Auditor General
MANITOBA

Report to the Legislative Assembly

Investigation of the Protection for Persons in Care Office (PPCO)

Independent Investigation Report

Website Version

July 2023

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Auditor General
MANITOBA

July 2023

Honourable Myrna Driedger
Speaker of the Legislative Assembly
Room 244, Legislative Building
450 Broadway
Winnipeg, Manitoba R3C 0V8

Dear Madam Speaker:

It is an honour to submit my report, titled *Investigation of the Protection for Persons in Care Office (PPCO)*, to be laid before Members of the Legislative Assembly in accordance with the provisions of Section 28 of *The Auditor General Act*.

Respectfully submitted,

Original Signed by:
Tyson Shtykalo

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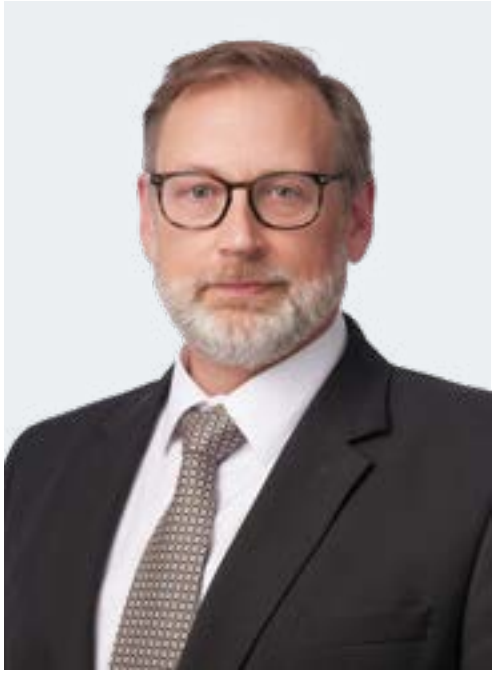
Auditor General's comments



The Protection for Persons in Care Office (PPCO) has a key role in protecting vulnerable Manitobans by receiving and investigating allegations of abuse and neglect in health-care facilities.

My Office received several calls with allegations from Manitobans describing alarming incidents where loved ones living in personal care homes were physically or verbally harmed. However, the resulting PPCO investigations concluded there was no abuse.

We found the allegations were valid and were not isolated cases. We also found some families and victims waited over 3 years for PPCO investigations to start.

I am deeply concerned by our findings and recognize the painful experiences the victims and families went through. The purpose of *The Protection for Persons in Care Act* is to protect vulnerable people in care. Unfortunately, the processes used by PPCO to determine if abuse occurred were flawed and failed to reach reasonable conclusions.

Issues with the definition of abuse were identified in 3 separate reports released over the past decade, but the PPCO did not take meaningful action to remedy the situation.

I acknowledge the efforts of the PPCO staff members who recognized there were issues, and brought forward their concerns to senior leadership and to my Office.

I would like to thank PPCO management and staff for their cooperation, and my staff for their dedication and hard work on this troubling investigation.

Original Signed by:
Tyson Shtykalo

Tyson Shtykalo, CPA, CA
Auditor General

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Why we did this investigation

- The Protection for Persons in Care Office (PPCO) is a government body that investigates allegations of abuse and neglect in health facilities.
- We received multiple allegations regarding the PPCO.

What we found

ALLEGATION 1 — **PPCO is concluding "unfounded for abuse" when victims are punched, slapped, kicked, or sexually assaulted.**

ALLEGATION CONFIRMED

- Caregivers hit or sexually assaulted victims, yet PPCO concluded "unfounded for abuse."
- PPCO's threshold for determining serious harm/abuse is extremely high.
- 10+ years with no action to address known problem with abuse definition.

ALLEGATION 2 — **Victims are waiting up to 3+ years for investigations to start.**

ALLEGATION CONFIRMED

- In 2022, the PPCO had a backlog of files with some allegations dating back to 2018 where investigations hadn't even been started yet.
- Significant impact on victims, families, and alleged abusers, plus loss of evidence and credibility.

ALLEGATION 3 — **PPCO is not publicly reporting statistics on investigations.**

ALLEGATION CONFIRMED

- PPCO stopped producing annual reports in 2016.
- PPCO does not report any information on the results of its investigations.

What we recommended

- This report includes 12 recommendations to the PPCO to improve the investigation process and protect vulnerable Manitobans.

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Response from Manitoba Health

The Province of Manitoba acknowledges its receipt of the Office of the Auditor General's (OAG) *Investigation of the Protection for Persons in Care Office* (PPCO) report and accepts the recommendations, without reservation.

The Province fully commits to taking actions to address each of the OAG recommendations. Given the PPCO's role in protecting vulnerable and, especially, aged Manitobans in long-term care settings, the department commits to providing regular updates on its efforts to make the necessary changes to address the fundamental issues identified in this report.

The Province acknowledges parties have been waiting too long to have their matter investigated by the PPCO, and delays impact the efficacy of the investigative process and can place an emotional toll on the people involved.

Changes to the definitions of abuse and neglect within *The Protection for Persons in Care Act* received Royal Assent on May 30, 2023. These changes remove any ambiguity and room for interpretation, making it clear that actions alone may be deemed abuse or neglect, regardless of whether the patient experienced any serious harm as the result of those actions.

Beyond the OAG recommendations, the Province of Manitoba will continue to improve the PPCO by also increasing the focus on preventing abuse and neglect. This process will include collaboration with its stakeholders to achieve a shared understanding of the PPCO's unique and important role in advancing patient and resident safety within Manitoba's health care system.

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The Protection for Persons in Care Office (PPCO)

The Protection for Persons in Care Office (PPCO) of Manitoba Health is the body charged with carrying out the functions of *The Protection for Persons in Care Act* (PPCA/Act) by investigating allegations of abuse and neglect. The office opened on May 1, 2001 as a 15-member team of investigators assembled to look into allegations brought to the PPCO. As at July 2022, the office had 6 investigators and 4 vacant positions.

The Protection for Persons in Care Act (PPCA)

The Protection for Persons in Care Act was created in April 2001. The PPCA sets out the requirement for a service provider or anyone else to report neglect or abuse in health facilities which include hospitals, personal care homes, the Selkirk Mental Health Centre, or an institution/organization designated as a health facility. Facilities are required to report suspected abuse or neglect in writing to the PPCO. The general public can report suspected abuse or neglect in any manner. The Act sets out procedures for the Minister of Health to receive, investigate, and provide remedy for substantiated instances of abuse or neglect.

According to the Province's April 30, 2001 news release, the Act was "designed to protect Manitobans in hospitals and personal care homes against physical, sexual, mental, emotional, and financial abuse at the hands of family members, acquaintances, or caregivers." The Minister at the time said, "*The Protection for Persons in Care Act* is an extra safeguard built into Manitoba's high-quality health care system. We now affirm in law the treatment we expect our loved ones to have, in a safe and secure environment free from the fear or reality of any type of abuse." This was to be achieved through mandatory reporting of elder abuse, and protection for employees who blow the whistle on fellow staff or management.

What the PPCO does

The PPCO is the Minister's delegate for the PPCA, which means it is responsible for carrying out the provisions outlined in the Act, including:

- Accepting reports of alleged abuse or neglect in a health facility.
- Determining whether a more extensive investigation is warranted.
- Conducting investigations.
- Determining if abuse or neglect occurred.
- Providing notice of the directions issued, and findings to the patient/victim or committee, or any other person the Minister feels should be notified.

The Act defines abuse and neglect as follows:

"abuse" means an act or omission that:

(a) is mistreatment, whether physical, sexual, mental, emotional, financial or a combination of any of them, and
(b) causes or is reasonably likely to cause
  (i) death of a patient,
  (ii) serious physical or psychological harm to a patient, or
  (iii) significant loss to a patient's property,

but does not include neglect;

"neglect" means an act or omission that:

(a) is mistreatment that deprives a patient of adequate care, adequate medical attention or other necessaries of life, or a combination of any of them, and
(b) causes or is reasonably likely to cause
  (i) death of a patient, or
  (ii) serious physical or psychological harm to a patient

PPCO's process

As per the PPCO's policy manual, if an allegation falls within the jurisdiction of the PPCO, and an investigator has "reasonable grounds to believe that a patient has been or is reasonably likely to be abused or neglected, then he/she will formally recommend that the allegation be elevated to investigation." The PPCO Director is ultimately responsible for approving an allegation for investigation.

An investigation can result in one of 2 conclusions:

- Founded for abuse or neglect.
- Unfounded for abuse or neglect.

According to the PPCO, a founded conclusion means that the incident occurred and it meets the legal definition of abuse or neglect as set out in the PPCA. On the other hand, an unfounded conclusion results from one of 2 situations: the incident not occurring as described, or the incident not meeting the legal definition of abuse or neglect as set out in the PPCA.

Once an investigation is completed, the PPCO provides a results letter to the health-care facility involved, the relevant regional health authority, the alleged abuser and the alleged victim. The results letter explains the outcome and conclusion of the investigation. The PPCO's results letter to the facility may contain binding directions which means the facility is required to carry out the directions.

If appropriate, the PPCO may also refer the matter to other investigatory bodies such as the police or a professional regulatory college. This referral does not prevent the PPCO from conducting its investigation and subsequently issuing directions.

At the end of an investigation, the PPCO is required to refer founded conclusions to the Adult Abuse Registry Committee (AARC) if 2 criteria are met in the PPCA Regulation. Section 3 of the *Protection for Persons in Care (Adult Abuse Registry) Regulation* states:

> The Minister must provide a report to the adult abuse registry committee under Section 8.2 of the Act if the Minister believes a person has abused or neglected a patient, and also believes that:
>
> (a) for the purpose of the clause 8.2(1)(b) of the Act, the person
>
> (i) is employable, or may become employable, or
>
> (ii) is able to do volunteer work, or may be able to do volunteer work; and
>
> (b) for the purpose of clause 8.2(1)(c) of the Act, the abuse or neglect did not occur because the person was not properly trained.

The AARC is a board of government appointed individuals who represent the following groups: law enforcement, lawyers, health professionals, and persons with experience in providing care or services to specified adults. The committee reviews investigations completed by government officials responsible for investigating such matters. The AARC's role is to determine whether the alleged abuser should be placed on the registry. Once determined, the AARC sends the abuser's name to the Registrar of the Adult Abuse Registry. The Registrar is responsible for placing names on the Adult Abuse Registry. When individuals are placed on the registry their name will stay on the registry for a minimum of 10 years.

In 2020-21, the PPCO received 2282 reports of abuse or neglect. The PPCO undertakes roughly 50 investigations per year.

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Objective

The objective of our investigation was to determine the validity of allegations regarding the PPCO's timeliness of investigations, and concerns surrounding unfounded conclusions.

Allegations

1. The PPCO is concluding "unfounded for abuse" in situations where victims are punched, slapped, kicked, or sexually assaulted.
2. The PPCO is not conducting investigations into allegations in a timely manner. Victims and families are waiting up to 3+ years after submitting an allegation before an investigation is even started.
3. The PPCO is not providing the public with any sort of statistics or information on the number of investigations it's conducting or the outcomes of those investigations. There is inadequate transparency to the public.

Scope and approach

We conducted our investigation between October 2021 and July 2022, while the scope of our investigation covered 2015 to 2021. Our work centered around the PPCO's investigations into allegations involving personal care homes and not other types of health-care facilities. In addition to the allegations noted above we comment on other findings discovered during the course of our investigation. Our investigation was conducted in accordance with *The Auditor General Act*.

As part of our investigation procedures, we examined the following:

- PPCO's investigation policy manual for areas of weaknesses.
- A sample of 10 investigation files for compliance against the policy manual.
- 14 investigation reports provided by PPCO staff and management for instances of unfounded conclusions.
- A cross-jurisdictional comparison of Manitoba PPCO's publicly reported statistics vs the statistics reported by other PPCO offices across Canada.

We also interviewed 13 current and former PPCO staff members, and reviewed processes and information provided by the PPCO.

Subsequent events

In April 2023, following the examination period of our investigation (October 2021 to July 2022), we were told of two subsequent events:

1. Proposed legislative changes to the *Vulnerable Persons Living with a Mental Disability Amendment Act*. The alteration to the legislation would affect the definition of abuse for the PPCO.

   Subsequently, the legislative change received Royal Assent on May 30, 2023. We did not audit the impact of the legislative change as it was outside of our examination period.

2. PPCO made changes to their senior management including appointing:

   – A new Executive Director.
   – A new Director.

1 Allegations confirmed regarding serious issues at the Protection for Persons in Care Office

Our investigation into the allegations we received regarding the Protection for Persons in Care Office (PPCO) confirmed serious systemic issues exist. These issues jeopardize PPCO's ability to produce meaningful investigation results to help protect vulnerable Manitobans in care.

We found:

- PPCO is concluding "unfounded for abuse" in cases where vulnerable Manitobans were punched, beaten, or sexually assaulted **(SECTION 1.1)**.
- Victims are waiting up to 3+ years before investigations are started **(SECTION 1.2)**.
- PPCO public reporting on the outcome of its investigations is inadequate **(SECTION 1.3)**.

1.1 PPCO concluded 'unfounded for abuse' in cases where vulnerable Manitobans were punched, beaten, or sexually assaulted

We received numerous allegations that victims in personal care homes were being assaulted, yet PPCO was deeming these incidents to be "unfounded for abuse".

When speaking with PPCO staff members during the course of our investigation, both investigators and management provided us with numerous examples of files where they felt the allegation should be founded, but the final conclusion was ultimately unfounded for abuse. We selected 3 examples to demonstrate cases where vulnerable individuals were assaulted yet PPCO concluded unfounded for abuse. These examples contain summaries of information and wording taken from PPCO's investigation reports.

Example 1

DETAILS OF THE INCIDENT
A health-care aide at a personal care home kicked a resident in the shin, who suffered a large skin tear. The resident started bleeding, and after the wound was cleansed, it continued to bleed. The facility contacted the Winnipeg Police Service due to the serious nature of the incident and injury.

PPCO CONCLUSIONS
1. Incident occurred
2. Mistreatment occurred
3. **Unfounded for abuse**

PPCO documented reasoning for concluding unfounded for abuse:

- The alleged victim made a full recovery.
- The alleged victim does not remember the incident.
- The act of kicking did not interfere in a serious or substantial way with the alleged victim's well-being.

Example 2

DETAILS OF THE INCIDENT
Two health-care aides at a personal care home held down an elderly person forcefully on the bed to change their clothing from pajamas to day clothes. Both health-care aides also used threatening and vulgar language towards the elderly patient:

- "You're a f***ing prick"
- "You're a f***ing bastard"
- "I am going to f***ing kill you"

PPCO CONCLUSIONS
1. Incident occurred
2. Mistreatment occurred
3. **Unfounded for abuse**

PPCO documented reasoning for concluding unfounded for abuse:

- There was no evidence of a change in the alleged victim's behavior after the incident.
- The alleged victim was severely cognitively impaired; therefore, it is unlikely the incident would interfere with his psychological integrity or well-being in a substantial way.
    - PPCO conclusion quote: "As a result of the information provided by [the Director of Care of the facility] concerning the alleged victim's mental status, the PPCO is unable to conclude that the acts of swearing at and threatening a patient and applying an unauthorized restraint either did, or were reasonably likely to cause serious harm."
    - The facility's Director of Care stated: The alleged victim is so severely cognitively impaired, that despite how traumatic the experience was, it's unlikely to interfere "with his psychological integrity or well-being in a substantial way."

Example 3

DETAILS OF THE INCIDENT
A health-care aide at a personal care home hit a victim with severe dementia in the face with a remote from a transfer lift. The health-care aide then lowered the transfer lift onto the victim's abdomen pressing the metal onto the victim's belly while the victim screamed. This resulted in lacerations to the victim's face, as well as bruising and swelling on their abdomen and shoulders. The police were called, charges were laid against the health-care aide for assault, and a "No Contact Order" was issued to protect the person who reported the incident.

PPCO CONCLUSIONS
1. Incident occurred
2. Mistreatment occurred
3. **Unfounded for abuse**

PPCO documented reasoning for concluding unfounded for abuse:

PPCO conclusion quote: "[Alleged victim] did not require acute medical or psychological care after this incident. Though this was a serious incident, there was no evidence to support that it interfered in a substantial way with the patient's well-being nor was it reasonably likely to. As such, this incident is unfounded for abuse."

Key points from the file:

- The investigator's original conclusion was **founded** for abuse.
- Quote of the investigator's original conclusion: "An assault of this type would reasonably place the patient at risk for serious long-term emotional distress (fear and anxiety) and risk for physical pain both in her face, her abdomen and her shoulders. Evidence supports that these applied injuries in a fragile elderly person can lead to a deterioration of health and even death. As a result, this investigation is founded for abuse by [the alleged abuser]."
- The Director disagreed with the investigator's conclusion.
- The Director left various comments on the investigator's draft report including:
  - "The test isn't 'would be reasonable to expect' "
  - "What medical evidence exists to support that the injuries were reasonably likely to cause serious harm?"
  - There was no "need for acute care treatment".
  - It's "mistreatment, not abuse."
- The Director made the investigator change the decision to unfounded for abuse.
- The conclusion was ultimately changed to **unfounded** for abuse.

The purpose for the creation of *The Protection for Person's in Care Act* was to protect vulnerable persons in care. The examples above show that the PPCO's interpretation of the Act has resulted in a failure to reach reasonable conclusions. PPCO conclusions and directions are key to fulfilling their role in protecting vulnerable Manitobans.

In order to determine the root causes of why PPCO was concluding allegations as unfounded for abuse, we analyzed PPCO's investigation process to determine how investigations are being conducted.

The PPCO investigation process involves:

- Receiving complaints.
- Accepting reports of alleged abuse or neglect in a health facility.
- Determining whether a more extensive investigation is warranted.
- Conducting investigation procedures to determine if the incident occurred, and if it resulted from mistreatment.
- Determining if injuries were significant enough to meet the threshold for abuse and neglect.

The PPCO uses a 3-step process to determine whether abuse or neglect is founded or unfounded:

Step 1: On a balance of probability did the incident occur? PPCO investigators attempt to determine if it's more likely than not that the incident occurred as described by the complainant.

Step 2: Did mistreatment occur? The PPCO defines mistreatment as "treating someone badly, cruelly, or unfairly."

Step 3: This involves a 2-part analysis:

a. Did the mistreatment cause serious harm **or**
b. Was the mistreatment reasonably likely to cause serious harm?

The Supreme Court of Canada defines serious harm as "any hurt or injury whether physical or psychological that interferes in a substantial way with the physical or psychological integrity, health or well-being of the complainant." This definition is what the PPCO uses as its threshold for determining serious harm.

Within the sample of investigation files we examined, we saw cases where Manitobans in care had been punched, kicked, or sexually assaulted. The PPCO determined that the incidents occurred, but were unfounded for abuse. We identified 3 reasons why the PPCO is concluding unfounded in these cases.

1.1.1 PPCO's threshold for serious harm is extremely high

In our review of the PPCO investigation files, we found that the PPCO uses an extremely high threshold to prove that serious harm occurred. PPCO's interpretation for serious harm was based on the Supreme Court of Canada's definition. In order to meet this high threshold, the PPCO requires evidence of long-lasting physical or emotional harm. We reviewed files where victims recovered from their injuries and/or couldn't remember the incident, and the PPCO ruled the abuse allegations to be unfounded. According to the PPCO's practice, if a victim recovered from their injuries, or a victim could not remember being assaulted (due to having dementia or some other cognitive impairment), then there would be no evidence of emotional or physical harm exhibited by the victim, thus they could not establish that the threshold for serious harm was met.

We interviewed investigators who told us that they would frequently bring founded conclusions to management for approval, disagreements would occur, and their decisions would ultimately be overturned. These disagreements were not recorded in the files. Investigators said that management heavily discouraged the documentation of such discussions. Management confirmed that these disagreements did take place, and that the overturning of investigator decisions also occurred. Management told us that the reason for overturning investigator decisions was that the threshold for abuse or neglect was not met, under their interpretation of the Act.

According to the PPCO's practice, if a victim recovered from their injuries, or a victim could not remember being assaulted (due to having dementia or some other cognitive impairment), then there would be no evidence of emotional or physical harm exhibited by the victim, thus they could not establish that the threshold for serious harm was met.

1.1.2 PPCO lacks a process to identify if serious harm is reasonably likely to occur

The PPCA states that abuse or neglect is:

"an act or omission …. that causes **or is reasonably likely** to cause … serious … harm".

As stated earlier above in Step 3, the process of determining serious harm is a 2-part analysis. The first part is for the PPCO to determine if serious harm occurred. If serious harm cannot be established, then according to *The Protection for Persons in Care Act* (PPCA) definition of abuse or neglect, the PPCO should consider if the mistreatment could have reasonably likely led to serious harm. We found there is no requirement in the PPCO's policy manual to make this determination, or to document it in case files. The policy manual should have a defined process for determining if serious harm is reasonably likely to occur. In the example below, the PPCO assumed that a serious sexual assault of a vulnerable patient did not lead to serious emotional harm.

Example of a file where the PPCO did not consider whether an action was reasonably likely to lead to serious harm

Details of the incident

A vulnerable patient was seriously sexually assaulted by a care worker.

PPCO conclusions

The PPCO found the victim credible and determined the serious sexual assault had taken place. However, the PPCO deemed the allegation as unfounded for abuse.

Reasoning (direct quote)

"The investigator noted many qualities of an emotionally traumatized victim throughout the investigation and noted that the AV [alleged victim], with psychological care and support, was able to move forward from the incident remarkably well. Given that the PPCO cannot establish that this incident impacted the AV in a substantial way, the investigation is unfounded for abuse."

1.1.3 PPCO does not have a process for the use of medical opinions

Investigators told us that in certain cases where they felt an allegation should be concluded as founded, management was unwilling to do so without a medical opinion. Management told us that they wanted a medical opinion as evidence for a defense, should their decision ever be questioned in the courts.

The Act is silent on the use or requirement of medical opinions to support conclusions. Additionally, the PPCO's policy manual is also silent on the use or requirement of medical opinions. We could not find a formal requirement for investigators to obtain medical opinions.

Recommendation 1

We recommend that the PPCO's policy manual include a process to assess and document:

a. Whether serious harm is reasonably likely to have occurred, and
b. If/When medical opinions are necessary, and what alternative evidence is acceptable if a medical opinion can't be obtained.

Guidance should be included to ensure that both these elements are applied consistently.

1.1.4 Interpretation issues have been known for years

The interpretation issues regarding the high threshold of serious harm being used at the PPCO have been ongoing for over 10 years.

In 2019, the PPCO began drafting a proposal to update the Act, with the intent of bringing it up to the PPCO's legal counsel to initiate change. However, efforts to pursue this plan stalled and ultimately no changes were made to the Act. We were told that the PPCO's attention was focused on clearing a 3-year backlog of files (see **SECTION 1.2** for more information on the backlog).

Over the last 10 years, 3 other reports have been published which drew attention to the PPCO's interpretation problem. The 3 reports were released by the Ombudsman of Manitoba, a task force external to PPCO, and the Department. Despite the issue being raised 3 times by 3 separate bodies over the course of 10 years, the PPCO still failed to take meaningful action to remedy the situation.

The following table highlights the 3 reports that raised the interpretation problem, along with brief excerpts of the related findings.

Despite the interpretation issue being raised 3 times by 3 separate bodies over the course of 10 years, the PPCO still failed to take meaningful action to remedy the situation.

Report title	Excerpt of findings (read the reports for full details)
2021 – Pathway to Dignity: Rights, Safeguards, Planning and Decision Making *By: Manitoba task force of members in consultation with Manitoba Families*	"The definition of abuse in the act is also different than that seen in some other jurisdictions. Notably, Manitoba legislation requires that abuse or neglect be reasonably likely to cause serious physical or psychological harm. This means that a slap in the face is not necessarily considered abuse under the legal definition in the Act, since it does not lead to lasting physical consequences. **Such examples are at odds with common sense. The task force strongly believes that the Act creates an overly strict test to prove that a person has been abused.**"
2016 – Internal Service Review Report: The Protection for Persons in Care Office *By: Manitoba Family Services*	"Legislative challenges exist for the office.... The lack of policies to provide interpretation to the content of the Act has resulted in unclear thresholds used to make critical decisions, and high-level explanations for decisions made. The end result is decisions are not easily understood as measurable, and consequently defendable. Additionally, the "legal opinion" related to the definition of abuse has essentially been made a scapegoat for the confusion, ... Interestingly, the case law used in the legal opinion, R. V. McCraw, is the same case law documented in the Ombudsman's Review of 2011, which was

Report title	Excerpt of findings (read the reports for full details)
	directed at ensuring incidents/concerns were not dismissed due to a perceived narrow interpretation the PPCO had been using to determine if an investigation was warranted. **Staff and management have pointed to a need for changes to be made to the legislation, specifically to the definitions of abuse and neglect.**"
2011 – Report on the Protection for Persons in Care Office *By: Manitoba Ombudsman*	"**Under the current working definition of abuse one of the conditions that makes care facility residents vulnerable and in need of protection, namely, a mental impairment, may inadvertently shield abusers.** This may result when the abusive act would normally cause emotional harm but because of the inability of a patient to comprehend the action and indicate what had occurred, the assessment of the consequence to the patient may be that it is difficult or impossible to determine if there has been emotional harm. **This is a particular concern given that this legislation is intended to protect residents of care facilities who are often elderly patients who can be physically frail and also suffering from some type of mentally debilitating condition such as dementia.**"

Recommendation 2

We recommend the PPCO update the definition of abuse and neglect in the Act and/or ensure their interpretation of the definition is in line with the objective of protecting vulnerable Manitobans in care.

1.2 Some victims waiting up to 3+ years for investigations to start

A significant issue we found at the PPCO was the amount of time it takes from when an allegation is first submitted to the PPCO to the time an investigation starts. This issue is made even more significant by the fact that it has been ongoing for over 10 years without resolution. As at October 2022 the PPCO still had allegations from 2018 waiting to be investigated.

The PPCO provided various reasons for the inability to clear the backlog which included:

- A shortage of investigators.
- Challenges in hiring additional investigators.
- A few unexpected and urgent investigations that required all hands-on deck.
- Temporary investigators loaned to the office who lacked experience and training.

Another issue we found was the amount of time it took for the PPCO to complete an investigation. Of the 10 investigation files we pulled for testing, we analyzed the amount of time it took to complete an investigation (from the time an allegation was first received by the PPCO to when the investigation was closed). We found that the shortest timeframe was 440 days and the longest investigation took 1,278 days (or about 3.5 years).

Whether reviewing the amount of time it takes to start an investigation, or the time to complete an investigation, investigations are not being conducted in a timely manner.

Four consequences of the backlog

As the backlog of investigation files has continued to build up over the years, 4 consequences have emerged which cast doubt on the effectiveness of the PPCO:

a. *Impact on the families and victims*

A significant consequence of the backlog is the impact the delays have on families and victims. An investigator shared a case of speaking to an individual whose family member (the victim) had just passed away. The family was grieving and the investigator was asking questions about abuse that took place multiple years earlier. The investigator was concerned of the emotional impact of asking detailed questions on abuse which occurred such a long time ago and when the family was in mourning. The PPCO is the place where victims and families turn to for help in resolving allegations of abuse or neglect, but instead, many were met with years long wait times before their allegation is even brought to the investigation stage.

The PPCO is the place where victims and families turn to for help in resolving allegations of abuse or neglect, but instead, many were met with years long wait times before their allegation is even brought to the investigation stage.

b. *Loss of evidence impacting investigations*

Another consequence to the lengthy backlog is the potential loss of evidence that occurs when it takes years before an allegation gets to the investigation stage. This affects the PPCO's ability to properly conduct investigations. The PPCO told us that the 3- to 4-year delay negatively impacts the quality of its investigations:

- Evidence may no longer exist.
- Victims may have already passed away.
- Staff and witness contact information may no longer be available.
- Witnesses and/or staff may have moved and can no longer be contacted.

Investigators told us they could not get accurate information from witnesses when interviews were being conducted 3 years after the alleged incident.

In order to conduct evidence-based investigations, evidence needs to be obtained in a timely manner. The backlog has impacted the PPCO's ability to obtain this information and to conduct quality investigations.

c. *Impact on the PPCO's credibility*

Investigators we spoke to questioned the value of investigating allegations 3 and 4 years after an alleged incident, and the value of the PPCO's role.

We were told families, victims, and facilities questioned the PPCO's credibility because they were being contacted by the office years after an alleged incident occurred, and are asked to recall facts and details that had long faded from memory.

d. *Impact on the accused*

The impact of the backlog is not only profound for the victims of alleged abuse or neglect, but also for the alleged abusers. Facility staff who have allegations raised against them are also waiting for the PPCO investigation to start and conclude. When allegations are presented, facilities often complete internal investigations soon after the allegations were brought to the facility's attention. If the allegations are found not to have merit in the internal facility investigation, the staff member would still have the allegation as a lingering concern until the PPCO concluded their process years after the alleged incident. All parties should be entitled to investigations that are concluded within a reasonable timeframe.

Consequence to victims and families of 3+ year wait times for investigations to complete

We spoke with several families through our citizen concern process who provided their experiences with PPCO. One family was required to wait up to 3.5 years for the PPCO to complete an investigation. Their family member experienced significant acts of abuse by staff at a personal care home and PPCO failed to complete the investigation in a timely manner.

The family described finding bruising on their mother who has limited cognitive capability and was living in a personal care home. In order to identify the origin of the bruising, the family installed security cameras in the room which subsequently filmed acts of abuse where their mother was struck by a healthcare aide and had a hydraulic lift thrown at her face.

The family described their pain at watching their mother suffering significant acts of abuse on video. The PPCO delays were so substantial that their mother had passed away before PPCO even started their investigation. The family questioned what evidence would remain 3.5 years from the time of the abuse.

The family also described their frustration with the significant investigation delays because it meant that the alleged abuser could get another job working with vulnerable Manitobans while the investigation was conducted. They believed the delay may result in the alleged abuser continuing to mistreat vulnerable Manitobans at other facilities. Without a completed investigation the PPCO cannot refer an alleged abuser to the AARC for inclusion on the adult abuse registry which would prevent them from working with vulnerable Manitobans.

PPCO delays in submitting abuse/neglect reports to the AARC

In addition to the 3-year backlog noted above, we found further delays with the PPCO submitting reports to the AARC. Under Section 8.2(1) of *The Protection for Persons in Care Act* (PPCA) and under Section 3 of the PPCA Regulation, the Minister of Health is required to report abuse or neglect to the Adult Abuse Registry Committee (AARC). See the Background section for a quote of Section 3 of the PPCA Regulation. If the PPCO arrives at a founded conclusion for abuse or neglect, and the alleged abuser meets the requirements set out in the regulations, then the PPCO is required to submit a report to the AARC.

We found that the PPCO was not submitting abuse or neglect reports to the AARC in a timely manner. Between 2015 and 2021, it took anywhere from one to 37 months for the PPCO to submit a completed and signed report to the AARC (this covers the time between when the investigation is completed and signed, to the time a report is sent to the AARC). PPCO management was unable to provide an explanation on why such delays occurred, but they did indicate that they would be looking into the cause of this issue and potentially adding timelines within their policy manual in the future.

During the delay in submitting referrals to AARC, alleged abusers can continue working with vulnerable patients in the healthcare field. This is not reasonable.

Delays in determining whether to put alleged abusers on the list

We noted, according to PPCO's records there are delays occurring on the AARC and/or Registrar's end. While we didn't audit the AARC or the Registrar since it was outside the scope of this investigation, the statistics we requested from the PPCO (see table below) show that alleged abusers are not being placed on the registry in a timely fashion.

PPCO submitted report to AARC	AARC decision as at October 2022	Time delay
2015 (1 file)	TBD: still no decision on whether to place the alleged abuser on the registry (pending a decision)	7 years
2019 (2 files)	Pending a decision	3 years
2020 (1 file)	Pending a decision	2 years
2021 (3 files)	Pending a decision	~1 year

Recommendation 3

We recommend that the PPCO revise their investigation policy to include a section with procedures on submitting abuse or neglect reports to the AARC. Such procedures should include, but are not limited to:

a. Reasonable timelines for the submission of reports to the AARC.
b. Tracking of compliance with timelines.
c. Possible follow-up procedures if necessary.

Three factors that make the backlog hard to clear

During our investigation, we found 3 issues that make the backlog hard for the PPCO to clear. These 3 issues were as follows:

a. *There is no option to streamline investigations*

PPCO's current investigation process does not allow for investigations to be streamlined if circumstances change. If an allegation has been approved for investigation, then the allegation must go through the entire investigation process even if there may no longer be a valid reason to invest time and resources into continuing the investigation.

Investigators have faced instances where they felt that a full investigation was no longer warranted or beneficial. An example could include a situation where all of the following criteria are met:

- A consideration of the context and nature of the allegation.
- It has been years since the alleged incident occurred.
- The alleged abuser no longer works at the facility or in the healthcare field with vulnerable patients.
- The facility has already implemented measures to help ensure a future repeat of the same situation doesn't occur again.

In these cases, PPCO investigators have told us that even if they were to complete the investigation from start to finish, they would not be issuing any directions to the facility or adding any value. Investing time into these types of situations may not be the best use of the PPCO's time and resources, both for overall efficiency, and in terms of clearing the backlog.

Recommendation 4

We recommend that the PPCO determine the merits of adding an option in its investigation process to streamline investigations. If the PPCO decides to implement this option, the process should be supported by:

a. Policy manual guidance on key considerations which must be met before any investigation is streamlined.
b. Documentation requirements for all conclusions and discussions which are to be maintained in the file.
c. Appropriate communication to all parties involved.

b. *PPCO investigators perform the work of both inquiries and investigations*

Investigators told us that the PPCO is the only place they've been employed where they are required to perform the work for both preliminary inquiries and investigations. In all other previous investigation positions they held, there were always separate individuals to handle the two roles, which allowed investigators to fully dedicate their time and attention to handling investigations.

PPCO investigators stated that performing both inquiries and investigations was not an efficient process and that it took away valuable time that was needed to focus on investigations.

The PPCO indicated that there was an attempt made to assess the value of splitting the duties of inquiries vs investigations, however, after a short period of testing PPCO management decided this was not a good process and discontinued the initiative.

Recommendation 5

We recommend that the PPCO:

a. Assess the merits of having separate staff handle the inquiry process.
b. Implement changes and procedures if required.

This would allow investigators to focus their time and attention on investigations.

c. *Approval delays in the investigation process*

A common theme raised among investigators was that there are 2 points in the investigation process that add to the backlog:

1. It can take months for allegations to get approved from the inquiry stage to the investigation stage.
2. It can take months for Investigation Reports (a completed investigation) to be reviewed.

The Director, who is responsible for both of the approval points, confirmed to us that:

1. It takes a couple of months to approve allegations from the inquiry stage to the investigation stage.
2. Investigation reports are sitting on the Director's desk for quite a bit longer than the inquiry approvals. The oldest investigation report that was sitting on the Director's desk at the time of our interview was from October 2021. This represented an 8-month delay at that time.

Under the current system, one person in the investigation process may be responsible for a number of approvals. A bottleneck can occur if this individual falls behind in granting these approvals.

In SECTION 2, we address several other process weaknesses that the PPCO faces which ultimately contribute to an inefficient investigation process.

1.3 PPCO public reporting is inadequate

Publicly reporting on an organization's work is a crucial tool that allows policymakers and the public to determine if an entity is fulfilling its mandate. Public reporting also ensures that an organization is transparent, and can assist in identifying risks and trends over time that an organization should take steps to address.

The PPCO stopped producing annual reports in 2016. PPCO management stated that creating the reports was not particularly helpful to the public or the PPCO. Management told us staff time could be better spent conducting investigations. The only public reporting the PPCO has provided since 2016 is in the Department of Health's annual report, and on their website. The PPCO reports the number of new concerns it receives, and the number of educational sessions it conducts in any given year. These metrics do not provide a sufficient picture to determine if the PPCO is meeting the expectations of policymakers and the public, or provide information regarding risks facing the PPCO.

We reviewed other jurisdictions to identify metrics that provide value to the public, policymakers and the PPCO itself. These metrics are broken down by regional health authorities, individual healthcare facility, and/or both. They include:

- Number of concerns received.
- Number of founded and unfounded investigations based on:
  - The position of the alleged abuser.
  - Nature of the abuse or neglect.
  - Type of health-care facility (personal care home, hospital, long-term care facility).

- Investigations founded for mistreatment.
- Investigations founded for serious abuse or neglect.

- The average length of time to complete an investigation.
- Number of investigations pending.
- Number of investigations completed.

Another risk factor that could be valuable for the PPCO to consider reporting is the ownership status of a healthcare facility (public vs. private). We have seen significant public concerns identified in the media regarding care in private, for-profit, personal care homes. By publicly reporting on abuse or neglect investigations based on the ownership of the facility, the PPCO could provide the public and policymakers with a tool to help evaluate potential risks.

Recommendation 6

We recommend the PPCO produce a report, at least annually, which provides statistics regarding its investigations. The PPCO should consider reporting statistics published by other PPCO offices in Canada as well as any other potential information which could benefit the public and policymakers.

PPCO does not provide any public information regarding individual investigations

The PPCO does not publicly disclose the nature of individual allegations received, the results of completed investigations, or directions provided to health-care facilities. The absence of public reporting limits Manitobans' ability to: determine if care is being appropriately provided at a given facility, identify potential risks within the healthcare system, and/or determine if a particular care facility is appropriate for their loved one. This is not consistent with other jurisdictions we reviewed. For example, Alberta provides decision summary reports based on each health-care authority. The decision summary reports detail the investigations conducted in each health-care facility, while still maintaining confidentiality. The reports include a brief summary of information including:

- The position of the alleged abuser involved (for example: facility staff or a patient).
- The allegation.
- The type of abuse.
- The conclusion of the investigation (founded or unfounded).
- Directions, if issued.
- Implementation status of the directions (implemented or not, and the date of implementation).

Recommendation 7

We recommend the PPCO provide a summary of individual completed investigations at least annually.

This should include:

a. A summary of the initial allegation.
b. Position of the alleged abuser.
c. Outcome of the concluded investigation.
d. Any accompanying directions issued by the PPCO.
e. The implementation status of the directions.

2 Process to receive, review, investigate, and report on abuse or neglect allegations needs to be improved

This section covers the findings from our investigation procedures where we examined the following:

- The PPCO's investigation policy manual for completeness and areas of weaknesses.
- A sample of 10 investigation files for compliance against the PPCO policy manual.

2.1 PPCO has an investigation policy manual but improvements are needed

The PPCO has an investigation policy manual that covers each of the 4 main parts of the investigation process: to receive, review, investigate, and report. However, we found that the policy manual lacks key elements to ensure quality investigations.

No prioritization of allegations on a risk basis

We found that the PPCO's policy manual does not provide guidance on prioritizing allegations based on risk. PPCO management's practice is to prioritize investigations based on when they were received, with the oldest files prioritized for assessment.

The Director told us that investigators are allowed to have discussions with management if they feel a specific allegation should be prioritized ahead of older files. However, rarely do newer allegations get pushed to the front of the queue.

Prioritizing investigations based on risk would allow the PPCO to concentrate on allegations with the greatest and most immediate danger to victims in personal care homes. For example, there are situations that could carry a higher risk such as:

- An allegation involving an alleged abuser who is still working with vulnerable individuals.
- An allegation where a victim may be nearing the end of their life and crucial information needs to be obtained prior to the victim's passing.

We did find some investigations that were prioritized in rare circumstances, such as the investigation into the pandemic response at the Maples Personal Care Home, however, such instances were not the norm.

Recommendation 8

We recommend that the PPCO implement a risk prioritization process for investigations, and document it in their policy manual. Guidance for this process can include, but is not limited to:

a. Risk factors to consider.
b. Documentation of reasons for prioritization and resulting conclusion.
c. Review and signoff requirements.

No documentation of key decisions

Investigators told us that they would often conclude founded on the results of an investigation, only to have that decision overturned by the Director. Investigators said they made attempts to document these conversations in the files, but management discouraged the recording of such information. Best practice would be to document any and all key decision-making discussions. The policy manual is silent on whether these types of conversations are to be documented.

Recommendation 9

We recommend that the PPCO require all key decision-making discussions to be documented in the investigation files, including all changes to investigator conclusions.

No documented quality assurance process

The PPCO does not have a documented quality assurance process. A quality assurance process is a best practice standard of determining whether processes are meeting specific measures. For the PPCO, this would serve to identify whether investigations are meeting their timelines, documentation requirements, and procedures as set out in the policy manual. Without the use of this tool, the PPCO lacks a formal mechanism to identify and document whether investigations are meeting timelines or following policies, thus losing out on a critical opportunity to identify problems and areas for improvement.

At the time of our investigation, the PPCO was not performing quality assurance audits on investigation files; though it did do them at one point in 2016 for a brief period. The PPCO was only conducting quality assurance audits of inquiry files.

Results from the inquiry files audits were documented, however, the form used for the documentation could be improved. Additionally, the form used by the PPCO for investigation audits was not sufficient as it did not list any key information set out in the policy manual such as:

- Internal process timelines to be met.
- Specific procedures that must be performed.
- A checklist of all communication that must be sent to the parties involved.

See **APPENDIX 1** for the quality assurance form that was used by the PPCO for past investigation audits.

Recommendation 10

We recommend that the PPCO implement a documented quality assurance process. This should include:

a. Guidance on how files (inquiry and investigation) are selected for audit (for example: risk based).
b. How many files should be selected.
c. How often audits should occur.
d. The use of an audit checklist listing the key requirements of the policy manual.
e. A follow-up process to address training or education for PPCO staff, if needed.
f. Requirements for documentation of the audits.

2.2 PPCO does not always follow procedures set out in its investigation policy manual

We reviewed whether the PPCO was in compliance with its investigation policy manual. We did this by analyzing a sample of 10 investigation files. We found a number of non-compliance issues. The major issues we found are presented below, while other more minor issues will be provided to the PPCO in a management letter.

Communication letters not always sent to victims and their families, despite PPCA requirement

Part of the PPCO's investigation process is to ensure that communication letters are sent to victims or their designated alternates, both at the start of an investigation (letters of notice) and at the conclusion of an investigation (results letters). These letters let the victim know there are reasonable grounds to believe they may have been abused, let the victim know the PPCO is starting an investigation, and provide the results of the investigation.

Out of the 10 investigation files reviewed, we found 6 files had no letters of notice sent to the victim or the victim's designated alternate.

Ensuring that victims and their families are aware of allegations of abuse or neglect and that an investigation is commencing is a requirement within the Act.

Section 5(3) of the PPCA states that:

> "As soon as practicable after referring the matter to an investigator, the minister shall notify the patient that a report of abuse or neglect has been made and that an investigation is to be conducted. If the patient has a committee, the notice is to be given to the committee instead."

We also found that communication with victims and families was lacking at the end of an investigation. Part of the PPCO's investigation process is to provide victims or their designated alternates a results letter at the conclusion of the investigation. A results letter notifies the victim that the investigation has been completed, and it provides the PPCO's conclusion.

Out of the 10 investigation files reviewed, we found 6 files where the results letter was not located in the file.

Therefore, 60% of victims and their families from our sample were left without any form of communication. Victims and families deserve to know when an investigation is started on their allegation, as required by legislation, and the results of the investigation once it's completed.

Recommendation 11

We recommend that the PPCO create procedures to ensure that letters of notice, and results letters per their policy manual are tracked and sent. This could include, but is not limited to:

a. Checklists of letters to be sent.
b. Signoffs.

No formal tracking of directions issued

Following an investigation, the PPCO can issue directions to a facility to help prevent future incidents from occurring and to improve practices. These directions are binding, which means that facilities are required to implement them. See sidebar for examples of directions commonly issued by the PPCO to facilities.

Examples of directions issued by the PPCO

- "The facility will review documentation practices in regards to patients chart/ progress notes and it will ensure that patients files provide adequate information for facility staff to administer individualized care that meets professional standards."
- "That the facility reinforce with all staff, including those who provide direct care, housekeeping, dietary, and reception, the reporting requirements of the *Protections for Persons in Care Act* and provide evidence of same to PPCO."

Although the PPCO directions to facilities are binding in nature, investigators told us on more than one occasion that they felt the PPCO wasn't making meaningful directions to actually address root cause problems related to allegations. Investigators felt that the office was making high-level, general directions such as attending PPCO training sessions, or re-reading facility policy/training manuals. We did not audit the effectiveness of the PPCO's directions issued, as it was outside the scope of our investigation.

The PPCO policy manual requires that the "Executive Director ensures all directions to a facility are recorded on the directions database for monitoring purposes." We found the PPCO does not have a central database. Without a database, investigators must independently track directions. This is done via Outlook calendar reminders, personal handwritten lists, and sticky notes.

A central database to track implementation of directions would allow the PPCO to:

- Track all directions that the PPCO has issued to facilities.
- Track whether directions are being appropriately implemented.
- Track whether directions are implemented within their 100-day deadline per their policy manual.
- Identify if facilities are receiving similar directions repeatedly.
- Obtain statistics on the number of directions issued to facilities or regions.
- Use statistics to perform risk analysis to identify higher risk facilities or regions.

The PPCO informed us that they are in the process of implementing a new electronic system to track investigations, and that this new system should be able to track directions.

Two additional issues we found related to the implementation of directions are that the PPCO does not always:

- Document why a direction has been accepted by PPCO as implemented.
- Provide a PPCO signoff to indicate that a direction has been implemented.

Recommendation 12

We recommend that the PPCO develop a process to:

a. Track all directions issued by the PPCO.
b. Provide reminders for follow-up.
c. Require signoffs and documentation prior to clearing directions.
d. Track vital statistics to provide data for risk monitoring and trend analysis.

2.3 Significant reduction in the PPCO education sessions to facilities

Apart from their responsibilities in conducting abuse and neglect investigations, the PPCO investigators also provide information sessions to the nearly 200 health-care facilities in Manitoba, including 124 personal care homes. Sessions can be initiated at the facility's request or as part of a direction issued by the PPCO. The PPCO can also provide sessions to groups and organizations such as seniors advocacy institutions. The sessions provide health-care facility staff with guidance on what constitutes abuse and neglect, good practices on care, and their requirement to contact the PPCO when abuse or neglect is witnessed or suspected.

Investigators felt the sessions helped prevent problems and inform front-line staff of their responsibilities to immediately report instances of abuse and neglect. One interviewee told us that "the vast majority of staff have no idea PPCO exists. They don't know what they're supposed to report. Granted there are posters up, but I don't think they have a clue. And you can't fault them. If we are not educating them, they have no way of knowing."

One interviewee told us that "the vast majority of staff have no idea PPCO exists. They don't know what they're supposed to report. Granted there are posters up, but I don't think they have a clue. And you can't fault them. If we are not educating them, they have no way of knowing."

During our investigation, allegations of abuse were reported by local media regarding a personal care home. The allegations consisted of a whistleblower who claimed that upwards of 15 residents were abused by 2 personal care home staff. Four concerns were reported to the PPCO by the personal care home administration in early 2022. The remainder of the allegations were not reported until June 2022. In total, 15 to 16 allegations of abuse or neglect were reported. We found that over the last 5 years, the only PPCO staff education session presented to this personal care home was in October 2019. No other PPCO staff education session was provided between 2017 and 2022. Considering the delays in reporting the allegations to the PPCO, we question whether personal care home staff and administration knew that they have a requirement to report allegations of abuse/neglect to the PPCO in a timely manner.

As seen in the chart below, educational sessions have declined over the last 5 years from a high of 57 sessions provided in 2015/16 down to 6 in 2020/21, this constitutes an 89% reduction in educational sessions delivered.

PPCO educational sessions conducted annually	
Fiscal Year	Number of educational sessions delivered
2015/16	57
2016/17	46
2017/18	26
2018/19	42
2019/20	35
2020/21	6

The significant reduction in educational sessions is a result of the PPCO management discouraging investigators from providing educational sessions to facility staff. Management said they were focused on tackling the 3- to 4-year backlog of investigations, and also navigating restrictions brought on by the COVID-19 pandemic. However, by reducing educational sessions it's difficult for the PPCO to fulfil its purpose of working towards the prevention and detection of abuse and neglect in healthcare facilities.

Summary of recommendations

RECOMMENDATION 1

We recommend that the PPCO's policy manual include a process to assess and document:

a. Whether serious harm is reasonably likely to have occurred, and
b. If/When medical opinions are necessary, and what alternative evidence is acceptable if a medical opinion can't be obtained.

Guidance should be included to ensure that both these elements are applied consistently.

Manitoba Health Response:

Manitoba Health agrees with this recommendation and has undertaken measures to address.

Changes to *The Protection for Persons in Care Act* (Act) received Royal Assent on May 30, 2023. The Act has been amended to remove the determination of serious harm from a finding of whether abuse or neglect occurred.

Serious harm is now to be considered at the point of referral to the Adult Abuse Registry Committee (AARC). The department is commencing further work to define serious harm and the threshold for applying the concept in the PPCO's referrals to the AARC.

PPCO's policy manual, processes, and training are being updated to reflect this change.

RECOMMENDATION 2

We recommend the PPCO update the definition of abuse and neglect in the Act and/or ensure their interpretation of the definition is in line with the objective of protecting vulnerable Manitobans in care.

Manitoba Health Response:

The department agrees with this recommendation and has made significant progress to address.

Changes to the definitions of abuse and neglect within *The Protection for Persons in Care Act* (Act) received Royal Assent on May 30, 2023.

Abuse is now defined as conduct that constitutes physical, emotional, psychological, sexual or property abuse. Such conduct is not required to cause serious physical or psychological harm to be considered abuse.

The definition of "neglect" has also been replaced. Under the previous definition, only acts or omissions that cause serious physical or psychological harm constitute neglect. The definition of "neglect" now includes acts or omissions that cause physical or psychological harm even if the harm is not serious.

These amendments align with leading practice in other jurisdictions and in the public's understanding of these concepts.

PPCO's policy manual, processes, and training are being updated to reflect this change.

RECOMMENDATION 3

We recommend that the PPCO revise their investigation policy to include a section with procedures on submitting abuse or neglect reports to the AARC. Such procedures should include, but are not limited to:

a. Reasonable timelines for the submission of reports to the AARC.
b. Tracking of compliance with timelines.
c. Possible follow-up procedures if necessary.

Manitoba Health Response:

The department agrees with this recommendation and has been updating its practice standards and policy manual to ensure timeliness of the PPCO referral process to the AARC, once serious harm has been determined.

It now holds regular, standing meetings with the Adult Abuse Registry Committee Coordinator to review and to address any and all outstanding referrals.

The PPCO will continue to conduct training and education exercises in conjunction with the AARC.

RECOMMENDATION 4

We recommend that the PPCO determine the merits of adding an option in its investigation process to streamline investigations. If the PPCO decides to implement this option, the process should be supported by:

a. Policy manual guidance on key considerations which must be met before any investigation is streamlined.
b. Documentation requirements for all conclusions and discussions which are to be maintained in the file.
c. Appropriate communication to all parties involved.

Manitoba Health Response:

The department agrees with this recommendation and has taken considerable steps to adapt investigations to changing circumstances while still ensuring the integrity of the investigative process itself.

The PPCO has adjusted its investigation processes in response to key considerations such as false allegations, misidentified accused, or other new information that is brought forward.

PPCO policy, templates, and training are being updated to reflect that all case-related decisions are documented on the file and that appropriate communication takes place.

RECOMMENDATION 5

We recommend that the PPCO:

a. Assess the merits of having separate staff handle the inquiry process.
b. Implement changes and procedures if required.

This would allow investigators to focus their time and attention on investigations.

Manitoba Health Response:

Manitoba Health agrees with this recommendation.

The PPCO is developing a dedicated intake function that expects to improve overall investigation response time.

The department is recruiting an additional investigator to ensure the PPCO's adherence to investigation timelines.

RECOMMENDATION 6

We recommend the PPCO produce a report, at least annually, which provides statistics regarding its investigations. The PPCO should consider reporting statistics published by other PPCO offices in Canada as well as any other potential information which could benefit the public and policymakers.

Manitoba Health Response:

The department agrees with this recommendation and remains committed to enhancing transparency by making accessible the information that patients, residents, families and policy-makers require for their decision-making processes.

The PPCO's website is being updated to include the number and type of investigations it has conducted. Further improvements are anticipated, to increase transparency with the public.

RECOMMENDATION 7

We recommend the PPCO provide a summary of individual completed investigations at least annually.

This should include:

a. A summary of the initial allegation.
b. Position of the alleged abuser.
c. Outcome of the concluded investigation.
d. Any accompanying directions issued by the PPCO.
e. The implementation status of the directions.

Manitoba Health Response:

The PPCO agrees with this recommendation and has already undertaken considerable steps to move this recommendation forward.

Having access to information that highlights facility, region, and health system investigation trends is of utmost importance as it may impact both placement and policy decisions.

The PPCO's website is being updated to include the number and type of investigations it has conducted. Further improvements are anticipated.

RECOMMENDATION 8

We recommend that the PPCO implement a risk prioritization process for investigations, and document it in their policy manual. Guidance for this process can include, but is not limited to:

a. Risk factors to consider.
b. Documentation of reasons for prioritization and resulting conclusion.
c. Review and signoff requirements.

Manitoba Health Response:

The department agrees with this recommendation and has begun incorporating risk prioritization into its processes.

Being responsive to Manitoba's most-vulnerable populations is an integral component of the PPCO's work to enhance the public's trust.

PPCO policy, processes, templates, and training are being updated to reflect that all case-related decisions are documented on the file and that appropriate communication takes place.

RECOMMENDATION 9

We recommend that the PPCO require all key decision-making discussions to be documented in the investigation files, including all changes to investigator conclusions.

Manitoba Health Response:

Manitoba Health agrees with this recommendation.

Documenting key decisions is a cornerstone of accountability. The PPCO has already updated its policy manual to reflect this expectation and all key decision-making discussions are documented in the investigation files.

The PPCO has introduced software that captures a record of all user activity.

RECOMMENDATION 10

We recommend that the PPCO implement a documented quality assurance process. This should include:

a. Guidance on how files (inquiry and investigation) are selected for audit (for example: risk based).
b. How many files should be selected.
c. How often audits should occur.
d. The use of an audit checklist listing the key requirements of the policy manual.
e. A follow-up process to address training or education for PPCO staff, if needed.
f. Requirements for documentation of the audits.

Manitoba Health Response:

The PPCO agrees with this recommendation and has commenced work to build an effective quality assurance process.

Comprehensive audit checklists are now a required component of each file and a staff training and education plan has been initiated.

Further improvements to the PPCO's policy manual, processes, and training are anticipated following the implementation of a documented quality assurance process.

RECOMMENDATION 11

We recommend that the PPCO create procedures to ensure that letters of notice, and results letters per their policy manual are tracked and sent. This could include, but is not limited to:

a. Checklists of letters to be sent.
b. Signoffs.

Manitoba Health Response:

The department agrees with this recommendation in that the PPCO investigative process must include communication at various stages.

The PPCO's practice standards have been updated to reflect communication with affected parties as a key component of the process.

PPCO policy manual and training will be updated to reflect expectations surrounding communication at each stage of the investigation process.

RECOMMENDATION 12

We recommend that the PPCO develop a process to:

a. Track all directions issued by the PPCO.
b. Provide reminders for follow-up.
c. Require signoffs and documentation prior to clearing directions.
d. Track vital statistics to provide data for risk monitoring and trend analysis.

Manitoba Health Response:

The department agrees with this recommendation.

Ensuring follow-through on directions is a significant underpinning of the accountability relationship and assists in identifying risks, trends and any necessary next steps at the system level.

PPCO is updating its policy manual, processes, and training to facilities and staff to ensure implementation of all directions.

The PPCO's reporting software is being updated to log, track, and provide notifications on all directions issued by the PPCO, permitting the PPCO to identify and monitor risks and trends.

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Appendix 1: PPCO template for quality assurance audits on investigation files

File Review of [File number] _____

Completed by [Name] _____

Witnesses/Interviews (Documented)

Documentation

_____ _____

[Name] Date
Manager, PPCO

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Vision
Government accountability and public administration excellence for Manitobans.

Mission
To provide independent information, advice and assurance on government operations and the management of public funds.

Values
Independence – We are independent from government and our work is objective and unbiased.

Integrity – We act with honesty and uphold high ethical standards.

Innovation – We promote innovation and creativity in what we do and how we do it.

Teamwork – We work as a team by sharing each other's knowledge and skills to reach our goals.

Auditor General
Tyson Shtykalo

Assistant Auditor General - Investigations & Strategic Projects
Jeffrey Gilbert

Principals
Jacqueline Ngai
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