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

REPORT

The Honourable Eileen E. Gillese
Commissioner

Volume 1 – Executive Summary and Consolidated Recommendations

Volume 2 – A Systemic Inquiry into the Offences

Volume 3 – A Strategy for Safety

Volume 4 – The Inquiry Process

Ontario

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

July 31, 2019

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

Dear Mr. Attorney:

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

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

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

Yours very truly,

Eileen E. Gillese
Commissioner

400 University Avenue
Suite 1800C
Toronto, Ontario M7A 2R9
info@longtermcareinquiry.ca

400 Avenue University
Bureau 1800C
Toronto (Ontario) M7A 2R9
info@longtermcareinquiry.ca

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

REPORT

The Honourable Eileen E. Gillese
Commissioner

Volume 1 – Executive Summary and Consolidated Recommendations

Volume 2 – A Systemic Inquiry into the Offences

Volume 3 – A Strategy for Safety

Volume 4 – The Inquiry Process

This Report consists of four volumes:

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

ISBN 978-1-4868-3584-3 (PDF)
ISBN 978-1-4868-3580-5 (Print)

Disponible en français

VOLUME 1

Contents

Dedication

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

Executive Summary

I. Introduction

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

Wettlaufer committed all but the last Offence in licensed, regulated, long-term care (LTC) homes in southwestern Ontario. She committed the last Offence in a private home where she was providing publicly funded nursing care.

Until the Offences came to light, there was nothing remarkable about Wettlaufer. She was born on June 10, 1967, and raised in a town in southwestern Ontario. After graduating from high school, she tried a few different college programs before settling on nursing as a career. She became a registered nurse and a member of the College of Nurses of Ontario in 1995. She was a nurse for 22 years, during which time there were "ups and downs" in her personal life and in her work life. In her personal life, she faced issues common enough today – failed relationships, a search for her sexual identity and acceptance of it, mental health challenges, and substance addiction. In her work life, at times she enjoyed success and at other times she was viewed as sloppy, lazy, and prone to making insensitive and inappropriate comments to her colleagues.

In September 2016, the veneer of an apparently normal life was stripped off by Wettlaufer herself. She abruptly resigned from her nursing job and checked herself into the Centre for Addiction and Mental Health in Toronto. There she announced to her treating psychiatrist that, over the previous nine years, she had harmed and killed a number of people in the course of her nursing practice by injecting them with insulin overdoses. Without the benefit of notes or documentation of any kind, Wettlaufer then handwrote a four-page confession in which she set out the details of the Offences. Shortly thereafter, she voluntarily met with police, gave them her handwritten confession, and answered their questions. After the police investigated her claims, she was charged.

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

In June 2017, Wettlaufer was convicted of the Offences and sentenced to life in prison with no chance of parole for 25 years.

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

This public inquiry was established to find answers to these questions.

II. Setting the Stage

Four myths repeatedly surfaced during this Inquiry. These myths seriously distort the nature of the problem that the Offences represent and must be debunked, once and for all.

Myth 1: The Offences were mercy killings.	NOT TRUE
Myth 2: The pressures on the long-term care system will pass, once the baby-boom generation is gone.	NOT TRUE
Myth 3: The threat that Wettlaufer represents is gone because she is in jail, serving a life sentence.	NOT TRUE
Myth 4: The Offences caused only limited harm.	NOT TRUE

A. The Offences Were *Not* Mercy Killings

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

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

No one has the right to define the value and meaning of someone else's life and decide when it is time for that life to be over. This statement is particularly true for healthcare providers, who have been given the privilege and power of caring for us. The vulnerable members of our communities who rely on the long-term care system have lives with value and meaning for them and their loved ones. It is their right – and our collective obligation – to ensure that they live out their lives in safety and security, and with dignity.

B. Long-Term Care Is *Not* a Baby-Boom Problem

Like the rest of Canada, Ontario's population is aging. One primary reason for this aging is the life trajectory of the baby-boom generation, who were born between 1946 and 1965. On its own, the aging of the baby-boomers would present a self-limiting challenge. However, Ontario's population redistribution is also due to increasing life expectancy and low birth rates dating back to the 1970s. The trend of older Canadians making up a significant proportion of the overall population will therefore continue long after the influence of this postwar generation has passed.

Further, the demands facing the long-term care system result not simply from the sheer number of older Ontarians. They are also a function of the rising acuity (level of care needed) of older Ontarians: people are living longer, and their later years are often accompanied by cognitive and physical impairment. Despite the supports that facilitate aging at home, some older Ontarians require more care than can be provided in their homes. Those requiring constant care or monitoring may become residents in long-term care homes.

In 2019, Ontario's 626 long-term care homes provided 78,667 beds for residents.[2] The long-term care home resident population is undeniably one of high needs. The vast majority of residents have some form of cognitive impairment and physical frailty, along with chronic health conditions

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

that have compromised their well-being. In 2017–18, 90% of residents in long-term care homes had some form of cognitive impairment, and 86% needed extensive help with activities such as eating or using the washroom.[3] The numbers of residents with cognitive impairments and those who require extensive or complete support with everyday activities are steadily increasing.[4]

Ontario's population redistribution and the increasing acuity of older Ontarians are facts of modern life. We cannot dismiss the challenges that these matters pose for the long-term care system on the basis that they will disappear with time.

C. The Threat Has *Not* Passed

The murders Elizabeth Wettlaufer committed while working as a nurse are shocking and tragic. However, they are not unprecedented. 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. Expert evidence presented in this Inquiry shows that since 1970, 90 healthcare serial killers have been convicted throughout the world, including in Canada, the United States, and Western Europe.[5] Even during this Inquiry, the media reported the arrests of two more alleged healthcare serial killers. In July 2018, a British healthcare worker was arrested on the suspicion that she had murdered eight babies and tried to kill six others while she worked at the Countess of Chester Hospital in northwestern England.[6] Days later, there were reports that a Japanese nurse had been arrested on the suspicion that she injected disinfectant into intravenous bags, killing approximately 20 elderly patients in her care at a Yokohama hospital.[7]

---

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

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

5 Except where otherwise indicated, the Expert Report of Professor Beatrice Crofts Yorker Schumacher, May 27, 2018, is the source of information in this section.

6 "U.K. police arrest health care worker on suspicion of baby murders," *Associated Press*, July 3, 2018, https://www.ctvnews.ca/world/u-k-police-arrest-health-care-worker-on-suspicion-of-baby-murders-1.3997617 [accessed March 14, 2019].

7 Julian Ryall, "Japanese nurse investigated over 20 killings at end of shifts to avoid 'nuisance' of telling families of deaths," *Telegraph*, July 10, 2018, https://www.telegraph.co.uk/news/2018/07/10/japanese-nurse-investigated-20-killings-end-shifts-avoid-nuisance/ [accessed March 14, 2019].

Healthcare serial killer cases began to be documented in the 1850s – at the same time that advances in medical technology, such as improvements to the syringe and the refinement of opium into morphine, made it easier for healthcare workers to kill patients surreptitiously. However, it was not until 1970 that healthcare serial killer cases began to be more systematically uncovered and documented. Documented cases since then show that the healthcare serial killer phenomenon goes beyond a few shocking, isolated incidents. Professor Crofts Yorker, an expert on the healthcare serial killer phenomenon, was retained to give evidence in this Inquiry. In preparing her expert report, Professor Crofts Yorker reviewed the cases of 131 healthcare providers who, between 1970 and May 2018, had been prosecuted for serial murders and/or assaults of patients in their care. These cases took place in 25 countries, primarily in Western Europe and the United States. Of the 131 healthcare providers who were prosecuted, 90 were convicted.

Professor Crofts Yorker acknowledges that the number of healthcare serial killers is quite small, as is the number of serial killers generally. However, while the known number of healthcare serial killers is small, the number of victims is not. The 90 healthcare serial killers convicted since 1970 have been found guilty of murdering at least 450 patients. They have also been convicted of assault or grave bodily injury involving at least 150 other patients. But, according to Professor Crofts Yorker, those figures significantly understate the actual number of victims: the total number of suspicious deaths attributed to the 90 convicted healthcare serial killers exceeds 2,600.

Furthermore, after the prosecution of a healthcare serial killer is complete, it is not unusual for the number of deaths linked to a particular HCSK to be revised upward. For example, German nurse Niels Högel was sentenced in 2008 for attempted murder. In 2015, he was sentenced to life for two murders and for several attempted murders. In August 2017, the police concluded there was evidence that Högel was responsible for the deaths of at least 90 patients.[8] In November 2017, the total number of victims attributed to Högel was revised to 106, with further suspicious deaths still under investigation.[9] In January 2018, German prosecutors charged Högel with the

8 "German nurse suspected of murdering at least 90 patients," *Guardian*, Aug. 28, 2017, https://www.theguardian.com/world/2017/aug/28/german-nurse-niels-hoegel-suspected-murdering-90-patients [accessed March 14, 2019].

9 "Un infirmier allemand soupçonné d'une centaine de meurtres," *Le Monde*, Nov. 9, 2017, https://www.lemonde.fr/europe/article/2017/11/09/un-infirmier-allemand-soupconne-d-une-centaine-de-meurtres_5212789_3214.html [accessed March 14, 2019].

murder of 97 additional patients.[10] Högel subsequently admitted to killing these patients.[11] Investigators and prosecutors ultimately indicated he may have killed more than 200 people. Dr. Harold Shipman, a British physician, is another such example. Shipman was convicted of murdering 15 patients in 2000.[12] A public inquiry concluded that he had in fact killed 215 of his patients over the course of his career, and it identified a further 45 deaths associated with Dr. Shipman as suspicious.[13]

In this Inquiry, questions also arose, after Wettlaufer was convicted, as to whether she had committed additional crimes. While in prison for the Offences, Wettlaufer told prison staff that she had harmed two other residents in LTC homes. Police investigated the two other disclosed incidents but laid no charges in relation to them.

In conclusion, the fact that Wettlaufer is behind bars does not mean that we are safe from healthcare serial killers – it means only that we are safe from her.

[10] "Jailed German serial killer charged with 97 new counts of murder," *USA Today*, Jan. 23, 2018, https://www.usatoday.com/story/news/world/2018/01/23/jailed-german-serial-killer-charged-97-new-counts-murder/1056823001/ [accessed March 14, 2019].

[11] "German nurse admits to killing 100 patients as trial opens: Niels Hoegel, already serving 15 years, has been accused of deliberately overdosing victims," Guardian, Oct. 30, 2018, https://www.theguardian.com/world/2018/oct/30/german-nurse-serial-killer-niels-hoegel-on-trial-100-patients-deaths [accessed March 13, 2019].

[12] Great Britain, Shipman Inquiry, *The Shipman Inquiry: First Report* (Manchester: Shipman Inquiry, [2002]), p 16, para 1.48 (Dame Janet Smith, chair).

[13] *Shipman Inquiry: First Report*, p 3, para 22. See also *The Shipman Inquiry: First Report*, p 198, paras 14.6–14.7, discussing a statistical review of Shipman's clinical practice, published by Professor Richard Baker in 2001. The large number of suspicious deaths is supported by the conclusions of Professor Baker, who compared the death rates among Dr. Shipman's patients with those of other comparable general practitioners. Professor Baker estimated that the number of excess deaths "about which there should be concern" was likely 236, which is very close to the 215 killings found by the inquiry, particularly if some of the 45 additional "suspicious" deaths were in fact killings.

D. The Harm Is *Not* Limited

The suffering and harm the Offences caused is greater than can be imagined.

1. The Victims

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

Clotilde Adriano[14]

Albina deMedeiros[15]

James Silcox

Maurice Granat

Wayne Hedges

Michael Priddle

Gladys Millard

Helen Matheson

Mary Zurawinski

Helen Young

Maureen Pickering

Arpad Horvath

Sandra Towler

Beverly Bertram

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

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

2. The Surviving Victim and the Victims' Families and Loved Ones

The only surviving victim who can communicate has been profoundly affected by the attack on her in her own home. Her description of the physical and psychological effects of the insulin overdose is horrifying: she was doubled over and moaning in pain and thought she was dying. She became afraid to go to bed at night and afraid to have visitors. Her personal relationships suffered.

The victims' family members and loved ones continue to struggle with feelings of sadness, anger, guilt, grief, anxiety, fear, depression, and betrayal. Some have lost trust in healthcare professionals, people in positions of authority, and the government. Others have withdrawn from family and friends, and most have difficulty eating, sleeping, and focusing.

3. The Immediate Communities

The shock and horror caused by the Offences radiated in waves outward from the victims and their families. Many residents in the long-term care homes in which the Offences were committed became fearful, as did their families. Those who worked with Wettlaufer in the homes were shattered. They feel shame over what happened and guilt at not preventing it. Those in the Ministry of Health and Long-Term Care responsible for long-term care homes, and the inspectors tasked with conducting inspections in them, were sickened.

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

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

4. The Broader Community

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

III. The Inquiry

A. Mandate and Purpose

This Inquiry had a two-year lifespan. It was established on August 1, 2017, pursuant to the *Public Inquiries Act, 2009*,[16] and Order in Council 1549/2017 (OIC). The OIC set July 31, 2019, as the deadline by which I was to deliver a report to the Attorney General on the Inquiry's activities, complete with recommendations on how to prevent similar tragedies.

The Commission mandate is set out in paragraph 2 of the OIC: it is to inquire into the events that led to the Offences, and the circumstances and contributing factors that allowed them to be committed. The OIC is clear that the Inquiry's overarching obligation is to make recommendations on how to avoid similar tragedies in the long-term care system. It is important to note the specificity of the tasks that the Inquiry was to fulfill. The Inquiry was not tasked with conducting a general review of the long-term care system, nor was it asked to make recommendations on how LTC homes or the LTC system might be improved more generally. Its job was to inquire into the Offences; determine how they were committed over such a long period, without detection; and make recommendations on how to avoid similar tragedies in the future.

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

B. Process

The Inquiry's work was conducted in two parts. Part 1 fulfilled the Commission mandate to inquire into the Offences and uncover the truth of what happened. It laid the factual foundation on which part 2 rested. The goal of part 2 was to develop recommendations on how to avoid similar tragedies in the long-term care system.

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

[16] SO 2009, c 33, Schedule 6.

Commission counsel then conducted investigations into five areas:

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

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

Part 1 culminated in the public hearings in which Commission counsel presented the results of their investigations through both documentary evidence (primarily through Overview Reports) and the testimony of some 50 witnesses. The hearings ran for 39 days between June and the end of September 2018. In the hearings, Commission counsel led the evidence, and the 16 Participants,[17] most of whom had their own counsel, tested and supplemented it.

All but three days of the public hearings – those devoted to expert and technical evidence – were held in the Elgin County courthouse in St. Thomas, Ontario. I chose that location because it was close to the communities in which the Offences had been committed, making it easier for those most directly affected by the Offences to attend in person. A live webcast of the public hearings was accessible through the Inquiry website, making it possible for people to watch the hearings without having to attend in person. The recordings remained on the website until January 2019. Transcripts of the public hearings were also posted on the Inquiry website.

[17] Previous public inquiries have framed the rights of third parties to be involved in the work of the inquiry, particularly its public hearings, as "standing." In accordance with section 15 of the *Public Inquiries Act, 2009*, I approached this matter as the right to participate. Consequently, those given the right to participate in the Inquiry's public hearings were called the Participants.

The Inquiry commissioned expert reports from Professor Beatrice Crofts Yorker and Ms. Julie Greenall. Dr. Michael Hillmer provided technical expertise. The expert and technical evidence was heard in three days of public hearings in Toronto. Professor Crofts Yorker gave expert evidence on the phenomenon of healthcare serial killers. Ms. Greenall offered expert evidence on best practices in safe medication storage, administration, and auditing / tracking. Dr. Hillmer provided technical evidence on work under way in the Ministry of Health and Long-Term Care on data analytics and trend analysis for mortality rates in long-term care homes.

In part 2, Commission researchers looked to other parts of Canada and the world to learn about healthcare serial killers, different approaches to long-term care, and the complexities of medication management in LTC homes. In addition to research, we engaged in extensive consultations in part 2. In October and November 2018, I held 19 individual and small-group consultations with the Participants and other stakeholders in the LTC system. Five were full-day consultations, and the remaining 14 each ran for approximately four hours. The consultation process continued on an informal basis through to a two-day Plenary session in late January 2019 in Toronto, which brought together all those who had participated in the consultations. Recommendation development was ongoing throughout part 2.

IV. Three Principal Findings

A. Introduction

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

- if Wettlaufer had not confessed, the Offences would not have been discovered;
- the Offences were the result of systemic vulnerabilities, and, therefore, no findings of individual misconduct are warranted; and
- the long-term care system is strained but not broken.

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

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

First, Justice Thomas made this finding when he sentenced Wettlaufer to life in prison, stating, "Without her confessions, I am convinced this offender would never have been brought to justice."[18]

Second, the evidence showed that no one suspected that Wettlaufer was intentionally harming those under her care – not the residents or their families, not those who worked alongside Wettlaufer, and not those who managed and supervised her. None of the reports or complaints that the Ministry of Health and Long-Term Care received from or about the homes where Wettlaufer was working suggested that she might be intentionally harming residents. Nothing raised the suspicion of the many Ministry inspectors who regularly attended at the homes in the period in which Wettlaufer committed the Offences. Nothing sounded alarm bells for the coroners who conducted death investigations on some of the victims. Although the College of Nurses of Ontario (College) received the termination report that Caressant Care (Woodstock) filed with it when it fired Wettlaufer, the College saw nothing that raised concerns about Wettlaufer's treatment of residents. Its decision to take no action beyond "banking with notice"[19] the termination report shows that it had no serious concerns about the care that Wettlaufer provided to residents.

Third, Dr. Michael Pollanen, Ontario's chief forensic pathologist, gave evidence both at the criminal proceedings against Wettlaufer and at this Inquiry that, even if full death investigations (including autopsies) had been conducted on all the murder victims, it is unlikely they would have produced evidence that Wettlaufer had intentionally injected them with overdoses of insulin. Dr. Pollanen explained a number of difficulties in identifying insulin overdose after death:

- no mechanism currently exists to diagnose hypoglycemia (a low blood sugar level caused by, among other things, too much insulin in the body) by using samples from a dead body;

[18] Reasons for Sentence, p 10.

[19] "Banking with notice" refers to giving the nurse member notice that a copy of the report will be kept on file with the College, to be reviewed should further concerns come to the College's attention.

- hypoglycemia leads to non-specific symptoms associated with other medical conditions;
- there are serious practical challenges to identifying hypoglycemia caused by insulin administration;
- deaths from insulin overdoses often occur days after the insulin was administered, and the passage of time makes detecting insulin overdoses virtually impossible; and
- changes that occur after death make it difficult to distinguish between natural insulin produced by the body and synthetic insulin introduced into it.

The fact that the Offences were discovered only because Wettlaufer confessed to them 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. Some fundamental changes must be made – changes directed at preventing, deterring, and detecting intentional wrongdoing by healthcare providers.

C. No Findings of Individual Misconduct

I make no findings of misconduct because the Offences were the result of systemic vulnerabilities, not the failures of any individual or organization within it. Because it was systemic failings – not individual ones – that created the circumstances allowing the Offences to be committed, it would be unfair of me to embark on a personal attribution of responsibility. It would also be ineffective: assigning blame to individuals will not remedy systemic problems or guard against similar tragedies.

Moreover, given the need for those throughout the long-term care system to work collaboratively in resolving the systemic issues, assigning blame to individuals or organizations is counterproductive. Systemic issues are "best dealt with by encouraging people to go down a path where they can change the things that went wrong."[20] In the *Report of the Arbour Inquiry into the Events at the Prison for Women in Kingston*, Justice Louise Arbour explained: "Attribution of personal blame would suggest personal rather than systemic

[20] Justice Archie Campbell, "The Bernardo Investigation Review," in Allan Manson and David Mullan (eds), *Commissions of Inquiry: Praise or Reappraise?* (Toronto: Irwin Law, 2003), 400.

shortcomings and justifiably demoralize the staff, while offering neither redress nor hope for a better system."[21]

The fact that I make no findings of misconduct is not meant to suggest that there were no individual shortcomings or that there is nothing the stakeholders can do individually to improve the safety and security of residents. Of course, improvements can be made – and I make specific stakeholder recommendations on those matters. What this finding highlights is that there is no simple "fix." We cannot point our fingers at any given individual or organization, identify the shortcomings we find there, and end the threat posed by wrongdoers such as Wettlaufer by remedying those shortcomings.

Systemic issues – like the ones in this Inquiry – are complex, multifaceted, and polycentric in nature. If we are to achieve the common goal of safety and security for the residents and clients in the long-term care system, we must look at the operation of the system as a whole. Systemic issues require a systemic response that goes beyond the actions of individual stakeholders. An effective systemic response requires all those in the system – both individuals and organizations – to work together to address the systemic failings that have been identified. Collaboration, co-operation, and communication must become the watchwords for the system.

D. The Long-Term Care System Is Strained but Not Broken

The evidence at the public hearings painted a comprehensive picture of the long-term care system and how it operates. It also made clear that the system – and those who work in it – are under pressure. Long-term care homes are the most regulated area of healthcare in the province. Despite limited resources, the staff in these homes must meet the regulatory dictates and provide care for residents with ever-increasing acuity.

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

---

[21] Arbour Inquiry into the Events at the Prison for Women in Kingston, referenced in Campbell, "Bernardo Investigation Review," 400.

The *Long-Term Care Homes Act, 2007*[22] and its regulations[23] create a solid regulatory framework for resident-centred care. They impose clear standards for long-term care homes and a rigorous inspection regime to enforce those standards. The regulatory regime plays an important role by establishing minimum standards of care for residents on a broad range of matters, including residents' rights, care, and services; reporting requirements; medication management; infection control; food safety and quality; and staffing in the home. It places obligations on all licensees of long-term care homes which are detailed, comprehensive, and prescriptive. By setting the foundation for good resident care in Ontario's LTC homes, this regulatory regime is designed to ensure that residents are safe and secure, and treated with dignity and respect.

Through this Inquiry, I have seen first-hand that the vast majority of those who work in long-term care are dedicated both to the ideals of resident-focused care and to the people for whom they provide care. Witnesses in the public hearings came from all parts of the long-term care system, including those who work in long-term care homes, those who inspect the homes, and those responsible for ensuring the safe delivery of publicly funded home care. The pain they felt as a result of the Offences was evident. What was also evident was their passion for the work they do and their commitment to the residents and clients in the long-term care system.

In the part 2 consultations, I met directly with many stakeholders, including residents, frontline staff, those in management positions in long-term care homes, individuals engaged in policy development and oversight at the Ministry, professional regulatory bodies, and professional advocacy bodies. All who came to the consultations did so willingly, eagerly, and fully prepared. They offered thoughtful and constructive comments, observations, and ideas for further consideration. Afterward, many provided additional information relating to issues that had been raised in the consultations. Like those who gave evidence at the public hearings, I found the people who attended the consultations to be hard-working individuals who care deeply about long-term care. Many in both groups said the same thing: their work in long-term care is a vocation, not just a job.

[22] SO 2007, c 8.

[23] O Reg 79/10.

Stakeholder initiatives are incontestable evidence of the dedication and commitment to care of the individuals who work in the long-term care system. I point to two groups of these initiatives. The first group of stakeholder initiatives was undertaken, while the Inquiry was ongoing, in response to issues that the Commission and I had identified in the public hearings and the consultations. Examples of initiatives in this group include the establishment of a working group on the medication management system in long-term care homes, amendments to the *Coroners Act*, and increasing the amount of information about nurses' employment history available through the College of Nurses of Ontario. The first group of initiatives shows that the stakeholders did not wait for this Report before acting. When they learned of something that could be done to improve the long-term care system, if the matter was within their control, they acted immediately.

The second group of initiatives consists of stakeholder-led programs that predated the Inquiry and are aimed at improving the lives of residents and those who work with them. This group includes the medication safety pilot project and the clinical support tools program. These innovative programs are collaborative in nature and show that the long-term care system has strong leadership capabilities within it. These initiatives also show that big steps forward in long-term care cannot be undertaken by a single organization. To make lasting improvements will require a systemic response.

There is real significance to my finding that the long-term care system is not broken. Ontario has no need to jettison the existing regulatory system and start over. Instead, we need to identify and acknowledge the strengths of the existing system and build on them. Celebrating the existing areas of excellence in the long-term care system should inspire others in the system to follow suit. However, we must also step up and acknowledge the vulnerabilities in the long-term care system which the Offences and this Inquiry have exposed. That can be done through implementing the Inquiry recommendations.

V. A Roadmap to the Recommendations

Below you will find the Consolidated Recommendations found in this Report. There are 91 recommendations in all. The following six points offer guidance on the structure and flow of the recommendations.

1. This Report consists of four volumes, but recommendations are made only in Volumes 2 and 3 (although not in every chapter). All recommendations are found at the end of chapters.

2. Each recommendation in the Consolidated Recommendations is placed below the chapter title in which it can be found. The text of the chapter itself provides the context for each recommendation. In addition, the recommendations at the end of the chapters are amplified with rationales and details.

3. Volume 2 comprises Chapters 1–14. These chapters summarize the results of the Commission's inquiries into the Offences and the circumstances in which they were committed. They consider each of the major stakeholders that were the focus of the Commission's inquiries. The recommendations found in Volume 2 are directed at individual stakeholders.

4. Volume 3 comprises Chapters 15–19. These chapters set out the results of the Inquiry's work on the systemic issues, and its recommendations for addressing the systemic vulnerabilities in Ontario's long-term care system. The recommendations are directed at all stakeholders in the LTC system, even where I call on them to be led by named institutions. Although most of the recommendations are directed at long-term care homes, a number are directed at the home care system.

5. Systemic issues require a systemic response. The recommendations in Volume 3 are based on four systemic responses:

    - *Prevention.* The best way to deter healthcare serial killers is to strengthen the long-term care system by building capacity and excellence throughout it. I recommend that the Ministry play an expanded leadership role directed at prevention. The Ministry's expanded role would include establishing a dedicated unit to support long-term care homes in achieving regulatory compliance and spreading best practices; providing bridging and laddering programs in long-term care homes; and encouraging innovation and the use of new technologies in the long-term care system.

- *Awareness.* We can prevent, deter, and detect only matters of which we are aware. Thus, the essential first line of defence in combatting healthcare serial killers is to build awareness throughout the healthcare system of the possibility of intentional harm by healthcare workers. I recommend that the Office of the Chief Coroner and the Ontario Forensic Pathology Service be made responsible for developing and implementing a strategic plan to build, develop, and maintain this awareness. The Office of the Chief Coroner and the Ontario Forensic Pathology Service is uniquely positioned in the healthcare system to assume this responsibility. However, as the companion recommendations on this matter make clear, the responsibility for delivering the education and training necessary to equip all healthcare providers requires a systemic response.
- *Deterrence.* I recommend that a three-pronged approach be taken to deter wrongdoers from intentionally harming residents through the use of medications. Deterrence is a matter in which I call for the long-term care homes to take the leadership role, with appropriate funding support from the Ministry. First, the already solid medication management system in long-term care homes must be strengthened through infrastructure changes, the use of technology, and increasing the role of pharmacists. This recommendation must be read in conjunction with a recommendation directed at the Ministry, which seeks an immediate expansion of the funding parameters of the nursing and personal care envelope to permit long-term care homes to use funds to pay for a broader spectrum of staff, including pharmacists and pharmacy technicians. Second, I make recommendations that will improve medication incident analysis in long-term care homes by, among other things, the use of a standardized, rigorous incident analysis framework. Third, I make recommendations directed at increasing the number of registered staff in long-term care homes.
- *Detection.* Ontario has a strong death investigation system with excellent leadership. We need to build on those strengths by tailoring the death investigation process as it applies to deaths in long-term care homes. I recommend that the Office of the Chief Coroner and the Ontario Forensic Pathology Service increase the number of resident death investigations, based on a redesigned Institutional Patient Death Record and the use of data analytics.

6. The recommendations in this Report are also designed to improve resident care and quality of life. Human and financial resources are stretched thin in the long-term care system, so it is important to use those resources wisely, making changes that will improve not only the safety and security of those in the long-term care system but also the quality of their daily lives.

VI. Conclusion

This Inquiry was established because of concern for the safety and well-being of residents in long-term care homes in Ontario and those receiving publicly funded healthcare services in their homes. The recommendations that follow fulfill the Inquiry mandate to address the threat to resident and client safety posed by a healthcare serial killer such as Wettlaufer. They are effective, workable strategies to avoid similar tragedies through prevention, deterrence, and detection.

I make three points about the cost of implementing these recommendations.

First, many of the recommendations cost little or nothing to implement. For these recommendations, what is required is a willingness on the part of those who work in long-term care to accept that changes must be made to certain aspects of their work and, then, to embrace those changes. Based on my first-hand experience during the Inquiry with the people who work in the long-term care system, I am confident that these recommendations will be implemented.

Second, for those recommendations that require funding, the cost is proportional to the serious threat that healthcare serial killers present in the long-term care system. If we take into consideration that implementing the recommendations will also improve the quality of life for residents in long-term care homes, their cost is fully justified.

Third, the delivery of this Report forces us, as a society, to decide if we are willing to make the financial investment necessary to improve not only the safety and security of older Ontarians but also the quality of their lives.

I conclude by expressing my hope that this Inquiry has helped to begin the healing for those who have suffered as a result of the Offences and to restore public confidence in Ontario's long-term care system.

CONSOLIDATED RECOMMENDATIONS

My complete recommendations appear below.[1]

Chapter 1
Foundations: The Context, Findings, and a Roadmap for the Report

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

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

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

Chapter 4
The Role of Long-Term Care Homes

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

a. Administrators and directors of nursing should receive training:

- on best practices in the screening, hiring, and management and discipline of registered staff;
- on conducting workplace investigations;
- as recommended elsewhere in this Report, such training to be provided by the Ministry of Health and Long-Term Care, the College of Nurses of Ontario, and the Office of the Chief Coroner / Ontario Forensic Pathology Service; and
- on their reporting obligations to the Ministry and the College.

b. Registered staff must receive comprehensive ongoing training on:

- the requirements of the *Long-Term Care Homes Act, 2007* (LTCHA), relating to the prevention of resident abuse and neglect, and their reporting obligations under section 24(1) of the LTCHA;
- the home's medication administration system, and the identification and reporting of medication incidents; and
- the redesigned Institutional Patient Death Record, once it is created, such training to be provided by the Office of the Chief Coroner / Ontario Forensic Pathology Service.

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

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

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

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

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

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

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

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

Chapter 7
Agency Nurses in Long-Term Care Homes

11 Licensees should minimize the use of agency nurses. To achieve this, they should develop proactive strategies such as maintaining a roster of casual employees who are members of the regular nursing staff and can cover shifts in the case of an unexpected absence.

12 If agency nurses must be used, licensees should thoroughly vet agencies before entering into contracts with them to ensure that the agency's management and staff have the knowledge, skills, and experience required to provide services effectively and safely to the home's residents, including on the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations.

13 Licensees should ensure that their contracts with agencies:

- require the agency to, at all times, have a roster of nurses who have been oriented to the licensee's home and meet the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations;
- set out clear responsibilities and expectations for the agency in terms of its hiring, screening, and training of registered staff; and
- set out a clear process for reporting performance concerns from the licensee to the agency.

Chapter 8
Home Care Service Providers

14 Service provider organizations that provide publicly funded home care services on behalf of a Local Health Integration Network must ensure that their management and staff receive training in the following areas:

- Management
  - Human resources, including: best practices for screening and selecting candidates; interview techniques; checking references; performing background checks; and obtaining feedback about, and assessing the suitability of, new employees during the probationary period;
  - Investigating risk events; and
  - Policies and procedures for entering risk events and complaints into the relevant events management software.
- Staff
  - Policies and procedures for reporting risk events and complaints to their supervisors.

15 Service providers should maintain a permanent personnel file containing an employee's performance history, along with records of any complaints and concerns.

16 Service providers must establish a process for reporting unusual incidents, including unauthorized entry into a client's home. This process must:

- require such incidents to be promptly reported to the Local Health Integration Network;
- categorize these incidents as high risk;
- clearly set out how frontline staff are to report such events to their supervisors, and within what time frame; and
- designate one individual within the organization to investigate incidents of this nature, and to prepare and maintain records of the investigation.

17 Once the Office of the Chief Coroner and the Office of the Forensic Pathology Service (OCC/OFPS) creates a modified version of the Institutional Patient Death Record (IPDR) for use in deaths occurring in the private homes of those having recently received publicly funded home care (see Chapter 18), service providers should ensure their staff receive training from the OCC/OFPS on its use and encourage frontline workers to review the modified IPDR when they learn of a client's death.

18 Service providers are strongly encouraged not to use subcontractors. If subcontractors must be used, service providers must establish formal practices to verify that subcontractors are properly reporting complaints and risk events to them, and conducting rigorous screening and background checks of all staff who will provide services to Local Health Integration Network clients.

Chapter 9
The Role of the Ministry of Health and Long-Term Care

19 The Ministry of Health and Long-Term Care must expand the funding parameters of the nursing and personal care envelope to permit long-term care homes to use these funds to pay for a broader spectrum of staff, including porters, pharmacists, and pharmacy technicians.

20 The Ministry of Health and Long-Term Care should encourage, recognize, and financially reward long-term care homes that have demonstrated improvements in the wellness and quality of life of their residents.

21 The Ministry of Health and Long-Term Care (Ministry) should create a new, permanent funding envelope for long-term care (LTC) homes to fund training, education, and professional development for all those providing care to residents in LTC homes. The Ministry should permit LTC homes to use the funding envelope for, among other things:

- costs of staffing the shifts of those away on training;
- stipends for staff completing training that requires a leave of absence;
- course fees;
- development of training materials; and
- costs of annual membership fees associated with joining organizations such as the Ontario Long Term Care Association and AdvantAge Ontario.

22 The Ontario government must repeal that part of section 222(3) of Ontario Regulation 79/10 which exempts licensees from ensuring that medical directors and nurse practitioners (registered nurses in the Extended Class) receive the training required of direct care staff under section 76(7) of the *Long-Term Care Homes Act, 2007* (LTCHA). Section 76(7) of the LTCHA requires that staff providing direct care to residents undergo training on topics such as abuse recognition and prevention, mental health issues, and behaviour management.

23 The Ministry of Health and Long-Term Care must develop a public awareness campaign to educate and raise awareness of those who work, volunteer, or visit family and friends in long-term care homes about their reporting obligations under section 24(1) of the *Long-Term Care Homes Act, 2007* (LTCHA). Section 24(1) of the LTCHA requires that any person who has reasonable grounds to suspect improper or incompetent treatment or care, or the abuse or neglect of residents (among other things), must report his or her suspicion and the information on which it is based to the Director (a position created by the LTCHA and filled by a person in the Ministry) and not simply to management in the home.

24 The Minister of Health and Long-Term Care should issue a policy directive to clarify the meaning of "reasonable grounds" and "improper or incompetent treatment" in section 24(1).

25 The Ministry of Health and Long-Term Care (Ministry)'s Long-Term Care Home Quality Inspection Program (LQIP) has been assigning risk or performance levels to long-term care homes since 2013, based primarily on data from Ministry inspections. The Ministry should refine its LQIP Performance Assessment to better identify homes struggling to provide a safe and secure environment for residents by giving more weight to findings of non-compliance relating to high-risk areas for residents than to findings of non-compliance less likely to impact resident safety or security. For example, a finding of non-compliance for failing to report suspected abuse or neglect is more significant than a finding of non-compliance for failing to ensure that planned menu items are available at each meal and snack.

26 Those responsible for coordinating and conducting inspections at the Ministry of Health and Long-Term Care should ensure that all Critical Incident reports and complaints relating to high-risk incidents are given the highest priority and inspected as quickly as possible to ensure that any ongoing risk to residents is immediately remedied.

27 Those responsible for coordinating and conducting inspections at the Ministry of Health and Long-Term Care should draw on the following when establishing inspection priorities:

- the Long-Term Care Home Quality Inspection Program Performance Assessments; and
- data produced by the Information Management, Data and Analytics Branch showing homes with higher than expected mortality rates.

28 The Ministry of Health and Long-Term Care should review the Long-Term Care Home Quality Inspection Program Performance Assessment results to identify long-term care homes struggling to provide a safe and secure environment for their residents. Where a home has fallen below level 1 performance for two consecutive quarters, the Long-Term Care Homes Division should take action to assist that home in returning to the level 1 classification.

29 When a finding of non-compliance has been issued to a licensee for failing to report as required by section 24(1) of the *Long-Term Care Homes Act, 2007*, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections in long-term care homes should ensure that the next resident quality inspection (RQI) conducted in that home is the intensive RQI, regardless of the performance level assigned to the home.

30 Before beginning an inspection involving either missing narcotics or allegations of staff-to-resident abuse, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections should ensure that the assigned inspector reviews previous Critical Incident reports to determine whether the staff member involved in those incidents is named in earlier reports.

31 The Ministry of Health and Long-Term Care should establish a formal communications policy and process to ensure that its inspectors share relevant information with the College of Nurses of Ontario (College) about members of the College who may pose a risk of harm to residents.

Chapter 12
The Role of the CCACs and LHINs in the Provision and Oversight of Home Care Services

32 All Local Health Integration Networks (LHINs) should adopt the same electronic events reporting system. The system should:

- be set up in a manner that allows all data to be accessed and searched by all LHINs; and
- contain a dedicated, searchable field for the name of the staff member involved in reported incidents.

33 Local Health Integration Networks should modify or clarify their reporting requirements for service providers on unusual incidents, including unauthorized entry into a patient's home by:

- clarifying that all such events must be reported;
- clarifying that all such events are considered high risk; and
- requiring service providers to immediately notify the patient's care coordinator when such an incident occurs, and to follow up with a written report setting out the steps the service provider took to investigate the incident.

34 Local Health Integration Networks (LHINs) should provide additional training for both service providers and LHIN staff, as follows:

- For service providers: on using the LHIN's electronic events reporting system and reporting requirements.
- For LHIN staff: on using the LHIN's electronic events reporting system and reporting requirements, and the steps to take when a complaint or risk event is reported.

35 Local Health Integration Networks (LHINs) should prepare written information about:

- the signs and symptoms of toxicity;
- the steps to take if toxicity is suspected; and
- information on the safe storage and disposal of medications.

As a standard practice, LHIN care coordinators should distribute this information to all home care patients who receive injectable medications and should discuss this information when conducting medication reviews with them.

36 Local Health Integration Networks should inform home care patients of MedsCheck at Home, a program through which a community pharmacist goes into a patient's home and reviews medications the patient is taking and how they are being stored. The pharmacist will safely remove expired medications or those the patient no longer uses.

37 Local Health Integration Networks should conduct regular audits to ensure that all service providers are:

- carrying out their obligations related to hiring, screening, education, and training of staff; and
- reporting all incidents.

38 Local Health Integration Networks should amend their services agreements to require, as a condition of approving a service provider's proposed subcontractor, that:

- the service provider ensure the subcontractor is conducting rigorous screening and background checks of all staff; and
- the service provider establish a process to verify, on an ongoing basis, that the subcontractor is properly reporting all complaints, risk events, and other incidents to it.

39 Once the Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) creates a modified version of the Institutional Patient Death Record (IPDR) for use in deaths occurring in the private homes of those having recently received publicly funded home care (see Chapter 18), the Local Health Integration Networks (LHINs) should:

- require care coordinators and other appropriate LHIN staff to take training from the OCC/OFPS on the use of the modified IPDR;
- encourage care coordinators to review the IPDR when a client dies and, if that review triggers concerns, to contact the OCC/OFPS; and
- encourage service providers to train frontline workers on the modified IPDR and its use.

Chapter 13
The College of Nurses of Ontario

40 The College of Nurses of Ontario must educate its membership and staff on the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care.

41 The College of Nurses of Ontario should strengthen its intake investigation process, following receipt of termination and other reports, by training intake investigators:

- on the healthcare serial killer phenomenon and how to conduct their inquiries in light of it;
- to explain the purpose of their inquiries to those they interview;
- to identify and interview not only the contact person listed in the report but also other relevant people at the member's place of employment; and
- to identify, in advance of an interview, the information that the interviewee should review before speaking to the investigator, to ask the interviewee to review that information before the interview, and to ask the interviewee to have the information with him or her during the interview.

42 The College of Nurses of Ontario must review its policies and procedures and revise them, as necessary, to reflect the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care.

43 The College of Nurses of Ontario (College) told the Inquiry that it intends to share the research it has conducted on the healthcare serial killer phenomenon with other health regulators in Canada, the United States, and internationally. The College should pursue this initiative with the goal of leading a larger discussion among regulators about how to prevent, deter, and detect healthcare professionals who may seek to intentionally harm those in their care.

44 The College of Nurses of Ontario should regularly review its approved nursing programs to ensure that they include adequate education and training on nursing care for an aging population, and the possibility that a healthcare provider might intentionally harm patients/residents.

45 The College of Nurses of Ontario should use its influence with post-secondary institutions offering approved nursing programs to:

- promote the inclusion of information on the healthcare serial killer phenomenon in their curricula, in courses such as professional responsibility and patient risk management;
- ensure that they are providing adequate education and training on nursing care for an aging population;
- promote the discussion of nursing in long-term care (LTC) homes – including the career opportunities it provides – in a balanced way; and,
- promote student placements in LTC homes.

46 The College of Nurses of Ontario (College) should take steps to improve reporting by long-term care home employers and facility operators by educating them on their mandatory reporting obligations to the College under sections 85.1–85.6 of Schedule 2 (Health Professions Procedural Code) to the *Regulated Health Professions Act*, particularly reports on terminating a member's employment and reports where there are reasonable grounds to believe that a member is incompetent or incapacitated. This education should clarify the relationship between the employer and facility operator's mandatory reporting obligation to the Director (a position created by the *Long-Term Care Homes Act, 2007* (LTCHA), and filled by a person in the Ministry of Health and Long-Term Care) under section 24(1) of the LTCHA, and their reporting obligation (if any) to the College in respect of the same matter.

47 The College of Nurses of Ontario (College) should revise its publication entitled *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses* so that it clearly explains employer and facility operator mandatory reporting obligations under the *Regulated Health Professions Act*, the types of information to be included in the reports, and how the College will use the information provided in those reports.

48 The College of Nurses of Ontario (College) should revise its template form for mandatory reports and the process for submitting those reports to the College. The revised template form should:

- include a declaration by the person completing the report that (1) the person understands and has complied with his or her reporting obligations; and (2) the contact person identified in the report is familiar with the nurse member's practice and is the appropriate person for the College to contact;
- contain clear instructions on its face requiring the reporter to provide all relevant information relating to the member. In cases of a termination report, this may include some or all of the member's discipline history but will always include a copy of the letter of termination from the employer to the member;
- ensure that the "Incidents" section in the revised template report form expands automatically to allow the reporter to fill in all relevant information and incidents;
- provide a plain-language explanation of the words "incapacitated" and "incompetent"; and
- enable the report, once completed, to be submitted to the College by email.

49 The College of Nurses of Ontario (College) should institute a program to educate members on their reporting obligations to the College arising from the *Regulated Health Professions Act*, the College's Practice Standards, and the Professional Misconduct Regulation to the *Nursing Act*. This program should expressly address when members must report, to the College, suspected abuse and neglect of patients and residents by other nurses.

Chapter 14
The Office of the Chief Coroner and the Ontario Forensic Pathology Service

50 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should replace the Institutional Patient Death Record (IPDR) with a redesigned evidence-based resident death record, following consultation with stakeholders. The redesigned IPDR should require the long-term care home registered staff member completing it to:

- answer a series of evidence-based questions that will prompt the registered staff member to provide clinical observations and other information about the resident's death;
- indicate if there are aspects of the resident's decline or death that were inconsistent with the expected medical trajectory of death;
- indicate if the family or other care providers, such as personal support workers, raised concerns about the resident's care in the period leading up to and including the death; and
- indicate if the person completing the redesigned IPDR is uncertain as to the answer to any question, and to explain the reason for the uncertainty on the form itself.

51 The redesigned Institutional Patient Death Record (IPDR) should clearly state on its face that:

- it is to be completed by the registered staff person in the long-term care home who was providing the resident with the most direct care at the time of death, following consultation with the personal support workers caring for the resident in the period leading up to death;
- the person completing the redesigned IPDR should promptly submit it to the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) and, at the same time, send copies to the long-term care home's medical director, director of nursing, and pharmacist, as well as to the resident's treating physician(s) or nurse practitioner (if any); and
- those receiving a copy of the redesigned IPDR must review it and promptly contact the OCC/OFPS if they have any concerns about the resident's death or the accuracy of the information set out in the IPDR.

52 The Office of the Chief Coroner and the Ontario Forensic Pathology Service must take steps to ensure that licensees of long-term care homes have their staff submit the completed redesigned Institutional Patient Death Record to it electronically.

53 The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should require that, where a resident dies in hospital within 30 days of being transferred to the hospital from a long-term care (LTC) home, a redesigned Institutional Patient Death Record (IPDR) be submitted to it for that death. The OCC/OFPS should work with LTC homes and hospitals to work out a process for the submission of the redesigned IPDR, including who is to submit the form and how necessary medical records will be shared.

54 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should provide training for all registered staff in long-term care homes who may be called on to complete the redesigned Institutional Patient Death Record. The training should include education on:

- the expected trajectory of death and how to assess whether a resident's death departs from that expected trajectory; and
- the meaning of a "sudden and unexpected" death.

55 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should establish as a best practice that, at the preliminary consultation stage, coroners should:

- speak with the deceased's family or the person who had the decision-making power for the deceased; and
- advise the deceased's family or decision-maker that, if the coroner decides that no death investigation will be undertaken, the family or decision-maker can contact the regional supervising coroner with their questions.

56 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should prepare written materials about the death reporting and investigation process and provide those materials to long-term care homes for distribution, at appropriate times, to the families of residents.

57 The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should mandate that if, after conducting a preliminary consultation, a coroner decides not to perform a death investigation, the coroner must complete a standard document (e.g., a revised version of the case selection data form) setting out the reasons for the decision and submit that document electronically to both the regional supervising coroner and the OCC/OFPS within specified timelines.

58 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should develop protocols and policies on the involvement of forensic pathologists in the death investigation process of residents in long-term care homes.

59 The Office of the Chief Coroner and the Ontario Forensic Pathology Service should develop a standardized protocol for autopsies performed on the elderly and should train forensic pathologists on this protocol.

60 The Government of Ontario should continue to support the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) financially in establishing and maintaining a cadre of specially trained coroners who:

- agree to dedicate a portion of their practice to coroner work, to be specified in a contract with the OCC/OFPS.
- receive specialized training on long-term care homes, their resident populations, and best practices in conducting preliminary consultations and death investigations of residents.

61 The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should ensure that the work of coroners in long-term care (LTC) homes be performed as much as possible by the cadre of coroners. If local coroners continue to perform death investigations of residents in LTC homes, the OCC/OFPS should require that they take ongoing training on performing death investigations in LTC homes.

Chapter 15
Building Capacity and Excellence in the Long-Term Care System

62 The Ministry of Health and Long-Term Care (Ministry) must play an expanded leadership role in the long-term care system by:

- establishing a dedicated unit within the Long-Term Care Homes Division to:
  - support long-term care (LTC) homes in achieving regulatory compliance; and
  - identify, recognize, and share best practices leading to excellence in the provision of care in LTC homes;
- providing bridging and laddering programs in LTC homes; and
- encouraging innovation and the use of new technologies in the long-term care system.

Both the Ministry and the dedicated unit should work collaboratively with stakeholders throughout the LTC sector, drawing on existing partnerships and forging new ones.

63 The Long-Term Care Homes Division within the Ministry of Health and Long-Term Care must communicate and collaborate with the Home and Community Care Branch and the Local Health Integration Networks (or successor organization) in providing healthcare services to older Ontarians.

Chapter 16
Building Awareness of the Healthcare Serial Killer Phenomenon

64 The Government of Ontario must ensure that a strategic plan is in place to build awareness of the healthcare serial killer phenomenon.

65 The Government of Ontario should make the Office of the Chief Coroner and the Ontario Forensic Pathology Service responsible for developing this strategic plan, working collaboratively with stakeholders in the healthcare and long-term care systems. The strategic plan should set out systematic, ongoing, and measurable steps for developing awareness of the healthcare serial killer phenomenon within the healthcare system.

66 The Government of Ontario should make the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) responsible for implementing the strategic plan. The OCC/OFPS should develop standardized information on the healthcare serial killer phenomenon and provide it to organizations and institutions responsible for the delivery of education and training to students, professionals, and staff in the healthcare system and in allied programs and fields.

67 The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) should conduct ongoing research on national and international developments concerning the healthcare serial killer (HCSK) phenomenon, including what is being done to deter and detect HCSKs. It should disseminate the results of that research as appropriate, including to organizations and institutions that deliver education and training on the potential for intentionally caused harm by healthcare providers. The OCC/OFPS should engage in regular monitoring to ensure that the requisite education and training are being delivered.

68 The Government of Ontario should provide the Office of the Chief Coroner and the Ontario Forensic Pathology Service with funding for one full-time employee to develop and implement the strategic plan (see Recommendations 65–67). Funding should be sufficient to hire an individual with a strong knowledge and understanding of the healthcare system, including its policy dimensions; demonstrated leadership and organizational skills; an understanding of the importance of evidence-based work; and the ability to consult with, and bring together, diverse stakeholders in the development of the strategic plan.

69 The Government of Ontario should provide the Office of the Chief Coroner and the Ontario Forensic Pathology Service with funding so it can engage a specialist in adult education to work with organizations and institutions responsible for educating and training their respective populations on the healthcare serial killer phenomenon (see Recommendation 70).

70 The organizations and institutions responsible for educating and training the groups that make up the healthcare system must be responsible for the delivery of education and training on the possibility that healthcare providers may intentionally harm those in their care. I recommend that the following institutions and organizations provide that education and training (see Chapter 16, Figure 16.6):

- colleges and universities;
- regulators, including the College of Nurses of Ontario and the Ontario College of Pharmacists;
- the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians;
- the Long-Term Care Homes Division in the Ministry of Health and Long-Term Care;
- Local Health Integration Networks or any successor organization;
- licensees of long-term care homes;
- the Office of the Chief Coroner and the Ontario Forensic Pathology Service;
- the Ontario Association of Residents' Councils;
- residents' councils;
- Family Councils Ontario; and
- family councils.

71 Long-term care homes, residents' councils, family councils, Ontario Association of Residents' Councils, and Family Councils Ontario should collaborate to ensure that the information they deliver is consistent and suitable for their particular audience.

72 The organizations and institutions listed in Recommendation 70 above should address the healthcare serial killer phenomenon in the broader context of such matters as risk management, patient / resident safety, patient / resident outcomes, and/or professionalism, rather than as a stand-alone matter.

73 The organizations and institutions listed in Recommendation 70 above should revise their relevant policies, practices, and procedures to reflect the possibility that a healthcare provider could intentionally cause harm.

Chapter 17
Deterrence Through Improved Medication Management

A three-pronged approach should be taken to deter wrongdoers from intentionally harming residents through the use of medication:

- strengthen the medication management system in long-term care (LTC) homes;
- improve medication incident analysis in LTC homes; and
- increase the number of registered staff in LTC homes.

Strengthen the Medication Management System in Long-Term Care (LTC) Homes

74 The Minister of Health and Long-Term Care should issue a policy directive clarifying that a licensee must ensure that the long-term care home's written policy for the destruction and disposal of drugs covers insulin cartridges.

75 During the annual resident quality inspections in long-term care homes, Ministry of Health and Long-Term Care inspectors should confirm that the licensee's written policy on drug destruction and disposal includes the destruction and disposal of insulin cartridges and that the registered staff in the home are complying with that policy.

76 The Ministry of Health and Long-Term Care should establish a program, to run for a three-year period, under which long-term care homes can apply for a grant to fund one or more of the following:

- installation of glass doors, windows, and/or walls in medication rooms and other rooms in which medications are stored;
- installation of security cameras in medication rooms and other rooms in which medications are stored, as well as in common areas and at entrances and exits;
- purchase or upgrade of integrated automated dispensing cabinets;
- purchase of a barcode-assisted medication administration system;
- hiring, on a full-time or part-time basis, of a staff pharmacist and/or pharmacy technician.

Note: This recommendation must be read in conjunction with Recommendation 19, which seeks an immediate expansion of the funding parameters of the nursing and personal care envelope to permit long-term care homes to use those funds to pay for a broader spectrum of staff, including pharmacists and pharmacy technicians.

77 The amount of the Ministry of Health and Long-Term Care grant described in Recommendation 76 above should be tied to home size as follows:

- small home (64 beds or fewer): a maximum of $50,000 each over the three-year period;
- medium home (more than 64 but fewer than 129 beds): a maximum of $125,000 each over the three-year period; and
- large home (129 beds or more): a maximum of $200,000 each over the three-year period.

Improve Medication Incident Analysis in LTC Homes

78 Management in long-term care homes should cultivate a "just culture" – one in which human error is dealt with openly rather than punitively.

79 Long-term care homes should analyze medication incidents and adverse drug events through an incident analysis framework that includes screening for the potential of intentional harm.

80 The Minister of Health and Long-Term Care should issue a policy directive requiring long-term care homes to treat the use of glucagon as a medication incident, as that term is described in section 1 of Ontario Regulation 79/10.

81 The Long-Term Care Homes Division of the Ministry of Health and Long-Term Care must advise long-term care homes that the use of glucagon constitutes a medication incident and is subject to the requirements of section 135 of Ontario Regulation 79/10.

82 Long-term care homes should document and track the use of glucagon to identify patterns and trends, and they should flag where further investigation should be undertaken.

83 The Long-Term Care Homes Division of the Ministry of Health and Long-Term Care should consult with organizations such as the Institute for Safe Medication Practices Canada to develop a comprehensive list of rescue agents and "trigger tools" that identify potential medication incidents. It should consider whether, like glucagon, use of these rescue agents and trigger tools ought to be treated as medication incidents. If so, that information should be given to the long-term care homes with appropriate explanations and instructions on how to use it.

84 The Minister of Health and Long-Term Care should issue a policy directive requiring long-term care homes to treat severe or unresponsive hypoglycemia as a medication incident, as that term is described in section 1 of Ontario Regulation 79/10.

Increase the Number of Registered Staff in LTC Homes

85 The Ministry of Health and Long-Term Care should conduct a study to determine adequate levels of registered staff in long-term care (LTC) homes on each of the day, evening, and night shifts. The Minister of Health and Long-Term Care should table the study in the legislature by July 31, 2020. If the study shows that additional staffing is required for resident safety, LTC homes should receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope.

Chapter 18
Detecting Intentionally Caused Resident Deaths

86 The Office of the Chief Coroner / Ontario Forensic Pathology Service should increase the number of death investigations of residents in long-term care homes, using information from the redesigned Institutional Patient Death Record. That information should be used when deciding whether, in respect of resident deaths, to initiate a preliminary consultation and/or conduct a death investigation.

87 The Ministry of Health and Long-Term Care (Ministry) has created four preliminary data analytics models that can be used to identify long-term care homes with a higher than expected number of deaths. The Ministry should move, as quickly as possible, to finalize a data analytics model, after consultations with experts and stakeholders. Once the data analytics model is finalized, the Ministry should share information from it with the Office of the Chief Coroner / Ontario Forensic Pathology Service on a regular and ongoing basis.

88 The Office of the Chief Coroner / Ontario Forensic Pathology Service should use data analytics to analyze aggregated data from the redesigned Institutional Patient Death Records to detect patterns and unusual trends in resident deaths in long-term care homes. This information should also be used when deciding whether to initiate a preliminary consultation and/or a death investigation.

89 The Office of the Chief Coroner / Ontario Forensic Pathology Service should use the information from the Ministry of Health and Long-Term Care's data analytics model, once finalized, as well as the redesigned Institutional Patient Death Records (IPDRs) and the data analytics of the redesigned IPDRs when considering whether a multidisciplinary team should be assigned to investigate a resident's death or a home with a pattern of unexpected deaths.

90 The Office of the Chief Coroner / Ontario Forensic Pathology Service (OCC/OFPS) should modify the Institutional Patient Death Record (IPDR) for use by caregivers when a person receiving publicly funded home care dies. The modified IPDR should assist the caregivers in knowing when to report a death to the OCC/OFPS and how to make that report.

91 The Office of the Chief Coroner / Ontario Forensic Pathology Service should train staff in Local Health Integration Networks (or a successor organization) and service provider organizations on how to use the modified Institutional Patient Death Record.