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1. INTRODUCTION

(1) The Interior Health Authority (the "Authority") was established to deliver public health care services in an effective and cost-efficient manner. To maintain and enhance the public's trust, the Authority has articulated its commitment to exemplary standards of organizational behaviour and practice in a combination of policy statements approved by the Board of Directors (the "Board") including:

(a) Corporate Conduct 3.12

(b) Clinical Ethics 3.14; and

(c) Research and Research Ethics 3.13.

These policies provide support for decision making as well as appropriate reporting mechanisms for various concerns that may be encountered. In many cases, matters can easily be resolved through timely communication with an immediate supervisor or other member of management.

(2) The Board assigns to the President and Chief Executive Officer (the "CEO") overall accountability for the realization of the following Policy objectives:

(a) the issuance of appropriate administrative guidelines;

(b) the establishment of internal controls designed to prevent or detect failures in respect of the expected standards of performance;

(c) the process for the handling of allegations of wrongdoing; and,

(d) the responsibility for appropriate follow-up action where failures have been identified.

(3) The Board has also approved Medical Staff Bylaws which assign to the Health Authority Medical Advisory Committee ("HAMAC") a defined role in the handling of alleged unprofessional and unethical conduct or breach of professional ethics codes, Bylaws, Rules and policies of the Ministry of Health and Board policies, etc. by medical staff.

2. DEFINITIONS

(1) Safe Reporting: Reporting of an alleged/perceived wrongdoing that has occurred or is occurring in connection with the organization, using any formal mechanism available in the organization for receiving these reports.

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(2) Wrongdoing: Behaviour that undermines the quality of care; is a danger to health and safety; is unlawful or unethical; and/or is against organizational policy, contracts, or other obligatory standards.

3. PURPOSE

(1) While the Authority's internal controls are intended to prevent or detect improper activities, even the best systems and internal controls cannot provide absolute safeguards. The Authority has a responsibility to facilitate and encourage processes that enable an individuals and organizations, hereinafter called the "Person", to independently report legal, regulatory, financial, ethical, health/safety or policy violations. The purpose of this *Safe Reporting Policy* (the "Policy") is to provide such a process to any Person who wishes to report, in good faith, any matters covered in this Policy.

(2) The Policy does not replace established processes for the handling of allegations of wrongdoing nor does it replace or supersede reporting obligations as described in the *Health Professions Act*, and other legislation.

(3) The Policy is intended to supplement these processes and provide a means by which a Person can report perceived issues to an authority independent of management in special circumstances where they are unaware of or do not have access to an existing process; or have sound reason to believe that the existing processes are not appropriate or have failed to deal with the concerns expressed; or are unsure where else to report a concern.

(4) The Policy must be used with discretion and not as a means of circumventing management which is firmly committed to the responsible handling of any and all breaches of expected standards of personal and organizational behaviour.

4. SCOPE

(1) This Policy applies to all Persons associated with the Authority including:

(a) all individuals who provide services on behalf of the Authority including: staff, medical staff, Board Directors, students, volunteers, vendors and their employees, contractors and their employees and subcontractors and their employees;

(b) all researchers and members of staff and medical staff who conduct research at or under the auspices of any of the Authority's hospitals, health centres, agencies or their affiliated research institutes;

(c) patients and the public; and,

(d) all other parties associated with the Authority.

(2) All individuals identified in 1(a) above also have a duty to report real or perceived misconduct by others.

5. APPLICABILITY

(1) This Policy governs any perceived improper conduct or wrongdoing, which includes, but is not limited to, serious actions that:

(a) are unlawful or not in compliance with any laws, regulations, or contractual obligations to which the Authority is subject;

(b) do not adhere to the policy objectives established by the Authority for organizational behaviour including AU0100 (Standards of Conduct for Interior Health Employees);

(c) may amount to fraud or other unethical conduct and/or corrupt activity;

(d) represent the unauthorized use, misuse, or waste of public funds or resources, which may be of a tangible or intangible nature;

(e) are of substantial and specific danger to the patient, public health, safety, or the environment; or

(f) do not adhere to appropriate Authority accounting policies or procedures, internal accounting controls, or auditing procedure.

(2) Matters reported under this Policy for which there are established legal processes for the reporting and investigation of improper conduct or violations will be referred to the appropriate specialized investigation mechanism including:

(a) labour agreement violations covered by an applicable Collective Agreement;

(b) reports on safety hazards and unsafe conditions made in accordance with the provision of Section 3.10 of the WCB Occupational Health and Safety Regulations;

(c) patient care concerns which should be addressed through the Patient Care Quality Office; and

(d) misconduct related to behaviours identified in Interior Health's Workplace Environment Policy (AU 1000) which would be dealt with through the internal mechanisms of that policy.

In extraordinary circumstances, the Independent Authority may use discretion in determining if there is sufficient reason (and legal ability) to bypass the specialized investigation mechanism and investigate the report via the dedicated safe reporting process. Sufficient reason may include, but is not limited to, a potential conflict of interest between the specialized investigation mechanism and the nature of the alleged wrongdoing. Special investigation mechanism that have statutory obligations cannot be bypassed (i.e. Medical Health Officers have a statutory obligation to investigate alleged contraventions of the *Community Care and Assisted Living Act*).

6. USE OF AN INDEPENDENT AUTHORITY

(1) The Internal Audit function is designated the "Independent Authority" for the Authority. Internal Audit is an independent function with the Authority and has free and unfettered access to the Board of Directors.

(2) In situations where a Person wishes to report a perceived wrongdoing, and is convinced that the normal internal process for such reporting is inadequate or has failed to respond adequately to his/her concerns, the allegation should be directed to the Independent Authority. Reports may be made in writing or verbally; they will be received via a dedicated and confidential point of contact (phone, e-mail and mail) with the how to contact details publicized on both external and internal Authority websites. If an interpreter is requested, one will be provided as soon as reasonable.

(3) Reports should be marked "Private and Confidential" and provide as much detail as possible, including the nature of the alleged wrongdoing, the name of the person alleged to have committed the alleged wrongdoing, and other pertinent information. The information should be as precise as possible. The submission of a Person's contact information (phone and email) is strongly encouraged.

(4) The Independent Authority, or their designate, upon request, will meet personally with the Person. Based on the information provided in the initial report and/or in any subsequent meeting, the Independent Authority will make an initial determination as to whether the nature of the disclosure and the circumstances in which it is presented are such that it should be pursued under this Policy. In making that determination, the Independent Authority may seek the counsel of the Senior Executive Team, the CEO or Board Chair.

(5) Where the allegation is directed against a health care professional, accountable to a regulatory college, board or association as designated by the *Health Professions Act*, and where the allegation pertains to the clinical practice of, that individual, the appropriate regulatory college, board or association will be notified as specified by the *Health Professions Act*.

(6) Where the decision is that the particular disclosure involved does not warrant handling under this Policy, the Person making the report has the option of using or re-visiting the appropriate management process, assuming that process has not been exhausted.

(7) Where the decision is that the particular disclosure involved should be pursued under this Policy, the Independent Authority will proceed as set out in Section 7 below.

(8) The report to the Independent Authority and all information collected during the course of any subsequent follow-up will remain confidential, except as may be necessary to conduct a fair investigation, to take any required corrective or remedial action, or in accordance with applicable law.

7. MERIT ASSESSMENT

(1) When it has been determined that the disclosure should properly be managed under this Policy, the Independent Authority will:

(a) inform the Person making the allegation that a merit assessment is to be conducted and that a report outlining the further action to be taken may be expected within 45 calendar days; and,

(b) arrange for the conduct of the merit assessment as hereinafter provided.

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(2) The objective of the merit assessment is to ascertain the facts; review the alleged misconduct in the context of relevant policies and procedures; conduct a preliminary assessment of the disclosing individual's safety and risk of retaliation; and determine whether there is substantive evidence of culpable action or a deliberate disregard of the expected standards of conduct.

(3) Where the allegations involve clinical, managerial, administrative or other non-clinical staff, the Independent Authority will consult with the Vice President, Human Resources and Mental Health and Substance Use and/or the Chief of Professional Practice and Nursing in determining where the responsibility is to be placed for the conduct of the merit assessment. Taking into account the nature and seriousness of the issue identified, the Independent Authority may elect to conduct the merit assessment or delegate this responsibility to an appropriate member of management.

(4) Where the allegations involve medical staff, the Independent Authority will consult with the Vice President Medicine & Quality in determining where responsibility is to be placed for the conduct of the merit assessment.

(5) Where the allegations involve the Corporate Director, Internal Audit, the Board Chair will consult with the CEO in determining where responsibility is to be placed for the conduct of the merit assessment.

(6) Where the allegations involve a member of the Senior Executive Team, the Independent Authority will consult with the CEO in determining where the responsibility is to be placed for the conduct of the merit assessment.

(7) Where the allegations involve the CEO, the Independent Authority will consult with the Board Chair in determining where the responsibility is to be placed for the conduct of the merit assessment.

(8) Where the allegations involve vendors, patients and/or their family member or a member of the general public, the Independent Authority will consult with the CEO in determining where the responsibility is to be placed for the conduct of the merit assessment.

(9) Where the allegations involve a member of the Board, the Independent Authority will refer the allegations to the Auditor General to determine where the responsibility is to be placed for the conduct of the merit assessment.

(10) Notwithstanding the subsection (9) above, the Independent Authority, after advising the Board Chair, may elect to consult with an authority other than the individuals identified in subsections (3) to (8) when, in the opinion of the Independent Authority, the circumstances so warrant.

(11) The party conducting the merit assessment will respect the rights of the disclosing person and the rights of the individual against whom the allegations are made to a fair and impartial investigation. Without limiting the scope of this duty, and having regard for the importance of fair process, the party conducting the investigation will:

(a) make their findings in light of the principle that the burden of proving wrongdoing is on the party alleging it, and not on the party against whom it is alleged ; and

(b) respect the rights of the individual against whom the allegations are made to provide full answer to the allegations.

(12) The merit assessment should be conducted as expeditiously as practical and the findings returned to the Independent Authority.

8. MERIT ASSESSMENT REVIEW

(1) Except where a conflict of interest may occur, the Independent Authority will review the merit assessment with the CEO and present a joint recommendation to the Board. Where a conflict of interest with the CEO may be involved, Independent Authority will deal directly with the Board Chair in developing the action recommendation.

(2) When the allegation involves medical staff, the Vice President Medicine & Quality must be involved in the review.

(3) Where the merit assessment reveals no deliberate or culpable wrongdoing, nor any requirement for a revision of existing standards, practices and controls, the recommendation may be made to the Board that the issue be returned to the CEO to be resolved through counseling/training by the appropriate management officer or supervisor.

(4) Where the merit assessment reveals no deliberate or culpable action but indicates a need for a revision of existing standards, practices and controls, the recommendation may be made to the Board that the issue be returned to the CEO to be resolved by management through appropriate amendments/changes coupled with any necessary training.

(5) When issues are returned to the CEO for handling, the Board will be kept informed of action taken.

9. FORMAL INVESTIGATION

(1) The merit assessment may give rise to a formal investigation.

(2) When the disclosure relates to the integrity of the Authority's financial practices or records, the Chief Financial Officer and Chair of the Audit and Finance Committee and will be included in the decision-making as to how the investigation is to be handled.

(3) In all cases, responsibility for the investigation will be assigned so as to preclude any reasonable third-party complaints in respect to competence, integrity and independence. This may, in certain cases, require the involvement of qualified external resources.

(4) Unless there are mitigating circumstances, it is expected that any further investigation under this Policy will be conducted and the findings returned within 45 calendar days upon the conclusion of the merit assessment.

(5) Where the investigation substantiates the allegations of culpable misconduct or wrongdoing or a deliberate disregard of the expected standards of conduct, corrective action will be taken as promptly as possible.

(6) In this final step, responsibility will transfer from the Independent Authority to the Board Chair, CEO, and, in the case of medical staff, the Vice President of Medicine & Quality. The independence of the process will be maintained by a requirement that the Board approve all recommendations pertinent to the disposal of the allegations handled under this Policy.

(7) Where allegations involve employees the results of the investigation will be reviewed by the CEO who will recommend to the Board the action to be taken.

(8) Where allegations involve:

(a) the CEO, the results of the investigation will be reviewed by the Board Chair who will recommend to the Board the action to be taken.

(b) medical staff, the results of the investigation will be reviewed by the CEO and the Vice President of Medicine & Quality who will recommend to the Board the action to be taken.

(9) In cases where the cancellation, suspension, restriction or non-renewal of privileges is judged necessary, this recommendation will also be forwarded by the CEO to the HAMAC in accordance with the provisions of Article 11 of the Medical Staff Bylaws. The Board will give due weight and consideration to the recommendation of the HAMAC in making its decision.

(10) The specific action taken in any particular case will depend on the nature and gravity of the issue and the necessary response. Where appropriate, the person(s) responsible will be disciplined, up to and including the termination of employment or the termination of the individual's relationship with the Authority, as may be appropriate in the circumstances.

(11) In accordance with the *Medical Staff Bylaws*, nothing in this Policy alters the right of the CEO or Vice President of Medicine & Quality to summarily restrict or suspend the privileges of a member of the medical staff in circumstances where there are serious or potential problems which may adversely affect the care of patients or the safety and security of patients or staff (Section 11.2.1 *Medical Staff Bylaws*).

(12) In its sole judgement, the Authority may also make the facts established by its investigation(s) known to the appropriate enforcement agency and/or institute legal proceedings to seek restitution.

10. CONFIDENTIALITY

(1) Individuals who fail to respect the highly confidential nature of the investigative process, including the Person making the report, respondents to the report or witnesses involved in the investigation, will be subject to disciplinary or administrative measures up to and including termination of employment or contractual relationships. Individuals who do not have any contractual relationship with the Authority will be required to sign a confidentiality agreement prior to being advised of the status of the merit assessment.

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11. ACCOUNTABILITY TO THE DISCLOSING PERSON

(1) Whether the allegations relate to either non-medical or medical issues, a summary of the ultimate findings of the merit assessment or investigation will be presented, on a without prejudice basis, to the Person who made the initial disclosure. The information released should be adequate to demonstrate that the issue raised has been thoroughly investigated and appropriate action taken.

(2) Prior to the release of such information to the disclosing Person, a non-disclosure agreement will be required with respect to the rights of any and all persons affected by the disclosure.

(3) Responsibility will rest with the Independent Authority for the written exchange with the Person making the disclosure in respect to the handling and final disposition of the issue.

(4) If a Person making a disclosure under this Policy is not satisfied with the action that has been taken regarding their concern, and feels it is necessary to further pursue the issue identified, within thirty days of being advised of the decision, the Person may ask the Board, in writing, to review the decision. The Person must set out the basis for seeking a review of this nature.

(5) The Board Chair, in consultation with the Chair of the Governance & Human Resources Committee or with the Board as a whole, will within 14 calendar days, make a determination as to whether there is to be a further investigation and, if so, how this investigation is to be conducted, including the option of third party involvement.

(6) If it is determined that a further investigation is not warranted, the Person making the allegation will be so advised in writing.

12. PROTECTION FROM REPRISAL

(1) The Authority will not take, tolerate or allow any direct or indirect reprisal, harassment or even informal pressure, against a Person who, in good faith, reports a perceived wrongdoing. Any such reprisal will in itself be considered a serious breach of this Policy. A person or persons who attempt to, or execute, an act of reprisal toward the individual making the disclosure may be faced with disciplinary action including termination of employment or termination of the reprising individual's relationship with the Authority.

(2) Allegations of reprisal should be reported through the same channels as are provided for all allegations reported under this policy.

(3) The right to protection from reprisal does not extend to or in any way include immunity for an individual found to be involved in perceived wrongdoings reported under this policy or that form part of related investigations.

13. FALSE AND MALICIOUS ALLEGATIONS

(1) Where an investigation determines that a Person's report was made in bad faith or with malicious intent, action may be taken including, if appropriate, disciplinary proceedings.

14. RECORDS OF DISCLOSURE & ACTION TAKEN

(1) Internal Audit will retain a confidential copy of all reports, merit assessments and any formal investigations undertaken through this Policy.

(2) An aggregate statement will be presented to the Board as part of the Annual Internal Audit Report. This statement will include the following information:

(a) the number of allegations received through this special process;

(b) the nature of the allegations;

(c) the number resolved through management; and

(d) the number of investigations conducted and the number in which the allegations were substantiated.

(3) All information provided the Board will be in summary form so as to respect the confidentiality of individuals whose allegations have been handled through the special disclosure process provided by this Policy.