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

The Honourable Eileen E. Gillese
Commissioner

Ontario

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

L'honorable Eileen E. Gillese
Commissaire

Commissioner's Remarks on the Public Release of the Inquiry Report

July 31, 2019

Woodstock, Ontario

A. INTRODUCTION

Good afternoon – bonjour mesdames et messieurs. My name is Eileen Gillese. It has been my honor and privilege to serve as the Commissioner of the Public Inquiry into the Safety and Security of Residents in the Long-term Care Homes System.

Yesterday, I delivered my four-volume final Report and Recommendations to the Government of Ontario. I now release the Report and Recommendations to the people of Ontario. The Report is the result of intensive work over the past two years by a dedicated team and the input and assistance of a great many people, far too numerous to identify by name today. I invite you to look at the Acknowledgments at the beginning of volume 2 in which I recognize and thank the many people and organizations who contributed to the work of the Inquiry.

A copy of these remarks and the full Report will be available on the Inquiry website, in both French and English, shortly after I conclude these remarks.

I anticipate that my remarks will take approximately a half hour. In them, I will focus on the Recommendations in the final Report. Before discussing the Recommendations, however, I will briefly describe the three foundations on which they rest.

B. THE FOUNDATIONS FOR THE RECOMMENDATIONS

1. The Inquiry Process

To develop effective Recommendations on how to avoid similar tragedies in the future, I needed two things.

First, I needed a full factual understanding of the Offences and the circumstances in which they were committed; the long-term care system; and the roles played by the major stakeholders in that system. Part 1 of the Inquiry process provided me with this. In Part 1, Commission counsel conducted thorough system-wide investigations into the Offences. The results of those investigations were made public and strenuously tested in the Public Hearings last summer. In the interests of time, I will say nothing more about the investigations. Chapters 3 – 14 of Volume 2 of the Report are summaries of the investigations.

Second, I needed research to be conducted, the advice of experts, and extensive consultations with those who work in the long-term care system. Part 2 of the Inquiry process fulfilled these needs. Volume 4 of the Report describes the Inquiry process, including that relating to Part 2.

2. Debunking Myths

A reasoned consideration of this Report and its Recommendations depends on facts, not myths. I wish to address four myths that repeatedly surfaced during the Inquiry. These myths seriously distort the nature of the problem that the Wettlaufer Offences represent and must be de-bunked.

a. MYTH: **The Offences were mercy killings. <u>NOT TRUE</u>**.

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 them. Indeed, Wettlaufer herself never claimed she acted out of a sense of mercy. She said she committed the Offences because she was angry about her career, her

responsibilities and her life, and that after killing or harming she felt a release, a sense of “euphoria”.

Wettlaufer is a serial killer. Like other serial killers, she committed the Offences for her own gratification and for no other reason.

b. MYTH: Long-term care issues are a baby-boomer problem. <u>NOT TRUE</u>.

It is true that Ontario’s population is aging and one reason for this is the baby-boomer generation (those born between 1946 and 1965). It is NOT true that the challenges facing the long-term care system will end when the baby-boomers have died. Why? Because Ontario’s population redistribution (an increased proportion of older people) is also due to: (1) low birth rates dating back to the 1970s, and (2) the increasing life expectancy of Ontarians. Therefore, the trend of older people making up a significant proportion of the overall population of Ontario will continue long after the baby-boomer generation has passed.

It is also important to understand that Ontario’s long-term care system is facing serious challenges not simply because of the sheer number of older Ontarians. The increased challenges are also a function of the rising acuity (level of care needed) of older Ontarians. People are living longer, and our later years are often accompanied by cognitive and physical impairment. Whether people live at home as they age or are residents in long-term care homes, as acuity levels increase so do the workloads of those who provide care and support for an aging population.

c. MYTH: Wettlaufer is in jail so the threat she poses has passed. <u>NOT TRUE</u>.

Wettlaufer is a healthcare serial killer. A growing body of research and literature shows that healthcare serial killing is a phenomenon which, while rare, is long-standing and universal in its reach, with documented cases dating back to the 1800s. In light of the healthcare serial killer phenomenon, we cannot assume that because Wettlaufer is behind bars, the threat to the safety and security of those receiving care in the long-term care system has passed.

Expert evidence presented at the Public Hearings shows that since 1970, 90 healthcare serial killers have been convicted in, among other places, the United States, Britain, and Western European countries. Because of Wettlaufer, Canada is now also on the list of countries with convicted healthcare serial killers. It is notable that, during the Inquiry, the media reported the arrests of two more alleged healthcare serial killers – one in England and the other in Japan – and that continuing police investigations into convicted German healthcare serial killer Niels Hogel revealed he had killed at least a hundred more patients than those for which he had already been convicted.

And, the fact that healthcare serial killing is rare does not mean that we can ignore its existence. While the known number of healthcare serial killers is small, the number of their victims is not. The 90 convicted healthcare serial killers have been found guilty of murdering at least 450 patients and convicted of assault or grave bodily injury of at least 150 others. According to Inquiry expert evidence, these figures significantly understate the actual number of victims. On that evidence, over 2,600 suspicious deaths are attributed to the 90 convicted healthcare serial killers.

d. MYTH: The harm caused by the Offences is limited to the victims and their loved ones. <u>NOT TRUE</u>.

Yes, the victims and their loved ones are those who suffered the most direct harm from the Offences. The extent of their suffering is profound and continues to this day. However, the harm caused by the Offences does not end with the victims and their loved ones.

The Offences caused residents in long-term care homes to be fearful for their safety and their families shared that fear. Those who work in long-term care suffered too. They feel shame that a healthcare provider could do such a thing and guilt that they were unable to prevent it. As well, the Offences cast an undeserved stain on the many fine people who work in long-term care and are committed to those for whom they provide care.

The Offences also shocked and horrified the members of the communities in which they took place.

Further, the Offences shocked Ontario society as a whole. It was widely reported in the media that the Offences shook public confidence in Ontario's long-term care system. People are now worried about whether the long-term care system can safely provide care for their loved ones and for themselves as they age. Widespread lack of trust and worry is a significant form of harm.

Yes, the Offences are personal tragedies for the victims and their loved ones. However, to suggest that the harm caused by the Offences is limited to them is to fundamentally misunderstand both the Offences and the scope of harm they caused. The Offences are tragedies of substantial public interest and demand our collective response, if we are to prevent similar tragedies in the future.

3. My Principal Findings

a. No Knowledge of the Offences without Wettlaufer's Confession

The Offences would have not have been discovered if Wettlaufer had not confessed and turned herself in to the police. On the facts, this finding is self-evident.

Wettlaufer committed the Offences over the nine-year period from 2007 - 2016. In September 2016, when Wettlaufer confessed that she had harmed and killed residents for whom she was providing nursing care, she was not under suspicion or investigation nor were any of the incidents involving the victims of the Offences. The evidence in this Inquiry shows nothing that would have triggered an investigation into Wettlaufer or the incidents underlying the Offences. Thus, it is patent that the Offences would not have been discovered without Wettlaufer's confession. A description of the evidence in support of this finding is in Chapter 1 of Volume 2.

This finding is significant because it 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. Fundamental changes must be made – changes that are directed at preventing, deterring, and detecting wrongdoing of the sort that Wettlaufer committed.

b. No Findings of Individual Misconduct

As Commissioner, I have the power to make findings of misconduct. As you will see in the Report, I make no such findings. That is because the Offences were the result of systemic vulnerabilities in the long-term care system, and not the failures of any individual or organization within it. It appears that no one in the long-term care system conceived of the possibility that a healthcare provider might intentionally harm those within their care and, consequently, no one looked for this or took steps to guard against it.

Because it was systemic vulnerabilities – not individual failings – that created the circumstances allowing the Offences to be committed, it would be unfair to make findings of individual misconduct, which would suggest that those individuals or organizations were at fault. It would also be counterproductive to make findings of misconduct because assigning blame to individuals would not remedy systemic problems, guard against similar tragedies, or encourage those in the long-term care system to make the changes called for in the Report.

This finding is significant because it tells us that there is no simple “fix” in terms of avoiding similar tragedies in the future. Systemic issues demand systemic responses. Systemic responses require collaboration, co-operation, and communication throughout the system. I might add that I received many suggestions that looked like they might be simple “fixes” but further investigation showed they were not. For example, many suggested that when a resident in long-term care dies, a blood sample should be taken and tested to see if it contains an elevated level of insulin. As I explain in Chapter 19 of Volume 3, this cannot be done, and even if it could, the expert evidence is that it would be of little or no use in detecting whether there had been an intentional administration of an insulin overdose.

c. The LTC System is Strained but not Broken

Long-term care homes are the most highly regulated area of healthcare in Ontario. Despite limited resources, the staff in these homes must meet the regulatory dictates and provide care for residents with ever-increasing acuity. However, while the long-term

care system is strained, it is not broken. The regulatory regime that governs the long-term care system, together with those who work in it, provide a solid foundation on which to address the systemic issues identified in the Inquiry.

The *Long-Term Care Homes Act, 2007,* and its regulations, create a resident-centered framework that imposes clear minimum standards of care on a broad range of matters and a rigorous inspection regime to enforce those standards. And, importantly, initiatives taken by various stakeholders in the long-term care system are incontestable evidence of their dedication and commitment to care.

These stakeholder initiatives are of two sorts. The first are initiatives that stakeholders undertook during the Inquiry in response to issues identified in the Public Hearings and the consultations. The stakeholders did not wait for this Report to be released before acting. When they learned of something that could be done to improve the long-term care system, if the matter was within their power, they acted immediately. The second group of initiatives were stakeholder-led innovations to improve the quality of residents' lives and those who work with them. These initiatives show there is strong leadership in the long-term care system, a willingness to collaborate, and a commitment to innovation. Time does not permit me to review these initiatives but I urge you to read Chapter 15 of the Report where I describe them – it is unbelievably heartening.

My finding that the long-term care system is not broken is significant because it means there is no need to jettison the existing regulatory system and start over. Instead, our response must be two-pronged. First, we need to spread and share existing excellence in the long-term care system. Second, we need to acknowledge the vulnerabilities in the system that this Inquiry has exposed and address them by implementing the Recommendations in the Report.

C. THE RECOMMENDATIONS

There are 91 Recommendations in the Report. How is one to approach that number of Recommendations, especially when they are wide-ranging in scope and widely divergent in subject matter? How do the Recommendations fit together, if at all? How do we know which are the most important and why?

The answer to these questions is **PADD – Prevention, Awareness, Deterrence, and Detection.** These four strategies – prevention, awareness, deterrence, and detection – are the organizing tool for understanding the Recommendations and how they fit together.

The goal of the Recommendations is to avoid future tragedies similar to those inflicted by Wettlaufer. The strategies to be used in accomplishing that goal are prevention, awareness, deterrence, and detection (**PADD**). Each strategy is the subject matter of a chapter in Volume 3. Each strategy addresses a systemic vulnerability identified by this Inquiry. Each strategy also requires a systemic response. That is, for the strategy to be effective, multiple stakeholders in the long-term care system must engage in its implementation – no one stakeholder can do it alone.

In short, **PADD** is the shorthand term for the four strategies designed to avoid similar tragedies. The strategies are Prevention, Awareness, Deterrence, and Detection and they are systemic in nature. Chapters 15 – 18 of Volume 3 are devoted to the systemic issues and the called-for systemic responses. Chapter 15 is dedicated to Prevention. Chapter 16 is dedicated to Awareness. Chapter 17 is dedicated to Deterrence. And, Chapter 18 is dedicated to Detection.

While the systemic responses drive the Recommendations, the Recommendations made for specific stakeholders (found in Volume 2) are designed to work in conjunction with each **PADD** strategy.

I will now consider the four **PADD** strategies.

PREVENTION (Chapter 15)

The best way to **prevent** similar tragedies in the future is to strengthen the long-term care system and encourage excellence in resident care.

Recommendations to facilitate Prevention

1. **Systemic Recommendation 62** calls for the Ministry of Long-Term Care to play an expanded leadership role by establishing a dedicated unit to do three things. First,

support long-term care homes in achieving regulatory compliance and spread best practices. Second, provide bridging and laddering programs in long-term care homes to increase the skills of those who work in them and offer opportunities for advancement, thereby building human resource capacity and addressing the long-standing problem of a shortage of registered staff. Third, encourage innovations and the use of new technologies in the long-term care system.

Recommendation 62 is a systemic recommendation. You might argue that it isn't. After all, in it I squarely place responsibility on the Ministry. But, as you will see when you read the Recommendation in full (particularly the amplified version found at the end of Chapter 15), Recommendation 62 calls for the work of the new unit to be done collaboratively, with stakeholders throughout the long-term care system, drawing on existing partnerships and forging new ones.

2. Specific Recommendations that work in conjunction with the systemic recommendation for Prevention

Recommendations to long-term care homes that they:

- Strengthen their training and education requirements (Recommendations 3, 4, 5); and
- Limit and improve the use of agency nurses (Recommendations 11, 12 and 13).

Recommendations to the Ministry that it:

- Expand the funding parameters of the nursing and personal care envelope (Recommendation 19);
- Recognize and reward long-term care homes that have made demonstrated improvements in the wellness and quality of life of their residents (Recommendation 20);
- Create a new, permanent funding envelope to fund training and education in long-term care homes (Recommendation 21);
- Strengthen the education requirements relating to medical directors and nurse practitioners (Recommendation 22);

- Refine the LQIP (Long-Term Care Home Quality Inspection Program) Performance Assessment to better identify homes struggling to provide a safe and secure environment for residents and use the LQIP data when establishing inspection priorities (Recommendations 25 - 27);
- Identify long-term care homes who have fallen below level 1 performance for two consecutive quarters and assist the homes to return to the level 1 classification (Recommendation 28); and
- Where a licensee fails to report reasonable suspicions of negligence and abuse, as required by section 24(1) of the *Long-Term Care Homes Act, 2007*, ensure that the next RQI (resident quality inspection) conducted in the home is the intensive RQI, regardless of the performance level assigned to the home (Recommendation 29).

AWARENESS (Chapter 16)

It is not possible to deter or detect something unless you are aware that it exists. That is a central lesson learned by this Inquiry and by countless prior public inquiries and similar processes. Thus, to avoid similar tragedies in the future, it is critical that **awareness** is developed, throughout the healthcare system, of the possibility that a healthcare provider could intentionally harm those in their care. Note that this possibility is not limited to long-term care: healthcare serial killing has occurred across the healthcare system. Therefore, **awareness** must be developed throughout the healthcare system.

Recommendations to build Awareness

1. Systemic Recommendations 64 – 73 provide a roadmap for building, developing, and maintaining this awareness in a positive way. I recommend that the Office of the Chief Coroner and the Ontario Forensic Pathology Service lead this initiative, beginning with the creation of a strategic plan. Thereafter, it should conduct ongoing research to keep up-to-date on the healthcare serial killer phenomenon in other jurisdictions. It should also provide standardized key information and support to the

organizations and institutions that deliver education and training to healthcare and allied service providers. The Recommendations also provide guidance to the relevant organizations and institutions on how to develop the necessary awareness without creating a climate of fear and mistrust.

2. Specific Recommendations that work in conjunction with the systemic recommendations to build Awareness

Recommendations that the College of Nurses:

- Educate its membership and staff on the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care (Recommendation 40);
- Strengthen its intake investigation process by, among other things, training its intake investigators on the healthcare serial killer phenomenon and how to conduct their inquiries in light of it (Recommendation 41);
- Review and revise its policies and procedures to reflect the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care (Recommendation 42);
- Share its research on the healthcare serial killer phenomenon with other healthcare regulators in Canada, the United States, and internationally (Recommendation 44); and
- Review its approved nursing programs to ensure they include adequate education and training on the possibility that a healthcare provider might intentionally harm patients/residents, and work with post-secondary institutions offering approved nursing programs to assist with this (Recommendations 44 and 45).

DETERRENCE (Chapter 17)

Like many healthcare serial killers, Wettlaufer committed the Offences by injecting her victims with overdoses of insulin that she had diverted from their intended use. Long-

term care homes must make changes to the medication management system to **deter** staff from diverting medications and make it more likely that they will be caught if they do.

Recommendations to build Deterrence

1. **Systemic Recommendations 74 – 85** set out a three-pronged approach for deterring wrongdoers from intentionally harming residents through the use of medication. First, strengthen the medication management system in long-term care homes. Second, improve medication incident analysis in long-term care homes, including by establishing specific strategies for incidents relating to possible insulin overdoses. Third, increase the number of registered staff in long-term care homes.

   Recommendation 76 deserves specific attention. It calls for the Ministry to establish a grant program to provide funding to long-term care homes for infrastructure changes to increase visibility around medications and key locations in the home; to harness the power of technology in detecting medication diversion, improve the tracking and auditing of medications, and reduce their stocks; and enable pharmacists and pharmacy technicians to play an expanded role in long-term care homes. The expanded role envisaged for pharmacists and pharmacy technicians will lead to reduced stocks of medication, improved medication reconciliations, improved quality of resident care, fewer medication errors, improved investigation into medication incidents, significant cost savings, and improved resident outcomes.

   I have recommended government grants ranging from $50,000 to $200,000 per long-term care home, depending on size, for these measures.

   Recommendation 85 also deserves specific attention. It calls for the Ministry to conduct a study to determine adequate levels of registered staff in long-term care homes on each of the day, evening, and night shifts; to table the study in the legislature by July 31, 2020; and to provide long-term care homes

with a higher level of funding for staff if the study shows that additional staffing is required for resident safety.

2. Specific Recommendations that work in conjunction with the systemic recommendations to build Deterrence

Recommendations that long-term care homes:

- Adopt a hiring/screening process that includes robust reference and background checking where there are gaps in a resume or the candidate's previous employment was terminated, and close supervision in the probationary period (Recommendation 6); and
- Require the Director of Nursing to conduct unannounced spot checks on evening and night shifts, including on weekends (Recommendation 7);
- Take reasonable steps to limit the supply of insulin (Recommendation 10);

DETECTION (Chapter 18)

Steps must be taken to strengthen Ontario's death investigation process, as it relates to residents in long-term care homes, so that it is better equipped to **detect** intentionally caused resident deaths.

Recommendations to Facilitate Detection

1. Systemic Recommendations 86 – 89 are a blueprint for the Office of the Chief Coroner and Ontario Forensic Pathology Service to meaningfully increase the number of death investigations of residents using information from a redesigned Institutional Patient Death Record (IPDR) and the Ministry of Health's data analytics model. The IPDR is the form that long-term care homes must complete and submit to the Office of the Chief Coroner for every resident death.

2. Specific Recommendations that work in conjunction with the systemic recommendations to facilitate Detection

Recommendations that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- Redesign the IPDR so it is evidence-based; contains more and better information about a resident's death, including information from the family and personal support workers who attended to the resident's care; is reviewed by other healthcare providers; and completed by registered staff who are familiar with the resident and trained on the completion of the redesigned IPDR (Recommendations 50, 51, and 54);
- Ensure that the redesigned IPDRs are submitted electronically so the information in them can be aggregated and used to look for trends, spikes, and clusters of deaths (Recommendation 52);
- Require that a redesigned IPDR be submitted for a resident who dies in hospital within 30 days of being transferred to the hospital from a long-term care home (Recommendation 53);
- Establish as a best practice that, at the preliminary consultation stage, coroners speak with the deceased's family about the resident's death and advise the family what they can do if the decision is made that no death investigation will be undertaken (Recommendation 55);
- Prepare written materials on the death reporting and investigation process and provide the materials to long-term care homes for distribution, at appropriate times, to families of residents (Recommendation 56);
- Strengthen the processes around the decision not to conduct a death investigation; develop protocols and policies on the involvement of forensic pathologists in the death investigation process; and develop a standardized protocol for autopsies performed on the elderly (Recommendations 57- 59);
- Maintain and strengthen the cadre of specially trained coroners who will, among other things, help fulfill many of the foregoing recommendations (Recommendations 60 and 61).

Recommendations that the Ministry:

- Ensure that inspections involving either missing narcotics or allegations of staff-to-resident abuse are preceded by reviews of previous critical incident reports involving the same staff member (Recommendation 30);
- Establish a formal communications policy and process to ensure that Ministry inspectors share relevant information with the College of Nurses of Ontario about members of the College who may pose a risk of harm to residents (Recommendation 31).

Recommendations that long-term care homes:

- Electronically submit the IPDR and the redesigned IPDR, when it becomes available, to the Office of the Chief Coroner and Ontario Forensic Pathology Service (Recommendation 9).

Recommendations that the College of Nurses of Ontario:

- Take specified steps to improve reporting by long-term care home employers and facility operators on their mandatory reporting obligation relating to termination reports and reports relating to incompetence and incapacity (Recommendations 46 - 48); and
- Institute a program to educate its members on their reporting obligations relating to suspected abuse and neglect of patients and residents by nurses (Recommendation 49).

RECOMMENDATIONS RELATING TO PUBLICLY FUNDED HOMECARE

The long-term care system does not consist solely of long-term care homes. It includes publicly funded home care services, such as nursing, personal support, physiotherapy, and occupational therapy. These services assist aging Ontarians (among others),

allowing them to remain in their own homes as long as possible. It is important to keep in mind that Wettlaufer committed her last Offence while providing the victim with publicly funded nursing services in her own home.

The home care setting is different from the long-term care home in a number of ways. As a result, I made different types of Recommendations aimed at improving the safety and security of those receiving home care services.

Chapter 8 (Recommendations 14 – 18) and Chapter 12 of Volume 2 (Recommendations 32 – 39) contain the bulk of the Recommendations directed at improving safety in the home care setting. The Recommendations directed at Service Provider Organizations call for increased training for management and staff and an improved process for reporting unusual incidents. The Recommendations to the LHINs are directed at clarifying the reporting arrangements with service providers and conducting audits to ensure that service providers are carrying out their obligations in the hiring, screening, and training of staff and the reporting of incidents.

The Recommendations in Chapters 8 and 12 are supported and reinforced by Recommendations 63, 90 and 91. Recommendation 63 calls for the Ministry to collaborate with the Home and Community Care Branch and the LHINs. Recommendations 90 and 91 provide guidance to the Office of the Chief Coroner and the Ontario Forensic Pathology Service on steps that can be taken to assist caregivers in knowing when to report deaths in the home care setting.

D. CONCLUSION

I will conclude with a few final remarks.

First, to the residents in Ontario's long-term care homes – I hope and trust that the Report and Recommendations will serve to better ensure your safety and security. Please know that, when developing the Recommendations, we never lost sight of the fundamental principle in section 1 of the *Long-Term Care Homes Act, 2007:* to make

long-term care homes the *real* homes of the residents, places in which they live with dignity, and in security, safety and comfort.

Second, to the victims and their families and loved ones – this Report is dedicated to you. The Dedication is found at the beginning of both Volumes 1 and 2. It reads as follows:

> 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.

Third, to all those who work in the LTC system – Volume 3 of the Report is entitled "A Strategy for Safety" and is dedicated to you. The Dedication in Volume 3 reads as follows:

> Volume 3 of the Report is dedicated to the many nurses and other caregivers who perform their jobs in the long-term care system with great kindness and skill. Our Strategy for Safety cannot succeed without their continued dedication to those in their care. In opening our eyes to the one nurse who harmed, we must not forget the work of the many who are a credit to their professions.

I close by recalling the words of Pearl Buck, the author, who said:

> Our society must make it right and possible for [older] people not to fear the young or be deserted by them, for the test of a civilization is the way that it cares for its [vulnerable] members.

I call upon the Ontario government and all stakeholders in the long-term care system to consider the Recommendations in this report and to do their part in implementing them. If Ontario is to be measured, as Ms. Buck said, on how we care for our vulnerable members, then seize the opportunity presented by this Report to become the acknowledged national leaders in caring for those in the long-term care system.

Ladies and Gentlemen, thank you for coming today and for your kind attention as I publicly release the final Report of the Public Inquiry into the Safety and Security of Residents in the Long-term Care Homes System.

I will now turn the proceedings over to co-Lead Commission Counsel, Mark Zigler, who will take questions from the media.

Commissioner Eileen E. Gillese
July 31, 2019
Woodstock, Ontario