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Canada

Report into allegations of inappropriate conversations with Veterans about Medical Assistance in Dying (MAiD)

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EXECUTIVE SUMMARY

Like other Canadians, there are Veterans suffering from terminal illnesses who are choosing to proceed with Medical Assistance in Dying (MAiD) as a means to end their suffering. If a Veteran has chosen to pursue MAiD with their primary care provider and calls to inform Veterans Affairs Canada (VAC), employees can help the Veteran and their family understand the VAC benefits to which they would be entitled, as well as to discuss any other supports or services that might be relevant in the Veteran's circumstances. This support can include resource coordination and navigation such as connecting a Veteran and their family to community resources, mental health practitioners, grief counsellors, pastoral outreach or other local resources. This support does not include VAC employees providing advice or suggestions on MAiD-related considerations.

On 21 July 2022, a Veteran contacted the VAC call centre to file a complaint alleging that a VAC employee had inappropriately raised MAiD to the Veteran during a phone conversation earlier that day. The Veteran alleged that the employee also referred to having provided information on MAiD to another Veteran. The Department took immediate action by apologizing to the Veteran and reassigning the Veteran's file to the employee's manager.

Recognizing the seriousness of the allegation, management initiated a fact-finding process on July 22. The files of the other Veterans assigned to the employee were reviewed and analyzed to look for indications of conversations about MAiD.

On August 19, the Minister of Veterans Affairs instructed the Department to conduct a full and thorough investigation of all aspects related to the situation and to ensure all possible steps were being taken to ensure an incident like this does not occur in the future.

On August 22, the review of the Veterans' files assigned to the employee uncovered a second incident where MAiD had been inappropriately discussed with a Veteran. The next day, written guidance on MAiD was immediately shared with all Veteran-serving staff and five information sessions were held over the following four weeks to reinforce that initiating conversations with Veterans about MAiD is completely unacceptable and to give staff an

opportunity to engage on the issue. At these sessions it was evident VAC staff understood they were not to raise MAiD to Veterans and that if Veterans raised it, they were to advise that MAiD considerations should only be discussed with their primary care provider. The file review was expanded to include an additional 2,153 files which the employee had worked on since 2016 when MAiD became legal.

While the review was ongoing, the Department proactively reached out to Veterans and stakeholders to discuss the issue and reiterate that MAiD is not a VAC service and that VAC employees have no role or mandate to recommend or raise it with Veterans or family members. Veterans who may have had similar experiences were strongly encouraged to come forward.

In November 2022, the Department became aware of two more Veterans with whom the same employee had raised MAiD.

In the meantime, the Department reviewed all 402,000 files in its client databases, dating back to June 2016 when MAiD legislation came into effect. This search and analysis did not uncover any instances where MAiD had been raised inappropriately with the exception of the four incidents already identified. While additional allegations were brought forward – through appearances at the Standing Committee on Veterans Affairs, media and correspondence to the Department – VAC was able to thoroughly investigate allegations which included a Veteran's full name. No information was found to validate any of these allegations that inappropriate discussions related to MAiD had taken place.

Based on the review and analysis of the employee's 2,153 files; a search of all 402,000 files in VAC's databases; discussions with case managers, Veteran service agents and their managers; a review of all incoming communications to the Department on this issue; and feedback from staff training and information sessions, VAC has concluded these were four incidents completely isolated to a single employee. The employee no longer works for the Department. Further, it has concluded that this is not a widespread, systemic issue, nor is it a reflection of the work of hundreds of case managers and Veteran service agents who interact with the utmost care, compassion and respect with Veterans every single day.

This investigation has brought to light a number of opportunities for improvement in how VAC manages and oversees significant incidents related to Veterans' well-being. While the Department took action to address the specific issue raised by the Veteran and new measures are in place to prevent this type of incident from happening again, processes and procedures can be further improved. In 2023, the Department's Audit and Evaluation Division will conduct an independent and objective review of the escalation process. This will include the processes and procedures in place in the Service Delivery Branch for the identification, reporting and following up on sensitive/significant incidents raised by Veterans (or brought to the attention of VAC). Opportunities for improvement identified in this review will be fully implemented.

The Department is committed to maintaining Veterans' trust in Veterans Affairs Canada. Veterans and their families should always feel confident they will receive the care, compassion and respect they righty deserve from VAC.

VAC has referred the four incidents to the Royal Canadian Mounted Police for their consideration. The Department will continue to review any allegations brought forward; to date, all additional allegations have been confirmed to be unfounded.

The purpose of this report is to provide an overview on what the Department's investigation found and what the Department has done to ensure this situation does not happen again. The report outlines:

- The details and circumstances of what happened and what actions the Department took as new information was brought forward.
- The methodology the Department used to investigate whether other Veterans were impacted through similar experiences.
- The steps VAC is taking to improve staff training, quality assurance and management oversight of significant incidents, as well as plans to consult Veterans on the issue of recording their conversations with VAC employees.

BACKGROUND

Frontline staff supporting Veterans

Veterans are supported by a team of VAC staff dedicated to providing them with the appropriate level of support and services based on each individual's unique needs. The Veteran Services Team consists of Veteran Service Agents and Case Managers, who report to a Veteran Service Team Manager. The team has access to doctors, nurses, occupational therapists, mental health specialists, rehabilitation specialists, and provincial and local programs and service providers to ensure Veterans have the support they need.

Typically, a Veteran Service Agent (VSA) is the primary point of contact for Veterans and their families and helps them get the services they need. VSAs also conduct transition interviews for releasing members of the Canadian Armed Forces and the Royal Canadian Mounted Police and conduct comprehensive screenings to determine the Veteran's needs, assess risks and action referrals as needed.

Case Management Services

Through the initial screening, if a Veteran is deemed to have higher needs or risks, a case manager is assigned to the Veteran. Veterans who require the support of a case manager include individuals that have complex needs in areas such as physical health, mental health, employment, financial, housing, social integration, life skills, or are finding it difficult to navigate a transition/ change in their lives. Case managers work with Veterans to identify needs, set goals, and create a plan to help them achieve their highest level of independence, health, and well-being.

As of January 2023, VAC has 482 case managers providing case management services to Veterans and their family members.

Targeted Assistance & Guided Support

VSAs provide support to Veterans and their families through targeted assistance and guided support:

Targeted Assistance
Veterans with minimal needs who occasionally require help with a specific inquiry or task receive targeted assistance. It is typically short term to address a specific need. For example, a Veteran may have specific questions related to their need for housekeeping and grounds maintenance through the Veterans Independence Program. Guided support is available to Veterans who require more support.

Guided Support
Working closely with the Veteran, the VSA analyzes the Veteran's needs, coordinating and integrating services and helping them navigate the system to ensure their needs are met. Generally, the type of Veteran who requires this level of assistance is not case-managed but needs some extra help.

In addition to providing guided support to Veterans, VSAs also respond to secure messages received via MyVAC Account and receive transferred calls from the National Contact Centre Network (NCCN). These secure messages and calls are from Veterans and family members who often do not have case managers and have questions about VAC's programs and benefits. These interactions with Veterans are noted in their file.

As of January 2023, VAC has 186 veteran services agents supporting Veterans through guided support.

Support for Veterans Available through NCCN & MyVAC Account (MVA)
Veterans can also call VAC's National Contact Centre Network to get general information and request services. As of 16 January 2023, VAC has 125 NCCN analysts responding to calls. For Veterans who prefer to do business online, they can send a secure message through MyVAC Account. VSAs respond to these secure messages and a complete record of the exchange is saved in the Veteran's file for future reference.

Calls to the NCCN are recorded — a common practice for call centres in order to monitor the quality of services and because discussions are generally not sensitive. If a caller's request goes beyond the authority of

the NCCN analyst, the call is transferred to a VSA in their area. These phone conversations are not recorded. VAC's current practice holds that recording interactions between case managers and Veteran service agents and Veterans could harm the building of a trusting relationship and limit the importance and accuracy of the information shared by Veterans. VAC does not record phone interactions the same way it does not record home visits, transition interviews and in-person services with Veterans or their family members. However, after any interaction with a Veteran has occurred, staff are required to document the interaction in the Veteran's file. (**Annex A**: Record of Veterans' Communications with VAC Staff)

Medical Assistance in Dying (MAiD)

MAiD became legal in Canada in June 2016 when federal legislation was passed which allows eligible Canadian adults to request medical assistance in dying. MAiD is a deeply complex and personal medical issue that falls outside the jurisdiction of VAC. Providing advice on MAiD is not a VAC service and employees have no role or mandate to recommend or raise it with Veterans or family members.

Like other Canadians, there are Veterans suffering from terminal illnesses who are choosing to proceed with MAiD as a means to end their suffering. If a Veteran has chosen to pursue MAiD with their primary care provider and calls to inform the Department, employees can help the Veteran and family understand the VAC benefits to which they would be entitled, as well as to discuss any other supports or services that might be relevant in the Veteran's circumstances. This support can include resource coordination and navigation such as connecting a Veteran and their family to community resources, mental health practitioners, grief counsellors, pastoral outreach or other local resources. This support does not include VAC employees providing advice or suggestions on MAiD-related considerations.

SUMMARY OF INCIDENTS & ACTIONS

Date	Event Description & Action
Veteran #1 21 July 2022	A Veteran contacted the Veterans Affairs Canada (VAC) call centre to file a complaint alleging that a VAC employee had inappropriately raised Medical Assistance in Dying (MAiD) with the Veteran during a phone conversation earlier that day. The Veteran indicated the employee also referred to having provided information on MAiD to another Veteran. The call centre analyst apologized to the Veteran for the incident and assured them that it would be escalated to management immediately.
July 22	An internal fact-finding process was initiated. The manager reviewed the Veteran's file and contacted the Veteran to apologize on behalf of the Department. The manager assured the Veteran that discussing MAiD with Veterans, and proposing it as an option, is not part of VAC's practice, nor is it acceptable. The manager advised the Veteran that the Department would look into the incident and stay in touch with the Veteran. The Veteran's file was reassigned to the manager.
July 27	The manager and employee met to discuss the call with the Veteran. The notes in the Veteran's file validated the subject of MAiD had been raised to the Veteran and that MAiD was repeated a second time as an option during their conversation. The notes also confirmed that information on MAiD had been provided to another Veteran.
July 28	The manager again contacted the Veteran to apologize and advise that the Department was taking the situation very seriously and would be taking action. The Veteran asked for details on what actions would be taken but the manager was unable to share this information due to privacy concerns. The Veteran requested a formal written apology.

August 1	The Veteran sent a secure message through MyVAC Account to ask what actions had been taken to address the issue with the employee. The Veteran was told, due to privacy issues, no information could be shared.
August 9	A comprehensive review and analysis was started on the files of the other Veterans for whom the employee was actively providing guided support services to look for indications of conversations about MAiD.
August 11	A formal, written apology was sent to the Veteran from VAC's Assistant Deputy Minister, Service Delivery.
August 17	The National Contact Centre Network (NCCN) began tracking calls where MAiD is referenced. The Director General (DG) of Field Operations surveyed all Area Directors across Canada and instructed them to have conversations with frontline employees about MAiD.
August 19	The Minister of Veterans Affairs instructed the Department to conduct a full and thorough investigation and take all measures to ensure this does not happen again to any Veteran.

Date	Event Description & Action
Veteran #2 August 23	The analysis of the files for the other Veterans who the employee was actively supporting identified a second Veteran with whom MAiD was raised. Management was immediately made aware of this case. Written guidance was sent to frontline employees to advise that employees shall not provide advice or suggestions to Veterans on the issue of MAiD. As well, if a Veteran was seeking advice on MAiD, they were to refer the Veteran to their primary care provider.

August 25 - September 14	Five question and answer sessions were held with 750 staff to give them an opportunity to ask questions about the written guidance and training materials they had received on MAiD. These conversations reinforced that staff understood they were not to raise MAiD with Veterans.
August - November	VAC's Deputy Minister and Assistant Deputy Minister Service Delivery proactively reached out to and met with Veterans' organizations to discuss the issue and reiterate that the situation was unacceptable. They also spoke of the importance of ensuring that Veterans in need of support, continue to reach out in order to receive the help they require.
August - November	VAC's Deputy Minister and Assistant Deputy Minister Service Delivery proactively reached out to and met with Veterans' organizations to discuss the issue and reiterate that the situation was unacceptable. They also spoke of the importance of ensuring that Veterans in need of support, continue to reach out in order to receive the help they require.
October 20 - November 24	The Minister of Veterans Affairs and senior Departmental officials appeared before the Standing Committee on Veterans Affairs on October 20 and November 24 to testify about allegations that MAiD was inappropriately raised to Veterans. The Minister appealed to Veterans to come forward if they had experienced a similar situation. The Department also widely promoted the services and supports available for Veterans with mental health conditions and Veterans in crisis through its website and social media platforms. On November 24, the Minister proactively shared that the Department's investigation had revealed a total of four incidents.
September - December	Throughout the fall months, some Veterans, family members and stakeholders contacted the Department to voice concerns or ask questions. Staff were provided information to ensure consistent responses were provided to reinforce that MAiD is not a VAC service and that MAiD discussions should be between a Veteran and their primary care provider. Each time a new allegation was raised, it was thoroughly investigated. Management interviewed frontline staff and reviewed all of these Veterans' files, but no information was found to validate any of the allegations brought forward.

Date	Event Description & Action
Veteran #3 November 3	At a meeting, management asked the employee about the phone conversation with the Veteran, as well as the second Veteran with whom MAiD had been raised. Through these discussions, management was made aware of a third Veteran with whom MAiD had been discussed.

Date	Event Description & Action
Veteran #4 November 10	Another VAC employee, who was authorized to work in a Veteran's file, found inappropriate references to the employee having raised MAiD with a Veteran. Management was made immediately aware of the fourth Veteran with whom the employee had provided information on MAiD.
December 13	The internal fact-finding process related to the four incidents/Veterans concluded
Mid-December	Employee no longer works with Veterans Affairs Canada.
Ongoing	Correspondence to the Department related to MAiD is responded to on a priority basis and any additional allegations brought forward continue to be thoroughly investigated.

THE INVESTIGATION

Scope

On August 19, the Minister of Veterans Affairs instructed the Department to conduct a full and thorough investigation into the matter, specifically on what had transpired in this situation, how extensive the cases were and how the Department could ensure that this situation would not be repeated in the future.

To ensure the Department reviewed the situation in a comprehensive way, the investigation included:

- A review of the employee's active Veteran client files
- A review of an additional 2,153 files connected to the VSA in question since 2016 when MAiD became legal to determine if there were other impacted Veterans
- A review of all 402,000 files in VAC's client databases to determine the full extent of the issue, including a review of secure MyVAC Account messages (English and French files reviewed and analyzed dated back to June 2016 when MAiD legislation came into effect)
- Discussions and interviews with case managers, Veteran service agents, Veteran Service Team managers and front-line staff
- Feedback from staff training and information sessions about the new directive/guidance on MAiD
- Information obtained through the review and monitoring of all incoming communications to the Department, including MyVAC account secure messages and calls to the National Client Contact Centre (NCCN), and
- Information obtained through VAC's new reporting process which was established to ensure when MAiD is raised in communications it gets escalated to management to determine what follow up may be required

To complement the file review and analysis, Departmental staff spoke directly to the other impacted Veterans as well as Veteran-serving frontline staff and key stakeholders. Senior officials also testified twice about MAiD before the Standing Committee on Veterans Affairs and heard testimony from others at the Committee. Veterans were asked to come forward if they had experienced

a similar situation. Information from all of these sources formed part of the investigation. Throughout fall 2022, as the Department became aware of new information, steps were taken to prevent this type of situation from happening again. Specifically, new training materials on MAiD were developed and shared with new and existing frontline staff; new written guidance was shared with frontline staff to provide clear direction about MAiD; and training and information sessions were held for 750 staff to ensure the guidance was understood and to give staff an opportunity to ask questions and engage on the issue.

Review & analysis of files

Review of Veteran Service Agent's Files

On July 22, the Veteran's file was reviewed to ensure appropriate Departmental supports were in place. The file was reassigned to the Veteran Service Team Manager who was identified as the Veteran's new point of contact.

Next, a comprehensive review and analysis was started on the files of the other Veterans for whom the employee was actively providing guided support services to look for indications of conversations about MAiD. These Veterans were reassigned to a new VSA. The new VSAs reached out to the Veterans to tell them they would be their new point of contact with VAC.

Finding: The analysis of the employee's active files immediately identified a second Veteran with whom MAiD had been raised.

> Veteran #2
>
> This Veteran was receiving guided support services and was assigned to the VSA employee. During the initial screening, the Veteran had a conversation with the employee regarding their significant health issues and notes in the file indicate MAiD was introduced into the conversation. Several months later when they were speaking and the Veteran expressed continued frustration regarding his declining situation, notes indicated the VSA raised MAiD a second time.

An additional 2,153 files in which the employee had worked on since 2016 when MAiD became legal were reviewed and fully analyzed.

Finding: Two additional incidents were found in the search of 2,153 Veterans' files, as described below.

- Third Veteran/Incident Uncovered During a Meeting with Employee on November 3

  Veteran #3

  A Veteran called the Department for information in 2019 and was directed to the VSA employee. The Veteran discussed their diagnosis of a terminal illness and the employee discussed MAiD with the Veteran and how their VAC benefits might be impacted. This Veteran was not assigned to the VSA, and this was the only time that they spoke.

Finding: A review of this Veteran's file confirmed that MAiD was discussed.

- Fourth Veteran/Incident Discovered by Another Employee on November 10

  Veteran #4

  A Veteran sent a secure message to VAC in 2022 to request information on the Attendance Allowance benefit. The message was referred to the VSA employee for follow up. The employee conducted a screening and advised the Veteran that they were not eligible for this benefit via secure message. The Veteran expressed despair over a worsening health condition. The employee responded the same day providing empathy and also information on MAiD. The Veteran thanked the VSA for the information. This was the only interaction between the employee and the Veteran.

Finding: A review of the secure messages in the Veteran's file confirmed MAiD was raised.

Broader review of 402,000 files

Following the review of the individual VSA employee's files, the department engaged in a broader review of all client files to ensure no other Veterans were dealing with similar situations. VAC conducted a search and analysis of 402,000 Veterans, family or caregiver's files across its client database systems. The search dated back to 2016 with the coming into effect of the Medical Assistance in Dying (MAiD) legislation.

Finding: No incidents were found where MAiD was raised inappropriately during the search of the 402,000 files.

Further actions taken to determine extent of issue

Once the initial two cases were identified, VAC broadened its investigation further to determine if MAiD was being inappropriately offered to other Veterans. A number of steps were taken to ensure employees were fully aware that MAiD is not a VAC service and employees have no role or mandate to recommend it. Furthermore, Veteran-serving staff had no authority or expertise to offer such services nor to refer Veterans to explore this as an option.

- **Conversations with staff:** To complement the file review and analysis, management spoke with staff. The Director General (DG) of Field Operations surveyed all Area Directors across Canada on August 17 and instructed them to have conversations with frontline employees. No other cases were identified through these conversations, and it was reaffirmed that VAC staff understood they have no role or mandate to recommend or raise MAiD with Veterans. The DG reinforced to Area Directors, verbally and in writing (on August 23), that VAC employees shall not provide advice or suggestions to Veterans on the issue of MAiD. As well, if a Veteran was seeking advice on MAiD, they were to refer the Veteran to their primary care provider.
- **Directive on MAiD sent to staff:** Written guidance on MAiD was sent to all front-line employees on August 23. The guidance provided information about MAiD; instructed employees that if a Veteran brings up MAiD, they are to refer them to their primary care provider; and what to do when a Veteran chooses that option in consultation with their primary care provider. The guidance also stated that if MAiD was raised by a Veteran, employees were to advise their supervisors and Area Director that it had been raised so it could be escalated to senior management.
- **Question & answer sessions with staff:** After the written directive/ guidance was disseminated to staff, question and answer (Q&A) sessions were organized to provide VAC employees with a venue to ask questions and allow managers to provide further education on how to approach a situation if MAiD is mentioned by a Veteran. A

total of 750 staff participated in five Q&A sessions which were held on August 25, August 30 (two sessions), September 7 and September 14.

- **Training for staff on MAiD:** While VAC staff are trained in situations involving Veterans who may be in crisis situations, specific training on MAiD was developed and offered to existing and new employees in fall 2022. This training will continue to be mandatory for frontline staff. Training on how to support Veterans in crisis and VAC's suicide awareness & intervention protocol were also reviewed with staff.

- **Tracking Veterans & stakeholder feedback on MAiD:** In mid-August the department started tracking MAiD related feedback coming into the Department to ensure proper follow-up and action. Channels included calls to the National Client Contact Centre; secure messages sent through My VAC Account; emails to VAC officials; and media calls and inquiries. As of January 2023, no further incidents of MAiD being inappropriately discussed with a Veteran have been confirmed through this tracking system. Only the four isolated incidents identified have been found and validated.

  Between 21 July 2022 and 30 December 2022, the Department received 235 MAiD-related communications from Veterans and family members as well as others, through one of four channels: the National Client Contact Network (NCCN) calls; correspondence (letters and emails); information email requests; and MyVAC Account secure messages. All of these inquiries were responded to on a priority basis using standard approved messaging. With respect to any additional allegations raised about MAiD being inappropriately discussed with Veterans, each allegation which included a Veteran's full name was thoroughly investigated and none of them have been validated.

- **Engaging with stakeholders:** The Deputy Minister and Assistant Deputy Minister of Service Delivery proactively engaged with Veterans' organizations to discuss the issue and reiterate that the situation was unacceptable and not part of VAC's usual practice. They explained some of the early actions VAC took to improve staff awareness of guidance about MAiD and asked for their support in encouraging Veterans to continue to contact VAC for the services and support they need.

Investigation conclusion

Based on a comprehensive analysis of files, conversations with the employee, Veterans and VAC staff, and the tracking of MAiD incidents with no subsequent cases being validated with information available, the Department has only confirmed the four cases. While additional allegations were brought forward – through appearances at the Standing Committee on Veterans Affairs, media and correspondence to the Department – VAC thoroughly investigated each of the allegations which included a Veteran's full name and was unable to validate any allegations that inappropriate discussions related to MAiD had taken place. VAC has concluded these were four incidents isolated to one employee who is no longer employed with the Department. Further, it has concluded that this is not a widespread, systemic issue, nor is it a reflection of the work of hundreds of case managers and Veteran service agents who interact with the utmost care, compassion and respect with Veterans every single day. This conclusion has been made based on all of the information available to the Department through the period of this investigation. VAC has referred the four incidents to the Royal Canadian Mounted Police for their consideration.

FORWARD ACTIONS

Although they were isolated to just one employee, the Department understands the seriousness of these incidents and wants Veterans to trust that VAC employees are available to support their needs in a respectful and compassionate manner. While early actions have been taken to ensure this type of incident does not happen again, further actions aimed at maintaining Veterans' trust will be taken.

Moving forward, the Department will:

- Strengthen and deliver mandatory and clear employee training and materials on MAiD for new and existing frontline staff
- Establish enhanced reporting procedures immediately that will ensure that significant incidents are raised to the Assistant Deputy Minister and Deputy Minister levels more quickly where appropriate.
- Increase Monitoring for Issues and Trends

- Conduct a Review of the Escalation Process — to be led by the Department's Audit and Evaluation Division
- Consult with Veterans and stakeholders on recording telephone conversations with case managers and Veteran service agents

Strengthen and deliver mandatory employee training on MAiD

- Prior to this incident, there was no specific guidance on MAiD included in VAC's training materials because it was understood that Veterans should only discuss MAiD considerations with their primary care provider. Explicit guidance around MAiD and how to have conversations about MAiD is now included in VAC's training program for new and existing employees. Going forward, training on MAiD will be mandatory and it will reinforce that providing advice on MAiD is not a VAC service and will provide information on the available programs and services offered to support the health and well-being of Veterans.
- VAC has created training specialized for all employees who provide direct, front-line support to Veterans. Work is underway to standardize training for all front-line employees and ensure staff have access to consistent information. The Department is committed to ensuring staff has the tools and training they need to do their jobs. It will be looking at how it can learn from this situation with a focus on ensuring Veterans receive the best possible support from VAC.

Establish enhanced reporting procedures and strengthen processes

This incident has highlighted the need for VAC to review its quality assurance (QA) framework across the full spectrum of services delivered to Veterans and their families. VAC is committed to exploring QA from a broader service delivery to Veterans lens. With service points across the country, VAC is continually working to improve service to Veterans and further steps will be taken to strengthen its existing QA processes with a goal to:

- Ensure the quality of service is exceptional at every step of the process and follows the standards of practice, policy, directives, guidelines and business processes as intended, and

- Allow employee performance concerns to be addressed as they occur and provide frontline staff with regular feedback on the quality of their work.
- Identify opportunities to improve how VAC delivers services to Veterans, former RCMP members and their families.

Through the investigation, the reporting process for alerting all levels of management about significant incidents in a timely manner was identified as a weakness. A new business process has been developed that will help to ensure when Veterans raise MAiD with front-line staff, employees are to advise their supervisors and Area Director so it can be escalated to senior management. If a Veteran raises MAiD, employees are directed to raise it with their manager. The manager and area director now escalate it to the Director General of Field Operations. If further investigation reveals any inappropriate action, the incident would then be raised to the Assistant Deputy Minister Service Delivery and the Deputy Minister. Front-line staff have received training on this new business process to ensure it is understood and fully implemented. This process will be examined as part of the Audit and Evaluation Division's review to identify ways to make it as efficient and effective as possible.

During fiscal year-end performance management discussions, managers will engage front-line staff in discussions about MAiD to determine if they have any related training needs or questions about the new guidance on MAiD and to identify further opportunities for improvement. Starting on 1 April 2023, area directors will have a new commitment added to their Performance Management Agreements requiring them to conduct increased QA monitoring of files, phone calls and secure messages.

Increase monitoring for issues and trends

VAC's existing QA efforts will also be further enhanced to include specific monitoring around how frontline employees are handling discussions about MAiD, as well as any other emerging issues. Since November 2022, additional resources have focused on increasing monitoring and oversight.

- Calls to the NCCN are recorded and managers regularly review these recordings for quality assurance and training purposes. Managers are now reviewing more calls for each analyst — more than doubling the volume of calls being monitored. Reviewing more calls will help to identify staff learning needs and it will also help the Department to quickly identify service delivery trends and emerging issues.
- Secure messages received from Veterans via MyVAC Account will continue to be regularly reviewed. For new staff working on secure

messages, managers will review their first 30 secure messages. On an ongoing basis, 7 messages per month will be reviewed for each staff member responding to secure messages. This represents 2% of messages being reviewed which is the accepted industry standard. When applicable, staff use pre-written response templates to ensure standardized service and quality.

- Increased review of call recordings and file reviews will allow management to identify issues at the individual level and correct it with the employee. If trends are identified broader training might be required to help address any gaps. Management will discuss these trends at the regular Field Operations Management Committee meetings.

In addition to strengthening QA efforts, VAC will continue to regularly survey Veterans to gauge satisfaction and areas of concern. For example, the NCCN measures their level of satisfaction with the service received by offering the option of completing a survey after the call. Feedback from these surveys and other program-specific surveys will enable VAC to identify further opportunities to improve service to Veterans and their families.

2023 escalation process review by Departmental Audit and Evaluation Division

The Department's Audit and Evaluation Division will conduct an independent and objective review of the escalation process. This will include the processes and procedures in place in the Service Delivery Branch for the identification, reporting and following up on sensitive/significant incidents raised by Veterans (or brought to the attention of VAC). This review is expected to commence in April 2023, and opportunities for improvement identified in the review will be fully implemented.

Consultation with Veterans & stakeholders on recording telephone conversations

Currently, the only calls VAC records are those to the National Contact Centre Network (NCCN). Since this incident came to light, it has been suggested that calls between Veterans and the VAC employees who serve them should be recorded. Others have raised privacy concerns about recording conversations and how it could damage the building of a trusting relationship between the

Veteran and VAC employees serving them. Recording conversations would be a significant shift in practice for VAC, however the Department is open to hearing from Veterans on this approach.

In 2023, the Department will use a variety of channels to engage with Veterans and stakeholders to get their feedback on recording calls between a Veteran and their case manager or their Veteran service agent. Through a consultation process, VAC will assess the impact it could have on Veterans, determine how it could be beneficial for Veterans, and hear any other concerns Veterans may have. In addition to meeting with Veterans' organizations, the Department will use its Let's Talk Veterans online consultation tool to take the pulse of opinions on the recording of calls. The Department is also reviewing other federal and provincial government departments' policies related to recording conversations with clients. All input gathered will help to refine a proposed way forward in improving service to Veterans. Veterans can rest assured that no changes will be made until after a full and thorough consultation process has taken place.

CONCLUSION

The Department places the highest priority on ensuring that Veterans and their families have the support and services they need when and where they need them. This includes ensuring that encounters with VAC staff are conducted in a respectful and compassionate way. The distress this situation has caused to those involved and the Veteran community as a whole cannot be underestimated. The Department deeply regrets what transpired and takes very seriously issues related to MAiD and Veterans' well-being. The steps taken through this investigation and the changes being implemented will serve to maintain the trust of the Veteran community.

Through its comprehensive investigation, the Department has confirmed the four cases isolated to a single employee who is no longer with the Department. Each additional allegation that has been brought forward to date has also been thoroughly investigated and confirmed to be unfounded. The Department remains open to hearing from Veterans and stakeholders and encourages anyone with information to come forward. VAC will continue talking with Veterans and employees about this issue and will follow up on any new information or requests that it receives. Any Veteran who is not comfortable bringing an issue forward to the Department should contact the Office of the Veterans' Ombud.

VAC staff are the Department's greatest asset. The Department is concerned that these incidents, isolated to one employee, may cause Veterans to hesitate in reaching out to the Department. Veterans Affairs Canada staff remain committed to ensuring a continued, high standard of service and care for Veterans and their families. The new and strengthened quality assurance processes put in place, combined with increased staff training and guidance, will help to prevent this type of situation from happening again. The Department will do everything in its power to maintain Veterans' trust in Veterans Affairs Canada.

ANNEXES

ANNEX A - Record of Veterans' communications with VAC staff

NOTE: The information that follows is VAC's current policy with respect to recording conversations between Veterans and case managers or Veteran Service Agents (VSA). As noted in the report, in 2023 the Department commits to engage with Veterans and stakeholders to gather feedback on recording calls.

1. Policy and procedures

VAC does not have a policy on recording phone interactions between Veterans and case managers or VSAs because it does not record such interactions due to the sensitive nature of their conversations. It is believed that recording interactions between Veterans and their case managers or VSAs could harm the building of a trusting relationship and prevent Veterans from sharing important information. It does not record phone interactions the same way, it does not record home visits, transition interviews and in-person services to all of its Veterans.

The only conversations with Veterans that VAC records are calls to its National Contact Centre Network (NCCN) as this is a common practice of call centers in order to monitor the quality of services. As well, these conversations are less sensitive since Veterans are mostly calling to receive information or be directed to other services.

2. Standard and procedure of notetaking and file-keeping

After an interaction with a Veterans has occurred, documentation must follow in their file. For the VSA's role, the documentation would most often be found in CSDN through the screening tool or in client notes or GCcase. For Case Managers, the information would be documented in GCcase under the Veterans' plan or in the case management assessment.

If Area Office staff need to follow-up in writing with the Veteran following a conversation, My VAC Account can be used if the Veteran is registered, and they would use official decision letters if it is related to VAC program related decisions (letters would be available in CSDN and GCcase). These letters would be uploaded to MyVAC Account or mailed out if the Veteran is not registered with MyVAC Account.

ANNEX B - Directive: Role of the Veteran Service Team regarding Medical Assistance in Dying (MAiD)

Note: This guidance/directive was distributed to VAC's frontline staff on 23 August 2022 and posted on the internal website. Subsequently, five Q&A sessions were held with staff to ensure the guidance was understood and to give staff an opportunity to ask questions.

Medical Assistance in Dying (MAiD) is a deeply complex and personal medical issue that is out of the jurisdiction of Veterans Affairs Canada staff.

MAiD is discussed and administered by a treating physician or a nurse practitioner directly to the Veteran or is prescribed to the Veteran for self-administration. A Veteran must be eligible for government-funded health insurance for MAiD, and this decision must be discussed and made directly with the Veteran's physician or nurse practitioner. (See: Dying with Dignity Canada).

Veterans Affairs Canada (VAC) employees shall not provide advice or suggestions to Veterans on the issue of MAiD. If a Veteran is seeking advice or assistance with MAiD, the employee must refer the Veteran to their primary care provider.

Any mention of MAiD by a Veteran must be reported to the Area Director of the responsible area who will advise the Director General of Field Operations.

If a Veteran has chosen to pursue MAiD with their primary care provider and shares this information with a member of the Veteran Service Team (VST), VAC can support the Veteran in navigating VAC benefits and services available. Veterans may consider the following potential benefits and services, including but not limited to: VAC Assistance Service, Pastoral Outreach, Disability Benefits, Additional Pain and Suffering Compensation, Critical Injury Benefit, Veterans Independence Program (VIP), Allowances, War Veterans Allowance, Caregiver Recognition Benefit, and associated treatment benefits, if applicable. Support can include resource coordination and navigation such as connecting a Veteran and their family to community resources, mental health practitioners, grief counsellors, pastoral outreach or other local resources. The VST should never provide advice, suggestions, or options relating to the MAiD process itself, as this should only occur between the Veteran and their primary care provider.

The VST can support the survivor and dependents with potential VAC services and support available to them, including the VAC Assistance Service, Disability Benefits in Respect of Death for Survivors and Dependent Children, Veterans Independence Program (VIP), Funeral and Burial Assistance, or Educational Assistance for Children, and the Hope Program.

The VST member supporting a Veteran who has chosen to pursue MAiD with their primary care provider is strongly encouraged to consult with:

- a Standards Training and Evaluation Officer (STEO) for assistance in navigating the benefits and services available to the Veteran and their family, and/or;
- a Case Management Practice Consultant (CMPC) for support or debrief when they are having a conversation with a Veteran and their family surrounding this sensitive topic.

Additional guidelines and business processes that may assist the VST in supporting a Veteran who has chosen to pursue MAiD with their primary care provider include: Guidelines for Caring Carefully, Guidelines for Engaging Families and Mental Health Resources Available to Veterans' Family Member.

ANNEX C – Presentation deck: Role of the VST regarding Medical Assistance in Dying (MAiD)

Q & A Session

August, 2022

What is MAiD?

Medical assistance in dying is the name of Canada's assisted dying legislation.

It refers to the administering of medications by a physician or nurse practitioner that – at the person's request – causes their death;

Or the prescribing of medications by a physician or nurse practitioner that a person can take to cause their own death.

MAiD / AMM

Medical Assistance in Dying (MAiD) is a deeply complex and personal medical issue that is out of the jurisdiction of Veterans Affairs Canada staff.

Dying with Dignity Canada

VAC Role

Medical Assistance in Dying

Employees:

Shall not provide advice or suggestions to Veterans on the issue of MAiD.

Must refer the Veteran to their primary care provider.

Must report any mention of MAiD to the Area Director of the responsible area who will advise the Director General of Field Operations.

Can support the Veteran in navigating VAC benefits and services available if the Veteran has chosen to pursue MAiD with their primary care provider.

Consultation

The VST member supporting a Veteran who has chosen to pursue MAiD with their primary care provider is strongly encouraged to consult with:

- a STEO for assistance in navigating the benefits and services available to the Veteran and their family and/or;

- a CMPC for support or debrief when they are having a conversation with Veteran and their family surrounding this sensitive topic.

Guidelines and Business Processes

Guidelines for Caring Carefully

Guidelines for Engaging Families

Mental Health Resources Available to Veterans' Family Member.

Questions

ANNEX D - Questions & answers on MAiD directive

The following Questions and Answers are not intended to deepen your understanding regarding Medical Assistance in Dying but rather clarifies impact to Veterans Affairs Canada employees as it relates to your role and responsibilities.

Question 1: What is Medical Assistance in Dying (MAiD)?

Answer 1: Medical Assistance in Dying is seeking an approved assisted death where the requestor is well-informed throughout the process and includes safeguards in place to ensure they are informed and know their options and truly, voluntarily seek approval for this remedy. The requestor retains until the very last moment, the right to change their mind on proceeding with MAiD. MAiD can be received by:

- the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
- the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

MAiD legislation is the removal of such acts as criminal acts for which prosecution would occur.

Question 2: What should I do if a Veteran does not have a primary care provider such as a physician or nurse practitioner and has questions about MAiD?

Answer 2: If a Veteran does not have a primary care provider, the Veteran Service Team (VST) member can support the Veteran in connecting with their local health authority who can assist them in obtaining a primary care provider to have their questions answered. As indicated in the Directive, it is not the responsibility of the VST (or any VAC employee) to provide advice, guidance or suggestions to Veterans relating to a client's considering or seeking MAiD.

Question 3: What should I do if a Veteran is considering or has chosen MAiD and would like to understand the impact to their VAC benefits and services?

Answer 3: Veterans who explore the possibility of MAiD may approach VAC to learn the potential impact on their benefits. They may also wish to learn how this could impact VAC benefits for their families. VAC continues to offer support to Veterans in understanding the impact on their benefits and services when are considering or have chosen to pursue MAiD. Case specific objective information can be provided to the client by the VST member about VAC benefits, services and programs. Please refer to the Condolence and Benefit Information Letter Process for additional information on various scenarios and consultation with a Standards Training and Evaluation Officer (STEO) is encouraged as each situation should be examined on case-by-case basis.

Question 4: A Veteran I am working with is expressing interest in pursuing MAiD and is also experiencing thoughts of suicide. What should I do?

Answer 4: The MAiD process, including procedural safeguards to ensure there is informed consent for the person pursuing MAiD is clearly outlined in the Criminal Code of Canada and under its supporting regulations. If you are concerned the Veteran who has expressed interest in pursuing MAiD may also be experiencing thoughts of suicide, please refer to the Suicide Awareness and Intervention Protocol and you may consult with your manager and a Subject Matter Expert (SME) such as Mental Health Officer (MHO) to support you with this protocol.

Question 5: As a VAC employee, I am feeling impacted by a conversation with a Veteran who is exploring or has chosen to pursue MAiD. What supports are available to me?

Answer 5: It is important that you feel supported when a Veteran you are working with has decided to pursue MAiD with their primary care provider. You are encouraged to consult with your Case Management Practice Consultant (CMPC), or your manager for support in navigating this situation. Guidelines for Caring Carefully provides helpful strategies and information for you relating to self-care, navigating work-induced stress and others. In addition, the Employee Assistance Program (EAP) provides the support of a confidential counsellor for all VAC employees.

Question 6: What is the role of VAC Health Professionals with respect to MAiD?

Answer 6: Canada's MAiD legislation is part of the Criminal Code of Canada

and is outside of the jurisdiction of VAC. VAC has no role in the assessment of Veterans for the purpose of MAiD. Veterans should contact their primary care provider, or their local or regional health authority if they wish to learn more about and/or pursue MAiD.

Question 7: A Veteran I am working with has pursued MAiD with their primary care provider. Do I follow the Suicide Notification Process?

Answer 7: According to Veterans Affairs Canada, if a Veteran pursues MAiD with their primary care provider, they are not considered to have completed suicide. Please follow the Condolence and Benefit Information Letter Process.

Question 8: What and how do I document a discussion of MAiD with a Veteran?

Answer 8: If a client has brought up the topic of MAiD to a Veteran Service Team member, you should document the facts of the conversation as you would for any other Veteran contact. Please see Service Delivery Documentation Guidelines - Training for more information on documentation.

Question 9: What and how should I report information when I have had a discussion of MAiD with a Veteran?

Answer 9: The Veteran Service Team member should report that a discussion of MAiD occurred with a Veteran directly to their manager and the date of the discussion. Identifiers such as name or file number are not required. The information will be provided to the Area Director and subsequently to the Director General of Field Operations.

Question 10: Why am I reporting to management information regarding discussions of MAiD with a Veteran?

Answer 10: Reporting information regarding discussions of MAiD allows the Department to understand trends and explore possible training needs and for you to be supported following these discussions with Veterans.

Question 11: Where can we direct media inquiries on the topic of MAiD?

Answer 11: If a VAC employee receives a media inquiry, they are to follow the following operational process: General Public or Media Inquiries. VAC employees are not to comment on the media inquiry, and are to provide the caller with the general inquiries phone number (613-992-7468).