to your to you uh to that point in your life with

WETTLAUFER: yeah

HERGOTT: with all these people

WETTLAUFER: yeah

HERGOTT: okay and where was that

WETTLAUFER: that was here in town

HERGOTT: was it okay

WETTLAUFER: do you want his name

HERGOTT: (unintelligible) do you wanna tell me it it's up to you

WETTLAUFER: [REDACTED]

HERGOTT: okay

WETTLAUFER: he's with the [REDACTED]

HERGOTT: okay

WETTLAUFER: that was oh no sorry it wasn't did I just say 2014

HERGOTT: mm hm

WETTLAUFER: it was 2013

HERGOTT: was it okay

WETTLAUFER: okay alright

HERGOTT: so so be before we get into this um I know that there's a statement which we have and that I've watched where you attended the police station in Toronto

17:46:07



WETTLAUFER: yes

HERGOTT: uh fifty-two (52) division is that correct

WETTLAUFER: yup that's correct

HERGOTT: okay I honest I get I think it was Detective HAMILTON and I honestly can't remember any other detectives name and I know it started with an A um and you met with them for uh

WETTLAUFER: an hour and a half

HERGOTT: I I was gonna say about an hour and a half

WETTLAUFER: that was nuts (laughs)

HERGOTT: yeah and at that point you had in your possession um a photocopy of this document

WETTLAUFER: yeah

HERGOTT: right

WETTLAUFER: yeah

HERGOTT: and you went through and you read it out

WETTLAUFER: yes

HERGOTT: okay and it following that they started uh with the first name on the list and they wanted to just try and get a little bit more detail of

WETTLAUFER: yes

HERGOTT: of of the involvement in each circumstance

WETTLAUFER: okay

HERGOTT: of each death right

WETTLAUFER: okay

HERGOTT: that's what I'd like to do today just get some more details

WETTLAUFER: okay

HERGOTT: okay so

WETTLAUFER: it's a long list

HERGOTT: it is it is but I think that if you and I I think we can get through together

WETTLAUFER: yup I'm sure we can

HERGOTT: and and

WETTLAUFER: as long as you're patient with me

HERGOTT: I am I've got all the time in the world

WETTLAUFER: okay

HERGOTT: I'm not going anywhere

WETTLAUFER: cuz I'm physically comfortable it's a nice chair but

HERGOTT: yeah but at

WETTLAUFER: (unintelligible)

1.7:47:07



HERGOTT: anytime you need to get up and wonder around if you like I said if you wanna take a break an uh have me leave and just kinda stretch your legs an whatever the case may be go ahead

WETTLAUFER: okay

HERGOTT: and if you have to use the washroom at any time just let me know

WETTLAUFER: alright

HERGOTT: okay because like I said I'm I'm yours as long as we need to be

WETTLAUFER: okay

HERGOTT: okay and I'm not pressuring you to uh to stay longer than you want to but I think that uh I think if we just kinda sit down and go through this like I said we'll get through it together

WETTLAUFER: yes

HERGOTT: I'm uh I'm a pretty patient person and I'm here to just listen to what you have to tell me okay

WETTLAUFER: okay

HERGOTT: okay like I said I I appreciate it okay so um how bout we just do this together I'll just bring this over here

WETTLAUFER: okay

HERGOTT: is that okay

WETTLAUFER: sure

HERGOTT: okay so I'm I'm not gonna have you read through this entire document

WETTLAUFER: okay

HERGOTT: cuz I've already ha you already did that right

WETTLAUFER: I have written it I have read it I have you know, lived it so

HERGOTT: yeah absolutely so mister SILCOX

WETTLAUFER: yes

HERGOTT: okay September of 2007

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: he's the first one that died as a result of what I did

HERGOTT: okay and and before you get into that uh you have signed and kinda page numbers all that kinda stuff onto these documents

WETTLAUFER: yeah

HERGOTT: so we'll just go in order of of how you've written it okay and I know that the detectives in uh in Toronto kinda had

17:48:21



this in their possession and just kinda got you to recall some things

WETTLAUFER: yeah

HERGOTT: um I'm I'm just gonna keep it here because uh I mean you've already written this out

(01:10:02 dur)

WETTLAUFER: yeah

HERGOTT: so what's on here is we already know that um I just have some follow-up questions jus

WETTLAUFER: okay

HERGOTT: just with regards to each circumstance so mister SILCOX um it says here you were working a double shift uh from three (3) till seven (7) right

WETTLAUFER: three (3) p.m. to seven (7) a.m.

HERGOTT: right okay and this was at Caessant Care

WETTLAUFER: yes

HERGOTT: okay in Woodstock

WETTLAUFER: yes

HERGOTT: okay and tell me about your your knowledge of of James an and your daily interactions during a shift with him

WETTLAUFER: um I didn't see him every time he wasn't always my patient I just knew from what uh people had said that he would grab the the nurses uh breasts and butt buttocks an he would say horribly inappropriate things about his wife that now he was there you know

HERGOTT: mm hmm

WETTLAUFER: [REDACTED]

[REDACTED] an just would say innapropriate things and he did touch me inappropriately once

HERGOTT: okay and where was that on your body

WETTLAUFER: on my breast

HERGOTT: on your breast okay and were you alone in the room at that point or

WETTLAUFER: yeah

HERGOTT: okay well did he have a roommate at all

WETTLAUFER: I

HERGOTT: did Jim have a roommate

WETTLAUFER: I he must of he wasn't in a single room

HERGOTT: okay

WETTLAUFER: so he was either in a double room or quadruple room

17:49:36



HERGOTT: okay would you remember any other residents that would be roomed with him at that time or

WETTLAUFER: no

HERGOTT: no okay

WETTLAUFER: no

HERGOTT: that's okay um what portion of the home was was James in at this point

WETTLAUFER: he was in the kay there's an East wing the South wing North wing he was in the North wing

HERGOTT: mm hmm

WETTLAUFER: which half down and he was either in a double bed or a quadruple bed

HERGOTT: okay alright and um the the diagnosis of hi his health at at the time you were caring for him do you remember

WETTLAUFER: he was post hip surgery and he had dementia

HERGOTT: okay alright and do you remember how old he was approximately

WETTLAUFER: no I don't I'm (unintelligible)

HERGOTT: end of eighties (80's)

WETTLAUFER: yup

HERGOTT: okay and sorry he was not a diabetic

WETTLAUFER: not a diabetic

HERGOTT: and sorry you said he had dementia

WETTLAUFER: yes

HERGOTT: okay which you've also noted here as well right

WETTLAUFER: yeah

HERGOTT: okay so tell me about the night uh was this the first person that you did this too

WETTLAUFER: that I that I tried well there were other people that I've done it too that didn't die

HERGOTT: prior to James

WETTLAUFER: prior to James

HERGOTT: okay

WETTLAUFER: he's the first one

HERGOTT: and are they documented on here

WETTLAUFER: he's the first one who died

HERGOTT: right

WETTLAUFER: back here

HERGOTT: but there's some other

WETTLAUFER: people who didn't die

HERGOTT: right so I can't read that first name (unintelligible)

17:50:52



(simultaneously talking)

WETTLAUFER: Clotilda ADRIANO

HERGOTT: okay so that was I mean they're both September 2007

WETTLAUFER: (unintelligible) yeah

HERGOTT: but that was before James

WETTLAUFER: yup

HERGOTT: okay so was this your first attempt at at overdosing these people on insulin

WETTLAUFER: yes Clotilda was

HERGOTT: who's Clotilda

WETTLAUFER: and I didn't really want her to die I just I don't know I was just angry and um had this sense inside me that she might be a person that God wanted back with him

HERGOTT: mm hmm and is that that feeling you're referring to that you had in your stomach at times

WETTLAUFER: yeah yeah

HERGOTT: okay is that is that the point and I hate to get off ta off topic here but the point where you had these feelings in your stomach and almost that laughter after it happened

WETTLAUFER: yeah

HERGOTT: is that the part that you didn't tell doctor KAHN

WETTLAUFER: yes

HERGOTT: okay okay I just wanted to be clear on that

WETTLAUFER: I told him about the laughter in my stomach but not the feeling that this might be the person that God wants

HERGOTT: okay okay

WETTLAUFER: but the I just (unintelligible)

HERGOTT: it's your feelings right

WETTLAUFER: mm hmm i honestly felt that God wanted to use me and he kept doctor KAHN kept asking me do you think God chose you for a special purpose I kept saying no cuz that does not sound like a special person you know

HERGOTT: yeah

WETTLAUFER: so but yeah I just had a sense after my marriage broke up that God was gonna re use me for something and then after a while I started to really wonder after some of the murders

HERGOTT: mm hmm

WETTLAUFER: if it was God or if it was the devil fooling me

HERGOTT: mm hmm did you feel like you were doing the right thing for these people

17:52:19



WETTLAUFER: no
 HERGOTT: okay
 WETTLAUFER: no
 HERGOTT: okay
 WETTLAUFER: I felt like I was doing what I was supposed to do but it wasn't what was right for them
 HERGOTT: okay okay um so James then um it was an evening that this one took place right
 WETTLAUFER: yup
 HERGOTT: um it says here at about nine thirty (9:30)
 WETTLAUFER: yup
 HERGOTT: run me through a portion of things
 WETTLAUFER: uh about nine thirty (9:30) I gave him a dose of uh fifty (50) milligrams of insulin he's not nondiabetic so I went into I used a borrowed insulin pen borrowed insulin and gave him an insulin shot and at three thirty (3:30) the PSW well throughout the night he was yelling out I love you and I'm sorry an that said not to me but just you could hear him calling out in his room and that's what he was calling out
 HERGOTT: mm hmm
 WETTLAUFER: and then at three thirty (3:30) the uh PSW's came to me and said that he was gone
 HERGOTT: okay
 WETTLAUFER: so I did what we're supposed to do I went and listened to his heart and chest
 HERGOTT: mm hmm
 WETTLAUFER: called the doctor called the family cuz that's what they wanted family came in to sit with him for a while
 HERGOTT: mm hmm
 (01:15:00 dur)
 WETTLAUFER: doctor came in and uh said that his cause of death was from uh an embolism due to his uh post hip he'd had a
 HERGOTT: hip surgery
 WETTLAUFER: he'd had hip surgery
 HERGOTT: okay
 WETTLAUFER: doctor ruled it embolism due to post hip surgery
 HERGOTT: okay alright um who do you think he was talking to when he was yelling out I love you
 WETTLAUFER: I thought it might be his his family
 HERGOTT: okay

17:53:52



WETTLAUFER: I really did and when they came in and talked to me they wanted to know if he'd said anything

HERGOTT: right

WETTLAUFER: so I told them and I was so ashamed

HERGOTT: yeah

WETTLAUFER: so ashamed an

HERGOTT: when you were speaking with his family

WETTLAUFER: yes

HERGOTT: kay and is that the uh the family that kinda commended you for the work that you had done an spoke to you like how much they appreciated having (simultaneously talking)

WETTLAUFER: yes and that I had been there for him an yeah

HERGOTT: how'd that make you feel

WETTLAUFER: awful

HERGOTT: yeah

WETTLAUFER: absolutely awful

HERGOTT: how did you deal with it

WETTLAUFER: um I just went home went to bed you know I felt awful maybe I fought with my girlfriend

HERGOTT: okay

WETTLAUFER: did some exercising you know

HERGOTT: yeah

WETTLAUFER: played some games on the computer and just tried to forget about it

HERGOTT: okay did you have a uh have a problem sleeping that night at all or anything like that

WETTLAUFER: um

HERGOTT: or did ya

WETTLAUFER: well I was working nights so I was uh

HERGOTT: woulda been during the day then

WETTLAUFER: um I would say I tossed and turned a bit yeah

HERGOTT: okay

WETTLAUFER: felt pretty bad and I didn't wanna see the family again so I tried to make sure I wasn't working when they came to pick up his stuff an

HERGOTT: okay

WETTLAUFER: I wasn't

HERGOTT: and what room do you remember the like a room number or just like you said that

WETTLAUFER: no it was down the North wing

17 : 55 : 02



HERGOTT: the wing yeah okay when you an where did you get the insulin from for James for mister SILCOX you said you had taken some insulin pens

WETTLAUFER: um it was

HERGOTT: where where'd you get those

WETTLAUFER: the insulin was kept in a fridge in the medication room

HERGOTT: okay

WETTLAUFER: we had two (2) medication rooms

HERGOTT: okay

WETTLAUFER: insulin was kept in a fridge in the medication room and uh extra pens were kept in the drawer so you could just say somebody you had someone admitted and you needed a pen in a hurry

HERGOTT: mm hmm

WETTLAUFER: so you just put the insulin in the pen an an put the needle on and dial up the dose and get a

HERGOTT: and how was that documented to know that so so that Caressant Care would know that you were taking that insulin

WETTLAUFER: they didn't keep track of insulin

HERGOTT: okay so it was just uh something that was available for the nurses use when they knew that it was appropriate for the certain patients

WETTLAUFER: yes now each patient has their own insulin

HERGOTT: right

WETTLAUFER: and maybe somebody noticed somebody may have noticed that a lot of insulin was missing if a lot was used but I was always careful to use different people

HERGOTT: okay okay different people's insulin

WETTLAUFER: insulin yes

HERGOTT: okay alright and mister SILCOX and where where did you inject the insulin into his body

WETTLAUFER: I'm not really sure I'm gonna say his arm or his uh torso

HERGOTT: okay and did he know what was going on at that point

WETTLAUFER: not really

HERGOTT: was he uh was he uh a verbal patient like could he ca converse with you an

WETTLAUFER: oh yeah he he

HERGOTT: communicate

WETTLAUFER: didn't really converse he did a lot of yelling out don't really remember him reacting when I gave it to him

17:56:32



HERGOTT: so he he didn't react

WETTLAUFER: I I don't remember him reacting no

HERGOTT: okay would he maybe just think it's a a regular portion of his day

WETTLAUFER: probably

HERGOTT: uh receiving medications that he he so required

WETTLAUFER: probably cuz he had dementia

HERGOTT: okay

WETTLAUFER: yup

HERGOTT: okay alright was there anything else you can remember about mister SILCOX

WETTLAUFER: um his wife and daughter loved him a lot

HERGOTT: mm hmm and how did that make you feel

WETTLAUFER: crappy

HERGOTT: yeah

WETTLAUFER: horrible

HERGOTT: yeah

WETTLAUFER: um he (sighs) yeah like I said he could be a bit of a handful but you know he ate and drank normally took his pills when you told him to

HERGOTT: mm hmm

WETTLAUFER: so nothing else I can really remember about him

HERGOTT: okay

WETTLAUFER: but this is you know nine (9) years ago so

HERGOTT: it's a while ago

WETTLAUFER: yeah

HERGOTT: okay so how long after sorry when did you break up with your your husband was it

WETTLAUFER: I broke up with him

HERGOTT: was it August 22nd 2007

WETTLAUFER: oh no no I broke up with him in uh end of January beginning of February 2007

HERGOTT: okay okay so it was quite some time till September until you actually

WETTLAUFER: yeah

HERGOTT: alright I guess

WETTLAUFER: by that time I was in a new relationship with a woman

HERGOTT: okay who was that

WETTLAUFER: her name was Maureen

HERGOTT: Maureen okay alright um did you ever disclose to her what you were doing

17:58:00



WETTLAUFER: no absolutely not

HERGOTT: so you just kinda went about your thing with mister
SILCOX

WETTLAUFER: yeah

HERGOTT: uh went home that day did your kinda some exercising
computer games went to sleep did you work again that
next day

WETTLAUFER: I don't remember

HERGOTT: don't remember do you remember who you would've
been working with on that occasion no

WETTLAUFER: no

HERGOTT: no

WETTLAUFER: no I don't I'm sorry

HERGOTT: okay are you okay

WETTLAUFER: yeah oh yeah

HERGOTT: do you want to get up and stretch

(01:20:00 dur)

WETTLAUFER: I just do a lot of fidgeting

HERGOTT: okay that's okay hey you're not bothering me I just want
to make sure that you're comfortable

WETTLAUFER: yeah I'm okay

HERGOTT: okay

WETTLAUFER: if I need something I'll just do it

HERGOTT: okay gotcha do you remember who your supervisor
would have been at that point

WETTLAUFER: well that would be Helen Crombez

HERGOTT: that was the head nurse

WETTLAUFER: yeah she was always like whoever was on as the nurse
was the charge nurse

HERGOTT: okay

WETTLAUFER: so I was the charge nurse

HERGOTT: mm hmm

WETTLAUFER: and at night thought as the charge nurse from three (3) to
eleven (11) I was in charge of uh one (1) two (2) three (3)
four (4) five (5) six (6) seven (7) eight (8) PSW's

HERGOTT: mm hmm

WETTLAUFER: and I was a re yeah and then there was two (2) other
wings and so at night as the charge nurse I was
responsible to look after the um RPN on the other side
like be a resource for her

HERGOTT: okay

17:59:26



WETTLAUFER: there were four (4) PSW's on that side and four (4) PSW's on my side so nine (9) people

HERGOTT: okay

WETTLAUFER: and then misses CROMBEZ (ph) of course she wasn't around at night

HERGOTT: okay

WETTLAUFER: but

HERGOTT: she just worked days

WETTLAUFER: yeah

HERGOTT: yeah

WETTLAUFER: but she's who we all she's who we all answered to

HERGOTT: okay

WETTLAUFER: she was her and the executive director Brenda I don't remember her last name

HERGOTT: okay

WETTLAUFER: I'm sorry I'm probably gonna pass gas eventually

HERGOTT: that's fine don't worry about it so as far as mister SILCOX goes then besides what you were feeling in your stomach okay and besides that you thought that this was a purpose that you were given on on your relationship or after breaking up with your husband right

WETTLAUFER: yes

HERGOTT: that you've that you've you you indicated that he wasn't a very nice man

WETTLAUFER: no he wasn't

HERGOTT: just is that a portion of

WETTLAUFER: um

HERGOTT: what happened

WETTLAUFER: I don't know

HERGOTT: okay

WETTLAUFER: I wondered if that's a portion of how I chose him

HERGOTT: mm hmm

WETTLAUFER: and afterwards I did feel a release and a relief

HERGOTT: mm hmm

WETTLAUFER: like a release of pressure

HERGOTT: okay because throughout this document an and as we go through it a lot of these people you kinda describe them as as not very nice people

WETTLAUFER: yeah

HERGOTT: right

WETTLAUFER: yup

18:00:41



HERGOTT: so I'm not sure if that's uh a tendency or a a pattern that we see as far as is that why you chose these people

WETTLAUFER: yeah I'm not it might be but I also know I just felt like they were the ones

HERGOTT: right

WETTLAUFER: I had a feeling inside that they were the ones

HERGOTT: okay before before you injected insulin in mister SILCOX was it a spur of the moment thing had you thought about it that uh when you reported for duty at three (3) o'clock in the afternoon

WETTLAUFER: um I started thinking about it about six (6) at night I think

HERGOTT: okay okay and do you remember who the pronouncing doctor would've been

WETTLAUFER: no

HERGOTT: like how did how did that process work

WETTLAUFER: that process the way it worked was uh person found with no vital signs

HERGOTT: mm hmm

WETTLAUFER: nurse goes in with a stethoscope

HERGOTT: mm hmm

WETTLAUFER: listens for one (1) minute

HERGOTT: mm hmm

WETTLAUFER: if there's no heartbeat no uh lung sounds nurse goes and calls the doctor on call

HERGOTT: okay

WETTLAUFER: um there was a flow sheet that we had to fill out if we thought it was a coroner's case

HERGOTT: mm hmm

WETTLAUFER: in this case I don't believe we thought it was and then um family is called

HERGOTT: okay

WETTLAUFER: and the doctor may wait to come in and uh pronounce in the morning

HERGOTT: oh okay

WETTLAUFER: family can come in and visit the body at any time

HERGOTT: okay

WETTLAUFER: so then the PSW's would get the the body ready

HERGOTT: okay so prior to the doctor announcing in the morning the family could come in an

WETTLAUFER: yeah

HERGOTT: and spend time

18 : 02 : 07



WETTLAUFER: yeah so the PSW's would get clean him up put on uh you know clean clean britches an

HERGOTT: right

WETTLAUFER: clean up the bed and stuff

HERGOTT: right so you said you said mister SILCOX you said we didn't think it was a coroner's case who who who said

WETTLAUFER: oh

HERGOTT: (unintelligible) would've that been

WETTLAUFER: I guess I'm using the royal we

HERGOTT: okay gotcha

WETTLAUFER: (laughs)

HERGOTT: okay so would that be just a decision that you were in charge to make

WETTLAUFER: um no there's a there's a form

HERGOTT: okay

WETTLAUFER: on the computer and you go down through it and if it says if you tick off anything that says yes you notify the coroner

HERGOTT: okay alright but you would've clicked off those boxes yourself

WETTLAUFER: yes

HERGOTT: okay so obviously knowing that you had done this to mister SILCOX did you feel that you wouldn't click yes so that attention wouldn't be drawn to you

WETTLAUFER: you know I honestly can't remember if he was a coroner case or not

HERGOTT: okay

WETTLAUFER: he might have been

HERGOTT: now would insulin in

WETTLAUFER: I would I uh even though I did this to these people when I did their but the it's phrased as does anyone have a reason to believe that this death was not natural

HERGOTT: right

WETTLAUFER: so yeah I would clicked I wouldn't click that one if I had given him an insulin

HERGOTT: right

WETTLAUFER: yeah you're right

HERGOTT: okay okay alright and I just wanted to clarify that just to

WETTLAUFER: yeah yeah

HERGOTT: that was just a question okay um anything else you can think about for mister SILCOX

18 : 03 : 30



(01:25:02 dur)

WETTLAUFER: no

HERGOTT: okay Maurice how did you pronounce Maurice's last name

WETTLAUFER: GRANAT

HERGOTT: is it GRANAT okay so tell me a little bit about Maurice this says that this occurred in September or or October of twenty (20)

WETTLAUFER: yeah

HERGOTT: uh sorry 2007

WETTLAUFER: yeah

HERGOTT: and this was at Caressant Care

WETTLAUFER: yup

HERGOTT: okay tell me a little bit about (simultaneously talking)

WETTLAUFER: (unintelligible)

HERGOTT: your interactions with Maurice

WETTLAUFER: he was another one who liked to grab breasts and asses

HERGOTT: okay

WETTLAUFER: he was sometimes a patient of mine see at that time I wasn't I didn't have a set floor that I worked on I worked on all the different floors as a nurse I was filling in

HERGOTT: mm hmm

WETTLAUFER: so uh he wa (sighs) one afternoon I was working with him and he did grab me

HERGOTT: mm hmm

WETTLAUFER: and uh again I got that feeling inside that this is his time to go

HERGOTT: okay

WETTLAUFER: so I gave him an overdose of insulin after supper

HERGOTT: okay

WETTLAUFER: and uh I believe he died the next day

HERGOTT: okay and what was your shift that do you remember what shift you were working at that point

WETTLAUFER: it was three (3) to eleven (11)

HERGOTT: three (3) p.m.

WETTLAUFER: yeah to eleven (11) p.m.

HERGOTT: till eleven (11) p.m. so like an afternoon shift

WETTLAUFER: so he died he died when I wasn't there

HERGOTT: okay and he was known for it says here grabbing the staff's breasts and asses

18 : 04 : 43



WETTLAUFER: yes

HERGOTT: okay and do you remember who you would've been working with at that point

WETTLAUFER: no

HERGOTT: okay do you remember um where Maurice was within Caressant Care

WETTLAUFER: yeah he was down the North wing I think he was in a in a double room on the right hand side

HERGOTT: kay

WETTLAUFER: yeah

HERGOTT: and do you remember who

WETTLAUFER: and then

HERGOTT: his roommates would've been at all

WETTLAUFER: no i don't but I do remember that when he started going downhill after the insulin overdose they moved him to the palliative care room right by the uh nurses desk

HERGOTT: okay and at what point of the day do you think that you sorry think you said this already but just to confirm what what time of the day do you think it was when ya injected him with

WETTLAUFER: when I injected him um it was afternoon I'm thinking four thirty (4:30) five thirty (5:30)

HERGOTT: okay alright um and what was his reaction to receiving the insulin

WETTLAUFER: again it was just kinda like oh okay I just said the doctor wants you to have a vitamin shot

HERGOTT: okay

WETTLAUFER: that's what I usually said

HERGOTT: okay and was he able to communicate was he verbal what's (unintelligible)

WETTLAUFER: he was he was verbal

HERGOTT: could converse

WETTLAUFER: not totally but he could say some things yes

HERGOTT: okay alright and did he question his vitamin shot at all

WETTLAUFER: no

HERGOTT: okay um and he passed away the next day

WETTLAUFER: yes

HERGOTT: okay so being that you weren't there when he had passed away you wouldn't have been the one checking the boxes

WETTLAUFER: that's right

18:06:15



HERGOTT: so do you know by chance what nurse would've been responsible for uh mister GRANAT

WETTLAUFER: um no I don't

HERGOTT: no

WETTLAUFER: no

HERGOTT: okay did ya ever have any concerns that he didn't pass away while you were working and that you know suspicion may have arised

WETTLAUFER: no I no I didn't I well yes I did a little bit I always wondered if they'd find the site where I gave the shot and something you know they've there'd be an investigation I always wondered that

HERGOTT: right

WETTLAUFER: but other than that no

HERGOTT: and even though it it passed through your mind did you jus

WETTLAUFER: (unintelligible)

HERGOTT: continued on about your duties

WETTLAUFER: yup

HERGOTT: okay and do you remember what part of the body he would've been injected in

WETTLAUFER: uh maybe the leg cuz at that point he didn't have a lot of body fat so

HERGOTT: Maurice didn't

WETTLAUFER: he didn't no and when you give a a subcutaneous injection it goes in to the body fat so

HERGOTT: okay and you documented that he was a cancer patient

WETTLAUFER: yes

HERGOTT: okay do you remember what type of cancer he had

WETTLAUFER: I think it was prostraight

HERGOTT: prostate

WETTLAUFER: prostate yeah

HERGOTT: okay and what was the what did the outcome uh hold for his future as far as the the cancer in his body

WETTLAUFER: he was dying

HERGOTT: was he how old do you think Maurice was

WETTLAUFER: seventy-five (75) seventy-six (76)

HERGOTT: alright and sorry he was in a double room

WETTLAUFER: yeah I believe it was a double room yes

HERGOTT: okay do you remember who you would've been working with that day

18 : 07 : 45



WETTLAUFER: no

HERGOTT: same supervisor or the (unintelligible) charge or the head nurse

WETTLAUFER: yup

HERGOTT: okay

WETTLAUFER: sorry I'm

HERGOTT: that's okay

WETTLAUFER: like it's so far along

HERGOTT: ii it's a long time ago

WETTLAUFER: yeah

HERGOTT: I mean obviously it's a significant event in your life

WETTLAUFER: yeah

HERGOTT: but it's a long time ago

WETTLAUFER: yes

HERGOTT: so I I no I'm not I don't I'm not concerned that you can't remember every question that I ask you cuz you just if you can do the best that you can that's all I can ask for

WETTLAUFER: okay

HERGOTT: okay um anything else you can remember about uh Maurice at all

WETTLAUFER: not really no

HERGOTT: no okay do you know if (simultaneously talking)

WETTLAUFER: (unintelligible) there were people that loved him

HERGOTT: do you know if he was a coroner's case

WETTLAUFER: there were people who loved him that that I remember I don't know if he was a coroner's case

HERGOTT: who loved Maurice who did you know that would come visit

(01:30:01 dur)

WETTLAUFER: he had he had friends that would come and visit him that were like family to him

HERGOTT: mm hmm

WETTLAUFER: a man and a woman that's all I remember

HERGOTT: okay and how did it make you feel when when Maurice passed away

WETTLAUFER: not good

HERGOTT: and what happened from there you just

WETTLAUFER: I just uh well I wasn't there when he passed away I I I didn't work that day

HERGOTT: do you remember if you worked the next day

18 : 08 :



WETTLAUFER: I might have I know when I found out that he died I looked to see how long it took an like I read the notes and stuff to see what had gone on

HERGOTT: okay

WETTLAUFER: I'm just getting a coin out to fidget with

HERGOTT: yeah no problem whatever you need um so after you had found out he had passed you kinda read through the documents and

WETTLAUFER: yeah

HERGOTT: do you remember seeing anything there kinda said oh oh you know

WETTLAUFER: no

HERGOTT: this isn't a good thing for me or

WETTLAUFER: no

HERGOTT: okay so

WETTLAUFER: and even if I had I couldn't have altered them

HERGOTT: you could've or could

WETTLAUFER: could not

HERGOTT: okay um the next person on your list is Helen MATHESON

WETTLAUFER: yup

HERGOTT: okay so you go from September or October to '07

WETTLAUFER: yup

HERGOTT: and then Helen was 2011

WETTLAUFER: yeah

HERGOTT: what what happened between those years

WETTLAUFER: I think um you'll see the big

HERGOTT: was there some attempts

WETTLAUFER: attempts um

HERGOTT: okay in '08 and '09

WETTLAUFER: yeah

HERGOTT: okay okay and we'll get to those

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: Helen I don't remember a lot about she was very quiet very determined um just seemed to be waiting to die

HERGOTT: mm hmm

WETTLAUFER: again I had that feeling that you know this is the one

HERGOTT: mm hmm

WETTLAUFER: and um I made a bit of a fuss about her that night because she was very lucid

18:10:11



HERGOTT: mm hmm

WETTLAUFER: and we talked about how much she liked blueberry pie and ice cream

HERGOTT: okay

WETTLAUFER: so on my on my break I went to uh Wal-mart and I got a small blueberry pie and some ice cream

HERGOTT: mm hmm

WETTLAUFER: and brought it to her and she had three (3) or four (4) bites

HERGOTT: nice

WETTLAUFER: and then that night I overdosed her

HERGOTT: okay

WETTLAUFER: cuz like I said I had that feeling that it was her time to go an

HERGOTT: what do you mean by that do you think she was towards the end of her life at that point or

WETTLAUFER: no that she was the person to go next

HERGOTT: okay and that was in your mind in your stomach

WETTLAUFER: yeah

HERGOTT: where was that feeling

WETTLAUFER: in my chest area and

HERGOTT: in your chest

WETTLAUFER: after I did it I got that laughter

HERGOTT: okay when would you feel that laughter would you feel it right after you injected it or once the person passed away

WETTLAUFER: um both

HERGOTT: yeah

WETTLAUFER: both

HERGOTT: okay yeah alright and Helen was uh you state here that she wasn't a diabetic

WETTLAUFER: no

HERGOTT: okay just out of curiosity how much insulin would it take to kill someone

WETTLAUFER: see it don't know

HERGOTT: that wasn't a diabetic or

WETTLAUFER: I don't know

HERGOTT: you don't know that

WETTLAUFER: no so it was kinda hit and miss

HERGOTT: you didn't know that as a nurse that this amount or

WETTLAUFER: no there is no set amount

HERGOTT: okay and I'm just I I just

18 : 11 : 19



WETTLAUFER: yeah

HERGOTT: simply just don't know that answer (unintelligible)

WETTLAUFER: no there is no set amount

HERGOTT: okay alright so different people would react differently to different amounts is that fair to say

WETTLAUFER: yes

HERGOTT: okay

WETTLAUFER: yup

HERGOTT: an and would it obviously make a difference if they were diabetic or not a diabetic

WETTLAUFER: yup

HERGOTT: alright

WETTLAUFER: I believe she died the next day

HERGOTT: okay and it said uh oh in your note here the doctor declared her to be uh palliative and she died two (2) days later

WETTLAUFER: two (2) days later okay

HERGOTT: and do you remember how much insulin that you had given Helen

WETTLAUFER: sixty (60) I don't know

HERGOTT: okay and where would you have gotten that from

WETTLAUFER: from from the same

HERGOTT: the same

WETTLAUFER: place I always get it

HERGOTT: okay do you remember where Helen was in in Caressant Care

WETTLAUFER: yes she was on the South wing and probably at about four (4) doors down from the nurses' station in a double room on the right hand side if you were facing the end she was on the right hand side

HERGOTT: um di you you don't say a lot of negative things about Helen here did you did you get along with her okay did she ever do anything to

WETTLAUFER: she

HERGOTT: to harm you or

WETTLAUFER: no no she was very quiet it was just I got that feeling thi yeah she's next it's her time to go

HERGOTT: alright and uh her health at that point what was her diagnosis



WETTLAUFER: she was um I couldn't tell you her diagnosis just that she was she didn't get out of bed a lot and she had to be fed her food fed her pills

HERGOTT: okay

WETTLAUFER: so she was she was near her end of her life

HERGOTT: how old do you think Helen was when this happened

WETTLAUFER: I'd say about eighty-five (85) or eighty-six (86)

HERGOTT: okay okay and do you remember what doctor would've were you there when she passed away two (2) days later

WETTLAUFER: I don't think so

HERGOTT: you don't think so so you won't wouldn't be able which doctor pronounced her even

WETTLAUFER: no

HERGOTT: not too sure

WETTLAUFER: once I gave the insulin overdose unless I was there for the shift they died I di kinda just layed low and didn't yeah have anything to do with them

(01:35:00 dur)

HERGOTT: so so if you issued an insulin injection to somebody Helen for instance do you remember where Helen was injected

WETTLAUFER: probably her arm

HERGOTT: okay um so do you remember if she had a reaction at all

WETTLAUFER: a reaction (unintelligible)

HERGOTT: do you know if she confronted you on what you were doing at all was she able to

WETTLAUFER: she might have said ow

HERGOTT: was she used to getting insulin or needles or

WETTLAUFER: I don't know if she was

HERGOTT: okay alright um but she wasn't combative or or

WETTLAUFER: mm mmm

HERGOTT: she didn't confront you and ask you what you were doing

WETTLAUFER: no

HERGOTT: okay alright an an you said once once you gave them their insulin

WETTLAUFER: you just I just kinda I tried to stay away from it sometimes I was very interested to see what was happening

HERGOTT: mm hmm

WETTLAUFER: I would just try to stay away from it

18:14:17



HERGOTT: okay would you ever go back into their rooms if while they were still alive to see kinda how they were progressing through the

WETTLAUFER: if they were if they were my if they were my uh charge yes I had to

HERGOTT: kay even though you had attempted to take their lives

WETTLAUFER: yes

HERGOTT: okay and you would um wa what kind of symptoms would they show what is it different for everyone or

WETTLAUFER: um well usually they'd get very diaphoretic red um like they'd lose consciousness they'd shake

HERGOTT: okay

WETTLAUFER: some people um one (1) person had a seizure think it was just one (1) person

HERGOTT: mm hmm

WETTLAUFER: two (2) people stroked right out

HERGOTT: right after receiving the

WETTLAUFER: not right after but they stroked out

HERGOTT: over time okay

WETTLAUFER: an an actually three (3) people cuz they believed James stroked out as well so

HERGOTT: mister SILCOX

WETTLAUFER: mister SILCOX yeah

HERGOTT: okay okay okay um November 2011

WETTLAUFER: mm hmm

HERGOTT: Mary ZERWINSKI is that

WETTLAUFER: yes

HERGOTT: how you recall uh her na her last name being pronounced

WETTLAUFER: yup

HERGOTT: and this was at Caressant Care

WETTLAUFER: yup

HERGOTT: okay and you said that she wasn't a diabetic but she had dementia

WETTLAUFER: that's right

HERGOTT: okay

WETTLAUFER: but she could talk and communicate a lot

HERGOTT: Mary could

WETTLAUFER: yes she was she was uh feisty

HERGOTT: was she

WETTLAUFER: yeah

18:15:45



HERGOTT: uh

WETTLAUFER: she didn't hurt the nurses or anything she's just very outspoken and feisty an

HERGOTT: mm hmmm

WETTLAUFER: one (1) night she said you know I'm gonna die tonight

HERGOTT: Mary said that

WETTLAUFER: yes and I said oh and she said yeah why don't you get me into the why don't you get me into the deathbed so I can die and I said are you sure and she said yeah put me to bed I'm gonna die so I said okay and I went to the other nurse that was working with me and uh she said oh okay well let's put her in the palliative care room if that's what she wants so we did and then I thought well she must be the next one

HERGOTT: mm hmmm

WETTLAUFER: I had a feeling inside of me she must be the next one

HERGOTT: okay

WETTLAUFER: because she was saying she was gonna die but there's no signs she was gonna die so I gave her a an overdose of insulin

HERGOTT: okay

WETTLAUFER: she became palliative and she died I think within a couple a days

HERGOTT: okay

WETTLAUFER: I think

HERGOTT: yeah it says she's died the next afternoon is what you'd (unintelligible) wrote here about um

(knocking sound)

HERGOTT: oh

U/I MALE: (unintelligible)

HERGOTT: oh perfect

U/I MALE: some water

HERGOTT: (unintelligible)

WETTLAUFER: thanks

U/I MALE: here ya go

WETTLAUFER: which one has the vodka in it

HERGOTT: (laughs) no answer from him [REDACTED]

[REDACTED]

[REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

18:16:52



WETTLAUFER: [REDACTED]
[REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: okay okay um where was that in relation to where she was like where was Mary in in Caressant Care

WETTLAUFER: she was down the South wing couple of rooms down to the the uh down to the nurses' office

HERGOTT: mm hmm

WETTLAUFER: and uh she yeah so sh we did put her in the palliative bed

HERGOTT: okay and would that be a decision that you would make or someone else would have to make for you

WETTLAUFER: together we made it

HERGOTT: okay

WETTLAUFER: yeah [REDACTED] and I made it together

HERGOTT: but a supervisor wouldn't have to oh say okay go ahead an

WETTLAUFER: no no we have we had enough autonomy that if we thought someone was um palliative we could call the doctor tell him what was going on

HERGOTT: mm hmm

WETTLAUFER: move uh move the person to the palliative bed

HERGOTT: mm hmm

WETTLAUFER: and get orders for palliative care

HERGOTT: okay okay and do you remember how much insulin you would've given Mary

WETTLAUFER: I think she may have been the first person that I gave long acting and short acting together

HERGOTT: okay

WETTLAUFER: I think

HERGOTT: and can you just uh what besides the actual obvious uh in the uh title of the the actual drug itself long acting short

18 : 18 : 34



acting what was the biggest difference between the two
(2)

(01:40:10 dur)

- WETTLAUFER: one (1) one (1) drops your blood sugar right away the other um starts working through your body an dropping it gradually over a long period of time but just keeps dropping it
- HERGOTT: okay and what would the combination of those two do together
- WETTLAUFER: uh say too much
- HERGOTT: did you know or
- WETTLAUFER: I didn't know for sure but I figured it would be much stronger than just the short acting
- HERGOTT: right okay makes sense
- WETTLAUFER: yeah
- HERGOTT: I think you would know more than I would but um do you remember where you injected Mary
- WETTLAUFER: uh probably her arm
- HERGOTT: in her arm
- WETTLAUFER: I told her I told her it was for her pain
- HERGOTT: and do you know if she was in a single room double room
- WETTLAUFER: well we had moved her from the double room to the uh palliative care room
- HERGOTT: okay
- WETTLAUFER: right kiddo corner from the nurse's office
- HERGOTT: okay so where did you inject her in the palliative bed or in her
- WETTLAUFER: in in the palliative bed
- HERGOTT: okay and she she had vocalized to you that she thought that she was gonna die that night
- WETTLAUFER: yes so I said okay she must be the one when I gave the insulin I got that
- HERGOTT: mm hmm
- WETTLAUFER: feeling inside and the laughter
- HERGOTT: mm hmm and she ever said something to like uh something to you before about wanting to die
- WETTLAUFER: nnn not like that no she's like I wanna die I wanna die I wanna die tonight put me in bed I'm gonna die
- HERGOTT: and that was new to you
- WETTLAUFER: yes
- HERGOTT: okay do you remember what shift you were working

18:19:57



WETTLAUFER: afternoons three (3) to eleven (11)

HERGOTT: okay and about what time do you think you would've moved her into the palliative bed and injected her

WETTLAUFER: um might've been after supper so about seven (7)

HERGOTT: okay and Mary ever done anything to harm you or

WETTLAUFER: no

HERGOTT: upset you in any way

WETTLAUFER: no nope she was fun

HERGOTT: okay she was uh so she was spunky and outspoken

WETTLAUFER: yeah

HERGOTT: okay um do you remember being present when she died

WETTLAUFER: I don't think I was

HERGOTT: okay alright and therefore probably wouldn't be a part of checking the boxes

WETTLAUFER: no no I didn't do the boxes for her

HERGOTT: okay who was there to see Mary on a regular basis who came to see Mary

WETTLAUFER: I don't know

HERGOTT: no

WETTLAUFER: I don't know

HERGOTT: do you know if she had family

WETTLAUFER: um maybe a son but I don't know

HERGOTT: alright and an Mary being we'll refer to huh her as your fourth (4th) victim

WETTLAUFER: yes

HERGOTT: uh the fourth (4th) person that uh well that you were successful in uh in using insulin injections how did your emotions start to to feel

WETTLAUFER: um

HERGOTT: and were they just kept continuing

WETTLAUFER: (sighs) I kept having a lot of guilt a lot of guilt um Mary well as you'll see after Mary was Gladys and after Gladys there was a period of two (2) years where I didn't do it

HERGOTT: mm hmm

WETTLAUFER: three (3) years where I didn't do it

HERGOTT: mm hmm what was going on in your life at that point

WETTLAUFER: I was trying very very hard to get close to God to make sure that this wasn't him and to just live my life read the bible go to church

HERGOTT: mm hmm

WETTLAUFER: and not do that cuz I didn't wanna do it anymore

18 : 22 : 03



HERGOTT: mm hmm

WETTLAUFER: so I tried very hard I was still using a little bit

HERGOTT: the hydromorphs

WETTLAUFER: yeah

HERGOTT: and alcohol

WETTLAUFER: yeah

HERGOTT: okay what was your drink of choice

WETTLAUFER: rye

HERGOTT: yeah

WETTLAUFER: (laughs) I shouldn't say it like that

HERGOTT: hey

WETTLAUFER: but I make it sound like it's yeah rye

HERGOTT: would ya

WETTLAUFER: rye and Bailey's

HERGOTT: yeah

WETTLAUFER: yup pop a rye and pop down some water

HERGOTT: yeah

WETTLAUFER: yeah rye and water

HERGOTT: okay and uh typically how much would you would you drink in a week

WETTLAUFER: in a week probably about eight (8) or nine (9)

HERGOTT: yeah

WETTLAUFER: yeah (unintelligible)

HERGOTT: like like shots of rye or

WETTLAUFER: uh drinks so I don't know

HERGOTT: okay

WETTLAUFER: how many shots

HERGOTT: okay alright

WETTLAUFER: if you're gonna go by shots I don't know three (3) to a drink so like three (3) times nine (9)

HERGOTT: okay

WETTLAUFER: twenty-seven (27)

HERGOTT: okay so like you'd be drinking triples

WETTLAUFER: yeah

HERGOTT: okay alright how would that make you feel in in combination with the hydromorphs an

WETTLAUFER: I never did it with the hydromorphs

HERGOTT: no

WETTLAUFER: no

HERGOTT: it was either one or the other

WETTLAUFER: it was either one or the other

18:23:04



HERGOTT: okay

WETTLAUFER: cuz uh those more just for when I didn't have

HERGOTT: mm hmm

WETTLAUFER: the hydromorphs

HERGOTT: mm hmm

WETTLAUFER: and if I was going out but I didn't go out with people I always went out mostly by myself and just I took scratch and win tickets and took booze an

HERGOTT: just yeah

WETTLAUFER: I would drink an do my scratch to wins

HERGOTT: yeah okay um as significant and disturbing as this may be to the people that are gonna hear this an and (unintelligible) this obviously there's a lot of uh families that we're gonna contact

(01:45:14 dur)

WETTLAUFER: yes

HERGOTT: an and speak to um although this wasn't and I hate to classify it into different areas but these weren't necessarily violent deaths like how did do you think these people died peacefully did they struggle at all

WETTLAUFER: um all the people you've talked about so far died peacefully in my opinion

HERGOTT: okay

WETTLAUFER: and I am sorry I'm sorry for what the families went through at the time

HERGOTT: mm hmm

WETTLAUFER: and I'm extremely sorry for what they're going to go through I it's awful

HERGOTT: if you could say something to them what would you say to them

WETTLAUFER: what can you say to them that would matter um I'm sorry isn't enough I should've gotten help sooner um I took something from you that was precious an taken too soon um I honestly believed at the time that God wanted me to do it but I know now that's not true and uh if I could take it back if I could get help sooner I would've and I am sorry and like I said uh I'd admire you for (unintelligible) whether it took one (1) year two (2) years ten (10) years whatever it took for you to finally get help that's that's a big step

HERGOTT:

WETTLAUFER: oh thank you

18 : 25 : 07



HERGOTT: right I mean uh you could've been in this situation an an taken this to your grave

WETTLAUFER: yes

HERGOTT: and who would've known right

WETTLAUFER: that's what I was told to do by a lawyer

HERGOTT: what's that

WETTLAUFER: take it to my grave and not tell anybody

HERGOTT: so you confided in a lawyer as well about this

WETTLAUFER: a long time ago yeah

HERGOTT: was it after all of these people that

WETTLAUFER: it it was 2014 before I uh

HERGOTT: and before you went to Welland or

WETTLAUFER: yeah

HERGOTT: sorry to the

WETTLAUFER: the Welland (unintelligible)

HERGOTT: rehab center

WETTLAUFER: yeah to the rehab facil center

HERGOTT: so you spoke to a lawyer

WETTLAUFER: spoke to a lawyer and that's she was the one who told me to get help um I need to go to the bathroom

HERGOTT: no problem (unintelligible) just for the record and uh so it's documented I have six twenty-six (6:26)

WETTLAUFER: wow

HERGOTT: we'll just take a break okay

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: you remember where you're going

WETTLAUFER: yeah

HERGOTT: kay

(no conversation heard from 01:47:36 to 01:51 :40 dur)

HERGOTT: ya all set

WETTLAUFER: yeah

HERGOTT: do you need anything else at all

WETTLAUFER: no

HERGOTT: are you sure

WETTLAUFER: no I had a caramel

HERGOTT: oh did ya perfect um just for the record here I have

WETTLAUFER: (coughs)

HERGOTT: six thirty (6:30) and that'll just resume things okay okay

you okay

18 : 30 : 26



WETTLAUFER: yup

HERGOTT: okay want me to carry on

WETTLAUFER: yup that's cool

HERGOTT: (unintelligible) so Gladys oh so this takes us to November of 2011

WETTLAUFER: mm hmm

HERGOTT: at Caressant Care um it says here Gladys was a type two (2) diabetic um and had dementia

WETTLAUFER: severe dementia

HERGOTT: did she yeah how old do you think Gladys was

WETTLAUFER: ninety (90) ninety-two (92)

HERGOTT: ninety-two (92) okay and where was Gladys within uh Caressant Care

WETTLAUFER: East wing um three (3) doors down from the main desk in a double room

HERGOTT: okay do you remember her roommates at all

WETTLAUFER: no

HERGOTT: no okay um an an uh obviously these are repetitive questions an

WETTLAUFER: yeah

HERGOTT: you might remember some of the roommates throughout uh as we go along here so that's why I just keep asking the same questions um tell me a little bit about Gladys what did shh what was she like when you cared for her

WETTLAUFER: um well when I first started caring for her she was walking and talking and she had quite the spirit um she wa (laughs) she once punched a man

HERGOTT: oh

WETTLAUFER: because uh she she overheard the nurses telling one of the gentleman no you can't push your wife around you have to come with us and she turned around and she said you can't treat a woman like that boom

HERGOTT: and hit the man

WETTLAUFER: and hit the man

HERGOTT: (laughs)

WETTLAUFER: so then we're all in a state of trying to keep them from fighting with each other trying to keep them from hurting us

HERGOTT: right

WETTLAUFER: yeah she was very

HERGOTT: (sneezes)

18 : 32 : 04



WETTLAUFER: spunky

HERGOTT: excuse me

WETTLAUFER: but she went down downhill fast

HERGOTT: did she

WETTLAUFER: eventually um she was just um dementia didn't take her pills well didn't eat well very stubborn woman

HERGOTT: mm hmm

WETTLAUFER: and uh as always one evening I just got that red surging feeling that she was gonna be the one

HERGOTT: mm hmm

WETTLAUFER: and um gave her insulin overdose

HERGOTT: did you ever get that feeling outside of work

WETTLAUFER: no never

HERGOTT: no did you ever get that feeling going to work knowing that that something was going to happen that shift

WETTLAUFER: no it always happened at work

HERGOTT: okay so if I were to use the phrase spur of the moment would it be something

WETTLAUFER: (sighs)

HERGOTT: that you would just have that feeling come on or

WETTLAUFER: yeah I guess you could say it was uh

HERGOTT: would it build up

WETTLAUFER: spur of the moment but it would it would usually start happening you know focused on one patient and then this I would feel that red surge and which is what made me think it was God

HERGOTT: okay okay

WETTLAUFER: which I am so embarrassed

HERGOTT: well like I said I'm not here to judge you alright

WETTLAUFER: I know

HERGOTT: right um you says you you explained that it was difficult for towards the end giving her her pills um do you remember what you were working what uh the shift when you injected Gladys

WETTLAUFER: I believe I was working was either working nights or days

HERGOTT: okay

WETTLAUFER: cuz I know it was close to the end of my shift

(01:55:01 dur)

HERGOTT: okay

WETTLAUFER: that I did it and the person who came on the next shift I think it was nights so this person who came on the next

18 : 33 : 32



shift checked her all over and started to call the doctor
and had her admitted palliative an

HERGOTT: mm hmm

WETTLAUFER: started her on a pain pain regimen and

HERGOTT: okay and do you remember how much insulin you gave
her

WETTLAUFER: no I don't

HERGOTT: do you remember if it was long or short or a mix

WETTLAUFER: I I probably at that point I think I was giving everybody a
mix

HERGOTT: okay so once once Mary was the first person you said
that you gave

WETTLAUFER: yes

HERGOTT: the the long and the short acting to

WETTLAUFER: yeah

HERGOTT: and then following that it was

WETTLAUFER: everybody

HERGOTT: pretty much everyone from there forward

WETTLAUFER: yeah

HERGOTT: okay um and that was at again at Caressant Care

WETTLAUFER: yes

HERGOTT: was that insulin taken from the same location as

WETTLAUFER: yeah

HERGOTT: as you always would

WETTLAUFER: yes

HERGOTT: okay is there camera's in in the

WETTLAUFER: in the med rooms

HERGOTT: med rooms

WETTLAUFER: no

HERGOTT: no

WETTLAUFER: no

HERGOTT: nothing at all

WETTLAUFER: nope

HERGOTT: okay so you could access whatever you like an

WETTLAUFER: well not whatever you like but yeah within reason

HERGOTT: but the insulin because you said

WETTLAUFER: the insulin

HERGOTT: they didn't even keep track of it

WETTLAUFER: um the insulin uh yeah the insulin um we could get
valium we could get like injectational valium

HERGOTT: mm hmm

18 : 34 : 31



WETTLAUFER: um yeah it was fairly easy to take meds from there
HERGOTT: okay okay um and we'll get into that sorry I was gonna ask you a question about (unintelligible) uh down the road um you know how long it took for Gladys to die
WETTLAUFER: I believe she died the next afternoon or that afternoon
HERGOTT: okay and do you know if you were present for that
WETTLAUFER: no I was not
HERGOTT: so therefore wouldn't have been a part of the the process of of the pronouncing and checking the boxes
WETTLAUFER: no no
HERGOTT: um
WETTLAUFER: when someone's dying it seems like it takes longer than it does
HERGOTT: mm hmm
WETTLAUFER: if you're around if you know what I mean
HERGOTT: mm hmm I do
WETTLAUFER: yeah so
HERGOTT: mm hmm
WETTLAUFER: well I'm sorry that you know that
HERGOTT: thank you um as far as Gladys goes do you remember if you worked the next day to to learn about Gladys' death or
WETTLAUFER: um I think I worked two (2) days later
HERGOTT: okay
WETTLAUFER: I think I worked the day after her death whenever that was
HERGOTT: okay what would went through your mind on on your days where you inject so Gladys for instance you inject her uh you worked nights it says here so
WETTLAUFER: yeah
HERGOTT: eleven (11) till seven (7) you did this at five (5) o'clock do you go home and carry it on about if you have one (1) two (2) three (3) days off whatever
WETTLAUFER: yeah
HERGOTT: the case was what was going through your mind on those days off
WETTLAUFER: I'm
HERGOTT: were you thinking when would
WETTLAUFER: yeah
HERGOTT: when's Gladys gonna die

18:35:56



WETTLAUFER: I would wonder if she had died I would wonder you know
if this would be the time I would get caught

HERGOTT: mm hmm

WETTLAUFER: you know what was I going every time every time I
walked in after somebody passed away I always
wondered is this the day I'm gonna get caught

HERGOTT: mm hmm what kinda consequences played through your
head if you uh if you wa damn I'm I'm caught the gigs up
what what kinda consequences did you think

WETTLAUFER: jail

HERGOTT: you were gonna face if if that were to happen

WETTLAUFER: fired

HERGOTT: back in 2011

WETTLAUFER: fired jail um no more nursing license

HERGOTT: mm hmm

WETTLAUFER: that's exactly what I'm looking at now

HERGOTT: mm hmm

WETTLAUFER: although I took myself out instead of being fired but

HERGOTT: right

WETTLAUFER: jail and no more nur nursing license

HERGOTT: an as far as in 2011 through an an having that feeling like
when did those feelings start to say uh in your mind like I
wonder if this is the time I'm gonna get caught
(simultaneously talking)

WETTLAUFER: probably

HERGOTT: did it happen right at mister SILCOX

WETTLAUFER: probably every time

HERGOTT: or did it

WETTLAUFER: yeah

HERGOTT: yeah

WETTLAUFER: probably every time

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: okay um and Gladys uh do you think uh did she have a
reaction when you injected her

WETTLAUFER: she fought a little bit

HERGOTT: did she

WETTLAUFER: yeah

HERGOTT: what do you mean by that



WETTLAUFER: like she struggled around so I I found a spot on her that I said I could do where she couldn't reach me and pinch me

HERGOTT: okay would that be something typical if you were giving her medication she liked to pinch

WETTLAUFER: yeah pinch scratch seal up her mouth

HERGOTT: is that common in patients

WETTLAUFER: uh yeah

HERGOTT: yeah yeah okay

WETTLAUFER: and um like even the the PSW's who had to change her uh product

HERGOTT: mm hmm

WETTLAUFER: sometimes she'd fight them and scratch them and pinch them and twist their hair an yeah

HERGOTT: do you think that played into any part of your actions with Gladys

WETTLAUFER: um

HERGOTT: particularly with Gladys

WETTLAUFER: I don't know I think some of the um I think some of it did you know her stubbornness and stuff an

HERGOTT: mm hmm

WETTLAUFER: yeah it did kind of okay you're the next one to go

HERGOTT: mm hmm

WETTLAUFER: but again there was always the the red surging that I identified as God telling me this is the one

HERGOTT: mm hmm

WETTLAUFER: yeah this is how you work for me

HERGOTT: kay did you ever try and fight that feeling

WETTLAUFER: later on as you'll see

HERGOTT: mm hmm okay but when you got that feeling in your chest an and stomach would you you directly go to get the insulin

WETTLAUFER: um pretty much as as soon as I had time with the rest of my job

HERGOTT: mm hmm how many patients would you be caring for during

WETTLAUFER: thirty-two (32)

HERGOTT: on one (1) shift

WETTLAUFER: thirty-two (32)

HERGOTT: where you'd be responsible for all thirty-two (32)

(02:00:00 dur) 18 : 38 : 28



WETTLAUFER: yep thirty-two (32)
HERGOTT: so each nurse would have thirty-two (32)
WETTLAUFER: yep nurse uh or registered practical nurse registered practical nurse
HERGOTT: okay so that's a busy day
WETTLAUFER: mm hmm
HERGOTT: and I know we talked about it earlier but again just to revisit that you you think that's something that played into this
WETTLAUFER: I think so
HERGOTT: the stresses of the job
WETTLAUFER: I oh yeah I definitely think so
HERGOTT: cuz you had a lot going on in your life
WETTLAUFER: yeah I I definitely think that stress played into it maybe made me made my mind more susceptible to
HERGOTT: mm hmm
WETTLAUFER: that
HERGOTT: hmm did you ever go to work um intoxicated by alcohol or drugs at all
WETTLAUFER: um no
HERGOTT: did you ever use at work
WETTLAUFER: yes
HERGOTT: the hydromorphs
WETTLAUFER: yes
HERGOTT: kay often
WETTLAUFER: (exhales) probably once or twice a week
HERGOTT: yeah
WETTLAUFER: yeah
HERGOTT: okay and when you were at Caressant Care where would you have got your hydromorphs from
WETTLAUFER: oh there's a number of ways you can get them
HERGOTT: right
WETTLAUFER: you can sign off that somebody got their sign off that somebody wanted a P R N
HERGOTT: mm hmm
WETTLAUFER: and then take it instead
HERGOTT: okay
WETTLAUFER: you can uh take them their regular medication and if they're not able to identify it
HERGOTT: mm hmm
WETTLAUFER: take it instead

18 : 39 : 38



HERGOTT: okay

WETTLAUFER: you can take their regular medication that's in capsules and if they are able to identify it open the capsules take the stuff out

HERGOTT: mm hmm

WETTLAUFER: put the capsule back together again give them the (unintelligible) capsule

(simultaneously speaking)

HERGOTT: (unintelligible)

WETTLAUFER: take it yourself

HERGOTT: and how would you typically ingest the hydromorphs

WETTLAUFER: I just swallowed it I never shot it I never snorted it

HERGOTT: yep okay okay and do you remember how much you gave Gladys

WETTLAUFER: of the insulin

HERGOTT: mm hmm

WETTLAUFER: I think I gave her eighty (80) sixty (60)

HERGOTT: okay

WETTLAUFER: I think

HERGOTT: okay and her reaction after after she kind of pinched and and struggled a little bit with you

WETTLAUFER: she relaxed and then um by the time the next nurse came on she was red she was sweating she was incoherent she her blood signs her vital signs were all down

HERGOTT: and how do you know that

WETTLAUFER: because I was just leaving when the next nurse came on and she P S W's came to her and said something's going on with Gladys and she said come with me they have to go check on Gladys

HERGOTT: and did you

WETTLAUFER: um actually I actually helped her move Gladys to the palliative care room

HERGOTT: okay, and do you remember

WETTLAUFER: scared outta my gourd the whole time that she was going to say that it was something I did

HERGOTT: thinking okay was she still able to communicate at that point

WETTLAUFER: no

HERGOTT: do you remember what nurse that was that you moved (unintelligible)

18 : 40 : 57



WETTLAUFER: Karen I don't remember her last name

HERGOTT: okay

WETTLAUFER: if I sit for a minute if I sat for a minute I could probably remember

HERGOTT: okay well if it comes to ya

WETTLAUFER: um

HERGOTT: might just be one of those things that pops in your head in a few moments right

WETTLAUFER: yeah RUTLEDGE

HERGOTT: Karen RUTLEDGE

WETTLAUFER: yeah

HERGOTT: okay she's still there do you know

WETTLAUFER: yep far as I know

HERGOTT: okay Mrs. Helen YOUNG so this is where you have a bit of a gap again

WETTLAUFER: yeah

HERGOTT: 2011 to 2013 with successful injections

WETTLAUFER: yeah

HERGOTT: but there was and there wasn't even any attempts

WETTLAUFER: no not from in November 2011 I came home from a uh cruise of the Caribbean

HERGOTT: mm hmm

WETTLAUFER: and I was feeling guilty

HERGOTT: mm hmm

WETTLAUFER: I was feeling damned I was feeling confused I I was feeling like I just didn't want to do it anymore I was feeling like if I could somehow connect with God strongly enough that I wouldn't do it anymore

HERGOTT: mm hmm

WETTLAUFER: and so I spent a lot of time reading my bible and praying and deciding I just wasn't going to do it anymore so I had the odd urge to do it but I resisted by going to church reading my bible praying and telling God I didn't believe him that he wanted me to do it anymore

HERGOTT: mm hmm what church were you going to at that point

WETTLAUFER: um [REDACTED]

HERGOTT: where's that

WETTLAUFER: [REDACTED]

HERGOTT: oh okay yep

WETTLAUFER: [REDACTED]

18 : 42 : 42



HERGOTT: [REDACTED]

WETTLAUFER: it's kitty corner from [REDACTED]

HERGOTT: yep

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED] so as far as fighting off that do would you still have that feeling like that burning feeling

WETTLAUFER: sometimes

HERGOTT: okay

WETTLAUFER: but I did a lot of praying about it and I would I just did a lot of praying reading my bible getting very involved in my faith getting very involved in my church

HERGOTT: right okay and and obviously with what you've told us so far that it helped

WETTLAUFER: yep

HERGOTT: with what you've documented

WETTLAUFER: yeah

HERGOTT: is there anything else that we need to be aware of that happened in between those times

(02:05:01 dur)

WETTLAUFER: no

HERGOTT: okay

WETTLAUFER: no

HERGOTT: okay

WETTLAUFER: I didn't tell anybody or anything like that

HERGOTT: okay except for [REDACTED] that the pastor sorry when did you

WETTLAUFER: that was I told him after Helen YOUNG

HERGOTT: okay

WETTLAUFER: he was after Helen YOUNG

HERGOTT: I'm just going to turn this off if it keeps vibrating. I apologize for that

WETTLAUFER: that's okay I may fart and I may have to apologize for that well there ya go um so that was after Helen

HERGOTT: that I told [REDACTED] yeah

HERGOTT: right okay so Helen was uh at Caressant Care where was uh where was Helen's room

WETTLAUFER: she was on A 5 I had been transferred to A side which is the new unit like well relatively new and 10-12 years? old people I was on the first floor I was the charge nurse for

18 : 44 : 16



the first floor and she was in the room closest to the nurses station

HERGOTT: okay where so where was A was that if I for me going to

WETTLAUFER: umm

HERGOTT: Caressant Care would it be closer to Fyfe or closer to Norwich Ave which side or

WETTLAUFER: okay so there's the retirement home

HERGOTT: mm hmm

WETTLAUFER: there's the (unintelligible) retirement home

HERGOTT: mm hmm

WETTLAUFER: to the uh to the nursing home there's the North wing there's South wing there's East wing and then down at the end of the hallway of East wing is uh unit one (1) and unit two (2) in a building right on top of each other

HERGOTT: and what was the purpose of that area of of Caressant Care

WETTLAUFER: oh it was it was all single rooms

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: so Helen was in her own room

WETTLAUFER: Helen was in her own room yeah it was all single that area

HERGOTT: alright um and Helen was a type 2 diabetic with dementia

WETTLAUFER: yep

HERGOTT: kay tell me a little bit more about Helen

WETTLAUFER: uh Helen was miserable she frequently yelled out help me nurse she frequently yelled out she wanted to die she just was not happy with her life she would wheel wheel around in her wheelchair saying help me nurse help me nurse help me nurse help me nurse and when you went to help her what do you want help with nothing get away with me go away help me nurse help me nurse didn't want to eat didn't want to drink very difficult to deal with

HERGOTT: mm hmm

WETTLAUFER: um constantly we would deal with and or we'd say what do you want help with I want to die why can't you help me die I wanna die and one it was like something snapped inside

HERGOTT: mm hmm

WETTLAUFER: and that red surge came back and I thought okay you will die

18:46:16



HERGOTT: mm hmm

WETTLAUFER: so uh I gave her a shot I came up to her and said this is for your pain I gave her a shot of long acting or short acting and she started to settle down and then um later on we put her into bed and I gave her more off more of the uh insulin I think it was long acting

HERGOTT: mm hmm

WETTLAUFER: she had a seizure she turned red she um was diaphoretic the P S W's called me to the bed side um I took all of her vital signs and I pretended to take her blood sugar and says

HERGOTT: okay yeah

WETTLAUFER: and said oh it's normal don't worry about it

HERGOTT: how did you go about that with people beside you

WETTLAUFER: cuz they're P S W's

HERGOTT: okay

WETTLAUFER: (laughs) don't no don't let anybody see that part of the

HERGOTT: no offense to the P S W's

WETTLAUFER: no but what I mean is when you (unintelligible) is P S W's nurses spend nurses focus on the meds

HERGOTT: right

WETTLAUFER: and treatment

HERGOTT: okay

WETTLAUFER: P S W's focus on like they were busy they were busy washing her

HERGOTT: mm hmm

WETTLAUFER: busy changing her

HERGOTT: mm hmm

WETTLAUFER: they were busy dealing with the fact that she was having diarrhea they were not doing the part of the job that I was doing

HERGOTT: right

WETTLAUFER: so they never would've noticed
(door opens)

UNKNOWN MALE: sorry
(door closes)

WETTLAUFER: where's my burger

HERGOTT: (unintelligible)

WETTLAUFER: so they never would've noticed um me not taking the blood sugar cuz I took her pulse

HERGOTT: right

18:47:42



WETTLAUFER: I did everything else so they wouldn't have noticed that I didn't do that because they were busy with everything else

HERGOTT: okay and you just (unintelligible) normal

WETTLAUFER: said nope blood sugar's good it's five point six (5.6) she's good

HERGOTT: which is is a a number that in your mind you was average and not be concerning at five point six (5.6)

WETTLAUFER: yeah

HERGOTT: or whatever you said

WETTLAUFER: yeah

HERGOTT: okay okay um do you remember what shift you were working at this point

WETTLAUFER: afternoons uh straight three (3) to eleven (11) at that point and straight three (3) to eleven (11) on on that ward

HERGOTT: oh okay

WETTLAUFER: and it started a little bit before that

HERGOTT: yeah okay and that would've been an individual room you said

WETTLAUFER: yeah

HERGOTT: okay and you don't remember um when Mrs. YOUNG died

WETTLAUFER: uh one (1) to two (2) days afterwards

(02:10:00 dur)

HERGOTT: kay and do do you know if you were present for that

WETTLAUFER: no I wasn't

HERGOTT: was there a different procedure at all when people passed away in that in that wing as opposed to where you were prior to

WETTLAUFER: no it was all the same in nursing home it was all the same policies

HERGOTT: okay

WETTLAUFER: it was just that nursing home that wing of the nursing home was built to accommodate the fact that um the owner took over Nor Villa

HERGOTT: oh okay

WETTLAUFER: in Norwich

HERGOTT: okay



WETTLAUFER: so everybody from Nor Villa got moved to the new part of the nursing home

HERGOTT: okay gotcha kay

WETTLAUFER: so that's the only reason and then eventually they all got mixed together

HERGOTT: right okay so being that it had it had been a few years then um when you injected uh Mrs. YOUNG and you were successful in in causing her death how did it make you feel after those few years that these these urges and these feelings had come back

WETTLAUFER: I felt horrible I felt angry at myself I felt like I had failed myself I felt like God had failed me

HERGOTT: mm hmm did you continue to practice in the church

WETTLAUFER: I continued going to church yeah

HERGOTT: and do you believe in as much as you had

WETTLAUFER: umm I did but I was getting very confused so it was soon after that that I went to the pastor and told him what had happened

HERGOTT: mm hmm

WETTLAUFER: and uh he prayed over me and cuz he said that was the last thing he would've thought out of me

HERGOTT: mm hmm

WETTLAUFER: and his wife there too and they prayed over me

HERGOTT: mm hmm

WETTLAUFER: and they said to me now this is God's grace

HERGOTT: mm hmm

WETTLAUFER: but if if you ever do this again we will have to turn you into the police

HERGOTT: and where would these where would that conversation had taken place at the church

WETTLAUFER: in no in their house at the kitchen table

HERGOTT: okay

WETTLAUFER: and I kept going to their church

HERGOTT: and did how detailed would you have been in the conversation with [REDACTED]

WETTLAUFER: oh I had told I told him that I was taking people's lives by giving them overdoses

HERGOTT: what were you specific with names how much insulin you went through doing

WETTLAUFER: no no

HERGOTT: how many people

18 : 50 : 35



WETTLAUFER: I don't know if I told him how many people just that I was doing it and how long (unintelligible)

HERGOTT: okay and his response was to pray for you and pray over you

WETTLAUFER: he put his hands on me and have him put his hands on me and pray

HERGOTT: okay what uh what religion would that church practice

WETTLAUFER: [REDACTED]

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: kay alright um did Helen have any family that you recall that would come and visit her

WETTLAUFER: yeah she had a niece that loved her very much and was there at least twice a week

HERGOTT: would you ever converse with her

WETTLAUFER: before before she died yeah

HERGOTT: mm hmm

WETTLAUFER: yeah

HERGOTT: kay how old is she

WETTLAUFER: the same late fifty (50) early sixty (60)

HERGOTT: the niece

WETTLAUFER: the niece yeah

HERGOTT: and then Helen herself

WETTLAUFER: ninety (90)

HERGOTT: did you speak to her following Helen's death her niece

WETTLAUFER: once

HERGOTT: kay and when was that

WETTLAUFER: (exhales) I think it was a day or two (2) after when she was gathering her stuff and she cried on my shoulder and thanked me for being good to her

HERGOTT: again the feelings that you had at that point

WETTLAUFER: oh guilt shame anger like I had betrayed her and not that I was betrayed but betrayal

HERGOTT: mm hm

WETTLAUFER: that I had betrayed her

HERGOTT: and did you display any emotion at that point to her

WETTLAUFER: um I just you know gave her a hug back and said I was so sorry

HERGOTT: yeah

WETTLAUFER: but on that point I was getting very confused about was this God and was it not

18:52:07



HERGOTT: and when you resumed doing this did you have any besides the religious feelings that you were having did you have any other uh personal um feelings in your mind as as far as knowing the difference between right and wrong again

WETTLAUFER: yes yes I knew the difference between right and wrong but I thought that this was something that God or whoever wanted me to do it

HERGOTT: so when you were

(simultaneously speaking)

WETTLAUFER: I was starting at that point to to doubt that it was God

HERGOTT: okay when you resumed doing it

WETTLAUFER: yeah

HERGOTT: right okay alright was anyone working with you on that day that you can recall

WETTLAUFER: um P S W's but I don't remember their names

HERGOTT: okay

WETTLAUFER: and

HERGOTT: how many would there have been

WETTLAUFER: three (3)

HERGOTT: okay

WETTLAUFER: there would've been a student too I think

HERGOTT: okay

WETTLAUFER: but I can't remember

HERGOTT: and there would've been thirty-two (32) patients in that wing as well

WETTLAUFER: yeah

HERGOTT: that you were responsible for okay um March of 2014 Mrs. Maureen PICKERING at Caressant Care

WETTLAUFER: yeah

HERGOTT: tell me about Maureen

WETTLAUFER: mmm Maureen was a handful

HERGOTT: mm hmm

(02:15:00 dur)

WETTLAUFER: um she would attack all the patients she would pull their hair she would hit them she would pinch them eventually um it was decided that she needed a one-on-one (1 on 1) staff so sometimes they would (unintelligible) P S W's would be with her sometimes someone would come from the outside to be with her

18:53:47



HERGOTT: mm hmm

WETTLAUFER: but when one (1) when one (1) wasn't available it the role of the charge nurse

HERGOTT: okay

WETTLAUFER: and that was nuts

HERGOTT: yep

WETTLAUFER: sorry

HERGOTT: yep

WETTLAUFER: that's just absolutely nuts

HERGOTT: mm hmm

WETTLAUFER: so um she just got harder and harder to look after and one (1) night when I had had to look after her I got this idea like you know (sighs) I started to get the feeling that surge again I thought no I don't want her die but if I could somehow give her enough of a dose to give her a coma

HERGOTT: mm hmm

WETTLAUFER: or something to change her brainwaves maybe make her less you know maybe make her less mobile harder to handle left handle hard to handle

HERGOTT: right

WETTLAUFER: so uh yeah I overdosed her

HERGOTT: okay and was that in the same wing

WETTLAUFER: yes she was right across she had gone into the room that um Helen had been in

HERGOTT: okay

WETTLAUFER: yeah she was right across from the nurse's station

HERGOTT: okay as well obviously a single room at that point

WETTLAUFER: yep

HERGOTT: (unintelligible)

WETTLAUFER: that night she stroked and through her stroke she went to the hospital and when she came out she was there for a few there at the (unintelligible) nursing home for a few days and then she died so they forced (unintelligible) from the hospital I was fired from Caressant Care

HERGOTT: okay

WETTLAUFER: for medication errors that had nothing to do with this

HERGOTT: kay when you when you got transferred into the A wing would you still get the medication the same way do they handle them the same way

WETTLAUFER: yeah cuz there's (unintelligible) there

18:55:22



HERGOTT: okay okay and so sorry Maureen uh Mrs. PICKERING was transferred from Caressant Care to the hospital (simultaneously speaking)

WETTLAUFER: and then back

HERGOTT: and then back

WETTLAUFER: yep (unintelligible)

HERGOTT: (unintelligible) what was the time frame there do you remember

WETTLAUFER: two (2) days I think

HERGOTT: and

WETTLAUFER: but they knew that she was totally vegetative when she came back

HERGOTT: okay

WETTLAUFER: cuz she was

HERGOTT: so she was basically coming back to pass away

WETTLAUFER: yeah

HERGOTT: in Caressant Care

WETTLAUFER: yeah

HERGOTT: was she put in palliative care when she returned

WETTLAUFER: no she had her own room

HERGOTT: okay

WETTLAUFER: the palliative care room was for people who didn't have their own room

HERGOTT: right

WETTLAUFER: so that families could go and be with them

HERGOTT: okay

WETTLAUFER: and that you know not necessarily be in the residence and not be disturbed by the other residents

HERGOTT: right okay do you remember how much insulin that you gave to Mrs. PICKERING

WETTLAUFER: (exhales) it was a lot it was a lot um I am gonna say eighty (80) long acting and sixty (60) short acting something like that it was a lot of insulin

HERGOTT: why so much to her

WETTLAUFER: wasn't sure she would die or not and I really wanted to make sure that she uh their mind would change a bit before she back

HERGOTT: so the insulin caused her

WETTLAUFER: a stroke

HERGOTT: a stroke and then and then the the reason to travel to the hospital

18:56:43



WETTLAUFER: yeah

HERGOTT: um do you remember any reaction from her when you were injecting her

WETTLAUFER: no none at all

HERGOTT: do you remember what type of sorry I apologize what part of the body you gave it to her

WETTLAUFER: her arm

HERGOTT: left right

WETTLAUFER: um left left arm

HERGOTT: and no reaction she didn't

WETTLAUFER: um

(simultaneously speaking)

HERGOTT: (unintelligible)

WETTLAUFER: oh yeah the first time I gave it to her she said hey what was that for and I said that's your that's your vitamin injection

HERGOTT: which is like you said what you would typically tell people

WETTLAUFER: yeah

HERGOTT: okay how long in between then that you gave her the next dose

WETTLAUFER: probably an hour and a half two (2) hours

HERGOTT: kay and that was about what time did you say sorry

WETTLAUFER: oh I don't know

HERGOTT: you were still

WETTLAUFER: eight (8)

HERGOTT: working afternoons right

WETTLAUFER: yeah eight (8) or nine (9) at night

HERGOTT: okay okay yeah it says here at eight (8) o'clock you gave her eighty (80) units of long acting insulin

WETTLAUFER: yep

HERGOTT: okay did uh Miss PICKERING do you recall any family that she had

WETTLAUFER: she had two (2) friends that came and saw her a lot and she had a boyfriend that would come and see her

HERGOTT: okay how old was she

WETTLAUFER: eighty-two (82)

HERGOTT: how old was her boyfriend

WETTLAUFER: oh I have no idea

HERGOTT: no

WETTLAUFER: no

18:58:02



HERGOTT: but he would come on a regular basis and visit
(unintelligible)

WETTLAUFER: he would come and visit yep

HERGOTT: yeah (unintelligible) was there any restrictions on visiting
practices at all certain hours

WETTLAUFER: um basically no if they wanted to come late at night they
had to let us know

HERGOTT: okay

WETTLAUFER: so we could let them in and out

HERGOTT: okay

WETTLAUFER: if some and and that was more for palliative people

HERGOTT: right

WETTLAUFER: but no there was no real restrictions I mean there was the
odd patient who had a restriction like they can't leave the
building with this person or they can't leave the building
with that person or so and so shows up call the police
that sort of thing

(02:20:10 dir)

HERGOTT: okay do you do you remember if you were present when
she passed away

WETTLAUFER: I was not

HERGOTT: okay

WETTLAUFER: I had already been fired

HERGOTT: okay so sorry between the time that she when were you
fired

WETTLAUFER: um late March early April

HERGOTT: was it when she was in the hospital or did she come back
and then

WETTLAUFER: she had come back and then I was fired

HERGOTT: and then she kinda lived for a few more days

WETTLAUFER: yeah

HERGOTT: you were fired in the meantime

WETTLAUFER: yeah

HERGOTT: and then she passed

WETTLAUFER: performances that had nothing to do with her and my
timeline may be wrong

HERGOTT: mm hmm

WETTLAUFER: it may have been February

HERGOTT: mm hmm

18:59:15



WETTLAUFER: because I know that I know by the middle of April I was working again at um Meadow Park nursing home

HERGOTT: and that's in London

WETTLAUFER: yeah

HERGOTT: what was the the cause of your your firing then sorry there was a medication mix-up at Caressant Care

WETTLAUFER: I had had a few medication errors and strangely enough not on purpose one (1) of our residents was missing her long acting insulin that she got at supper

HERGOTT: okay

WETTLAUFER: and it was coming from pharmacy but I wanted to make sure that she got her insulin

HERGOTT: mm hmm

WETTLAUFER: but I took insulin from another person who I thought was the same insulin but it was short acting

HERGOTT: mm hmm

WETTLAUFER: and it gave her a seizure cuz she wasn't used to it and she was she was okay we we helped her and she was alright

HERGOTT: okay

WETTLAUFER: but when they figured it out I was fired because I had had other medication errors with (unintelligible)

(02:21:47 audio skips out for a second and D/C HERGOTT asks a question which is missed)

WETTLAUFER: no no different thing eye drops uh a lot of different stuff

HERGOTT: and what do you think that was a result of

WETTLAUFER: what med head med air

HERGOTT: mm hmm

WETTLAUFER: the work load yeah

HERGOTT: was it anything to do with were you still using at this point

WETTLAUFER: um you know what I never made it I never made it work there I never made a med error my work never

HERGOTT: besides your focus

WETTLAUFER: yep

HERGOTT: did you ever commit any of these deaths when you were using

WETTLAUFER: no none of them

HERGOTT: so no med errors no deaths

WETTLAUFER: when I was using

19:00:56



HERGOTT: breathing was all the feeling in your chest in your stomach (unintelligible)

WETTLAUFER: yeah the surging and the yep and then the laughter afterwards which was really it was like a cackling from from the pit of hell if that makes sense

HERGOTT: mm hmm did the cackling continue um when Mrs. YOUNG was injected with insulin

WETTLAUFER: um

HERGOTT: after after that two (2) year break

WETTLAUFER: yes

HERGOTT: yeah

WETTLAUFER: yes it did it became cackling
(simultaneously speaking)

HERGOTT: same feeling same cackling

WETTLAUFER: same feeling same cackling

HERGOTT: so then you did you work anywhere between Caressant Care and Meadow Park

WETTLAUFER: no

HERGOTT: okay did you go directly from one to the other

WETTLAUFER: pretty much within a month

HERGOTT: and and those medication errors be documented in a reference letter or

WETTLAUFER: no

HERGOTT: would you be made aware of anything like that at Meadow Park uh would be aware of the reason why you were

WETTLAUFER: umm

HERGOTT: let go from Caressant Care

WETTLAUFER: I told the person the person that hired me at Meadow Park she told me she had found my resume somewhere

HERGOTT: mm hmm

WETTLAUFER: but I never applied to Meadow Park

HERGOTT: oh really

WETTLAUFER: that she had found my resume somewhere and she called me cuz they needed a nurse

HERGOTT: oh okay

WETTLAUFER: so when we did our interview her name was Heather I forget her last name she's not there anymore um when we did our interview she said to me why did you leave and I told her I said I'll be absolutely honest with you I

19:02:19



was fired for med errors and she said well tell me about them and I did

HERGOTT: mm hmm

WETTLAUFER: and she said okay well I believe in second chances so you're hired full-time afternoons and it was a one (1) year contract

HERGOTT: okay and how long were you unemployed for then

WETTLAUFER: a month

HERGOTT: just a month

WETTLAUFER: yep

HERGOTT: kay and would you commute back and forth did you still live in Woodstock at the time

WETTLAUFER: I still lived in Woodstock and I commuted back and forth

HERGOTT: for straight afternoons

WETTLAUFER: yep

HERGOTT: what was that what were the hours for the straight afternoons

WETTLAUFER: uh either six thirty (6:30) no sorry either two thirty (2:30) to ten thirty (10:30) or three (3) to eleven (11)

HERGOTT: okay

WETTLAUFER: I'm not sure which it was

HERGOTT: so when you got to Meadow Park what was the difference as far as the work load the patients that you were responsible for (unintelligible)

WETTLAUFER: no different (laughs)

HERGOTT: thirty-two (32) patients

WETTLAUFER: extremely similar the only difference was that they um the R P N's would do the um if there were dresses that had to be done at night they'd do the dressings on the people at night that were my people

HERGOTT: okay

WETTLAUFER: but other other than that

HERGOTT: same

WETTLAUFER: yep

HERGOTT: okay and um your super (unintelligible) supervisor at that point at Meadow Park was that the same person that hired you Heather or

(00:25:04 dur)

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: she was the nursing supervisor

19:03:40



HERGOTT: okay so she'd be your direct supervisor

WETTLAUFER: yep

HERGOTT: okay um so Arpad or Art HORVATH

WETTLAUFER: yes

HERGOTT: tell me a little bit about him

WETTLAUFER: um he was mean he would grab the nurses and the and P S W's whenever they were trying to do things for him he would grab them he would twist their arms he would punch them very difficult to do uh care for and uh one (1) night I just got that surge and I thought that you need to go

HERGOTT: had he done something that night

WETTLAUFER: no not really just been his normal self and he fought he fought the first needle

HERGOTT: mm hmm

WETTLAUFER: and then um the second needle I got in and I forgot something about Maureen

HERGOTT: mm hmm

WETTLAUFER: I had given her a dose of whatever we dosed her with to calm her down before I ever gave her the insulin I forgot about that (unintelligible)

(simultaneously speaking)

HERGOTT: okay so you gave her (unintelligible)

WETTLAUFER: is it in there

HERGOTT: about Maureen

WETTLAUFER: yeah

HERGOTT: I don't think so

WETTLAUFER: I had given her a sedative dose before I ever gave her the insulin

HERGOTT: no you did you gave her Haldol

WETTLAUFER: yeah

HERGOTT: yeah and you recall doing that

WETTLAUFER: yes I do

HERGOTT: and then the two (2) insulin injections did it calm did the Haldol calm her do you remember

WETTLAUFER: no no it didn't so Art I gave a large amount of short acting and a large amount of long acting in between each other

HERGOTT: okay

WETTLAUFER: and then when I left for the night he was still okay when I came back the next day and work they said that he had had a stroke severe stroke and gone to the hospital and

19:05:27



the nurse that I talked to who had been on the night before she said do you know how low his blood sugar was and I said how low and she said oh like one point (1.) something and then and then she said but you know what I went home and I did some resource research

- HERGOTT: mm hmm
- WETTLAUFER: and sometimes having a had a stroke can make your blood sugar go low
- HERGOTT: really
- WETTLAUFER: yeah (laughs) that's what she said to me
- HERGOTT: that was odd to you
- WETTLAUFER: yeah that was odd but yeah so he lived for a couple of days and then he passed
- HERGOTT: do you remember what nurse that was
- WETTLAUFER: umm
- HERGOTT: that you conversed with
- WETTLAUFER: it was the night nurse uh was a short Filipino lady that's all I remember
- HERGOTT: it's okay okay um and you remember what time the night that you had injected Art
- WETTLAUFER: um I am gonna say at seven thirty (7:30) and then nine thirty (9:30)
- HERGOTT: okay and um his reaction to it
- WETTLAUFER: he fought it
- HERGOTT: did he
- WETTLAUFER: yeah he fought everything
- HERGOTT: was he ever when you were doing this were you ever did you ever speak to these people when you were injecting them
- WETTLAUFER: no
- HERGOTT: would you ever say anything to them
- WETTLAUFER: not unless they asked me what I was doing then I would just say it was their vitamin injection
- HERGOTT: okay but having that and I know it's documented in here a few times having that feeling of anger and and frustration would you ever
- WETTLAUFER: no
- HERGOTT: you would never state anything to vocalize your your anger towards that person as you were injecting them
- WETTLAUFER: no never
- HERGOTT: and Art then um where did you inject him

19:07:00



- WETTLAUFER: (sighs) his arm
- HERGOTT: mm hmm
- WETTLAUFER: and his thigh
- HERGOTT: okay and what were you telling him at that point that you were giving him did he ask
- WETTLAUFER: um kinda kinda but then I (unintelligible) have your medicine eventually I got it into him
- HERGOTT: okay okay and was their an immediate reaction to him at all did did he stroke right away
- WETTLAUFER: no he didn't stroke till I left
- HERGOTT: okay and then that's when you came in the next day and had the conversation with that
- WETTLAUFER: yeah
- HERGOTT: short Filipino nurse
- WETTLAUFER: yeah
- HERGOTT: okay
- WETTLAUFER: I don't remember her name
- HERGOTT: it's okay um the four (4) or five (5) days later that he passed away do you remember if that was back at Meadow Park or was it in the hospital
- WETTLAUFER: yeah it was in the hospital it may have been
- HERGOTT: okay he never came back
- WETTLAUFER: it may have been just been two (2) or three (3) days it seemed like it was four (4) or five (5)
- HERGOTT: mm hmm
- WETTLAUFER: and his family was devastated absolutely devastated
- HERGOTT: what was his uh health like at that point prior to you injecting him
- (simultaneously speaking)
- WETTLAUFER: other than other than dementia
- HERGOTT: mm hmm
- WETTLAUFER: he was fairly strong
- HERGOTT: mm hmm
- WETTLAUFER: he was in a wheelchair but he was a good eater and he was strong and
- HERGOTT: how old was he
- WETTLAUFER: I am gonna say maybe seventy-eight (78)
- HERGOTT: okay and who was his family members
- WETTLAUFER: he had a son named Art
- HERGOTT: mm hmm
- WETTLAUFER: who uh did um stand-up comedy

19-08-21



HERGOTT: oh no way okay
 WETTLAUFER: yeah but I I think it was just like Open Mike Night
 HERGOTT: right
 (02:30:00 dur)

WETTLAUFER: and then his his wife
 HERGOTT: okay that's it
 WETTLAUFER: that's all I remember I know he had others but that's the only ones I knew
 HERGOTT: do you remember if there were other son or daughters or just other family members that you could recall
 WETTLAUFER: there were other family members involved but I don't recall
 HERGOTT: okay okay um did you ever have any interaction with his family you said they were devastated when did you learn of that how did you know of that
 WETTLAUFER: oh they came in to take stuff out of his room
 HERGOTT: following his death
 WETTLAUFER: while he was still in the hospital
 HERGOTT: okay
 WETTLAUFER: they came to empty (unintelligible) stuff and then when he was gone they came in to take the rest
 HERGOTT: okay how did you feel having a conversation with them
 WETTLAUFER: awful um again like I betrayed them
 HERGOTT: mm hmm how ya feeling right now
 WETTLAUFER: can I go to the bathroom again
 HERGOTT: yeah yeah
 WETTLAUFER: I know we're almost done
 HERGOTT: we are I got uh seven ten (7:10)
 WETTLAUFER: alright

(WETTLAUFER leaves room at 02:31:13 and D/C HERGOTT leaves the room at 02:31:18)

(No conversation heard from 02:31:18 to 02:34:49)

HERGOTT: (unintelligible)
 WETTLAUFER: no thanks
 HERGOTT: (unintelligible)
 WETTLAUFER: okay

(WETTLAUFER and D/C HERGOTT enter room at 02:34:57)

19:13:30



(02:35:00 dur)

HERGOTT: okay we're gettin' there I have seven fourteen (7:14)

WETTLAUFER: kay

HERGOTT: to resume um so we left off at left off with Art

WETTLAUFER: yeah

HERGOTT: mister HORVATH at uh Meadow Park Nursing Home and
and I don't we cover this off Meadow Park is in London
right

WETTLAUFER: yeah

HERGOTT: we already talked about commuting right okay alright is
there anything you remember about Art at all

WETTLAUFER: not really well he was a big game hunter

HERGOTT: was ho yeah

WETTLAUFER: and he had pictures of it that all over (unintelligible)

HERGOTT: yeah did you ever converse with these people like what
they did for work and that type of thing like would you
remember details like that like Art for instance would you

WETTLAUFER: well Art was a big game hunter Maurice I don't know
James I don't know no I guess I never really did

HERGOTT: yeah okay alright and at Meadow Park where would you
get the insulin there

WETTLAUFER: again from the from the medication fridge

HERGOTT: okay

WETTLAUFER: and (unintelligible)

HERGOTT: and again wasn't tracked

WETTLAUFER: mm hmm

HERGOTT: okay why is that

WETTLAUFER: I don't know insulin's not something that's usually tracked

HERGOTT: right and just because it's not a concern to the to the
home

WETTLAUFER: yeah I mean I think it is now and some homes track it
now

HERGOTT: mm hmm okay and just a question out of curiosity it's just
my lack of knowledge of it that's all

WETTLAUFER: yeah

HERGOTT: ok, alright um now you have a portion of your on the on
the fourth (4th) page of this document that you wrote out
and before you uh when did you write this out I know it's
dated the twenty-fourth (24th) of September

WETTLAUFER: yes that's when I wrote it out

19:15:23



HERGOTT: you wrote this full document at that point
WETTLAUFER: twenty-fourth (24th) and twenty-fifth (25th)
HERGOTT: where were you at that point
WETTLAUFER: I was at the nurse at the uh CAMH
HERGOTT: and what made you prepare this document
WETTLAUFER: the doctor suggested to me that I should
HERGOTT: okay
WETTLAUFER: not not to give to the police but he said he says that if I
wrote it out it would be a good part of my therapy
HERGOTT: okay
WETTLAUFER: so
HERGOTT: okay
WETTLAUFER: and it take a large amount of pressure off me and help
me to really clarify the fact that no it wasn't God it was
something wrong with me psychologically that was
making me believe that it was God
HERGOTT: mm hmm
WETTLAUFER: it really helped me to clarify that
HERGOTT: alright and the original of this document
WETTLAUFER: is in my knapsack in the back of your car
HERGOTT: and we'll get we'll we'll get down the road to that point but
is is providing us with the original document something
you'd be willing to do
WETTLAUFER: yes
HERGOTT: and we'll get to that um
WETTLAUFER: do you have a stamp that you can stamp it as the original
HERGOTT: um i don't even think we'll need to do that
WETTLAUFER: okay
HERGOTT: we'll have you sign a consent form but we'll we'll
WETTLAUFER: okay
HERGOTT: get to that
WETTLAUFER: okay
HERGOTT: um it only if you're willing of course um you have a
portion on the fourth page here titled people who didn't
die
WETTLAUFER: mm hmm
HERGOTT: what can you tell me about
WETTLAUFER: okay Clotilda ADRIANO
HERGOTT: okay
WETTLAUFER: she was the first person i ever gave extra insulin to
HERGOTT: okay

19:16:49



WETTLAUFER: I think I gave her forty (40) unit I just again there was that surging but it wasn't so much that I wanted her to die it was more like let's see what happens and I gave insulin to her on more than one (1) occasion

HERGOTT: okay

WETTLAUFER: uh Albino

HERGOTT: and sorry she was prior to Mister SILCOX right

WETTLAUFER: yes

HERGOTT: so this was the first person

WETTLAUFER: yeah

HERGOTT: that you injected with insulin

WETTLAUFER: yeah

HERGOTT: and where at Caressant Care

WETTLAUFER: at Caressant Care

HERGOTT: and her room was where

WETTLAUFER: her room was in the East wing second (2nd) door on the left

HERGOTT: okay

WETTLAUFER: and then East wing first (1) door on the left was her sister Albina she was diabetic

HERGOTT: okay

WETTLAUFER: um she was October 2007

HERGOTT: sorry that was her sister

WETTLAUFER: Clotilda and Albina were sisters yeah

HERGOTT: oh okay

WETTLAUFER: um then there was Wayne he was on the North wing he was he had dementia he was diabetic um he could be uncooperative and uh I gave him a large overdose um because I thought it was his turn to go

HERGOTT: that was Wayne

WETTLAUFER: that was Wayne (unintelligible)

HERGOTT: and sorry how old was sorry and I hate to go back but I have a few more questions how old was Clotilda

WETTLAUFER: Clotilda was ninety (90) or so

HERGOTT: okay and her sister

WETTLAUFER: Albina was probably eighty (80) eighty-two (82)

HERGOTT: okay and did they have family that would come and visit

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: alright

19:18:13



WETTLAUFER: very much so
 HERGOTT: who would that be that would come and visit
 WETTLAUFER: Clotilda I think it was her daughters and Albina it was her husband
 HERGOTT: okay and long acting short acting
 WETTLAUFER: short acting at that that point
 HERGOTT: in 2007 you were still doing acting
 WETTLAUFER: yeah

(02:40:00 dur)

HERGOTT: okay and do you remember the dose that you would've gave
 WETTLAUFER: oh wait a second what would they get at night it was long acting cuz if it was what they got at night and with those two it was their own insulin just extra dose so
 HERGOTT: okay
 WETTLAUFER: probably twenty (20) to thirty (30) to forty (40) thirty (30) to forty (40)
 HERGOTT: mm hmm
 WETTLAUFER: extra
 HERGOTT: okay and then Wayne how old was Wayne sorry
 WETTLAUFER: I'd say sixty (60)
 HERGOTT: okay oh so he was younger
 WETTLAUFER: he yeah he had developmentally developmental challenges as well as dementia as well as being diabetic um as well as being a handful um and uh he wanted to die so again that one night I just felt that surging and but he didn't die (unintelligible)
 HERGOTT: how did you know he wanted to die
 WETTLAUFER: he would say it sometime that he just wanted to go
 HERGOTT: mm hmm where was Wayne in Caressant Care
 WETTLAUFER: he was in Room 8 which is the men's ward down at the end
 HERGOTT: sorry 8 or A
 WETTLAUFER: 8 8
 HERGOTT: the number
 WETTLAUFER: 8 North 8 North
 HERGOTT: kay and would that be roommates in there as well
 WETTLAUFER: yeah
 HERGOTT: okay do you know who he was roomed with at all

19:19:37



WETTLAUFER: mm no not at all
 HERGOTT: alright and Mike with Huntington's disease
 WETTLAUFER: that was 2009
 HERGOTT: what what is that disease
 WETTLAUFER: it robs you of your body and you still have your mind you get progressively more agitated you get progressively more psychotic and you're in a wheelchair and you've got all these movements that you can't control it's a horrible disease
 HERGOTT: and how old was Mike
 WETTLAUFER: he was fifty-four (54)
 HERGOTT: okay
 WETTLAUFER: and uh again one night I just felt that surging and I thought now this must be God because this man is not enjoying his life at all
 HERGOTT: hmm
 WETTLAUFER: so I gave him a large amount of insulin I think I gave him ninety (90) total
 HERGOTT: did he ever do anything to harm you
 WETTLAUFER: no never
 HERGOTT: okay did Wayne
 WETTLAUFER: no
 HERGOTT: Albina
 WETTLAUFER: no
 HERGOTT: Clotilda
 WETTLAUFER: no
 HERGOTT: okay alright um this takes us to a different location in Telfer Place in Paris that's obviously Paris Ontario correct
 WETTLAUFER: yeah
 HERGOTT: outside of Brantford Woodstock area
 WETTLAUFER: 2016 winter
 HERGOTT: okay and that was Sandra
 WETTLAUFER: yeah and I was
 HERGOTT: and how old was Sandra
 WETTLAUFER: Sandra I think she was in her seventies (70's)
 HERGOTT: okay and Telfer Place what was what was the break-up of the room there where was she located within Telfer Place
 WETTLAUFER: um she was she was down the wing straight down from the um nurse's desk about two (2) doors on the left 19:21:08



HERGOTT: okay

WETTLAUFER: and she had three (3) roommates

HERGOTT: mm hmm and she describe her about the personality and her health

WETTLAUFER: um tall um not very well she didn't walk anymore she had a good sense of humour um she often said she didn't want to be there

HERGOTT: mm hmm

WETTLAUFER: and so one night I gave her (unintelligible) an insulin overdose

HERGOTT: kay

WETTLAUFER: but she survived because the nurse that came on next um went to check on her to do something else and noticed that she was sweating

HERGOTT: mm hmm

WETTLAUFER: and took her blood sugar and saved her life

HERGOTT: hmm okay and how did these other people survive

WETTLAUFER: um it just didn't oh Clotilda and Albina

HERGOTT: mm hmm

WETTLAUFER: they found them to have short blood they found them to have low blood sugar and they gave them stuff to raise it and Wayne and Mike they just survived

HERGOTT: okay

WETTLAUFER: it was never found out

HERGOTT: was there anything to do with the gender male or female that this influenced the effect of it or was it just

WETTLAUFER: not that I know of

HERGOTT: again it just depended on the make-up of their body and their health

WETTLAUFER: yep

HERGOTT: and (unintelligible)

WETTLAUFER: yep not that I know of (unintelligible) gender

HERGOTT: okay um the nurse who saved Sandra

WETTLAUFER: yeah

HERGOTT: was there anything that ever came back on you

WETTLAUFER: no

HERGOTT: any retribution consequences

WETTLAUFER: nope she never figured it out that I know of

HERGOTT: kay (unintelligible)

WETTLAUFER: she even asked me about it and asked if I thought she done the right thing

19:22:44



HERGOTT: who was that do you remember her name

WETTLAUFER: Diane I don't remember her last name

HERGOTT: okay and what what were you working on at that point what shifts were you working on at Telfer Place

WETTLAUFER: whatever I got called in for

HERGOTT: okay

WETTLAUFER: I was actually working for a nursing agency at that time called Life Guard Agency

HERGOTT: mm hmm

WETTLAUFER: and I was sent to Telfer through Life Guard

HERGOTT: I see so you were never employed by Telfer Place

WETTLAUFER: no

HERGOTT: oh

WETTLAUFER: no I was employed by Life Guard and I would go to Telfer and two (2) other places as well

HERGOTT: mm hmm okay and that's when you got involved with Saint Elizabeth as well right when you were with Life Gaurd

WETTLAUFER: yeah um yeah just I was only with Saint Elizabeth like a month and a half before I quit

HERGOTT: okay okay 2016 of August which is not too long ago um you're employed with Saint Elizabeth it says here

(02:45:06 dur)

WETTLAUFER: yep I was frustrated with my job I was I had a huge um huge workload having to learn a lot of new things just a lot of frustration um the weekend that this happened there I had all all of the people that I had to look after most of them were in Ingersoll and now I (unintelligible) and uh on the Saturday I went in and I was doing my care and uh this is really the only one that was pre-planned cuz on the Saturday I went in and I was doing care on Beverly and I noticed that she had a PICC line which is a line that takes medication straight to your heart

HERGOTT: mm hmm

WETTLAUFER: and that she was a diabetic and so the next day when I went in I was really frustrated and I could just really feel the surging and the laughing and I I gave her a huge amount I gave her I think it was one eighty (180) three (3) three (3) doses of sixty (60)

19:24:29



HERGOTT: okay

WETTLAUFER: through the PICC line

HERGOTT: did she question that at all or

WETTLAUFER: no cuz I used one (1) to rinse the PICC line one (1) to put
in her ii antibiotics and one (1) to rinse the PICC line
again

HERGOTT: okay

WETTLAUFER: and uh she survived she was fine the next day

HERGOTT: did you go see her the next day

WETTLAUFER: no but I was able to check on my computer cuz she was
seen every day by a nurse

HERGOTT: oh okay

WETTLAUFER: like I could go into (unintelligible) and she how she was

HERGOTT: okay and that was just a computer program used by
Saint Elizabeth

WETTLAUFER: yes

HERGOTT: I see

WETTLAUFER: on their own tablet

HERGOTT: okay and these other people where did you inject them

WETTLAUFER: um their arm

HERGOTT: all of them

WETTLAUFER: all of them yep

HERGOTT: okay

WETTLAUFER: Sandy it was probably her leg cuz

HERGOTT: mm hmm

WETTLAUFER: she was a little more difficult

HERGOTT: mm hmm in August of of 2016 then with Beverly you
don't remember Beverly's last name

WETTLAUFER: no I don't

HERGOTT: okay

WETTLAUFER: and I don't even remember her first name was Beverly

HERGOTT: oh okay

WETTLAUFER: I could probably oh I don't know if I could tell you the
weekend it was or not

HERGOTT: but she lived in Ingersoll

WETTLAUFER: yeah

HERGOTT: did she live in a home or

WETTLAUFER: uh yeah in a home like

HERGOTT: like her own residence I mean or

WETTLAUFER: [REDACTED]



HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: do you remember where in Ingersoll it was

WETTLAUFER: no I don't

HERGOTT: no okay um how can you have the name Beverly but you're not sure what her name is

WETTLAUFER: cuz I am not sure if it was Bev or Bea or

HERGOTT: I gotcha okay okay and that was the only one you had given through the PICC line

WETTLAUFER: yeah

HERGOTT: did you know what the result would be compared to a direct injection into an arm or a leg or a thigh

WETTLAUFER: I'd never done it before

HERGOTT: compared to a PICC line

WETTLAUFER: I had never looked at it I had no idea

HERGOTT: okay

WETTLAUFER: she went she went to sleep fairly quickly

HERGOTT: mm hmm

WETTLAUFER: and I left

HERGOTT: mm

WETTLAUFER: but when I checked uh the next day to see how she was through the next nurse

HERGOTT: mm hmm

WETTLAUFER: there was no change

HERGOTT: how old was she

WETTLAUFER: she was sixty-three (63) sixty-four (64)

HERGOTT: okay and what was her diagnosis as far as her health

WETTLAUFER: she was diabetic and she had large ulcers on her leg

HERGOTT: okay

WETTLAUFER: and she also had a um severe infection

HERGOTT: okay how'd that make you feel going through all that

WETTLAUFER: awful

HERGOTT: do you feel like there's a burden lifted off your shoulders

WETTLAUFER: yeah

HERGOTT: yeah

WETTLAUFER: I've done the right thing

19:27:11



HERGOTT: do you feel there's a sense of relief

WETTLAUFER: yes and now I know that it wasn't God and I am ashamed of myself

HERGOTT: mm hmm

WETTLAUFER: that that happened but I also think that it was mental health you know I think it was I wasn't in my right my right mind or I would've been able to tell I mean who I was raised to believe in God I was raised from a baby to a Sunday school so how could I get such a strong feeling

HERGOTT: mm hmm

WETTLAUFER: that this is what God wanted unless it was something wrong in my head

HERGOTT: mm and it always talked about what you would say to the families and so on and so forth but um again I I feel terrible for the for the people that are gonna find out in the days and weeks to come about what actually happened

WETTLAUFER: yeah

HERGOTT: to their loved ones right

WETTLAUFER: it is

HERGOTT: um

WETTLAUFER: I feel horrible

HERGOTT: um

WETTLAUFER: if there was ever anything I could do so that nobody did this again I'd do it

HERGOTT: okay just a few other things to cover off and

WETTLAUFER: okay

HERGOTT: that um the things that some of these people would do to you the hitting the pinching the grabbing of your breasts would you ever report that

(02:50:04 dur)

WETTLAUFER: yeah oh yeah it was always reported in charts (unintelligible)

HERGOTT: and that's documented on their charts

WETTLAUFER: yeah

HERGOTT: okay and was there any there was obviously never and obviously but was there ever any charges or criminal matters that came of any of this

19:28:43



WETTLAUFER: no no that's part of working at a nursing home that's just what they do it might even be your fault dear

HERGOTT: who would say that

WETTLAUFER: Mrs CROMBEZ

HERGOTT: yeah okay do you think that might have played a role in in your actions

WETTLAUFER: no no

HERGOTT: kay um Maureen your ex what was Maureen's last name

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

HERGOTT: [REDACTED]

HERGOTT: yeah where is she now

WETTLAUFER: [REDACTED]

HERGOTT: when's the last time you talked to her

WETTLAUFER: I think about what four (4) years ago when she wanted money to move back

HERGOTT: oh

WETTLAUFER: we were only together for a year

HERGOTT: okay so she came here from [REDACTED]

WETTLAUFER: yeah and brought her two (2) kids

HERGOTT: okay the teenaged kids

WETTLAUFER: yeah

HERGOTT: I think you mention it in your uh Toronto statement

WETTLAUFER: yeah we got involved (unintelligible) with C A S with them

HERGOTT: mm hmm when they were here

WETTLAUFER: mm hmm

HERGOTT: have you this document that you prepared that and I know that you had stated the reason why I guess you'd call it the breaking point of why you stopped

WETTLAUFER: yeah

HERGOTT: was the possibility that you were gonna have to be dealing with kids

WETTLAUFER: yes that's right

HERGOTT: right

WETTLAUFER: yes

HERGOTT: is there anyone else within your career path that isn't listed on these four (4) documents or these four (4) pieces of paper that you'd be responsible for their deaths

WETTLAUFER: no absolutely not

19:30:24



HERGOTT: and if we were to tell you that we've come across some fairly significant or suspicious uh deaths at our nursing homes

WETTLAUFER: where I'd been

HERGOTT: right what would you say to that

WETTLAUFER: I'd say it wasn't me

HERGOTT: okay so there's no one else involved

WETTLAUFER: no

HERGOTT: um that was felt victim to your actions

WETTLAUFER: no

HERGOTT: okay um just just repeat to me again the people that you've disclosed this to besides myself tonight

WETTLAUFER: okay um the very first person I've ever disclosed this to was um another girlfriend at the time her name was [REDACTED] [REDACTED] that was after I killed a couple of people and uh she told me not to do it again or she was going to turn me into the police

HERGOTT: mm hmm when was that

WETTLAUFER: um that oh I couldn't tell 2008 I think

HERGOTT: mm hmm

WETTLAUFER: um and then uh 2011

HERGOTT: mm hmm

WETTLAUFER: when I decided to stop killing my friend [REDACTED] [REDACTED] I told her what I had been doing and that I had stopped and then um I told my pastor

HERGOTT: mm hmm

WETTLAUFER: and then after that I told the in 2014 after Art passed away I uh went on a holiday and uh that's when I really decided that this had to stop

HERGOTT: mm hmm

WETTLAUFER: and so um I told um a friend [REDACTED] and he lives in B C um then uh I told when I came back I got a good criminal lawyer [REDACTED]

HERGOTT: mm hmm

WETTLAUFER: and then while I was in the Toronto when I was in CAMH well I told my friend before I ever went I told my cousin [REDACTED]

HERGOTT: mm hmm

WETTLAUFER: I told my friend [REDACTED] and I told my friend [REDACTED]

HERGOTT: mm hmm



WETTLAUFER: and then while I was in CAMH I told um someone who I thought was a friend ██████████

HERGOTT: hmm

WETTLAUFER: who turned around and called the police to make sure that it had really been dealt with

HERGOTT: mm hmm

WETTLAUFER: and I understand that he thought he was doing the right thing I understand that but he said oh I won't tell anybody I was using him as a resource for support and he turned around and

HERGOTT: right

WETTLAUFER: when I was when I had already you know I had already shared it so why would he call the police

HERGOTT: so why do you think that none of these people confronted police

WETTLAUFER: maybe they didn't believe me I don't know maybe they just thought maybe they thought I was doing more (unintelligible) patient wanted it done

HERGOTT: mm hmm

WETTLAUFER: you know

HERGOTT: and as far as believing you are these close people to you that you shared other deep dark secrets with maybe over time that

WETTLAUFER: I've I wouldn't say deep dark secrets but lots of stuff yeah

HERGOTT: cuz this is a pretty serious thing

WETTLAUFER: yes it is it's horrible

HERGOTT: and telling me

WETTLAUFER: it's the worst thing

(02:55:01 dur)

HERGOTT: and telling these people and I just find it hard to believe that no one would come forward until ██████ which is five (5) six (6) people down the road right

WETTLAUFER: yeah

HERGOTT: of of having knowledge of it

WETTLAUFER: yeah I hear ya yeah

HERGOTT: and and everything you're telling us is the truth

WETTLAUFER: yes it is yes sir

HERGOTT: there's nothing that's been fabricated

WETTLAUFER: no sir no

19:33:52



HERGOTT: and you're sure about that

WETTLAUFER: I know so

HERGOTT: what would we find in your home did you ever document any of this activity at all

WETTLAUFER: um once and a while I joll I journaled on it and it might there might be some in my home but I don't know

HERGOTT: where would those be

WETTLAUFER: I think I threw it out in my if if it's around it would be in like a spiral binder in um either my desk my other desk or my um fol my um whatchamacallit c'mon you put file file folders into it

HERGOTT: like a filing cabinet

WETTLAUFER: yes a filing cabinet thank you

HERGOTT: okay you're welcome

WETTLAUFER: yeah

HERGOTT: and then do you live ho uh alone

WETTLAUFER: yes I do

HERGOTT: in Woodstock

WETTLAUFER: yeah

HERGOTT: okay

WETTLAUFER: did you want someone to come with me and look

HERGOTT: well to be honest with you the part of the investigation there has already been a search warrant executed at your house

WETTLAUFER: oh so the search has already has already been a search at my house

HERGOTT: I don't know what stage its at because we've been conversing for quite some time

WETTLAUFER: okay

HERGOTT: it's probably close to being completed

WETTLAUFER: okay

HERGOTT: but I am just asking because you've been so cooperative

WETTLAUFER: yeah

HERGOTT: and and again I do appreciate that

WETTLAUFER: yeah

HERGOTT: I really do um it just makes things a lot easier right um if I know where certain thing might be and you said you might have thrown them out

WETTLAUFER: yeah

HERGOTT: you might not have

WETTLAUFER: I might not have kept them

19:35:14



HERGOTT: alright

WETTLAUFER: and then at the very end of my coffee table there's a box and it's got pictures and uh a photo album in it there might be something in there too

HERGOTT: what would be in there

WETTLAUFER: uh a (unintelligible) um (sigh) writing writing pad

HERGOTT: okay and what types of things what types of things would you you document

WETTLAUFER: just what I have done how bad I felt when it happened just trying to figure out what was going on in my head

HERGOTT: mm hmm mm hmm

WETTLAUFER: yeah

HERGOTT: searching for answers

WETTLAUFER: yeah

HERGOTT: but you're not sure if you got rid of those or not yet

WETTLAUFER: I thought I got rid of them all but I don't know if I did for sure

HERGOTT: okay okay would there be anything else as far as computer documents or anything like that

WETTLAUFER: um there would be I accessed a computer support group for borderline personality disorder

HERGOTT: mm hmm

WETTLAUFER: it would be on that it would be on that website

HERGOTT: oh is this an open forum that you could join

WETTLAUFER: yeah

HERGOTT: and post comments and

WETTLAUFER: yeah

HERGOTT: what website was that

WETTLAUFER: I couldn't tell you but I could find it on my computer

HERGOTT: okay and would that be something that you'd be willing to share with us

WETTLAUFER: of course

HERGOTT: and give us some time to

WETTLAUFER: yeah

HERGOTT: print those documents and computer website and whatnot

WETTLAUFER: yeah

HERGOTT: okay what's your tattoo mean

WETTLAUFER: hopes and dreams

HERGOTT: what does that mean to you

WETTLAUFER: I that I had hopes for the future and dreams of the future

19:36:40



HERGOTT: yeah what are your hopes of the future now after
 WETTLAUFER: (sighs)
 HERGOTT: the beginning of the last few hours
 WETTLAUFER: that somehow some way I can help somebody there's got
 to be somebody who has where ever I go jail penitentiary
 there's got to be somebody I could help maybe
 somebody who can't read maybe somebody who can't
 write
 HERGOTT: mm hmm
 WETTLAUFER: maybe somebody that's done worse than me and feels
 like that they will never be forgiven
 HERGOTT: mm hmm
 WETTLAUFER: maybe somebody that's done less and feels like they will
 never be forgiven there's got to be something that can
 come from this maybe somebody can study me and
 come up with answers and new medications so this
 doesn't happen again
 HERGOTT: mm hmm
 WETTLAUFER: that's my hopes and dreams now
 HERGOTT: is there anything worse than taking someone else's life
 WETTLAUFER: uh yeah
 HERGOTT: whats that
 WETTLAUFER: child mul child molestation absolutely
 HERGOTT: did you feel like you might harm the children in Ingersoll if
 you were to work with them
 WETTLAUFER: I was afraid that I that I might get that feeling of wanting
 to give them insulin overdoses especially since they were
 dia diabetic and I just I panicked there was no way I
 absolutely not open to that
 HERGOTT: mm hmm
 HERGOTT: is there anything else you can think of right now
 HERGOTT: no
 WETTLAUFER: no I think I did pretty good
 HERGOTT: I think you did I am just gonna
 WETTLAUFER: what happens now
 HERGOTT: I am just gonna get you to sit tight uh and we'll arrange to
 uh see what the next steps are
 WETTLAUFER: oh okay I might not be going home then
 HERGOTT: I will get back to you with that

19:30:16



WETTLAUFER: okay
 HERGOTT: um we've discussed your um original document that's in your backpack
 WETTLAUFER: yeah
 HERGOTT: if I were to prepare a form which is a consent to search or consent form to provide us with those documents would that be something that you'd be willing to sign

(03:00:03 dur)

WETTLAUFER: yeah sure
 HERGOTT: okay
 WETTLAUFER: there's some stuff in there too that I did (unintelligible) nurse
 HERGOTT: hmm in your backpack
 WETTLAUFER: yeah
 HERGOTT: okay what kind of things are those
 WETTLAUFER: like it's like a chain-linked thing so you start at what you did and you go backwards to how you're feeling like what you coulda done different and all that
 HERGOTT: okay do you feel like you're time at CAMH helped you
 WETTLAUFER: yeah very much so
 HERGOTT: yeah you receive the care that you probably needed
 WETTLAUFER: yeah and an increase in medication which I feel like I needed
 HERGOTT: okay
 WETTLAUFER: yeah
 HERGOTT: alright um sit tight for a few moments
 WETTLAUFER: okay
 HERGOTT: and I'll get back to you shortly okay again on my uh phone I've got seven thirty-nine (7:39)
 WETTLAUFER: kay
 HERGOTT: P M and uh let me get with uh some answers and
 WETTLAUFER: okay
 HERGOTT: and where we want from here
 WETTLAUFER: I'd like to go home
 HERGOTT: okay well sit tight and we'll we'll see whats going to happen
 WETTLAUFER: even if I have to wear an ankle bracelet I'd like to go home
 HERGOTT: okay alright thank you Beth

19:39:32



WETTLAUFER: thank you
HERGOTT: appreciate it
WETTLAUFER: thank you
HERGOTT: thank you
WETTLAUFER: can someone cut these off of me now
HERGOTT: yeah we'll get someone to get those off for you
WETTLAUFER: okay
HERGOTT: yep I'll be right back

(D/C HERGOTT exits room at 03:01:14)

WETTLAUFER: right

(no conversation heard from 03:01:14 to 03:23:01)

(D/C HERGOTT enters room at 03:23:01)

HERGOTT: I am sorry Beth
WETTLAUFER: that's okay
HERGOTT: you could imagine that uh things of this nature take some time
WETTLAUFER: yep I understand
HERGOTT: and I appreciate your patience with me
WETTLAUFER: I understand
HERGOTT: thank you so I have eight oh two (8:02) I just have to we're in the home stretch here
WETTLAUFER: okay
HERGOTT: okay and I am gonna explain to you everything that's gonna go on
WETTLAUFER: okay okay
HERGOTT: fair enough
WETTLAUFER: okay
HERGOTT: okay okay so um first off a few things that and you remember the gentleman who transported us back from Toronto and uh also Karen ur
WETTLAUFER: yeah
HERGOTT: my partners they've just been monitoring and
WETTLAUFER: right right
HERGOTT: making some notes and things like that just some things that are are concerning and that we just need to firm up
WETTLAUFER: okay

20:02:18



HERGOTT: so first off and and I said there there has been a search warrant executed at your residence

WETTLAUFER: okay

HERGOTT: and there was some paperwork uh with regards to a Remington gun shotgun of some sort

WETTLAUFER: oh

HERGOTT: what what would that be for

WETTLAUFER: just to look at I guess I like guns

HERGOTT: okay

WETTLAUFER: yeah

HERGOTT: alright do you have any in the home

WETTLAUFER: no no I used to

HERGOTT: did you

WETTLAUFER: I've

HERGOTT: where do you have them

WETTLAUFER: I had a uh 22

HERGOTT: yeah

WETTLAUFER: um

HERGOTT: was it a Remington by chance

WETTLAUFER: not that I know of

HERGOTT: okay

WETTLAUFER: but um my my husband has a gun that his dad gave me

HERGOTT: okay

WETTLAUFER: that we would shoot with but uh uh at the um (unintelligible) at the at the uh gun club and shoot

HERGOTT: mm hmm

WETTLAUFER: and when we uh broke up I did the paperwork to give it back to him

HERGOTT: mm hmm

WETTLAUFER: that might be

HERGOTT: okay

WETTLAUFER: what they found

HERGOTT: okay alright

(simultaneously speaking)

WETTLAUFER: but I haven't got any

HERGOTT: but there's there's no firearms in your house right now

WETTLAUFER: no sir

HERGOTT: okay

WETTLAUFER: nope never will be

20:03:17



HERGOTT: okay alright um the username like what would your username be on that blog that you would uh write on that support group

(03:25:02 dur)

WETTLAUFER: ohh I you know what I'd have to go and look

HERGOTT: yeah

WETTLAUFER: honestly

HERGOTT: it's not like your name and a couple of numbers or

WETTLAUFER: no

HERGOTT: nickname or anything like that

WETTLAUFER: no I'd have to be sitting down in front of the computer to remember it and even to find the support group

HERGOTT: okay um these are a bunch of random questions it's all thrown together here um the insulin that you used the short acting the long acting was their an actual brand or a a make of the insulin that you would use

WETTLAUFER: um might've been Novulin

HERGOTT: okay

WETTLAUFER: might've been Lenovo um can't remember the name of the other one

HERGOTT: kay okay um when you worked with Life Guard

WETTLAUFER: yeah

HERGOTT: um I know that you'd mentioned they'd send you to certain locations and certain homes

WETTLAUFER: yeah

HERGOTT: what what were the there was Telfer Place and there was two (2) others

WETTLAUFER: okay there was there was

HERGOTT: was one of them in Port Dover

WETTLAUFER: more than there was Telfer Place

HERGOTT: yeah

WETTLAUFER: um that was the very first than there was um uh I am gonna (unintelligible) Telfer Place Port Dover Dover Cliffs

HERGOTT: mm hmm

WETTLAUFER: is what it was called

HERGOTT: mm

WETTLAUFER: um I did uh one (1) P S W shift at a place in New Hamburg

HERGOTT: kay

WETTLAUFER: but I couldn't tell you the name of it

20 : 04 : 53



HERGOTT: mm hmm

WETTLAUFER: and also I worked at um uh Telfer Place and Dover Cliffs are both owned by the same people and they have another nursing home in Brantford um but I can't remember the name of it

HERGOTT: that's okay we'll be able to locate that

WETTLAUFER: and then and then Park Lane Terrace in Strat in uh Paris and Hardy Terrace I think is outside of Paris oh and um what was the other one called um oh Lord it's way far out of town it's like an hour and a half drive from here my dad grew up in that area um like it's in the Jarvis area Jarvis Simcoe area it's all I couldn't tell you I am sorry my brain's shot for the night

HERGOTT: that's okay okay that's about it anything you can think of

WETTLAUFER: yep

HERGOTT: okay

WETTLAUFER: is my house gonna be a mess when I get back

HERGOTT: no

WETTLAUFER: oh okay

HERGOTT: I wouldn't think so no no

WETTLAUFER: okay

HERGOTT: it's not that kind of a it's not like you see on T V and

WETTLAUFER: yeah (makes unidentified sounds)

HERGOTT: things start flyin' everywhere right

WETTLAUFER: yeah

HERGOTT: um your Facebook page at one point there was a comment or I don't know where it is on your timeline about a pediatric nurse did you ever work with a pediatric nurse

WETTLAUFER: oh that I was gonna be working with the kids

HERGOTT: that's what that referred to in Ingersoll

WETTLAUFER: in Ingersoll yes

HERGOTT: okay gotcha alright alright um and just to go back through the names of people here so we've got [REDACTED] [REDACTED] that you divulged this to right

WETTLAUFER: yep

HERGOTT: that's your cousin

WETTLAUFER: that's my cousin

HERGOTT: kay [REDACTED]

WETTLAUFER: [REDACTED]

HERGOTT: [REDACTED]

20:06:46



WETTLAUFER: I am not giving you her last name
 HERGOTT: yep that's fine [REDACTED]
 WETTLAUFER: yep
 HERGOTT: [REDACTED]
 WETTLAUFER: yep [REDACTED]
 HERGOTT: [REDACTED]
 WETTLAUFER: [REDACTED]
 HERGOTT: yep who else
 WETTLAUFER: um the lawyer whose name I cannot remember
 HERGOTT: that's okay was it female
 WETTLAUFER: yep
 HERGOTT: [REDACTED]
 WETTLAUFER: [REDACTED]
 HERGOTT: [REDACTED]
 WETTLAUFER: yep
 HERGOTT: okay um
 WETTLAUFER: [REDACTED]
 HERGOTT: right
 WETTLAUFER: [REDACTED]
 HERGOTT: [REDACTED]
 WETTLAUFER: yep
 HERGOTT: who's that
 WETTLAUFER: she was a friend from the nursing home
 HERGOTT: what one
 WETTLAUFER: from um from um um um Caressant Care I told her after I
 had stopped with her son and she stopped being my
 friend because of it
 HERGOTT: okay
 WETTLAUFER: and [REDACTED] she was she was a girlfriend
 HERGOTT: how do you spell her last name
 WETTLAUFER: oh good ga
 HERGOTT: [REDACTED]
 WETTLAUFER: [REDACTED] I think
 HERGOTT: okay where does she work
 WETTLAUFER: she doesn't she's on O D S P
 HERGOTT: did she work at a nursing home with you
 WETTLAUFER: no
 HERGOTT: okay
 WETTLAUFER: never
 HERGOTT: just a friend



WETTLAUFER: yeah

HERGOTT: you know where she lives in town

WETTLAUFER: she lives in Toronto

(03:30:02 dur)

HERGOTT: kay okay um we're gonna wrap things up but here's what's here's what's gonna happen

WETTLAUFER: okay

HERGOTT: okay and part of this is going to be up to you um ww what are your plans going forward from here if you were to going forward from here

WETTLAUFER: going forward from here

HERGOTT: right

WETTLAUFER: I want to go home

HERGOTT: okay

WETTLAUFER: I want to have a good night sleep

HERGOTT: okay

WETTLAUFER: I want to spend uh Thanksgiving weekend with my family

HERGOTT: okay

WETTLAUFER: and I want to be available to the police at any time they need me

HERGOTT: kay

WETTLAUFER: and if I have to come back for trial I have to come back for trial

HERGOTT: okay

WETTLAUFER: I have no plans of leaving um I can surrender my car if you want me to

HERGOTT: okay are your parents are you close with your parents

WETTLAUFER: very

HERGOTT: like what type of relationship do you have with them

WETTLAUFER: very very close I have to tell them tonight what's happened

HERGOTT: with mom and dad

WETTLAUFER: yeah they know that um they know that I've been in they know that I've been in the hospital

HERGOTT: mm hmm

WETTLAUFER: but I just told them it was for treatment but yeah my plan tonight is to go and talk to them one-on-one like face-to-face and tell them (unintelligible)

HERGOTT: what do you think their reaction's gonna be

WETTLAUFER: they're gonna be devastated

HERGOTT: what do you think

20:09:41



WETTLAUFER: I am gonna I am gonna plan on stayin' stayin' the night there

HERGOTT: okay

WETTLAUFER: so they have access to me

HERGOTT: okay what type of support do you think you're gonna get from them

WETTLAUFER: eventually all the support I need

HERGOTT: kay alright

WETTLAUFER: I also plan to go to my A A groups I had planned on doing ninety (90) meetings in ninety (90) days

HERGOTT: mm hmm

WETTLAUFER: and uh just keep up with like I plan to uh see one of the things with me is I isolate and I start to not do well so I plan to do uh do the Thanksgiving thing keep up with my friends clean clean my apartment tell my parents those are my plans I have no plans to leave town

HERGOTT: okay

WETTLAUFER: this is I've done this and I am ready to face it but I would like to go home for a night

HERGOTT: yeah I think that's gonna happen

WETTLAUFER: (sighs) oh bless you

HERGOTT: okay I think that's gonna happen as I said at the very very beginning of this whatever time we started ago hours ago um you're not under arrest right now

WETTLAUFER: okay

HERGOTT: okay but as you can imagine okay

(WETTLAUFER's phone rings and she answers it)

WETTLAUFER: call you back in thirty (30) minutes that was my cousin

HERGOTT: gotcha okay um as I said at the beginning of this you're not under arrest

WETTLAUFER: okay

HERGOTT: but as you can imagine

WETTLAUFER: I will be

HERGOTT: an investigation like this is

WETTLAUFER: yeah

HERGOTT: is something that we've never dealt with

WETTLAUFER: right

HERGOTT: it's something that doesn't happen very often

WETTLAUFER: okay

20:11:16



HERGOTT: something that you rarely hear about

WETTLAUFER: right

HERGOTT: okay I don't know of many but you're not the first person to do this

WETTLAUFER: right

HERGOTT: okay having said that we have a responsibility to protect the public

WETTLAUFER: right

HERGOTT: right you know where I am coming from when I say that

WETTLAUFER: yeah

HERGOTT: okay

(simultaneously speaking)

WETTLAUFER: absolutely absolutely

HERGOTT: okay you've done some some things to some innocent people

WETTLAUFER: absolutely

HERGOTT: some pretty what people

WETTLAUFER: horrible things

HERGOTT: are gonna have people are gonna have opinions of you

WETTLAUFER: monster

HERGOTT: and people are gonna have right exactly um having said that there's something in the Criminal Code of Canada and this is usually result in someone being charged with a criminal offence and being placed on such a thing called an 8 10 peace bond

WETTLAUFER: okay

HERGOTT: kay and basically what an 8 10 peace bond is is kind of a promise given by your or your word given to us and it's a a court document that's issued by a judge that puts you on certain conditions you have a certain condition limiting you from doing certain things having certain things in your possession attending certain locations and if you were to breach those conditions

WETTLAUFER: right

HERGOTT: then you'd be arrested and further charged with

WETTLAUFER: okay

HERGOTT: breaching is what's called an 8 10 peace bond

WETTLAUFER: okay

HERGOTT: so basically you've heard of a restrir a restraining order

WETTLAUFER: yes

HERGOTT: it's similar to that

20:12:37



WETTLAUFER: okay

HERGOTT: okay a lot of people call it a restraining order but it's actually in Canada called an 8 10 peace bond

WETTLAUFER: okay

HERGOTT: and again it just limits you from doing certain things attending certain locations uh it could be things like uh still getting help for your mental health uh your substance abuse

WETTLAUFER: yeah

HERGOTT: surrendering your passport uh

WETTLAUFER: I have no passport

HERGOTT: not practicing as an R N

WETTLAUFER: yeah

HERGOTT: not attend nursing homes things like that

WETTLAUFER: yeah okay

HERGOTT: if that were an option which like I said usually that occurs with people that are charged people are convicted of certain offences

WETTLAUFER: right

HERGOTT: that's part of their their punishment usually

WETTLAUFER: okay

HERGOTT: would you be willing to enter into an 8 10 peace bond prior to be criminally charged

WETTLAUFER: absolutely

HERGOTT: okay and do you understand what I mean by the 8 10 peace bond

WETTLAUFER: yes it means I have to do it or I come back and I am in jail until everything else happens

(03:35:02 dur)

HERGOTT: alright I I don't know what would happen if you were to breach it as far as jail and the consequences

WETTLAUFER: yeah

HERGOTT: the only thing I want to make sure that it's clear to you and and that I am make sure that I'm getting my point across is that it's basically a document that you're gonna swear to sign and uh and uh agree

WETTLAUFER: yeah



HERGOTT: not to do certain things not to have certain things in your possession and I am not I am not saying it's gonna happen right now

WETTLAUFER: okay

HERGOTT: because it has to go in front of a judge

WETTLAUFER: oh okay

HERGOTT: okay it it's just an option that we're looking at because as I said we have a responsibility to protect the public

WETTLAUFER: yes absolutely

HERGOTT: okay that's why I wanna know what your plans are

WETTLAUFER: yes

HERGOTT: I want to know that you're gonna go home and be supported by your family

WETTLAUFER: yeah

HERGOTT: I wanna know that you're
(simultaneously speaking)

WETTLAUFER: cell phone will be charged at all times always on my body if you need me

HERGOTT: okay

WETTLAUFER: I will be here any if you need me to come here I'll be here if you need me to wait for you to come and get me I'll do it I am totally committed

HERGOTT: okay alright I think we have your do we have your cell phone number

WETTLAUFER: 519

HERGOTT: yep

WETTLAUFER: 532

HERGOTT: mm hmm

WETTLAUFER: 6471

HERGOTT: okay

WETTLAUFER: home phone number is 519 290

HERGOTT: yep

WETTLAUFER: 0724

HERGOTT: kay

WETTLAUFER: parent's phone number

HERGOTT: don't worry about that I'll get one when we I'll get your parents when we go

WETTLAUFER: okay

HERGOTT: um okay you understand what I what we just talked about

WETTLAUFER: oh yeah absolutely

HERGOTT: cuz it's a very unique situation right

20:14:56



WETTLAUFER: yeah I am so thankful

HERGOTT: where you confessed to to certain things

WETTLAUFER: yeah

HERGOTT: and we have quite a bit of leg work that you could imagine

WETTLAUFER: yes

HERGOTT: to um piece this investigation together and see where we go from here

WETTLAUFER: okay

HERGOTT: uh there's a lot of people that we'll consult in it and determine the final answer uh of what your fate is

WETTLAUFER: okay

HERGOTT: okay

WETTLAUFER: alright

HERGOTT: um but I have I know that you're aware of the extent of what you've done

WETTLAUFER: yes

HERGOTT: I know that you verbalize and and spoke about how you feel and that obviously you can't take it back but you know

WETTLAUFER: I am relieved that I've confessed it

HERGOTT: mm hm

WETTLAUFER: I feel sorry for the people that are now gonna find out

HERGOTT: mm hhm

WETTLAUFER: sorry to say it

HERGOTT: yep

WETTLAUFER: it should they should (unintelligible) difficult (unintelligible)

HERGOTT: yeah

WETTLAUFER: like (unintelligible)

HERGOTT: yeah something along those lines (unintelligible)

WETTLAUFER: I really have to pee I'm sorry

HERGOTT: no problem I've got eight sixteen (8:16) and I think that'll probably conclude things but

WETTLAUFER: okay

HERGOTT: I'll let you use the washroom and go from there

[WETTLAUFER and D/C HERGOTT exit the room. They return 3 minutes later. The interview continues for 6 minutes thereafter. During the remaining 6 minutes Ms Wettlaufer consents to seizure of the handwritten confession, tells police she also recently disclosed her conduct to the College of Nurses and transportation was arranged for her return to her parents' home.]

20:15:54

Appendix D to the Agreed Statement of Fact – CAMH discharge summary

Appendix D to the Agreed Statement of Fact

Centre for Addiction and Mental Health (CAMH)

Discharge Data



Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE
 MRN: 806240 Encounter #: 00020149910
 DOB: 10/06/1967 Age: 49 years

Discharge Data

Document Type:	Discharge Note
Service Date/Time:	05/10/2016 16:00
Result Status:	Auth (Verified)
Perform Information:	Alan Kahn, MD, FRCPC (13/10/2016 00:05)
Sign Information:	Alan Kahn, MD, FRCPC (16/10/2016 00:15)

Visit (Encounter)

Interaction Time
1310-1500

Discharge Diagnosis

Major Depressive disorder - recurrent, no evidence of a clinical Major Depressive episode during the admission

Alcohol use disorder - binge type, mild severity

Opioid use disorder - mild severity (in terms of frequency and amount)

Borderline Personality Disorder

Antisocial Adult behaviour - many symptoms but not clearly meeting criteria of conduct disorder prior to age of 15y/o

r/o Binge Eating Disorder

Completed by (if not completed by MRHCP)

Alan Kahn, MD, FRCPC

Discharge Disposition

cancel Form 3 - make voluntary

D/c home - Woodstock detectives are driving her back to Woodstock, will question her and then will release her pending further investigation of her claims

f/u with GP and psychiatrist if necessary

provided with scripts for medication - 4 days worth x 3 repeats

Alert Indicators

Allergies

Abilify
Haldol

Course While in Hospital

Presenting Complaint(s)

cc: suicidality and depression

Flags: @ -Abnormal, C -Critical, L -Low, H -High

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Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE

MRN: 806240

Encounter #: 00020149910

DOB: 10/06/1967

Age: 49 years

Discharge Data

There is thorough documentation regarding Elizabeth's presentation, her self report, and review of her psychiatric symptoms over the course of her 3 week admission to the Women's unit at CAMH in the admission and progress notes. This will be a briefer summary of this admission.

Elizabeth is a 49yo divorced woman with no children from Woodstock who has been working as an RN for over 20 years, although at times working as a PSW due to lack of RN positions and fact that she had her license restricted for a time early in her nursing career due to overdosing on hospital medication while at work. Elizabeth travelled voluntarily to the CAMH Emergency Department as she had been struggling with increasing depression and suicidality over the past several months, in context of continuing to use ETOH and hydromorphone and guilt about her actions as a nurse. In particular, she told both the Social Worker and psychiatrist Dr. Sokolov in the Emergency Department that she had been providing intentional overdoses to many of her patients over the past 10 years, including her belief that these overdoses resulted in eight deaths. She admitted having provided two overdoses in 2016, including one in February and another one towards the end of August. The most recent insulin overdose did not result in death of the patient. She realized that, due to her inability to control her urge to provide insulin overdoses to her patients when very distressed, she could no longer work as a nurse after her employer suggested she start working with children/ adolescents with diabetes in Woodstock. She initially drove off to Quebec with the intention of escaping her life, but then decided to turn around and face her actions. She came to CAMH in Toronto for help, after reading about the services online, including noting that CAMH did have a Forensic service.

Elizabeth was admitted to the Women's Unit on a Form 1 due to her stated suicidality and the very concerning nature of her claims about having lethally overdosed a number of her patients as a nurse.

Summary of Key Results

Elizabeth was treated by psychiatrist Dr. Alan Kahn for the duration of her admission on the Women's unit. She was placed on Form 3 after the first assessment by Dr. Kahn, to ensure that she remained on the unit due to the recent risk she posed both to herself and to her patients as their treating nurse. She was agreeable to staying in hospital, understood the reasoning for the involuntary status on Form 3, and did not appeal this Form. Prior to the Form 3 expiring at the 14 day mark, Dr. Kahn did extend her involuntary admission to the Women's unit by issuing a Form 4 on September 30th, to ensure that she would not leave hospital prior to the team deeming that it was safe for her to be voluntary and discharged.

She was treated by hospitalist Dr. Dalo Ryan for her medical concerns including hypertension, which was poorly controlled after having stopped her antihypertensive nearly 5 months prior to admission. She was also seen briefly by 3-4 other psychiatrists during the Weekend and once when Dr. Kahn was away for two days towards the end of her admission. Dr. Kahn usually saw Elizabeth with her primary nurse, RN Michelle Desanti. Both Dr. Kahn and RN M Desanti independently documented on the sessions. Nurse M Desanti also spent time with Elizabeth on weekends and at other times working on a chain analysis (to understand better the sequence of events, thoughts, feelings, and behaviours leading up to Elizabeth intentionally overdosing a patient with insulin) and developing a Wellness (safety) Plan (outlining symptoms related to her varying levels of distress and the skills she can use to better manage this stress).

In summary, Elizabeth spoke in detail about her history, including her psychiatric history, substance use history, personal history, and professional history. Based upon Dr. Kahn's assessment, Elizabeth appeared to have recently had symptoms consistent with Major Depressive Episode - moderate to severe, although the full range of these symptoms was not apparent over the course of her 2.5 week stay on the unit. She indicated finding both the fluvoxamine 200mg qam and quetiapine 200mg qhs to be helpful for her mood, anger, anxiety and sleep. She did not wish to change the medication and the only change she agreed to was increasing the Quetiapine to 300mg qhs to further assist her with her sleep and anxiety. During the becoming overly stressed at times about work and relationship, and also become very critical of herself regarding quality of her work. However, she did not clearly meet criteria for any one particular primary Anxiety disorder. Elizabeth spoke openly about her longstanding struggles with both alcohol and opiates, and had periods of sobriety at varying times. She admitted to frequently stealing hydromorphone from her patients' medication supply when the opportunity presented itself, sometimes as often as a few times a month. She denied ever using more than a few pills a time. Much of this behaviour seemed to have worsened since her husband left her 10 years ago, but this behaviour was present prior to her marriage as well.

With regards to her personality style, Elizabeth had significant symptoms of Borderline Personality disorder, including significant mood instability, impulsivity, fear of abandonment, unstable relationships, and anger. In addition she had many symptoms consistent with

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Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE

MRN: 806240

Encounter #: 00020149910

DOB: 10/06/1967

Age: 49 years

Discharge Data

Antisocial personality disorder, as documented in the notes. However, in reviewing her childhood and adolescent years, it was unclear if she fully met criteria for conduct disorder, especially prior to the age of 15, despite there being several episodes of oppositional behaviour including running away from camp for one day and pulling fire alarm at school intentionally to make a situation more difficult for a teenage boy whom she did not like.

Elizabeth talked in detail about her relationship with her parents and the difficulties with being brought up in a controlled Baptist home environment. She also spoke in detail about her varied 10 yr marriage including her dissatisfactions with the relationship, her sexual frustrations, and her disappointment when her husband left her due to suspicion that she was in contact via computer with another woman. AS outlined in the progress notes, Elizabeth's hospitalization in Woodstock and several suicidal behaviours occurred in the context of her troubled marriage and depression. Elizabeth also spoke about her bisexuality and her tumultuous relationships following her divorce.

Over several sessions, she talked in detail about her actions where she would intentionally give her patients lethal doses of insulin while at work. Elizabeth was aware that she did not have to talk about these actions, and she chose to speak about them in detail, despite being aware that there were limits to patient-physician confidentiality. She was informed that her statements would be documented, and thus could be accessed by police, professional organizations (such as the College of Nursing), and other possible investigators. Elizabeth was repeatedly very clear that she came to hospital to talk about her actions, to get help, and to eventually speak to police about her actions. She indicated that she did not think she could benefit from further psychiatric care in Woodstock, highlighting how unhappy she was with her admission to Woodstock psychiatric inpatient unit over 10 years ago, and her dissatisfaction with her ongoing psychiatrist. She also did not feel confident in reporting her actions to police on her own, for fear that she would not be believed or not get the support she needs, including her medication if she were to be put in jail. Elizabeth was very clear that she has told various contacts over the past few years about her actions, and has still not been able to stop after telling them (including a lawyer, a priest, and a sponsor from Alcoholics or Narcotics Anonymous). Elizabeth stated that she came to CAMH to talk openly about her actions, get the help she needed, and become better prepared for the eventual reporting of her actions to both the police and College of Nursing. She stated that she wanted this to happen and asked Dr. Kahn for assistance in doing so.

Throughout the admission, she was deemed capable to consent to release of medical information, along with being capable to consent to treatment and manage her finances. Dr. Kahn also recommended to Elizabeth that she obtain a lawyer to assist her with her confession. Elizabeth responded that she will get a lawyer when it is necessary, but believed that a lawyer would just tell her not to talk anymore about what she had done. Elizabeth consistently reaffirmed that she came to hospital to tell the truth about her actions and face the consequences of them. She also wanted Dr. Kahn and the team to contact the police and College of Nursing. Elizabeth voluntarily signed release of information forms, thus providing Dr. Kahn and CAMH to specifically provide any and all the information she provided to the various police organizations along with the Ontario College of Nursing. She also allowed her medical information to be obtained from Dr. Fernando/ Woodstock Hospital, as well as from London Health Sciences Center (London, ON), where she was admitted briefly in the last 10 years.

Elizabeth's story was consistent throughout several tellings in terms of details provided, chronology, and her explanations for her actions. Overall, Elizabeth explained that she had difficulty dealing with the anxiety, irritation, and frustrations of both her personal and working life. While alcohol and opioids provided her with some relief from the stress at times, she often could not find an adequate method to manage the building pressure. She explains that she started to intentionally overdose patients whom she was working with in order to relieve this stress. By giving vulnerable people a potentially lethal dose of insulin, she felt both more powerful and a release of this pressure. Sometimes she was angry at a particular patient, and wanted them to die. At other times, she admitted that she was more indifferent and saw this individual as someone who she could overdose without suspicion. She admits that there were times when she had regret following the overdose and was hoping that the particular patient would not in fact die. Despite this, she never intervened to prevent the death from hypoglycemia. She admitted that she never wanted to be caught and was thus very careful in the choice of her victims and time she provided the overdoses. She stated that overtime, she did get less satisfaction from providing the overdoses. She was very distraught that she continued to do them, especially in 2016 when she states not having done this in nearly 1.5 yr. She again was clear that as long as she works as a nurse, she will not be able to stop this action and thus she feels she not had to stop working as a nurse, but also has confess to her actions. Over the course of her description of her actions, she admitted to feeling "lighter" and relief about finally doing the right thing. Towards the end of admission, she remained steadfast in her determination to see her confession through, and described feeling respect for herself for the first time in over 10 years. She described feeling as:

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MRN: 806240

Encounter #: 00020149910

DOB: 10/06/1967

Age: 49 years

Discharge Data

though she was turning back to God, and becoming a child of God again. Please see the progress notes for more details regarding her statements.

In discussion and meetings with upper management at CAMH, it was decided that Dr. Kahn speak with the Canadian Medical Protective Association to determine what he was legally allowed and mandated to report in this scenario. The lawyer whom Dr. Kahn was connected to strongly advised Dr. Kahn that he would be expected to contact both the police and College of Nursing in this circumstance, due to seriousness of Elizabeth's claims of homicide, and the continued risk she would pose were she to be released from hospital as a practicing nurse with access to the same vulnerable patients. Upper management and Dr. Kahn agreed that it was appropriate for Dr. Kahn to notify both the police and the Ontario College of Nursing. Elizabeth was informed of this decision and she agreed with this as well, signing the consent forms for disclosure of medical information. Dr. Kahn spoke with an investigator at the Ontario College of Nursing, Vicky Wolf, and provided a verbal description of Elizabeth's case, her claims, and our concerns. I informed Vicky Wolf that Elizabeth may also like be calling, which Elizabeth did voluntarily do. Elizabeth also had prepared a four page summary outlining the eight patients who died as a result of the insulin overdoses that she administered, along with the details of 4-6 other patients whom received overdoses but did not die. Elizabeth was able to document the full names of the patients who died, the location, the year and month, and some of the circumstances regarding the overdose. Elizabeth prepared this document on Dr. Kahn's suggestion, to assist her in conversation with both the police and College of Nursing. She did so willingly and found it helpful to write this out and talk about it. Elizabeth provided a copy to Dr. Kahn/ CAMH and we did review this document briefly. She also requested that this be faxed to the Ontario College of Nursing, and provided Dr. Kahn with a fax number, that she received from Vicky Wolf after Elizabeth herself called OCN to declare her intention of giving up her nursing license and reasons for this.

As documented in the chart, Dr. Kahn also spoke with Detective Sergeant Heather Nicols from 52 division about this case. That same day, Detectives K Hamilton and P Alberga arrived from 52 division and took a recorded audio statement from Dr. Kahn regarding the case. They were aware of Elizabeth's written 4 page document chronicling the deaths of her patients, but did not request it at that time and were not provided with it. The next day, Elizabeth willingly and voluntarily went in to 52 division with police to give an recorded AV statement about her actions. She also provided them with the 4 page written document. She reported anxiety when making her statement but said she was treated well and felt respected.

Throughout this time, she was having fluctuating anxiety. She was encouraged to speak to nurses, use her Wellness/ safety plan, and only used medication as a last resort. She avoided lorazepam when possible due to the risk of tolerance and dependence, instead using loxapine 25mg prn when more agitated or anxious.

Elizabeth was generally well behaved on the unit. She did remain as an involuntary patient during her 2.5 week stay to ensure that she was safely held as an inpatient during the admission. She did once early in the admission lie to an evening nurse and stated that Dr. Kahn provided her with 15 minute unaccompanied passes off the unit. This was not the case and the nurse was aware of this. Elizabeth admitted to not telling the truth the next day, but explained that she just wanted fresh air and an opportunity to get a coffee. A few days later, one nurse reported that Elizabeth said in a joking manner that she had thoughts of changing the patient name tags on the medication bins of the nursing cart, as a way to play a game on the nurses. She did not do so but this was not taken as a playful joke. Another issue arose when Elizabeth told several patients in private that her concern about discharge was that she may be going to jail. While this information came up in a general private discussion about discharge anxieties, and Elizabeth did not indicate why she may go to jail, this information caused several patients to be very anxious around Elizabeth. The final issue that arose on the unit was Elizabeth frequently clashing with another female patient on the unit towards the end of her admission. While there was no over physical contact or threats made, it was clear that both Elizabeth and this other woman were frequently verbally clashing, and it appeared that Elizabeth did intentionally provoke her several times. The team had to address this issue several times with Elizabeth.

On the final day of admission, it was arranged that detectives from the Woodstock police department would be coming to Toronto to speak with Elizabeth, after they were in contact with the detectives from the Toronto 52 division. They were clear that they were not arresting Elizabeth or taking her into custody at this time, but instead offering her a ride back to Woodstock so that they could speak to her on her return home. Dr. Kahn and CAMH upper management were comfortable with this discharge plan. Dr. Kahn spoke with Elizabeth about this plan, and she to was comfortable with the plan. She said she was anxious but overall feeling optimistic and good about what she has done on the Women's unit. She was feeling better and felt she was on the right track. She was future oriented and denied any suicidality or homicidality. She was clear that she would not be returning to work as a nurse, and was expecting to be arrested at some point. She expressed again her main anxiety and remorse about the impact the publicity of her actions will have on

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 DOB: 10/06/1967 Age: 49 years

Discharge Data

her family along with the families of the patients who died as a result of Elizabeth's actions.

Elizabeth was provided with medication for one day and a script of her regular medication for 4 days with 3 repeats. No lorazepam prn was provided. Loxapine prn 25mg for anxiety was provided x 8 tabs with two repeats. Form 5 was filled out and her form 4 was cancelled, thus making her a voluntary patient. Elizabeth was discharged from the unit and left willingly with the detectives, who were driving her back to Woodstock with the intention of questioning her further about her claims.

Lab Results
 Last Month

Metabolic Profile:	Electrolyte Profile:
Cholesterol, Total: -----	Sodium Lvl: 140 mmol/L (29/09/16)
Triglyceride: -----	Potassium Level: 3.9 mmol/L (29/09/16)
HDL Cholesterol: -----	Chloride Lvl: 100 mmol/L (29/09/16)
LDL Cholesterol: -----	BUN: 5.8 mmol/L (29/09/16)
Chol/HDL: -----	Creatinine: 56.1 mcmol/L (29/09/16)
Glucose Fasting: 6.1 mmol/L (20/09/16)	eGFR: -----
Hb A1c (Glycated Hb): -----	Calcium Total: 2.35 mmol/L (20/09/16)
Glucose Random: -----	Magnesium Level: 0.95 mmol/L (20/09/16)
Glucose 2 Hr: -----	Phosphate: 1.48 mmol/L (20/09/16)
Insulin: -----	
U Creatinine: -----	
U Microalb: -----	
U Microalbumin/Cr Ratio: -----	

Hematology + Coag:

WBC: 9.02 x10 ⁹ /L (20/09/16)	RBC Folate: -----
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Age: 49 years

Discharge Data

RBC: 4.24 x10 ¹² /L (20/09/16)	Vitamin B12: 313 pmol/L (20/09/16)
Hgb: 123 g/L (20/09/16)	Ferritin Lvl: -----
Hct: 0.379 L/L (20/09/16)	Iron: -----
Platelet: 237 x10 ⁹ /L (20/09/16)	Iron Sat: -----
Reticulocytes Count, Absolute: -----	TIBC: -----
Reticulocyte, %: -----	Transferrin: -----
Immature Retic Fraction: -----	INR: -----
Neutrophil Count: 5.77 x10 ⁹ /L (20/09/16)	PT: -----
Lymphocyte Count: 2.55 x10 ⁹ /L (20/09/16)	PTT: -----
Monocyte Count: 0.48 x10 ⁹ /L (20/09/16)	
Eosinophil Count: 0.12 x10 ⁹ /L (20/09/16)	
Basophil Count: 0.06 x10 ⁹ /L (20/09/16)	

Urinalysis + Urine Culture:

Urine Culture: -----	WBC Urine Microscopic: -----
Glucose Random Urine: -----	RBC Urine Microscopic: -----
Ketones Random Urine: -----	UA Epithelial Cells: -----
UA Specific Gravity: -----	Bacteria: -----
Blood Random Urine: -----	Mucous: -----
pH Random Urine: -----	
Protein Random Urine: -----	
Nitrite Random Urine: -----	
Leukocyte Random Urine: -----	

Chemistry(Other):

ALT: 31 unit/L (29/09/16)	Albumin Lvl: -----
AST: 15 unit/L (29/09/16)	Amylase Lvl: 27 (30/09/16)

Flags: @ -Abnormal, C -Critical, L -Low, H -High

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Report Request ID: 2457703

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Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE
 MRN: 806240 Encounter #: 00020149910
 DOB: 10/06/1967 Age: 49 years

Discharge Data

Alkaline Phosphatase: 99 unit/L (29/09/16)	Troponin-I: -----
GGT: -----	CRP: -----
CK, Total: -----	: ()
TSH: 1.920 mIU/L (20/09/16)	: ()
T4 Free: -----	: ()
T3 Free: -----	: ()
Total Protein: -----	

Diagnostic Results
 No qualifying data available.

Interventions
 Inpatient Team Goals Grid- CAMH Team

Goal	Intervention	Responsible Clinician	Status
to teach coping skills	attend individual and group sessions	Nursing, Psychiatrist, Social Work, Other	
risk management	Q15 observation	Nursing	To be reviewed
legal issues	continue to follow it up	Psychiatrist	To be reviewed

Advance Directives
 No qualifying data available

Assessments

Mental Status Exam
 Cooperative, approp dressed, obese, appearing stated age; Mood - nervous but good; affect - euthymic, normal range; Thought process - linear, goal oriented; TC - denied any SI (no intent, plan or means); protective factors included her religion, optimism for the future, her family; no H: no psychosis; no hallucinations; Insight- full; Judgement- aware of conseq of her actions

Diagnosis

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Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE

MRN: 806240

Encounter #: 00020149910

DOB: 10/06/1967

Age: 49 years

Discharge Data

Diagnosis

Adult antisocial behavior
 Alcohol use disorder, Mild
 Borderline personality disorder
 Major depressive disorder, Recurrent episode, Unspecified
 - no current MDE

Opioid use disorder, Mild
 r/o Binge Eating disorder

Other Conditions Impacting Hospital Stay

Ongoing

Adult antisocial behavior
 Alcohol use disorder, Mild
 Borderline personality disorder
 Major depressive disorder, Recurrent episode, Unspecified
 Obsessive-compulsive disorder
 Opioid use disorder, Mild

Historical

No qualifying data

Discharge Plan

All Medications at Discharge

Fluvoxamine 200mg qhs

Quetiapine 300mg qhs IR formulation

Loxapine 25mg prn - q4hr; for anxiety/ agitation

HCTZ 25mg qam

Ramipril 2.5mg qam

prn Acetaminophen

prn Naproxen

Follow-up Instructions for the Client/Patient

as above - d/c back to Woodstock with detectives
 - she may be arrested at some point by the police

does not intend to return to work as a nurse

if/u with GP and psychiatrist Dr. Fernando in Woodstock

Follow-up Plan Recommended to be Implemented by the Receiving Provider

External Follow-Ups:

ConnexOntario -

Central Intake Shelter Line -

Flags: @ -Abnormal, C -Critical, L -Low, H -High

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Client/Patient: WETTLAUFER, ELIZABETH TRACY MAE
MRN: 806240 Encounter #: 00020149910
DOB: 10/06/1967 Age: 49 years

Discharge Data

211 Toronto -

Internal Follow-Ups:

No qualifying data available

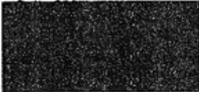
Referrals

none

Provider Contact Information (CAMH Physician: Please forward to Health Records Distribution/Review for external distribution)

Family Physician

Jonny Tam



Fernando, Menthrihewage Lakshman Dayasundara (#53811)



Referring Physician

No Physician Information Available

Electronically signed by

Alan Kahn, MD, FRCPC 16.10.16 00:15

Document Type: IP Summary/Clinical Summary ED Transfer
Service Date/Time: 05/10/2016 13:28
Result Status: Auth (Verified)
Perform Information: Alan Kahn, MD, FRCPC (05/10/2016 13:28)
Sign Information: Alan Kahn, MD, FRCPC (05/10/2016 13:28)

IP Summary/Clinical Summary ED Transfer
Inpatient Client/Patient Summary

Centre for Addiction and Mental Health (CAMH)

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Appendix D – Institutional Patient Death Record



Office of the
Chief Coroner

Institutional patient death record

Form to be used by facilities to which the Long-Term Care Homes Act 2007 applies, for the mandatory report required when a resident dies in the facility or off the premises and in the care of a long-term care home staff member.

Where a resident dies on the premises of a long-term care home to which the Long-Term Care Homes Act, 2007 applies, the Coroners Act requires that the death be immediately reported to a coroner. Online submission of this form is required.

Instructions:

1. Please complete this form immediately after a resident dies on your premises.
2. After answering the 8 questions below:

- (a) If all answers to the 8 questions below are "No", submit the completed form. No call to Provincial Dispatch is required.
- (b) If there are one or more "Yes" answers, please call Provincial Dispatch immediately to report the death, and record the name of the coroner in the field below, then submit the form.

If you have any questions contact:		Provincial Dispatch telephone:	
Office of the Chief		416-314-4100 (GTA)	
occ.inquiries@ontario.ca		1-855-299-4100 (Toll-free)	
Deceased last name		Deceased first name	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of death (yyyy/mm/dd)	Time of death (hh:mm)
Institution name			
Institution address			
Unit number	Street number	Street name	P.O. Box
City/town		Province	Postal code
1. Accidental death? (An accident is an event that caused unintended injuries that began the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to Provincial Dispatch).			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Suicide? (Death due to an external factor initiated by the deceased.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Homicide? (Death due to an external factor initiated by someone other than the deceased.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
*If there is a possibility of suicide or homicide, telephone both the police and Provincial Dispatch, remove any other residents and seal the room until they arrive.			
4. Undetermined? (The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the family or any of the care providers raised concerns about the care provided to the deceased?			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has there been a recent increase in the number of deaths in your Long-Term Care Home?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has there been a recent increase in the number of transfers to hospital?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Last name of person completing this form		First name of person completing this form	
Title		Telephone number (include area code) of person completing this form	
		Telephone extension	
Signature Submitted online by			Date completed (yyyy/mm/dd)
Last name of coroner		First name of coroner	Coroner telephone number (include area code)

Appendix E – Medication Inspection Protocol



Ministry of Health and Long-Term Care
Performance Improvement and Compliance Branch

Inspection Protocol Medication

Home-related – Mandatory

Home Name: _____ Inspection Number: _____ (*hard copy use only*)
Date: _____
Inspector ID: _____

Definition / Description	
Adverse drug reaction:	A harmful and unintended response by a resident to a drug or combination of drugs which occurs at doses normally used or tested for the diagnosis, treatment or prevention of a disease or the modification of an organic function
Controlled substance:	A controlled substance within the meaning of the <i>Controlled Drugs and Substances Act</i> (Canada)
Drug:	A substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of drug in subsection 1 (1) of the <i>Drug and Pharmacies Regulation Act</i> , including a substance that would be excluded from that definition by virtue of clauses (f) to (i) of that definition, but does not include a substance referred to in clause (e) of that definition.
Medication incident:	A preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes: <ul style="list-style-type: none"> • An act of omission or commission, whether or not it results in harm, injury or death to a resident, or • A near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted
Natural health product:	Natural health product, as that term is defined from time to time by the <i>Natural Health Products Regulations</i> under the <i>Food and Drugs Act</i> (Canada), other than a product that is a substance that has been identified in the regulations made under the <i>Drug and Pharmacies Regulation Act</i> as being a drug for the purposes of that Act despite clause (f) of the definition of 'drug' in subsection 1 (1) of that Act. (<i>this definition for the purposes of r. 132 only</i>)
Pharmacist:	A member of the Ontario College of Pharmacists who holds a certificate of registration as a pharmacist.
Prescriber:	A person who is authorized under a health profession Act as defined in the <i>Regulated Health Professions Act, 1991</i> to prescribe a drug within the meaning of that Act.
Prescription:	A direction from a prescriber directing the dispensing of any drug or drugs for a resident.



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Inspection Protocol Medication

Topical: A drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area to which it is applied.

Use

The home-related mandatory IP is used to review the home's medication administration and management during the Resident Quality Inspection of the LTC home.

The nursing inspector may also use this IP to inspect concerns related to medication administration and management during any type of inspection.

The inspection focuses on the licensee's obligations to meet the requirements of the *Long Term Care Homes Act, 2007 and Ontario Regulation 79/10* in the following areas:

O. Reg. 79/10 s. 8	Policies, etc., to be followed and records
O. Reg. 79/10 s. 114 -118	Drugs
O. Reg. 79/10 s. 119 - 121	Pharmacy Service Provider
O. Reg. 79/10 s. 122 -137	Obtaining and Keeping Drugs

Procedure

Each section within this IP contains statements that provide guidance to the inspector in the collection of information during an inspection and may not be applicable in every situation. The information collected will be used to determine whether a home is in compliance with the LTCHA.

This IP contains three (3) Parts:

Part A - Medication administration, drug storage areas, and drug destruction records

Part B - Medication administration / processes

Part C - Medication management system

During the Resident Quality Inspection:

- One (1) assigned nursing inspector will complete the applicable questions in Part A with the focus on safe medication administration and drug storage practices. And, in Part B and C complete the questions relating to the LTCH processes for handling of Medication Incidents and Adverse Drug Reactions.
- The inspector is responsible for observing the following:

- One (1) drug storage area observed for narcotics and controlled substances.
- Medication administration for one resident. The selected resident may reside in any location of the LTCH. Select a resident identified with high risk conditions and associated medication regimes. Example: insulin-dependent diabetes, pain management, anticoagulant therapy. The selected resident is not required to be part of the census sample. The entire medication / treatment pass for the selected resident will be observed.

Note: The inspector will increase the medication administration sample to up to three residents maximum if concerns are identified.

- Review the LTCH processes for handling of medication incidents and adverse drug reactions, and



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Medication**

- review the records kept of any medication incidents and adverse drug reactions.
- 4. Where non-compliance is identified, the findings will be communicated during team meetings.
- 5. The nursing inspector will complete the applicable questions in Part B and/or C related to the non-compliance identified in Part A and/or B.
- 6. The inspector must document evidence to support non-compliance in the 'Notes' section when answering 'No'.

PART A: Medication Administration and Drug Storage

Resident / Substitute Decision-Maker Interview

Interview the resident or SDM, if any, as appropriate to determine:

- Whether the resident / SDM was advised about the resident's medical condition, and involved in the development of his or her medication regime
- Whether resident / SDM was provided information on the risks and benefits of medications, has an understanding of this information, and is allowed to exercise their right to consent or refuse consent to treatment
- Whether the home staff provided information about the risks and benefits, and offered alternative approaches where interventions were declined or refused
- Whether staff administer medications as appropriate
- Whether staff assess and monitor the resident for effectiveness of medications given.

Information Gathering	
Notes	

Staff Interviews

Interview registered staff located in various resident home areas on various shifts where appropriate, to determine their awareness of the home's medication policies and protocols.
Where non-registered nursing staff administers a topical, determine that the staff member has been trained.

Information Gathering	
Notes	

Observations

The Medication Administration
Observe the administration of medications to determine:

- Compliance with principles for the safe and timely administration of medications practices and in



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accordance with the directions specified by the prescriber.

- Where non-registered nursing staff administers a topical, determine that the staff member has been trained by a member of the registered nursing staff and is supervised by a member of the registered nursing staff
- Where a resident is permitted to administer a drug to himself or herself, that a physician or registered nurse in the extended class or other prescriber who attends the resident has authorized this and it is consistent with the home's written policies.
- Whether drugs are in the original labelled container, or as packaged by pharmacy service provider or Ontario Government Supply.

Drug Storage Observations

Nurse inspector(s) will make observations of drugs and biologicals stored in narcotic and controlled substances storage areas, to determine:

- Secured (double-locked) locations, accessible only to designated staff
- Narcotics / controlled substances storage count consistent with drug record log
- Clean and sanitary conditions
- Areas protected from heat, light, and humidity as per manufacturer's instructions
- No more than a 3-month supply is kept in the home (excluding emergency drug supply)
- A separate key (in possession of staff) for narcotic and controlled substances stored in separate double-locked areas

Information Gathering

Notes

Administration of Drugs

No.	Yes	No	N/A	Question	Act/Reg.
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident?	r. 131 (1)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber?	r. 131 (2)
Note					

No.	Yes	No	N/A	Question	Act/Reg.
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs?	r. 134 (a)



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Notes	
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No.	Yes	No	N/A	Question	Act/Reg.
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:</p> <p>(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals</p> <p>(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical, and</p> <p>(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff?</p>	r. 131 (4)(a)(b)(c)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident?	r. 131 (5)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the licensee ensure that no resident who is permitted to administer a drug to himself or herself, keeps the drug on his or her person or in his or her room except,</p> <p>(a) As authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, and</p> <p>(b) In accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber?</p> <p><i>Note: "dentist" means a member of the Royal College of Dental Surgeons of Ontario r. 131 (8)</i></p>	r. 131 (7) (a)(b)
Notes					

Drug supply

No.	Yes	No	N/A	Question	Act/Reg.
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time?	r. 124



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**Inspection Protocol
Medication**

Notes



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Packaging of drugs

No.	Yes	No	N/A	Question	Act/Reg.
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed?	r. 126
Notes					

Safe storage of drugs

No.	Yes	No	N/A	Question	Act/Reg.
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the licensee ensure that drugs are stored in an area or a medication cart,</p> <ul style="list-style-type: none"> i. that is used exclusively for drugs and drug-related supplies, ii. that is secure and locked, iii. that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and iv. that complies with manufacturer's instructions for the storage of the drugs (i.e. expiration dates, refrigeration, lighting)? <p>Note: This subsection does not apply with respect to drugs that a resident is permitted to keep on his or her person or in his or her room in accordance with subsection 131 (7).</p>	r. 129 (1) (a) (i) (ii) (iii) (iv)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart?	r. 129 (1) (b)
Notes					

Security of drug supply

No.	Yes	No	N/A	Question	Act/Reg.
11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that all areas where drugs are stored are kept locked at all times, when not in use?	r. 130. 1
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator?	r. 130. 2
Notes					



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Drug destruction

No.	Yes	No	N/A	Question	Act/Reg.
13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of: <ol style="list-style-type: none"> i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. a physician or a pharmacist? 	r. 136 (3) (a) (i) (ii)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
14.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of: <ol style="list-style-type: none"> i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. one other staff member appointed by the Director of Nursing? 	r. 136 (3)(b)(i)(ii)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable?	r. 136 (6)
Notes					

PART B: Medication Administration / Processes

(Complete applicable questions for **Mandatory Tasks in Part B & C**, and if non-compliance is identified in Part A)

Record Review / Interview

Review policies and protocols for safe administration of medication processes to determine whether:

- Procedures are in place for safe medication administration
- Monitored dosage system for drug administration is used
- Proper packaging of drugs is maintained
- Drugs are stored safely – for instance, medication cart which is secured and locked, for controlled substances and all other drugs
- There are records for drug ordering and receiving
- There are policies and procedures for medication incidents and adverse reactions
- There are policies and procedures that address home's responsibility for drug destruction and disposal.



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Medication**

Handling of Medication Incidents and Adverse Drug Reactions

The Inspector will review the LTCH's written processes for handling of medication incidents and adverse drug reactions to determine:

- Processes are developed and implemented to ensure that every medication incident involving a resident and that every adverse drug reaction is:
 - Documented, together with a record of the immediate and corrective actions taken to assess and maintain the resident's health, and prevent recurrence.
 - Every medication incident and adverse drug reaction is reported to the
 - Resident,
 - Resident's SDM, if any,
 - Director of Nursing and Personal Care,
 - Medical Director,
 - Prescriber of the drug,
 - Resident's attending physician or the registered nurse in the extended class attending the resident, and
 - Pharmacy service provider.
- Records are kept:
 - All medication incidents and adverse drug reactions are documented, reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions;
 - Corrective action is taken as necessary, related to the results of the review and analysis of medication incidents and adverse drug reactions in order to reduce or prevent recurrence; and
 - A written record is kept of everything, including the review.

Review the LTCHs records,

- All medication incidents and adverse drug reactions for the last **quarterly review and inspect on only three (3) medication incidents (highest risk)**. This will provide a look at the home's processes and quarterly review statistics and medication incident analysis.

Interview the resident or SDM, if any, as appropriate to determine:

- Whether staff inform the resident/SDM of any medication incidents and adverse drug reactions.

Interview registered staff to determine:

- Whether written processes are in place related to medication incidents and adverse drug reactions, including documentation and records.

Information Gathering

Notes	
--------------	--

Medical directives and orders – drugs

No.	Yes	No	N/A	Question	Act/Reg.
16.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the	r. 117 (a)



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				resident's condition is assessed or reassessed in developing or revising the resident's plan of care?	
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
17.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs?	r. 117 (b)
Notes					

Information in every resident home area or unit

No.	Yes	No	N/A	Question	Act/Reg.
18.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the following are available in every resident home area or unit in the home: <ol style="list-style-type: none"> 1. Recent and relevant drug reference materials 2. The pharmacy service provider's contact information, and 3. The contact information of at least one poison control centre or similar body? 	r. 118 paras 1, 2, 3
Notes					

Retaining of pharmacy service provider (Part B)

No.	Yes	No	N/A	Question	Act/Reg.
19.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee retain a pharmacy service provider for the home?	r. 119 (1)
Notes					

Responsibilities of pharmacy service provider

No.	Yes	No	N/A	Question	Act/Reg.
20.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For each resident of the home, does the licensee ensure that the pharmacy service provider participates in the following activities: <ul style="list-style-type: none"> • the development of medication assessments • medication administration records • records for medication reassessment, and • maintenance of medication profiles? 	r. 120. 1
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
21.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the pharmacy service provider participates in the evaluation of therapeutic outcomes of drugs for residents?	r. 120. 2
Notes					



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No.	Yes	No	N/A	Question	Act/Reg.
22.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the pharmacy service provider participates in risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization?	r. 120. 3
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
23.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the pharmacy service provider participates in developing audit protocols for the pharmacy service provider to evaluate the medication management system?	r. 120. 4
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
24.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the pharmacy service provider participates in educational support to the staff of the home in relation to drugs?	r. 120. 5
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
25.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the pharmacy service provider participates in drug destruction and disposal if required by the licensee's policy?	r. 120. 6
Notes					

System for notifying pharmacy service provider

No.	Yes	No	N/A	Question	Act/Reg.
26.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a system is in place for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident?	r. 121
Notes					

Purchasing and handling of drugs

No.	Yes	No	N/A	Question	Act/Reg.
27.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug: <ul style="list-style-type: none"> a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario? 	r. 122 (1) (a) and (b)



Ministry of Health and Long-Term Care
Performance Improvement and Compliance Branch

Inspection Protocol Medication

				Note: This subsection does not apply where exceptional circumstance exist such that a drug prescribed for a resident cannot be provided by, or through an arrangement made by, the pharmacy service provider r. 122 (2)	
Notes					

Monitored dosage system

No.	Yes	No	N/A	Question	Act/Reg.
28.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a monitored dosage system is used in the home for the administration of drugs?	r. 125 (1)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
29.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the monitored dosage system promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities?	r. 125 (2)
Notes					

Administration of drugs

No.	Yes	No	N/A	Question	Act/Reg.
30.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse?	r. 131 (3)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
31.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Where a resident is permitted to administer a drug to himself or herself, does the licensee ensure that there are written policies to ensure that the residents who do so understand: (a) The use of the drug (b) The need for the drug (c) The need for monitoring and documentation of the use of the drug, and (d) The necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room?	r. 131 (6) (a)(b)(c)(d)
Notes					

Drug record (ordering and receiving)

No.	Yes	No	N/A	Question	Act/Reg.
32.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the	r. 133 (1-9)



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				<p>following information, in respect of every drug that is ordered and received in the home:</p> <ol style="list-style-type: none"> 1. The date the drug is ordered 2. The signature of the person placing the order 3. The name, strength and quantity of the drug 4. The name of the place from which the drug is ordered 5. The name of the resident for whom the drug is prescribed, where applicable 6. The prescription number, where applicable 7. The date the drug is received in the home 8. The signature of the person acknowledging receipt of the drug on behalf of the home 9. Where a controlled substance is destroyed, including documentation as per section 136 (4)? 	
Notes					

Resident's drug regimes

No.	Yes	No	N/A	Question	Act/Reg.
33.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs?	r. 134 (b)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
34.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	At least quarterly, does the licensee ensure that there is a documented reassessment of each resident's drug regime?	r. 134 (c)
Notes					

Medication incidents and adverse drug reactions

No.	Yes	No	N/A	Question	Act/Reg.
35.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the licensee ensure that every medication incident involving a resident and every adverse drug reaction is:</p> <ol style="list-style-type: none"> (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider? 	r. 135 (1) (a) (b)
Notes					



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No.	Yes	No	N/A	Question	Act/Reg.
36.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that: (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b)?	r. 135 (2) (a) (b) (c)
Notes					

Restraining by administration of drug, etc., under common law duty

No.	Yes	No	N/A	Question	Act/Reg.
37.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty, is documented, and does the licensee ensure that the following are documented: 1. Circumstances precipitating the administration of the drug 2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug 3. The resident's response to the drug 4. All assessments, reassessments and monitoring of the resident 5. Discussions with the resident or where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug?	r. 137 (2) (1-5)
Notes					

PART C: Medication Management System

(Complete applicable questions if non-compliance is identified in Part A)

No.	Yes	No	N/A	Question	Act/Reg.
38.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the licensee developed an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents?	r. 114 (1)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
39.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the licensee ensured that written policies and protocols are developed for the medication management system to ensure the	r. 114 (2)



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Medication**

				accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home?	
Notes					



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No.	Yes	No	N/A	Question	Act/Reg.
40.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are the written policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices?	r. 114 (3) (a)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
41.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are the written policies and protocols reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director?	r. 114 (3) (b)
Notes					

Policies to be followed

No.	Yes	No	N/A	Question	Act/Reg.
42.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act?	r. 8 (1) (a)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
43.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with?	r. 8 (1) (b)
Notes separated a and b into two questions					

Quarterly evaluation

No.	Yes	No	N/A	Question	Act/Reg.
44.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least <u>quarterly</u> to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system?	r. 115 (1)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
45.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the quarterly evaluation of the medication management system include at least: (a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place	r. 115 (3) (a)(b)(c)



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				<p>residents at risk</p> <p>(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act, and</p> <p>(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices?</p>	
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
46.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the changes identified in the quarterly evaluation are implemented?	r. 115 (4)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
47.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented?	r. 115 (5)
Notes					

Annual evaluation

No.	Yes	No	N/A	Question	Act/Reg.
48.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets <u>annually</u> to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system?	r. 116 (1)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
49.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the annual evaluation of the medication management system: <ul style="list-style-type: none"> (a) include a review of the quarterly evaluations in the previous year as referred to in section 115, (b) use an assessment instrument designed specifically for this purpose, and (c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices? 	r. 116 (3) (a)(b)(c)



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Notes

No.	Yes	No	N/A	Question	Act/Reg.
50.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that the changes identified in the annual evaluation are implemented?	r. 116 (4)

Notes

No.	Yes	No	N/A	Question	Act/Reg.
51.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented?	r. 116 (5)

Notes

Retaining of pharmacy service provider

No.	Yes	No	N/A	Question	Act/Reg.
52.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is the pharmacy service provider a holder of a certificate of accreditation for the operation of the pharmacy under section 139 of the <i>Drug and Pharmacies Regulation Act</i> ?	r. 119 (2)

Notes

Transition

No.	Yes	No	N/A	Question	Act/Reg.
53.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there a written contract between the licensee and the pharmacy service provider setting out the responsibilities of the pharmacy service provider?	r. 119 (3)

Notes

No.	Yes	No	N/A	Question	Act/Reg.
54.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the written contract provide that the pharmacy service provider shall: (a) provide drugs to the home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the <i>Drug and Pharmacies Regulation Act</i> , and (b) perform all the other responsibilities of the pharmacy service provider under the Regulation?	r. 119 (4) (a) (b)

Notes



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Emergency drug supply

No.	Yes	No	N/A	Question	Act/Reg.
55.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee who maintains an emergency drug supply for the home ensure that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and the Administrator, are kept?	r. 123 (a)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
56.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee who maintains an emergency drug supply for the home ensure that a written policy is in place to address: <ul style="list-style-type: none"> • the location of the supply, • procedures and timing for reordering drugs, • access to the supply, • use of drugs in the supply, and • tracking and documentation with respect to the drugs maintained in the supply? 	r. 123 (b)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
57.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee who maintains an emergency drug supply for the home ensure that, at least annually, there is an evaluation done by the Medical Director, pharmacy service provider, DONPC and Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs?	r. 123 (c)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
58.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee who maintains an emergency drug supply for the home ensure that any recommended changes resulting from the evaluation are implemented?	r. 123 (d)
Notes					

Changes in directions for administration

No.	Yes	No	N/A	Question	Act/Reg.
59.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern <u>changes in the administration of a drug</u> due to modifications of directions for use made by a prescriber, including temporary discontinuation?	r. 127



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Notes

Sending of drugs with a resident

No.	Yes	No	N/A	Question	Act/Reg.
60.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the <u>sending of a drug</u> that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged?	r. 128

Notes

No.	Yes	No	N/A	Question	Act/Reg.
61.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that where a resident wishes to use a drug that is a natural health product and that has not been prescribed, there are written policies and procedures to govern the use, administration and storage of the natural health product?	r. 132 (1)

Notes

Monitored dosage system

No.	Yes	No	N/A	Question	Act/Reg.
62.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered?	r. 130. 3

Notes

Medication incidents and adverse drug reactions

No.	Yes	No	N/A	Question	Act/Reg.
63.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure that: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b)?	r. 135 (3) (a)(b)(c)

Notes



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Drug destruction and disposal

(Complete applicable questions if non-compliance is identified in Part A)

No.	Yes	No	N/A	Question	Act/Reg.
64.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the licensee ensure that, as part of the medication management system, a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of:</p> <p>(a) all expired drugs</p> <p>(b) all drugs with illegible labels</p> <p>(c) all drugs that are in containers that do not meet the requirements for marking containers specified under section 156 (3) of the <i>Drug and Pharmacies Regulation Act</i>, and</p> <p>(d) a resident's drug where,</p> <p>i. The prescriber attending the resident orders that the use of the drug be discontinued</p> <p>ii. The resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the <i>Vital Statistics Act</i> or the resident's attending physician, or</p> <p>iii. The resident is discharged and the drugs prescribed for the resident are not sent with the resident?</p>	r. 136 (1) (a)(b)(c)(d)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
65.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the home's drug destruction and disposal policy include that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs?</p>	r. 136 (2) 1
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
66.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the home's drug destruction and disposal policy include that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs?</p>	r. 136 (2) 2
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
67.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Does the home's drug destruction and disposal policy include that drugs are destroyed and disposed of in a safe and environmentally</p>	r. 136 (2) 3



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				appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices?	
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
68.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the licensee ensured that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record: <ol style="list-style-type: none"> 1. The date of removal of the drug from the drug storage area 2. The name of the resident for whom the drug was prescribed, where applicable 3. The prescription number of the drug, where applicable 4. The drug's name, strength and quantity 5. The reason for destruction 6. The date when the drug was destroyed 7. The names of the persons who destroyed the drug 8. The manner of destruction of the drug? 	r. 136 (4) (1-8)
Notes					

No.	Yes	No	N/A	Question	Act/Reg.
69.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the licensee ensure: <ol style="list-style-type: none"> (a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective? (b) that any changes identified in the audit are implemented; and (c) that a written record is kept of everything provided for in clauses (a) and (b)? 	r. 136 (5) (a)(b)(c)
Notes					

Based on information collected during the inspection process, the inspector may determine the need to select and further inspect other related care / services areas. When this occurs, the inspector will document reason(s) for further inspection in ad hoc notes, select and complete other relevant IPs related to medication, for example:

- Admission and Discharge
- Critical Incident Response
- Dignity, Choice and Privacy
- Falls Prevention
- Pain
- Personal Support Services



Ministry of Health and Long-Term Care
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Inspection Protocol Medication

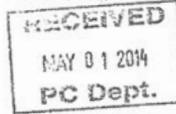
- Prevention of Abuse, Neglect and Retaliation
- Quality Improvement
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home
- Skin and Wound Care
- Sufficient Staffing
- Training and Orientation

Appendix F – Letter and Termination Report



Caressant Care Nursing
and Retirement
Homes Limited

Woodstock Nursing Home



April 17, 2014

College of Nurses
101 Davenport Rd.,
Toronto, On M4R 3P1

To Whom It May Concern:

Re: Elizabeth Wettlaufer
Registration #: 9581737

Enclosed please find the Report form for Facility Operators and Employers. We are reporting the termination of the above named individual to the College of Nurses. She was terminated due to a medication error which resulted in putting a resident at risk.

If you have any questions feel free to contact myself or Helena Crombez, Director of Nursing at Caressant Care Woodstock at the number listed below.

Regards

Brenda Van Quaethem
Administrator

Report Form for Facility Operators and Employers



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFERMIÈRES
ET INFERMIERS DE L'ONTARIO

THE STANDARD OF CARE.

MAY 01 2014

PC Dept.

College of Nurses of Ontario
101 Davenport Rd., Toronto, ON M5R 2P1
www.cno.org

Telephone: 416 928-0900
Toll-free (Ontario): 1 800 397-5526
Fax: 416 928-1914

Attention: Executive Director

Date of Report: March 31, 2014

Please check all applicable boxes:

Under RHPA section 85.2 Facility operators are required to report:

- sexual abuse of a client by a health professional
- if a health professional is:
- incompetent
 - incapacitated

Under RHPA section 85.5 Employers are required to report:

- termination or resignation in lieu of termination for reasons of professional misconduct, incompetence or incapacity

Reporter Information

CARESSANT CARE NURSING HOME

Name of facility/agency/employer

81 FYFE AVENUE

Street Address

WOODSTOCK, ON

City

N4S 8Y2

Postal code

N4S 86W

Contact Person:

HELEN CROMBEZ

Name

DIRECTOR OF NURSING

Position

519-539-6461

Phone

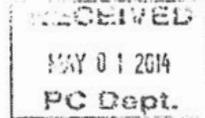
519-539-7467

Fax

hcrombez@caressantcare.com

Email

Please review the College's Collection of Personal Information statement in the Mandatory Reporting: A process guide for employers, facility operators and nurses to understand how the College uses your information. (http://www.cno.org/Global/docs/ib42008_fsMandReporting.pdf)



Reporter Information (continued)

Type of setting (choose one):

- Acute care
 Retirement
 LTC
 Home care
 Correctional facility
 Palliative
 Mental health
 Occupational health
 Other:

Nature of Report:

- Practice
 Conduct
 Incapacity

Member Information

Member's Name

ELIZABETH WETTLAUFER

Registration Number

9581737

Date of hire

JUNE 27, 2005

Termination or resignation date

MARCH 31, 2014

Address (if known)

857 James Street, Apt. 2504
WOODSTOCK, ON N4S 8H6

Type of shift (Days/Nights/Weekends): EVENINGS

Unit/practice that member worked: Level 1

Nurse/client ratio: 32:1

Employment Status:

- Full-time
- Part-time
- Casual

Member's Role:

- Staff nurse
- Charge nurse
- Administration
- Other:

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Describe the event(s) that led to this report (who, what, where, when, and why) in chronological order starting with the most recent.

Date	Incident/Event	Consequences to client/other	Member response/explanation	Employer action
Mar. 20/14	<p>Administered insulin to a resident belonging to another resident. The insulin was not the same insulin. Bethel had come on shift at 15:00 hour to work the 15:00 to 23:00 hour shift. The Day nurse had reported to Bethel at change of shift that the insulin was ordered and would be coming in with the medication delivery between 17:00 and 18:00 hour. Bethel said she did not remember hearing this. She said she went to the refrigerator and substituted the insulin from another resident as it was the same. It was not.</p> <p>The insulin pen was left opened on the medication cart by the day nurse as a reminder to Bethel that the refill was needed. The day nurse in her report said she had reviewed this with Bethel during shift report a couple of times.</p>	<p>-resident had an episode of hypoglycemia</p>	<p>-Bethel was upset when she heard and she said she thought she loaded the cartridge with the same insulin. Bethel admitted to taking another resident's insulin when she knew she was not to borrow</p>	<p>Termination</p>

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<p>Jan. 28/14</p>	<p>Work Performance: A resident was spoken to in an inappropriate manner. This resulted in upsetting the resident. Bethie failed to document the interventions that she said she tried to use to calm the resident. In an effort to calm the resident she then gave medication outside of the allowable time frame. She gave the Trazadone early along with Tylenol and Risperdal</p> <p>The focus in this Home has been validation therapy, not reality orientation.</p>	<p>-resident was upset with Beth's verbal interactions saying "I'm not sick. I don't have Alzheimer's, I don't forget"</p>	<p>-Bethie's response was that she used this method before with other residents -for giving the medication early Bethie felt it was warranted</p>	<p>Bethie received a five (5) day suspension</p> <div data-bbox="800 351 1005 475" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED JAN 31 2014 PC Dept.</p> </div>
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Jan. 22/14	<p>Incorrect treatment of a hypoglycaemic episode. Blood glucose (less than 4). Did not follow proper policy and procedure by not giving the proper food and drink items in the quantities specified in the procedure.</p> <p>-incomplete charting/untimely charting by failing to change the time to when the episode occurred. (late entry charting)</p> <p>-no communication with the physician or Dietitian (referrals)</p>	-Resident was stable	-Bethie thought she did right, she said it was a busy night	Counseling
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<p>Dec. 19/13</p>	<p>Administered eye drops incorrectly... gave 2 types of eye drops at same time. Family member told her this was incorrect and Belthe said "I know".</p>	<p>-possible adverse condition of eye sight over time</p>	<p>-Belthe said it was a busy night, she was running late & gave both drops at once, said she shouldn't have done it</p>	<p>Belthe received a letter of warning on poor work performance with warnings of further incidents leading to further discipline up to and including termination.</p> <p style="text-align: right;">RECEIVED MAY 31 2014 PC Dept.</p>
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<p>Nov. 25/13</p>	<p>Urine sample was obtained from a difficult resident with the help of a Resident's wife. It was given to a PSW who gave it to Bethie. It was Bethie's responsibility to dip test it. This was not completed and the urine sample had to be discarded as it was stale</p>	<p>-Possible late identification of a urine infection</p>	<p>Bethie said she was busy, the resident showed no signs of an UTI, it was a PSW who had the idea to obtain a urine sample and Bethie said she did not feel the doctors would do anything about it.</p>	<p>Letter to identify that her work performance was not adequate in this and other areas with warning that further incidents would lead to further discipline up to an including termination Examples of work performance not to standard were not doing assessments, processing and following up on doctor's orders and other work as required of Registered Staff</p> <div data-bbox="793 354 989 482" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED MAY 31 2014 PC Dept.</p> </div>
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<p>April 08/13</p>	<p>Medication charted as given but was not given. In total there were 4 medications not given for a resident. -3 medications @ 16:00 hour - one other medication at 20:00 hour This resident was overlooked during two med passes and this would not be possible if Bethe followed proper eMAR drug administration practices</p>	<p>-no effect to resident</p>	<p>-Bethe thought she had given them -Bethe said she did not require reinstruction on how to give medication properly</p>	<p>-5 day suspension</p>
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<p>Max. 14/13</p>	<p>-Narcotic given but not signed for. At med count the narcotic was missing. Upon investigation Bethie recalled giving the narcotic along with a Tylenol. She did not sign for it on the MAR or on the individual Narcotic Sheet -she also gave medication early</p>	<p>-no effect to resident</p>	<p>-she realized she did 3 things wrong 1. Not signing the Mar 2. Not signing the individual narcotic record 3. Giving medication early</p>	<p>1 day suspension She received education on proper medication administration</p> <div data-bbox="854 369 1047 493" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED MAY 31 2014 PC Dept.</p> </div>
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Feb. 12/13	Medication Administration -did not administer following proper procedure and left meds at a dining room table -also did not administer mineral oil to another resident as required	-no effects to resident	-knew it was serious if another resident would have taken the medication belonging to another resident	Bethel received a written warning Also reviewed process of medication administration and importance of doing treatments as assigned
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<p>Sep1.03/ 2012</p>	<p>Not taking medication refrigerator temps (Aug. 31, 2012) Not taking vaccine medication refrigerator temps (Aug. 27 & 29, 2012) -narcotics not properly counted with oncoming shift (September 03, 2012)</p>	<p>-no effect to residents</p>	<p>-Belthe didn't think of counting medication with oncoming shift. She said she knew of the memo reviewing proper procedure for narcotic count, but didn't think to do it -she forgot to take frig temps</p>	<p>Belthe received a written warning with a review of proper procedure for narcotic count and a review of importance of temperatures for proper medication and vaccine storage as outlined with Public Health Ontario</p> <div data-bbox="795 360 992 480" style="border: 1px dashed black; padding: 5px; text-align: center;"> RECEIVED MAY 01 2014 PC Dept. </div>
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<p>Aug. 29/12</p>	<p>-not assessing a resident when required, it had been reported to Bethel that a resident was not herself</p>	<p>-resident was not herself at time, no adverse event</p>	<p>-Bethel stated she was not feeling well herself -Bethel said she was working through a module on professionalism from the CON website. This was on her own initiative.</p>	<p>Written Warning</p> <p style="text-align: right;">RECEIVED MAY 01 2014 PC Dept.</p>
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Other comments:

There were other reports from staff that did not lead to discipline but were considered at time of termination. These reports had to do with attendance, professional behaviour

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