**THE OFFICE OF THE COMMISSION
FOR THE
PROTECTION OF PERSONS IN CARE**

**1700-242 Hargrave Street
Winnipeg, MB R3C 0VI
Canada**

Strengthening Protection for Persons in Care

Summary of Research, Findings and Recommendations for a New Office to Replace the Existing Protection for Persons in Care Office

**The Honourable William J. Burnett, K.C.
Commissioner**

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Introduction

The Protection for Persons in Care Office (the "PPCO"), a division of Manitoba Health, is responsible for receiving and investigating reports of abuse or neglect of adult patients in Manitoba health facilities.

In July 2023, the Government of Manitoba (the "Province") received a report from the Office of the Auditor General (the "Auditor General") concerning its investigation of the PPCO. The Auditor General's report identified serious concerns relating to the timeliness of PPCO investigations and unfounded conclusions made by the PPCO. The report also addressed the concern that the PPCO was not providing the public with statistics or information on the number of investigations it was conducting or the outcomes of those investigations, with the result that there was inadequate transparency.

As a result of the Auditor General's report, and to provide greater accountability and transparency to the public, the Province announced that it would be replacing the PPCO with a new independent office (the "new office") to receive, investigate and act upon reports of abuse or neglect in Manitoba health facilities. The Province also announced that the new office would report directly to the Legislative Assembly (the "Assembly").

On September 1, 2023, the Province created this Commission to provide advice and recommendations in relation to the new office.

THE PPCO

Overview of the PPCO

Since 2001, *The Protection for Persons in Care Act*, CCSM c P144 (the "PPCA") has governed the reporting of abuse or neglect of adult patients, residents and other persons in care (collectively "persons in care") in Manitoba health facilities. Operators of health facilities (hospitals, personal

care homes and other designated institutions) have a duty to protect persons in care from abuse or neglect. The PPCA imposes a mandatory reporting requirement when a person has a reasonable basis to believe that a person in care is or is likely to be abused or neglected. These reports are made to the PPCO, a delegate of the Minister of Health, Seniors and Long-Term Care (the "Minister"). The PPCO investigates complaints and provides reports to the Minister. The Minister may give operators of health facilities directions to protect persons in care from abuse or neglect, and operators are required to comply with these directions. Where necessary, referrals are made to the executive director under *The Adults Living with an Intellectual Disability Act,* CCSM c A6.1 (the "ALIDA"), or a professional regulatory body. Further, the PPCO may make a referral to the Adult Abuse Registry Committee (the "AARC") if it concludes that abuse or neglect occurred and that no extenuating circumstances as set out in the regulations exist.

A description of the PPCO reporting and investigation process is set out in **Appendix 1**.

Legislative and Operational Approaches in Other Jurisdictions

The Commission completed an extensive review of legislative and operational approaches with respect to the reporting and investigation of abuse or neglect of persons in care across Canada, in other common law jurisdictions (United Kingdom, Australia and New Zealand) and in the United States. See **Appendix 2** for a summary of the jurisdictional scan.

Proposed New Office

Based on its review of legislative and operational approaches in Manitoba and other jurisdictions, the Commission concluded that the new office should be independent, impartial and at arm's length from health facilities and service providers, and free from political interference; that all reporting of adult abuse or neglect in Manitoba health facilities, together with the investigation activities of the PPCO, should be transferred to the new office; that all operators of health facilities should continue to have a duty to protect persons in care from abuse or neglect, and to maintain a reasonable level of safety for them; and that all mandatory reporting requirements should remain in place.

The Commission also determined that the new office should be resolution-oriented, that it must provide timely investigation and reporting on complaints of abuse or neglect, that it should publish statistics and additional information on the number of investigations it conducts and the outcome of such investigations, and that it must be more transparent and accountable to persons in care, families, caregivers and members of the public.

With a view to obtaining input from key stakeholders, the Commission proposed that the essential characteristics of the new office would include the following:

- An individual (the "Officer") would be appointed by resolution of the Assembly to lead the new office; the appointment would be for a fixed term; and the individual would be an officer of the Assembly and would be accountable to it;

- The new office would receive and respond to reports of abuse or neglect from health facilities, caregivers, persons in care and others, would facilitate resolution where

appropriate or viable, and would undertake investigation and report on incidents of alleged abuse or neglect on a timely basis;

- Reports of abuse or neglect at the intake level would be promptly reviewed to determine if jurisdiction rested with the new office or another person or body. If so, the new office would refer the matter to that person or body for determination. The new office would receive a report on any investigations or on any conclusions reached by that person or body;

- The new office would decline jurisdiction on any allegation of abuse or neglect while the substance of the allegation was before a court;

- All of the PPCO's investigative powers would be transferred to the new office, including access to the premises, records and information of health facilities. The new office would have additional powers, such as the ability to conduct examinations under oath, to compel production of documents, to obtain subpoenas, to make applications to court for assistance, and to carry out investigations on its own initiative;

- No person would be permitted to obstruct, destroy or provide false or misleading information to the new office, and any such contravention would be an offence;

- Timelines would be specified for investigations and their completion;

- The new office would try, to the fullest practical extent, to involve the person in care and caregiver;

- A health facility could not take any adverse steps against an employee that reports abuse or neglect, nor could it discontinue or threaten to discontinue services to a person in care because of a report made to the new office;

- After completing an investigation, the new office would issue its report, which would include the reasons for its conclusions. The report would be shared with the person in care, the subject of the complaint, any employer of that person, the health facility, the AARC in accordance with the regulations, and (where applicable) the police;

- Any recommendations made by the new office in its report to a health facility would be public, and the health facility would be identified;

- A health facility would report to the new office the steps that it had taken or proposed to take to give effect to any recommendation. If the health facility declined or failed to give effect to a recommendation, the new office would notify the Minister, and would also include the matter in its annual report to the Assembly;

- The new office would provide (at minimum) annual reporting on its operations. Such reporting would include:

  (a) the performance of the office;
  (b) the number of reports of abuse or neglect received that year;
  (c) the number of referrals to other bodies/persons for review and/or investigation;
  (d) the number of facilitated resolutions;
  (e) the number of investigations undertaken, and reports issued, including findings of abuse or neglect, recommendations to health facilities and replies thereto;
  (f) the status of any outstanding matters from the preceding year;
  (g) the number of persons referred to the AARC and to the police; and
  (h) any other recommendations the new office wished to make to the Assembly.

  In addition, the new office would have the power to make a special report to the Assembly on any matter of pressing importance or urgency;

- The new office would preserve confidentiality on all matters that come to its knowledge. There would be no personal information in any report made by the new office regarding the person in care, the caregiver or the alleged offender;

- The new office would investigate any health facility if so directed by the Lieutenant Governor in Council or the Assembly, and would thereafter deliver a report in a timely fashion;

- The new office would oversee all staffing, including addressing the diverse set of skills and backgrounds required to fulfill its mandate; and

- The new office would present an annual estimate of the funds required for the purpose of carrying out its obligations.

Stakeholder Submissions

With the assistance of Manitoba Health and the Department of Families, input on the proposed new office was solicited from a wide range of interested stakeholders, including health facilities, hospitals, personal care homes and institutions, regional health authorities, public interest and advocacy groups, healthcare unions, professional associations, private and government agencies and officials, representatives of seniors, visible minorities, persons with physical and intellectual disabilities, Indigenous peoples and others. A list of the stakeholders and a copy of the letter sent to stakeholders dated December 21, 2023, are attached as **Appendices 3 and 4**.

In addition, the Commission obtained input from senior officials in the PPCO, the AARC and the Adulty Abuse Registry (the "AAR"), and from Special Counsel appointed by the Province to review past files handled by the PPCO.

The Manitoba Association of Residential & Community Care Homes for Everyone ("MARCHE") provided a submission on its behalf and on behalf of 25 other stakeholders. Aside from MARCHE

and Deer Lodge Centre, no health facility (hospital, personal care home or designated institution) or regional health authority responded to the Commission's request for submissions. In contrast, the Commission received important submissions from others, which greatly assisted the Commission in its work. One stakeholder, the Manitoba Ombudsman, provided a submission on a confidential basis.

Generally speaking, the submissions received were insightful and detailed, and they provided useful perspectives to the Commission. While portions of some of the submissions were not directly related to the mandate of the Commission or the new office, the Commission acknowledges the importance of each submission. A summary of the submissions is attached as **Appendix 5**.

Overall, there appears to be widespread support for the proposed new office. Significantly, no stakeholder opposed the creation of a new independent office at arm's length from health facilities and service providers, and outside the political sphere.

The stakeholders' main concerns, suggestions and clarifications are summarized below:

1. **Adequate funding for the new office.** A common theme among the submissions was the importance of adequate funding. Simply put, stakeholders said that without such funding, the new office will not be able to correct the concerns identified by the Auditor General.

2. **The distinct role of the new office.** Many stakeholders commented on the importance of clearly defining (and distinguishing between) the role of the new office and the role of the Seniors' Advocate. See, for example, the submissions of the Centre on Aging, the Long Term & Continuing Care Association of Manitoba ("LTCAM"), the Provincial Personal Care Home Liaison ("PCHL") and the Seniors Advocacy Coalition.

3. **The importance of timely investigations and reporting.** Virtually every stakeholder stressed the need for timely investigations and timely reporting by the new office.

4. **Improving care.** Most of the stakeholders felt that improving care for Manitobans was of utmost importance. For example, the Assembly of Manitoba Chiefs ("AMC") advised that it was committed to collaborating to ensure that the establishment of the new office aligns with high standards of care and accountability. The College of Registered Nurses ("CRN") submitted that the new office should respond to situations where the operator of a health facility has failed to provide a reasonable level of safety for patients (as required by section 2 of the PPCA) even if there is no explicit abuse or neglect. The College of Physicians & Surgeons of Manitoba ("CPSM") said that it would support a mandate of investigating matters for the purpose of finding a means of improving care as opposed to a mandate that is limited to determining whether abuse or neglect occurred. The CPSM submitted that the new office should use restorative practices to address harm that has occurred and use unfortunate incidents as learning lessons for improving future care. This submission was also supported by the PCHL.

5. **New office to be resolution oriented.** The proposal that the new office "would facilitate resolution where appropriate or viable" was generally well-accepted, although stakeholders believe that clarification is required to identify when this approach would be appropriate. The PCHL stated that it could be of great value when investigations are inconclusive, while the Manitoba Nurses Union said that the new office should utilize early resolution processes where a complainant's concerns could be addressed, and a formal investigation is not necessary.

6. **Additional investigatory powers.** Stakeholders supported the additional powers proposed by the Commission for obtaining information and records, including the power to compel examinations under oath. Some stakeholders (the Manitoba Association of Healthcare Professionals and the CRN) sought clarification as to whether these additional powers would impact the rights of employees in unionized settings or regulatory bodies who are governed by their own legislation. The CRN also sought clarification as to whether the additional powers proposed by the Commission would permit the new office to require production of the CRN's records.

7. **Procedural rules.** A number of stakeholders submitted that the new office should adopt and follow procedural rules and that such rules should be made available to health facilities, persons in care (or their committee), service providers (who are the subject of a report of abuse or neglect), professional regulatory bodies and the public. The joint submission from the Association of Regulated Nurses of Manitoba ("ARNM") and the Canadian Nurses Protective Society ("CNPS") proposed that the requirements of procedural fairness be embedded in the legislation.

8. **Enhanced training.** Many submissions emphasized the need for staff training in a number of areas, including conducting investigations, interviewing witnesses and procedural fairness. Some stakeholders felt that training must be an annual and ongoing requirement, and that the new office should disclose the specific training provided in its annual report to the Assembly. The AMC submitted that there is a need to improve cultural and sensitivity training and recommended that the new office have culturally competent advocates who can effectively communicate and address the needs of First Nation residents. The Centre on Aging also emphasized the need to provide training on trauma-informed care, equity, diversity and inclusion.

9. **Third party obligation to provide report.** The Commission proposed that a professional or regulatory body must provide the new office with a copy of their report and/or their conclusions arising from an investigation of a regulated member. The CRN noted that *The Regulated Health Professions Act,* CCSM c R117 may restrict its ability to share information with the new office.

10. **Sharing draft report.** Some stakeholders submitted that the new office should provide a draft copy of the investigation report to the health facility and that there should be

consultation with the health facility regarding proposed recommendations. According to MARCHE, representing 25 personal care homes, past recommendations from the PPCO were at times simply not realistic, nor economically feasible, and consultation is essential.

11. **Protecting the privacy of persons in care and their families.** The Commission proposed that the new office would preserve confidentiality on all matters that come to its knowledge, and in particular, that there would be no personal information in any report that would identify the person in care or the person who is the subject of the report. The Commission also proposed that any recommendations made by the new office in its report to a health facility would be public, and that the health facility would be identified. One stakeholder (the Alzheimer Society of Manitoba) cautioned that while naming the health facility would result in greater transparency and accountability to persons in care, families, caregivers and members of the public, such identification may result in increased feelings of fear, unease and worry for patients and their families.

12. **Declining jurisdiction.** The Commission proposed that the new office would decline jurisdiction on any allegation of abuse or neglect while the substance of the allegation is before a court. One stakeholder submitted that the new office should also be permitted to decline to investigate any report of abuse or neglect if the new office believes that the basis of the report is without merit.

13. **Acting on own initiative.** A number of stakeholders proposed that the new office should have the power to act on its own initiative and should not be restricted to responding to specific complaints received or referrals from the Lieutenant Governor in Council or the Assembly.

14. **Education for health facilities.** Many stakeholders proposed that an essential function of the new office is to educate health facilities, to bring awareness to the mandatory requirement to report abuse or neglect and to highlight preventative measures that would reduce the risk of reoccurrence of situations that could become abusive or neglectful.

15. **Data collection and publication.** In addition to compiling and publishing data, stakeholders proposed that the new office analyze data to identify recurring circumstances or trends. Such analyses would lead to improvements being made in health facilities, including preventative measures for the protection of persons in care. The PCHL also suggested that annual reporting be more than statistics and include a "state of affairs" on the protection of persons in care by illustrating best practices as well as potential risks.

16. **Accessibility and communications.** The Centre on Aging stressed the need to ensure that access to and communications from the new office (specifically to persons in care and their families) be made available in age-friendly and accessible ways.

Recommendations of the Commission

As a result of the submissions, the information provided by PPCO, AARC and AAR staff and further research, the Commission is satisfied that many of the essential characteristics of the new office were set out in the Commission's letter to stakeholders dated December 21, 2023. In addition, the Commission believes that the following additions, modifications and/or clarifications would be appropriate:

(a) The new office must receive adequate funding to fulfill its mandate;

(b) The new office should have the power to act on its own initiative and to take proactive and preventative measures on matters related to alleged abuse or neglect in health facilities;

(c) The new office must have the ability to decline, cease or refuse to investigate any report of abuse or neglect that is without merit or that does not fall within its jurisdiction;

(d) The new office should continue to receive reports of abuse or neglect orally or in writing. All communications by the new office, including intake forms, investigation reports and recommendations, must be made available in simple and user-friendly language, and where there are language barriers, the new office should enlist translation services;

(e) Health facilities must report to the Officer if an employee or volunteer is suspended or discharged or has resigned because they have allegedly abused or neglected a person in care. The report must be made in writing within seven days of the suspension, discharge or resignation;

(f) All reports of abuse or neglect received by the new office must be addressed in a timely manner. Where an investigation is undertaken, a final investigation report must be completed within a specified time following receipt of the report. The Commission proposes a period of 180 days, with the proviso that an extension could be granted in exceptional circumstances prescribed by regulation. Timelines for each step are essential and should be continuously monitored from the date a report is received through to completion of the investigation, issuance of a final investigation report (with or without recommendations to a health facility and/or referral to the AARC), receipt of a reply from the health facility and implementation of recommendations;

(g) If, in the opinion of the new office, a report of abuse or neglect warrants facilitated resolution or a streamlined investigation, steps to attempt resolution or to streamline the investigation should be reasonably pursued. The new office must also have the ability to make a referral to the police at any time;

(h) A robust set of powers must be given to the new office. This would permit the new office to obtain relevant information and records following the receipt of a report of abuse or neglect, including at the intake phase, and to obtain expert advice or assistance at any stage

of an investigation. Specifically, the new office must have power to compel health facilities and others (including the alleged offender) to produce relevant information and records and to answer questions under oath. Provided however that this power would not apply to information that is subject to legal privilege or to the records or working files of a regulatory body concerning investigations undertaken by it pursuant to its governing legislation;

(i) The new office should adopt procedural rules, consistent with the principles of procedural fairness, which should be publicly available;

(j) After completing an investigation, the new office must issue an investigation report, which will set out the investigator's conclusions and the reasons for them and any recommendations to a health facility, including a specified timeframe for the implementation of the recommendations. A finding of abuse or neglect would not be a pre-condition to issuing recommendations. At the discretion of the new office, a draft of the proposed report may be provided to the health facility for its review and comments before it is finalized. The requirements in section 8(3) of the PPCA should be strengthened to provide that health facilities would be required to respond to recommendations made by the new office and directions from the Minister within a specified time and further that they would be subject to sanctions if they failed to follow directions without reasonable excuse. A copy of the final investigation report must be provided to the health facility, the person in care, the alleged offender, their employer at the time of the incident and their current employer (if different), the Minister of Health, the AARC, the police (where appropriate) and any other interested person;

(k) The new office would not name or directly identify the person in care, the caregiver or the alleged offender;

(l) The new office should be deemed to be an investigative body for purposes of various privacy laws, and privacy laws and policies would not defeat the ability of the new office to obtain and examine relevant information and records in a confidential and private manner. As an investigative body, the new office would not be subject to access to information requests and could not be compelled to furnish working files, or to give evidence (in any court proceeding, arbitration, inquiry or other proceeding), in relation to an investigation report and/or any directions;

(m) The investigation report (including information and records gathered by the new office, its records and working file), any recommendations made by the new office and directions from the Minister, and the response from the health facility, would not be admissible in any court, grievance, inquiry or in any proceeding relating to the alleged offender, including any proceeding in relation to their continued employment and/or termination of employment. A complete copy of the investigation report, any recommendations or directions, and the response from the health facility would be furnished with any referral

to the AARC, but not the working files, information and records gathered by the new office for purposes of its investigation report or any recommendations;

(n) The Officer appointed to lead the new office would be appointed under Part 3 of *The Public Service Act,* CCSM c P271;

(o) The duties and services of the new office should be provided in a manner that recognizes the pluralistic, multicultural characteristics of Manitoba's aging population. The new office must have representation from Indigenous peoples;

(p) There must be continuous training of office staff to ensure that they have the knowledge, skills and competence to perform their jobs, including training on cultural sensitivity, language barriers and investigatory techniques and reporting. As well, the new office must provide educational sessions to health facilities and others on relevant topics, including what is/is not abuse or neglect, mandatory reporting of abuse or neglect and preventative measures;

(q) Upon receipt of a written request (in a prescribed form) from a health facility in relation to a volunteer, a person seeking employment or an existing service provider, the new office would advise whether the person has been the subject of a referral to the AARC;

(r) The new office will gather and analyze data on reports of abuse or neglect and will take proactive steps to provide information and observable trends to health facilities and the Assembly. Reports to the Assembly by the new office may include recommended best practices for health facilities and, where possible, identification of potential risks, with the objective that preventative steps be taken by the appropriate bodies, including government;

(s) Investigation reports, recommendations to and replies from the health facilities and all reports to the Assembly will be publicly available and will be published on the new office's website. Working files, information and records gathered by the new office will not be publicly available, and no one employed by the new office may be compelled to give evidence in a court or judicial proceeding with respect to anything coming to their knowledge in carrying out their responsibilities and exercising the powers given to them;

(t) No proceedings shall lie against the new office or its staff for anything they do, report or say in the course of the exercise or performance, or intended performance, of their functions and duties, unless it is shown that they acted in bad faith;

(u) A person or health facility that contravenes the new legislation, including wilfully obstructing or making a false report, will be guilty of an offence and liable on conviction to a fine of not more than $50,000 or to imprisonment for a term not exceeding 2 years, or both;

(v) Within five years after the legislation creating the new office comes into force, a committee of the Assembly shall undertake a comprehensive review of the operation of the legislation and shall submit a report to the Assembly; and

(w) The distinction between the role of the new office and the role of the Seniors' Advocate must be clearly articulated. The legislation creating the new office should specify that the new office is not a "service provider" and that it does not provide or deliver "seniors' services" as defined in the proposed *Seniors' Advocate Act*. While the new office will have no obligation to provide information to the Seniors' Advocate, it will investigate systemic problems or concerns referred to it by the Seniors' Advocate with respect to persons in care and may make recommendations to the Assembly in relation to such matters.

A summary of the recommended legislative requirements for the new office is set out in **Appendix 6.**

Alternatives to an Independent Office

When the PPCA was introduced in 2001, the Minister at the time said that it was an extra safeguard "designed to protect Manitobans in hospitals and personal care homes" to ensure "a safe and secure environment free from the fear or reality of any type of abuse".

Problems with the PPCA and the PPCO have been identified in three previous reports dating back more than 13 years. In 2016, a service review was conducted "to provide recommendations to strengthen the overall functioning of the PPCO".

Notwithstanding those reports, the Auditor General's investigation in 2023 confirmed that "serious systemic issues" had not been resolved. Among his findings, the Auditor General concluded that victims had waited up to 3 years before investigations were started, that this issue was made even more significant by the fact that it had been ongoing for over 10 years without resolution, that investigations were not being conducted in a timely manner and that the PPCO's reporting on the outcome of investigations was inadequate.

The Auditor General was "deeply concerned" and said that "unfortunately, the processes used by the PPCO to determine if abuse occurred were flawed and failed to reach reasonable conclusions." In his report, the Auditor General identified each of his concerns and made 12 recommendations.

A restructuring of the PPCO to address those concerns could be accomplished in a variety of ways, including:

1. maintaining the existing PPCO and incorporating some of the recommendations described in this summary;
2. establishing a specialized government tribunal that would report to the Minister and that would have some of the essential characteristics described in this summary; and
3. creating a new independent office that would report to the Assembly.

As noted at the beginning of this summary, the mandate of the Commission is to make recommendations in relation to the third option.

In the course of its work, the Commission learned that the PPCO has made a significant effort to address the Auditor General's concerns. Some of the steps taken by the PPCO subsequent to the Auditor General's report are listed in Appendix 1. Recently, the Commission was advised that the PPCO has eliminated the backlog of investigations and that investigations are now being completed in less than 180 days.

The Commission acknowledges that with proper oversight and adequate resources, and with appropriate amendments to the PPCA, many of the PPCO's past issues could be addressed by a revamped PPCO or a specialized government tribunal. However, the Commission submits that neither of these options will quickly restore public confidence nor will they provide the level of impartiality, independence and accountability that would be achieved through the creation of a new independent office.

OTHER OBSERVATIONS

Opportunity to Align Obligations

In making its recommendations in relation to the new office, the Commission noted certain differences between the protections afforded under the PPCA and the protections afforded under the ALIDA.

As noted previously, section 2 of the PPCA provides that operators of health facilities have a duty to protect patients from abuse and neglect and to maintain a reasonable level of safety for them.

In contrast, section 20.1 of the ALIDA provides that no person shall abuse or neglect an adult living with an intellectual disability, and section 20.2 provides that a service provider (any person who provides care, support services or related assistance to an adult living with an intellectual disability) has a duty to take all reasonable steps to protect such a person. Under the ALIDA, any person who breaches those provisions is guilty of an offence and subject to a significant fine and/or imprisonment. Further, in any proceeding for such an offence, the accused carries the onus to prove on a balance of probabilities that they took all reasonable steps to protect the adult living with an intellectual disability (section 164(1.1)).

There are no similar provisions in the PPCA. Significantly, the duty in the PPCA to protect patients applies only to "operators of health facilities" and only to patients in those facilities.

In addition, section 26(1) of the ALIDA provides that the executive director may at any time and without court order take such emergency intervention action as is necessary to protect an adult living with an intellectual disability, including removing the adult to a safe place. Section 26(4) provides that the duration of the emergency intervention cannot exceed 120 hours, and during that time it suspends the power of any substitute decision maker (s. 27).

Again, there are no similar provisions in the PPCA.

The Commission believes that there may be times when such emergency intervention by the new office may be required. The Commission therefore recommends similar emergency intervention provisions for the new office.

While technically not part of its mandate, the Commission believes that the legislation creating the new office may provide an opportunity to align obligations in the PPCA (for the protection of persons in care in health facilities) with the obligations in the ALIDA (for the protection of adults living with intellectual disabilities).

Concluding Remarks

No legislative framework for an independent office can anticipate all eventualities for the protection of persons in care in Manitoba. It is an area that is complex and multifaceted, as is evident from the submissions received by the Commission, and in the report of the Auditor General.

The Commission believes that a new office structured in the manner described in Appendix 6 will result in an effective, neutral and impartial investigation office to replace the existing PPCO. The new office would be non-partisan and independent; it would not be an advocate for an individual or a special interest group; it would be empowered with effective and extensive investigation powers; it would protect persons in care by being proactive in providing timely resolutions of reports of abuse or neglect; and it would provide greater accountability and transparency to Manitobans.

Appendix 1

THE CURRENT PROTECTION FOR PERSONS IN CARE OFFICE

PPCO Reporting and Investigation Process

A report of suspected abuse or neglect can be made orally or in writing to the PPCO (the "report"). To facilitate reporting, the PPCO website (https://www.gov.mb.ca/health/protection/) has a template form which can be completed by anyone who wishes to make a report, and which is automatically submitted to the PPCO. If the subject matter of the report is an emergency, the PPCO recommends that local law enforcement be immediately contacted. PPCO staff provide assistance to anyone who contacts them to report suspected abuse or neglect.

Upon receipt of a report, an intake worker assesses whether there is reason to believe that abuse or neglect has occurred, or is likely to occur, and whether the PPCO has jurisdiction (ss. 5-9) (Unless otherwise indicated, all references to sections in this Appendix are references to sections of the PPCA.) Provided the intake criteria are met, the report moves forward as an investigation, and an investigator is assigned (s. 5). At the intake level, a referral is made to a professional regulatory body (college) if a professional is the person who is alleged to have committed abuse or neglect (s. 9). The PPCO may also refer the matter to the police. If a report is discontinued at the intake level, the person in care or their committee (if applicable) and the health facility are informed.

Once an investigator is assigned, the investigator contacts the patient or their committee and the health facility to inform them of the investigation and the process that will be followed (s. 5(3)). During the investigation, the investigator will gather relevant information and records, including records in the possession of the health facility (s. 6). The investigator also interviews the person who made the report, the person in care (if possible), staff at the health facility and any other person who can provide information (s. 6). The investigator will also attempt to speak with the service provider who is alleged to have committed the act of abuse or neglect, but that person cannot be compelled to speak to the investigator, nor is there a requirement for the suspect to co-operate with the investigation.

The PPCA permits an investigator to enter a health facility at any reasonable time, and to require any person to give information and to produce any record relating to the matter being investigated (s. 6). If an individual declines to be interviewed, the investigator has no power to compel an examination under oath.

On completing the investigation, the investigator is required to set out their conclusions and the reasons for their conclusions in an investigation report and to provide it to the director of the PPCO, who is a delegate of the Minister of Health (s. 7(1)). The determination by an investigator as to whether an allegation of abuse or neglect is founded or unfounded is assessed on a "balance of probabilities" following consideration of all available evidence. In general terms, the investigator is required to consider all of the available evidence and to apply the definitions of "abuse" and "neglect" in the PPCA, together with the criteria and extenuating circumstances set forth in the

Protection for Persons in Care (Adult Abuse Registry) Regulation, MR 21/2013, as amended by MR 158/2023.

In preparing the investigation report, the PPCA directs the investigator to try, to the fullest practical extent, to involve the person in care and to determine and accommodate that person's wishes (s. 7(2)).

Upon completion of its report, the PPCO may give a health facility any directions it considers necessary to protect patients from abuse or neglect, including timelines for compliance with such directions (s. 8(1)). The PPCO is required to provide a copy of the directions to the person in care or their committee, and to any other person the PPCO believes should be notified, having regard to the nature of the abuse or neglect reported and the need to protect the person in care's privacy (s. 8(2)). Within the time specified in the directions, the health facility is required to comply with the directions and to provide a written report to the PPCO describing the actions that have been or will be taken to comply (s. 8(3)).

If, after investigation, the PPCO believes abuse or neglect of a person in care involved the employment duties of a person (*i.e.* a service provider), the PPCO must report to that person's employer, manager or supervisor, the name of the service provider who abused or neglected the person in care, together with the circumstances of the abuse or neglect. The report must include the nature and details of the abuse or neglect, the timeframe within which the abuse or neglect occurred, and the relationship of that provider to the person in care (s. 8.1(1)). In addition, the PPCO may provide the person's employer, manager or supervisor with further information relating to the abuse or neglect, including personal information and personal health information, if the PPCO receives a request from the employer, manager or supervisor and believes that providing the information is necessary to protect patients and other specified adults from abuse or neglect (s. 8.1(2)).

Where an investigator believes that a person in care has been abused and/or neglected, that the person who committed the abuse and/or neglect meets the criteria set out in the regulations, and that there are no extenuating circumstances as set out in the regulations, the PPCO must report the matter to the AARC (s. 8.2(1)). The PPCO reports to the AARC by completing a template AARC form. The report to the AARC does not include a copy of the PPCO investigation report.

Once the above process is completed, the role of the PPCO is essentially at an end unless the PPCO receives a request from the AARC for further information about its report. The PPCO may investigate the matter and provide the AARC with further information that relates to the report (s. 8.2(2)).

Of note, the PPCA does not specify any timelines to be met by the PPCO following receipt of a report of abuse or neglect. There are presently no mandated timelines following receipt of a report for an assessment to be completed, an investigator being assigned, an investigation undertaken, preparation of an investigation report, issuance of any directions to a health facility and any referral to the AARC.

A flowchart depicting the existing PPCO reporting and investigation process is attached.

Steps Taken by the PPCO Subsequent to the Auditor General Report

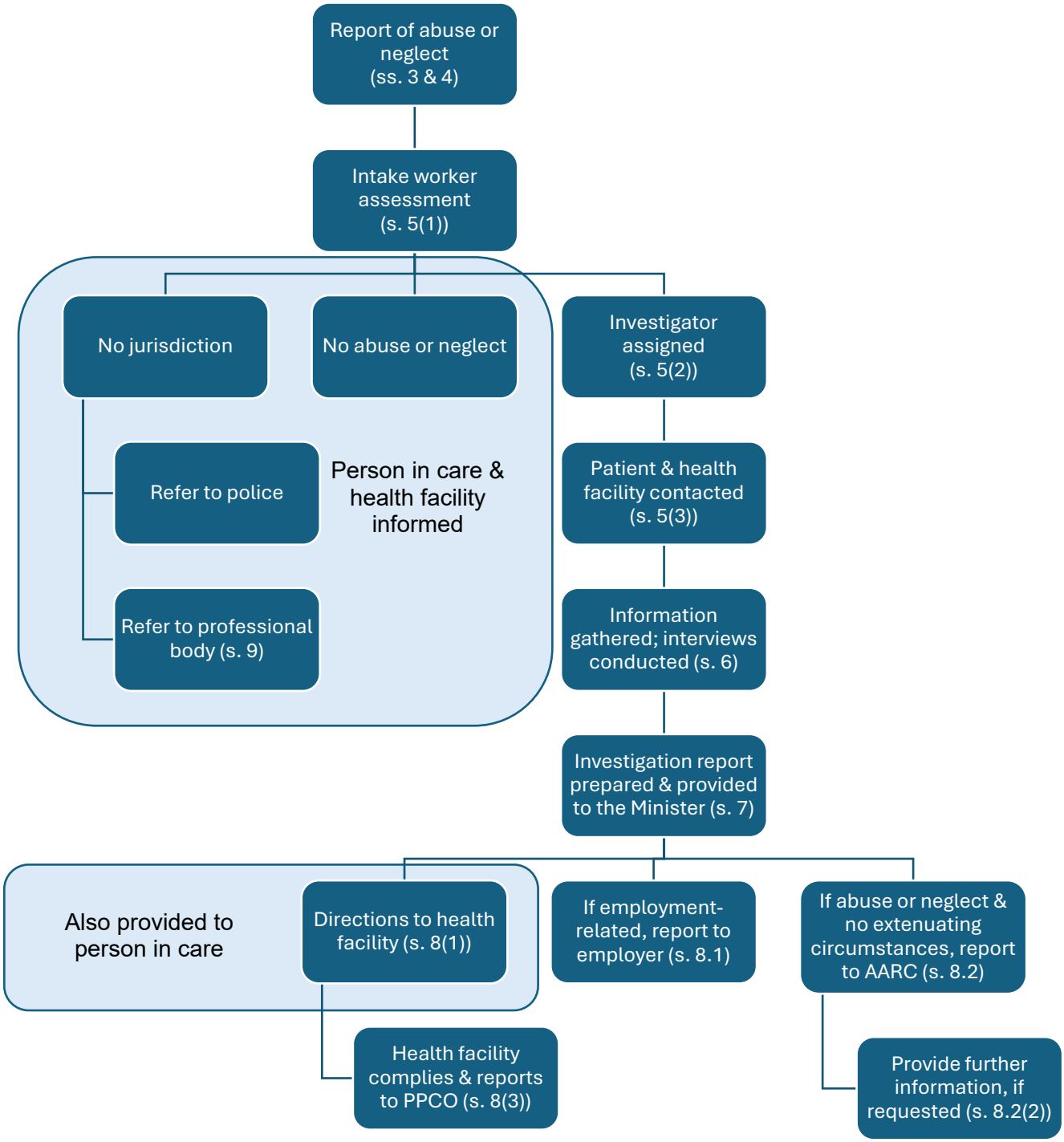
The Auditor General's report included 12 recommendations.

Since the issuance of that report, the PPCO has implemented changes that include:

1. hiring additional staff;
2. implementing timelines for each stage of its process;
3. tracking each report to monitor if timelines are being met and to identify where follow-up is required;
4. developing a dedicated intake function that involves reviewing and assessing all new reports in a timely manner to determine if investigation is warranted;
5. holding focus groups and carrying out surveys of health facility staff to obtain feedback on the reporting process. This has resulted in revisions to the referral form, including pre-populated questions based on the type of reporter (*i.e.* family, community or facility staff), the ability to display definitions within the questions and an acknowledgement that the report to PPCO was successfully submitted;
6. requiring all investigators, including the director, to take formal training in investigation and interviewing techniques;
7. an ongoing process for updating PPCO policy and procedures;
8. establishing regular PPCO meetings to communicate changes;
9. assigning staff to review approximately 8,200 files (commencing in 2017) to capture essential data, establishing an internal database and publishing statistics on the PPCO website;
10. assigning staff to perform file audits and incorporating audits and reporting functions into the database, where possible;
11. providing educational sessions to staff at health facilities;
12. meeting with regions to develop an improved communication process; and
13. establishing a better relationship with Winnipeg Police Services and the AARC.

The PPCO website reports that for 2023-2024, 2612 reports of abuse or neglect were received and that the PPCO delivered 68 educational sessions to its reporting entities.

THE EXISTING PPCO PROCESS



Appendix 2

PPCO – JURISDICTIONAL SCAN

Manitoba

The Protection for Persons in Care Act

There are several Manitoba statutes which relate to the protection of persons in care. The key statute is *The Protection for Persons in Care Act*, CCSM c P144 (the "PPCA").[1] It was originally enacted as SM 2000, c 12 and came into force on May 1, 2001.[2] It was significantly amended in 2012.[3] It imposes a duty to report abuse or neglect of patients (s. 3(1)).[4] Patients may also report abuse or neglect that they have experienced (s. 4). Upon receiving a report of abuse or neglect, the Minister of Health is required to investigate the matter and consider whether a more extensive investigation is warranted (s. 5(1)).[5] If there are reasonable grounds to believe that a patient is or is likely to be abused or neglected, the matter is referred to an investigator to carry out a more extensive investigation (s. 5(2)). The patient (or their committee) is notified as soon as practicable thereafter (s. 5(3)). The minister may delegate or appoint investigators (s. 5(4)). Investigators are to involve patients to the fullest practical extent (s. 7(2)). The investigator reports their findings to the minister (s. 7(1)). Upon receiving an investigator's report, the minister may give directions to the health facility involved (s. 8(1)). The operator of the health facility must comply with the minister's directions and is required to provide a written report to the minister describing their compliance actions (s. 8(3)). In certain circumstances, the minister must make reports to the employer of the person who abused or neglected the patient (s. 8.1(1)). Additionally, the minister may provide a report to the AARC, in accordance with the regulations (s. 8.2(1)).[6] If the minister believes on reasonable grounds that a person has abused or neglected a patient or has failed to comply with the duty to report, the minister may refer the matter to the body that governs the person's professional status (s. 9(1)). The body is then required to investigate the matter (s. 9(2)).

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[1] This report does not review the findings of the Auditor General regarding this legislative regime (https://www.oag.mb.ca/audit-reports/investigation-of-the-protection-for-persons-in-care-office-(ppco)-2023).

[2] For additional information regarding the *PPCA*'s legislative history, see Darla L Rettie, "The Protection for Persons in Care Act" (2001) 28:2 Man LJ 245.

[3] *The Protection for Persons in Care Amendment Act*, SM 2012, c 16, in force on March 15, 2013. These amendments separated the concepts of "abuse" and "neglect" and added ss. 8.1 & 8.2. The definitions of "abuse" and "neglect" were changed at the beginning of this year (*The Vulnerable Persons Living with a Mental Disability Amendment Act*, SM 2023, c 19, s 79).

[4] In s. 1(1), "patient" is defined as:

> an adult who
> (a) is a resident or an in-patient in a health facility or is receiving respite care in such a facility,
> (b) is receiving services in a geriatric day hospital that is managed by a hospital designated by regulation under *The Health Services Insurance Act*,
> (c) is receiving services in an emergency department or urgent care centre of a health facility, or
> (d) is receiving any other services provided by a health facility that are specified in the regulations,
> but does not include an adult living with an intellectual disability within the meaning of *The Adults Living with an Intellectual Disability Act*[.]

"Health facility" is defined in s. 1(1) to mean hospitals, personal care homes and other facilities designated by regulation.

[5] The minister may delegate any powers or duties under the *PPCA* (see s. 14).

[6] *The Adult Abuse Registry Act*, CCSM c A4 is the subject of a separate appendix, so it is not discussed in-depth herein.

Two regulations have been enacted pursuant to the *PPCA*. One designates certain health facilities, in connection with s. 1(1).[7] The other regulation is entitled the *Protection for Persons in Care (Adult Abuse Registry) Regulation*, MR 21/2013, which was recently amended by the *Protection for Persons in Care (Adult Abuse Registry) Regulation, amendment*, MR 158/2023 (in force on January 1, 2024). It details the particulars that need to be included in reports to employers under s. 8.1 of the *PPCA* (s. 2). It also sets out criteria and extenuating circumstances for reporting under s. 8.2(1) of the *PPCA* (s. 3). It prescribes the information that must be contained in the minister's report to the AARC (s. 4).

Other Relevant Manitoba Legislation

Another relevant statute is *The Adults Living with an Intellectual Disability Act*, CCSM c A6.1, formerly known as *The Vulnerable Persons Living with a Mental Disability Act*.[8] As described in s. 1(1), an "adult living with an intellectual disability" is defined as "an adult living with an intellectual disability who needs assistance to meet their basic needs with regard to personal care or management of their property". "Intellectual disability" is further defined as "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour both of which manifested before the age of 18 years, but excludes an intellectual disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*".

Part 3 addresses abuse. It provides that "[n]o person shall abuse or neglect an adult living with an intellectual disability" (s. 20.1). Pursuant to s. 21, reports of abuse go to the executive director. Section 22 states that the executive director will investigate. Additional steps in the process are outlined in s. 25. Reports regarding professionals believed to have abused or neglected an adult living with an intellectual disability are governed by s. 25.1. Abuse or neglect may also be reported to the AARC (s. 25.3(1)).

The Health System Governance and Accountability Act, CCSM c H26.5 makes brief mention of quality and patient safety reporting in Manitoba, but the reporting requirements are specific to health authorities, health corporations and healthcare organizations. It also addresses critical incident reporting.

The *Personal Care Homes Standards Regulation*, MR 30/2005, passed pursuant to *The Health Services Insurance Act*, CCSM c H35, includes some provisions regarding complaint processes in personal care homes.

In addition, Canada and Manitoba recently entered into a bilateral funding agreement regarding Aging with Dignity, which contemplates the expansion of "elder abuse services".[9]

[7] *Designation of Health Facilities Regulation*, MR 61/2001.
[8] See *The Vulnerable Persons Living with a Mental Disability Amendment Act*, SM 2023, c 19, s. 2.
[9] https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/aging-dignity-bilateral-agreements/manitoba-funding.html.

British Columbia

In British Columbia, the key statute is the *Adult Guardianship Act*, RSBC 1996, c 6.[10] Under that legislation, reports of abuse or neglect are made to a designated agency (s. 46). The designated agency investigates (ss. 47-49). Criminal offences are, of course, reported to the police (s. 50). After the investigation, the designated agency may refer the individual to appropriate services, involve the Public Guardian & Trustee or apply for certain court orders.[11]

The *Community Care and Assisted Living Act*, SBC 2002, c 75 provides that adult persons in care have the right to be protected from abuse and neglect. Regulations under the Act require registrants to report incidents of abuse.[12]

Additionally, BC has a *Patient Care Quality Review Board Act*, SBC 2008, c 35. This legislation is linked to their regional health authorities. The Minister has fairly significant involvement in the processes and procedures under the Act.[13] Care quality complaints first go to the complaint office. Then there are review boards, who can review complaints. Section 9 addresses the composition of review boards, including who may not participate. The legislation also includes reporting requirements at both stages.

Alberta

Alberta, like Manitoba, has a *Protection for Persons in Care Act*, SA 2009, c P-29.1.[14] Under this Act, the Minister designates a Director (s. 4), complaints officers (s. 5) and investigators (s. 6). The duties of complaints officers are set out in s. 11. The powers of investigators are detailed in s. 12. The investigator prepares a report for the Director (s. 14). The Director makes a decision (s. 15). Any appeal goes to an appeal panel (s. 16), which is appointed by the Minister (s. 17). The Minister also has investigatory powers (s. 19).

Alberta also has *An Act to Protect Patients*, SA 2018, c 15, which pertains to sexual abuse/misconduct by healthcare professionals. Alberta has also recently passed a *Continuing Care Act*, SA 2022, c C-26.7, which came into force on April 1, 2024.[15] With respect to complaints of abuse or neglect, it simply indicates that such complaints shall be referred to the minister responsible for the *Protection for Persons in Care Act* (s. 30(4)).

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[10] Note that many of the provisions of this statute are not yet in force, including the Public Guardian and Trustee's investigatory powers under s. 30 (https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/sup00600#section30). Further note that the BC Human Rights Commission has launched an inquiry into detentions under this Act: https://bchumanrights.ca/inquiries/aga/.

[11] Section 51; see s. 56 for details regarding court orders.

[12] *Assisted Living Regulation*, BC Reg 189/2019, s. 51; *Residential Care Regulation*, BC Reg 96/2009, s. 77.

[13] See, for example, ss. 6 & 16.

[14] Indeed, Manitoba's legislation was based on the original Alberta statute: Rettie, *supra* note 2 at 249. For additional background information regarding the Alberta legislation, see Monica Pauls & Leslie D MacRae Krisa, *The Response to Elder Abuse in Alberta: Legislation and Victim Focused Services*, 2006 CanLIIDocs 28 <https://canlii.ca/t/285w>, particularly the Legislative Summary in Appendix A. As they note at p. 24 of that Appendix, this legislation was proclaimed in 1998 and was the first adult protection legislation of its kind in Canada.

[15] There are a few sections which will come into force on April 1, 2025 (https://kings-printer.alberta.ca/1266.cfm?page=C26P7.cfm&leg_type=Acts&isbncln=9780779843930&display=html).

Saskatchewan

Saskatchewan's *Personal Care Homes Regulations, 1996*, RRS c P-6.01 Reg 2 address patient abuse or neglect.[16] Section 34(1)(j) states that every care home resident has the right "to be free from any actions from the licensee or staff of a punitive nature, including physical punishment, threats of any kind, intimidation, verbal, mental or emotional abuse or confinement". Licensees must ensure that patients' rights are respected (s. 34(2)). Section 13 defines "serious incidents" which must be reported to the resident's family/supporter, doctor, the department and the regional health authority. Additionally, the licensee must prepare a written report pertaining to the incident. One such "serious incident" is "any harm or suspected harm suffered by a resident as a result of unlawful conduct, improper treatment or care, harassment or neglect on the part of any person".

Under the *Registered Nurses Act, 1988*, SS 1988-89, c R-12.2, any person can submit a written complaint that a nurse has committed professional incompetence or professional misconduct. Professional misconduct includes physical abuse, verbal abuse, and financial abuse (s. 26).

Saskatchewan also has an *Adult Guardianship and Co-decision-making Act*, SS 2000, c A-5.3. Court orders are available in situations where a decision-maker has acted improperly or endangered a person's well-being (s. 67).

Ontario

Ontario has recently revised their legislation in this area, pursuant to the *Fixing Long-Term Care Act, 2021*, SO 2021, c. 39, sch 1. This regime places significant responsibility on licensees of long-term care facilities. They must have policies and procedures and conduct investigations. Complaints are forwarded to the Director (s. 26(1)(c)), along with results of investigations (s. 27(2)). The Director has an inspector conduct an investigation (s. 29). Again, the police are notified of any criminal offences (s. 105 of the regulation).[17]

Section 13.1 of Ontario's *Excellent Care for All Act, 2010*, SO 2010, c 14 created the office of the Patient Ombudsman.[18] The Patient Ombudsman is appointed by the Lieutenant Governor in Council. The Patient Ombudsman serves for a fixed term (with a maximum of two terms). There is an emphasis on facilitated resolution of complaints. The Patient Ombudsman may also conduct investigations, as necessary.[19] As in BC, there are specific reporting requirements.

Originally, the Ontario Patient Ombudsman was connected to a health care quality organization. The government initially considered assigning this role to the provincial ombudsman, but ultimately

[16] Passed pursuant to the *Personal Care Homes Act*, SS 1989-90, c P-6.01.
[17] *General*, O Reg 246/22, which also contains detailed definitions of abuse (s. 2) and neglect (s. 7).
[18] The *Excellent Care for All Act* received Royal Assent on June 8, 2010, which is when it came into force, except for ss. 3, 4 and 18(2), which came into force by proclamation. The Patient Ombudsman provisions were brought into force on January 7. 2016, as part of the *Public Sector and MPP Accountability and Transparency Act, 2014*, SO 2014, c 13 (Sch. 5).
[19] A recent case regarding the scope of the Patient Ombudsman's mandate is *The Governing Council of the Salvation Army in Canada v Patient Ombudsman*, 2024 ONCA 40.

decided to create a separate office.[20] Over time, it appears that the Ontario Patient Ombudsman has become progressively more independent from their department of health.

Additionally, there is a targeted legal aid clinic for elderly persons in Ontario – the Advocacy Centre for the Elderly.[21]

Quebec

The governing legislation in Quebec is the *Act to Combat maltreatment of seniors and other persons of full age in vulnerable situations*, CQLR c L-6.3. Institutions must adopt policies to combat maltreatment of seniors and of persons in vulnerable situations who receive health and social services, whether such services are provided in a facility maintained by the institution or in-home (s. 3). Policies must be reviewed every five years (s. 7). Local service quality and complaints commissioners must report complaints received concerning cases of maltreatment of seniors and of persons in vulnerable situations each year (s. 14). The Minister responsible for Seniors is charged with combatting maltreatment of seniors and of persons in vulnerable situations (s. 16). Division III of Chapter III of the statute sets out the concerted intervention process. Section 20.4 requires that:

> The Minister responsible for Seniors must enter into a Quebec-wide framework agreement to combat maltreatment of seniors and persons in vulnerable situations with the Minister of Public Security, the Minister of Justice, the Minister of Health and Social Services, the Director of Criminal and Penal Prosecutions, the Autorité des marchés financiers, the Commission des droits de la personne et des droits de la jeunesse, the Public Curator and any other government department or other body considered useful.

The Minister is also responsible for establishing a maltreatment assistance, assessment and reference centre (s. 20.7).[22]

Section 21 contains mandatory reporting requirements for healthcare professionals and social service providers. Section 21.1 creates various offences and imposes fines; the fine amounts are doubled for subsequent offences. Chapter IV.1 addresses confidentiality and immunity from proceedings. Chapter IV.2 outlines the powers granted to the Minister's inspectors and investigators.

Additionally, s. 48 of Quebec's *Charter of Human Rights and Freedoms*, CQLR c C-12 provides that "[e]very aged person and every handicapped person has a right to protection against any form of exploitation."

New Brunswick

New Brunswick has a *Family Services Act*, SNB 1980, c F-2.2. The Minister is responsible for

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[20] André Marin, "The Ontario Ombudsman: Amicus of Civil Litigation" (2014) 34th Annual Civil Litigation Conference 15, 2014 CanLIIDocs 33409, p. 2 : https://canlii.ca/t/stlm. See also https://www.cp24.com/news/liberals-urged-to-grant-oversight-of-health-care-system-to-ontario-ombudsman-1.1916331.

[21] https://www.acelaw.ca/about/ace/.

[22] See also https://maltraitancedesaines.com/en/.

investigations (s. 35). The Minister may provide social services, refer the matter to a community social services agency, another government department or agency, law enforcement, regional health authorities or other appropriate services (s. 37). The legislation also includes provisions regarding incompetent adults (s. 37(1.1)) and protective care.

Nova Scotia

Nova Scotia, like Manitoba, has a *Protection for Persons in Care Act*, SNS 2004, c 33. Facilities are under a mandatory reporting requirement to the Minister (s. 4(2)). The general (permissive) reporting provision permits reports to the Minister or the Minister's delegate (s. 6). The Minister conducts the initial investigation (s. 8(1)). The Minister may appoint an investigator, where warranted (s. 8(2)). The investigator reports to the Minister (s. 10). The Minister may issue directives (s. 10) or refer matters to professional regulatory bodies (s. 12). The Minister may delegate these responsibilities pursuant to s. 15. Abuse is defined in the accompanying regulation.[23]

The Minister is a similarly central figure in the *Adult Protection Act*, RSNS 1989, c 2. Under s. 4, the Minister designates a Co-ordinator. Under s. 6, the Minister makes inquiries and pursuant to s. 7, the Minister provides assistance.

Prince Edward Island

In Prince Edward Island, there is an *Adult Protection Act*, RSPEI 1988, c A-5. Under s. 5, the Minister carries out an investigation.[24] Where an adult is in need of protection, the Minister develops a case plan (s. 8). Estate-related matters are reported to the Public Trustee (s. 24).

Healthcare quality improvement and apologies are governed by the *Health Services Act*, RSPEI 1988, c H-1.6, but it does not address patient abuse or neglect *per se*.

Newfoundland & Labrador

Newfoundland & Labrador also have an *Adult Protection Act, 2021*, SNL 2021, c A-4.02. Section 9 establishes a Director of Adults in Need of Protective Intervention. Section 10 provides the authority to appoint directors who, in turn, report to the Provincial Director. A director completes an evaluation (s. 13). After an evaluation, the director may direct that an investigation be completed (s. 14). Investigators must be social workers, subject to one time-limited exception (s. 15). The investigation report is submitted to the director in the prescribed form. Adults in need of protection are reported to the Provincial Director (s. 23(3)). A service plan is created. Criminal matters are referred to the police. The investigation report and service plan are submitted to the Provincial Director (s. 23(4)).

The *Patient Safety Act*, SNL 2017, c P-3.01 addresses quality assurance and unintended events.

The Territories

In the territories, legislation on this subject is fairly limited. Yukon has an *Adult Protection and*

[23] *Protection for Persons in Care Regulations*, NS Reg 364/2007, s. 3.
[24] Subsection 2.1(2) gives the Minister the power to delegate; s. 30.1 indicates that peace officers may assist.

Decision Making Act, SY 2003, c 21, Sch A. A designated agency may make inquiries (s. 62). It can refer matters to the RCMP, restorative justice programs, or apply for an adult protection order or other court orders (s. 69).[25]

Nunavut and the Northwest Territories have a *Guardianship and Trusteeship Act*, SNWT 1994, c 29, s. 10 of which provides for the appointment of temporary guardians.[26] The NWT's *Nursing Profession Act*, SNWT 2003, c 15 identifies abuse as one type of unprofessional conduct, but there is no additional government framework for investigating such complaints outside of the usual system of professional regulation. Nunavut's *Family Abuse Intervention Act*, SNu 2006, c 18 applies to cases involving abuse by family members.[27]

United States

Adult Protective Services and Long-term Care Ombudsmen are standard in every state, though their definitions of who is an elder and what constitutes abuse vary.[28] Federal regulations have been proposed to promote national service standards within such programs.[29] The American approach is addressed in greater detail in Appendix 9.

United Kingdom

The key legislation in the UK is the *Care Act 2014*. It requires local councils to make enquiries when concerns about abuse or neglect arise. A local authority has a duty to make enquiries where there is reasonable cause to suspect an adult with care and support needs is being abused or neglected, or is at risk of being abused or neglected, and because of those needs is unable to protect themselves against the abuse or neglect (s. 42). The overarching approach is characterized as "safeguarding".[30] Each local authority has a Safeguarding Adults Board, which is a multi-agency body to help and protect adults in its jurisdiction (s. 43). Safeguarding Adults Boards have a duty to arrange for a Safeguarding Adults Review in response to certain safeguarding incidents (s. 44).

The Care Quality Commission ("CQC") is the regulator for health and social care services in the UK. Registered health and social care service providers must inform the CQC of abuse incidents or allegations. They also inform the local authority safeguarding team. Section 14.118 of the statutory guidance indicates that employers should also report workers to professional regulators. The Local

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[25] See also the *Adult Protection and Decision-Making Regulation*, YOIC 2005/78.
[26] See, similarly, the *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2.
[27] See, similarly, the *Protection Against Family Violence Act*, SNWT 2003, c 24. Some provinces also have similar legislation: *e.g.*, *Protection Against Family Violence Act*, RSA 2000, c P-27; *Family Violence Protection Act*, SNL 2005, c F-3.1; *Victims of Family Violence Act*, RSPEI 1988, c V-3.2; *Family Violence Prevention Act*, RSY 2002, c 84. In Manitoba, see *The Domestic Violence and Stalking Act*, CCSM c D93.
[28] https://www.justice.gov/elderjustice/elder-justice-statutes-0#EAIS. See also https://www.americanbar.org/content/dam/aba/administrative/law_aging/2020-elder-abuse-reporting-chart.pdf; https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program; and https://www.nursinghomeabusecenter.com/legal/state-laws/.
[29] https://www.federalregister.gov/documents/2023/09/12/2023-19516/adult-protective-services-functions-and-grant-programs.
[30] The six key principles that underpin all adult safeguarding work are set out in c 14 of the statutory guidance (akin to regulations in Canada): (1) empowerment; (2) prevention; (3) proportionality; (4) protection; (5) partnership; and (6) accountability.

Government and Social Care Ombudsman addresses complaints regarding private care providers.[31]

Australia

Australia's approach to elder abuse is currently in a state of transition.[32] In 2017, the Australian Law Reform Commission released a report on elder abuse.[33] The Royal Commission into Aged Care Quality and Safety was established in October 2018. It issued its final report in 2021.[34] The National Plan to Respond to the Abuse of Older Australians was launched in 2019.[35] A National Elder Abuse Prevalence Study was released in December 2021.[36] It was the largest study of elder abuse in Australia to date. It found that one in six older Australians experience elder abuse each year.

Australia has an Aged Care Quality & Safety Commission.[37] It is the national regulator of aged care services. Australia is in the process of passing new aged care legislation.[38] It will likely come into force this summer. It is somewhat complicated, but comprehensive. There are different categories of care providers and they have different registration, reporting and/or audit requirements. There is also an Aged Care Code of Conduct.[39] The approach is very patient-centric. The new approach will include early intervention and restorative justice as well as more formal investigation and enforcement mechanisms. There is a Complaints Commissioner to address complaints that cannot be resolved internally by care providers.[40]

New Zealand

The New Zealand Longitudinal Study of Ageing showed that 10% of New Zealanders over 65 experience abuse, but only 1 in 14 incidents are reported.[41] The Office for Seniors helps to raise awareness regarding elder abuse and the Elder Abuse Response Service, a free, confidential 24-hour helpline.[42] The Aged Care Commissioner oversees the aged care sector in New Zealand.[43] The Commissioner makes decisions on complaints and formal investigations into older people's health and disability services, to protect their rights under the *Code of Health and Disability Services*

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[31] https://www.lgo.org.uk.
[32] The legislation currently in force is the *Aged Care Act 1997*, no. 112 and the *Aged Care Quality and Safety Commission Act 2018*, no. 149, as well as the *Aged Care Quality and Safety Commission Rules 2018*.
[33] *Elder Abuse: A National Legal Response* (14 June 2017), https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/.
[34] https://www.royalcommission.gov.au/aged-care.
[35] https://www.ag.gov.au/rights-and-protections/publications/national-plan-respond-abuse-older-australians-elder-abuse-2019-2023.
[36] https://aifs.gov.au/research/research-reports/national-elder-abuse-prevalence-study-final-report.
[37] https://www.agedcarequality.gov.au. Australia tends to avoid the use of the word "elder" in this context out of respect for their Indigenous peoples.
[38] https://www.agedcarequality.gov.au/about-us/legislation-and-policies.
[39] https://www.legislation.gov.au/F2018L01837/latest/text.
[40] For additional information, see https://www.health.gov.au/our-work/aged-care-act/about and https://www.health.gov.au/sites/default/files/2023-05/a-new-model-for-regulating-aged-care-and-new-aged-care-act-frequently-asked-questions.pdf. See also the submission of the Manitoba Nurses Union dated February 27, 2024.
[41] https://www.ageconcern.org.nz/Public/Public/Info/Health_Topics/Elder_Abuse.aspx.
[42] https://officeforseniors.govt.nz/our-work/raising-awareness-of-elder-abuse/.
[43] https://www.hdc.org.nz/our-work/aged-care-commissioner/.

Consumers' Rights.[44] The *Code* is a regulation under the *Health and Disability Commissioner Act 1994*.[45] The *Code* was created in 1996 and applies to all providers of health and disability services. It sets out 10 rights, including the right to complain.

Professional caregivers who abuse or neglect their patients can be the subject of a complaint to the Health and Disability Commissioner.[46] The Health and Disability Commissioner's Office is an independent organization. After conducting an initial review of a complaint, they may refer the complainant to a health and disability advocate, to see if it can be resolved by agreement. The advocate acts as the complainant's representative and supporter, not as a neutral mediator. The Commissioner can also arrange for mediation. If the complaint cannot be resolved informally, the Commissioner can launch a formal investigation. In serious cases, the Commissioner will begin a formal investigation without first trying to resolve the dispute informally.

If the Commissioner's office decides to investigate, an investigation officer is appointed. The investigator notifies both sides and collects information about the complaint. The Commissioner has broad investigative powers to summon witnesses, take evidence under oath and require the production of documents. Once all the necessary information is gathered, the Commissioner may seek an expert opinion regarding whether the provider met the appropriate standards. The Commissioner then decides whether the *Code* was breached. The Commissioner acts impartially and not as an advocate. The Commissioner's final decision is recorded in a written report. A relatively straightforward investigation will usually take six to nine months, whereas more complicated investigations can take 18 months to two years.[47] The Ombudsman can review the Commissioner's investigations and decisions. Alternatively, judicial review is available through the courts.

United Nations

The United Nations has designated 2021-2030 as the Decade of Healthy Ageing. They have identified five priorities for tackling the abuse of older people:

1. combat ageism;
2. generate more and better data on prevalence and on risk and protective factors;
3. develop and scale up cost–effective solutions;
4. make an investment case for addressing the issue; and
5. raise funds to tackle the issue.[48]

World Elder Abuse Awareness Day is commemorated each year on June 15. The United Nations General Assembly officially recognized this Day in 2011.[49]

There is an International Society for Quality in Health Care.[50] Australia's Aged Care Quality and

[44] https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/.
[45] https://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html.
[46] https://communitylaw.org.nz/community-law-manual/test/protection-for-older-people-against-abuse-or-neglect/.
[47] https://communitylaw.org.nz/community-law-manual/chapter-17-disability-rights/health-and-disability-services-your-rights-and-how-to-enforce-them/complaining-about-a-breach-of-your-rights/.
[48] https://www.who.int/publications/i/item/9789240052550.
[49] A/RES/66/127 (https://www.un.org/en/observances/elder-abuse-awareness-day/background).
[50] https://isqua.org.

Safety Commission is a member.[51]

INDEPENDENT INVESTIGATION OFFICES

There are several Manitoba statutes that create independent investigation offices, including *The Ombudsman Act*, CCSM c O45;[52] *The Auditor General Act*, CCSM c A180; *The Advocate for Children and Youth Act*, CCSM c A6.7; *The Conflict of Interest (Members and Ministers) Act*, CCSM c C171; and *The Elections Act*, CCSM c E30. [53]

Independent investigation offices in Manitoba share a number of similarities. Generally, the appointment must be recommended by the Standing Committee of the Assembly on Legislative Affairs. There is a legislated appointment process. The appointed individuals are officers of the legislative assembly.[54] They serve for a specified term. There are limits on their suspension, removal or salary reductions. They may not hold any other public office or engage in any partisan political activity. They conduct investigations and provide reports to government. Many of these statutes contain mandatory review provisions.

ADDITIONAL RESOURCES

- Canadian Centre for Elder Law, https://ccelderlaw.ca/
- Stephen Coughlan *et al*, *Mistreating Elderly People: Questioning the Legal Response to Elder Abuse and Neglect* (Halifax, 1995)
- R.M. Gordon, "Adult Guardianship and Adult Protection Legislation in Canada: Recent Reforms and Future Problems" (1995) 14(2) Can J on Aging 89
- Hon. Stephen Goudge, Q.C., *Streamlining the Physician Complaints Process in Ontario* (February 2016)
- International Ombuds Association, "Frequently Asked Questions About Ombuds", https://www.ombudsassociation.org/ombuds-faq
- Law Reform Commission of Saskatchewan, *Civil Rights in Saskatchewan Long-term Care Facilities*, 2013 CanLIIDocs 4 <https://canlii.ca/t/7dn>[55]
- Lynn Kirwin *et al*, *Vulnerable Persons: Protection and Remedies in Canada* (looseleaf)
- *La protection des personnes vulnérables*, vol. 547 (Éditions Yvon Blais, 2024)
- Manitoba Law Reform Commission, *Adult Protection and Elder Abuse* (December 1999), http://www.manitobalawreform.ca/pubs/pdf/archives/103-full_report.pdf
- Monica Pauls & Leslie D MacRae Krisa, *The Response to Elder Abuse in Alberta: Legislation and Victim Focused Services - Final Report*, 2006 CanLIIDocs 28 <https://canlii.ca/t/285w>.

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[51] https://www.agedcarequality.gov.au/about-us/our-vision.

[52] For additional information regarding the Ombudsman's office, see https://www.ombudsman.mb.ca/info/about-the-office.html & https://www.ombudsman.mb.ca/uploads/document/files/2022-23-annual-report-web-en.pdf (includes a summary of the complaints handling process).

[53] See also *The Lobbyists Registration Act*, CCSM c L178 and *The Freedom of Information and Protection of Privacy Act*, CCSM c F175.

[54] See *The Legislative Assembly Management Commission Act*, CCSM c L114, s. 6.

[55] See esp. p. 16: "Experience with mandatory reporting suggests that it will improve outcomes only if there are resources to handle the increased volume of complaints. Otherwise, reporting legislation may create a false sense that the problem of abuse is being addressed: 'Reporting legislation does not create solutions to abuse problems - it is only a means of people referring to a particular service to investigate.'"

Appendix 3

LIST OF PERSONS AND ORGANIZATIONS FROM WHOM THE COMMISSION SOUGHT SUBMISSIONS

Department of Health

Interlake-Eastern Regional Health Authority

Interlake-Eastern Regional Health Authority	Marion Ellis
Arborg & Districts Health Centre	Pat Barkman
Arborg Personal Care Home	Michelle Bobowski
Ashern Personal Care Home	Teresa Grouette
Beausejour Hospital	Glennda Gould
Betel Home Foundation	Jacob Ahiaegbe
Betel Personal Care Home	Jacob Ahiaegbe
East-Gate Lodge	Cindee Bialek
Elizabeth M. Crowe Memorial Hospital	Doreen Lucier
Emerson Health Centre	Marlo Friesen
Eriksdale Personal Care Home	Michelle Bobowski
Fisher Branch Personal Care Home	Keltie Kadynuik
Goodwin Lodge Personal Care Home	Keltie Kadynuik
Johnson Memorial Hospital (Gimli Community HC)	Julie Sigurdson
Kin Place Personal Care Home	Cheryl Fudali
Lac du Bonnet Personal Care Home	Clayton Fisher
Lakeshore General Hospital	Shelley Bjornson
Lundar Personal Care Home	Teresa Grouette
Pinawa Hospital	Tracy Abraham
Pine Falls Hospital	Leana Oversby
Pioneer Health Services	Sheri Brennan
Red River Place	Sandra Goers
Rosewood Lodge Personal Care Home	Mararete Moulden
Stonewall & District Health Centre	Jessica Bullen
Sunnywood Manor Personal Care Home	Angelina Hartwell
Tudor House Personal Care Home	John Ashley Martyniw
Whitemouth District Health Centre	Cheryl Fudali

Northern Regional Health Authority

Northern Regional Health Authority	Raj Sweda
Flin Flon General Hospital	Ingrid Olson
Flin Flon Personal Care Home	Jeremy Wright

Gillam Hospital	Sascha Conway
Lynn Lake Hospital	Deepkumar Patel
Nisichawayasihk Personal Care Home	Debra Linklater
Northern Lights Manor	Jeremy Wright
Northern Spirit Manor	Kristyn Wickdahl
Pinaow Wachi	Nellie Swanson
Snow Lake Health Clinic	Kelly Wiwarchuk
St. Anthony's General Hospital	Ingrid Olson
St. Paul's Personal Care Home	Karley Hanson
Thompson General Hospital	Lorraine Larocque

Prairie Mountain Health Region

Prairie Mountain Health	Carol Gower
Baldur Manor	Jaret Box
Bayside Personal Care Home	Jaret Box
Benito Health Centre	Amanda Watts
Birch Lodge Personal Care Home	Leah Black
Boissevain Health Centre	Nicole Barclay
Brandon Regional Health Centre	Janet Twerdoclib
Bren-Del-Win Lodge	Tracy Mills
Carberry Health Centre	Jarret McKinnon
Carberry Personal Care Home	Amber Seitz
Cartwright Davidson Memorial Health Centre	Jaret Box
Country Meadows Personal Care Home	Jocelyn Scheper
Dauphin Regional Health Centre	Carla Garton
Dauphin Personal Care Home	Crystal Abraham
Deloraine Health Centre	Shawn Lockhart
Delwynda Court Personal Care Home	Tracy Mills
Dinsdale Personal Care Home	Dan Knight
Dr. Gendreau Personal Care Home	Rosily Kochuvareet
Elkwood Manor	Lindsay Cooper
Erickson & District Health Centre	Kimberly Toews
Evergreen Place Personal Care Home	Tracy Mills
Fairview Personal Care Home	Debbie Rea
Gilbert Plains Care Home	Crystal Abraham
Glenboro Personal Care Home	Amber Seitz
Glenboro Health Centre	Jarret McKinnon
Grandview Health Centre	Anna Lungal
Grandview Personal Care Home	Aaron Miner
Hamiota Health Centre	Lana Hogg
Hartney Community Health Centre	Thea Dennis
Hillcrest Pesonal Care Home	Sandra Goers
McCreary/Alonsa Personal Care Home	Kim Toews
Melita Health Centre	Stacey Wessing

Melita Personal Care Home	Lindsay Cooper
Minnedosa Health Centre	Lana Hogg
Minnedosa Personal Care Home	Greg Paddock
Morley House Personal Care Home	Leah Black
Neepawa Health Centre	Lindsay Cooper
Reston Health Centre	Shawna Gork-Levasseur
Rideau Park Personal Care Home	Vicki Ketch
Riverdale Health Centre/Personal Care Home	Greg Paddock
Roblin Health Centre	Abbey Vorlicek
Roblin Crocus Court Personal Care Home	Jesus Dangat
Rossburn Personal Care Home	Roseanne Yaremchuk
Russell Personal Care Home	Jesus Dangat
Russell Health Centre	Abbey Vorlicek
Sandy Lake Personal Care Home	Kim Toews
Sherwood Nursing Home	Amanda Campbell
Shoal Lake-Strathclair Health Centre	Leah Black
Souris Personal Care Home	Thea Daniels
Souris Health Centre	Nicole Barclay
St. Paul's Home	Aaron Miner
Ste. Rose General Hospital	Rosily Kochuvareed
Sunnyside Manor	Roseanne Yaremchuk
Swan Valley Personal Care Home	Amanda Watts
Swan Valley Lodge	Amanda Watts
Swan Valley Health Centre	Nicole Kotak
Tiger Hills Manor	Amber Seitz
Treherne Health Centre	Jarret McKinnon
Tri-Lake Health Centre	Shawn Lockhart
Valleyview Care Centre	Connie Krahn
Virden Health Centre	Stacey Wessing
Wawanesa Health Centre	Chris Van De Woestyne
West-Man Nursing Home	Amanda Campbell
Westview Lodge Personal Care Home	Tracy Mills
Willowview Personal Care Home	Lindsay Cooper
Winnipegosis & District Personal Care Home	Michelle Quennelle

Southern Health – Santé Sud

Southern Health- Santé Sud	Jane Curtis
Altona Community Memorial Health Centre	Helen Hoeppner
Bethesda Place	Stephanie Rozsa
Bethesda Regional Health Centre	Ron Morrice
Boundary Trails Hospital	Lorraine Cassan
Boyne Lodge Personal Care Home	Helen Hoeppner
Carman Memorial Hospital	Lori Wychopen
De Salaberry District Health Centre	Theresa Courcelles

Douglas Campbell Lodge	Shauna Sanderson
Eden Mental Health Centre	Brad Unger
Emerson Health Centre	Marlo Friesen
Foyer Notre Dame	Marcie Dupasquier
Heritage Life Personal Care Home	Shelly Mall
Lions Prairie Manor	Shauna Sanderson
MacGregor Health Centre	Julie Sigurdson
Menno Home for the Aged	Krista Driedger
Morris General Hospital	Mathew Norris
Notre Dame Health Centre	Mathew Norris
Pembina-Manitou Health Centre	Jen Giesbrecht
Portage District Health Centre	Karen Yanchycki
Prairie View Lodge	Alison Fijala
Red River Valley Lodge	Ron Morrice
Repos Jolys Personal Care Home	Ron Morrice
Rest Haven Care Home	Tannis Nickel
Rock Lake Health District Hospital	Alison Fijala
Rock Lake Health District Personal Care Home	Alison Fijala
Salem Home Inc.	Karin Oliveira
Seven Regions/Gladstone Health Centre	Michelle Klaassen
St. Claude Health Centre	Danitra Lemky
Ste. Anne Hospital	Jo-Anne Marion
Tabor Home Inc.	Carolyn Fenny
Third Crossing Manor	Shirley Guenther
Villa Youville	Yann Boissonneault
Vita & District Health Centre	Stephanie Rozsa

Winnipeg Regional Health Authority & Shared Health

Winnipeg Regional Health Authority	Mike Nader
Shared Health	Lanette Siragusa
Actionmarguerite (St. Boniface)	Micheline St-Hilaire
Actionmarguerite (St. Joseph)	Micheline St-Hilaire
Actionmarguerite (St. Vital)	Micheline St-Hilaire
Beacon Hill Lodge	Tara-Lee Yakielashek
Bethania Mennonite PCH	Gary Ledoux
Calvary Place Personal Care Home	Helmut Plett
Cancercare Manitoba	Dr. Sri Vacaratnam
Charleswood Care Centre	Karla Struthers
Churchill Health Centre	Megan Quinlan
Concordia Hospital	Margaret Kamer
Concordia Place	Carrie Fruehm
Deer Lodge Centre	Kevin Scott
Donwood Manor	Paul Nyhof

Fred Douglas Lodge	Greg Reid
Golden Door Geriatric Centre	Kelly Barnert-Loewen
Golden Links Lodge	Marcy-Lynn Larner
Golden West Centennial Lodge	Nancy Hovmand
Grace Hospital	Sharon Stevens
Health Sciences Centre	Dr. Shawn Young
Heritage Lodge	Lowell Friesen
Holy Family Nursing Home	Angela Peeler
Kildonan Personal Care Centre	Matthew Braun
Lions Personal Care Home	Gilles Verrier
Luther Home	Keith Bytheway
Maples Personal Care Home	Kathy Pajic
Meadowood Manor	Nicole Boonstra
Misericordia Health Centre	Caroline Dekeyster
Misericordia Place	Jennifer Taylor
Oakview Place	Sandra Goers
Park Manor Care Home	Abednigo Mandalupa Jr.
Pembina Place Mennonite Personal Care Home	Gary Ledoux
Poseidon Care Centre	Temenuzhka Koleva
River East Personal Care Home Ltd.	Kim Rohm
River Park Gardens	Kevin Scott
Riverview Health Centre	Kathleen Klaasen
Selkirk Mental Health Centre	James Wasio
Seven Oaks General Hospital	Jodi Kortje
Southeast Personal Care Home	Kevin Friesen
St. Amant	Ben Adaman
St. Boniface Hospital	Nicole Aminot
St. Norbert Personal Care Home	Kim Hykawy
The Convalescent Home of Winnipeg	Sharon Wilms
The Middlechurch Home of Winnipeg Inc.	Kevin Scott
The Saul and Claribel Simkin Centre	Lauri Cerqueti
Tuxedo Villa	Sandra Goers
Victoria General Hospital	Kaydi Ann Borgersen
Vista Park Lodge	Sandra Goers
West Park Manor	Ruben Wollmann

Others within Department of Health

Age & Opportunity: Support Services for Seniors	Amanda Macrae
Alzheimer Society of Manitoba	Erin Crawford
Centre on Aging, University of Manitoba	Michelle Porter
College of Licensed Practical Nurses of Manitoba	Jennifer Breton
College of Occupational Therapists in Manitoba	Michelle Martin-Strong
College of Physicians & Surgeons of Manitoba	Dr. Anna Ziomek
College of Physiotherapists of Manitoba	Jennifer Billeck
College of Registered Nurses of Manitoba	Deb Elias

College of Registered Psychiatric Nurses of Manitoba	Laura Panteluk
Good Neighbours Active Living Centre/Prevent Elder Abuse Manitoba (PEAM)	Susan Sader
La Fédération Des Aines Franco-Manitobains	Lucienne Chateauneuf
Long Term & Continuing Care Association of Manitoba	Sue Vovchuk
Manitoba Association of Residential & Community Care Homes for the Elderly	Julie Turenne-Maynard
Manitoba Association of Seniors Centres	Connie Newman
Manitoba College of Social Workers	Barbara Temmerman
Manitoba First Nation PCH Operator	Christopher Hersak
Provincial Personal Care Home Liaison	Charles Gagne
Rainbow Resource Centre – Over the Rainbow	Noreen Mian

Others within Department of Families

Abilities Manitoba	Margo Powell
Community Living Manitoba	Aileen Najduch
Continuity Care	Suzanne Swanton
Family Advocacy Network of Manitoba	Debra Roach
Inclusion Winnipeg	Janet Forbes
Intellectual Disability Issues Advisory Council	Claire Gumieny
Manitoba League of Persons with Disabilities	Melissa Graham
Manitoba Possible	Lindsey Cooke
People First Manitoba	Valerie Wolbert
Vulnerable Persons Task Force	Dale Kendel

Community Living Disability Services – Agencies

Arcane Horizon Inc.	Chris Bauer
Aspen Winds/Vents de Tremble	Michaela Knibbs
Association for Community Living – Beausejour Branch	Susie Roosewinkle
Association for Community Living – Flin Flon Vocational Training Centre	Samantha Thorimbert
Association for Community Living – Interlake Branch	Jimm Simon
Association for Community Living – Portage la Prairie Branch	Sash Junkin
Association for Community Living – Swan River	Daphne Currie
Association for Community Living – Virden Branch	Lisa James
Blue Sky Opportunities Inc.	Ryan Potter
Brandon Community Options Inc.	Brenda Elmes
Can Do People Inc.	Kim Corlett
Career Connections Inc.	Joy Escalera
CBI Health Group	A. Malanchuk
Community Ambitions Day Service Inc.	Heather Caners

Community Bridges Gimli	Heather McNeill
Community Respite Service Inc. (Western)	Michelle Hammond
Community Respite Service Inc. (Winnipeg)	Michelle Hammond
Community Venture (The Salvation Army)	Kim Park
Com-Span Inc.	Jackie Nabudere
Connect Employment Services Inc.	Krista Bissett
COR Enterprises Inc.	Terri Silvius
Cornerstone Christian Care Inc.	Chris Buffington
DASCH Inc.	Karen Fonseth-Schlossberg
Doves Homes	Nicole Kehler
El'dad Ranch	Kevin Drain
enVision Community Living	Jeannette DeLong
EPIC Opportunities Inc.	Ruby Reimer
EPIC/SMILE St. Malo Inc.	Jackie Prowse
Equal Opportunities West (SJAI Employment Services)	Susan Morgan
Essential Living Assistance Services Inc. (ELA)	Diane Turski
Fairfax Community Resources Inc.	Kelly Miller
Family Visions Inc	Laurie Jackson
Frontier Trading Company Inc.	Bailey Jonsson
Gaining Resources Our Way (GROW)	Sandy Sheegl
Gateway Resources Inc.	Kimberly Nelson
Grandview Gateways Inc.	Wanda Simpson
Hearthstone Community Group	Lori Zdebiak
Imagine Ability Inc.	Audra Penner
Inclusions Selkirk	Maria Freeman
Independent Living Resource Centre	John Young
Innovative LIFE Options, Inc.	Patti Chiappetta
Juniper Centre Inc.	James Goble
K & D Transitions & Supports Inc.	Karen Fecyk
Kin Glen Group Home	Denyse Palas
L'Arche Winnipeg, Inc.	Dominic Opaka
L'Avenir Cooperative Inc.	Marc Piche
Life's Journey Inc. (Western)	Jodi Roney
Life's Journey Inc. (Winnipeg)	Graham Wyllie
Marymound Inc.	Nancy Parker
MBS Residence	Angele Michaud
Mrs. Lucci's Resource Centre	Karen Kost
Network 4 Change	Kelly Fiebelkorn
New Directions for Children, Youth, Adults and Families Inc.	Dr. Jennifer Frain
Norman Community Services	Laurie Sealey
Norshel Inc.	Colin Rivers
Norshel Residential Inc.	Lesley Heber
Opportunities for Independence	Brad Torgerson
Options Pathways & Transitions Inc.	Kelly Bennett

Oshki-Giizhig Inc.	Eric Friesen
Parkland Regional Community Inc.	Roberta Senek
Parkland Residential & Vocational Services Inc.	Darrin Clinton
Portage ARC Industries Inc.	Tara Ryzner
Prairie Partners Inc. (Western)	Misheyla Iwasiuk
Prairie Places Inc. (Winnipeg)	Quinn Adams-Sneisen
Premier Personnel	Ernie Thiessen
Project S.A.M Inc.	Brian McEachern
Pulford Community Living Services Inc.	Rod Retelback
Riverdale Place Workshop Inc.	Alex Janower
Riverside Community Residence Inc.	Shannon Bodnarchuk
Riverton Care Services Inc.	Jeannette Nikols
Rolling Dale Enterprises Inc.	Kristen Scott
ROSE Inc.	Kimberly McCarthy
Samtak Co-op Inc.	Karen Hay
SCE LifeWorks	Oly Backstrom
Shalom Residence Inc.	Mike Goldberg
Simaril Inc.	Jeff Daly
Somerset Villa Inc.	Brandy Giesbrecht
Southwest Community Options Inc.	Rhonda Beare
SPIKE Inc.	Peter Court
Sprucedale Industries Inc.	Donna Purkess
Step to Step Living	Antonio D'Ottavio
Swan Valley Advocacy Services	Kathleen Hunt
The Link (Youth & Family Services)	Kerri Irvin-Ross
The Pas Association for Human Development	Cathy Lipscomb
Touchwood Park Association Inc.	Arleigh Wilson
Trailblazers Life Choices Inc.	Andrew Morris
Transcona Springfield Employment Network (TSEN)	Deanne Greenaway
Turning Leaf Community Support Services Inc.	Barkley Engel
Visions of Independence	Jennifer Hagedorn
WASO Inc.	Karen Goodman Wong
Wings of Power Inc.	Guy Borlase
Winnipegosis & District Residential Inc.	Coleman Lytwyn
Winnserv Inc.	Malinda Roberts

Others

Adult Abuse Registry Committee	Janet Forbes
Assembly of Manitoba Chiefs Secretariat	Howard Burston
Canadian Union of Public Employees (CUPE)	Gina McKay
City of Brandon – Police Service	Randy Lewis
City of Winnipeg Police – Vulnerable Persons Unit	Manager
Doctors Manitoba	Theresa Oswald
Keewatinohk Inniniw Minoayawin Inc.	Dr. Barry Lavallee
Liberal Member of Legislative Assembly	Cindy Lamoureaux

Manitoba Association of Health Care Professionals	Jason Linklater
Manitoba Bar Association, Elder Law Subsection	Krista Clendenning
Manitoba Bar Association, Health Subsection	John Martens
Manitoba Gerontological Nursing Association	Brandy Stadnyk
Manitoba Government and General Employees' Union (MGEU)	Kyle Ross
Manitoba Inuit Association	Nastania Mullin
Manitoba Keewatinowi Okimakanak, Inc.	Kelvin Lynxleg
Manitoba Métis Federation, Inc.	David Chartrand
Manitoba Nurses Union	Mike Sutherland
Manitoba Ombudsman	Jill Perron
Ms K. Gilson, Special Counsel	
Provincial Protection Investigation Union (PPIU)	Jana Aranson
Public Interest Law Centre	Byron Williams
Community Education Development Association (Seniors Advocacy Coalition)	Lucille Bruce & Tom Simms
RCMP – Vulnerable Unit	Manager
Sioux Valley Dakota Nation	Christopher Hersak
Southern Chiefs' Organization Inc.	Joy Cramer
Speaker of the Manitoba Legislative Assembly	Tom Lindsey
The Francophone Affairs Advisory Council	Angela Caissie
The Honourable Premier Wab Kinew	
The Leader of Official Opposition	Heather Stefanson
The Manitoba Advocate for Children and Youth	Sherry Gott
The Public Guardian & Trustee Office of Manitoba	Keri Ranson

Appendix 4

THE OFFICE OF THE COMMISSION
FOR THE
PROTECTION OF PERSONS IN CARE

1700-242 Hargrave Street
Winnipeg, MB R3C 0VI
Canada

December 21, 2023

COMMISSION ACCEPTING SUBMISSIONS

RE: New Office to Replace the Protection for Persons in Care Office

Currently, the Protection for Persons in Care Office ("PPCO"), a division of Manitoba Health, is responsible for receiving and investigating reports of abuse or neglect of adult patients in Manitoba health facilities.

In July, 2023, the Government of Manitoba (the "Province") received a report from the Office of the Auditor General concerning its investigation of the PPCO. The Auditor General's report identified serious concerns relating to the timeliness of PPCO investigations and unfounded conclusions made by the PPCO. The report also addressed the concern that the PPCO was not providing the public with statistics or information on the number of investigations it was conducting or the outcomes of those investigations, with the result that there was inadequate transparency.

As a result of the Auditor General's report, and to provide greater accountability and transparency to the public, the Province announced that it would be replacing the PPCO with a new independent office (the "new office") to receive, investigate and act upon reports of abuse or neglect in Manitoba health facilities. The Province also announced that the new office would report directly to the Legislative Assembly (the "Assembly").

On September 1, 2023, the Province created this Commission to provide advice and recommendations in relation to the new office.

Overview of PPCO

Since 2001, *The Protection for Persons in Care Act*, CCSM c P144 (the "Act") has governed the reporting of abuse or neglect of adult patients, residents, clients and/or other persons in care (collectively "persons in care") in Manitoba health facilities. Operators of health facilities (hospitals, personal care homes and other designated institutions) have a duty to protect persons in

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care from abuse or neglect. The Act imposes a mandatory reporting requirement when a person has a reasonable basis to believe that a person in care is or is likely to be abused or neglected. These reports are made to the PPCO, a delegate of the Minister of Health, Seniors and Long-Term Care. The PPCO investigates complaints and provides reports to the Minister. The Minister may give operators of health facilities directions to protect persons in care from abuse or neglect, and operators are required to comply with these directions. Where necessary, referrals are made tothe executive director under *The Adults Living with an Intellectual Disability Act,* CCSM c A6.1, or a professional regulatory body. Further, the PPCO may make a referral to the Adult Abuse Registry Committee if it concludes that abuse or neglect occurred.

Proposed New Office

The Commission has undertaken an extensive review of legislative and operational approaches with respect to the reporting and investigation of abuse or neglect of persons in care across Canada and in other common law jurisdictions (the United States, the United Kingdom and Australia). The Commission has also considered the report from the Office of the Auditor General and its recommendations, together with a number of other reports relating to the protection of persons in care.

Based on this review, the Commission proposes that a new office be created, independent and at arm's length from health facilities and service providers, and outside the political sphere. All reporting of adult abuse or neglect in Manitoba health facilities, together with the investigation activities of the PPCO, would be transferred to the new office. As before, all operators of health facilities would continue to have the duty to protect persons in care from abuse or neglect, and to maintain a reasonable level of safety for them, and all mandatory reporting requirements would remain in place. Where a person has a reasonable basis to believe that a person in care has been or is likely to be abused or neglected, such reporting would be to the new office.

The Commission envisions that the new office would be resolution-oriented, would provide timely investigation and reporting on complaints of abuse or neglect, would publish statistics and additional information on the number of investigations it conducts and the outcome of such investigations, and would be more transparent and accountable to persons in care, families, caregivers and members of the public.

More specifically, the Commission proposes that the essential characteristics of the new office would include the following:

- An individual would be appointed by resolution of the Assembly to lead the new office; the appointment would be for a fixed term; and the individual would be an officer of the Assembly and would be accountable to it;

- The new office would receive and respond to reports of abuse or neglect from health facilities, caregivers, persons in care and others, would facilitate resolution where appropriate or viable, and would undertake investigation and report on incidents of alleged abuse or neglect on a timely basis;

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- Reports of abuse or neglect at the intake level would be promptly reviewed to determine if jurisdiction rested with the new office or another person or body. If so, the new office would refer the matter to that person or body for determination. The new office would receive a report on any investigations or on any conclusions reached by that person or body;

- The new office would decline jurisdiction on any allegation(s) of abuse or neglect if the substance of the allegations was before a court;

- All of the PPCO's investigative powers would be transferred to the new office, including access to the premises, records and information of health facilities. The new office would have additional powers, such as the ability to conduct examinations under oath, to compel production of documents, to obtain subpoenas, to make applications to court for assistance, and to carry out investigations on their own initiative;

- No person would be permitted to obstruct, destroy or provide false or misleading information to the new office, and any such contravention would be an offence;

- Timelines would be specified for investigations and their completion;

- The new office would try, to the fullest practical extent, to involve the person in care and caregiver;

- A health facility could not take any adverse steps against an employee that reports abuse or neglect, nor could it discontinue or threaten to discontinue services to a person in care because of a report made to the new office;

- After completing an investigation, the new office would issue its report which would include the reasons for their conclusions. The report would be shared with the person in care, the subject of the complaint, any employer of that person, the health facility, the Adult Abuse Registry Committee in accordance with the regulations, and (where applicable) the police;

- Any recommendations made by the new office in its report to a health facility would be public, and the health facility would be identified;

- A health facility would report to the new office the steps that it had taken or proposed to take to give effect to any recommendation. If the health facility declined or failed to give effect to a recommendation, the new office would notify the Minister of Health, and would also include the matter in its annual report to the Assembly;

- The new office would provide (at minimum) annual reporting on its operations. Such reporting would include:
  (i) the performance of the office;
  (ii) the number of reports of abuse or neglect received that year;
  (iii) the number of referrals to other bodies/persons for review and/or investigation;
  (iv) the number of facilitated resolutions;

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(v) the number of investigations undertaken, and reports issued, including findings of abuse or neglect, recommendations to health facilities and replies thereto;
(vi) the status of any outstanding matters from the preceding year;
(vii) the number of persons referred to the Adult Abuse Registry Committee and to the police; and
(viii) any other recommendations the new office wished to make to the Assembly.

In addition, the new office would have the power to make a special report to the Assembly on any matter of pressing importance or urgency;

- The new office would preserve confidentiality on all matters that come to its knowledge. There would be no personal information in any report made by the new office regarding the person in care, the caregiver or the person who is the subject of the report;

- The new office would investigate any health facility if so directed by the Lieutenant Governor in Council or the Assembly, and would thereafter deliver a report in a timely fashion;

- The new office would oversee all staffing, including addressing the diverse set of skills and backgrounds required to fulfill its mandate; and

- The new office would present an annual estimate of the funds required for the purpose of carrying out its obligations.

In summary, the new office would protect persons in care by being proactive in providing timely resolutions to reports of abuse or neglect. It would be empowered with effective and extensive investigation powers, and it would be non-partisan and independent from government, health facilities and regulated health professions. The new office would be accountable to Manitobans through regular public reporting.

Submissions on the new office are an essential step in allowing the Commission to consider a wide range of perspectives and to assist in the process of establishing the new office.

We are seeking your contribution, input, feedback and suggestions regarding the new office. If you are interested, would you kindly provide a written submission (not exceeding 10 pages), by email, fax or regular mail to:

The Commission for the Protection of Persons in Care
1700-242 Hargrave Street
Winnipeg, MB R3C 0V1
Attention: Mr. William J. Burnett
Commissioner
wjb@commission-protectionofpersonsincare.ca

Fax: 431-815-4992

The Commission's mandate does not include a review or consideration of any past files handled by the PPCO. As announced by the Province on July 27, 2023, that review is being performed by Special Counsel Kimberley Gilson. The Commission requests that anything related to past files handled by the PPCO be directed to Kimberley Gilson at 204-510-3367 or kim@gilsonlaw.ca.

All submissions received concerning the new office will be read and considered by the Commission. Thereafter, the Commission will make its recommendations to the Province.

Submissions are not confidential. You may, however, submit anonymous comments, or you may identify yourself but request that your comments be treated confidentially. If you do not comment anonymously, or request confidentiality, the Commission may quote from or refer to your submissions.

The deadline for receipt of submissions is February 29, 2024. The Commission may consider late submissions in exceptional circumstances. If you wish to seek an extension to make a late submission, please email wjb@commission-protectionofpersonsincare.ca.

Thank you for your time and interest in improving protection for persons in care in Manitoba.

Yours truly,

William J. Burnett
Commissioner

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Annexe 4

BUREAU DE LA COMMISSION CHARGÉE DE LA
PROTECTION DES PERSONNES RECEVANT DES SOINS

242, rue Hargrave, bureau 1700
Winnipeg (Manitoba) R3C 0VI
Canada

Le 21 décembre 2023

LA COMMISSION ACCEPTE LES SOUMISSIONS

OBJET : Un nouveau bureau remplacera l'Office de protection des personnes recevant des soins

À l'heure actuelle, l'Office de protection des personnes recevant des soins (l'« Office »), une division du ministère de la Santé, est chargé de recevoir les signalements de mauvais traitements ou de négligence envers les patients adultes dans les établissements de santé au Manitoba, et de mener des enquêtes au sujet de ces signalements.

En juillet 2023, le gouvernement du Manitoba (la « Province ») a reçu un rapport du Bureau du vérificateur général concernant son enquête sur l'Office. Le rapport du vérificateur général relevait d'importantes préoccupations quant au caractère opportun des enquêtes de l'Office et aux conclusions non fondées auxquelles ce dernier aboutissait. Le rapport traitait également du fait que l'Office ne fournissait pas au public les statistiques ou l'information sur le nombre d'enquêtes qu'il menait ni des résultats de ces enquêtes, ce qui constituait un manque de transparence adéquat.

À la suite du rapport du vérificateur général, et pour accroître la responsabilité et la transparence à l'égard du public, la Province a annoncé qu'elle remplacerait l'Office par un nouveau bureau indépendant (le « nouveau bureau ») qui se chargerait de la réception, de l'enquête et du traitement des signalements de mauvais traitements ou de négligence dans les établissements de santé du Manitoba. La Province a aussi annoncé que le nouveau bureau relèverait directement de l'Assemblée législative (l'« Assemblée »).

Le 1er septembre 2023, la Province a créé cette commission pour fournir des conseils et des recommandations au sujet du nouveau bureau.

Aperçu de l'Office

La *Loi sur la protection des personnes recevant des soins*, CPLM, c. P144 (la « Loi ») régit, depuis 2001, les signalements de mauvais traitements ou de négligence envers les patients adultes, les résidents, les clients ou les autres personnes recevant des soins (collectivement, les « personnes recevant des soins ») dans les établissements de santé du Manitoba. Les gestionnaires des établissements de santé (hôpitaux, foyers de soins personnels et autres établissements désignés) ont l'obligation de protéger les personnes recevant des soins contre les mauvais traitements et la négligence. La Loi impose une obligation de signalement lorsqu'une personne a des motifs raisonnables de croire qu'une personne recevant des soins subit ou risque de subir des mauvais traitements ou fait l'objet ou risque de faire l'objet de négligence. Ces signalements sont faits à

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l'Office, agissant à titre de représentant du ministre de la Santé, des Aînés et des Soins de longue durée. L'Office enquête sur les plaintes et fournit des rapports au ministre. Le ministre peut donner aux gestionnaires des établissements de santé des directives en vue de la protection des personnes recevant des soins contre les mauvais traitements ou la négligence, et les gestionnaires sont tenus de s'y plier. Au besoin, des renvois peuvent être faits au directeur général en vertu de la *Loi sur les adultes ayant une déficience intellectuelle*, CPLM, c. A6.1, ou à un organisme professionnel réglementaire. De plus, l'Office peut renvoyer une personne vers le comité de protection contre les mauvais traitements infligés aux adultes s'il conclut qu'il y a eu des mauvais traitements ou de la négligence.

Proposition de nouveau bureau

La Commission a entrepris un examen approfondi des approches législatives et opérationnelles concernant les signalements de mauvais traitements ou de négligence chez les personnes recevant des soins, et les enquêtes sur ces signalements, dans l'ensemble du Canada et dans d'autres endroits relevant de la common law (les États-Unis, le Royaume-Uni et l'Australie). La Commission a également pris connaissance du rapport du Bureau du vérificateur général et de ses recommandations, ainsi que de plusieurs autres rapports portant sur la protection des personnes recevant des soins.

Sur la base de cet examen, la Commission propose la création d'un nouveau bureau indépendant, sans lien de dépendance avec les établissements de santé et les fournisseurs de services, et hors de la sphère politique. Tous les signalements de mauvais traitements ou de négligence dans les établissements de santé du Manitoba, ainsi que les activités d'enquête de l'Office, seraient transférés au nouveau bureau. Comme avant, tous les gestionnaires des établissements de santé (hôpitaux, foyers de soins personnels et autres établissements désignés) demeureraient tenus de protéger les personnes recevant des soins contre les mauvais traitements et la négligence, et de maintenir des niveaux raisonnables de sécurité pour elles, et toutes les exigences obligatoires relatives aux signalements demeureraient en place. Lorsqu'une personne aurait des motifs raisonnables de croire qu'une personne recevant des soins subirait ou risquerait de subir des mauvais traitements ou ferait l'objet ou risquerait de faire l'objet de négligence, elle le signalerait au nouveau bureau.

La Commission prévoit que le nouveau bureau sera axé sur la résolution des cas, procédera en temps opportun à des enquêtes et à la production de rapports sur les plaintes de mauvais traitements ou de négligence, publiera des statistiques et des renseignements additionnels sur le nombre d'enquêtes réalisées ainsi que les résultats de ces enquêtes, et sera plus transparent et responsable à l'égard des personnes qui reçoivent des soins, des proches, des soignants et des membres du public.

Plus précisément, la Commission propose que le nouveau bureau soit au moins doté des caractéristiques essentielles suivantes :

- un particulier serait nommé par résolution de l'Assemblée pour diriger le nouveau bureau, sa nomination aurait une durée déterminée, et le particulier serait un haut fonctionnaire de l'Assemblée et relèverait de celle-ci;

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- le nouveau bureau recevrait les signalements de mauvais traitements ou de négligence des établissements de santé, des soignants, des personnes recevant des soins ou d'autres parties, y répondrait, faciliterait la résolution lorsque cela est approprié ou viable, et mènerait des enquêtes sur les allégations de mauvais traitements ou de négligence en temps opportun;

- les signalements de mauvais traitements ou de négligence au niveau de la prise en charge seraient rapidement examinés pour établir si la compétence relèverait du nouveau bureau, d'une autre personne ou d'un autre organisme. Le cas échéant, le nouveau bureau renverrait la question à cette personne ou à cet organisme à des fins de détermination. Le nouveau bureau recevrait un rapport sur les enquêtes ou sur les conclusions auxquelles aboutirait cette personne ou cet organisme;

- le nouveau bureau refuserait compétence quant aux allégations de mauvais traitements ou de négligence si le fond des allégations était présenté devant un tribunal;

- tous les pouvoirs d'enquête de l'Office seraient transférés au nouveau bureau, notamment l'accès aux lieux, aux dossiers et aux renseignements des établissements de santé. Le nouveau bureau serait doté de pouvoirs additionnels, comme la capacité d'effectuer des interrogatoires sous serment, d'exiger la production de documents, d'obtenir des assignations à comparaître, de présenter des demandes d'aide au tribunal, et d'effectuer des enquêtes de sa propre initiative;

- personne ne serait autorisé à obstruer l'accès aux renseignements, à détruire les renseignements ou encore à fournir des renseignements faux ou trompeurs au nouveau bureau, et toute contravention de la sorte constituerait une infraction;

- des calendriers seraient précisés pour les enquêtes et leur échéance;

- le nouveau bureau tenterait, dans toute la mesure du possible, de faire intervenir la personne recevant des soins et le soignant;

- un établissement de santé ne pourrait pas prendre de mesures négatives à l'encontre d'un employé qui signale un cas de mauvais traitements ou de négligence, ni ne pourrait mettre fin ou menacer de mettre fin aux services fournis à une personne recevant des soins en raison d'un signalement fait au nouveau bureau;

- une fois une enquête terminée, le nouveau bureau publierait son rapport, qui contiendrait les motifs de ses conclusions. Le rapport serait communiqué à la personne recevant des soins, à la personne faisant l'objet de la plainte, à l'employeur de cette personne, à l'établissement de santé, au comité de protection contre les mauvais traitements infligés aux adultes conformément à la réglementation et, le cas échéant, à la police;

- toute recommandation qu'émettrait le nouveau bureau dans son rapport à un établissement de santé serait publique, et l'établissement de santé serait identifié;

- un établissement de santé signalerait au nouveau bureau les mesures qu'il aurait prises ou qu'il proposerait de prendre afin de donner suite à une recommandation. Si l'établissement

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de santé refusait ou omettait de donner suite à une recommandation, le nouveau bureau en aviserait le ministre de la Santé, et en ferait également mention dans son rapport annuel à l'Assemblée;

- le nouveau bureau fournirait, au minimum, un rapport annuel sur ses activités. Un tel rapport comprendrait :
  (i) la performance du bureau;
  (ii) le nombre de signalements de mauvais traitements ou de négligence reçus dans l'année en question;
  (iii) le nombre de renvois vers d'autres organismes ou personnes à des fins d'examen ou d'enquête;
  (iv) le nombre de cas réglés;
  (v) le nombre d'enquêtes entreprises et de rapports publiés, indiquant les conclusions de mauvais traitements ou de négligence, les recommandations aux établissements de santé et les réponses à celles-ci;
  (vi) l'état d'avancement de toute question non résolue l'année précédente;
  (vii) le nombre de personnes renvoyées au comité de protection contre les mauvais traitements infligés aux adultes et à la police;
  (viii) toute autre recommandation que le nouveau bureau souhaiterait formuler à l'Assemblée.

  En outre, le nouveau bureau aurait le pouvoir de soumettre un rapport spécial à l'Assemblée sur toute question d'importance pressante ou urgente;

- le nouveau bureau assurerait la confidentialité de toutes les questions dont il prendrait connaissance. Les rapports du nouveau bureau ne contiendraient pas de renseignements personnels concernant la personne recevant des soins, le soignant ou la personne faisant l'objet du rapport;

- le nouveau bureau enquêterait tout établissement de santé si le lieutenant-gouverneur en conseil ou l'Assemblée lui demandait de le faire, et présenterait par la suite un rapport en temps opportun;

- le nouveau bureau superviserait tous les employés, et gérerait notamment l'expérience et les différents ensembles de compétences requis pour s'acquitter de son mandat;

- le nouveau bureau présenterait une estimation annuelle des fonds nécessaires à l'exécution de ses obligations.

En résumé, le nouveau bureau protégerait les personnes recevant des soins en procédant proactivement à une résolution expéditive des signalements de mauvais traitements ou de négligence. Il serait investi de pouvoirs d'enquête efficaces et étendus; et serait non partisan et indépendant du gouvernement, des établissements de santé et des professions de santé réglementées. Le nouveau bureau rendrait des comptes aux Manitobains en publiant régulièrement des rapports publics.

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Les soumissions relatives au nouveau bureau constituent une étape essentielle pour permettre à la Commission d'envisager une vaste gamme de perspectives et d'assister au processus de création du bureau.

Je sollicite votre contribution, votre rétroaction, vos commentaires et vos suggestions concernant le nouveau bureau. Si vous le souhaitez, je vous serais reconnaissant de fournir une soumission par écrit (maximum de dix pages) par courriel, par télécopieur ou par la poste à la:

Commission chargée de la protection des personnes recevant des soins
242, rue Hargrave, bureau 1700
Winnipeg (Manitoba) R3C 0V1
À l'attention de : M. William J. Burnett
Commissaire

wjb@commission-protectionofpersonsincare.ca

Télécopieur : 431 815-4992

Le mandat de la Commission ne comprend pas l'examen ou la considération des dossiers antérieurs traités par l'Office. Comme l'a annoncé la Province le 27 juillet 2023, cet examen est réalisé par Kimberley Gilson, avocate-conseil spéciale. La Commission demande que tout renseignement lié aux dossiers antérieurs gérés par l'Office soit communiqué à Kimberley Gilson au 204 510-3367 ou à kim@gilsonlaw.ca.

La Commission lira et examinera toutes les soumissions qu'elle recevra concernant le nouveau bureau. Par la suite, elle présentera ses recommandations à la Province.

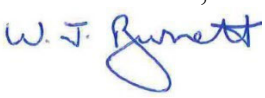
Les soumissions ne sont pas confidentielles. Vous pouvez toutefois soumettre vos commentaires de façon anonyme ou vous identifier tout en demandant que vos commentaires soient traités de façon confidentielle. Si vous ne commentez pas de façon anonyme ou ne demandez pas le traitement confidentiel de vos commentaires, la Commission pourra citer vos commentaires ou s'y reporter.

La date limite pour la réception des soumissions est le 29 février 2024. La Commission ne considérera les soumissions tardives que dans des circonstances exceptionnelles. Pour demander une prorogation afin de remettre une soumission tardive, envoyez un courriel à wjb@commission-protectionofpersonsincare.ca.

Je vous remercie de votre temps et de votre intérêt à l'égard de l'amélioration de la protection des personnes recevant des soins au Manitoba.

Veuillez agréer l'expression de mes meilleurs sentiments.

Le commissaire,



William J. Burnett

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Appendix 5

SUMMARY OF STAKEHOLDER SUBMISSIONS

On December 21, 2023, the Commission requested input, feedback and suggestions from a wide range of stakeholders. A brief summary of the submissions received is set forth below. The information shared provided valuable insights and perspectives that assisted the Commission in providing advice and recommendations in relation to the new office. While portions of the submissions were not directly related to the mandate of the Commission or the new office which will replace the Protection for Persons in Care Office ("PPCO"), the Commission acknowledges the importance of each submission.

1. ADULT ABUSE REGISTRY COMMITTEE ("AARC")

The AARC advised that it supported the creation of a new office and proposed that an independent office should be considered for referrals of abuse and neglect under *The Adults Living with an Intellectual Disability Act*, CCSM c A6.1 ("ALIDA"). The AARC also supported enhanced powers for gathering evidence, as this will result in the AARC having better evidence when making its decisions. The AARC expressed concerns about the timeliness of referrals from the PPCO and noted that an inability to serve individuals with required notices has often frustrated the AARC process.

2. ALZHEIMER SOCIETY (MANITOBA) ("Society")

The Society provided a synopsis of its role in Manitoba, noting that over the last 40 years, it has become the leading resource in the Province for families impacted by dementia. The Society advised that there are more than 18,400 Manitobans living with dementia, that it logs nearly 15,000 client contacts annually and that as many as 69% of people living in long-term care have dementia.

The Society submitted that in the later stages of dementia, responsive or reactive behaviours are often more prevalent, creating additional challenges for healthcare staff, and that meeting the complex care needs of persons living with dementia requires more time, attention and flexibility from healthcare providers. This is especially challenging when coupled with chronic understaffing in health facilities and a lack of priority placed on dementia education and awareness.

According to the Society, when systems are not properly put in place to afford protections and to act on allegations of abuse, neglect or mistreatment, it is incredibly difficult for families to trust that persons living with dementia in health facilities will be treated with respect and that their inherent dignity will be honored.

The Society cautioned that care and consideration must be exercised regarding the Commission's proposal to name health facilities who have received recommendations from the new office.

While it recognized this proposal would be more transparent and accountable to persons in care, families, caregivers and members of the public, the Society says that there exist longstanding feelings of fear, unease and worry for care partners when a person living with dementia is admitted to a health facility. The Society believes that there may also be impacts to other persons living in a named long-term care facility, to their families and to those being asked to consider imminent placement in that facility, if the health facility is named by the new office.

The Society submits that without adequate systems in place to protect those most vulnerable and to act on allegations of abuse, neglect or mistreatment, Manitoba has failed in its duty to protect its residents.

3. ASSEMBLY OF MANITOBA CHIEFS ("AMC")

The AMC advised that it is committed to collaborating with the Commission to ensure that the establishment of the new office aligns with high standards of care and accountability.

The AMC stressed the need to improve the response time to complaints of abuse and neglect, the need for dedicated support and representation, the need for comprehensive protocols specifically tailored to individuals with dementia, and the need to improve cultural and sensitivity training for staff members responsible for the care of First Nation residents.

The AMC strongly recommended that the new office have a First Nations advocate. The AMC noted that language barriers can create further challenges, underscoring the importance of having culturally competent advocates who can effectively communicate and address the needs of First Nations. According to the AMC, these measures will promote inclusivity and equity, and foster trust and confidence among First Nations in the Manitoba healthcare system.

4. ASSOCIATION OF REGULATED NURSES OF MANITOBA ("ARNM") & CANADIAN NURSES PROTECTIVE SOCIETY ("CNPS")

ARNM is a provincial association which serves all professional nursing designations in Manitoba (registered nurses, nurse practitioners, registered psychiatric nurses and licensed practical nurses, graduate nurses, nursing students and former registered nurses). ARNM also serves as the provincial liaison with CNPS.

CNPS is the entity that provides risk management services, professional liability protection and legal services to over 150,000 nurses in Canada, including legal representation to nurses who are the subject of PPCO investigations.

ARNM/CNPS collaborated in their submissions to the Commission and advised that they fully supported the proposed changes. In particular, ARNM/CNPS support a resolution-oriented model, the requirement for timely investigations, the expanded powers of investigation (which allow a more comprehensive review) and a requirement that the person who is the subject of a complaint be given a copy of the investigation report and the rationale for any decision. Additional considerations raised by ARNM/CNPS focused on the investigative process of the new office, and specifically the requirements of procedural fairness being embedded in the legislation.

ARNM/CNPS submit that the new office should:

(a) provide appropriate notification of the investigation to the individual who is the subject of the complaint, along with particulars of the alleged abuse or neglect;
(b) provide disclosure of sufficient information to the individual under investigation to enable the individual to appropriately respond to the allegations of abuse or neglect;
(c) ensure that investigators are properly trained/educated, know how to properly assess the reliability of evidence and understand the requirements of procedural fairness; and
(d) make its rules and procedures publicly available so that members of the public, patients, facilities and individuals who are the subject of a report understand the process and can participate meaningfully in it.

ANRM/CNPS propose, at a minimum, that subsections 5(3), 6(2), 7(2) and section 8 of *The Protection for Persons in Care Act*, CCSM c P144 be amended to be consistent with the principles of procedural fairness.

ARNM/CNPS expressed concerns regarding the lack of timelines in the Act for the initiation and completion of an investigation. ARNM/CNPS advised that they did not have any concern with requiring a person under investigation to provide information to an investigator.

ARNM/CNPS propose that there should be a right of appeal from the findings of the PPCO (or its successor) as found in other Canadian jurisdictions.

ARNM/CNPS also recommended related changes to the AARC to better delineate the obligations of the AARC when determining whether an individual should be placed on the Adult Abuse Registry.

Finally, ARNM/CNPS proposed that the new office be required to submit a draft of any recommendation to the health facility for input prior to presenting the recommendation in final form, to ensure that the recommendation is practical and relevant.

5. CENTRE ON AGING ("Centre")

The Centre is supportive of the new office and the power of the new office on its own initiative to carry out widespread investigations (not just reported cases or individual incidents).

The Centre made a number of recommendations to improve the new office and to increase transparency and accountability to the public, including that the new office:

(a) ensure communications are made available in age-friendly and accessible ways;
(b) clearly delineate and communicate to the public its role being distinct from other offices, including the role of the seniors' advocate;
(c) implement mandatory training and/or mandatory reporting of training for all health facilities and staff of the new office, which should include training on the new definitions of abuse and neglect, and on matters of ageism/ableism;
(d) provide educational sessions to health facilities regarding the reporting process to the new office, including dissemination of the statutory whistleblower protection;

(e) provide training on equity, diversity and inclusion regarding abuse and neglect;
(f) provide training on trauma-informed care and better reporting; and
(g) enhance data gathering and compile data for trends including incidents/institutions and regions and, where possible, to cross-reference such data with data from other relevant offices.

6. COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA ("CPSM")

The CPSM is the regulatory body that oversees physicians and surgeons in Manitoba.

The submissions of the CPSM addressed the following areas:

(a) the new office must be sufficiently resourced with properly trained staff;
(b) processes for receiving, triaging, investigating and reporting must be efficient to meet the timeliness objective;
(c) the mandate/mission of the new office must be clearly articulated; CPSM would support a mandate of investigating matters for the purpose of finding a means of improving care as opposed to a mandate that is limited to determining whether abuse or neglect occurred;
(d) the new office should use restorative practices (which include accountability) to address harm that has occurred and use unfortunate incidents as learning lessons for improving future care; and
(e) the new office should have the ability to conduct random audits for the purpose of determining if care can be improved.

7. COLLEGE OF REGISTERED NURSES OF MANITOBA ("College")

The College supports the creation of a more effective office to address issues of neglect or abuse in Manitoba health facilities.

The submissions of the College addressed the following areas:

(a) reporting to the new office should also occur in cases where a "reasonable level of safety" is not provided or maintained for persons in care. The College would like the new office to respond to situations where there is an insufficient level of safety being provided even if there is no explicit abuse or neglect;
(b) while it is appropriate for the new office to refer any cases involving registered nurses and nurse practitioners to the College for investigation, the College says that it is limited by section 140(2) of *The Regulated Health Professions Act,* CCSM c R117 to sharing with the new office the outcome of their investigation, but not details of the investigation, unless otherwise ordered by a court. In this context, the College questioned whether the additional powers proposed to be given to the new office would apply to regulators and their staff, given their obligation to maintain confidentiality under the legislation. If the intent is for the additional powers to apply to regulators, the College believes that clarity is required to determine the extent to which the additional powers of the new office would affect its statutory responsibilities;
(c) the new office should continue to report to the College registered nurses and nurse practitioners found to have abused or neglected a patient, so that the College can assess the need for and apply the necessary professional sanctions on such individuals; and

(d) the College said that it required clarification as to the meaning of the Commission's proposal that the new office would be independent from regulated professions.

8. DEER LODGE CENTRE ("Deer Lodge")

Deer Lodge expressed support for the new office and the essential characteristics of that office described in the Commission's letter dated December 21, 2023. Deer Lodge also commented on the need for the new office to be adequately funded and staffed to fulfill its role. Deer Lodge said that in the past there were significant challenges for the PPCO in it not being able to provide timely investigations and reports, and to hold question and answer sessions at health facilities.

9. FAMILY ADVOCACY NETWORK OF MANITOBA ("Family Advocacy")

Family Advocacy provided a summary of its work advocating for the protection of persons supported by Community Living and Disability Services, as well as a summary of some tragic incidents surrounding persons in care.

Family Advocacy expressed support for the recommendations in the Commission's letter dated December 21, 2023.

According to Family Advocacy, access to justice for the elderly, intellectually disabled and people with mental health issues has been virtually non-existent, and there is inadequate use of trained peace officers for investigations.

Submissions from Family Advocacy in relation to the new office focused on:

(a) it being well funded, and the need for more staff;
(b) where appropriate, the need for earlier referrals to the police;
(c) more training for staff at the health facilities, including mandated standardized training;
(d) a database to track incident reports;
(e) better reporting;
(f) hiring and training of experienced staff to handle the needs of persons in care (the elderly and persons with dementia, intellectual disabilities and autism), and the interview techniques applicable to them;
(g) clarification on facilitated resolutions and when they are applicable in the context of reports of abuse or neglect; and
(h) the need for an appeal process.

10. LONG TERM & CONTINUING CARE ASSOCIATION OF MANITOBA ("LTCAM")

LTCAM is a non-profit organization representing over 10,000 elderly individuals and staff across Manitoba's care continuum. Established in 1959, LTCAM has grown to include non-profit and private assisted living, supportive housing, and personal care home residences in all regional health authorities.

LTCAM raised a number of concerns with the proposed new office, specifically:

(a) concerns with the appointment process potentially giving rise to partisan influences and ensuring that safeguards are in place so that the new office remains impartial and protected from political interference;
(b) concerns with the accountability of the new office; and
(c) concerns relating to the role of the seniors' advocate within the new framework.

11. MANITOBA ASSOCIATION OF HEALTHCARE PROFESSIONALS ("MAHCP")

MAHCP is a union of approximately 7,000 members and represents 85% of allied health professionals in Manitoba, working in 44 professions in healthcare settings across the Province, including hospitals, clinics, long-term care and community facilities.

The submissions of MAHCP covered a number of important areas, including:

(a) the need for statutory provisions for the enforcement of the mandatory reporting requirements to the new office;
(b) the need for additional funding for the new office;
(c) the requirement for experienced workers, and the question of whether there are experienced investigators to draw upon;
(d) the need for clarity regarding the circumstances when the new office would decline jurisdiction, including when the allegations of abuse or neglect are before the courts; and
(e) the need to consider the impact on unionized staff rights and how the process used by the new office would affect collective agreement rights and the grievance process.

12. MANITOBA BAR ASSOCIATION, ELDER LAW SUBSECTION ("Subsection")

The Subsection supports the creation of the new office described in the Commission's letter dated December 21, 2023.

The Subsection says it is essential that:

(a) investigations into reports of abuse or neglect of persons in care be conducted in an efficient and timely manner and further, where action is necessary, that such action is taken in a timely manner;
(b) the office has sufficient power and ability to investigate reports of abuse or neglect;
(c) there be transparency regarding the reports, the investigations and outcomes, balanced with the necessity of protecting personal information and privacy. The number, nature and extent of abuse and neglect cases reported to the office and the outcome or related investigations is of public interest and is a useful source of information to examine, further understand, respond to and prevent instances of abuse and neglect;
(d) health facilities are accountable for implementing the recommendations made by the office; and
(e) the new office operates independently in a manner which enables complete focus on the protection of persons in care.

13. MANITOBA NURSES UNION ("MNU")

The MNU represents about 97% of all unionized nurses in Manitoba, including registered nurses, nurse practitioners, registered psychiatric nurses and licensed practical nurses.

The MNU provided a national snapshot of legislation dealing with protection of persons in care and highlighted both the Alberta and Ontario legislation. The MNU also referred to Australia's Aged Care Quality and Safety Commission established in 2020 that deals with persons in care. The MNU referred to the recent appointment of a Complaints Commissioner in Australia and relied upon certain aspects of the Australian model in its submissions.

MNU expressed support for the new office and recommended modeling the new office on the Australian Commission. Among their submissions, the MNU felt that the new office should:

(a) be apolitical and independent from health facilities and staff;
(b) be granted PHIA exemption under *The Personal Health Information Act*, CCSM c P33.5;
(c) have enhanced powers to compel co-operation by staff and the production of information and all relevant materials;
(d) have a sufficient operating budget to achieve its stated purposes;
(e) have concrete benchmarks for complaint inquiries, investigations and resolutions. The MNU submits that conducting initial inquiries within days of a complaint has the dual benefit of timely response to the complainant to validate their concern and allows an investigator to connect with potential witnesses in a timely fashion;
(f) be fully transparent with the public in terms of the complaint process and the publication of complaints data, so as to foster trust in the new office;
(g) include early resolution processes where a complainant's concern(s) are addressed, and a formal investigation is not necessary; and
(h) annually publish complaints data, similar to the data published by the Manitoba Ombudsman in connection with complaints and referrals.

14. MANITOBA OMBUDSMAN

The Manitoba Ombudsman provided feedback on a confidential basis.

15. MANITOBA ASSOCIATION OF RESIDENTIAL & COMMUNITY CARE HOMES FOR EVERYONE ("MARCHE")

MARCHE is an association of 25 personal care homes situated in Winnipeg and rural Manitoba.

MARCHE supports the changes to the definitions of abuse and neglect and the new office.

However, MARCHE felt it was important to make the Commission aware of their past negative experience with the PPCO, which they advised related to poor response time, delayed responses and outdated methods of functioning. In particular, MARCHE advised that past recommendations from the PPCO were at times simply not realistic or feasible. MARCHE stated that often the reality in which personal care homes operate is misunderstood by those who are recommending changes. MARCHE asked that future recommendations be made in consultation with the long-term care sector

and its leaders, and that there be a real appreciation for chronic underfunding spanning close to two decades which has contributed to financial pressures that are now not sustainable.

MARCHE advised that they are presently seeing more timely responses, and they are now working collaboratively with the PPCO to understand the rationale behind the changes, to ensure they infuse this difficult work with trauma-informed practices, and to identify ways MARCHE and the PPCO can support one another going forward. MARCHE agreed that the publication of statistics and additional information on the number of investigations conducted, and the outcome of such investigations, will allow more transparency and accountability to the people they support, their families and caregivers, and the public.

16. PROVINCIAL PERSONAL CARE HOME LIAISON (Mr. Gagne)

In 2022, Mr. Gagne was contracted to support the implementation of the Stevenson Recommendations following the report on the Maples Personal Care Home. Mr. Gagne is also the Provincial Personal Care Home Liaison.

Mr. Gagne believes there is general support for the new office, and he himself supported the importance of responsiveness, timeliness and transparency.

Mr. Gagne submits that:

(a) it is important that the role of the new office be very clear if the resolution-oriented approach is used to address allegations of abuse or neglect, and he believes that the approach could be of great value when investigations are inconclusive;
(b) the obligation of the new office should not simply be to determine if there was abuse or neglect, but also to benefit from an objective perspective on what may have been or was perceived to constitute abuse or neglect;
(c) not only can the new office provide value in resolving very complex situations, it can also recommend preventative measures that reduce the risk of reoccurrence or situations that could become abusive or neglectful;
(d) in matters where the incidents or complaints are referred to another body or jurisdiction, it is important to coordinate the reporting and sharing of conclusions and recommendations. In some cases, there needs to be a deep understanding of the contributing factors;
(e) the role of the new office includes responsibility to prevent abuse or neglect by adopting a "zero-tolerance" for situations that expose vulnerable people to any form of abuse or neglect (perceived, alleged or real); and
(f) annual reporting to the Assembly should be more than statistics, and it should include a "state of affairs" on the protection of persons in care by illustrating best practices as well as potential risks.

17. PROVINCIAL PROTECTION INVESTIGATIONS UNIT ("PPIU")

PPIU is a unit within the Department of Families (Community Living disAbility Services) that is mandated under the ALIDA to investigate allegations of abuse or neglect of an adult living with intellectual disabilities.

The PPIU submitted that there is a need for:

(a) a robust information system for tracking statistics and trends for annual reporting, as well as statistics for offender tracking, number of referrals and investigation into each health facility, type of abuse and any specific trend emerging in health facilities;
(b) ongoing education and training sessions for health facilities and their staff to assist them in identifying abuse and neglect, reporting, interviewing and gathering information, safety planning, and the investigation process;
(c) ongoing training of investigators to improve their skills;
(d) sufficient staffing to allow investigators to complete thorough investigations in a timely manner;
(e) allowing for outcomes, other than "founded" or "unfounded" but which hold individuals and facilities accountable. For example, other outcomes could be classified as: (i) substantiated with referral to the AARC – where there is sufficient evidence to meet the legislated threshold and no exception applies; (ii) substantiated without referral to the AARC – where there is sufficient evidence to meet the legislated threshold but an exception applies; (iii) inappropriate conduct – where there is sufficient evidence to confirm that an inappropriate act or omission occurred but the act or omission did not meet the legislated threshold; (iv) unsubstantiated – where there is insufficient evidence to establish that abuse, neglect or inappropriate conduct occurred;
(f) a clear and concise investigation process, with standards to ensure quality assurance; and
(g) a meeting with the health facility following an investigation to discuss the outcome and any recommendations provided to the facility.

18. SENIORS ADVOCACY COALITION ("Coalition")

The Community Education Development Association and the Public Interest Law Centre ("PILC") received a grant from the Manitoba Law Foundation to complete community consultations and a report that would support the development of a new non-profit seniors' advocacy association in Manitoba.

Although the Commission's letter to stakeholders was sent to the PILC, no response was received. The Commission was later asked by the Coalition to extend the time for filing a submission, which it did. The Coalition expressed disappointment with the fact that the Commission was only accepting written submissions.

The Coalition's main concern is that "the definition of what constitutes abuse remains too narrow."

The Coalition also expressed concern that while the PPCO addresses issues of abuse and neglect for persons in care, it does not address issues of abuse and neglect of older adults living in the community.

The Coalition believes that the proposed *Seniors' Advocate Act* should be amended to provide the Seniors' Advocate with the same investigative powers as are recommended for the new office to replace the PPCO.

19. SPEAKER OF THE MANITOBA LEGISLATIVE ASSEMBLY

The letter from the Honourable Tom Lindsey, Speaker of the Legislative Assembly, raised a number of concerns and made several important observations. His concerns included the timeliness of reviews and responses, the consequences for the failure of a health facility to give effect to a recommendation received, and whether a report of abuse or neglect would be reported if resolved by the new office. The Speaker submitted that the new office needs to adopt a more proactive approach, meaning it should conduct inspections and investigations regularly rather than waiting for allegations to arise. The Speaker also advised that the goal is to prevent abuse before it occurs, and that the Commission report should address staffing shortages, training concerns, facility cleanliness and appropriateness.

20. VULNERABLE PERSONS LIVING WITH A MENTAL DISABILITY TASK FORCE (Mr. Kendel)

The submissions by Mr. Kendel offered a summary of his perspective on collaboration between community and government, statistical information, the need to focus on adults living with intellectual disabilities, the problems that continue to arise with persons in care and the investigation process, the fact that few referrals reach the AARC and the court system.

Recommendations included more awareness and training about abuse, neglect and self-neglect, and the continued need for: mandatory reporting of abuse or neglect; quick intervention; thorough investigations; appropriate police involvement, charges and convictions; use of the AARC; support being offered to the person in care; communications with key support people about the progress of the investigation; and a complete explanation of the results of the investigation.

A copy of the recommendations previously made by the Task Force were appended to his submission.

Acknowledgments by Stakeholders

The Commission received formal acknowledgments to their request for submissions from the following stakeholders:

A. College of Physiotherapists
B. Inclusion Winnipeg
C. The Leader of the Official Opposition (Heather Stefanson)

D. Manitoba Keewatinowi Okimakanak Inc. (MKO)*

*The Commission was advised by MKO on February 29, 2024 that it was unable to provide submissions as it required additional time and funds, which they were unable to resource at that time. MKO expressed to the Commission appreciation of the endeavors the new office intends to take to protect persons in care, by being proactive in providing timely resolutions to reports of abuse and neglect in health facilities, through its empowerment with extensive investigation powers, accountability to Manitobans and its independence from government. The Commission advised MKO that it did not have the resources to provide funding to anyone for written submissions, and they should contact Manitoba Health to determine whether it is able to provide funding for that purpose. The Commission also advised that while it was operating under relatively strict timelines, it would appreciate their input and was prepared to extend the deadline for providing a written submission. Nothing further was received from MKO.

Appendix 6

LEGISLATIVE REQUIREMENTS FOR THE NEW OFFICE

APPOINTMENT OF OFFICER

1. A person (the "Officer") shall be appointed by resolution of the Assembly for a fixed term to lead the new office. The Officer shall be an officer of the Assembly and accountable to it.

2. As an Officer of the Assembly, the Officer shall not be:
   (a) eligible to be nominated for, elected as, or sit as, a member of the Assembly; and
   (b) permitted to hold any other public office, carry on any trade, business or profession, or engage in any partisan political activity.

3. The Officer, and all persons employed under the Officer, shall be employees within the meaning of *The Civil Service Superannuation Act*, CCSM c C120.

4. Persons employed under the Officer shall be appointed under s. 58 of *The Public Service Act*, CCSM c P271, and the Officer shall be responsible for managing staff in accordance with that section.

5. The Officer shall not have carriage of any proceeding before the AARC or in any court proceeding.

6. Except on the ground of lack of jurisdiction, no proceeding of the Officer is void for want of form, and no proceedings or decisions of the Officer shall be challenged, reviewed or quashed in any court.

7. No proceedings lie against the Officer, or against any person employed under the Officer, for anything they may do, report or say, in the exercise or performance or intended exercise or performance of their functions and duties, unless it can be shown they acted in bad faith.

ROLE, RESPONSIBILITIES AND POWERS OF THE OFFICER

8. The Officer shall have the following responsibilities:
   (a) to receive and respond to reports of abuse or neglect from health facilities, caregivers, persons in care and others, including where there are reasonable grounds to believe that a person in care is or is likely to be abused or neglected;
   (b) to facilitate resolution of reports of abuse or neglect, where appropriate or viable;
   (c) to undertake investigations, to issue a final investigation report (with or without recommendations to a health facility) and to make referrals to the AARC and the police (if warranted);
   (d) to monitor each step of the process from receipt of the report of abuse or neglect until the issuance of a final investigation report and the implementation of any recommendations; and

(e) to report to the Minister of Health and to the Assembly when a health facility fails to implement a recommendation.

9. Reports of abuse or neglect shall be promptly reviewed to determine if jurisdiction rests with the Officer. If jurisdiction rests with another person or body, the Officer shall refer the matter to that person or body and shall receive a report from that person or body describing the investigation performed and the conclusions reached. The report will be shared by the Officer with the health facility, the person in care or their committee, and any other person deemed appropriate by the Officer, and the report will be publicly available and published on the new office's website.

10. The Officer shall decline jurisdiction of any report of abuse or neglect while the substance of the matter is before a court. The Officer shall have the ability to apply to the Court of King's Bench regarding any question arising with respect to jurisdiction.

11. If, in the opinion of the Officer, a report of abuse or neglect warrants facilitated resolution or a streamlined investigation, steps to attempt resolution or to streamline the investigation shall be reasonably pursued. If, during an investigation, the parties voluntarily desire to engage in facilitated resolution of the reported abuse or neglect, and the investigator deems it advisable in the circumstances, it may take place. Any resolution reached shall be part of the investigation report, including the terms of the resolution. Failure to reach resolution between the parties will not disqualify the Officer from continuing to complete an investigation, to issue a final investigation report and to make recommendations.

12. The Officer may decline, cease or refuse to investigate any report of abuse or neglect if:
    (a) it does not fall within the Officer's jurisdiction;
    (b) the details of the abuse or neglect were known to the person in care or their committee for more than one year before the report is made to the Officer;
    (c) it is without merit, frivolous or vexatious, not made in good faith or concerns a trivial matter;
    (d) upon a balance between the public interest and the interests of the person in care, the report should not be investigated, or the investigation should not be continued; or
    (e) the circumstances do not require investigation.

13. Where the Officer decides not to investigate or ceases to investigate, the Officer shall inform the person in care or their committee, the health facility and any other interested person as deemed appropriate by the Officer.

14. When an investigation is undertaken by the Officer, a final investigation report shall be completed within a specified time following receipt of the report. The Commission recommends a period of 180 days, with the proviso that an extension could be granted in exceptional circumstances prescribed by regulation.

15. The Officer shall:
    (a) ensure that all communications by the new office, including intake forms, investigation reports and recommendations will be made available in simple and user-friendly language, and where there are language barriers, the Officer shall enlist translation services;

(b) have the ability to make a referral to the police at any time; and
(c) try, to the fullest practical extent, to involve the person in care, their committee and/or any other interested person deemed appropriate by the Officer.

16. All of the PPCO's existing investigative powers shall be transferred to the Officer. In addition, the Officer shall be given a robust set of investigative powers which shall permit the Officer to:
    (a) enter any place for the purposes of an investigation;
    (b) compel the production of relevant information and records;
    (c) inspect equipment;
    (d) summon persons, including the alleged offender, for purposes of conducting examinations under oath or to require questions to be answered under oath;
    (e) obtain expert advice or assistance at any stage of an investigation; and
    (f) apply for warrants and make applications to court for assistance.

    These investigative powers will not apply to information that is subject to legal privilege, to the police or their records, or to any records or working files of a regulatory body concerning investigations undertaken by it pursuant to its governing legislation.

17. The Officer shall adopt and follow procedural rules, consistent with the principles of procedural fairness, and such rules shall be publicly available and published on the new office's website.

18. After completing an investigation, the Officer shall issue a final investigation report, which will set out the investigator's conclusions and the reasons for them and any recommendations to a health facility, including a specified timeframe for the implementation of the recommendations. A finding of abuse or neglect shall not be a pre-condition to issuing recommendations. At the discretion of the Officer, a draft investigation report may be provided to the health facility for its review and comments before it is finalized. A draft investigation report to a health facility shall be exempt from disclosure pursuant to an access to information request directed to the health facility.

19. A copy of the final investigation report must be provided to:
    (a) the health facility;
    (b) the person in care or their committee;
    (c) the alleged offender, and if the incident occurred during the course of their employment, their employer at the time of the incident and their current employer (if different);
    (d) the Minister of Health;
    (e) the AARC (where applicable);
    (f) the police (where applicable); and
    (g) any other interested person as deemed appropriate by the Officer.

20. Any recommendations made by the Officer to a health facility shall specify timelines for a response from the health facility and timelines for the implementation of the recommendations. All recommendations shall be made public, and the health facility shall be identified.

21. A health facility shall report to the Officer the steps that it has taken or plans to take to give effect to a recommendation. If the health facility declines or fails to meet a specified timeline, or to give effect to a recommendation, the Officer shall notify the Minister of Health, and the matter shall form part of the Officer's annual report to the Assembly.

22. The requirements in section 8 of the PPCA shall be strengthened to require health facilities to respond to recommendations made by the Officer and directions from the Minister of Health within a specified time, and to further provide that a health facility will be subject to sanctions if it fails to follow directions from the Minister without reasonable excuse.

23. The Officer shall be permitted to delegate to one or more employees any responsibility or power of the Officer for the purposes of, *inter alia*, dealing with reports of abuse or neglect, intake functions, facilitated resolution, investigations, preparation of reports, making recommendations to health facilities and referrals to any third party.

24. The Officer shall have the power to act on its own initiative and to take proactive and preventative measures on matters related to alleged abuse or neglect in health facilities. However, such initiative and power will not authorize the Officer to investigate any decision, recommendation, act, order or omission of government, or the courts, or any other inquiry or legal proceeding. Further, if the Minister of Justice certifies in writing to the Officer that the investigation of a matter would be contrary to the public interest, the Officer shall not investigate or continue any investigation.

25. The Officer shall have the power to make a special report to the Assembly on any matter of pressing importance or urgency.

26. The Officer shall gather and analyze data on reports of abuse or neglect and shall take proactive steps to provide information and observable trends to health facilities and the Assembly. Reports to the Assembly by the Officer may include recommended best practices for health facilities and identification of potential risks, with the objective that preventative steps be taken by the appropriate bodies, including government.

27. The Officer shall investigate a health facility, if so directed by the Lieutenant Governor in Council or the Assembly, and shall thereafter deliver a report in a timely fashion. A copy of the report shall be delivered to the health facility, the Minister of Health and the Assembly.

28. The Officer is not a "service provider" and does not provide or deliver "seniors' services" as defined in the proposed *Seniors' Advocate Act*. While the Officer shall have no obligation to provide information to the seniors' advocate, the Officer shall investigate systemic problems or concerns referred to the Officer by the Seniors' Advocate with respect to persons in care and may make recommendations to the Assembly in relation to such matters.

PRIVACY AND CONFIDENTIALITY

29. Every investigation by the Officer shall be conducted in private, and the Officer shall take all necessary steps to protect the identity of the individual who made the report of abuse or neglect.

30. The Officer shall not name or directly identify the person in care, the caregiver or the alleged offender, and the Officer shall maintain confidentiality with respect to all information that comes to its knowledge in the performance of duties or the exercise of powers. Notwithstanding these requirements, the Officer may disclose any matter which is considered necessary to establish grounds for the conclusions and recommendations made in a final investigation report.

31. The Officer shall not hold any hearings, and no person shall be entitled, as of right, to be heard by the Officer.

32. The Officer shall be deemed to be an investigative body for purposes of various privacy laws, and privacy laws and policies shall not prevent the Officer from obtaining and examining relevant information and records in a confidential and private manner. As an investigative body, the Officer shall not be subject to access to information requests and cannot be compelled to furnish working files or to give evidence (in any court proceeding, arbitration, inquiry or other proceeding) in relation to an investigation report and/or any recommendations.

33. The investigation report (including information and records gathered by the Officer, their records and working file), any recommendations made by the Officer and directions from the Minister, and any response from the health facility, will not be admissible in any court, grievance, inquiry or in any proceeding relating to the alleged offender, including any proceeding in relation to their continued employment and/or termination of employment. A complete copy of the investigation report, any recommendations or directions and any response from the health facility shall be furnished with any referral to the AARC, but not the working files, information and records gathered by the Officer for the purposes of its investigation report or any recommendations.

34. Investigation reports, recommendations and replies from health facilities and all reports to the Assembly shall be publicly available and published on the new office's website. The health facility shall be required to preserve confidentiality when submitting replies to the Officer, and the Officer shall have the power to edit or redact any replies for purposes of confidentiality.

35. Working files, information and records gathered by the Officer shall not be publicly available, and no one employed by the Officer may be compelled to give evidence in a court or judicial proceeding with respect to anything coming to their knowledge in carrying out their responsibilities and exercising the powers given to them.

36. Health facilities shall report to the Officer if an employee or volunteer is suspended or discharged or has resigned because they have allegedly abused or neglected a person in care. The report must be made in writing within seven days of the suspension, discharge or resignation.

37. Upon receipt of a written request (in a prescribed form) from a health facility in relation to:
    (a) a volunteer;
    (b) a person seeking employment; or
    (c) an existing service provider;
    the Officer shall advise whether the person has been the subject of a referral to the AARC.

BUDGETS, STAFF, TRAINING AND EDUCATIONAL SEMINARS

38. The duties and services of the Officer shall be provided in a manner that recognizes the pluralistic, multicultural characteristics of Manitoba's aging population. The new office must have representation from Indigenous peoples and will prioritize the hiring of Indigenous and visible minority specialists to support persons in care and caregivers, to assist in outreach by the new office, and to build cultural awareness within the new office and health facilities.

39. The Officer shall oversee all staffing and training requirements, including addressing the diverse set of skills and backgrounds required to fulfill the Officer's mandate. There must be continuous training of office staff to ensure that they have the knowledge, skills and competence to perform their jobs, including training on cultural sensitivity, language barriers, investigatory techniques and reporting.

40. The Officer shall provide educational sessions to health facilities and others on relevant topics, including what is/is not abuse or neglect, mandatory reporting of abuse or neglect and preventative measures.

ANNUAL REPORTING & ESTIMATE

41. The Officer shall provide (at minimum) annual reporting on its operations to the Assembly. Such reporting shall include:
    (a) the performance of the office;
    (b) the number of reports of abuse or neglect received that year;
    (c) the number of referrals to other bodies/persons for review and/or investigation;
    (d) the number of facilitated resolutions;
    (e) the number of reports of abuse or neglect that were not investigated or discontinued;
    (f) the number of investigations undertaken, reports issued, findings of abuse or neglect, recommendations to health facilities, and replies from health facilities;
    (g) details of any situation where a health facility declined or failed to meet a specified timeline, or failed to give effect to a recommendation;
    (h) the status of any outstanding matters from the preceding year;
    (i) the number of investigations where the Officer failed to meet the specified timeline for the completion of a final investigation report and the reasons for the failure to meet the specified timeline;
    (j) the number and nature of educational sessions carried out during the preceding year;
    (k) training received by staff in the preceding year;
    (l) any investigations initiated by the Officer, the rationale for same and any recommendations;
    (m) any investigation the Officer initiated at the direction of the Lieutenant Governor in Council, and any recommendations;
    (n) any special report on any matter of pressing importance or urgency;

(o) any recommendations on best practices to improve upon the protection for persons in care, including preventative measures;
(p) details of any certification received from the Minister of Justice that an investigation would be contrary to the public interest;
(q) the number of persons referred to the AARC and to the police; and
(r) any other recommendations.

42. The Officer shall present an annual estimate of the funds required for the purpose of carrying out the Officer's obligations.

PROTECTION OF PERSONS WHO REPORT

43. Provided the report of abuse or neglect is made in good faith, no action may be brought against a person who submits a report to the new office.

44. A health facility shall not be permitted to:
(a) take any adverse employment action against an employee or any adverse action against a volunteer who makes a report of abuse or neglect or suspected abuse or neglect; or
(b) discontinue and/or threaten to discontinue services to a person in care as a result of a report of abuse or neglect or suspected abuse or neglect.

45. No person is guilty of an offence under another enactment by reason only of having complied with a request or requirement of the Officer to provide information or access to information and records.

PROTECTION, OFFENCE AND PENALTY PROVISIONS

46. The protection, offence and penalty provisions in the PPCA shall be enhanced and strengthened in a manner similar to the provisions found in sections 20.1– 21.2, 25.1, 26 – 28, 160, 160.1, 162 and 164 of the ALIDA. Significantly, the legislation creating the new office shall provide that no person shall abuse or neglect a person in care and that service providers shall have a duty to take all reasonable steps to protect persons in care.

47. No person shall be permitted to obstruct, destroy or provide false or misleading information to the new office, and any such contravention shall be an offence.

48. A person or health facility that contravenes the new legislation, including wilfully obstructing or making a false report, will be guilty of an offence and liable on conviction to a fine of not more than $50,000 or to imprisonment for a term not exceeding two years, or both.

MANDATORY REVIEW

49. Within five years after the legislation creating the Officer comes into force, a committee of the Assembly shall undertake a comprehensive review of the operation of the legislation and submit a report to the Assembly. The report may include recommendations for improving the effectiveness of the new office.