In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

Affidavit of Dr. G. Richard Mann

I, Dr. G. Richard Mann, of the City of London, in the Province of Ontario, MAKE OATH AND SAY:

1. I am the Regional Supervising Coroner ("RSC") for the West Region London Office (the "London Office"). I swear this Affidavit to provide evidence to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the "Inquiry") on the work of the London Office, and my involvement in the retrospective death investigations that arose after Elizabeth Wettlaufer confessed to the offences. I have knowledge of the information contained in this Affidavit.

Background: Training and Experience

2. I graduated from medical school in 1981, and following residency training I began a rural family medicine practice in Kincardine, Ontario in 1984. I also worked in community hospitals, practicing emergency medicine, anesthesiology and obstetrics.

3. I was appointed as a coroner by Order-in-Council on October 3, 1985. For the next 23 years, I maintained a full-time rural family medicine practice while also working part-time as a coroner.

4. In April 2008, I was appointed as the RSC for the London Office. The RSC is a full-time role, and I therefore left my family medicine practice.

5. A copy of my curriculum vitae (LTCI00072711) is attached as Exhibit A to this Affidavit.

The Role of the RSC and the London Office

6. The London Office covers Bruce, Chatham-Kent, Elgin, Essex, Grey, Huron, Lambton, Middlesex, Oxford and Perth counties. The following chart summarizes the number of death investigations completed by the London Office for the years identified as provided by the Office of Chief Coroner (the "OCC"), as well as the number of those investigations that involved deaths in long term care homes ("LTC homes"):

Year	Total Deaths Investigated	Total LTC Home Investigations
2007	2831	585
2008	2458	505
2009	2323	427
2010	2429	457
2011	2259	507
2012	2380	450
2013	2350	302
2014	2027	137
2015	2056	129
2016	2187	151

7. The decrease in the number of death investigations in LTC homes since 2013 can be attributed in part to the fact that there was no longer a requirement to investigate threshold deaths (i.e. every tenth death) in LTC homes.

8. As of 2018, I supervise approximately 55 investigating coroners that work in the London Office region. This number has declined slightly from the approximately 60 investigating coroners working in the London Office region as of 2008.

9. As the RSC, my role includes responding to inquiries from families about the status of death investigations, and supervising the local coroners in the region. This includes:

a. mentoring new coroners for a certain number of cases. For example, when a new coroner gets a call from central Provincial Dispatch about a case, they call me to discuss it and we agree upon an investigative plan. They go to the scene, they review the scene, examine the body, talk to family, gather information and we discuss what they have learned to this point in time. We discuss what the next steps should be, which may include:

i. requesting a post mortem examination;

ii. asking for toxicology;

iii. asking the police to provide more information;

iv. gathering information from other sources; and/or

v. reviewing medical history.

The investigating coroner can call at any time if they have any other questions. I then will review their preliminary Coroner's Investigation Statement / Form 3 (the "Form 3") and provide edits, corrections or suggested changes. The investigating coroner implements these and makes any final edits. This process would be followed with all new coroners until I felt they met the standard of the coroners in the region;

b. responding to inquiries from investigating coroners about a particular death investigation, or about coroner practice issues generally;

c. auditing Form 3s by reviewing and finalizing the Form 3s at the conclusion of death investigations (the process described in further detail below); and

d. conducting educational sessions in the community upon request (as described further below).

10. On rare occasions, I also act as an investigating coroner, if no local coroner is immediately available to accept a death investigation. I then transfer the case to a local coroner to complete when a local coroner becomes available.

11. The London Office does not generally provide its own educational sessions to its local coroners. Training is provided through the OCC.

12. After a change to the reporting structure in 2018, I and the other nine RSCs who cover Regional Offices report to Deputy Chief Coroner James Sproule. Previously, half of the RSCs reported to one Deputy Chief Coroner, and the other half reported to the other Deputy Chief Coroner.

Notification and Assignment of a Local Coroner to a Death Investigation

13. Prior to Provincial Dispatch coming fully into use in 2012, each Regional Office had its own procedures for assigning cases to coroners. The London Office had a number of answering services that the public would call to report a death. The individual who answered the calls would contact coroners on a rotating basis, based on each local coroner's proximity to the death being reported, to see if they could take the case.

14. Since approximately 2012, Provincial Dispatch controls the distribution of cases to local coroners. Individuals contact Provincial Dispatch to report a death, and each call is assigned to the next available coroner in the appropriate jurisdiction on a rotating basis.

15. Under both systems, the answering service or the dispatcher at Provincial Dispatch then contacts a coroner and provides the coroner with contact information for the person who reported the death. The coroner should then call the contact person to obtain further information about the death. After a discussion with the contact person (and, if the coroner feels it is necessary, discussions with any other individuals that the coroner feels are appropriate), the coroner determines if the case should be accepted and a death investigation conducted. This determination is to be made using the legislative criteria for a death investigation under section 10 of the *Coroners Act* (the "section 10 criteria").

16. After determining whether to conduct a death investigation, the coroner is now required to call Provincial Dispatch back to inform them if the case has been accepted or not. Under the answering service system, the local coroner in my region was not required to call the answering service back to advise of their decision.

17. As RSC, I do not receive notification of what calls are being made to my local coroners from Provincial Dispatch, and I therefore do not provide oversight of the coroner's decision as to whether or not a death meets the section 10 criteria and will be investigated, unless specifically consulted.

18. Prior to 2010, if the local coroner determined that the section 10 criteria were not met, I usually did not learn of the case. The local coroner was not required to provide the London Office (or the OCC) with any paperwork regarding that decision.

19. However, since 2010, the London Office might learn of a declined case through an invoicing process; namely, since 2010, a coroner can seek compensation for the time he or she spends ascertaining whether or not a potentially natural death should be investigated, by submitting the *Case Selection Data Form* (LTCI00071436 – attached as Exhibit B) and the *Case Selection Invoice* (LTCI00071437 – attached as Exhibit C) to the Regional Office. Payment is approved by the RSC. The *Best Practice Guideline #4 re: Investigating Coroners' Acceptance of Natural Deaths for Investigation* (LTCI00071435) is also attached as Exhibit D.[1]

20. I will review the *Case Selection Data Forms* that are received at the London Office. I will contact the submitting coroner if I have any questions or require further information. I will direct a coroner to investigative a death if I believe it should be investigated, based on the information on the *Case Selection Data Form* and those subsequent discussions.

21. Payment to the local coroner on submitting a *Case Selection Invoice* is in the amount of $30 for calls received between 07:00-24:00 hours, and $60 for calls received between 24:00-07:00 hours.

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[1] *Best Practice Guideline #4: Investigating Coroners' Acceptance of Natural Deaths for Investigation* dated September 20, 2010 (LTCI00071435); *Case Selection Data Form* (LTCI00071436); *Case Selection Invoice* (LTCI00071437), each at Exhibit 7,Overview Report – Office of the Chief Coroner/Ontario Forensic Pathology Service ("OCC/OFPS OR), Tab D.

Below is a chart summarizing the number of *Case Selection Data Forms* received by the London Office since 2011:

Year	Case Selection Data Forms Received
2011	453
2012	397
2013	484
2014	537
2015	656
2016	511
2017	539
2018	242

22. If the local coroner determines that the section 10 criteria are met, and starts a death investigation, Provincial Dispatch enters the information into the Coroner's Information System ("CIS"), which is a provincial-wide database accessible by the OCC and Regional Offices. Every morning, Provincial Dispatch provides the Regional Offices with a list of cases that have been generated over the last 24-hour period in the CIS. This list is reviewed by administrative assistants in the London Office, who then open a paper file for each new case. The CIS is accessible to staff at the Regional Office, but not to investigating coroners.

23. Prior to 2012, I (and the London Office as a whole) might not learn of a death investigation being conducted by one of the local coroners until they had completed their investigation and submitted a Form 3. In July 2007, the (then) Southwest Regional Office implemented a Case Notification Form (completion of which enabled local investigating coroners to inform the Regional Office that they had accepted a death as an investigation), but completion of Case Notification Forms was not consistently used. In or about 2012, the centralization of reporting to the Provincial Dispatch rendered the Case Notification Form redundant. A copy of the Memorandum dated July 19, 2007 to all coroners in the Southwest Region re: Case Notification Form (LTCI00071820) is attached as Exhibit E.

24. A search of the records of the OCC showed that a Case Notification Form was completed and submitted to the London Office in respect of the death investigation relating to Wayne Hedges (LTCI00064920 p. 5), a copy of which is attached as Exhibit F.[2] I have no independent recollection of reviewing this form at the time.

The Submission of Form 3s by Investigating Coroners

25. Investigating coroners are required to submit a Form 3 in final version at the completion of a death investigation.

26. Investigating coroners can submit preliminary Form 3s while they are awaiting further information (for example, a post mortem examination report, toxicology testing, etc.), but where the investigation is straightforward, the London Office will generally just receive a final Form 3.

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[2] *Case Notification Form re: new Coroner's Investigation Death* re: Wayne Hedges dated January 30, 2009 (LTCI00064920 p. 5), Exhibit 7, OCC/OFPS OR, Tab B(4).

27. As I understand it, Form 3s are submitted electronically to the OCC by the local coroner as a secure document in the CIS. Administrative staff at the OCC will download the secure document and match it to the case number assigned by Provincial Dispatch. Once completed, a notification is sent to the London Office relaying that the Form 3 has been received, and my administrative assistants will download the Form 3. I will then review and finalize the Form 3, as described in further detail below.

28. The Form 3s use some drop-down options for completion, with pre-set options. For example, the names of the LTC homes drop-down and can be selected, such that it would be possible to search for all deaths in a particular home. On the other hand, causes of death are completed without drop-down options.

29. Local coroners must submit Form 3s within 180 days of the death being reported, or their pay is reduced. Assuming Form 3s are submitted on time, coroners are paid $450 per death investigation (the reduced rate is $225). My understanding is that the $450 fee is based on the assumption that the average investigation takes 3 hours to complete. If an investigation takes significantly longer than that, the coroner can apply to the Regional Office for consideration of an increase based on an hourly rate. This happens very rarely.

30. The London Office does not have a regular system to ensure that a Form 3 is in fact submitted by an investigating coroner. Administrative staff at the London Office do review files that have been open for some time to determine their status and what documents remain outstanding (e.g., the Form 3, post mortem examination report, police report, etc.). However, the London Office relies, in large part, on the local coroner to submit all outstanding documents to the London Office and to close files

in a timely manner. The London Office does not have a "tickler" system, due to resources and my lack of comfort with computer systems.

31. I have not undertaken any data analysis of the information contained in the Form 3s at the London Office to assist with my work or to identify trends. I have never had occasion to ask the OCC or a Deputy Chief Coroner for any such data or analysis.

My Review of Form 3s

32. I review and finalize each Form 3 for every death investigation undertaken in the London Region. This process includes:

a. reviewing the Form 3 and all other information submitted (which may include a post mortem examination report if conducted, police, fire marshal or Ministry of Labour reports if involved, medical records in some cases). Institutional Patient Death Records ("IPDRs") are not submitted with Form 3s, and I therefore do not review them during my review of Form 3s;

b. considering whether the Form 3 conforms with internal standards (this includes editing the Form, as necessary, to correct typos or remove extraneous information), and whether the cause of death on the Form 3 accords with the international classification of death employed by the Office of the Registrar General for Medical Certificates of Death. This is important as the cause of death on the Form 3 will be same as on the Medical Certificate of Death;

c. considering whether the Form 3 "makes sense" in light of the information collected as part of the death investigation. This means both medical sense and common sense,

and I will ask myself whether the cause of death appears correct on a balance of probabilities. I will sometimes call the local coroner if I have any questions as a result of this review; and

d. stamping the hard copy of the Form 3 containing my handwritten edits, and providing it to my assistant, who inputs my edits into the CIS and signs off on it electronically. The file is then closed, or "QA-ed". The date at the bottom left coroner of the Form 3 that states "QA – [date/month/year]" is the date that the file is closed by my office. This information is then stored on the CIS, and can be accessed by the OCC or the Regional Office.

33. The aforementioned review of Form 3s may take place a few months after the death, depending on when the Form 3 is submitted by the investigating coroner and priorities and workload in the London Office.

34. The OCC has created "audit" documents for the content of Form 3s, and a copy of the current version of same is attached as Exhibit G (LTCI00071445).[3] I consider questions of the nature of those on the audit document when I am reviewing and finalizing Form 3s, but the expectation is not (and I do not) complete a formal audit of each Form 3 reviewed

35. I have used the audit document when I have had reason to undertake a review of a particular coroner's work. If in the course of my review of Form 3s, I notice pattern or recurrence of issues that needs correction, I rely on the audit document in my discussion with the investigating coroner about improving their practice.

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[3] *Audit of Coroner's Investigation Statement/Form 3* dated February 25, 2009 (LTCI00071445); Exhibit 7, OCC/OFPS OR, Tab D.

36. I do not perform random audits of Form 3s completed by investigating coroners. While I would like to conduct annual reviews of each of the investigating coroners in my jurisdiction, this is not done due to resource issues.

Institutional Patient Death Records

37. Death investigations in LTC homes are commenced by way of submission of an IPDR. The IPDR used to be faxed to the Regional Office. Beginning in approximately 2004, the IPDR was to be faxed centrally to the OCC. In 2011, IPDRs began to be submitted electronically and would be received through Service Ontario to the OCC.

38. Prior to the electronic submission of IPDRs through Service Ontario in 2011, there would be two occasions by which the London Office would receive a copy of the IPDR:

a. the OCC provided copies of IPDRs to the London Office where one or more of the questions was answered "yes"; and

b. on some occasions, when a LTC home erroneously faxed the IPDR to the London Office rather than the OCC.

39. A copy of a sample IPDR Version 3 (which was published by the OCC on February 16, 2007 - LTCI00071112) is attached as Exhibit H.[4]

40. When paper IPDRs were received at the London Office during my tenure as RSC, they were reviewed by either me or one of my two administrative assistants. If we received the paper IPDR directly from a LTC home, we would first redirect a copy of the IPDR to the OCC, and advise the LTC home that IPDRs should always be sent to the OCC directly.

[4] *Institutional Patient Death Record Version 3* (LTCI00071112), Exhibit 7, OCC/OFPS OR, Tab D.

41. If a paper IPDR had one or more question answered "yes", the London Office would confirm that a local coroner had been assigned to the case and that the death had been entered in CIS as appropriate. Where all questions were answered "no", the London Office would take no further steps unless we were made aware of a subsequent concern raised by a family member or a future investigating coroner (based, for example, on their review of a LTC home's Death Registry).

42. Where, since 2011, IPDRs are submitted electronically, I do not see or review them at any time. My understanding is that there is an electronic "force" feature that ensures the IPDR cannot be submitted electronically by a LTC home where any of the questions are answered "yes" unless the submitting party inputs the name of the local coroner who had been contacted.

43. I have reviewed the London Office's records and confirmed that the London Office presently does not store any IPDRs. To my knowledge, the information from the IPDR is not inputted anywhere for analysis. I do not know how the paper and electronic IPDRs are stored at the OCC.

44. The London Office did not independently corroborate the accuracy of the IPDRs. For instance, the London Office was reliant on the LTC homes identifying and reporting threshold and outbreak deaths (although local coroners would sometimes identify issues from reviewing a LTC home's Death Registry), until September 16, 2013, when threshold and cluster deaths no longer needed to be reported.

45. In both of my roles as an investigating coroner, as well as the RSC, I do not recall issuing instructions or guidelines to LTC homes to assist in their reporting of deaths to the OCC or RSC. The IPDR requires that persons in charge of the homes (or their delegates) are to complete the form. To my knowledge, the person in charge of the LTC home decides for themselves who can complete

an IPDR. In my view, it would be preferable for a treating physician or nurse to complete the IPDR (as opposed to a personal support worker for example), but this is not mandated by the OCC or RSC.

46. In my role as RSC, I have received telephone calls and provided advice to reporters at LTC homes from time to time, about whether a case required answering "yes" to any of the questions on the IPDR. In particular, I have received numerous calls seeking help to answer the question of whether a death was "sudden and unexpected".

47. I also provide advice to coroners, on request, regarding whether to accept a case for a death investigation, and the steps to be taken in the course of the investigation. This is an expectation of all of the RSCs, as part of their supervising role of coroners.

Educational Sessions

48. Part of my role as the RSC is to provide educational sessions on request to various stakeholders about death investigations or other topics relevant to the coroner system in Ontario. One example of the type of education session I have undertaken is to speak to the medical staff at local hospitals about completing medical certificates of death.

49. I cannot recall being asked to do an educational session at a LTC home. I am not aware of whether LTC Homes received training on completing IPDR (beyond the memoranda circulated by the OCC regarding IPDRs in 2004, 2007, 2011 and 2013).[5]

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[5] Each contained at Exhibit 7, OCC/OFPS OR, Tab D: *Memorandum #04-05 re: Revision to the Institutional Patient Death Record Form* dated March 14, 2004 (LTCI00071125); *Memorandum #07-02 re: Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner [via the Institutional Patient Death Record]* dated February 16, 2007 (LTCI00071113); *Memorandum #11-11 re: Change Respecting Notification of Coroner of the Death of a Resident of a Long-term Care Home* dated December 8 2011 (LTCI00069331); *Memorandum to All Ontario Long-term Care Home Licensees re: Changes to the Submission Procedures for the Institutional Patient Death Record Form and the Critical Incident Reporting Form*

Involvement of London Office at the Time of EW's Offences

50. As outlined above, the London Office does not presently store any historical IPDR forms. Accordingly, I cannot confirm if the London Office received any IPDRs at the time of death of any of Ms. Wettlaufer's victims, or if the IPDRs for those individuals were received by the OCC.

51. One of Ms. Wettlaufer's murder victims, James Silcox, was the subject of contemporaneous death investigation by a local investigating coroner in the London Region. One of her attempted murder victims, Wayne Hedges, was also investigated as a threshold death investigation when he later died. The Form 3s for Mr. Silcox (completed by coroner Dr. George - LTCI00065227 p. 1-2)[6] and Mr. Hedges (completed by coroner Dr. Urbantke - LTCI00064920 p. 1)[7] are attached as Exhibits I and J, respectively to this Affidavit.

52. I was not the RSC at the time of Mr. Silcox's death. As such, I did not review the Form 3 completed by the investigating coroner for this death investigation.

53. I was the RSC at the time of Mr. Hedges' death. However, I did not review and finalize the Form 3 completed by Dr. Urbantke. This was done my one of my RSC colleagues, as evidenced on the revised Form 3 (LTCI00064920 p.2-3), attached as Exhibit K. I do not have a specific recollection of why this occurred, but at times colleagues will assist one another with closing cases.

54. If I had been the RSC reviewing this Form 3, as this was the third death at the LTC home in 24 hours, I would have expected the investigating coroner to have looked at the Death Registry to

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(LTCI00069333); *Memorandum #13-04A re: Institutional Patient Death Record* dated September 16, 2013 (LTCI00069325).

[6] Exhibit 7, OCC/OFPS OR, Tab B, Tab 1 – *Coroner's Investigation Statement / Form 3 re: J. Silcox* (LTCI00065227 p. 1-2)

[7] Exhibit 7, OCC/OFPS OR, Tab B, Tab 4 – *Coroner's Investigation Statement / Form 3 re: W. Hedges* (LTCI00064920 p. 1)

verify the cause of death in those cases (e.g., whether the deaths were due to an infectious outbreak, fall, etc.) and to see if further action was necessary (e.g., whether, in the case of an infectious outbreak, public health officials were contacted, identifying the cause of the fall that led to the accidental death, etc.). If I had reviewed this Form 3, I would not have had any further questions or revisions to its contents.

Involvement in Retrospective Death Investigations

55. I learned of Ms. Wettlaufer's offences when I was contacted by police and local coroners (Dr. George and Dr. Urbantke), who advised me of the police investigation.

56. Based on the information the police provided about Ms. Wettlaufer's confession, I concluded that section 10 criteria were met in respect to the deaths and issued *Coroner's Authority to Seize During an Investigation* dated October 27, 2016 to Caressant Care Woodstock (in respect of Mr. Granat, LTCI00069424; Mr. Silcox, LTCI00069425; Ms. Young, LTCI00069427; Ms. Matheson, LTCI00069428; Ms. Zurawinski, LTCI00069429; Ms. Millard, LTCI00069430; and Ms. Pickering LTCI00069431, collectively attached as Exhibit L) and Meadow Park (in respect of Mr. Horvath, LTCI00069426, attached as Exhibit M).

57. I also put preliminary Form 3s on the CIS for each of the murder victims who did not yet have a Form 3, except Maureen Pickering. I would have intended to create preliminary Form 3s for each of the murder victims (noting that James Silcox already had a Form 3 completed contemporaneous to his death), and I cannot recall presently why I did not submit one with respect to Maureen Pickering.[8]

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[8] Each at Exhibit 7, OCC/OFPS OR, Tab B(42) - *Form 3 re: Maurice Granat (status: preliminary) by Dr. Mann* (LTCI00064916 p.9); *Form 3 re: Gladys Millard (status: preliminary) by Dr. Mann* (LTCI00065221 p. 8); *Form 3 re: Helen Young (status: preliminary) by Dr. Mann* (LTCI00065237 p. 8); *Form 3 re: Mary Zurawinski (status: preliminary) by Dr. Mann* (LTCI00065248 p. 8); at Tab B (43) - *Form 3 re: Arpad Horvath (status: preliminary) by Dr. Mann* (LTCI00065183 p. 8); Form 3 re: Helen Matheson (status: preliminary) by Dr. Mann (LTCI00065203 p.8).

58. I subsequently spoke to Dr. Huyer, who decided to centralize the coroner's involvement. The retrospective death investigations were then centrally handled by Dr. Huyer and Dr. Pollanen. I assisted when asked to do so, including, at Dr. Huyer's direction:

a. cancelling the previously issued *Coroner's Authority to Seize During an Investigation*, as reflected in my letters to Helen Crombez at Caressant Care dated November 15, 2016 (LTCI00064917) and to Nicole Ross at Meadow Park dated December 28, 2016 (LTCI00065183);[9] and

b. issuing the warrants and other documentation for the post mortem examinations of Mr. Horvath and Ms. Matheson including the *Warrants for Post Mortem Examination* (LTCI00065183 p. 22-25 and LTCI00065249 p. 17-20) and *Warrants to Take Possession of the Body of a Deceased Person* (LTCI00065187 and LTCI00065212 p. 1).[10]

59. Dr. Huyer completed the Final Form 3s in respect of the eight murder victims for whom he had completed retrospective death investigations. I reviewed and signed off on those Form 3s, because I was the RSC in the region in which the deaths occurred.

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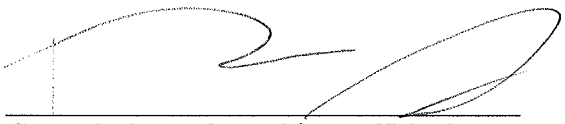
[9] Each at Exhibit 7, OCC/OFPS OR, Tab B, Tab 12 – *Letter from Dr Mann to Helen Crombez at Caressant Care dated November 15, 2016* (LTCI00064917); *Letter from Dr. Mann to Nicole Ross at Meadow Park dated December 28, 2016* (LTCI00065183).

[10] Each at Exhibit 7, OCC/OFPS OR, Tab B, Tab 28 – *Warrant for Post Mortem Examination re: A. Horvath (LTCI00065183 p. 22-25); Warrant for Post Mortem Examination re: H. Matheson (LTCI00065249 p. 17-20); Warrant to Take Possession of the Body of a Deceased Person re: A. Horvath* (LTCI00065187); *Warrant to Take Possession of the Body of a Deceased Person re: H. Matheson* (LTCI00065212 p. 1).

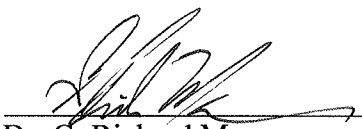
60. In order to finalize the Form 3s, I reviewed the post mortem examination reports and Agreed Statement of Facts from the criminal proceedings. I did not undertake any independent investigation beyond these steps in order to finalize the Form 3s. I signed off on the Form 3s completed by Dr. Huyer without significant edits.

SWORN BEFORE ME at the City of London, in the Province of Ontario, on July 5, 2018)



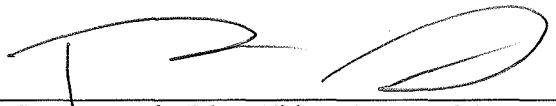
Commissioner for Taking Affidavits

REBECCA JONES



Dr. G. Richard Mann

This is Exhibit "A" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

CURRICULUM VITAE GEORGE RICHARD (RICK) MANN

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PROFESSIONAL EDUCATION & TRAINING

2010	Physician Management Institute Foundation Level – Self Awareness, Toronto
2009	Physician Management Institute Foundation Level III Management Dynamics, Toronto
2008	Physician Management Institute Level III Negotiation and Conflict Management Niagara-on-the-Lake
2007	Physician Management Institute Level I & II, Toronto, ON
1984	Certificate, College of Family Physicians of Canada
1981-1984	Family Practice Residency: Queen's University, Kingston, with 8 months Anaesthesia, 4 months Obstetrics, 2 months Neonatology
1982	General License-College of Physicians and Surgeons of Ontario
1981	M.D. Faculty of Medicine, Queen's University, Kingston, Ontario

EXPERIENCE

2008 – Present	Regional Supervising Coroner, West Region.
2003 – 2008	Partner, Kincardine Physician Group Family Medicine Practice.
1985 - 2003	Partner, Kinhuron Medical Centre Family Medicine Practice.
1984 - 2008	Active Medical Staff – Kincardine & District General Hospital/ South Bruce Grey Health Centre, Kincardine Inpatient Care • Anaesthesia • Obstetrics • Emergency Room

SCHOLARSHIPS & AWARDS

2010	Fellowship of Rural and Remote Medicine SRPC
1994	Fellowship, College of Family Physicians of Canada
1981	Aesculapian Award for Valuable Service within Queen's University
1979	Faculty of Medicine Athletic Letter
1975-1977	Tricolour Scholarship, Queen's University
1975	St. Andrew's College, Aurora, ON: Ontario Scholar, Governor General's Medal for Proficiency, Lieutenant Governor's Medal, Athletic Letter

CONFERENCE PRESENTATIONS

Mann, G.R., McAuliffe, N. & Wood, T. (2008 October) *Approach to the Decomposed Body* A presentation at the Annual Education Course for Coroners and Pathologists, Toronto, *Ontario*

Mann, G.R. (2001, June) *Disaster Preparedness – The Walkerton Ontario Experience.* A presentation at the International Association of Coroners and Medical Examiners Annual Meeting, Toronto, Ontario, Canada.

Mann, G.R. (2002, September) *The Walkerton Ontario Tragedy: A Coroner's Perspective. A presentation at* the Ontario Coroners' Association Educational Meeting, Autun, France.

Mann, G.R. (2004, September) *A Tight Squeeze: Death by Entrapment.* A paper presented to the Ontario Coroners' Association, Madrid, Spain.

Mann, G.R. (2007, October) *Eight Deadly Scenarios.* A presentation at the Annual Education Course for Coroners and Pathologists, Toronto, Ontario

Mann, G.R. & Dixon, Wm. (2007, October) *Post Mortem Corneal Retrieval.* A presentation at the Annual Education Course for Coroners and Pathologists, Toronto, Ontario

PROFESSIONAL ACTIVITIES

2010 - Present	Chair, Maternal & Perinatal Death Review Committee, Office of the Chief Coroner
2007	Medical Ministry International Medical/Surgical Mission, Peru
2006 - 2008	Adjunct Professor, Department of Family Medicine, Schulich School of Medicine & Dentistry, University of Western Ontario.
2006	Medical Ministry International Medical/Surgical Mission, Bolivia
2004	Medical Ministry, International Medical/Surgical Mission, Ecuador
2004 - 2008	President Medical Staff, South Bruce Grey Health Centre
1999 - 2017	Inquest Coroner, Province of Ontario
1985 - 2008	Coroner, Bruce County, Province of Ontario
1999 - 2000	Ontario Representative, Anaesthesia Committee, Society of Rural Physicians of Canada
1999 - 2004	Vice President Medical Staff, South Bruce Grey Health Centre
1997- 1999	Society of Rural Physicians of Canada – Ontario Regional Committee
1996 - 2008	Clinical Lecturer, Department of Family and Community Medicine, University of Toronto
1995 - 2004	Member of CME Governance Committee, Rural & Isolated Physicians, Ontario Medical Association.

PROFESSIONAL ACTIVITIES (Continued)

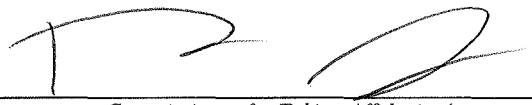
1995 - 1997	Member of Executive Rural Section, Ontario Medical Association
1991 - 1996	Executive, Ontario College of Family Physicians Chair of the Board, 1991-92; President Elect, 1992-93; President, 1993-94; Past President, 1994-95 Past Past President & Chair of Finance, 1995-96
1989 - 1992	Chief of Staff, Kincardine & District General Hospital

1987- 1991	Member of the Board of Representatives, Ontario Chapter, College of Family Physicians of Canada
1981- 1984	Resident's Advisory Committee in Family Medicine, Queen's University, Chair 1982-84; Liaison between Residents & Faculty
1982 - 1984	Kingston Housestaff Association, PAIRO Representative, PAIRO Director 1983-84
1979 - 1980	Secretary, Student Section Ontario Medical Association; Editor, Student Section Bulletin; Vice President, External Affairs, Aesculapian Society, Queen's University

CURRENT MEMBERSHIPS

2010	American Academy of Forensic Sciences (AAFS)
1995	Society of Rural Physicians of Canada (SRPC)
1986	Coroner's Association of Ontario (OCA)
1981	College of Family Physicians of Canada (CFPC), C.M.P.A.
1977	C.M.A., O.M.A

This is Exhibit "B" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Case Selection Data Form

Please complete all fields

(Please print legibly)

Coroner: _____

Date call received: _____ *(YYYY/MM/DD)* Time call received: _____ *(YYYY/MM/DD)*

Caller's Name/Position: _____

Caller's Contact #: _____

Decedent's Name: **Surname:** _____

First: _____

DOB: _____ *(YYYY/MM/DD)* DOD: _____ *(YYYY/MM/DD)*

Place of Death (address): _____

Brief Circumstances of Death/Action Plan:

_____

_____

_____

1. Was the death all natural? *i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event*	Y ☐	N ☐
2. Was the death reasonably foreseeable and does the cause flow logically from a natural disease process?	Y ☐	N ☐
3. Is there a designated health care practitioner to complete the Medical Certificate of Death?	Y ☐	N ☐
4. Is the case free of significant care related concerns from either family or care providers?	Y ☐	N ☐
5. Are OCC policy and/or Section 10 (2)(3) statutory obligations excluded? Includes: • Child with CAS involvement (direct service in the past 12 months); • Threshold case for a long term care facility; • Decomposed body; • Need for positive identification; Deaths in: a) Charitable institutions b) Children's residence under the *Child & Family Services Act* c) A supported group living residence under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act* d) A psychiatric facility under the *Mental Health Act* e) An institution under the *Mental Hospitals Act* A public or private hospital from which the decedent was transferred in "a" to "e" above.	Y ☐	N ☐

Accepted for a Death Investigation? (Criteria – answer "No" to any of questions #1-5, and/or careful consideration of Section 10 criteria)

Declined for Investigation? If yes, inclusion criteria for reporting and payment met?
Electronically submit **Data Form & Invoice** to the Regional Supervising Coroner's Office via Enterprise Attachment Transfer Service (EATS) or via Fax if EATS is unavailable for payment (See next page for invoice form)

Issued: 2010-09-20

This is Exhibit "C" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018

Commissioner for Taking Affidavits (or as may be)

Ontario

Case Selection INVOICE
Office of the Chief Coroner

Fee relating to the death of:	

Please pay: Coroner	
Coroner's address including postal code:	
Invoice Number (Mandatory):	
Invoice Date:	
Amount: Enter $30.00 (calls between 07:00-24:00 hours) or $60.00 (calls between 24:00-07:00 hours)	$30.00

****Note: Case Selection Data Form must accompany the invoice**

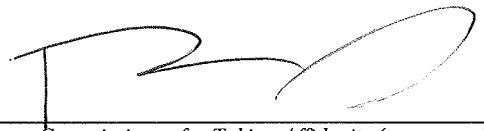
Coroner's Signature_____

For Office Use Only

Approved by: _____Regional Supervising Coroner

Issued: 2010-09-20

This is Exhibit "D" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Best Practice Guideline #4:

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Introduction

Many deaths reported to the Coroner do not meet the criteria for investigation as outlined in Section 10 of the *Coroners Act*. Natural deaths are often subject to an individual Coroner's interpretation as to whether or not the death will be accepted for investigation. Guidance can be provided by the *Coroners Act*, but even within the *Act*, interpretation varies from Coroner to Coroner. During an audit of Coroners' investigations that began in 2007 utilizing an audit tool, it was appreciated that there is diverse interpretation of the *Act*, and clear demonstrations that some Coroners accept many natural death investigations, and others, relatively few.

Background

Study of Natural Deaths:

In a study of Coroner's investigations, an early case selection project demonstrated that approximately 35% of calls received reporting a natural death were not accepted for investigation by Coroners. The data encouraged the development of an evidence-based formal project charter. The initial phase of this project charter involved the development of an audit tool. Three senior Coroners reviewed 25 randomly selected natural cases from each of the nine regions utilizing the audit tool. This review revealed that 24% of investigations of natural deaths conducted by Investigating Coroners appeared not to have required investigation. This 24% did not include cases where:

- there was no primary care practitioner;
- the primary care practitioner could not be located;
- or the primary care practitioner refused to attend;

as these were considered appropriate death investigations for the purposes of the study.

In addition to finding that 24% of the investigations of natural deaths in the province likely did not require investigation, the review revealed there were regional differences (ranging with a low of 8% and a high of 36%). Direct investigative experience and case reviews conducted anecdotally by Regional Supervising Coroners support these findings.

In the second part of the evidence-based review, approximately 100 reports of natural deaths were examined for two groups of Investigating Coroners. The Investigating Coroners were asked to utilize the Decision Tool (included below) which had been developed and refined in the initial phase of the study.

DECISION TOOL

1.	Was the death all natural? *i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event*	Y	N
2.	Was the death reasonably foreseeable and does the cause flow logically from a natural disease process?	Y	N
3.	Is there a designated health care practitioner to complete the Medical Certificate of Death?	Y	N
4.	Is the case free of significant care related concerns from either family or care providers?	Y	N
5.	Are OCC policy and/or Section 10 (2)(3) statutory obligations excluded?	Y	N

Includes:

- Child with CAS involvement (direct service in the past 12 months);
- Threshold case for a long term care facility;
- Decomposed body;
- Need for positive identification;

Deaths in:

a) Charitable institutions
b) Children's residence under the *Child & Family Services Act*
c) A supported group living residence under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*
d) A psychiatric facility under the *Mental Health Act*
e) An institution under the *Mental Hospitals Act*

A public or private hospital from which the decedent was transferred in "a" to "e" above.

If the answer to any of #1-5 above is "no", the death should be accepted for investigation.

Study Outcome:

One group of Investigating Coroners had a formal call schedule, and the other provided service on an *ad hoc* manner. In this study, Investigating Coroners documented data and were remunerated for all calls received reporting a natural death. The ***formal call group*** declined 46% of the calls received reporting a natural death and the ***ad hoc group*** declined 69% of the calls. Of importance, there have not been any complaints or concerns raised by any parties including health care professionals, the public or families of deceased individuals with respect to the decision by Coroners to decline a natural death for investigation, utilizing the Decision Tool.

Discussion with callers reporting a natural death to determine the need for investigation involves a time commitment by the Coroner. While many Coroners appropriately refuse to accept a natural death for investigation, this process has traditionally been undertaken without remuneration. The Office of the Chief Coroner (OCC) recognizes this time commitment and the responsibility assumed, and has been working with the Executive of the Ontario Coroners Association in an attempt to remedy this situation.

Purpose

1. To provide guidance and direction to Investigating Coroners with respect to accepting a natural death for investigation.

2. To ensure compliance with the *Coroners Act*.

3. To create uniformity with respect to death investigation undertaken by Investigating Coroners throughout the province, irrespective of whether or not a formal call schedule exists.

4. To provide an additional level of oversight through review of the Investigating Coroner's decisions with respect to accepting or declining a natural death for investigation.

Legislative Authority

Section 10 of the *Coroners Act* clearly delineates the circumstances that result in a Coroner being contacted. The threshold for contact arises from the initial line in Section 10(1):

> *"Every person who has reason to believe that a deceased person died,..."*

The decision to investigate under Section 10(1) is, however, discretionary.

Section 10 (2) (a-h) (3) (4.3) (4.5)

> *"...the coroner shall investigate the circumstances of the death..."*

and Section 10 (4) (4.1) (4.2) (4.4) (4.6-4.8) (5)
"*...the coroner shall issue a warrant to hold an inquest upon the body*"

indicate **mandatory investigations** for the Coroner.

Section 15(1) provides the authority and direction for a Coroner to initiate an investigation.

> "*Where a coroner is informed that there is in his or her jurisdiction the body of a person and* ***that there is reason to believe*** *that the person died in* ***any of the circumstances mentioned in Section 10****, the coroner shall issue a warrant to take possession of the body...*"

It is most important to understand that the requisite belief is that of a duly trained physician Coroner exercising his/her judgment with respect to Section 10.

Decision to Accept a Natural Death for Investigation

If the information provided leads the Coroner to believe that the requisite Section 10 criteria have been met, then the Coroner must issue a *Warrant to Take Possession of a Body*.

Common scenarios where a natural death may not necessarily be accepted for investigation would fall under:

Section 10(1)(d) "*suddenly and unexpectedly*"; or

10(1)(g) "*under such circumstances as may require investigation*".

The context of the death has historically resulted in varying interpretations of these sections. For example, in a Long Term Care setting, even though a person has coronary artery disease and other potentially fatal illnesses, if they appeared their normal self the day prior to being discovered deceased in bed the following morning, Long Term Care staff often regard this as "sudden and unexpected". Clearly from the Coroner's perspective, this death would be sudden but not unexpected (given the medical history available) and therefore would not necessarily meet Section 10 criteria and may not require investigation. Further brief inquiries would reassure the Coroner that it was not a threshold[1] case, that there were no concerns about medical care, and that the death was in all probability due to natural causes.

[1] Threshold case is defined in OCC Memorandum #07-02 as "every 10th death whether or not a local coroner investigated any of the previous nine deaths".

Equally, persons dying during or following hospitalization and whose death could be reasonably anticipated based on the elicited medical history do not necessarily require a death investigation if their death was not due to an adverse and/or sentinel event. This includes patients who present to a hospital emergency room for resuscitation following a witnessed collapse in the community, and whose collapse and death was certainly sudden, but not unexpected.

Investigating Coroners are encouraged to seek guidance for these natural deaths utilizing the criteria outlined within the Case Selection Data Form which follows.

Natural Death Case Selection Criteria

Following completion of the evidence-based study described earlier, the OCC has developed a new approach to assist Investigating Coroners with the vital decisions they must consider when determining whether or not to accept a natural death for investigation. In general, a natural death occurring in a health care setting, with multiple witnesses and often with ample clinical documentation should not be accepted for investigation. Exceptions to this include: deaths where there are allegations of negligence or malpractice directed at health care providers; or those issues delineated in the five questions set out in the Decision Tool.

Effective October 4, 2010, the OCC will compensate Investigating Coroners for the time to ascertain whether or not a natural death should be investigated (see fee structure below). The fees are felt to be commensurate with existing fees paid for a similar time commitment in a general medical practice. Investigating Coroners are required to complete and forward the *Case Selection Data Form* and *the Case Selection Invoice* electronically to the Regional Supervising Coroner's Office via Enterprise Attachment Transfer Service (EATS) or via Fax if EATS is unavailable **within one business day** of receiving the call to be eligible for payment.

Inclusion Criteria for Reporting and Payment

1. All ***natural deaths*** reported to a Coroner potentially for investigation, for which an investigation is not required.

A minimum/maximum time commitment will not be used to guide payment but it is anticipated that reasonable judgment will be used in determining when billing would be appropriate. For example, a hospital nurse calling and inquiring whether a natural expected death, without any care related concerns, was a coroner's case because the person was admitted less than 24 hours would likely take a short period of time and have little responsibility attached. Submission of an invoice should not be contemplated when dealing with such an inquiry. If, however, there has been considerable time spent attempting to gather sufficient information, or make additional phone calls prior to determining that an investigation is not required, then submitting a bill would be appropriate.

2. Timing and fees:
    a. $30 fee for calls received between 07:00-24:00 hours
    b. $60 fee for calls received between 24:00-07:00 hours

3. The Coroner will be required to submit a completed *Case Selection Data Form* and *the Case Selection* Invoice **within one business day** of receiving the call. Invoices submitted for payment after one business day will not be paid.

Exclusion Criteria for Reporting and Payment

1. All non-natural deaths-accidents, homicides, suicides and undetermined.

2. Natural deaths which a Coroner accepts for investigation.

3. If, after initially declining a natural death for investigation, circumstances require that the Coroner opens a death investigation, billing will not be accepted and payment will occur utilizing the usual investigative fees.

Procedure

1. Two forms have been developed for use:

    a. A Case Selection Data Form, and
    b. A Case Selection Invoice.

    The *Case Selection Data Form* will facilitate collection of data to ensure the case and decisions can be reviewed. The *Case Selection Invoice* should be completed and forwarded with the *Case Selection Data Form* when a natural death is deemed unnecessary for investigation. This is a separate document that allows efficient payment and reconciliation by government financial services.

2. Both forms **must be completed and submitted within one business day** of receiving the call to the Regional Supervising Coroner's Office, electronically via EATS or via Fax if EATS is unavailable, for payment to be considered.

3. The *Decision Tool* is included within the *Case Selection Data Form* to assist with case selection.

4. Use of the *Decision Tool* will guide and assist the Coroner through the decision process necessary to determine if a natural death requires an investigation. It is designed such that if **"NO" is the answer to any of the questions, an investigation is indicated.**

5. The information required on the *Case Selection Data Form* is straightforward with explanations for some of the sections provided below;

a. Caller Data - *to allow future contact as necessary*

- Enter the time the call **was received**, to allow the Regional Supervising Coroner to determine the appropriate fee for payment.
- Position (i.e. police officer, health care practitioner, family member)
- Contact Number, including area code and extension

b. Brief Circumstances of the Death/Action Plan

- State the reason the caller believed a Coroner should be contacted. (i.e. sudden and unexpected; outbreak in a long term care facility, palliative at-home death).
- A brief synopsis of the circumstances including enough detail to allow a clear understanding/reasoning why the case was not accepted.
- Note the plan that was developed for the caller (e.g. Emergency MD to complete Medical Certificate of Death). Coroners should include the backup plan to use when the initial plan is not successful. For example: if there is a natural expected death in a home with police involvement, the Coroner may suggest contacting the family practitioner; however, if the police cannot reach the family practitioner within an allotted period of time, the police may be required to contact the Coroner.

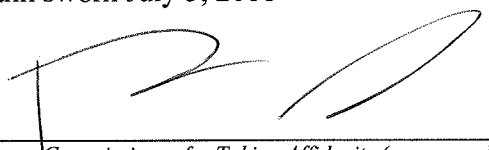
Concluding Remarks

Following careful review and consideration, the OCC is committed to moving in a new direction with respect to natural death investigations. This direction reflects an evidence-based approach.

It is anticipated that many benefits will arise from this new approach. Firstly, Coroners will receive guidance about what criteria should be considered when deciding whether or not to accept a natural death for investigation. Secondly, uniformity in approach across the province will be achieved. Thirdly, an added level of oversight will be achievable by careful review by the Regional Supervising Coroners of reported natural deaths declined for investigation. Fourth, Coroners will be compensated to receive calls about natural deaths which are declined for investigation, providing the appropriate documentation is completed and submitted in the allotted time period. Lastly, these calls provide Coroners the opportunity to educate callers about the types of natural deaths that require investigation.

Please do not hesitate to contact your Regional Supervising Coroner with any questions or concerns. Case-by-case clarification with your Regional Supervising Coroner is encouraged.

This is Exhibit "E" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Regional Supervising Coroner
Southwest Region
235 North Centre Road, Suite 303
London, On N5X 4E7
telephone 519-661-6624
facsimile 519-661-6617

Ministry of Community Safety and Correctional Services

Coroner Superviseur Régional
Région du Sud-Ouest
235 rue North Centre, #303
London, ON N5X 4E7
téléphone 519-661-6624
télécopieur 519-661-6617

Ministre de la Sécurité communautaire et des Services correctionnels

19 July 2007

MEMORANDUM

TO: All Investigating Coroners - Southwest Region

FROM: Dr Jack Stanborough, Regional Supervising Coroner - SW

Re: Case Notification Form

Please find attached a 'Case Notification Form' that I am providing by hard copy and will provide via e-mail to those of you who correspond by e-mail. The intent is to ask that you submit this form within a day of notification about a death, whether the death is accepted for investigation or not. This form can be sent in electronically or by fax. The purpose of this notification is twofold:

1. One of the issues we are dealing with is fair compensation for being 'on call' and a recognition that you're dealing with phone calls and notification about cases that don't need investigation as per Section 10 of the Coroners Act. In order to put the 'compensation case' forward I need to get a handle on how many calls you're getting and what percentage you're turning down as non-coroner's cases.

2. Most of the Southwest Region is not covered by a formal answering service, so we at the Regional Office may not be aware of a death for literally months after it has been investigated. This puts us in a rather awkward situation when lawyers, police, next of kin etcetera call regarding the death. The information you provide will also allow us to follow up with police, pathology, toxicology, etc. as required for outstanding reports.

Thank-you for your assistance with this form and if I don't already have it, please let me know your e-mail address. My anticipation is that the notification will be easier electronically.

Regards,

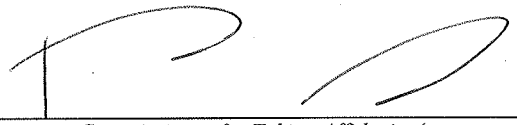
JStanborough MD

Case Notification Form

Within 24 hours of a new Coroner's Investigation Death: Email this form to Southwest Region Josie.Lynch@ontario.ca and Lynne.Little@ontario.ca
or via Fax: Southwest Region – 519-661-6617

Deceased Name:	
Date / time notified:	
Case Accepted:	Yes / No
Sex	
Date of Birth	
Date of Death	
Home Address	
Municipality	
Postal Code	
Location of Death	
Post Mortem Ordered	
Pathologist/Pathology Dept.	
Police Service	
Investigating Officer	
Police Occurrence #	
Preliminary Cause of Death	
Coroner:	
Any other pertinent information	

This is Exhibit "F" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

2009-836

Case Notification Form

Within 24 hours of a new Coroner's Investigation Death: Email this form to West Region – St. Catharines Office Jessica.Enns@ontario.ca and Lynne.Little@ontario.ca
or via Fax: West Region – London Office – 519-661-6617

Deceased Name:	Hedges, Wayne
Sex	M
Date of Birth	23 Apr 1951
Date of Death	24 Jan 2009
Home Address	Caressant Care Nursing Home
Municipality	Woodstock
Postal Code	N4S
Location of Death	Above
Post Mortem Ordered	no
Pathologist/Pathology Dept.	
Police Service	
Investigating Officer	
Police Occurrence #	
Preliminary Cause of Death	CVA
Coroner:	Urbantke
Any other information	10th death, 3rd death in 24hours

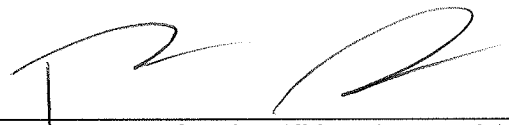
[redacted]
MD, CCFP, FCFP
Regional Supervising Coroner

JAN 30 2009

West Region - London Office

LTCI00064920-5

This is Exhibit "G" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Audit of Coroner's Investigation Statement/Form3

PURPOSE

To comprehensively review the Coroners Investigation Statement/Form3 (CIS) and provide feedback to the Investigating Coroner to allow for self-reflection and correction.

PROCEDURE

Score questions 1 - 35 on basis of 1 point for Y or N/A (total of 35 points)
Score questions 36 – 38 on basis of 5 points for Y (total of 15 points)
Convert score out of 50 to percentage.

Coroner's Name: _____ **OCC CIS Case #20**___--_____

Coroner's File # 20___- _____ **Decedent:** _____

Demographic Characteristics

1.	First and last names are spelled correctly	Y N	N/A
2.	Date of birth is included	Y N	N/A
3.	Residence address, including town/city is correct	Y N	N/A
4.	Postal code is included	Y N	N/A
5.	Date of death is correct	Y N	
6.	By What Means is correct	Y N	
7.	All environments are identified and listed appropriately	Y N	
8.	Correct Death Factor is used	Y N	
9.	Identifies and lists appropriate Involvements	Y N	N/A
10.	Identifies reports expected from other agencies	Y N	N/A
11.	Identifies pathologist and/or location of autopsy	Y N	N/A

Medical Cause of Death

12. Cause of death is appropriate and flows logically from investigation	Y	N	

Narrative Elements

13. States clear justification for acceptance of investigation	Y	N	
14. Describes relevant history of circumstances leading to death	Y	N	
15. Describes relevant past medical history	Y	N	N/A
16. Includes current medications only if relevant to cause of death	Y	N	N/A
17. Documents attendance at scene(s)	Y	N	N/A
18. Provides description of scene including location of body	Y	N	N/A
19. Documents examination of body and findings	Y	N	N/A
20. States reason why autopsy was/was not completed	Y	N	N/A
21. Includes preliminary autopsy findings (if conducted)	Y	N	N/A
22. Notes additional tests or examinations required/completed	Y	N	N/A
23. Documents communication with next-of-kin, or attempts	Y	N	N/A
24. Includes next-of-kin and/or Coroner's concerns/issues and resolution	Y	N	N/A
25. Documents organ retention and plans for future disposition	Y	N	N/A
26. Summarizes relevant facts of investigation and conclusions	Y	N	

Format and General Issues

27. No grammatical or spelling errors. No abbreviations, short forms	Y	N	
28. Well written, readable / understandable for non-medical requester	Y	N	
29. Factual in content, avoiding conjecture, supposition, opinion	Y	N	
30. Explains manner of death when indicated (suicide, undetermined)	Y	N	N/A
31. No personal/private information of individuals other than decedent	Y	N	

Exclusions

32. No finding of legal responsibility/no conclusion of law	Y	N
33. Avoids prejudicial remarks	Y	N
34. Avoids value judgments of decedent, witnesses, caregivers	Y	N
35. No comments on race, religion, place of origin, sexual orientation unless relevant to circumstances of the death	Y	N

Justification for Investigation / Overall Impression

36. Case was appropriately accepted pursuant to *Coroners Act*	Y	N	
37. Investigation and report consistent with *Guidelines for Death Investigation* including issued timelines	Y	N	
38. Appropriate notification of Regional Supervising Coroner (i.e. SIU, Criminally Suspicious Death, DU5, Potential Inquest, High Profile Case)	Y	N	N/A

SCORE _____/50 = _____% **(Benchmark is 90%)**

COMMENTS:

This is Exhibit "H" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018

Commissioner for Taking Affidavits (or as may be)

Ministry of Community Safety And Correctional Services

Office of the Chief Coroner

INSTITUTIONAL PATIENT DEATH RECORD
Version 3

The *Coroners Act* requires that **EVERY** death of a resident of a registered Nursing Home, Home for the Aged or Charitable Institution must be reported to the Office of the Chief Coroner. Persons in charge of such institutions (or their delegates) are required to report **EACH** resident's death to the Office of the Chief Coroner by completing and submitting this Record. When persons who normally reside in these institutions die within 30 days of transfer to hospital, the Hospital Administrator (or his/her delegate) must report **EACH** death by completing and submitting this Record to the Office of the Chief Coroner. The Hospital Administrator (or his/her delegate) must contact the institution where the individual was transferred from to obtain answers to questions 7 through 10.

In addition to submitting this Record, if the answer to **ANY** of the 10 questions listed below is **YES,** the death must **ALSO** be reported **DIRECTLY AND IMMEDIATELY to a local coroner**:

Name of deceased (print below) ☐ Male ☐ Female Age: Date and time of death (print below)

Name & Address of institution (print below) Type of institution *(choose one)*
☐ **Nursing Home** ☐ **Home for the Aged** ☐ **Charitable Institution**

Name & Address of Hospital *(if death occurred in a hospital)(print below)*

The questions below are intended to help determine if a local coroner should be contacted. If the answer to any of the questions is **YES**, a local coroner **MUST** be contacted **DIRECTLY AND IMMEDIATELY**. If a local coroner is called, the coroner's name must be entered at the bottom of this record.

1) Accidental Death? YES ☐ NO ☐
(An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner).

2) Suicide? YES ☐ NO ☐
(Death due to an external factor initiated by the deceased.)

3) Homicide? YES ☐ NO ☐
(Death due to an external factor initiated by someone other than the deceased.)

***If there is a possibility of suicide or homicide, telephone both the police and the coroner, and seal the room until they arrive.**

4) Undetermined? YES ☐ NO ☐
(The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)

5) Is the death both sudden and unexpected? YES ☐ NO ☐
(i.e. The death was not reasonably foreseeable.)

6) Has the family or any of the care providers raised concerns about the care provided to the deceased? YES ☐ NO ☐

7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution? YES ☐ NO ☐

8) Has there been a recent increase in the number of transfers to hospital? YES ☐ NO ☐

9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak? YES ☐ NO ☐

10) Is this a threshold case (threshold is every 10th death (for most institutions) whether or not a local coroner investigated any of the previous nine deaths)? YES ☐ NO ☐

PRINT BELOW Name and Title of Person completing this form | Signature | Telephone Number

Date Completed

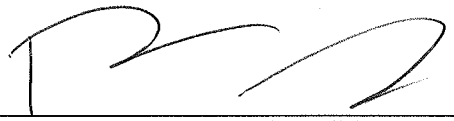
PRINT BELOW Name & telephone number of local coroner if a local coroner was called

Within 48 hours of the death, submit record by mail to:
Office of the Chief Coroner
26 Grenville Street, 2nd floor
Toronto, Ontario M7A 2G9

OR

Fax to:
Office of the Chief Coroner
416- 314-0888

This is Exhibit "I" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Statement #:	Coroner:	CIS Case #:
2007-043-A	48909 - DR George, William	2007-11982

Personal Details of Deceased

Name: Silcox, James **Gender:** Male **Date of Birth :** 17/Feb/1923 **Age:** 84 yrs
Address: 81 Fyfe AVE
City: WOODSTOCK **Province:** ON **Postal Code:** N4S 8Y2

Investigation Details

Status: Final **Inquest Required:** No **Death Pronounced:** 12/Aug/2007
By what means: Accident **Death Presumed:**

Environments

Environment(1)

Date: 12/Aug/2007
Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Fall / Jump - Same Level
Address: 81 Fyfe AVE
City: WOODSTOCK

Environment(2)

Date: 04/Aug/2007
Municipality: WOODSTOCK
Institution: Woodstock General Hospital
Environment: Hospital - Operation / Recovery Room / PACU
Death Factor: Fall / Jump - Same Level
Address: 310 Juliana DR
City: WOODSTOCK

Environment(3) PRIMARY

Date: 31/Jul/2007
Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Fall / Jump - Same Level
Address: 81 Fyfe AVE
City: WOODSTOCK

Involvements

823 LTC Facility - Not Threshold

Reports Expected

Police: N
Laboratory: N
Fire Marshal: N
Min. of Labour: N
Other: N

Pathologist **Hospital**

Medical cause of death: Complications of Fractured Right Hip
Due to / as a consequence of:

Contributing Factors: Alzheimer's, Diabetes, Cerebrovascular Disease

Narrative

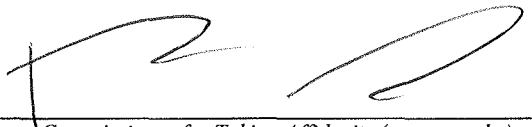
I was notified of the case at 05:15 hours. I was on scene at 06:45 hours. The decedent was lying supine in bed. There were no marks of external violence. He was last seen alive at 02:00 hours by the nursing staff on rounds. He was found unresponsive with vital signs absent at 03:55 hours. Lividity - blanching. Rigor - absent. His death was discussed with his family; they had no concerns. This 84 year old male nursing home resident had a fall on 31 July 2007 and sustained a right hip fracture. He was transferred to Woodstock General Hospital where he underwent surgery on 04 August 2007; a Moore prosthesis was inserted. The surgery was uneventful. He was transferred back to the nursing home on 10 August 2007. Past medical history: Alzheimer's dementia, Diabetes - insulin dependent, hypertension, cerebrovascular disease - previous history of cerebrovascular accident, hypothyroidism, diverticulosis, reflux, dyslipidemia. Medications: Insulin 30/70, Metformin 500 mg bid, Synthroid 0.15 mg od, Exelon 3 mg bid, Plavix 75 mg od, Lipitor 20 mg od, Pantoloc 40 mg od, Trazodone 25 mg od, Tylenol prn, Colace 100 mg bid. His death was as a result of complications following a fall in which he

Statement #:	Coroner:	CIS Case #:
2007-043-A	48909 - DR George, William	2007-11982

sustained a right hip fracture.

Coroner's Signature: _____ **Date:** _____

This is Exhibit "J" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Ontario Office of the Chief Coroner

Coroner's Investigation Statement
(Form 3)

Statement #:	Coroner:	CIS Case #:
2009-2004-A	48912 - DR Urbantke, Elizabeth	2009-836

Personal Details of Deceased

Name: Hedges, Wayne **Gender:** Male **Date of Birth :** 23/Apr/1951 **Age:** 57 yrs
Address: 81 Fyfe AVE
City: WOODSTOCK **Province:** ON **Postal Code:** N4S 8Y2

Investigation Details

Status: Final **Inquest Required:** No **Death Pronounced:** 24/Jan/2009
By what means: Natural **Death Presumed:**

Environments

Environment(1) PRIMARY

Date: 24/Jan/2009
Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Natural Disease - CNS/Neurologic
Address: 81 Fyfe AVE
City: WOODSTOCK

Involvements

822 LTC Facility- Threshold

Reports Expected

Police: N Min. of Labour: N
Laboratory: N Other: N
Fire Marshal: N

Pathologist **Hospital**

Medical cause of death: Cerebrovascular Accident
Due to / as a consequence of:

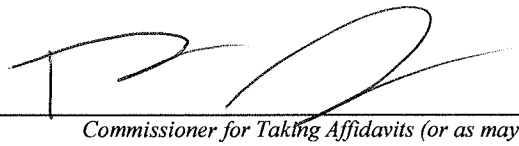
Contributing Factors: Diabetes

Narrative

The Caressant Care Nursing Home, Woodstock reported that a 57 year old man had died and his was the threshold death for the nursing home, the case was accepted as such.
The deceased was a 57 year old man who had been admitted to the Caressant Care Nursing Home on 22 Jan 2000. He had a medical history of cerebrovascular accident, Hashimoto's Thyrioditis, right femur fracture, diabetes, left hip fracture, schizophrenia, seizure disorder, gastritis and being mentally challenged. His medications included calcium, Atenolol, Dilantin, iron, Pantoloc, Trazadone, Insulin, Resperidol, Phenobarbital, Domperidone, Maxeran, Tiazac XC, Lescol, Lasix, Actonel and Synthroid. His level of care was comfort measures with no transfer to acute care facility.
Two days prior to death the deceased was noted to have a decreased level of consciousness and inability to swallow with unilateral drooling. It was felt that he had had another cerebrovascular accident. The family and physician were informed. Comfort measures were undertaken. Death was pronounced by the on call physician at 0805 on 24 January 2009. The cause of death was cerebrovascular accident. Family had no concerns.
Review of the previous deaths revealed no concerns. Coroners had been informed of deaths during an outbreak.

Coroner's Signature: _____ **Date:** _____

This is Exhibit "K" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018



Commissioner for Taking Affidavits (or as may be)

Coroner's Investigation Statement
(Form 3)

Statement #:	Coroner:	CIS Case #:
2009-2004-A	48912 - DR Urbantke, Elizabeth	2009-836

Personal Details of Deceased

Name: Hedges, Wayne **Gender:** Male **Date of Birth :** 23/Apr/1951 **Age:** 57 yrs
Address: 81 Fyfe AVE
City: WOODSTOCK **Province:** ON **Postal Code:** N4S 8Y2

Investigation Details

Status: Final **Inquest Required:** No **Death Pronounced:** 24/Jan/2009
By what means: Natural **Death Presumed:**

Environments
Environment(1)

Date: 24/Jan/2009
Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Natural Disease - CNS/Neurologic
Address:
City:

Involvements

822 LTC Facility- Threshold

Reports Expected

Police: N Min. of Labour: N
Laboratory: N Other: N
Fire Marshal: N

Pathologist **Hospital**

W.J. Lucas, MD CCFP
Regional Supervising Coroner

Medical cause of death: Cerebrovascular accident
Due to / as a consequence of:
Contributing Factors: Diabetes

NOV 2 3 2009
Central Region - Brampton Office

Narrative

The Caressant Care Nursing Home, Woodstock reported that a 57 year old man had died and his was the threshold death for the nursing home, the case was accepted as such.

The deceased was a 57 year old man who had been admitted to the Caressant Care Nursing Home on 22 Jan 2000. He had a medical history of cerebrovascular accident, Hashimoto's Thyrioditis, right femur fracture, diabetes, left hip fracture, schizophrenia, seizure disorder, gastritis and being mentally challenged. His medications included calcium, Atenolol, Dilantin, iron, Pantoloc, Trazadone, Insulin, Resperidol, Phenobarbital, Domperidone, Maxeran, Tiazac XC, Lescol, Lasix, Actonel and Synthroid. His level of care was comfort measures with no transfer to acute care facility.

Two days prior to death the deceased was noted to have a decreased level of consciousness and inability to swallow with unilateral drooling. It was felt that he had had another cerebrovascular accident. The family and physician were informed. Comfort measures were undertaken. Death was pronounced by the on call physician at 0805 on 24 January 2009. The cause of death was cerebrovascular accident. Family had no concerns.

Coroner's Investigation Statement
(Form 3)

Statement #:	Coroner:	CIS Case #:
2009-2004-A	48912 - DR Urbantke, Elizabeth	2009-836

Review of the previous deaths revealed no concerns. Coroners had been informed of deaths during an outbreak.

Coroner's Signature: _____ **Date:** _____

This is Exhibit "L" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018

Commissioner for Taking Affidavits (or as may be)

Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re:
Dans l'affaire de : Maurice GARNAT , deceased. , décédé(e).

To:
Destinataire : Director of Care

Caressant Care Woodstock

81 Fyfe Ave.,

Woodstock, ON, N4S 8Y2

I
Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de

Maurice Garnat who died on / décédé(e)(s) le

December 23, 2007 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from December 23, 2006 to December 23, 2007 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann (Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of / October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

Personal information contained on this form is collected under the authority of the *Coroners Act*, R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to the Chief Coroner, 25 Morton Shulman Avenue, Toronto ON M7A 2G9, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C.37, telle que modifiée. Si vous avez des questions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 25, avenue Morton Shulman, Toronto ON M3M 0B1, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.

Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re: / Dans l'affaire de : James SILCOX , deceased. / , décédé(e).

To: / Destinataire :
Director of Care
Caressant Care Woodstock
81 Fyfe Ave.,
Woodstock, ON, N4S 8Y2

I / Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de James Silcox who died on / décédé(e)(s) le August 17, 2007 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from August 17, 2006 to August 17, 2007 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation

Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re: / Dans l'affaire de : Helen YOUNG , deceased. / , décédé(e).

To: / Destinataire : Director of Care
Caressant Care Woodstock
81 Fyfe Ave.,
Woodstock, ON, N4S 8Y2

I / Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de Helen Young who died on / décédé(e)(s) le July 14, 2013 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from July 14, 2012 to July 14, 2013 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re: / Dans l'affaire de : Helen MATHESON , deceased. / , décédé(e).

To: / Destinataire :
Director of Care
Caressant Care Woodstock
81 Fyfe Ave.,
Woodstock, ON, N4S 8Y2

I / Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de

Helen Matheson who died on / décédé(e)(s) le

October 27, 2011 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from October 27, 2010 to October 27, 2011 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann (Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation

Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re:
Dans l'affaire de : Mary ZURAWINSKI , deceased. , décédé(e).

To:
Destinataire : Director of Care

Caressant Care Woodstock

81 Fyfe Ave.,

Woodstock, ON, N4S 8Y2

I
Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de

Mary Zurawinski who died on / décédé(e)(s) le

November 7, 2011 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from November 7, 2010 to November 7, 2011 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of / October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re: / Dans l'affaire de : Gladys MILLARD , deceased. / , décédé(e).

To: / Destinataire : Director of Care
Caressant Care Woodstock
81 Fyfe Ave.,
Woodstock, ON, N4S 8Y2

I / Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de Gladys Millard who died on / décédé(e)(s) le October 14, 2011 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from October 14, 2010 to October 14, 2011 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re: / Dans l'affaire de : Maureen PICKERING , deceased. / , décédé(e).

To: / Destinataire : Director of Care

Caressant Care Woodstock

81 Fyfe Ave.,

Woodstock, ON, N4S 8Y2

I / Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de

Maureen Pickering who died on / décédé(e)(s) le

March 28, 2014 (Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from March 28, 2013 to March 28, 2014 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

Personal information contained on this form is collected under the authority of the *Coroners Act*, R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to the Chief Coroner, 25 Morton Shulman Avenue, Toronto ON M7A 2G9, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C.37, telle que modifiée. Si vous avez des questions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 25, avenue Morton Shulman, Toronto ON M3M 0B1, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.

This is Exhibit "M" referred to in the Affidavit of Dr. George Richard Mann sworn July 5, 2018

Commissioner for Taking Affidavits (or as may be)

Office of the Chief Coroner
Bureau du coroner en chef

Coroner's Authority (or Delegated Authority) to Seize During an Investigation
Pouvoir (ou pouvoir délégué) du coroner de saisir pendant une enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Re:
Dans l'affaire de : Arpad HORVATH , deceased. , décédé(e).

To:
Destinataire : Director of Care

Meadow Park Nursing Home

1210 Southdale Road East,

London, ON, N6E 1B4

I
Je soussigné, Dr. G. Rick Mann (Name / Nom) am the Coroner investigating the death(s) of / suis le coroner chargé d'enquêter sur le ou les décès de

Maureen Pickering who died on / décédé(e)(s) le

August 31, 2014
(Date)

As a result of information that has been supplied to me, I have reasonable and probable grounds to believe that the following items/things are necessary for the purpose of the investigation: / Sur la foi des renseignements qui m'ont été fournis, j'ai des motifs raisonnables de croire que j'ai besoin des articles/choses qui suivent pour mener mon enquête :

A Copy of the complete Nursing Home Chart including, but not limited to, all paper and electronic information, consult notes and reports, progress notes, orders, lab & diagnostic imaging reports and nursing notes from August 31, 2013 to August 31, 2014 inclusive.

Accordingly, by the authority granted to me under the *Coroners Act*, I direct you to release the above items to: / En vertu du pouvoir qui m'est conféré par la *Loi sur les coroners*, je vous ordonne de remettre les articles susmentionnés à :

Dr. G. Rick Mann
(Name / Nom)

mail to Suite 303, 235 North Centre Road, London ON, N5X 4E7

Dated this / Fait le 27 (Day / Jour) day of October (Month / Mois) 20 16 at / à London, ON (Location / Lieu)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)
Dr. G. Rick Mann

Telephone No. / Tél. N°	Fax No. / Téléc. N°
519-661-6624	519-661-6617

Coroner's Signature / Signature du coroner

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