WHISTLEBLOWER			
SECTION: II-i **Administration – *Leadership***		**NO: 100**	
Issued By:	Executive V.P. & Chief Financial Officer	**APPROVAL DATES :**	
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Key Words:	Whistleblowing, misconduct, wrongdoing, misappropriation, mismanagement, unethical behavior, scientific integrity	**Cross Reference(s)**	CORP V-i 100 Harassment-Free Workplace, CORP IV-i 110 Prevention & Management of Violence in the Workplace, CORP VII-iii 100Patient Incident Reporting & Response, Corp II-ii 110 Signing Authority, Corp II-ii 111 Signing Authority – Revenue Related Contracts & Agreements, CORP II-ii 120 Expense Claims, CORP II-ii 130 Procurement, CORP II-ii 190 Contract Agreement, CORP III 110 Conflict of Interest, CORP III 140 Responsible Conduct of Research

1. PURPOSE:

To encourage and enable the communication of concerns about issues of honesty and integrity, public health and safety, financial, legal or operational matters in relation to ROHCG without fear of reprisal and to define a process for the allegation/disclosure of wrongdoing, also referred to as “whistleblowing”.

2. POLICY STATEMENT:

ROHCG is committed to delivering mental health care services, pursuing responsible research activities and conducting its operations with integrity and ethical conduct, safeguarding public health and safety, in compliance with legal and financial requirements and conducting its operations with behaviour that is consistent with the ROHCG Mission, Vision and Values. In keeping with this commitment, this policy provides an avenue for staff and other stakeholders to report their concerns with respect to any alleged wrongdoing within the ROHCG concerning issues of honesty and integrity, public health and safety and financial, legal or operational matters. This policy is intended to apply to concerns about incidents or activities that involve:

- Breach of legal obligations, rules, regulations or policy;
- Gross mismanagement, omission or neglect of duty;
- Gross mismanagement in the use or failure to use funds;
- Inappropriate recording or reporting of revenues or shortfalls;
- Inappropriate classification or presentation of assets or liabilities;

- Breach of fiduciary duty or abuse of trust;
- An abuse of authority;
- Endangerment of public health and safety in relation to the operations of the ROHCG.

Incidents or activities related to breaches of responsible conduct of research shall follow the procedures as set out in *CORP III 140 Responsible Conduct of Research.*

3. SCOPE:

This policy applies to the ROHCG (including the Institute of Mental Health Research (IMHR) and Royal Ottawa Foundation for Mental Health (ROFMH)) and their staff, trainees, vendors, donors, members of the general public and other Royal Ottawa Health Care Group (ROHCG) affiliates. This policy is not intended to apply to matters arising under a collective agreement that are within the jurisdiction of the grievance process or a labour arbitrator to resolve, or that are more appropriately addressed under another ROHCG policy.

4. GUIDING PRINCIPLES:

The ROHCG is committed to providing a work environment in which any person can raise concerns they may have about the subject matter covered by this policy without fear of reprisal. Accordingly, the ROHCG strictly prohibits discrimination, retaliation, threats or harassment of any kind against any person who reports such information to the ROHCG in good faith in accordance with this policy.

5. DEFINITIONS:

Disclosure is information brought forward in good faith and based on reasonable belief about a concern of wrongdoing in relation to the subject matter covered under this policy.

Duty of Loyalty is the expectation that the person will act responsibly and with integrity and discretion in relation to the wide range of information to which they have access in the course of their employment or training, in serving the research or public interest. This duty can be extended to those engaged in voluntary or contractual relationships with the ROHCG.

Neutral Third Party is an impartial individual who serves as a recipient of formal disclosures and who will triage and investigate disclosures, or oversee or delegate the investigation of disclosures and may otherwise assist in the resolution of disclosures under this policy.

Person is an ROHCG/IMHR/ROFMH employee, physician, Board of Trustees member, IMHR Board member, ROFMH Board member, Royal Ottawa Volunteer Association (ROVA) Board member, volunteer, student, contractor, vendor, donor, affiliate or a member of the general public making a disclosure under this policy.

Vexatious means an action that, when viewed objectively, is initiated without merit and is calculated to annoy, embarrass or harass.

Whistleblower is a person who, in good faith, makes a disclosure under this policy.

Wrongdoing refers to practices under the control of ROHCG that include: a breach of legal obligations, rules, regulations or policy, gross mismanagement, omission or neglect of duty, research misconduct, gross mismanagement in the use or failure to use funds, inappropriate recording or reporting of revenues or shortfalls, inappropriate classification or presentation of assets or liabilities, breach of fiduciary duty or abuse of trust, abuse of authority or endangerment of public health and safety in relation to the operations of the ROHCG. For the purposes of this policy, “wrongdoing” does not include violation of a collective agreement insofar as those types of concerns are intended to be addressed within the grievance and arbitration process.

6. PROCEDURE:

6.1 ACCOMMODATION: When a disclosure is made or a concern is brought forward under this Policy, considering the nature of the issues and any investigation, and the desire to maintain confidentiality, if it is deemed necessary under the circumstances and in consultation with the persons involved, management, at its discretion, may impose a leave of absence, a reassignment of duties, an alternative reporting relationship or such other appropriate accommodation measures pending resolution of the disclosure, concern or investigation in order to facilitate the integrity of the process and the confidentiality of the persons concerned. Such reasonable accommodation measures are intended as a protective measure and not in the nature of a reprisal when imposed for the purpose of this section and the Policy.

6.2 PROTECTION FROM REPRISAL: A person shall not take a reprisal against an employee or direct that one be taken against an employee because the employee has, in good faith,

(a) sought advice about making a disclosure;
(b) made a disclosure; or
(c) cooperated in an investigation under this policy; or
(d) provided a law enforcement officer with truthful information regarding the commission or possible commission of an offence, unless the individual reporting is one of the violators.

A person who takes a reprisal against an employee or directs that one be taken contrary to this policy is subject to appropriate disciplinary action, which may include termination of employment for employees and removal of privileges for Physicians. Appropriate disciplinary or other administrative measures that are taken to remediate or respond to a disclosure or a concern brought forward are not considered acts of reprisal.

6.3 INFORMAL PROCESS FOR BRINGING FORWARD CONCERNS:

6.3.1 Every person is encouraged to speak to their manager, or the manager responsible for the activity in question, should they have serious concerns about wrongdoing that involves the subject matter of this Policy. If the person bringing the matter forward is not comfortable speaking to their manager, or the manager responsible for the activity in question, they are encouraged to discuss the matter with another manager, either up the management line or connected to the subject matter of the concern. Any informal reporting matter involving the ROHCG CEO, IMHR President & CEO or Foundation President & CEO will be directed to the Chair of the ROHCG Board of Trustees, Chair of the IMHR Board of Directors or Chair-Foundation Audit Committee, respectively.

6.32 If the subject matter of the concern falls within the scope of another workplace policy or process, the matter should be brought forward under the other applicable policy or process (for example, *Harassment-Free Workplace Policy, Prevention & Management of Violence in the Workplace Policy* or processes provided for under collective agreements). Persons considering bringing a concern forward are encouraged to seek the advice and support of their manager, union representative or the human resources department for guidance as to which policy and/or process is applicable considering the nature and subject matter of the allegations.

6.3.3 The manager receiving information about the concern brought forward will review the matter to determine whether additional inquiry is required, whether the matter can be resolved informally or whether escalation to a higher level of management is required in order to

achieve a resolution. The manager shall take such appropriate steps as are warranted with a view to achieving a prompt resolution of the matter which may include discussing the matter with the persons involved and/or identifying and implementing organizational or management actions to be taken. The manager will ensure that the person bringing the matter forward is aware of the actions taken in connection with the person's report, subject to limitations imposed by confidentiality considerations and privacy laws.

6.3.4 Everyone involved in the informal resolution of a concern brought forward under this Policy must make every reasonable effort to preserve the dignity and privacy of all parties concerned. Therefore, the custody and distribution of information, emails and documents relating to a concern about wrongdoing brought forward and resolved informally under this Policy, must be maintained confidentially to the fullest extent reasonably possible considering the circumstances, respects the duty of loyalty as it relates to access to and use of information and the requirements of any laws and regulations concerning the use and disclosure of such information.

6.4 FORMAL DISCLOSURE PROCESS:

6.4.1 If a matter cannot be initiated or satisfactorily resolved under the informal process, every person is encouraged to bring forward their concerns about wrongdoing that falls within the subject matter of this policy by making a formal disclosure to the ROHCG Audit Committee Chair, the IMHR Finance & Audit Committee Chair for IMHR matters, Foundation Audit Committee Chair or to the Neutral Third Party.

6.4.2 Persons bringing a concern forward under the formal disclosure process are encouraged to identify themselves in connection with the disclosure, although matters may be brought forward anonymously. However, more can be done to address a situation if the report is not anonymous and the ability to communicate with persons making anonymous reports is compromised.

6.4.3 A formal disclosure about wrongdoing under this Policy, whether made by mail, by email, by leaving a voicemail or face-to-face meeting, should contain as much information as possible about the subject matter including the following, to the extent applicable under the circumstances: the nature and particulars of the wrongdoing, relevant dates, the identity of persons who are/may be involved and any policy, law, regulation, process or practice if at issue. Persons making formal disclosures under this Policy are encouraged to provide their personal contact information in order to facilitate communication with them.

6.4.4 A person making a formal disclosure under this Policy who is also a regulated health professional, must ensure that if such disclosure includes any personal health information, then such disclosure must be compliant with, and not prohibited by, the *Regulated Health Professions Act*, *the Mental Health Act, the Personal Health Information Protection Act* or other legislation and regulations governing the regulated health professions.

6.4.5 For every disclosure received, an acknowledgement of receipt of the disclosure will be made to the person making the disclosure, within one week of receipt (with the exception of anonymous reports or where the person has not provided contact information and it is not practical to do so).

6.4.6 Every formal disclosure will be recorded by the person(s) who receives it - the Neutral Third Party, the ROHCG Audit Committee Chair, IMHR Finance & Audit Committee Chair for IMHR matters or Foundation Audit Committee Chair for Foundation matters - they will review the disclosure and determine the most appropriate action to be taken. Unless the allegations are trivial, vexatious or fall within the jurisdiction of another policy or procedure, the report will

be investigated in accordance with principles of procedural fairness. The specific investigation protocol will depend on the circumstances of the particular matter being investigated. On a case-by-case basis, external resources may be used to conduct or assist in an investigation. The ROHCG Audit Committee Chair, IMHR Finance & Audit Committee Chair, Foundation Audit Committee Chair, the IMHR President & CEO, the ROFMH President & CEO and/or the Neutral Third Party may communicate with the Executive Vice President and CFO and/or the General Counsel to determine the most appropriate manner for conducting and overseeing the investigation.

6.4.7 All persons covered by the scope of this Policy are required to abide by the terms of this Policy and to cooperate in an investigation. Failure to cooperate, deliberately providing false information or making a vexatious disclosure will be subject to appropriate disciplinary action, up to and including dismissal or termination of privileges or the engagement for volunteers, students and contractors.

6.4.8 If, after the conclusion of the investigation, ROHCG determines that that the subject matter of the disclosure has been substantiated, appropriate action will be taken. Such action may include revising organizational processes or practices, implementing training, imposing performance management measures or disciplinary actions against persons involved in the wrongdoing up to an including termination of employment, privileges, the engagement or contract.

6.4.9 Every person making a formal disclosure under this Policy will be provided with a statement of action taken in connection with the disclosure following the outcome of the investigation or following the review of the person's disclosure if an investigation did not proceed, subject to any limitations in order to respect privacy and other legal considerations;

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6.5 RECORDS:

6.5.1 The final internal investigation report and related documents will be maintained in a segregated investigation file in the office of the General Counsel for a period of time to be determined by senior management on a case-by-case basis depending on the nature of the matter brought forward and applicable legal requirements.

6.5.2 The final external investigation report and related documents will be maintained in a segregated investigation file in the office of the General Counsel for a period of time to be determined by senior management on a case-by-case basis depending on the nature of the matter brought forward and applicable legal requirements..

6.5.3 If the allegations brought forward are substantiated and performance management measures or some form of discipline is imposed, a notification of the remedial or disciplinary measures will be placed in the personnel file of the person who engaged in the improper activity and will also be maintained in the segregated file in the office of the Executive VP & CFO, IMHR President & CEO for IMHR matters or President & CEO Foundation (internal investigations) or the General Counsel (external investigations). Notification in the personnel files of unionized employees will be maintained for a period of time in accordance with any applicable provisions of governing collective agreements and notification in the personnel files of non-unionized employees will be maintained for a period of five (5) years.

6.5.4 Information and records pertaining to investigations, and any associated documents and reports, will not be disclosed to any external third parties (for example, professional governing bodies or external agencies) except as required by law.

6.6 CONFIDENTIALITY: All disclosures of wrongdoing and concerns brought forward under this policy will be treated in a confidential and sensitive manner and in accordance with the provisions of the *Personal Health Information Protection Act* and other governing legislation. The whistleblower and any persons involved in the investigation must maintain discretion, respect the duty of loyalty and preserve the confidentiality of the information and the parties concerned.

6.7 CRIMINAL ACTIVITY: Disclosures or concerns brought forward that may involve criminal activity should be reported to the proper policing authorities for investigation by those receiving the information (Management, Chair, ROHCG Audit Committee, Chair, IMHR Finance and Audit Committee, Chair Foundation Audit Committee and/or Neutral Third Party). Individuals reporting concerns that may involve criminal activity have the right to report the information directly to the proper policing authorities.

7. RELATED PRACTICES AND / OR LEGISLATION:

Personal Health Information Protection Act, S.O. 2004,
Regulated Health Professions Act, 1991,
Public Hospitals Act
Business Corporations Act – O. Reg. 665/05 Income Tax Act, R.S.C. 1985 (5th supp.) c. 1, ss. 149.1(14) and 188.1(6).
Imagine Canada Ethical Fundraising and Financial Accountability Code

8. REFERENCES:

Guidelines established by certain colleges:

College of Physicians and Surgeons of Ontario's Policy on Mandatory Reporting (Policy #3-05)
College of Nurses of Ontario's Practice Standard entitled "Confidentiality and Privacy - Personal Health Information"
College of Nurses of Ontario's Professional Standards (revised '02) dated January 2004
College of Nurses of Ontario's Ethics Standard dated January 2004
College of Chiropractors of Ontario's Standard entitled "Record Keeping" (Standard 000-2)
College of Medical Laboratory Technologists of Ontario's Standard entitled "Mandatory Reports: What are they, why are they important to self-regulation and when must they be made?"
College of Psychologists of Ontario's "Guide to PHIPA - Ontario's Privacy Legislation"
Ontario College of Social Workers and Social Service Workers' Code of Ethics and Standards of Practice (2nd Edition 2008)
College of Occupational Therapists of Ontario's Essential Competencies of Practice for Occupational Therapists in Ontario, 2nd edition; The Competencies and Performance Indicators: Sections 1.2, 1.3. 1.4

9. APPENDIX: http://oreo.rohcg.on.ca/corporate/index.cfm

Appendix 1- Contact Information
Appendix 2 - Role of the Audit & Finance Committee Chairs
Appendix 3 – Role of the Neutral Third Party