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

WRITTEN CLOSING SUBMISSIONS OF THE COLLEGE OF NURSES OF ONTARIO

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PART I. OVERVIEW

1. The College of Nurses of Ontario (the "College" or "CNO"), which regulates more than 175,000 nurses in Ontario, has an overarching statutory mandate to protect the public. This Inquiry was established to examine the conduct of one of the College's former members, Elizabeth Wettlaufer ("EW"). EW was a Registered Nurse ("RN"), and a member of the College from June 8, 1995 to July 25, 2017. Unbeknownst to the College, her employers, and her colleagues, she murdered eight of her patients, attempted to kill four others, and assaulted two others. EW's actions caused, and continue to cause, tremendous suffering to the victims' family members and communities. Her actions have also shaken Ontarians' trust in the healthcare system.

2. The evidence at this Inquiry demonstrated that the College acted appropriately, and in the public interest, in its interactions with EW based on the circumstances known to the College and its employees at the time. Nonetheless, at the outset of the Inquiry, the College also committed to being introspective about any lessons to be learned so as to prevent similar tragedies in the future. Consistent with that commitment, the College has already identified potential recommendations for change, and has already implemented several of those changes.

3. The College's submissions are designed to outline the factual findings that it requests the Commissioner to make based on the documents and testimony presented at the Inquiry. These submissions are also designed to offer specific proposed recommendations for change or, more generally, areas in which recommendations would assist in avoiding future criminal conduct by nurse serial killers. The College

looks forward to further dialogue about these and other recommendations during the policy phase of this Inquiry.

PART II. EVIDENCE AND SUGGESTED FACTUAL FINDINGS

A. The College

4. The College is the regulatory body for RNs, registered practical nurses and nurse practitioners in the province. The *Regulated Health Professions Act* (the "RHPA") and the *Health Professions Procedural Code* (the "*Code*")[1], and the *Nursing Act* and its regulations set out the relevant statutory scheme.[2]

5. The College's overarching statutory duty is to serve and protect the public interest. The statutory scheme requires the College to regulate its members in a manner that maintains the public's confidence that nurses are fit to practise. As part of this mandate, the College establishes requirements for entry to practice, articulates and promotes the profession's standards of practice, administers a quality assurance program, and enforces its standards of practice and conduct through education, remediation and discipline.[3]

B. Summary of the College's interactions with EW

6. In addition to her initial registration with the College in 1995, and annual renewals, the College interacted with EW during three time periods:

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[1] Exhibit 4, Legislation Brief, Tab 8(2), *Regulated Health Professions Act, 1991*, SO 1991, c 18 ("*RHPA*"), and the *Health Professions Procedural Code*, being Schedule 2 to the RHPA (the "*Code*"), FD0000005.

[2] Exhibit 4, Legislation Brief, Tab 6(2), *Nursing Act, 1991*, SO 1991, c 32, and its regulations, Exhibit 4, Legislation Brief, Tab 6(5), *General*, O Reg 275/94, and Exhibit 4, Legislation Brief, Tab 6(4) *Professional Misconduct*, O Reg 799/93, FD0000005. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5211, ln 17 – pg. 5212, ln 1.

[3] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5217, ln 2 – pg. 5221, ln 25; Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 16; Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 3, FD0000005.

(a) Between 1995 and 1998, as a result of a report from Geraldton District Hospital ("Geraldton Hospital") that it had terminated EW's employment.

(b) In 2014, as the result of a report from Caressant Care Woodstock ("CCW") that it had terminated EW's employment.

(c) Between 2016 and 2017, as a result of a report from the Centre for Addiction and Mental Health, and EW herself, relating to EW's confession to murdering eight patients under her care.

7. The College's suggested factual findings, in relation to each of these interactions are outlined below.

C. Complaint received from Geraldton District Hospital, 1995-1998

8. The College first learned of potential concerns about EW in September 1995. EW's employer, Geraldton District Hospital, reported to the College that EW collapsed at work after taking Lorazepam from the hospital medication stock without authorization, and ingested the pills during her shift. EW gave conflicting versions of the relevant events.[4]

9. This information raised concerns about EW's capacity to practise safely and thus engaged the College's Fitness to Practise processes, which are set out in the RHPA. These processes ensure that issues related to nurses' health do not affect their ability to practise safely.[5] Where possible, members can obtain necessary treatment, and be

[4] Exhibit 8, CNO Overview Report, Tab A, paras. 3-5; Exhibit 8, CNO Overview Report, Tab B, para. 5: Letter from Marlene Pavletic to Margaret Risk (CNO) dated November 2, 1995, LTCI00037176. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5324, ln 7 - ln 19.

[5] Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 109.

monitored and/or supervised in a manner that permits them to practise without compromising the protection and safety of the public.[6]

10. Indeed, mental health issues alone are not an indicator that a nurse is incapacitated within the meaning of the *Code*, let alone a serial killer. Many nurses (indeed health professionals more generally) have health issues and are able to practise safely. As Beatrice Crofts-Yorker opined, so long as a nurse is managing his or her mental health issues, "sometimes they make some of the best nurses".[7]

11. Based on the evidence at the Inquiry, the College submits that the Commissioner should find that the College's response to the concerns about EW's practice reported by Geraldton Hospital was in accordance with the statutory scheme, and that the College took appropriate measures to protect the public in the circumstances that presented themselves at that time.

12. Upon receiving this information from Geraldton Hospital, the College, as part of its investigation, obtained all relevant employment and health-related information through interviews and document requests.[8] This information, and EW's own admissions to the College, indicated that she was suffering from a health-related problem that may have affected her capacity to practise safely and effectively. On this

[6] Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 111.

[7] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 77, ln 7 – ln 13. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5315, ln 23 – pg. 5315, ln 6. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5999, ln 3 – ln 8.

[8] Exhibit 8, CNO Overview Report, Tab A, paras. 6, 9, 11, 12. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5328, ln 19 – ln 31; pg. 5333, ln 9 – pg. 5334, ln 32.

basis, EW's matter was referred to the College's Executive Committee for incapacity proceedings.[9]

13. The Executive Committee appointed a Board of Inquiry which directed EW to undergo two expert independent medical assessments:

(a) Dr. Graeme Cunningham, an addiction specialist, opined that EW was "an incapacitated nurse under the [*RHPA*], who since December of 1995 ha[d] made significant changes in her lifestyle and is demonstrably in recovery." In his view, she required "no further assessment or treatment" at that time, other than to continue attending her recovery groups, and continue to be monitored by an addiction specialist, Dr. Martyn Judson, with reports to the College.[10]

(b) Dr. Michael Ross, Occupational and Organizational Psychiatrist, reported to the College that EW suffered from Major Depressive Disorder, Single Episode of Moderate Severity in relation to the incident at Geraldton Hospital. However, in his view, there was no current indication of Mood Disorder and no need for treatment, and it was unlikely she would develop further depression. As a result, in his view, she was no longer ill from a

[9] Exhibit 8, CNO Overview Report, Tab A, para. 17. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5339, ln 19 – ln 31. A detailed explanation of the Fitness to Practise regime as it existed in 1995, and as it exists today, is set out in Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 109-137.

[10] Exhibit 8, CNO Overview Report, Tab A, para. 24; Exhibit 8, CNO Overview Report, Tab B, para. 22: Report of Dr. Cunningham, undated from an assessment conducted on June 14, 1996, LTCI00037188. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5341, ln 22 – pg. 5342, ln 23.

psychiatric standpoint, no active treatment was required, and her "return to work [was] realistic and safe".[11]

14. After the College received these independent medical reports, it nonetheless conducted a number of additional inquiries to determine the appropriate terms and conditions to place on EW's certificate of registration. The College inquired into EW's efforts at recovery, and ordered a second assessment by Dr. Cunningham to evaluate her progress.[12] All of this information informed the ultimate terms, conditions and limitations to be imposed, on consent, on EW's certificate of registration.

15. On May 9, 1997, the College's Fitness to Practise Committee found EW to be incapacitated within the meaning of the *Code*, by reason of alcohol dependence. The Committee imposed detailed, case-specific terms, conditions and limitations on EW's certificate of registration for a period of one year including that:

(a) her chemical dependency not interfere with her ability to practise nursing,

(b) she advise her current employer, and any subsequent employer that her certificate was subject to the conditions set out in the order;

(c) that she obtain and continue to obtain treatment from her addiction specialist;

[11] Exhibit 8, CNO Overview Report, Tab A, para. 25; Exhibit 8, CNO Overview Report, Tab B, para. 25: Letter from Dr. Ross to Shirin Perston (CNO), dated September 12, 1996, LTCI00037191. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5343, ln 3 – pg. 5344, ln 17.

[12] Exhibit 8, CNO Overview Report, Tab A, paras. 28, 30, 31-34, 36. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5344, ln 18 – pg. 5346, ln 9.

(d) that she notify her family doctor and addiction specialist of the order, and deliver their signed acknowledgments confirming they would notify the College in writing immediately if EW's chemical dependency may interfere with her ability to practise;[13] and

(e) the one-year period of the terms, conditions and limitations on EW's certificate could be extended if the College received information that EW had relapsed to the use of alcohol.[14]

16. The College's decision to allow EW to continue to practise, subject to terms, conditions and limitations on her practice was consistent with the accepted and important principle that a nurse with mental health issues can often safely practice, if those issues are properly managed.[15] In this case, the College imposed terms, conditions and limitations on EW's ability to practise which required her to continue treatment with health care professionals, who had agreed to monitor her and communicate with the College if there were any concerns. The College's decision also ensured that EW's employer during the relevant period was aware of the conditions imposed on her.

17. Throughout the one year monitoring period, the College directly contacted EW's employer and healthcare providers to confirm her ongoing compliance with the order.

[13] Exhibit 8, CNO Overview Report, Tab A, para. 38. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5349, ln 17 – pg. 5351, ln 17.

[14] In and around 1995-1997, monitoring terms were typically shorter, and in some cases where it was determined appropriate, may last for one year: Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 135.

[15] Evidence of Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8022, ln. 7 – ln 18; Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 111.

None reported any concerns that her chemical dependency was interfering with her ability to practise nursing safely.[16]

18. On May 29, 1998, the College wrote to EW to advise her that, having fully complied with the terms, conditions and limitations on her certificate, the College would no longer be monitoring her, and her certificate of registration no longer had any conditions attached to it.[17]

19. In accordance with the RHPA, the order of the Fitness to Practise Committee was available on the College's public register for six years from the time of the order, that is, until May 9, 2003.[18] The RHPA has since been amended, such that findings of incapacity are now recorded on the public registered indefinitely.[19]

20. The information collected by the College fully supported the decision it made in relation to EW's 1995 conduct. The decision should not be evaluated by employing hindsight – in particular, our current knowledge that many years after EW complied with the terms, conditions and limitations on her certificate of registration, EW began to kill patients under her care.

[16] Exhibit 8, CNO Overview Report, Tab A, paras. 39-40, 43. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5353, ln 9 – pg. 5357, ln 1.

[17] Exhibit 8, CNO Overview Report, Tab A, para. 44; Exhibit 8, CNO Overview Report, Tab B, para. 44: Letter from Tracy Raso (CNO) to EW dated May 29, 1998, LTCI00036837. Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5357, ln 2 – ln 21.

[18] Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, paras. 52-53. Evidence of Anne Coghlan, Day 24, July 25, 2018, ln 4 – ln 25.

[19] Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 23(2) (FD0000005). Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5452, ln 26 – pg. 5453, ln 4.

D. Mandatory report received from Caressant Care Woodstock, 2014

1. College's intake investigation

21. On May 1, 2014, the College received a report from EW's employer, CCW, by regular mail (the "Report"). CCW reported that it had terminated EW's employment a month earlier for having committed what it deemed to be "a medication error that resulted in putting a patient at risk".[20] In her evidence at the Inquiry, Brenda Van Quaetham, who authored the report, testified that CCW did not consider the Report to be urgent.[21] Indeed, the College's *Mandatory Reporting: A process guide for employers, facility operators and nurses* requires that a report be filed immediately where there is a concern that the nurse poses a continued risk.[22]

22. The Report identified 10 incidents involving EW between August 29, 2012 and March 20, 2014, which resulted in various disciplinary measures, and ultimately, the termination of her employment with CCW.[23] Seven of the incidents in the Report involved medication issues, although the nature and severity of the issues varied.[24]

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[20] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5385, ln 14 – pg. 5386, ln 2. Exhibit 8, CNO Overview Report, Tab A, para. 49; Exhibit 8, CNO Overview Report, Tab B, para. 49: Cover letter from Brenda Van Quaethem to the CNO dated April 17, 2014, attaching Report Form for Facility Operators and Employers from Caressant Care Woodstock, dated March 31, 2014, LTCI00036848; Report Form for Facility Operators and Employers from Caressant Care Woodstock, dated March 31, 2014, LTCI00036841. Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 586, ln 3 – ln 26. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5524, ln 8 – ln 10.

[21] Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 586, ln 3 – ln 26. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5553, ln 5 – ln 9.

[22] Exhibit 25, *Mandatory Reporting: A process guide for employers, facility operators and nurses*, LTCI00060161, pg. 4.

[23] Exhibit 8, CNO Overview Report, Tab A, para. 49; Exhibit 8, CNO Overview Report, Tab B, para. 49: Cover letter from Brenda Van Quaethem to the CNO dated April 17, 2014, attaching Report Form for Facility Operators and Employers from Caressant Care Woodstock, dated March 31, 2014, LTCI00036848; Report Form for Facility Operators and Employers from Caressant Care Woodstock, dated March 31, 2014, LTCI00036841.

[24] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5905, ln 11 – ln 28.

23. The College's Reports Intake Team reviewed the Report within 24 hours of receipt to determine whether it required urgent attention, in accordance with the College's practice.[25] The Team determined that the Report did not require immediate attention, and assigned the Report to Intake Investigator Karen Yee, RN, JD, on July 23, 2014.[26] Ms. Yee was an experienced investigator at the College who had previously worked as an RN in the mental health sector.[27]

24. Ms. Yee's primary responsibility as intake investigator was to assess the risk that EW posed to the public, and recommend the appropriate regulatory response to that risk.[28] Intake investigators such as Ms. Yee have no statutory power to compel evidence, in contrast to those appointed to conduct an investigation pursuant to s. 75 of the *Code*. In a s. 75 investigation, the *Code* provides that the investigator has the same powers as a commissioner under the *Public Inquiries Act*, namely, to summons documents, and require witnesses to give evidence.[29]

25. Ms. Yee reviewed the Report, as well as EW's history with the College, including the Geraldton Hospital incident. The College's file pertaining to the Geraldton Hospital incident was made available to Ms. Yee before she commenced her work. Ms. Yee identified the nursing issues raised by EW's conduct, and the health issues raised by her prior history. She reviewed and summarized the Report, and formulated questions

[25] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5369, ln 22 – ln 32; pg. 5522, ln 16 – pg. 5523, ln 23.
[26] Exhibit 8, CNO Overview Report, Tab A, para. 51; Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5860, ln 26 – pg. 5862, ln 2; pg. 5927, ln 21 – pg. 5928, ln 16; pg. 5985, ln 6 – ln 8.
[27] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5829, ln 15 – ln 22; pg. 5830, ln 11 – pg. 5831, ln 10; pg. 5833, ln 26 – ln 31; pg. 5960, ln 18 – pg. 5961, ln 4.
[28] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5369, ln 26 – pg. 5370, ln 3; pg. 5371, ln 6 – ln 17. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5978, ln 28 – ln 32.
[29] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5463, ln 20 – pg. 5465, ln. 3; Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 75, (FD0000005).

to ask Helen Crombez, CCW's Director of Nursing, in advance of the interview. CCW appropriately identified Ms. Crombez, EW's supervisor for the seven years EW worked at CCW, as the person to be contacted by the College.

2. Intake investigator's interview with CCW Director of Nursing

26. On July 30, 2014, Ms. Yee interviewed Ms. Crombez, by telephone, to discuss the Report.[30] As already indicated, consistent with Ms. Yee's practice, she had summarized the Report's contents, and formulated a list of questions in advance of the interview. Her questions were designed, in part, to elicit any concerns Ms. Crombez had about EW's nursing practice, including concerns that went beyond the incidents described in the Report.[31] Ms. Yee took contemporaneous notes of her conversation with Ms. Crombez. In her evidence, Ms. Crombez did not dispute that Ms. Yee's contemporaneous notes substantially reflected their conversation.[32] Accordingly, there is no material dispute over what Ms. Crombez reported to Ms. Yee about EW's practice.

27. However, Ms. Crombez testified that she believed she did not have EW's personnel file with her during her conversation with Ms. Yee and had not reviewed it prior their call.[33] Ms. Yee's evidence was uncontradicted that Ms. Crombez never told her that she did not have the file with her, or needed to review EW's file before speaking

[30] Exhibit 8, CNO Overview Report, Tab A, para. 51.

[31] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5909, ln 16 – ln 24.

[32] There were only two very minor changes that Ms. Crombez said should be made to the notes to make them completely accurate. Ms. Yee confirmed that these two changes would not have changed her assessment or recommendation or what she included in her memo to Ms. Coghlan. Evidence of Helen Crombez,Day 5, Jun 11, 2018, pg. 1122, ln 22 – pg. 1125, ln 23. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 6010, ln 22 – pg. 6011, ln 22.

[33] Evidence of Helen Crombez, Day 4, June 8, 2018, pg. 866, ln 23 – ln 26.

with Ms. Yee. Had Ms. Crombez said so, Ms. Yee would not have interviewed her at that time, and would have arranged another time to discuss the Report.[34]

28. There is no dispute from Ms. Yee's contemporaneous notes that she was aware of EW's prior health history, and the 1997 order of the Fitness to Practise Committee, although she did not specifically identify EW's alcoholism in her memorandum. Ms. Yee did not limit her questions of Ms. Crombez to potential concerns about alcoholism, which was EW's prime health issue in the Geraldton Hospital incident. Instead, recognizing that health issues can manifest themselves differently over time, she sought to determine if EW was experiencing any kind of health issue that affected her practice, be it related to drug addiction, alcohol or mood disorder.[35]

29. Accordingly, Ms. Yee asked Ms. Crombez questions to elicit whether EW was experiencing any health issues which currently affected her ability to practise safely. CCW did not suspect that EW was abusing alcohol or drugs.[36] Ms. Crombez told Ms. Yee that EW had a health condition for which she was on medication, and that EW had explained that one of the errors identified in the Report was a result of a change in her medication.[37] In Ms. Yee's opinion, this information alone did not suggest a concern about EW's capacity. Many nurses take medications. Concerns about capacity arise where there is evidence that a nurse is currently impacted by a health condition.[38]

[34] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5848, ln 6 – ln 29; pg. 5924, ln 10 – pg. 5925, ln 22.
[35] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5897, ln 23 – pg. 5900, ln 1.
[36] Evidence of Brenda Van Quaetham, Day 2, June 6, 2018, pg. 431, ln 12 – ln 24; Evidence of Helen Crombez, Day 5, June 11, 2018, pg. 962, ln 1 – ln 6.
[37] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5886, ln 27 – pg. 5887, ln 25.
[38] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5434, ln 29 – pg. 5435, ln 11.

Indeed, Ms. Crombez told Ms. Yee that there was "no underlying issue or concern about EW's ability to practise safely."[39]

30. As elaborated upon below, Ms. Yee was not advised of additional information known to CCW about EW, including a warning to EW that "if continued poor work performance related to health issues continue, consideration may be given to [a] report to the College of Nurses for 'fitness to practice for review'".[40] The information made available to Ms. Yee did not support a concern about incapacity. In fact, Ms. Crombez acknowledged that she did not think EW was incapacitated, incompetent or unfit to practise. It is therefore not surprising or unreasonable that Ms. Yee did not infer that incapacity or unfitness to practise was an issue.

31. Ms. Yee also asked Ms. Crombez about the concluding lines of the Report, that "[t]here were other reports from staff [about EW] that did not lead to discipline but were considered at time of [her] termination. These reports had to do with attendance, professional behavior." Ms. Crombez told Ms. Yee that the "professional behavior" related to EW's relationship with her colleagues,[41] and that ultimately EW always took responsibility for her errors and was respectful and nice[42] but just didn't change her

[39] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5886, ln 4 – pg. 5888, ln 3; pg. 5903, ln 13 – pg. 5904, ln 6; pg. 6015, ln 7 – ln 11. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5441, ln 5 – pg. 5442, ln 15.

[40] Exhibit 6, Overview Report: The Facilities and Agencies, Volume 5, Caressant Care Chronology and Documents, para. 84, LTCI00016823.

[41] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5889, ln 19 – ln 30.

[42] Ms. Crombez qualified this portion of Ms. Yee's note stating that it should have read that EW was "respectful and nice to me" (meaning Ms. Crombez): Evidence of Helen Crombez, Day 4, June 8, 2018, pg. 870, ln 11 – pg. 871, ln 1.

practice.[43] Although the incidents described in the Report did not invariably show that EW took ownership of every error committed, the Director of Nursing's evaluation of her responsiveness to errors overall figured prominently – and appropriately so – in Ms. Yee's evaluation, and ultimately in Ms. Coghlan's evaluation.

32. Ms. Yee did not have information that EW was working at Meadow Park at the time of her investigation, as that information had not been reported to the College. Ms. Yee specifically asked Ms. Crombez if to her knowledge, EW was working elsewhere. Ms. Crombez did not know if EW was working anywhere else. Had Ms. Yee been aware of EW's subsequent employer, she would have contacted Meadow Park.[44]

3. College's determination of appropriate regulatory response

33. Ms. Yee's investigation, which included her consideration of EW's previous history, and her recommendation was reviewed by both her colleagues on the Intake Review Team, and the College's Executive Director, Ms. Coghlan. On this basis, the College concluded that EW created a low risk to the public, and that a regulatory response was necessary.[45]

34. The College determines the appropriate regulatory response based on the risk that is posed by the member's practice.[46] The most forceful regulatory actions are used

[43] Exhibit 8, CNO Overview Report, Tab A, para. 51; Exhibit 8, CNO Report, Tab B, para. 51: Interview summary completed by Karen Yee (CNO) of telephone discussion with Helen Crombez, dated July 30, 2014, LTCI00036847.

[44] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5933, ln 23– pg. 5934, ln 9; Exhibit 8, CNO Report, Tab B, para. 51: Memo to File of Karen Yee (CNO), dated July 24, 2014 (Note: contains information from after this date): LTCI00034993; Interview summary completed by Karen Yee (CNO) of telephone discussion with Helen Crombez, dated July 30, 2014, LTCI00036847.

[45] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5858, ln 14 – pg. 5859, ln 8; Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5381, ln 12 – pg. 5383, ln 12; pg. 5446, ln 15 – ln 21.

[46] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5446, ln 2 – ln 7.

when there is the highest risk of harm to clients. The information that the College received from Caressant did not, taken together, indicate that EW's conduct fell at the higher end of risk. Generally, a remedial regulatory response assists in promoting a culture where nurses are willing to recognize and reflect on their errors, and identify opportunities to improve practice.[47]

35. The College determined that given the low risk created by EW, the appropriate response was a remedial one: to provide EW with a copy of the Report, remind her of her accountability as a member of the College, and direct her to review practice Standards relevant to the issues identified in the Report. She was also advised that the information in the Report would be retained on file and considered should further concerns come to the College's attention. The College refers to this as "banking" the information with notice. Ms. Yee recommended this regulatory response, with which both the Intake Review Team, and Ms. Coghlan, the College's Executive Director, agreed.[48]

36. On October 14, 2014, Ms. Coghlan, on behalf of the College wrote to EW to notify her that the College had received information from CCW about her nursing practice and conduct, and enclosed a copy of CCW's letter. The letter also noted that the Fitness to Practise Committee had previously reviewed a matter regarding her nursing practice and conduct.

[47] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5254, ln 11 – pg. 5255, ln 2.

[48] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5904, ln 7 – pg. 5905, ln 32. Memo to File of Karen Yee (CNO), dated July 24, 2014 (Note: contains information from after this date), LTCI00034993; Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5417, ln 7 – pg. 5432, ln 15; pg. 5446, ln 8 – pg. 5447, ln 29;

37. The College reminded EW of her professional accountability to practise safely, encouraged her to reflect on the practice issues that gave rise to the Report, review the applicable standards of practice, and continue her professional development.[49] Though the letter was intended to be remedial, and contained language consistent with a remedial approach, Ms. Coghlan's evidence was that typically nurses who receive such letters consider them to be a warning.[50]

38. The College urges the Commissioner to find that its regulatory response to the Report was appropriate in the circumstances that were reported by CCW. CCW, which was in the best position to assess EW's practice, did not report to the College that EW's practice posed a significant risk. Ms. Crombez, a senior, experienced nursing supervisor, advised the College that there was no underlying issue or concern about EW's practice, but that she just never changed her practice. Ms. Yee accurately captured CCW's views of EW at the time of her termination: namely, that she was not unfit, incapacitated or incompetent, but she just never changed her practice.[51]

39. In arriving at this remedial response, The College undertook its own risk analysis of each of the incidents CCW reported, which spanned a period of close to two years, and considered them to be low-risk.[52] There was no sustained harm, or serious risk of

[49] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5443, ln 4 – pg. 5445, ln 27; Exhibit 8, CNO Overview Report, Tab A, paras. 51-53; Exhibit 8, CNO Overview Report, Tab B, para. 53: Memo to File of Karen Yee (CNO), dated July 24, 2014 (Note: contains information from after this date), signed by Anne Coghlan on October 14, 2014, LTCI00036833; Letter from Anne Coghlan (CNO) to EW, dated October 14, 2014, LTCI00036840.

[50] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5443, ln 26 – ln 31.

[51] Evidence of Helen Crombez, Day 5, June 11, 2018, pg. 1122, ln 27 – pg. 1125, ln 23. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 6012, ln 24 – pg. 6014, ln 13.

[52] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5446, ln 15 – pg. 5447, ln 4.

sustained harm, to residents respecting any of the incidents.[53] Consistent with all of the evidence at this Inquiry, a remedial response is typically the appropriate response to what appeared to be genuine medication errors.[54]

40. Though the College considered CCW's disciplinary response to each of the reported events, the College was required to and did conduct a risk assessment of each incident, and the incidents as a whole, to determine the level of risk created by EW.[55] While EW's practice never improved to the employer's satisfaction, leading to termination of her employment, the information provided by CCW supported the College's assessment that her practice posed a low risk.[56]

41. The medication errors reported by CCW to the College were each different in kind. Without knowing about the medication errors that were not mentioned in the Report, it appeared that EW had not made the same medication error repeatedly. The medication errors were relatively minor and not uncommon, and were committed over a significant period of time.[57] These medication incidents did not suggest concerns about EW's ability to administer medication safely, as they were typical medication errors that

[53] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5436, ln 17 – ln 24.

[54] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5253, ln 28 – pg. 5255, ln 2; pg. 5267, ln 5 – pg. 5269, ln 16; pg. 5503, ln 2 – pg. 5505, ln 26. Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 565, ln 9 – ln 24. Evidence of Helen Crombez, Day 5, June 11, 2018, pg. 927, ln 10 – ln 18. Evidence of Karen Routledge, Day 7, June 13, 2018, pg. 1465, ln 16 – pg. 1466, ln 19. Evidence of Wanda Sangenesi, Day 12, June 21, 2018, pg. 2787, ln 2 – ln 23. Evidence of Dirk Huyer, Day 19, July 17, 2018, pg. 4536, ln 23 – ln 30; pg. 4538, ln 7 – pg. 4539, ln 19.

[55] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5875, ln 6 – ln 24.

[56] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5892, ln 25 – ln 24.

[57] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5905, ln 13 – ln 15.

were low risk and amenable to remediation through review of the College's standards, and attention to professional accountability.[58]

42. The incident which led to the termination of EW's employment (administering insulin to a resident belonging to another resident) was described as a mistake,[59] and again is a not uncommon medication error. Given the practical context of nursing in long-term care - typically nurses administer a high volume of medication in a busy and demanding environment - it is not uncommon for a nurse to borrow medication belonging to one resident where another resident requires that medication. Similarly, administering the wrong medication is a common medication error.[60]

43. Given EW's health history with the College, the College asked questions of CCW to determine whether there was an ongoing health issue that affected her practice, particularly in relation to the incident involving narcotics. However, none of the information provided by CCW suggested there was an ongoing health issue that affected her practice, and the narcotic incident appeared to represent a medication error for which EW received education.[61]

44. Critically, EW showed some insight and accountability in relation to the incidents.[62] In relation to the final incident, CCW reported that EW was upset, and showed remorse when she learned she had loaded the cartridge with the wrong insulin.

[58] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5447, ln 5– ln 15.
[59] EW knew that the medication she administered did not belong to that patient – so it was not a "mistake" in that sense – but mistakenly believed (at least as presented) that the medication was the same.
[60] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5862, ln 28– pg. 5866, ln 28; Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5418, ln 7 – pg. 5419, ln 12.
[61] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5441, ln 15 – pg. 5442, ln 19; Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5875, ln 25 – pg. 5877, ln 25.
[62] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5891, ln 23 – pg. 5892, ln 28.

Where a nurse shows remorse, as EW did for a number of the incidents, it suggests that the nurse is self-reflecting on her actions and is less likely to repeat her mistakes.[63]

45. The College's remedial regulatory response to the Report – to notify EW of the Report, remind her of her professional accountability, and advise her that the information would be retained and considered should further concerns come to the College's attention – is associated with a recidivism rate of just 12.4%. In other words, 12.4% of members who were the subject of a mandatory report that was banked with notice were the subject of a subsequent report. This recidivism rate is below the average recidivism rate for all reports.[64]

4. Information in EW's personnel file not disclosed by CCW to the College

46. Based on the Report and her conversation with Ms. Crombez, Ms. Yee believed that she had a complete understanding of CCW's concerns about EW's practice at CCW.[65] With hindsight, we know that Ms. Yee was not provided with a complete picture of EW's practice while at CCW. Ms. Crombez and Ms. Van Quaethem candidly acknowledged in their evidence that the Report was inadvertently misleading in a number of important respects:

(a) the number of incidents of workplace discipline involving EW,

(b) the time period over which they took place, and

[63] Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5865, ln 6 – ln 16; pg. 5867, ln 2 – ln 10.

[64] Exhibit 125, Recidivism of Nurses Subject to a Report from an Employer, LTCI00072873; Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5505, ln 3 – ln 26.

[65] Exhibit 8, CNO Overview Report, Tab B, para. 49: Report Form for Facility Operators and Employers, dated March 31, 2014, LTCI00036841. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5885, ln 19 – ln 25; pg. 6017, ln 2 – ln 22; pg. 6018, ln 24 – pg. 6019, ln 12.

(c) the nature of the incidents themselves, including the repetition of the same types of medication errors.[66]

47. Of particular concern, CCW did not report a number of incidents that raised fundamental issues about potential abuse of patients or recklessness as to their pain. Unreported incidents included the following:

(a) a report that EW punctured a resident's hematoma using unsterilized scissors,[67] which could potentially be abuse; the College would have expected this to be reported;[68]

(b) a report that EW moved a client with a suspected broken hip[69] could also potentially be abuse; the College would have expected this to be reported;[70] and

(c) an incident which suggested that EW may have had a health issue which could affect resident safety, about which the College would have made further inquiries.[71]

[66] Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 570, ln 13 – pg. 572, ln 9; pg. 576, ln 12 – ln 27. Evidence of Helen Crombez, Day 5, June 11, 2018, pg. 1103, ln 13 – pg. 1105, ln 16; pg. 1110, ln 30 – pg. 1111, ln 31.

[67] Exhibit 6, Overview Report: The Facilities and Agencies, Volume 5, Caressant Care Chronology and Documents, para. 63: Handwritten notes of Wendy MacKnott, PSW, LTCI00016873..

[68] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5494, ln 27 - pg. 5495, ln 7.

[69] Exhibit 6, Overview Report: The Facilities and Agencies, Volume 5, Caressant Care Chronology and Documents, para. 63: Handwritten notes of Wendy MacKnott, PSW, LTCI00016873.

[70] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5494, ln 27 - pg. 5495, ln 7.

[71] Exhibit 6, Overview Report: The Facilities and Agencies, Volume 5, Caressant Care Chronology and Documents, para. 84: Written notice regarding not assessing a resident as required when it was reported that the resident was apparently not herself, LTCI00016823.; Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5549, ln 15 - ln 28; pg. 5549, ln 15 - ln 28.

48. Professor Yorker described some of EW's behaviour that was not reported to the College as "reckless", meaning she had made a behavioural choice to consciously disregard a substantial and unjustifiable risk.[72] The kind of intentional behaviour, reckless behaviour, and abuse that EW may have engaged in, based on the face of CCW's documentary record, represents high risk behaviour that puts clients at risk, and would amount to professional misconduct.[73]

49. These incidents that were not reported to the College revealed to Ms. Coghlan, learning about them for the first time at this Inquiry, a pattern demonstrating a nurse who:

(a) was not caring,

(b) was intentionally engaging in behaviour that was not consistent with the standards of practice,

(c) engaged in activities that were not reflective of professional nursing practice,

(d) had a disregard for the care and compassion that would be expected of any nurse providing care to residents and/or clients,[74] and

(e) was not putting the safety and well-being of the client first.[75]

[72] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8116, ln 7 – ln 32; Exhibit 163, Expert Report of Beatrice Crofts-Yorker, pg. 93, "AONE Guiding Principles to Protect Patients from Reckless Behaviour by Registered Nurses", LTCI00072896.
[73] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5255, ln 12 – ln 23.
[74] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5499, ln 12 - pg. 5500, ln 21.
[75] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5501, ln 18 – ln 23.

50. These incidents were also inconsistent with CCW's statement at the end of the Report that there were other issues which had not resulted in discipline, when in fact there were many other incidents that had indeed resulted in discipline.[76]

51. It is submitted that CCW should have reported these incidents to the College. This would have affected the College's risk assessment, and may have led to a more significant regulatory response, including a s. 75 investigation.[77] That said, it is extremely unlikely that even if the College had conducted a s. 75 investigation of all the incidents known to CCW staff, it would have discovered that EW had intentionally killed patients in her care.

52. Indeed, the evidence is clear that no one who worked with her, including Ms. Crombez (her direct supervisor for seven years) and Ms. Van Quaethem who were aware of her entire personnel file, came to that conclusion.[78] Professor Yorker opined that the typical methods for detecting a healthcare serial killer, such as an increase in the number of deaths, were simply not available in EW's case. In the absence of some level of suspicion from those working with her, it was very difficult to detect her offences.[79]

53. In fairness, while the College submits that CCW should have reported critical additional information about EW's practice, it also acknowledges that the evidence at

[76] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5499, ln 12 - pg. 5500, ln 21.
[77] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5477, ln 26 – pg. 5478, ln 22; pg. 5482, ln 13 – pg. 5483, ln 10; pg. 5494, ln 20 – pg. 5495, ln 21; pg. 5499, ln 12 – pg. 5500, ln 21.
[78] Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 563, ln 25 – pg. 564, ln 2. Evidence of Helen Crombez, Day 4, June 8, 2018, pg. 779, ln 7 - ln 10. Evidence of Karen Yee, Day 26, July 27, 2018, pg. 5946, ln 30 – pg. 5957, ln 7; ln 19 – pg. 5958, ln 23; pg. 5950, ln 22 – pg. 5952, ln 10; pg. 5955, ln 2 – ln 18; pg. 5997, ln 7 – ln 31; pg. 5998, ln 6 – ln 29.
[79] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8014, ln 20 – pg. 8015, ln 8.

this Inquiry suggests that opportunities exist to improve the process by which mandatory reports are made to the College, to ensure that employers do not omit critical information.

5. Inaccuracy of CCW letter to the College, received October 18, 2016

54. On October 18, 2016, after CCW had learned of EW's crimes, and more than two years after it submitted the Report, the College received a letter from Carol Hepting, VP Operations at CCW. Ms. Hepting wrote that CCW wished to "restate" its position that EW was "unfit to safely practice nursing" and had "serious concerns regarding [her] ability to practice with an unrestricted license".[80] Within one day of receiving the letter, the College contacted Ms. Hepting and advised her that the College was aware of concerns about EW which had recently emerged (described in greater detail below).[81]

55. In her evidence at the Inquiry, Ms. Hepting confirmed that in "restating CCW's position," she was specifically referring to the position it had set out in the Report.[82] The termination Report does not state that EW was "unfit to practice nursing safely" -- nor does it state any "serious concerns regarding [her] ability to practice with an unrestricted license." Moreover, the evidence is undisputed that Ms. Crombez never told the College that EW was unfit to practise nursing, incompetent or incapacitated, or even that she or Ms. Van Quaetham believed that EW posed a continued risk to the public.[83] Indeed, Ms. Crombez, in good faith, communicated the opposite message to the College. The

[80] Exhibit 8, CNO Overview Report, Tab B, para. 61: Letter from Carol Hepting (Caressant Care) to CNO, dated October 14, 2016, LTCI00036259.

[81] Evidence of Carol Hepting, Day 16, June 27, 2018, p. 3750, ln 3 – ln 21.

[82] Evidence of Carol Hepting, Day 16, June 27, 2018, pg. 3752, ln 29 – pg. 3753, ln 17; pg. 3755, ln 20 – ln 25.

[83] Evidence of Carol Hepting, Day 16, June 27, 2018, pg. 3753, ln 24 – pg. 3755, ln 19. Evidence of Helen Crombez, Day 5, June 11, 2018, pg. 1117, ln 19 – pg. 1118, ln 5; pg. 1124, ln 16 – ln 24. Evidence of Brenda Van Quaethem, Day 3, June 7, 2018, pg. 561, ln 4 – ln 11.

College asks the Commissioner to find that CCW's 2016 letter did not represent a "restatement" of a position earlier communicated to the College that EW was unfit.

E. College's comments on other employers' interactions with EW

56. The College had no other interactions with EW, or any of her other employers, until it learned of her confessions in September 2016, as described below. The College submits, however, that the evidence at this Inquiry supports findings that Meadow Park London Long Term Care ("Meadow Park") and Lifeguard Homecare Inc ("Lifeguard") should have reported concerns about EW to the College. This submission is intended only to reinforce the need to ensure, going forward, that facilities and employers understand when they should report concerns surrounding a nurse.

1. Meadow Park's obligation to report EW to the College

57. The circumstances surrounding EW's resignation from Meadow Park raised concerns about her capacity to practise safely. When EW resigned on September 25, 2014, she wrote in her resignation letter that she had an illness that required long term treatment and that she would be "unable to work during this treatment and also unable to work as an RN following treatment."[84] Shortly after receiving her letter of resignation, Meadow Park learned that following her final shift at the facility, EW had been in hospital due to an overdose, that she had a substance abuse problem, and that she was going for treatment.[85] Meadow Park also learned that narcotics were missing, and

[84] Exhibit 6, Overview Report: The Facilities and Agencies, Volume 6, LTCI00017578, pg. 173, para. 112.

[85] Exhibit 43, Affidavit of Heather Nicholas, AFF00010, paras. 72, 79-80. Email from Heather Nicholas to Jennifer Brown, LTCI00017598. Evidence of Heather Nicholas, Day 10, June 19, 2018, pg. 2170, ln 29 – pg. 2174, ln 9; pg. 2183, ln 14 – pg. 2184, ln 17; pg. 2189, ln 11 – ln 23; pg. 2252, ln 14 – pg. 2254, ln 21. Evidence of Melanie Smith, Day 11, June 20, 2018, pg. 2426, ln 4 – ln 23; pg. 2443, ln 15 – ln 21; pg. 2474, ln 17 – ln 30.

EW was suspected in their disappearance. However, Meadow Park never reported EW to the College.[86]

58. Meadow Park is a "facility operator" within the meaning of the RHPA. The RHPA requires a facility operator to file a report with the College where it "has reasonable grounds to believe that a nurse who practises at the facility is incompetent, incapacitated, or has sexually abused a patient."[87] Ms. Coghlan's evidence was that she would have expected Meadow Park to report EW to the College, as the available information raised concerns about her capacity to practice safely.[88] The College submits that the Commissioner should find that Meadow Park was required to report EW to the College in October 2014.

2. Lifeguard Homecare's information about EW

59. In or around early January 2016, EW's employer at that time, Lifeguard Homecare, learned that EW was a recovering alcoholic who was drinking again.[89] Ms. Coghlan's evidence was that she would have expected Lifeguard to report that information to the College, though it was not a mandatory report under the RHPA. As Ms. Coghlan explained, this was information that the College needed to fulfill its public

[86] Exhibit 43, Affidavit of Heather Nicholas, AFF00010, paras. 79-80.

[87] Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 85.2(1), FD0000005.

[88] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5290, ln 19 – pg. 5293, ln 16; Day 24, July 25, 2018, pg. 5470, ln 6 – pg. 5472, ln 17; pg. 5815, ln 16 - pg. 5815, ln 6; pg. 5533, ln 6 – ln 23; pg. 5564, ln 3 – pg. 5565, ln 19; pg. 5566, ln 7 – ln 29. Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 85.2, FD0000005.

[89] Exhibit 6, Overview Report: The Facilities and Agencies =, Volume 7, pg. 190, para. 13: Email from Taryn Smith to Heidi Wilmot Smith and Louise Allard, January 4, 2016, LTCI00017401.

protection mandate: a nurse who was a recovering alcoholic and had relapsed could potentially put clients at risk.[90]

F. College's response to EW's Confessions, 2016

60. On September 29, 2016, Dr. Kahn, EW's psychiatrist at the Centre for Addiction and Mental Health reported to the College that EW had confessed to murdering eight patients.[91]

61. The College submits that its response to EW's confessions was appropriate in the circumstances.

62. In addition to Dr. Kahn, Intake Investigator Vicki Wolf spoke with EW's most recent employers, Lifeguard Homecare, and Saint Elizabeth Healthcare. Ms. Wolf also spoke to the police, and to EW herself.[92]

63. On September 30, 2016, Ms. Coghlan quickly appointed Ms. Remy Pearson as Investigator on an emergency basis.[93] That same day, September 30, 2016, EW emailed the College that she was no longer fit to practice nursing, had deliberately harmed patients, and that she was being investigated by the police.[94] On October 14, 2016, the College accepted EW's email of September 30, 2016 as a resignation of her

[90] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5291, ln 9 – ln 18.

[91] Exhibit 8, CNO Overview Report, Tab A, para. 56. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5448, ln 3 – ln 8.

[92] Exhibit 8, CNO Overview Report, Tab A, para. 56.

[93] Exhibit 8, CNO Overview Report, Tab A, para. 57. Exhibit 8, CNO Overview Report, Tab B, para. 57: Memo from Vicki Wolf (CNO), dated September 30, 2016, LTCI00036850; Executive Director's Report, dated September 30, 2016, LTCI00036869; Appointment of Investigator Remy Pearson (CNO), dated September 30, 2016, LTCI00036248. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5448, ln 13 – ln 16.

[94] Exhibit 8, CNO Overview Report, Tab A, para. 57; Exhibit 8, CNO Overview Report, Tab B, para. 56: Email from EW to Investigations-Intake (CNO), dated September 30, 2016, LTCI00036232.

certificate to practise nursing and updated its Public Register to reflect that EW was no longer entitled to practise nursing.[95] The College had already taken these steps before receiving Ms. Hepting's letter on October 18, 2016.

64. At the time of EW's confessions, the College did not have the statutory power to immediately suspend or impose terms on EW's certificate of registration. However, the RHPA was amended in May 2017. Now, the Inquiry, Complaints and Reports Committee ("ICRC") can make an interim order suspending a member's registration prior to referral to the Discipline Committee or the Fitness to Practise Committee if the ICRC is of the opinion that the member's conduct exposes or is likely to expose his or her patients to harm or injury.[96] In other words, if EW's confessions were to occur today, the College would be able to almost immediately suspend her certificate of registration.[97]

65. In the months following her confession, the College investigated EW's practice; however, it limited its investigation at the request of the Assistant Crown Attorney so as to not interfere with the criminal proceedings.[98]

66. On June 22, 2017, following EW's conviction, the College's Inquiries Complaints Referral Committee referred specified allegations of misconduct to the Discipline

[95] Exhibit 8, CNO Overview Report, Tab A, paras. 59-60; Exhibit 8, CNO Overview Report, Tab B, para. 60: Screen shot of the CNO's Public Register, dated October 14, 2016, LTCI00071068. Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5449, ln 17 – pg. 5450, ln 15.
[96] Exhibit 4, Legislation Brief, Tab 8(2), *Code,* s. 25.4, s. 62, FD0000005.
[97] Evidence of Anne Coghlan, Day 24, July 25, 2018, pg. 5448, ln 17 – pg. 5449, ln 16.
[98] Exhibit 8, CNO Overview Report, Tab A, paras. 59, 62-64, 66.

Committee.[99] The Discipline Committee revoked EW's certificate of registration on July 25, 2017.[100]

67. Once EW confessed to her crimes, it was clear to the College that she would not be practicing nursing, and thereby creating a further risk to the public. Nonetheless, the College took immediate steps to appoint an investigator under s. 75 of the *Code* to investigate her practice, treated EW's correspondence as a resignation, and updated the public register to make clear that she could not practice nursing.

G. College's relationship with the Ministry of Health and Long-Term Care

68. There is currently no statutory requirement that Ministry of Health and Long-Term Care ("MHLTC") inspectors make a report to the College with respect to a nurse, unless the inspector is also a member of the College (or another regulated health profession), and the inspector has reasonable grounds to suspect a member of the College has sexually abused a patient.[101]

69. The MHLTC does not currently provide formal guidance to inspectors on circumstances where concerns about a nurse's practice should be reported to the College.[102] However, a number of inspectors testified about an informal practice that exists where they identify an issue with a nurse's practice. In such cases, the inspector will raise the concern with the nurse's employer to ensure a report has been made to

[99] Exhibit 8, CNO Overview Report, Tab A, para. 71.
[100] Exhibit 8, CNO Overview Report, Tab A, paras. 67-69, 71-72. Exhibit 8, CNO Overview Report, Tab B, para. 67: Executive Director's Report, dated March 7, 2017, LTCI00036425; Tab B, para. 69: Executive Director's Report, dated April 12, 2017, LTCI00036430; Tab B, para. 71: Decision of the Inquiries, Complaints and Reports Committee, dated June 22, 2017, LTCI00036830; Tab B, para. 72: Decision of the Discipline Committee (unsigned), LTCI00065375.
[101] Exhibit 4, Legislation Brief, Tab 8(2), *Code*, s. 85.1, FD0000005. Evidence of Karen Simpson, July 30, 2018, Day 27, pg. 6288, ln 24 - pg. 6289, ln 2.
[102] Evidence of Karen Simpson, Day 28, July 31, 2018, pg. 6366, ln 24 – ln 28.

the College. If the inspector remains concerned that an employer has not reported that nurse to the College, he or she will raise the issue with their manager. Ultimately, a member of the inspections branch (either the manager or the inspector himself or herself) may make a report directly to the College.[103]

70. During MHLTC's inspection at Meadow Park in 2014, Rhonda Kukoly, an RN and inspector, learned that EW was suspected in the disappearance of narcotics, and that EW had indicated to Meadow Park that she was unable to work as a nurse going forward due to a medical condition. While Ms. Kukoly described this information as "concerning", she felt that any risk at the home no longer existed because EW had resigned.[104]

71. The RHPA did not require Ms. Kukoly to make a report. However, Ms. Kukoly testified that she would typically suggest to facilities that they report a member to the College where she acquired information that suggested a capacity issue. Ms. Kukoly candidly acknowledged that she did not suggest Meadow Park report EW to the College, but that in hindsight, she wished she had.[105] The Inspections Branch's former director, Karen Simpson, testified that she would have expected Meadow Park to report this incident to the College.[106]

[103] Evidence of Karen Simpson, Day 27, July 30, 2018, pg. 6289, ln 3 – ln 16; Day 28, July 31, 2018, pg. 6364, ln 6 – ln 20. Evidence of Rhonda Kukoly, Day 29, August 1, 2018, pg. 6739, ln 10 – p. 6740, ln6; Day 30, August 2, 2018, pg. 6855, ln 10 – pg. 6857, ln 29.
[104] Evidence of Rhonda Kukoly, Day 29, August 1, 2018, pg. 6736, ln 17 – pg. 6737, ln 7.
[105] Evidence of Rhonda Kukoly, Day 29, August 1, 2018, pg. 6738, ln 30 – pg. 6739, ln 9.
[106] Evidence of Karen Simpson, Day 28, July 31, 2018, pg. 6367, ln 7 - ln 12.

H. Measures taken by the College since EW's confessions

72. After learning of EW's offences, the College has been introspective in considering how it might assist in preventing similar offences in the future. While awaiting the Inquiry's recommendations, the College has begun to consider how it can improve its processes to identify risk factors relating to patient harm so as to inform its decision-making.

73. To this end, the College undertook a literature review related to serial killers, with a particular emphasis on health care serial killers. The College summarized and analyzed how the evidence cited in this literature can be integrated into its existing processes. The summary has been circulated to College staff to ensure they are all alive to this phenomenon, and that they understand potential risk factors that might inform their work at the College. The College has also identified future short-term and long-term work to better improve its processes.[107] Professor Yorker's enthusiastic reaction to the memorandum was "applause".[108]

PART III. SUGGESTIONS ON RECOMMENDATIONS SO THAT SIMILAR OFFENCES MIGHT BE AVOIDED IN THE FUTURE

74. While the College submits that its regulation of EW's nursing practice was appropriate, based on the circumstances which presented themselves at the time, including the information that was reported to the College, the College looks forward to the opportunity to assist the Commissioner in recommending systemic changes:

(a) within its own processes,

[107] Exhibit 128, "Memo: Identifying risks: Learnings from the literature on health care serial killers", LTCI00072834.

[108] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8144, ln 25 – ln 26.

(b) in its partnerships with employers, facility operators, and the MHLTC, and

(c) through legislative amendment that will help to detect and deter nurse serial killers.

75. The proposals below are not exhaustive and are high level. The College looks forward to discussing these suggestions, and other proposals, with the Commissioner and her team, and the other participants, during the policy phase of the Inquiry.

A. The College's intake process

76. In 2017, the College received 323 complaints and 810 reports about nursing conduct.[109] So far in 2018, the number of reports the College receives has doubled.[110] Given this volume of reports, the College's intake process is designed to ensure that intake investigations are conducted as quickly as possible, and readily identify high risk behaviour.

77. As described above, the College has already begun to integrate the literature relating to health care serial killers into its processes. The College has provided a detailed memo to all of its investigators that identifies the key features of the literature, so that that they are alive to potential risk factors in the course of their work at the College. The College suggests that it continue to explore how evidence-based risk analysis can better inform its processes.

78. In accordance with Professor Yorker's recommendation, the College has begun to share its research with other healthcare regulators in Canada, the United States and

[109] Exhibit 121, Affidavit of Anne Coghlan, LTCI00072640, para. 71.
[110] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5235, ln 9 - ln 13.

internationally.[111] The College anticipates and hopes that its research to date, along with this Inquiry's report and recommendations, will foster a larger discussion amongst regulators about how to identify predictors of serious patient risk.

B. Improvements to the College's partnerships with stakeholders

79. Employers and facility operators are key partners for the College in ensuring that nurses provide safe and ethical care that is consistent with the standards of practice. The College recognizes it can assist employers and facility operators in meeting their reporting obligations under the Code, though employers and facility operators ultimately bear the statutory responsibility to comply with those obligations. With 13,000 different employers of 175,000 nurses in Ontario, practicing in a broad variety of practice settings ranging from large facilities to single employers, the College recognizes that an employer may inadvertently fail to alert the College about all of its safety concerns about a member's practice.[112]

80. To this end, the College welcomes recommendations to better ensure that reports to the College fully and accurately capture information relevant to the assessment of risk. In particular, the College would welcome the Commissioner's consideration of recommendations:

(a) to enhance the intake interview process, to ensure that reporters are aware of the purpose of the intake investigator's call, and have all relevant information available at the time of the call. The College has already begun to implement these initiatives;

[111] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8145, ln 5 - ln 8.
[112] Evidence of Anne Coghlan, Day 23, July 24, 2018, pg. 5232, ln 10 - ln 13.

(b) suggesting revisions to the College's *Mandatory Reporting: A process guide for employers, facility operators and nurses* to clarify the kind of information that should be included in a mandatory report form, and employers' reporting obligations;

(c) that the reporter, upon submitting a report, sign a declaration acknowledging that:

(i) the reporter understands and has complied with his or her reporting obligations, and

(ii) that the contact person identified is familiar with the member's practice, and is the appropriate contact person; and

(d) that employers be required to submit any termination letters along with reports to the College.

81. The College also suggests that the Commissioner consider requiring the College to include on its public register additional information about members' employment history, in particular:

(a) all of a member's current employers on the public register (presently only primary employers are available); and

(b) a member's previous employment history for a specified period.

82. The College welcomes the Commissioner's recommendations as to the length of previous employment history to be posted. The College recognizes that while this

information would assist employers in identifying additional areas for inquiry, these needs must be balanced against fairness to individual nurses. This information would not, however, be a substitute for employers' conducting their own due diligence when making hiring decisions.

83. The MHLTC is another key partner for the College in ensuring patient safety. The College suggests that it continue to collaborate with the MHLTC to identify shared areas of risk, and in particular on formulating specific guidance for Ministry inspectors in identifying when a report should be made to the College.

C. Suggestions for legislative change

84. The College suggests that the Commissioner consider recommending the following legislative amendments.

85. First, the RHPA should be amended to include whistleblower protection for health professionals making non-mandatory reports directly to the College in good faith. Professor Yorker testified that whistleblower protections can be very effective, and that there have been convictions of healthcare serial killers or prosecutions based on whistleblowers' reports.[113]

86. Second, s. 36 of the *Code* should be amended to enable the College to share information with employers about a member prior to the conclusion of an investigation in circumstances where the College has information that a nurse poses a serious risk to patient safety. Section 36 provides that the College must keep confidential all

[113] Evidence of Professor Beatrice Crofts-Yorker, Day 35, September 12, 2018, pg. 8044, ln 2 – pg. 8045, ln 14.

information that comes to its knowledge in the course of its duties, subject to certain enumerated exceptions.[114] As a result of s. 36, the College cannot currently share information that a member causes a potential risk to the public until the ICRC imposes an interim order, or the matter is referred to the Discipline Committee.

87. Third, the distinction in the *Code* between facility operators and employers should be removed, such that the mandatory reporting obligations for both are the same. The evidence at this Inquiry suggested a troubling amount of confusion as to the mandatory reporting obligations, some of which related to this distinction. Ultimately, to the extent a facility operator or employer has information suggesting that the College should assess the level of risk posed by a member's practice to the public, they should be required to report this information to the College.

88. Finally, legislative amendments should be made to allow the College to access the identity of nurses named in MHLTC inspections reports. Currently, inspection reports redact nurses' names, and the College must make a Freedom of Information request to obtain this information from the Ministry where the information raises issues of concern to the College. This is an unnecessarily cumbersome process that significantly delays the College's ability to identify nurses whose conduct creates a risk of harm.

89. The College looks forward to further dialogue about these and other suggested recommendations during the policy phase of the Inquiry.

Doc 2634656

[114] Exhibit 4, Legislation Brief, Tab 8(2),*Code*, s. 36, FD0000005.