In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 20 / VOL 20

July 18, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 20/Volume 20 of the Public Hearings in the above Inquiry proceedings taken at the Elgin County Courthouse, Court Room 201, 4 Wellington Street, St. Thomas, Ontario, on the 18th day of July, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Helen Martineau, CSR.
& Carissa Stabbler, CSR, RPR

A P P E A R A N C E S:

Mark Zigler, Esq., & Lindsay Merrifield, Esq., & Rebecca Jones, Esq., & Laura Robinson, Esq., & Christina Shiel-Singh, Esq.	Commission Counsel
Jared B. Schwartz, Esq.,	AdvantAge Ontario
Jane Meadus, Esq., & Susan E. Frazer, Esq.,	Ontario Association of Residents' Councils
David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock.
Megan Schwartzentruber, Esq.	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram
Rita Bambers, Esq., & Meagan Williams, Esq.,	Her Majesty the Queen in Right of Ontario

A P P E A R A N C E S (CONT'D)

Alex Van Kralingen, Esq.,	Arpad Jr. Horvath, Laura Jackson, Don Martin, Andrea Silcox, Adam Silcox-Vanwyk, Shannon Lee Emmerton, Jeffrey Millard, Judy Millard, Sandra Lee Millard, Stanley Henry Millard, Susie Horvath.
Nicole Butt, Esq.,	Ontario Nurses Association
Chris Hubbard, Esq.,	Dr. George

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09:34:21 --- Upon commencing at 9:34 a.m.
09:34:26 THE COMMISSIONER: Morning,
09:34:26 Ms. Robinson.
09:34:27 MS. ROBINSON: Morning,
09:34:29 Commissioner. We intend to
09:34:31 proceed this morning with further
09:34:33 examination of Dr. Mann by
09:34:35 Ms. Bambers on behalf of the
09:34:37 Province.
09:34:38 THE COMMISSIONER: All right.
09:34:38 Thank you.
09:34:41 Good morning Dr. Mann. Welcome.
09:34:44 THE WITNESS: Morning.
09:34:44 DR. RICHARD MANN: PREVIOUSLY AFFIRMED
09:34:47 EXAMINATION IN-CHIEF BY MS. BAMBERS:
09:34:58 Q. Morning, Dr. Mann.
09:34:59 A. Morning.
09:35:03 Q. You told us yesterday that
09:35:06 part of your job as a Regional Senior
09:35:07 Coroner was to review CIS statements, the
09:35:14 Form 3s, the coroner investigation
09:35:16 statements to -- in addition to spelling you
09:35:20 reviewed them to make sure they made sense?
09:35:22 A. Yes.
09:35:24 Q. And since the offences came
09:35:25 to light you've had an opportunity to review
09:35:30 the original Form 3 for James Silcox that
09:35:38 Dr. George completed?
09:35:40 A. Yes.
09:35:45 Q. And I understand in that case
09:35:46 the cause of death was determined to be
09:35:49 complications from his hip fracture?

09:35:52 A. That is correct.
09:35:53 Q. And having reviewed that
09:35:55 statement did that raise any concerns for
09:35:59 you when you were reviewing it?
09:36:02 A. At the time? That the death
09:36:04 occurred or after the revelations about
09:36:13 Ms. Wettlaufer?
09:36:14 Q. Well, I understand that you
09:36:16 only did review it after you knew of the
09:36:19 offences?
09:36:20 A. Correct.
09:36:20 Q. And my question is, had you
09:36:22 reviewed that at the time would that have
09:36:25 caused any concern for you? Did you see any
09:36:28 deficiencies in it for the kinds of things
09:36:30 that you were reviewing as a Regional Senior
09:36:32 Coroner?
09:36:33 A. If I had reviewed is it at
09:36:36 the time of the first -- I'm a bit confused,
09:36:42 sorry. I'm a bit confused about the
09:36:44 question.
09:36:45 Q. So had you reviewed the
09:36:47 statement in your normal course of approving
09:36:51 and signing off on CIS statements would
09:36:55 there have been any concerns in that
09:36:56 statement for you?
09:36:57 A. At the time that the death
09:37:00 occurred?
09:37:01 Q. Right.
09:37:02 A. No.
09:37:02 Q. Thank you, those are all my
09:37:03 questions.

09:37:04 THE COMMISSIONER: Thank you.
09:37:11 MS. JONES: Thank you. Next we'll have Mr. Van Kralingen on behalf of one of the family groups.
09:37:16 THE COMMISSIONER: Thank you.
09:37:17 CROSS-EXAMINATION BY MR. VAN KRALINGEN:
09:37:29 Q. Dr. Mann, because of yesterday's questioning I'm not going to be
09:37:33 asking you about every document in that
09:37:35 compendium that I've provided you, just to
09:37:37 give you some comfort.
09:37:40 A. Thank you.
09:37:41 Q. My name is Alex Van Kralingen, as you know I'm one of the
09:37:42 lawyers representing one of the victims
09:37:43 groups?
09:37:45 A. Yes.
09:37:47 Q. I'm wondering if you look at
09:37:48 the Case Selection Data Form, which is at
09:37:48 tab 4 of the document you have?
09:37:50 And, Commissioner, I've given you
09:37:52 the wrong document number but a comparable
09:37:56 document for the purposes of the public is at
09:37:58 document 71436.
09:38:00 THE COMMISSIONER: So the document
09:38:05 at tab 4 --
09:38:11 MR. VAN KRALINGEN: I've chosen a
09:38:12 Case Selection Data Form that's
09:38:13 actually not in evidence but here
09:38:17 this one that's on the screen,
09:38:19 which is 71436, is in evidence.
09:38:20 THE COMMISSIONER: Thank you.
09:38:28

09:38:28 BY MR. VAN KRALINGEN:
09:38:28 Q. So just so I understand your evidence from yesterday, you review all of the Case Selection Data Forms that are submitted to your office, is that right?
09:38:37 A. That's correct.
09:38:37 Q. How often do you do that review? How contemporaneous is that review?
09:38:40 A. Within a couple of days of receiving it.
09:38:42 Q. I believe you indicated yesterday that you rarely contact the local coroners to follow-up about what they've written in their Case Selection Data Form, is that fair to say?
09:38:54 A. That's fair to say.
09:38:56 Q. Have you ever received a Case Selection Data Form where a death investigation was declined and then directed a coroner to actually conduct a death investigation?
09:39:05 A. Yes, I have.
09:39:06 Q. How often has that happened?
09:39:08 A. It hasn't happened very often.
09:39:10 Q. Can you explain the last, for example, scenario where that occurred?
09:39:14 A. I don't have a recollection of a specific instance but a case where that might occur is, for example, if in the Case Selection Form the coroner indicated that an elderly individual in a psychogeriatric unit

09:39:42 1 at a hospital had a cardiac arrest and died
09:39:48 2 on the psychiatric unit of a cardiac arrest,
09:39:53 3 and that the -- it was felt because it was
09:39:59 4 a -- because it was a cardiac arrest that it
09:40:03 5 was a natural death and we did not need to
09:40:06 6 be involved.
09:40:07 7 However, because of the event
09:40:10 8 occurring in a psychiatric unit in a hospital
09:40:14 9 that is a case where a mandatory inquest --
09:40:20 10 or sorry, a mandatory investigation,
09:40:23 11 regardless of the manner of death, needs to
09:40:27 12 be undertaken.
09:40:27 13 So I would contact the coroner and
09:40:32 14 give them some education, reminding them that
09:40:36 15 a death in a psychiatric unit and a nursing
09:40:39 16 home -- or a hospital is a mandatory
09:40:44 17 investigation and we need to take it.
09:40:46 18 Q. So what you're suggesting is
09:40:47 19 in that circumstance that you've just
09:40:49 20 relayed to me here you saw that as part of
09:40:51 21 your oversight responsibilities to ensure
09:40:53 22 that a local coroner was properly conducting
09:40:56 23 a death investigation when one was required?
09:40:59 24 A. Yes.
09:41:00 25 Q. You'll agree with me that you
09:41:02 26 can't provide that oversight or mentoring of
09:41:04 27 a decision not to conduct a death
09:41:06 28 investigation unless you are somehow
09:41:09 29 informed that a death investigation was
09:41:11 30 declined?
09:41:12 31 A. That's correct.
09:41:13 32 Q. Is it fair to say that you

09:41:15 1 first heard about Maureen Pickering's death
09:41:17 2 after Ms. Wettlaufer's confession?
09:41:21 3 A. That's correct.
09:41:21 4 Q. You never knew before that
09:41:23 5 point that Dr. George had declined the
09:41:25 6 investigation?
09:41:26 7 A. Not to my knowledge.
09:41:33 8 Q. Could you go to tab 2 of the
09:41:34 9 documents you have in front of you? This is
09:41:42 10 document 71449. This is a September 20,
09:41:45 11 2010 memorandum from the then Chief Coroner
09:41:47 12 of Ontario, Dr. McCallum, to all coroners.
09:41:51 13 Have you seen this document before?
09:41:53 14 A. Yes, I have.
09:41:54 15 Q. Can you go to page -- it
09:41:56 16 discusses the acceptance of a natural death
09:41:59 17 for investigation. And if you go to page 2
09:42:02 18 I'd appreciate it.
09:42:03 19 The second paragraph there say:
09:42:09 20 "Documentation of natural deaths
09:42:11 21 declined for investigation will be
09:42:14 22 submitted to respective Regional
09:42:16 23 Supervising Regional Coroners
09:42:17 24 offices for tracking and
09:42:19 25 identification of any trends or
09:42:20 26 patterns."
09:42:25 27 Since 2010 has your office done any
09:42:27 28 analysis tracking trends or patterns of
09:42:29 29 natural deaths declined for investigation?
09:42:32 30 A. No, we have not.
09:42:34 31 Q. May I ask you why you
09:42:36 32 haven't?

09:42:42 A. Mostly on -- because of
09:42:47 workload and lack of time to be able to do
09:42:49 that.
09:42:50 Q. So resource issue, right?
09:42:51 A. Resource issue.
09:42:54 Q. We've discussed with
09:42:55 Dr. Huyer the fees associated with a death
09:42:58 investigation. And for death investigations
09:43:01 my understanding is that local coroners can
09:43:04 request additional compensation over and
09:43:06 above the standard $450 charge in
09:43:10 exceptional circumstances, is that your
09:43:12 understanding?
09:43:13 A. That is correct.
09:43:14 Q. And I assume that those
09:43:14 exceptions are related to whether death
09:43:18 investigations are either longer or more
09:43:19 detailed than is usually expected, is it
09:43:22 fair to say?
09:43:23 A. That's fair to say.
09:43:24 Q. Does the same principle apply
09:43:27 to the payment of associated with completing
09:43:29 the Case Selection Data Form? Is it
09:43:31 possible to ask for an additional payment if
09:43:34 completing that form or the process to
09:43:36 complete that form is a longer or more
09:43:39 detailed process?
09:43:40 A. My understanding is it is
09:43:42 not.
09:43:44 Q. Can you go to paragraph 9 of
09:43:46 your affidavit please? At paragraph 9 you
09:43:49 reference --

09:44:03 A. Sorry. Thank you.
09:44:15 Q. We're going to look at paragraph sub (d), actually over to the next page.
09:44:23 You indicate that you have conducted educational sessions relating to your role as a Regional Senior Coroner and the coroners office, is that correct?
09:44:33 A. That's correct.
09:44:34 Q. My understanding though is that you have not conducted such an educational session at a long-term care home, is that correct?
09:44:40 A. That's correct.
09:44:41 Q. My first question is, who are you providing the educational sessions to typically?
09:44:46 A. Typically to physicians, medical staff, police officers, organizations like service clubs professional organizations such as Society of Obstetricians and Gynecologists of Canada, that sort of thing.
09:45:18 Q. And without going into too much detail can you give me sort of an overview of the content of those educational sessions?
09:45:26 A. Depends on what the educational session is about. So, for example, Society of Obstetricians and Gynecologists it would be as my role as chair of the maternal and perinatal death

09:45:38 1 review committee.
09:45:39 2 And with physicians it may be what
09:45:43 3 the coroners office does; how we interact
09:45:46 4 with each other; how to complete -- how to
09:45:50 5 contact the coroner; what sort of deaths
09:45:53 6 would require contacting the coroners office
09:45:58 7 and how to complete medical certificates of
09:46:01 8 death.
09:46:02 9 Police services it would be related
09:46:04 10 to how the coroners office or the death
09:46:07 11 investigation system intersects and interacts
09:46:12 12 with law enforcement.
09:46:13 13 Q. Are those educational
09:46:14 14 sessions essentially upon request?
09:46:16 15 A. They are upon request.
09:46:18 16 Q. Given what we're learning
09:46:20 17 during the course of this Inquiry, do you
09:46:21 18 think there would be value in having some
09:46:25 19 form of a mandatory educational session
09:46:27 20 between the regional coroners office and any
09:46:29 21 given long-term care home within their
09:46:31 22 region?
09:46:32 23 A. I don't have a problem with
09:46:34 24 that and I would certainly be -- I've always
09:46:38 25 been willing to speak to whichever
09:46:43 26 organization or group that want information
09:46:46 27 about the coroners office, so I would not
09:46:49 28 be -- I would not object to that.
09:46:51 29 Q. Could you look at page 6 of
09:46:53 30 your affidavit? Which is just a few pages
09:46:56 31 before.
09:46:59 32 A. Try to move this mic so I'm

09:47:01 not hitting it all the time.
09:47:03 Q. Dr. Huyer had a similar issue
09:47:05 yesterday so you're not unique?
09:47:07 A. I noticed that.
09:47:11 Q. So you'll see at paragraph
09:47:12 6 -- not page 6 paragraph 6, sorry. It will
09:47:22 be on page 2, thank you.
09:47:24 There's a listing after the
09:47:26 narrative at paragraph 6, there's actually a
09:47:29 chart there for various years and total
09:47:31 deaths investigated, and that's relating to
09:47:33 the total deaths investigated in the London
09:47:36 office?
09:47:36 A. That is the total number of
09:47:39 deaths investigated by the London office as
09:47:41 provided by the Office of the Chief Coroner,
09:47:44 yes.
09:47:44 Q. Fair enough. If you could go
09:47:45 to paragraph 21 of the affidavit now, where
09:47:48 there's a listing of the Case Selection Data
09:47:49 Forms received?
09:47:50 I've done the math and compared the
09:48:09 numbers between paragraph 6 and paragraph 21,
09:48:11 and it appears that less than one-third of
09:48:15 the death investigations that are conducted
09:48:18 in the London region actually have a Case
09:48:21 Selection Data Form submitted. Does that
09:48:24 ratio seem to make sense to you?
09:48:26 A. I'm not sure that you're --
09:48:28 that that's a correct way of looking at
09:48:30 things.
09:48:31 Q. Okay.

09:48:31 A. The number -- so the first -- the first graph or column thing that you provided.
09:48:42 Q. Yes.
09:48:42 A. Is the number of investigations, period.
09:48:43 Q. Right.
09:48:46 A. Does not include case selections. Case selections are separate because they are not investigations.
09:48:47 Q. Well, a case selection form could lead to an investigation?
09:48:53 A. It could lead to an investigation, correct. So this represents the case selection forms, does not -- it does not -- it does not subtract from or -- it is different from the cases that are actually investigated.
09:48:56 Q. You're sort of dovetailing into my point here. Let's go through the process.
09:49:14 A. Okay.
09:49:15 Q. A best practice for a local coroner in London would be to use the case selection form in their determination as to whether a death investigation should occur at all, is it fair to say?
09:49:17 A. That's fair to say.
09:49:18 Q. So your hope would be in the majority of the more than 2,000 cases that are investigated each year that there would be a case selection data form associated
09:49:18
09:49:20
09:49:24
09:49:26
09:49:28
09:49:29
09:49:30
09:49:31
09:49:36
09:49:36

09:49:36 1 with that, is that fair to stay?
09:49:39 2 A. No.
09:49:39 3 Q. So maybe you can fix my
09:49:40 4 misunderstanding of that?
09:49:43 5 A. A case selection form is
09:49:45 6 provided for determination on whether on
09:49:48 7 investigation is initiated or not. If a --
09:49:51 8 so if a case selection form is provided then
09:49:56 9 the case is not taken on as an
09:50:01 10 investigation, so it will not occur in the
09:50:05 11 other list.
09:50:06 12 Q. So this helps clarify my
09:50:08 13 misunderstanding then. You're suggesting
09:50:10 14 that nobody would ever provide a case
09:50:13 15 selection form in a circumstance where they
09:50:16 16 accepted a death investigation?
09:50:17 17 A. That they would have accepted
09:50:19 18 it? No, but if on review of the case
09:50:21 19 selection form I felt that I needed more
09:50:27 20 information, contacted the coroner and then
09:50:29 21 with discussion with the coroner decided it
09:50:31 22 was indeed a coroners investigation, then
09:50:37 23 that would trigger that case selection form,
09:50:43 24 or that case selection number to be then put
09:50:48 25 into the investigations number.
09:50:51 26 Q. Fair enough. But we've
09:50:52 27 indicated those are moments that are few and
09:50:55 28 far between, correct?
09:50:56 29 A. Correct, there are very few
09:50:58 30 of those.
09:50:59 31 Q. Let's talk about your review
09:51:00 32 of Form 3s. If a Form 3 that you reviewed

identified a concern about possible patient abuse, or the quality of care provided to a registered -- by a Registered Nurse or other health practitioner, is there any barrier to the coroners office contacting either the Ministry of Health or professional regulatory body such as the College of Nurses to report what they believe?

A. No.

Q. Thank you kindly for your time, those are my questions.

A. Thank you, sir.

MS. JONES: And Mr. Scott on behalf of another of the family groups.

THE COMMISSIONER: Thank you.

MR. SCOTT: Morning, Madam Commissioner.

THE COMMISSIONER: Morning, Mr. Scott.

CROSS-EXAMINATION BY MR. SCOTT:

Q. Morning, Dr. Mann.

A. Morning, Mr. Scott.

Q. My understanding is that physicians are required to take and keep detailed and legible notes of all interactions with their patients, is that correct?

A. Yes.

Q. And that's required by the College of Physicians and Surgeons is that correct?

09:52:16 A. Correct.
09:52:16 Q. Is there any similar
09:52:18 requirement for coroners to do that?
09:52:21 A. Coroners should document,
09:52:26 make notes on their investigations and need
09:52:32 to be kept for at least ten years.
09:52:34 Q. And so you've used the word
09:52:36 "should", does that mean they should do it
09:52:40 but are they required to do it?
09:52:44 A. It's strongly encouraged.
09:52:46 Q. Okay. To the best of your
09:52:48 knowledge is it written down in a piece of
09:52:49 legislation anywhere?
09:52:50 A. Not to my knowledge.
09:52:53 Q. Are coroners given any kind
09:52:55 of a template to work from in order -- so a
09:52:59 preprinted form, for example, to write their
09:53:02 notes on?
09:53:04 A. There was at one point
09:53:05 distributed a case data form which was
09:53:09 provided to coroners, that they could use if
09:53:12 they wished, for -- for making notes, making
09:53:22 records for themselves. It was -- if I
09:53:26 remember correctly, it was a while ago that
09:53:29 it was available and I used it when I was an
09:53:32 investigating coroner. It was developed by
09:53:35 one of the investigating coroners as --
09:53:39 sorry. This was the way that I look -- you
09:53:44 know, I documented stuff. If you want to
09:53:46 use it go ahead and use it. So I took the
09:53:52 liberty of using it instead of developing my
09:53:55 own.

09:53:56 1 Some coroners who are more computer
09:54:00 2 literate than me will take their little
09:54:03 3 laptop, or whatever type of device, and write
09:54:06 4 things down at the scene and that's how they
09:54:08 5 keep their documentation.
09:54:11 6 Some people use notebooks. Some
09:54:15 7 people use sheets of paper and staple them
09:54:20 8 all together in my -- in my coroner file for
09:54:23 9 that patient, for that individual.
09:54:26 10 Q. So there's no standardized
09:54:27 11 way of doing it though, is that correct.
09:54:30 12 A. Presently there isn't.
09:54:31 13 Q. And if they take notes do
09:54:33 14 they then send them to your office?
09:54:36 15 A. No.
09:54:36 16 Q. So would they -- you say
09:54:38 17 they're required to keep them for ten years?
09:54:40 18 A. Correct.
09:54:41 19 Q. And after that they're
09:54:41 20 allowed to destroy them?
09:54:43 21 A. After that, after the last
09:54:44 22 contact with the individual -- same as
09:54:47 23 medical records, after a period of time,
09:55:02 24 after the last input into a file a file can
09:55:08 25 be destroyed.
09:55:11 26 Q. And is it fair to say that a
09:55:13 27 coroner can get a call from, I'll call it
09:55:19 28 the Toronto dispatch, at any time day or
09:55:22 29 night?
09:55:23 30 A. Depending on the system --
09:55:24 31 depending on the system of calling out
09:55:27 32 coroners within that area or region. But

09:55:30 1 certainly in southwestern Ontario that
09:55:33 2 would -- or in this region that would be the
09:55:37 3 case, yes.
09:55:38 4 Q. And I think it's that sort of
09:55:40 5 thing that keeps a lot of people out of
09:55:42 6 medicine? We just don't want to get up at 3
09:55:44 7 o'clock in the morning to go out in the rain
09:55:46 8 and do something. But if that coroner gets
09:55:49 9 that call at 2:30 a.m., and they're woken
09:55:51 10 up, now they're going to be speaking with
09:55:53 11 the person, let's say, who is the nurse at
09:55:56 12 the nursing home.
09:55:57 13 A. Okay.
09:55:57 14 Q. And is there a method? Is
09:56:00 15 there a system? Are they taught something
09:56:03 16 about how do you keep a record of that
09:56:06 17 conversation at 2:30 a.m. when you've just
09:56:09 18 woken up? How do you know you're getting
09:56:12 19 all that information down?
09:56:15 20 A. I can only speak personally.
09:56:17 21 Q. Okay. Let's start there.
09:56:23 22 A. Personally I usually had a
09:56:24 23 pen and a pad of paper at my bed side and I
09:56:29 24 would jot down some notes when someone was
09:56:36 25 talking to me. Later on I may -- it depends
09:56:43 26 on how -- it would depend on the timing and
09:56:46 27 things of that nature, but I would either
09:56:49 28 take those notes and expand on them either
09:56:51 29 at that specific time, or maybe with my
09:56:57 30 first cup of coffee in the morning. I'd
09:56:59 31 take my notes that I'd written down and fill
09:57:01 32 in some of the gaps, and then file that -- I

would file both into my file for that individual case.

Q. And when you are mentoring or training new coroners is that something you tell them that they should do?

A. Yes.

Q. And the form you talked about a few minutes ago, it sounds like that's a form you adopted that somebody else had created, is that correct?

A. That is correct.

Q. And do you provide that form to the 55 or so coroners in your jurisdiction?

A. I do not, but I believe it is part of the package that is provided to new coroners during the educational course.

Q. Thank you, sir, those are my questions?

A. Thank you, sir.

THE COMMISSIONER: Thank you, Mr. Scott.

MS. JONES: Mr. Golden on behalf of Caressant Care.

MR. GOLDEN: Good morning.

THE COMMISSIONER: Good morning, Mr. Golden.

CROSS-EXAMINATION BY MR. GOLDEN:

Q. Dr. Mann, I take it that part of your function as the Regional Senior Coroner is to make sure that the local coroners who are working under your

09:58:21 jurisdiction are meeting a basic standard of
09:58:24 expectation to continue on as local
09:58:27 coroners?
09:58:28 A. Yes.
09:58:28 Q. And I take it that with
09:58:29 respect to Dr. William George you would have
09:58:31 been satisfied throughout the period of time
09:58:34 that he's been a local coroner that he met
09:58:38 that standard?
09:58:39 A. Yes.
09:58:39 Q. And that he had the required
09:58:43 professional judgment to exercise as a
09:58:46 coroner?
09:58:46 A. Yes.
09:58:47 Q. We spoke yesterday at some
09:59:00 length about the term "sudden and
09:59:01 unexpected" and how it's used in the IPDR
09:59:05 form and in the legislation. And I'm
09:59:06 curious as to whether you agree that there
09:59:09 does seem to be some inconsistency in how
09:59:13 people understand and interpret those words?
09:59:15 Is that fair?
09:59:15 A. That's fair.
09:59:17 Q. And even within the local
09:59:19 coroners there doesn't seem to be complete
09:59:21 consistency in how they understand and
09:59:23 interpret those words, is that fair?
09:59:26 A. That would be also fair.
09:59:28 Q. And I understood, and we
09:59:31 heard this from Dr. Huyer but I believe from
09:59:34 you as well, that there hasn't been any
09:59:36 specific program aimed at long-term care

09:59:39 1 homes in terms of trying to educate how to
09:59:43 2 interpret those words, is that fair?
09:59:45 3 A. Not a -- it's more on an
09:59:48 4 individual basis.
09:59:49 5 Q. Well, let's talk about that.
09:59:50 6 Because you mention that one of the most
09:59:53 7 common inquiries you get from a long-term
09:59:55 8 care home is to have a discussion about what
09:59:58 9 those words mean and whether it applies to a
10:00:00 10 particular case. Do you remember saying
10:00:02 11 that yesterday?
10:00:03 12 A. Yes.
10:00:03 13 Q. And I wanted to get a better
10:00:05 14 sense, is that something that happens a
10:00:08 15 couple of time as week, a couple of times a
10:00:10 16 month, a couple of times a year? What's
10:00:12 17 your best sense of how often you actually
10:00:15 18 get those inquiries?
10:00:17 19 A. A couple of times -- well, a
10:00:19 20 couple of times a year at most.
10:00:21 21 Q. A couple of times a year at
10:00:23 22 most. Okay.
10:00:25 23 We also talked yesterday about the
10:00:29 24 Form 3s and your expectation that they have
10:00:32 25 to be or should be submitted within 180 days
10:00:37 26 of the death?
10:00:38 27 A. Correct.
10:00:41 28 Q. And my question for you is,
10:00:43 29 in the context of long-term care at least
10:00:45 30 it seems to me that 180 days from the date
10:00:49 31 of death is a particularly long time given
10:00:52 32 the goals that were talked about in the

10:00:56 1 coroners materials about looking for
10:00:58 2 potential patterns, problems, outbreaks. Do
10:01:04 3 you have a sense of whether that 1880 days
10:01:07 4 works in the long-term care context?
10:01:21 5 A. I'm not sure I completely
10:01:23 6 understand the question. If you can help me
10:01:25 7 along with it I'd appreciate it.
10:01:27 8 Q. I'm wondering what your view
10:01:29 9 is on whether 180 days is too long a time to
10:01:32 10 wait for a Form 3 when it relates to a death
10:01:36 11 in a long-term care home, given some of the
10:01:39 12 goals that have been expressed so far in the
10:01:43 13 evidence about what a coroner might learn
10:01:46 14 from reviewing a death in a long-term care
10:01:48 15 home?
10:01:49 16 A. I think that if there were
10:01:50 17 some significant concerns by the coroner
10:01:55 18 about what was going on in a long-term care
10:01:59 19 setting there would be a telephone
10:02:01 20 conversation and not necessarily waiting for
10:02:03 21 the Form 3 to be complete.
10:02:05 22 Q. Is there any written
10:02:06 23 guideline about what triggers that?
10:02:09 24 A. Not that I'm aware of.
10:02:12 25 Q. Dr. Mann, we also talked
10:02:14 26 yesterday about the elimination in 2013 of
10:02:19 27 the threshold investigations for long-term
10:02:24 28 care?
10:02:24 29 A. Yes.
10:02:25 30 Q. And you had given some
10:02:26 31 evidence about what you saw as the benefit
10:02:28 32 of actually having those threshold

10:02:30 investigations. And you were also here when
10:02:33 Dr. Huyer had indicated that in his view it
10:02:38 was really an ineffective process. And I'm
10:02:41 curious whether your view, from a London
10:02:43 perspective, from this region, is that the
10:02:48 threshold investigation is something that we
10:02:50 should not go back to?
10:03:01 A. I think that there is some
10:03:03 value, personally. I think that having a
10:03:15 coroner attend to a nursing home -- or
10:03:15 long-term care facility, I'm sorry, a
10:03:23 long-term care facility to look at what has
10:03:25 transpired over a period of time, allows us
10:03:31 to see if there are any patterns that have
10:03:35 arisen that may not have been picked up by
10:03:38 the IPDR.
10:03:44 It may also allow us to find cases
10:03:46 which actually should have been investigated
10:03:50 beforehand that weren't investigated at the
10:03:56 time, because perhaps there was some
10:04:00 misunderstanding from the person who
10:04:02 completed the form on some of the instances,
10:04:07 for example. And I think I explained this
10:04:09 yesterday as well in my testimony.
10:04:10 A fractured hip that may have
10:04:14 occurred sometime prior to the death and --
10:04:18 but the death appeared to the folks there,
10:04:22 who were completing the IPDR form, that this
10:04:26 was a natural death because they had this
10:04:29 heart attack and we tried CPR and they died
10:04:35 and it was a natural cause.
10:04:38 Well, in the coroner world

10:04:42 1 certainly that accident had a bearing on what
10:04:48 2 happened after it and, therefore, it would be
10:04:52 3 considered an accidental death. So it allows
10:04:56 4 us to pick up things. Those types of nuances
10:05:05 5 and things I don't think get picked up in an
10:05:16 6 IPDR.
10:05:16 7 And I think having the coroner come
10:05:20 8 in provides two things. One, it provides,
10:05:21 9 oh, there's this case that got missed and we
10:05:26 10 need to investigate it. And, two, it
10:05:28 11 provides education to the home that, you
10:05:30 12 know, if this person had a fall three months
10:05:33 13 ago, had fractured their hip, had their
10:05:36 14 surgery, came back.
10:05:37 15 And they were walking to the dining
10:05:40 16 hall every day prior to their fracture and
10:05:46 17 their fall but after that they were now
10:05:49 18 bedridden, which then makes them susceptible
10:05:52 19 to pulmonary emboli, and all sorts of other
10:05:58 20 complications, then that death should be
10:05:59 21 reported to the coroner. Not because you've
10:06:01 22 done anything wrong, or not because there's
10:06:03 23 anything criminal about it, but because it's
10:06:07 24 an accidental death that we need to
10:06:09 25 investigate so that perhaps we can help you
10:06:11 26 to prevent that fall from happening again.
10:06:15 27 Q. As a regional coroner have
10:06:17 28 you participated in discussions with your
10:06:21 29 fellow regional coroners or with the Office
10:06:23 30 of the Chief Coroner regarding Dr. Huyer's
10:06:28 31 conclusion that it's not an effective
10:06:30 32 process that we should go back to?

10:06:33 A. Back when the decision was
10:06:35 made I raised the concerns that I had and
10:06:43 what happened.
10:06:44 Q. And have there been any
10:06:46 discussions on the issue that involve
10:06:48 regional coroners since the Wettlaufer
10:06:50 offences have become known?
10:06:51 A. Not that I'm aware of.
10:06:57 Q. Dr. Mann, we also talked
10:06:59 yesterday about the obligations imposed by
10:07:01 your legislation, the Coroners Act, and in
10:07:04 particular section 10. And as I understood
10:07:06 it, and we talked about this with Dr. Huyer
10:07:09 as well, section 10 requires any person who
10:07:12 has reason to believe that a death has
10:07:15 occurred as a result of, for example,
10:07:18 negligence or misconduct, any person has to
10:07:21 report that to a coroner or police?
10:07:25 A. According to the Act, yes.
10:07:27 Q. And one of the questions that
10:07:31 I asked Dr. Huyer, I'm going to ask you as
10:07:33 well, have you ever had such a report from
10:07:36 the Ministry of Health or Long-Term care in
10:07:39 relation to a death that they have become
10:07:43 aware of in a long-term care facility?
10:07:46 A. I cannot recall that the
10:07:50 Ministry of Health has done that but
10:07:53 certainly under the legislation they could.
10:07:56 Q. Well, it's not just a matter
10:07:57 of "could" I suggest it's mandatory. It
10:08:00 says, "Small immediately notify a coroner".
10:08:02 Is that your understanding of the

10:08:03 obligation?
10:08:04 A. That's my understanding of
10:08:05 the obligation.
10:08:14 Q. Dr. Mann, as a regional
10:08:16 coroner have you been involved in
10:08:17 discussions regarding how to improve the
10:08:19 IPDR? And I'm talking specifically since
10:08:24 the Wettlaufer offences.
10:08:26 A. Not to my knowledge.
10:08:31 Q. And I just want to confirm,
10:08:32 in the London region is it still the policy
10:08:35 that if all the boxes on the IPDR are
10:08:37 checked "no" there won't be an
10:08:40 investigation, currently?
10:08:42 A. Currently that's correct.
10:08:47 Q. And, Dr. Mann, counsel for
10:08:50 the Ministry asked you about what your
10:08:53 opinion might have been had you looked at
10:08:54 that Form 3 for Mr. Silcox? And I'm curious
10:09:00 as to whether even with the benefit of
10:09:03 hindsight, and keeping in mind what the
10:09:05 practices were in place at the time, do you
10:09:07 believe that your local coroners, had they
10:09:12 investigated these Wettlaufer deaths, would
10:09:15 have been live to the issue that these were
10:09:18 homicides?
10:09:21 MS. JONES: Commissioner, I'm not
10:09:22 sure Dr. Mann can answer that
10:09:24 question. I think that presumes a
10:09:27 review of the medical records of
10:09:28 all of these patients. I think
10:09:29 that there would have to be a

10:09:32 better foundation laid before
10:09:34 Mr. Golden asks Dr. Mann that
10:09:36 question.
10:09:41 MR. GOLDEN: Well, he was asked
10:09:43 about the form -- reviewing the
10:09:44 form report for Mr. Silcox. And I
10:09:47 don't know why it's different --
10:09:49 BY MR. GOLDEN:
10:09:49 Q. Have you reviewed the
10:09:51 circumstances surrounding the other deaths?
10:09:53 A. Can you explain what you mean
10:09:54 by that?
10:09:54 Q. Have you reviewed the
10:09:56 circumstances surrounding the deaths of
10:09:57 Ms. Wettlaufer's other victims?
10:09:59 A. I have reviewed the Form 3s
10:10:02 and post-mortem reports, when they were
10:10:07 done, and the agreed statement of facts.
10:10:11 Q. Okay. Then I'm not going to
10:10:13 ask you further, thank you.
10:10:14 THE COMMISSIONER: Thank you.
10:10:16 Thank you, Mr. Golden.
10:10:17 THE WITNESS: Thank you.
10:10:26 MS. ROBINSON: Ms. Frazer on
10:10:27 behalf of the Ontario Association
10:10:28 of Residents Councils.
10:10:31 THE COMMISSIONER: Ms. Meadus,
10:10:32 thank you.
10:10:34 MS. ROBINSON: Ms. Meadus, my
10:10:35 apologies.
10:10:36 CROSS-EXAMINATION BY MS. MEADUS:
10:10:43 Q. Good morning, Dr. Mann?

10:10:44 A. Morning.
10:10:44 Q. My name is Jane Meadus and I'm here on behalf of the Ontario Association of Residents Councils, and that's an umbrella group that represents the 72,000 -- or 78,000 long-term care residents in Ontario.
10:10:59 A. Thank you.
10:10:59 Q. Okay?
10:10:59 So I just wanted to go back. I looked a at your CV and I couldn't see anything there about training for being a coroner. Can you explain what your training is. I know you've been a coroner for a long time. So what was your training to become a coroner?
10:11:15 A. Back in -- back in the 1980s there was no training course. So that back in the -- when I was appointed a coroner I attended a -- I think it was a two-day meeting after I had started working as a coroner. And I relied a lot on my Regional Supervising Coroner to provide me advice and assistance in what -- in the investigations that I was taking on early on. So I learned by the seat of my pants.
10:11:53 Q. Okay. On-the-job training?
10:11:55 A. On-the-job training.
10:11:56 Q. And another thing that you've told us is that you have one of the largest regions in southern Ontario?
10:12:02 A. The largest region.

10:12:04 Q. The largest region. And not
10:12:06 knowing counties down here I did myself a
10:12:08 map. And I understand you go down as far as
10:12:10 Windsor, up to Tobermory, almost over to
10:12:13 Waterloo and to Lake Erie, is that correct?
10:12:16 A. That's correct.
10:12:17 Q. So that helped me in my head
10:12:20 because I don't know the counties well.
10:12:21 So, are the coroner evenly
10:12:23 distributed through the area?
10:12:24 A. No.
10:12:25 Q. And do you have areas that
10:12:26 you have staffing issues with?
10:12:27 A. Yes.
10:12:28 Q. And would those be the more
10:12:29 rural areas? Would that be correct?
10:12:30 A. Not necessarily.
10:12:31 Q. Not necessarily? And what do
10:12:33 you do in those areas?
10:12:34 A. We try to recruit coroners
10:12:39 when and if we can. And we rely on the --
10:12:46 rely on coroners that already exist to
10:12:52 cross-cover, if possible.
10:12:55 So a coroner from Goderich, for
10:13:00 example, may end up going up to Kincardine,
10:13:03 or Bruce County, or somewhere else in order
10:13:07 to do an investigation if a coroner more
10:13:11 locally cannot be found.
10:13:12 Q. And what is the reason for
10:13:14 having trouble finding them? Is -- do you
10:13:17 think it's the monetary issue?
10:13:18 A. I think it is

multi-factorial. There are -- you have to have a bit of an interest in death investigation, and there is a time commitment. And there are certain physician groups where being able to commit that amount of time is challenging.

Because, for example, in my situation as a GP anesthetist when a call came to me when I was in the operating room I had to decline it because I was looking after the living. And, yes, the dead are important and I don't wish to say that they're not but I had another obligation to do.

There are -- you know, there are all sorts of other issues. Family issues, all sorts of other things that physicians may find that adding death investigation is part of their cadre of things that they do may be a little bit too much.

Q. And I wanted to now bring you to the process of what a coroner does. And we've heard about how they get a case and the investigation, but there are two extra parts that I don't think we've really heard about and I would just ask you to maybe briefly, because I don't have a lot of time unfortunately, just explain how does a case -- once an investigation has started we know there's the geriatric and long-term care review committee, how does a case get into that committee's sphere? How does it get referred there?

10:15:13 A. It's referred there on a
10:15:14 number -- on two different reasons. One, if
10:15:17 it is related to a homicide that occurs in a
10:15:22 long-term care facility then it gets
10:15:27 referred to the geriatric and long-term care
10:15:32 committee for review. And we heard from
10:15:35 Dr. Huyer that that has not happened with
10:15:37 these deaths but that doesn't mean that it's
10:15:39 not going to happen.
10:15:40 Q. Right.
10:15:41 A. One of the other issues is if
10:15:43 the Regional Supervising Coroner, or even
10:15:48 the coroner themselves, have concerns or
10:15:52 issues that they feel that the expertise of
10:15:57 the individuals on the geriatric and
10:16:00 long-term care committee could be used to
10:16:06 assist the process of the coroners
10:16:15 investigation; or if there's a feeling that
10:16:19 there may come recommendations from the
10:16:23 geriatric and long-term care committee which
10:16:26 could be used -- which could be provided to
10:16:29 either the long-term care facility itself,
10:16:33 if it is a sort of an isolated problem, or
10:16:39 to the broader community of long-term care
10:16:42 facilities, if there is a feeling that it
10:16:45 perhaps is a more global issue.
10:16:49 Q. Okay. Thank you.
10:16:50 And is there a similar process for
10:16:52 inquests? So we know there's some mandatory
10:16:55 inquests but there's also discretionary ones,
10:16:58 would it be a similar kind of process to call
10:17:01 an inquest into a death?

10:17:03 A. Yes.
10:17:04 Q. Okay. Thank you very much.
10:17:05 I would like to now bring up our
10:17:08 document 71445, which is Exhibit G in your
10:17:13 affidavit. And just while they're bringing
10:17:23 that up -- so this is the death of Wayne
10:17:25 Hedges who was -- he was reviewed as a
10:17:28 threshold case. And I understand that while
10:17:30 you were Regional Supervising Coroner at the
10:17:33 time you did not review this case. This was
10:17:37 a case that I believe you were aware for?
10:17:40 A. One of my colleagues --
10:17:43 Q. And Dr. Lucas I believe did
10:17:45 the review?
10:17:46 A. That's right.
10:17:47 Q. Can you go down to next page
10:17:48 please? I seem to have put down the wrong
10:17:57 number here. Let's try this again. Let's
10:18:00 try 64920, sorry, which is Exhibit K.
10:18:20 So this is for Wayne Hedges. And
10:18:22 can you just scroll down a little bit please
10:18:23 to page 2? And so this would be an example
10:18:30 of what the review would look like, is that
10:18:32 correct? They would note up on the document,
10:18:34 I would assume those are Dr. Lucas'
10:18:37 notations, is that correct?
10:18:38 A. The --
10:18:42 Q. In the pen.
10:18:43 A. In the presumably pen, yes.
10:18:45 Q. And can you go down a little
10:18:47 bit farther please? So this is just more of
10:18:51 some issues around capitalization and that

10:18:54 sort of thing, is that correct?
10:18:56 A. Yes.
10:18:57 Q. Okay. So we get to the
10:18:58 narrative and in that it says that this was
10:19:02 a threshold death; there was a finding that
10:19:06 it was felt that he had a cerebral vascular
10:19:09 accident. Is that correct?
10:19:10 A. Yes.
10:19:10 Q. Okay. And then this would
10:19:14 have been reviewed. And my understanding is
10:19:16 that this would be all that the coroner
10:19:18 would review? You wouldn't look at -- or
10:19:21 the regional supervisor would review. You
10:19:23 wouldn't look at the -- the records at the
10:19:29 home, is that correct?
10:19:30 A. That's correct.
10:19:31 Q. And would you speak to the
10:19:32 coroner or would you only do that if you had
10:19:34 questions?
10:19:34 A. I can't say what Dr. Lucas'
10:19:37 practice was. My practice was if I had
10:19:40 concerns I would speak to coroner but
10:19:42 otherwise I would not.
10:19:43 Q. And at the bottom it says,
10:19:45 "Family had no concerns." Do you see that?
10:19:49 A. I do.
10:19:50 Q. So I'm going to ask you to
10:19:51 bring up document 43003, and these are
10:20:02 notes, and this is in Exhibit 9 and these
10:20:02 are supporting documents to that exhibit,
10:20:04 which we will hear from the Ministry later.
10:20:07 So can we go to page 42?

10:20:17 1 And this is a document you will not
10:20:19 2 have seen. And so these are -- I'm expecting
10:20:24 3 we're going to hear from Ms. Kukoly, who is
10:20:29 4 from the Ministry of Health, and she's one of
10:20:30 5 the inspectors.
10:20:32 6 And she's a sister of -- the sister
10:20:35 7 of Wayne Hedges was being interviewed. I'm
10:20:38 8 going to provide this, this is already an
10:20:41 9 exhibit but I'm going to provide you with
10:20:42 10 these documents just for assistance.
10:20:44 11 THE COMMISSIONER: Thank you.
10:20:44 12 I think we should enter it now
10:21:08 13 because otherwise anyone trying to
10:21:09 14 follow the Webcast will be unable
10:21:11 15 to have access to it. If we do
10:21:14 16 that it will go up shortly.
10:21:15 17 MR. GOLDEN: My suggestion would
10:21:17 18 be we enter it for identification
10:21:19 19 because it's double, triple
10:21:20 20 hearsay. We don't know what
10:21:22 21 Ms. Kukoly is going to say.
10:21:26 22 THE COMMISSIONER: All right. I
10:21:26 23 think that's exactly right. So it
10:21:28 24 is a lettered exhibit. And Madam
10:21:31 25 Clerk, can you help me with this.
10:21:34 26 I have been trying to keep all the
10:21:36 27 lettered exhibits so we can sort
10:21:38 28 this out afterwards. I think that
10:21:40 29 we have only three lettered
10:21:43 30 exhibits so far. Is that -- I
10:21:46 31 don't know if you've been keeping
10:21:48 32 track of it?

10:21:51 THE CLERK: I have, I'm just going
10:21:52 to pull that up. Our next letters
10:22:00 exhibit would be F I believe.
10:22:03 THE COMMISSIONER: Okay. So we'll
10:22:04 call this Exhibit F for the
10:22:06 purposes of identification. Just
10:22:08 to be clear for everyone, the
10:22:11 letters exhibits will not be
10:22:13 placed on the website.
10:11:42 EXHIBIT NO. F: Marked for
10:11:42 identification, document 43003.
10:22:21 BY MS. MEADUS:
10:22:21 Q. Can you scroll down a little
10:22:22 bit please?
10:22:24 So this is an interview that they
10:22:26 did when they were doing the review, the
10:22:30 inspection of the home following the deaths,
10:22:32 okay? And this is an interview of the sister
10:22:35 of Mr. Hedges. So we can go along a little
10:22:37 bit further please.
10:22:39 So they asked a number of questions
10:22:47 about Mr. Hedges. So right here it says the
10:22:54 time is 1:54, and at that point in time the
10:22:57 interviewer said -- asked her if there
10:22:58 anything else you would like to add? And I'm
10:23:01 just going to review a little bit about what
10:23:01 she had to say.
10:23:01 "Can I ask you a question? Of
10:23:09 course you can. I don't know if
10:23:11 this is anything you can tell me or
10:23:13 if I have to wait. We're going to
10:23:15 see the Crown attorney in a couple

10:23:17 of days. Why weren't we getting
10:23:19 any answers from Caressant Care
10:23:20 when he passed a way? Mom and dad
10:23:22 tried and tried to get answers as
10:23:24 to what happened and they would not
10:23:25 tell them anything, and they
10:23:25 referred them to coroners office
10:23:27 and the coroners office had no
10:23:28 answers."
10:23:31 So a little bit farther down it
10:23:33 says, it was a question:
10:23:34 "So your mom and dad were looking
10:23:36 for answers before and after he
10:23:38 passed away about his condition?"
10:23:40 And his sister says:
10:23:42 "They called about 1 o'clock in
10:23:44 morning or something and said he
10:23:45 passed away. And they tried for --
10:23:46 I bet they tried for months to find
10:23:48 out, to find out why he passed
10:23:49 away. So to this day we still
10:23:51 really don't know why he passed
10:23:53 away."
10:23:53 And the questioner say:
10:23:55 "Did they talk to the doctor at
10:23:57 all? I don't know who they talked
10:23:59 to so I would imagine they did
10:24:01 because they tried every route
10:24:03 they could think of to find out
10:24:05 what was going on and nobody could
10:24:07 tell us anything. So I'm hoping
10:24:08 that maybe we can go up on the 6th

10:24:09 actually to the Courthouse to talk
10:24:11 to prosecutors office. I'm hoping
10:24:13 we can get answers then. I don't
10:24:14 know if we will or not."
10:24:16 And then there's a question:
10:24:17 "And they told you to call the
10:24:18 coroners office."
10:24:18 And the answer is:
10:24:20 "That's what my mom had said. They
10:24:22 said, well contact the coroners
10:24:23 office. Unless there was an
10:24:25 autopsy done there wouldn't be any
10:24:26 reason for the coroner to be
10:24:28 involved."
10:24:28 And then the question i:
10:24:29 "So to your knowledge the coroner
10:24:32 wasn't involved in his death?"
10:24:33 And the answer was:
10:24:34 "Not to my knowledge because there
10:24:36 was never an autopsy done or
10:24:37 anything. At least if there was we
10:24:40 weren't told there was."
10:24:42 So it would appear that there were
10:24:43 concerns in this family about the death and
10:24:45 that was not reflected on the document.
10:24:47 Would you agree from this information, from
10:24:50 this information.
10:24:51 MS. BAMBERS: Well, I'm just
10:24:52 concerned about how the question
10:24:53 is phrased, Commissioner, because
10:24:55 this is really kind of triple
10:25:00 hearsay. It's coming from what

10:25:02 1 the daughter was told by the
10:25:04 2 mother. The mother and father
10:25:07 3 both passed. If you read further
10:25:09 4 in this document she says that --
10:25:12 5 well, she does say we've heard --
10:25:14 6 she doesn't know who she spoke to,
10:25:16 7 who the parents spoke to. And it
10:25:18 8 also says that she read the
10:25:23 9 mother's diary.
10:25:25 10 So I'm concerned that even when
10:25:27 11 Rhonda Kukoly testifies we're not
10:25:29 12 going to -- there's no clear
10:25:32 13 statement of what the family told
10:25:37 14 anyone. And to suggest that they
10:25:39 15 had contact with the coroners
10:25:40 16 office and didn't get answers, it's
10:25:43 17 not clear at all.
10:25:43 18 So I'm okay with a more general
10:25:46 19 question of procedure but not what
10:25:47 20 was told to this witness.
10:25:50 21 MS. MEADUS: And I'm actually
10:25:51 22 trying to get to something that I
10:25:52 23 think will be very helpful so I'm
10:25:54 24 just going to ask the question.
10:25:55 25 BY MS. MEADUS:
10:25:55 26 Q. And understanding exactly
10:26:00 27 what has just been said, would you agree
10:26:03 28 that families don't really know what the
10:26:05 29 coroner office does necessarily?
10:26:09 30 A. I think that's a fair
10:26:09 31 statement that the public does not fully
10:26:12 32 understand what the coroners office does.

10:26:15 Q. And they don't know the
10:26:16 difference between an investigation and
10:26:18 having an autopsy; is that correct?
10:26:19 A. That would be a fair
10:26:20 statement.
10:26:21 Q. And from this kind of a
10:26:24 comment would you agree that it might be
10:26:25 helpful, especially in long-term care, to
10:26:28 have some kind of information package from
10:26:30 the coroners office explaining what the role
10:26:32 was, that could perhaps be given to families
10:26:35 so that they understood? And giving them
10:26:37 information about what they might ask if
10:26:39 they had questions?
10:26:40 A. The coroners office had -- at
10:26:44 that time had a pamphlet to that coroners
10:26:48 could provide to families with regards to
10:26:52 what a coroner is, what a coroners
10:26:56 investigation does and had a place on it for
10:26:59 the coroner to put their contact information
10:27:03 on the form, or on the pamphlet, so that the
10:27:08 family could contact the coroner if they had
10:27:13 any questions or concerns.
10:27:15 Subsequently we have developed a
10:27:17 booklet, that's bilingual, that also has all
10:27:22 the information that the coroners can provide
10:27:27 to families at the time of first contact.
10:27:33 And, again, it has a place for the coroner to
10:27:37 put their contact information on it so that
10:27:41 the families can contact the coroner. And it
10:27:45 also has on it the -- the regional coroners
10:27:52 offices so that if the family is having

10:27:57 1 difficulties contacting the coroner, because
10:28:00 2 they may have been away on holidays or they
10:28:03 3 may be working and unable to get to the phone
10:28:07 4 at that time, that the families can contact
10:28:10 5 the Regional Supervising Coroners office and
10:28:13 6 can inquire about those types of things.
10:28:17 7 And if a first-degree family member
10:28:23 8 contacts my office and asks, can you -- can I
10:28:28 9 have information about the investigation? We
10:28:32 10 will let them know that, yes, we can provide
10:28:35 11 that to you if you would -- we will send you
10:28:38 12 a form for you to fill out. We can send it
10:28:43 13 to you electronically. We can send it to you
10:28:46 14 by fax. We can send it to you by mail. All
10:28:49 15 you need to do is fill it out and we can
10:28:51 16 provide you with the reports when they are
10:28:56 17 available. And if you wish to speak to the
10:29:00 18 coroner then we will contact the coroner and
10:29:02 19 give them your contact information and let
10:29:06 20 them know that you are asking for
10:29:09 21 information.
10:29:10 22 Q. Okay. Thank you, those are
10:29:11 23 my questions.
10:29:13 24 THE COMMISSIONER: Sorry, may I
10:29:14 25 just ask one question?
10:29:17 26 MS. MEADUS: Sure.
10:29:17 27 THE COMMISSIONER: Who -- how does
10:29:18 28 the family member have an
10:29:20 29 opportunity to get those
10:29:21 30 pamphlets?
10:29:23 31 THE WITNESS: At first contact
10:29:24 32 when the coroner contacts the

10:29:27 1 family, so if in a setting, in a
10:29:34 2 home setting, for example, they
10:29:35 3 can provide the pamphlet.
10:29:38 4 THE COMMISSIONER: But it's
10:29:38 5 discretionary? It's up to the
10:29:40 6 coroner to decide whether or not
10:29:41 7 to give it to them?
10:29:43 8 THE WITNESS: It's recommended
10:29:43 9 that they do but it's not
10:29:45 10 mandatory that they do.
10:29:50 11 Now at 3 o'clock in the morning in a
10:29:54 12 long-term care setting that's a bit more
10:29:56 13 difficult, but the coroner should leave
10:29:58 14 something there for the nursing home to
10:30:03 15 provide to the family, or at least the
10:30:07 16 contact information of the coroner or how
10:30:10 17 to get in touch with the coroner.
10:30:13 18 THE COMMISSIONER: So if I may?
10:30:15 19 So has any thought been given to
10:30:18 20 leaving that kind of information,
10:30:19 21 or even a part of it, in the
10:30:22 22 nursing home -- in the long-term
10:30:25 23 care homes so that if the coroner
10:30:26 24 wasn't there or whatever they have
10:30:28 25 some information to provide or
10:30:30 26 not?
10:30:33 27 THE WITNESS: I don't think that
10:30:34 28 we've thought about that but that
10:30:36 29 might be something that we
10:30:38 30 would -- we as an office might
10:30:42 31 want to consider.
10:30:43 32 THE COMMISSIONER: Thank you, Ms.

10:30:43 Meadus.
10:30:45 MS. MEADUS: Thank you.
10:30:51 MS. ROBINSON: Ms. Butt on behalf
10:30:53 of the Ontario Nurses Association.
10:30:55 MS. BUTT: ONA has no questions.
10:30:58 THE COMMISSIONER: Thank you.
10:31:02 MS. ROBINSON: Ms.
10:31:02 Schwartzentruber on behalf of the
10:31:04 College of Nurses.
10:31:11 MS. SCHWARTZENTRUBER: College of
10:31:11 Nurses has no questions for this
10:31:12 witness.
10:31:12 THE COMMISSIONER: Thank you.
10:31:12 MS. ROBINSON: Mr. Schwartz on
10:31:12 behalf of AdvantAge Ontario.
10:31:15 MR. SCHWARTZ: AdvantAge Ontario
10:31:16 has no questions for this witness.
10:31:19 MS. ROBINSON: In that case
10:31:20 Ms. Bambers on behalf of the
10:31:22 Province.
10:31:27 RE-EXAMINATION BY MR. BAMBERS:
10:31:34 Q. Just one question, Dr. Mann,
10:31:35 you mentioned that to date there has been no
10:31:39 tracking of trends or patterns on the case
10:31:43 selection forms, correct?
10:31:46 A. Not to my knowledge.
10:31:47 Q. And as it stands now it would
10:31:52 require going through each paper and
10:31:54 identifying the trends because it's not
10:31:56 computerized?
10:31:57 A. That's correct.
10:31:58 Q. And that would be much easier

10:31:59 1 to do if it was computerized?
10:32:02 2 A. And I think, as Dr. Huyer was
10:32:04 3 mentioning in his testimony, we are -- we're
10:32:08 4 moving to a more robust and computer-based
10:32:13 5 system so that once we get there there would
10:32:17 6 be the possibility of being able to do some
10:32:22 7 of that tracking and searching.
10:32:26 8 Q. Thank you. Those are all my
10:32:28 9 questions.
10:32:29 10 A. Thank you.
10:32:30 11 THE COMMISSIONER: Thank you very
10:32:30 12 much.
10:32:33 13 MS. ROBINSON: We have no further
10:32:34 14 re-examination for Dr. Mann.
10:32:37 15 THE COMMISSIONER: Thank you very
10:32:37 16 much. Dr. Mann, thank you so
10:32:40 17 much. You're free to go. We very
10:32:42 18 much appreciate your time.
10:32:43 19 THE WITNESS: Thank you. Thank
10:32:43 20 you, Madam Commissioner,
10:32:45 21 appreciate the opportunity.
10:33:26 22 MS. JONES: Morning Commissioner.
10:33:29 23 THE COMMISSIONER: Morning.
10:33:30 24 MS. JONES: We've passed up a
10:33:31 25 document brief which we'll be
10:33:33 26 using for the next two witnesses.
10:33:35 27 And if I can now call Dr. William
10:33:37 28 George please?
10:33:38 29 DR. WILLIAM GEORGE: SWORN
10:34:25 30 EXAMINATION IN-CHIEF BY MS. JONES:
10:34:44 31 THE COMMISSIONER: Morning,
10:34:45 32 Dr. George, you sound like a very

10:34:46 soft spoken person so I will
10:34:48 encourage you to try to keep your
10:34:50 voice up. The transcriptionist
10:34:53 will still need to hear you.
10:34:55 Thank you so much.
10:34:56 THE WITNESS: All right.
10:34:59 BY MS. JONES:
10:35:00 Q. Morning, Dr. George.
10:35:02 A. Morning.
10:35:02 MS. JONES: And I note for the
10:35:03 benefit of the Commissioner that
10:35:05 Dr. George's co-counsel,
10:35:05 Mr. Hubbard, has joined us as
10:35:08 counsel table.
10:35:10 THE COMMISSIONER: Morning, Mr.
10:35:10 Hubbard.
10:35:11 BY MS. JONES:
10:35:11 Q. Dr. George, I'm going to
10:35:12 begin by asking you some questions about
10:35:13 your background. And you should have in
10:35:15 front of you a document brief. I'm going to
10:35:18 ask you to turn to tab 1 of that brief.
10:35:25 A. Okay.
10:35:25 Q. And is this your curriculum
10:35:27 vitae?
10:35:28 A. Yes, it is.
10:35:29 Q. And it is an accurate summary
10:35:30 of your education and work experience?
10:35:32 A. It is a brief summary.
10:35:34 Q. And if we can mark
10:35:35 Dr. George's curriculum vitae as the next
10:35:38 exhibit.

10:35:44 THE COMMISSIONER: So currently it
10:35:45 is 72831 in the documents?
10:35:49 MS. JONES: That's right, but it's
10:35:50 not yet an exhibit, Commissioner.
10:35:51 THE COMMISSIONER: Okay.
10:35:51 MS. JONES: And if we can pull
10:35:52 that up as well it's document
10:35:55 72831.
10:35:56 THE COMMISSIONER: So, Madam
10:35:56 Clerk, if I'm right that's Exhibit
10:35:57 106.
10:35:57 THE CLERK: That's right.
10:35:57 THE COMMISSIONER: So Exhibit 106,
10:35:57 a single page summary of
10:35:57 Dr. George's resume.
10:36:01 EXHIBIT NO. 106: Summary of
10:36:09 Dr. George's resume, document
10:36:12 72831.
10:36:27 BY MS. JONES:
10:36:27 Q. Dr. George, you are a
10:36:28 physician, correct?
10:36:29 A. Yes.
10:36:29 Q. And you have practiced
10:36:31 medicine in Ontario since 1989?
10:36:36 A. Yes, that's correct.
10:36:38 Q. And I understand from your
10:36:40 curriculum vitae that you graduated from
10:36:42 medical school in Bulgaria in 1986?
10:36:47 A. That's correct.
10:36:47 Q. And you then did a rotating
10:36:49 internship in Saskatchewan, for a year?
10:36:53 A. That's correct.

10:36:54 Q. And following that you did a
10:36:55 year of internal medicine residency at
10:36:58 Sunnybrook Hospital in Toronto?
10:36:59 A. That's correct.
10:37:02 Q. And I also understand, if we
10:37:04 look at your education, that in 1994 after
10:37:08 you had begun practicing medicine you did
10:37:11 return to school and do some postgraduate
10:37:14 training in anaesthesia?
10:37:17 A. That is correct.
10:37:17 Q. Most recently in the year
10:37:20 2017 you completed further education this
10:37:23 time in practical dermatology?
10:37:26 A. That's correct.
10:37:28 Q. Now in terms of your work
10:37:29 experience, if we look at your curriculum
10:37:32 vitae and we scroll down a little bit on the
10:37:35 page, the third point under your work
10:37:41 experience provides that between 1987 and
10:37:45 1992 you practiced as a general duty medical
10:37:50 officer and flight surgeon in the Canadian
10:37:51 Armed Forces?
10:37:52 A. That's correct.
10:37:53 Q. And there you held the rank
10:37:54 of Captain in the Air Force?
10:37:55 A. Yes.
10:37:56 Q. And we also learned under
10:37:58 your work experience that in 1994 you moved
10:38:01 to Woodstock where you started a private
10:38:03 practice?
10:38:04 A. That is correct.
10:38:05 Q. And I also understand that at

10:38:06 1 that time you began working at the Woodstock
10:38:08 2 General Hospital where you continue to work
10:38:13 3 until this day?
10:38:13 4 A. That's true.
10:38:14 5 Q. And in fact in 2011 you
10:38:17 6 became the chief of perioperative care at
10:38:21 7 the hospital?
10:38:23 8 A. Perioperative services.
10:38:24 9 Q. And what are perioperative
10:38:27 10 services?
10:38:27 11 A. That encompasses the
10:38:29 12 department of anesthesia, the department of
10:38:29 13 surgery, day care and post-operative care.
10:38:32 14 So it involves supervising about 65 or 70
10:38:35 15 people.
10:38:36 16 Q. There's also reference in
10:38:37 17 your curriculum vitae to your work as a
10:38:39 18 civil aviation medical examiner?
10:38:42 19 A. Yes, that's correct.
10:38:43 20 Q. And what does that role
10:38:44 21 entail?
10:38:45 22 A. As part of my stint in the
10:38:47 23 Canadian Armed Forces as a flight surgeon I
10:38:50 24 was responsible for maintaining flying crew
10:38:55 25 for our Air Force. And so when I left the
10:38:58 26 military I maintained my civil aviation
10:39:01 27 status and I do pilot physicals on a regular
10:39:05 28 basis.
10:39:06 29 Q. And does your current
10:39:08 30 practice involve a private practice, a
10:39:11 31 hospital practice and your civil aviation
10:39:13 32 medical examiner work?

10:39:17 A. Yes it does.
10:39:18 Q. And how do you divide your
10:39:20 time between those elements of your
10:39:22 practice?
10:39:22 A. Two day a week I'm in the
10:39:24 operating room; three days a week, Tuesday,
10:39:28 Wednesday and Friday I'm in my office; I
10:39:30 also have a nurse practitioner; and the
10:39:33 civil aviation and dermatology components
10:39:36 are added on to that. We also provide a
10:39:39 little bit of after-hours services through
10:39:40 our office as well.
10:39:42 Q. And is that a full-time
10:39:44 practice between all of those
10:39:46 responsibilities?
10:39:47 A. Yes.
10:39:47 Q. And in terms of your private
10:39:50 practice am I correct that it's part of a
10:39:52 family health team?
10:39:53 A. Yes.
10:39:55 Q. And as part of your family
10:39:57 health team practice are any of your
10:40:00 patients in long-term care homes?
10:40:02 A. Yes.
10:40:02 Q. And how does that work in
10:40:05 terms of seeing patients that are in
10:40:09 long-term care homes? Do you have certain
10:40:10 days on which you go and visit them?
10:40:13 A. At any given time I probably
10:40:13 have about four or five patients that are in
10:40:16 one of the three nursing homes in Woodstock
10:40:18 and I usually try and get to see them once

every couple of months.

Q. And have you ever had any patients at Caressant Care, Woodstock?

A. Yes, I have.

Q. And what about Meadow Park or Telfer Place?

A. No.

Q. Now, Dr. George, on top of the practice you've just described I understand you're also a coroner?

A. That's correct.

Q. And when did you become a coroner?

A. 2004.

Q. In 2004 when you became a coroner what training had you received?

A. As part of my medical school my last year we had a full year of forensic medicine. Subsequent to attending university I was a morgue attendant or the term is usually a "diener" in a morgue at the North York General hospital for a couple of years.

Our course through the coroners office was a 3-day course held in Toronto.

Q. Is so it fair to say that the required training you had was the then 3-day course in Toronto?

A. That's correct.

Q. But you also, through your own personal experience, had had some forensic medicine training in medical school

10:41:31 1 in Bulgaria?
10:41:33 2 A. That's correct.
10:41:33 3 Q. And is it your understanding
10:41:35 4 that that sort of forensic medicine training
10:41:37 5 is standard in our universities and medical
10:41:39 6 schools in Ontario?
10:41:40 7 A. I'm not sure that it is.
10:41:48 8 Q. After you did the new
10:41:49 9 coroners course did you receive any other
10:41:53 10 course-based training before you started to
10:41:55 11 work as a coroner in Ontario?
10:41:57 12 A. No. There was no course
10:41:58 13 after that, there was a mentorship period.
10:42:03 14 Q. And can you describe the
10:42:04 15 mentorship please?
10:42:05 16 A. At the time the regional
10:42:07 17 coroner was out in Guelph, Dr. Acheson, and
10:42:11 18 I was to call with each case that I had and
10:42:14 19 discuss with her each situation no matter
10:42:17 20 what time of day it was.
10:42:19 21 Q. And were you to call her at
10:42:21 22 the point of deciding whether or not to do a
10:42:23 23 death investigation or only once you had
10:42:26 24 decided to do a death investigation?
10:42:28 25 A. Either.
10:42:29 26 Q. Either, okay. And do you
10:42:30 27 have any recollection now about how long a
10:42:33 28 period of time that period of mentorship
10:42:36 29 was?
10:42:36 30 A. Six months.
10:42:43 31 Q. And when you say you were to
10:42:44 32 call the Regional Supervising Coroner were

there certain points throughout the process of deciding whether to do an investigation and conducting a death investigation that you were to check in with the Regional Supervising Coroner as part of your training?

A. Yes, I'd usually call her to start with and then she'd want to speak to me later about what I thought about the case and how I was going to put it together.

Q. Did you find the mentorship to be a helpful process?

A. Very helpful.

Q. And did you, when you started -- when you had done your course and you had started -- you had completed your mentorship did you feel you were appropriately prepared to work as a coroner?

A. I felt so. I always had the option of calling her in any kind of situation.

Q. Is it your understanding that once you become a coroner and you go through the mentorship and the new coroners course, is it your understanding that there's any further mandatory training that you're required to do to maintain your coroners status?

A. I'm not sure if it was mandatory but we were to attend the courses held every year by the coroners office every other year.

10:43:57 Q. So your understanding was the
10:43:58 expectation was to go to the annual coroners
10:44:01 course every two years?
10:44:03 A. Every other year.
10:44:04 Q. And did you do that?
10:44:05 A. I believe so.
10:44:09 Q. And we heard evidence earlier
10:44:11 that at a certain point that rotating every
10:44:15 year or every few years system changed to a
10:44:19 system where coroners were invited to come
10:44:21 every year if they chose to?
10:44:23 A. That's correct.
10:44:24 Q. And have you been attending
10:44:25 the annual coroners course since that
10:44:27 change?
10:44:28 A. Yes, the last one I attended
10:44:30 was last November.
10:44:36 Q. Other than the new -- sorry,
10:44:38 the annual coroners course do you attend
10:44:42 other coroner training?
10:44:45 A. Not formally.
10:44:48 Q. And today, now that you are
10:44:51 an experienced coroner, do you have any
10:44:54 ongoing mentorship by your Regional
10:44:55 Supervising Coroner?
10:44:57 A. The regional coroner is
10:45:01 always available by telephone and is always
10:45:04 ready to help. Even on-call when you call
10:45:08 somebody you usually get somebody on the
10:45:09 other end and you can have a discussion and
10:45:12 that can help you through a difficult
10:45:14 situation.

10:45:16 Q. And Dr. Mann has given
10:45:20 evidence that on occasion he'll review a
10:45:22 Form 3 and have questions about it and call
10:45:25 the local coroner. Have you been the
10:45:27 recipient of that sort of feedback on your
10:45:31 Form 3s?
10:45:31 A. Occasionally.
10:45:34 Q. We've also heard evidence
10:45:36 over the last couple of days, Dr. George,
10:45:40 from Dr. Huyer about certain memos and best
10:45:46 practice guidelines issued from his office.
10:45:48 You're familiar with those documents?
10:45:50 A. Yes.
10:45:51 Q. And do you receive those
10:45:52 documents in some way over the course of
10:45:54 your practice?
10:45:55 A. Yes, we receive them
10:45:57 electronically. We used to receive them in
10:45:59 the mail and they used to go into a big
10:46:01 binder.
10:46:02 Q. And now that you receive them
10:46:03 electronically what's your practice?
10:46:05 A. I save them as a PDF file.
10:46:08 Q. Do you review them?
10:46:09 A. Yes.
10:46:10 Q. And after you review them and
10:46:12 you save them do you have occasion to
10:46:15 reference them or refer to them?
10:46:17 A. Occasionally.
10:46:20 Q. And we've also heard evidence
10:46:22 about a Coroners Investigation Manual, and
10:46:26 as part of that Manual guidelines for death

10:46:28 1 investigations?
10:46:29 2 A. That's correct.
10:46:30 3 Q. You're familiar with the
10:46:33 4 Coroners Investigation Manual?
10:46:34 5 A. Yes.
10:46:34 6 Q. And is it fair to describe it
10:46:36 7 as a key foundational document for coroners
10:46:39 8 in Ontario?
10:46:40 9 A. Yes.
10:46:42 10 Q. And is it a document that you
10:46:47 11 keep yourself updated on as the document
10:46:50 12 changes?
10:46:50 13 A. Yes. It's downloaded as a
10:46:53 14 PDF file and it's got tabs so you can access
10:46:56 15 it fairly quickly.
10:46:57 16 Q. Okay.
10:46:57 17 A. And I believe it was last
10:47:00 18 updated in 2013.
10:47:02 19 Q. And do you have occasion to
10:47:05 20 reference the Coroners Investigation Manual
10:47:07 21 or the guidelines in the conduct of your
10:47:10 22 death investigations?
10:47:11 23 A. Yes.
10:47:16 24 Q. Dr. George, you're the first
10:47:19 25 local, currently-practicing coroner we've
10:47:24 26 heard from. And I'm going to ask you some
10:47:26 27 questions from that perspective about the
10:47:29 28 process of being contacted by provincial
10:47:31 29 dispatch?
10:47:32 30 A. Okay.
10:47:33 31 Q. So I understand from Dr. Mann
10:47:35 32 that until around 2012 there was a call

10:47:39 service in London?
10:47:40 A. That's correct.
10:47:42 Q. But since that time when you
10:47:44 get contacted about a death you would be
10:47:46 contacted through provincial dispatch?
10:47:49 A. Through central dispatch,
10:47:50 yes.
10:47:51 Q. Central dispatch. But that's
10:47:53 a provincial service?
10:47:54 A. Yes.
10:47:57 Q. And I want you to walk us
10:47:59 through the process of receiving the call
10:48:01 and determining whether or not to conduct a
10:48:04 death investigation. So, first,
10:48:08 approximately how many calls would you
10:48:11 receive from provincial dispatch on a
10:48:14 monthly basis?
10:48:16 A. Perhaps seven or eight calls,
10:48:17 maybe as many as 10 call as month.
10:48:20 Q. And has that number stayed
10:48:22 relatively consistent since 2004? Has it
10:48:25 gone up? Has it gone down?
10:48:27 A. It varies widely. You could
10:48:29 be very busy one week and not have a call
10:48:32 for several weeks.
10:48:33 Q. And are you, in your region,
10:48:34 on a call schedule or could you get calls at
10:48:37 any time?
10:48:38 A. We're on a -- we could get
10:48:41 calls ate at any time. I believe that the
10:48:44 central dispatch goes through a -- they go
10:48:47 through people.

10:48:49 Q. When you get a call from
10:48:50 provincial dispatch reporting on a death
10:48:52 what information do you receive?
10:48:54 A. Usually central dispatch will
10:48:59 call, and if it's in the middle of the night
10:49:00 I'll get up and go into the room where
10:49:04 there's a desk and put my glasses on,
10:49:06 because I can't see, and then I'll make some
10:49:08 notes.
10:49:09 And usually central dispatch will
10:49:12 provide a synopsis of what's occurred and
10:49:14 provide some telephone numbers, a telephone
10:49:17 number and a contact number.
10:49:19 Q. And the contact number is for
10:49:21 who?
10:49:21 A. Maybe for the police, it may
10:49:23 be the hospital, it may be long-term care
10:49:27 facility.
10:49:28 Q. And if it's a long-term care
10:49:29 facility who's typically the contact?
10:49:32 A. Typically if it's after hours
10:49:37 you would be put through to the ward where
10:49:38 the death has occurred. So it would be the
10:49:41 RN that would be on -- that would be taking
10:49:43 the call.
10:49:45 Q. And when you receive these
10:49:47 calls from provincial dispatch are there
10:49:49 ever occasions where you advise provincial
10:49:53 dispatch that you're not going to take the
10:49:54 case? And I don't mean you've weighed it
10:49:57 and decided on a death investigation, but
10:50:01 even that you're not going to go through

10:50:02 1 that process for some reason?
10:50:04 2 A. Yes, because, as Dr. Mann
10:50:05 3 stated, a lot of times I'm in the operating
10:50:08 4 room or I'm in the middle of something and I
10:50:09 5 can't leave so I would decline the case.
10:50:12 6 Q. And if you decline the case
10:50:14 7 what's your understanding of what happens
10:50:16 8 next?
10:50:16 9 A. They would move onto the next
10:50:18 10 person. I always qualify that with central
10:50:19 11 dispatch by saying that if they can't find
10:50:24 12 anybody to please call me back and I can see
10:50:26 13 what kind of arrangements I would make.
10:50:29 14 Q. And is it ever the case that
10:50:31 15 you can determine at that very first stage,
10:50:32 16 when you first get the call from provincial
10:50:35 17 dispatch, whether or not this is a coroner's
10:50:38 18 case?
10:50:38 19 A. Sometimes.
10:50:39 20 Q. And can you give me an
10:50:40 21 example of that?
10:50:42 22 A. Sometimes central dispatch
10:50:44 23 will call and they'll say that the police
10:50:46 24 have called from a home, and they'll say
10:50:48 25 that it's a palliative care patient who was
10:50:51 26 expected to die and that they can't get hold
10:50:54 27 of the family doctor.
10:50:55 28 Q. And what would happen in that
10:50:56 29 case?
10:50:58 30 A. I would try and locate
10:51:00 31 somebody or I would go out and do it myself.
10:51:07 32 Q. Now, if you do get a call

10:51:09 1 from provincial dispatch and you can't
10:51:12 2 immediately determine whether or not it's a
10:51:15 3 coroner's case do you go through a process
10:51:17 4 to make that determination about whether or
10:51:19 5 not a death investigation is warranted under
10:51:21 6 the Act?
10:51:22 7 A. Absolutely.
10:51:23 8 Q. And so what do you do? So
10:51:24 9 you get the call from provincial dispatch,
10:51:27 10 what's your next step?
10:51:28 11 A. They would provide me with a
10:51:30 12 name and the date of birth; and then a lot
10:51:32 13 of times from home I can simply access the
10:51:34 14 files, the medical records electronically
10:51:37 15 from the hospital and glean it information
10:51:40 16 from there, which is usually very useful.
10:51:44 17 Q. Obtaining the medical records
10:51:46 18 from the hospital?
10:51:47 19 A. From the hospital or from --
10:51:49 20 because we're in a family health team I have
10:51:51 21 access to all of the records as well. So we
10:51:55 22 can pull up somebody's records quite
10:51:59 23 quickly.
10:51:59 24 Q. Do you have access to that --
10:52:01 25 those sorts of records in the long-term care
10:52:03 26 home context?
10:52:04 27 A. No, we don't.
10:52:06 28 Q. So you're provided with a
10:52:08 29 contact information, and let's take the
10:52:10 30 long-term care home context. You don't have
10:52:12 31 access to the medical records. What do you
10:52:14 32 do next? Do you call the contact person?

10:52:17 A. I would call the contact
10:52:18 person.
10:52:19 Q. And can you walk me through
10:52:21 what questions you asked the contact person?
10:52:23 A. I would, you know, call the
10:52:26 contact person and ask, you know, what the
10:52:29 situation is. And most often they would
10:52:33 give you a brief summary of what had
10:52:36 occurred and, you know, what the situation
10:52:38 was and that kind of thing.
10:52:44 And then if I needed more
10:52:45 information then I would, you know, probably
10:52:50 look for more information on-line through the
10:52:53 Cerner system or through our EMR to find out
10:52:57 if I can see anything else on the patient if
10:53:00 they've been to hospital, et cetera.
10:53:15 Q. So if I understand your
10:53:16 evidence correctly, in the long-term care
10:53:17 home context you wouldn't have access to
10:53:23 long-term care home records at that stage?
10:53:24 A. No.
10:53:25 Q. But you might look to see if
10:53:27 you could access other either hospital
10:53:29 records or family health team records?
10:53:31 A. Yeah, a visit to the hospital
10:53:32 and that way I can get a summary of their
10:53:35 medications. I can get that from the
10:53:36 nursing home as well because they can read
10:53:38 it off the medication summary.
10:53:40 Q. Do you think it would be
10:53:41 helpful if you could access to long-term
10:53:45 care home records directly at this stage?

10:53:47 A. It would be helpful.
10:53:52 Q. You started to describe your
10:53:54 conversation with the contact person, that
10:53:55 you asked them about the circumstances of
10:53:57 the death. Do you ask them about the
10:53:58 patient's medical history.
10:54:01 A. Yes, the patient's medical
10:54:02 history: How long they've been there? What
10:54:05 their previous level of functioning was?
10:54:07 What their co-morbidities are? That kind of
10:54:12 thing. Whether anything else is happening
10:54:14 at the nursing home? Whether they're in the
10:54:15 midst of an outbreak? Or that kind of
10:54:19 thing.
10:54:20 Q. At this stage when you're
10:54:22 having this initial discussion with the
10:54:23 contact person do you have the Institutional
10:54:27 Patient Death Record?
10:54:30 A. When I'm on the telephone?
10:54:31 Q. Yes.
10:54:32 A. No.
10:54:35 Q. So how do you determine why
10:54:39 you've been called in terms of what boxes
10:54:41 have been checked "yes" on that
10:54:44 Institutional Patient Death Record?
10:54:47 A. I have the -- a case
10:54:50 selection form that's pinned to my bulletin
10:54:54 board in front of my desk and I go through
10:54:57 the elimination --
10:54:58 Q. Before we get there,
10:54:58 Dr. George, before we get to the case -- and
10:54:58 I do want to hear about that, but my

10:55:02 question is, taking a step back, you don't
10:55:04 have the IPDR in front of you, correct?
10:55:08 A. Right, I would ask the nurse
10:55:09 if there were anything checked off that was
10:55:11 of concern.
10:55:12 Q. Okay.
10:55:12 A. I'm sorry.
10:55:14 Q. That's all right. So you
10:55:15 would ask the nurse, What did you check off
10:55:17 on the IPDR?
10:55:18 A. That's right.
10:55:22 Q. And what are you trying to
10:55:24 determine at this initial stage when you're
10:55:27 speaking to the contact person? What
10:55:28 assessment are you making?
10:55:30 A. We're trying to determine if
10:55:32 the case is a coroners case, warrants
10:55:36 furthers investigation or not.
10:55:41 Q. And in a long-term care home
10:55:44 context what's typically the decision point
10:55:48 on that in terms of whether or not it's a
10:55:50 coroners case?
10:55:53 A. Whether the death was
10:55:54 accidental; whether there are any kind of
10:55:59 unusual circumstances; whether there's an
10:56:01 outbreak; whether there's an infectious
10:56:04 outbreak going on.
10:56:06 Q. Now, other than the
10:56:07 contact -- speaking to the contact person
10:56:10 and looking at the records, as you've
10:56:12 described, do you typically speak to anyone
10:56:14 else at this assessment stage?

10:56:16 A. Not usually.
10:56:20 Q. Do you ever speak to the
10:56:22 family at this stage if they're not the
10:56:24 contact person?
10:56:25 A. No.
10:56:26 Q. And what about treating
10:56:28 physicians? Do you ever speak to treating
10:56:31 physicians at this stage?
10:56:32 A. Yes.
10:56:33 Q. And under what circumstances
10:56:35 would you do that?
10:56:36 A. If there was some concerns
10:56:37 from the treating physician. Sometimes in a
10:56:40 nursing home the treating physician may have
10:56:43 initiated the call to central dispatch.
10:56:52 Q. When determining, again at
10:56:55 this assessment stage, whether or not to
10:56:57 conduct a death investigation do you have to
10:57:01 decide in some cases whether or not in your
10:57:04 view a death was sudden and unexpected?
10:57:09 A. Yes, that is one of the
10:57:10 questions.
10:57:11 Q. And in the context of a death
10:57:19 in a long-term care home what does "sudden
10:57:22 and unexpected" mean to you?
10:57:26 A. I'm not sure that the term
10:57:28 "sudden and unexpected" in a nursing home is
10:57:31 entirely appropriate. I think a death can
10:57:33 be sudden but it may have been foreseeable
10:57:35 or expected.
10:57:36 Many of these unfortunate people
10:57:38 have lots of co-morbid conditions. They're

10:57:44 1 deconditioned -- they have -- that's their
10:57:47 2 whole reason they're in a nursing home.
10:57:50 3 Q. But can the death of an
10:57:52 4 elderly person with multiple co-morbidities
10:57:55 5 can that death be considered sudden and
10:57:58 6 unexpected?
10:57:59 7 A. I'm not entirely sure that
10:58:03 8 that's a good term to be used in a nursing
10:58:06 9 home. I think a better term would be was
10:58:08 10 the death foreseeable or expected?
10:58:12 11 Q. Okay. So if we take your
10:58:14 12 terms then, is the death of an elderly
10:58:19 13 person with co-morbidities in a long-term
10:58:21 14 care home, is it always foreseeable and
10:58:25 15 expected or can it be not foreseeable and
10:58:28 16 unexpected, in your view?
10:58:29 17 A. No, I think it's more
10:58:31 18 expected than the general population.
10:58:33 19 Q. It's more expected?
10:58:35 20 A. More expected.
10:58:36 21 Q. But are there cases where it
10:58:38 22 could be considered unexpected?
10:58:40 23 A. There may be a nursing home
10:58:42 24 resident with -- who is there for -- who is
10:58:47 25 generally -- doesn't have a lot of
10:58:50 26 co-morbidities. In that kind of situation
10:58:52 27 it may be somebody that's been there for
10:58:54 28 many years that's mentally challenged or
10:58:58 29 something and doesn't have a lot of other
10:58:59 30 illnesses. And so in that case, you know,
10:59:02 31 it could be sudden and unexpected.
10:59:06 32 Q. And can you think of another

10:59:08 example for an elderly person with
10:59:11 co-morbidities where the death would be
10:59:13 sudden and unexpected or not foreseeable?
10:59:16 A. If, for example, they were
10:59:17 assaulted by another patient.
10:59:24 Q. Do you consider -- during
10:59:26 this assessment phase do you consider the
10:59:29 manner in which the patient died? Or do you
10:59:32 obtain information about that? So not just
10:59:35 that the patient passed away and what their
10:59:38 co-morbidities were, but also in their final
10:59:43 stages or their final days of life what
10:59:45 their condition was?
10:59:46 A. Yes. I usually ask, What
10:59:48 were the conditions surrounding their final
10:59:50 illness or the final days to get some sort
10:59:53 of an idea of what had gone on.
10:59:55 Q. And why is that important?
10:59:56 A. Because that can tell us
10:59:59 whether there was something going on and the
11:00:01 death was expected or, you know, something
11:00:04 serious was going on.
11:00:11 Q. Now, you referenced the Case
11:00:13 Selection Data Form, and perhaps we can turn
11:00:16 that up. That's at tab 21 of your document
11:00:22 brief and it's document 71436.
11:00:26 Dr. George, I believe you were
11:00:42 beginning to tell me about your process with
11:00:44 this Case Selection Data Form when I
11:00:46 interrupted you.
11:00:48 So now again we're staying with the
11:00:49 assessment phase, before you've decided

11:00:52 whether or not to do a death investigation.
11:00:54 Does this form, the Case Selection Data Form,
11:00:55 play any role in your assessment?
11:00:58 A. Yes. I keep it in front of
11:01:00 me on the wall, on my bulletin board and I
11:01:05 reference that while I'm speaking to whoever
11:01:07 is on the telephone.
11:01:09 Q. And when you say you
11:01:11 "reference" it do you complete it?
11:01:14 A. Not usually. I'm not in the
11:01:19 habit of completing it.
11:01:20 Q. And we see that the
11:01:22 question -- question number 2 on this Case
11:01:25 Selection Data Form refers to whether the
11:01:27 death was reasonably foreseeable? Is that,
11:01:31 in your view, a different way of looking at
11:01:34 sudden and unexpected or is that a different
11:01:36 question?
11:01:37 A. I think that that's a better
11:01:41 question.
11:01:42 Q. Why is that?
11:01:43 A. Because it says:
11:01:45 "Was the death reasonably
11:01:47 foreseeable and does the cause flow
11:01:49 logically from a natural disease
11:01:51 process."
11:01:53 So it's a lot easier to put things
11:01:56 together in that kind of a light.
11:01:57 Q. Now, you've testified that it
11:02:02 is not your practice to complete the Case
11:02:05 Selection Data form. Is it your
11:02:10 understanding that the completion of this

11:02:11 1 form is mandatory or discretionary?
11:02:13 2 A. I believe it's mandatory.
11:02:15 3 Q. And why do you believe it's
11:02:16 4 mandatory?
11:02:17 5 A. That was recommended in the
11:02:19 6 guidelines.
11:02:20 7 Q. So why don't you complete
11:02:23 8 this form?
11:02:24 9 A. Initially the form when it
11:02:26 10 was presented -- there was a precursor to
11:02:29 11 this form and it was mostly for, from what I
11:02:32 12 understood, for coroners that were receiving
11:02:34 13 a lot of calls that weren't coroners cases
11:02:38 14 and they weren't being reimbursed for them.
11:02:42 15 And that was one of the big concerns perhaps
11:02:46 16 about eight or nine years ago, maybe ten
11:02:49 17 years ago, that there are a lot of calls and
11:02:51 18 people wanted to be reimbursed for them.
11:02:53 19 So I believe the first memo came
11:02:56 20 out from Dr. Stanbrough and there was kind of
11:02:58 21 a basic form without, you know, all of this
11:03:01 22 detail on it that was submitted. And I did
11:03:03 23 use that at the time and then that fell by
11:03:05 24 the wayside.
11:03:06 25 Q. Okay. And if you turn to
11:03:09 26 document 71435, which is at tab 20 of your
11:03:14 27 document brief? You see the "Best Practice
11:03:28 28 Guideline for Investigating Coroners
11:03:29 29 Acceptance of Death Investigation", and
11:03:34 30 there is a date at the bottom of 2010. So
11:03:36 31 are you familiar with this best practice
11:03:38 32 guideline?

11:03:39 A. Yes.
11:03:40 Q. And if we turn now to page
11:03:46 7 -- well actually let's start at page 6.
11:03:55 Under "Procedure" it refers to -- there's
11:04:00 two documents, there's the Case Selection
11:04:01 Data Form and then there's the case
11:04:03 selection invoice. And then it says under
11:04:06 that:
11:04:06 "The Case Selection Data Form will
11:04:08 facilitate collection of data to
11:04:10 ensure the case and decisions can
11:04:13 be reviewed."
11:04:13 Right?
11:04:14 A. That's correct.
11:04:14 Q. And then if you turn over to
11:04:17 page 7? Under "Concluding Remarks" now
11:04:24 there's a paragraph which outlines the
11:04:31 anticipated benefits that will arise from
11:04:34 the submission of the Case Selection Data
11:04:36 Form and it says:
11:04:38 "First, coroners will receive
11:04:41 guidance about what criteria should
11:04:43 be considered."
11:04:44 So that's the first benefit. And
11:04:47 were you receiving guidance from this form in
11:04:49 making your assessment decisions?
11:04:52 A. Guidance from whom?
11:04:53 Q. The Case Selection Data Form
11:04:55 itself?
11:04:56 A. Yes, I was using it.
11:04:57 Q. Okay. And it says, "Second",
11:04:59 and looking at second and third at the same

11:05:03 time:
11:05:03 "Secondly, uniformity in approach
11:05:06 across the Province will be
11:05:08 achieved; and, thirdly, an added
11:05:10 level of oversight will be achieved
11:05:12 by a careful review of the form."
11:05:16 And did you appreciate that those
11:05:18 were also goals of the case selection data
11:05:22 form?
11:05:22 A. Yes.
11:05:22 Q. Okay. And, fourth, as you
11:05:25 mentioned, that coroners will be
11:05:28 compensated, which is the -- your
11:05:31 understanding that you expressed earlier?
11:05:33 A. Which was the main reason
11:05:34 that I thought that this was brought in.
11:05:36 Q. But now looking at these
11:05:39 concluding remarks, and the goals of the
11:05:43 Case Selection Data Form, do you have any
11:05:45 intention in terms of using this form and
11:05:48 submitting this form when doing case
11:05:50 assessments going forward?
11:05:52 A. Going forward, yes,
11:05:53 absolutely.
11:05:53 Q. Do you think it's a helpful
11:05:55 process?
11:05:55 A. I think so.
11:06:03 Q. Now, when you weren't -- you
11:06:09 weren't recording anything on the Case
11:06:10 Selection Form and submitting it, were you
11:06:14 otherwise recording notes during the
11:06:16 assessment process?

11:06:17 A. Yes. I usually had a pad and
11:06:19 paper and I was making notes on the paper.
11:06:23 Unfortunately I didn't maintain those
11:06:25 records for any significant length of time
11:06:29 when it wasn't a corner's case.
11:06:31 Q. So just to unpack that, you
11:06:32 would take notes while you were having your
11:06:34 discussions with dispatch?
11:06:35 A. While I was having a
11:06:37 discussion with dispatch; while I was
11:06:39 then -- when I would call and find out more
11:06:41 information about the case, whether or not
11:06:43 it was a corner's case or not, the
11:06:45 circumstances surrounding the death. I
11:06:48 would be making notes about that. I may
11:06:52 even check and call and find out more
11:06:54 information.
11:06:55 Q. Okay. And then if you
11:06:57 determined that the case was not a coroner's
11:07:00 case, did not meet the criteria for a
11:07:03 coroner's case what did you do with those
11:07:05 notes?
11:07:06 A. I didn't maintain them. I
11:07:07 kept them for a while but then disposed of
11:07:12 them.
11:07:12 Q. And when you say "for a
11:07:14 while" can you give me an idea of what that
11:07:16 means?
11:07:17 A. Probably for a couple of
11:07:18 weeks.
11:07:18 Q. And then you would dispose of
11:07:20 them?

11:07:21 A. Yeah.
11:07:23 Q. And we've heard evidence from
11:07:28 Dr. Huyer that from his perspective the
11:07:31 maintenance of notes, even when you rejected
11:07:35 a death -- let me use a different word, even
11:07:38 when you determined that a death
11:07:39 investigation was not warranted, that the
11:07:42 maintenance of notes was considered
11:07:43 mandatory by the Office of the Chief
11:07:44 Coroner. Did you appreciate that?
11:07:47 A. Not fully. It's because I
11:07:50 felt that, you know, those -- that
11:07:53 information could be obtained from central
11:07:55 dispatch and from the medical records either
11:07:58 at the nursing home, or through the
11:07:59 hospital, or the patient private records.
11:08:03 Q. Okay. So -- and I guess is
11:08:07 it -- to clarify your evidence, you're
11:08:11 giving reasons why perhaps in your view the
11:08:13 maintenance of notes wasn't important?
11:08:16 A. That's right. I didn't
11:08:17 actually see the patient.
11:08:18 Q. Okay, fair enough. But did
11:08:19 you have an understanding that from the
11:08:21 Office of the Chief Coroners view, and I can
11:08:24 take you -- and perhaps we should do that,
11:08:26 if I can take you to tab 24. And this is
11:08:35 document 72826.
11:08:56 And, Dr. George, this document is
11:08:58 part of the Coroners Investigation Manual.
11:08:59 This particular document we see the date at
11:09:03 the bottom June 2013, and there's been

11:09:06 1 evidence that it was the document in place
11:09:08 2 between June 2013 and June 2014. Does that
11:09:13 3 make sense to you?
11:09:14 4 A. That's correct.
11:09:15 5 Q. And if you turn now to page
11:09:18 6 11 in this document and you go under
11:09:31 7 "Reporting" please?
11:09:37 8 A. That's correct.
11:09:37 9 Q. And this document states
11:09:38 10 that:
11:09:38 11 "All cases reported to a coroner,
11:09:41 12 even those that the coroner
11:09:43 13 determines do not require a
11:09:45 14 coroners investigation should be
11:09:46 15 documented in a retrievable and a
11:09:49 16 reviewable manner by the coroner."
11:09:51 17 Do you see that?
11:09:52 18 A. Yes.
11:09:53 19 Q. And the next paragraph says:
11:09:55 20 "For cases declined for
11:09:56 21 investigation, coroners should make
11:09:58 22 and keep a brief record for their
11:09:59 23 own use, with the potential for
11:10:01 24 future review detailing the date,
11:10:01 25 name of the deceased, name of the
11:10:02 26 reporting person and sufficient
11:10:04 27 information to identify the case,
11:10:06 28 and indicating why it did not
11:10:08 29 require a coroners investigation."
11:10:11 30 A. Yes.
11:10:12 31 Q. And as part of your practice
11:10:15 32 would this have been a document that you

were familiar with?
A. Yes.
Q. So now having looked at that document, and again just now taking a step back, did you appreciate or do you now appreciate that the maintenance of notes was mandatory whether or not you accepted a case for investigation?
A. Yes, I realize now that that should have -- those records should have been kept.
Q. Fair enough. And going forward is that your intention?
A. Absolutely.
Q. Now, you've testified that you received seven to eight calls from provincial dispatch roughly a month, and of those calls can you give us a sense of how many then resulted in a death investigation that you personally would conduct as opposed to saying you weren't available to do it?
A. Probably three or four a month.
Q. And in your view is that a sufficient number of death investigations to maintain your skills as a coroner?
A. I think so, yes.
Q. I'm going to ask you some questions now about accepting cases for death investigations in the long-term care home context.
So, first, when was the last death

11:11:42 investigation you did in a long-term care
11:11:44 home?
11:11:45 A. I can't recall.
11:11:46 Q. Can you give us a sense? Is
11:11:47 it a matter of months or years?
11:11:50 A. I think it's years.
11:11:55 Q. And was there a certain point
11:11:57 where you stopped doing as many death
11:12:00 investigations in long-term care homes?
11:12:02 A. That was in 2013.
11:12:05 Q. And what was that the result
11:12:06 of?
11:12:06 A. They did away with the
11:12:09 investigation of threshold cases.
11:12:12 Q. And when they did away with
11:12:14 the investigation of threshold cases did
11:12:16 that have an impact on reducing the number
11:12:18 of death investigations you personally did
11:12:20 in long-term care homes?
11:12:22 A. Yes.
11:12:22 Q. And do you have any view
11:12:29 about that, from your perspective, the value
11:12:30 of threshold death investigations when you
11:12:32 were doing them before 2013?
11:12:34 A. My thought is that it was --
11:12:35 we're frequenting the nursing homes, the
11:12:39 long-term care facilities a lot less than we
11:12:42 were then. And we were in there on a
11:12:44 regular basis and getting to know people and
11:12:47 getting to know the situation I think a lot
11:12:49 better.
11:12:50 Q. When you were doing the

threshold deaths?

A. When we were in there doing threshold cases. Because a threshold case is an exercise in itself. You need to review the medical records, you need to go through all the motions. And I think if for nothing else as an educational thing that that would be very, very helpful for a lot of people.

Q. An educational thing for whom?

A. To maintain your competency as a coroner.

Q. For the coroners themselves?

A. Yes.

Q. Now, so I'm going to ask you some questions about your practice as of the time of your last death investigation in a long-term care home.

THE COMMISSIONER: Sorry, counsel, are you not going to explore a bit more the types of information and what he did when he investigated the threshold death? Is that all you were going to do on that?

MS. JONES: No, I'll ask him as well about the threshold but I can do it right now because I think it arises naturally at this point, Commissioner, so I'm happy to do it now.

11:13:51 BY MS. JONES:
11:13:51 Q. Dr. George, you were giving
11:13:53 evidence about your view on the value of the
11:13:56 threshold death investigation. So putting
11:13:58 aside all the standard steps you would take
11:14:01 on an investigation, which I'll take you
11:14:03 through a little bit more carefully in a
11:14:05 moment, on a threshold death investigation
11:14:09 was there anything unique about the
11:14:11 investigations you did when it was threshold
11:14:14 death investigation?
11:14:15 A. Well, you would be reviewing
11:14:17 the death register that's maintained by the
11:14:20 nursing home, and that provided lots of
11:14:23 useful information that would, you know --
11:14:26 glancing at that and reviewing that you
11:14:29 could see how many deaths there were in a
11:14:32 certain period of time; what kind of causes
11:14:35 were entered on the death certificate and
11:14:40 that kind of thing.
11:14:45 Q. I'm going to actually now
11:14:46 pass you so that we can talk about the death
11:14:49 register at this stage, Dr. George, this is
11:14:53 document 71970 underscore 01 and I'm going
11:15:01 to pass that up.
11:15:20 MS. JONES: Now, for the sake of
11:15:21 the record this document has
11:15:23 already been marked as an exhibit
11:15:26 as document 71970, earlier in the
11:15:31 proceeding or -- I believe it was
11:15:33 part of the Facilities Overview
11:15:34 Report, Commissioner. We've

11:15:36 conducted different redactions on
11:15:39 this version so that we can have a
11:15:41 little bit more information to
11:15:43 assist Dr. George.
11:15:44 So we'll look at this version and
11:15:49 mark it at least for identification
11:15:52 at this stage as well.
11:15:54 THE COMMISSIONER: Unless there's
11:15:54 a problem it should probably be
11:15:56 marked as an exhibit proper
11:15:59 because it is different than the
11:16:01 prior one, it has less redactions
11:16:03 as I understand it.
11:16:04 BY MS. JONES:
11:16:04 Q. Let me ask you, Dr. George,
11:16:07 do you have the document in front of you
11:16:08 now?
11:16:09 A. Yes I do, thanks.
11:16:11 Q. And we see that your name
11:16:12 appears three times on the right-hand side,
11:16:15 correct?
11:16:16 A. Yes.
11:16:17 Q. So can we take it from the
11:16:19 appearance of your name on this document
11:16:22 that on the occasions that you attended at
11:16:25 this home you would have reviewed the death
11:16:28 registry?
11:16:29 A. Yes.
11:16:29 MS. JONES: So perhaps on that
11:16:30 basis, Commissioner, we can mark
11:16:32 this as the next exhibit?
11:16:34 THE COMMISSIONER: Thank you very

much. Madam Clerk, exhibit number?
THE CLERK: 107.
THE COMMISSIONER: 107, thank you very much. Just to be clear then, Exhibit 107 it has been already entered into evidence as document 71 -- Ms. Jones?
MS. JONES: Document number 71970.
THE COMMISSIONER: Is it being entered as an exhibit because this document is not identical to document 71970.
MS. JONES: Different redactions have applied to this version. The one that was entered earlier in the proceeding for some reason it was entirely blacked out, other than Mr. Silcox's name, so you couldn't see the causes of death or the dates of death or any of that information.
THE COMMISSIONER: Thank you, counsel.
EXHIBIT NO. 107: Document titled "Resident Death or Transfer Record for", document number 71970-01.
BY MS. JONES:
Q. Now, Dr. George, looking at this document and lets take, based on the Commissioner's question to you, the context of a threshold death investigation in

11:17:48 particular.
11:17:48 Can you walk us through what you
11:17:51 would have done with the death register in
11:17:52 that context?
11:17:53 A. If it was a threshold case I
11:17:55 would be making sure that it was the tenth
11:17:59 death that we were actually investigating.
11:18:01 Q. And how did you make sure of
11:18:03 that?
11:18:03 A. They usually marked it.
11:18:08 Q. So they would mark somewhere
11:18:10 on this form that this is the tenth death?
11:18:13 A. Yeah, the previous one would
11:18:14 have been marked and then it would have been
11:18:16 the next one would have been the tenth
11:18:18 death.
11:18:19 Q. So you would determine that
11:18:20 it was in fact the tenth death?
11:18:23 A. Whether it was a threshold
11:18:24 case or not to start with.
11:18:26 Q. And then what would you do
11:18:27 next?
11:18:27 A. And then I would investigate
11:18:29 that case. I would review the chart, I
11:18:31 would discuss the case with the nursing
11:18:33 staff.
11:18:34 Q. This is the threshold death
11:18:37 case itself?
11:18:38 A. That's right.
11:18:39 Q. And would that investigation
11:18:40 differ from the investigations -- all the
11:18:42 other investigations you would do in a

11:18:45 1 long-term care home? So an accidental death
11:18:47 2 or --
11:18:48 3 A. Not significantly.
11:18:50 4 Q. So you would do the same
11:18:51 5 investigation in the threshold death context
11:18:54 6 as your standard practice?
11:18:55 7 A. Yes.
11:18:56 8 Q. But then was there a
11:18:57 9 difference between the threshold death
11:18:59 10 context and your standard practice -- your
11:19:01 11 standard investigations in relation to your
11:19:03 12 review of the death register?
11:19:05 13 A. No, no difference.
11:19:07 14 Q. So can we take your evidence
11:19:09 15 about your standard practice in doing a
11:19:13 16 death investigation as being the same as
11:19:15 17 your practice on a threshold death
11:19:17 18 investigation?
11:19:18 19 A. Absolutely.
11:19:19 20 Q. But because we have the
11:19:21 21 register in front of us let's do this part
11:19:23 22 now and then we'll go back and walk through
11:19:25 23 it in a bit more detail.
11:19:28 24 So if we take any of the names on
11:19:33 25 this list and imagine that you came in --
11:19:35 26 well, let's actually take Mr. Silcox since
11:19:39 27 the practice was the same for threshold and
11:19:41 28 nonthreshold deaths.
11:19:43 29 We see that your name appears
11:19:45 30 beside Mr. Silcox?
11:19:46 31 A. Yes.
11:19:46 32 Q. And what would you do, again

11:19:49 1 setting aside your investigation of
11:19:50 2 Mr. Silcox's death. What would you do in
11:19:53 3 terms of reviewing the other information on
11:19:55 4 this form?
11:19:56 5 A. I would review the previous
11:19:58 6 deaths above that and looking for patterns
11:20:01 7 or clusters of deaths.
11:20:04 8 Q. When you say you would review
11:20:05 9 the previous deaths would you pull the
11:20:07 10 charts for those patients?
11:20:09 11 A. No.
11:20:09 12 Q. So you would review this
11:20:10 13 document itself?
11:20:11 14 A. I would review this document
11:20:13 15 and the previous pages.
11:20:14 16 Q. And how many previous pages?
11:20:16 17 A. A couple of pages.
11:20:19 18 Q. And you said you would be
11:20:20 19 looking for patterns or clusters?
11:20:23 20 A. That's right.
11:20:24 21 Q. Can you give an example of
11:20:25 22 the kind of thing you would be looking for?
11:20:28 23 A. In -- it's not uncommon for
11:20:30 24 there to be outbreaks in the nursing home,
11:20:33 25 and in those types of situations sometimes
11:20:36 26 they have four or five deaths in a 24-hour
11:20:39 27 period.
11:20:39 28 Q. So if you saw that what would
11:20:41 29 you do?
11:20:42 30 A. I'd be concerned about it and
11:20:43 31 be asking questions why those deaths were
11:20:46 32 happening.

11:20:47 1 Q. Did you ever when you were
11:20:49 2 reviewing the death register find an example
11:20:51 3 of a case that should have been reported and
11:20:54 4 wasn't?
11:20:54 5 A. Not the death register.
11:20:59 6 Q. So not when reviewing the
11:21:01 7 death register?
11:21:02 8 A. Not when reviewing the death
11:21:03 9 register.
11:21:04 10 Q. And did you ever find
11:21:05 11 examples when reviewing the death register
11:21:07 12 of the death register itself not being
11:21:09 13 properly completed? And I'm going to give
11:21:12 14 you an example here.
11:21:14 15 A. At the top, I don't ever
11:21:15 16 remember seeing those numbers filled in.
11:21:17 17 Q. Okay. So the numbers that
11:21:18 18 you're referring to are the average number
11:21:20 19 of deaths per month?
11:21:21 20 A. The ranges, yes.
11:21:22 21 Q. You never saw those filled
11:21:24 22 in?
11:21:24 23 A. No.
11:21:25 24 Q. Did you ever ask for those to
11:21:26 25 be filled in?
11:21:28 26 A. I believe perhaps once or
11:21:29 27 twice I commented on that and nothing was
11:21:33 28 ever done about it.
11:21:34 29 Q. Okay. And so in terms of --
11:21:38 30 were you attempting to assess, when you're
11:21:41 31 looking at the death register, whether the
11:21:44 32 average number of deaths per month in the

11:21:46 facility or the average number of transfers
11:21:49 per month in the facility had increased?
11:21:52 A. I would be looking for things
11:21:54 like that. And, for example, looking at
11:21:55 this one this covers -- Mr. Silcox passed
11:21:58 away in August of 2007 and this register at
11:22:01 the top of the page is from May 2007.
11:22:05 Q. Okay. So what does that tell
11:22:07 you?
11:22:08 A. I didn't think that there
11:22:11 were an unusually high number of deaths for
11:22:13 that period.
11:22:14 Q. So you would do it by looking
11:22:16 sort of up the page and getting a sense of
11:22:19 whether there --
11:22:20 A. That's right.
11:22:21 Q. What would you be comparing
11:22:22 it to though if you didn't have the
11:22:24 information at the top completed?
11:22:26 A. I would also be looking at
11:22:27 the cause of death on here too because that
11:22:31 will also influence the number of deaths
11:22:34 that are occurring. Because there was
11:22:38 somebody with metastatic disease here, there
11:22:41 was somebody with cirrhosis, that type of
11:22:44 thing.
11:22:45 Q. But in terms of getting a
11:22:46 sense of whether there had been an increased
11:22:48 number of deaths or transfers what were you
11:22:51 using to determine when you're looking at
11:22:53 this that this is within the range that you
11:22:56 expected or higher or lower? What were you

11:22:58 comparing it to the numbers of death?
11:23:01 A. I would simply be look at,
11:23:02 you know, these numbers and making sure that
11:23:09 perhaps there wasn't an excessive number in
11:23:13 one month, for example, that type of thing,
11:23:17 or in a shorter type frame.
11:23:19 Q. And then you just testified
11:23:20 you would also look at the causes of death
11:23:22 to see patterns in that regard?
11:23:24 A. Right. And as you can see
11:23:26 from the register that a number of these
11:23:30 patients were transferred to the hospital
11:23:33 and that's where they died.
11:23:40 MS. JONES: Commissioner, I'm now
11:23:40 going to ask Dr. George to walk
11:23:42 through the steps of his death
11:23:44 investigation in a long-term care
11:23:44 home so perhaps it would be a good
11:23:47 time for the morning recess.
11:23:49 THE COMMISSIONER: Yes, thank you
11:23:50 very much, counsel.
11:23:50 -- RECESSED AT 11:23 A.M.
11:36:02 -- RESUMED AT 11:46 A.M.
11:46:32 THE COMMISSIONER: Go ahead,
11:46:32 Ms. Jones.
11:46:33 BY MS. JONES:
11:46:33 Q. Dr. George, if we can now
11:46:37 review your practice when conducting death
11:46:40 investigations in long-term care homes. And
11:46:44 my first question for you is is after you've
11:46:47 determined that you are going to conduct a
11:46:48 death investigation in the long-term care

11:46:50 1 home, do you contact the home and let them
11:46:53 2 know that you're going to be arriving?
11:46:55 3 A. Yes, I usually let them know
11:46:57 4 my estimated time of arrival.
11:46:59 5 Q. And is there a particular
11:47:01 6 time period in which you're supposed to
11:47:05 7 arrive to conduct a death investigation, an
11:47:08 8 expectation of when you would arrive on the
11:47:10 9 scene?
11:47:11 10 A. Ideally, it would be within
11:47:12 11 30 minutes, but that's -- that's not always
11:47:15 12 possible.
11:47:18 13 Q. And when you arrive at the
11:47:21 14 long-term care home, what happens next?
11:47:24 15 A. I usually go to the ward
11:47:26 16 where the death has occurred, and first
11:47:31 17 thing I would do is -- would -- you know,
11:47:32 18 the nurse would accompany me to the room
11:47:36 19 where the deceased is.
11:47:38 20 And then I would -- if the patient
11:47:39 21 hasn't already been pronounced, I would
11:47:42 22 pronounce them dead. And then I would do a
11:47:44 23 superficial examination of the body.
11:47:46 24 Q. Why do you say a superficial
11:47:47 25 examination?
11:47:49 26 A. We're not in the habit of
11:47:51 27 doing anything more than that. Just making
11:47:53 28 observations. That -- if there was anything
11:47:56 29 else to be done, then that would be done by
11:47:58 30 a medical examiner.
11:47:59 31 Q. Okay. So can you describe
11:48:01 32 what a superficial examination of the body

11:48:04 consists of?
11:48:04 A. How the patient is positioned
11:48:07 in the bed or if they're on the floor, how
11:48:10 they're clothed, their general nutritional
11:48:16 status, the lividity, rigor, whether the
11:48:21 body is cold to touch or not, that type of
11:48:24 thing.
11:48:24 If the person had a surgical
11:48:25 procedure, I'd be looking at the surgical
11:48:27 site to make sure it was intact and that
11:48:30 type of thing. Make sure that there are no
11:48:33 marks of external violence on the body.
11:48:35 Look around the room, make sure that there
11:48:38 isn't anything, you know, of concern.
11:48:40 Q. Okay. And you mentioned
11:48:42 lividity and rigor. What are those?
11:48:46 A. So rigor is, in layman's
11:48:51 term, a general state of stiffness. So if
11:48:53 it's within, you know, 4 hours of death,
11:48:56 there usually isn't any rigor. It usually
11:48:58 takes about 12 hours for rigor to set in.
11:49:01 And with respect to lividity,
11:49:05 that's -- we talk about capillary refill and
11:49:09 that type of thing. So in somebody who's
11:49:11 just passed away and if you pressed on the
11:49:12 skin, the capillaries would refill. If it
11:49:16 was longer than that, then it would be
11:49:18 fixed.
11:49:18 Q. And as the coroner in this
11:49:20 situation, do you take blood samples or
11:49:22 urine samples from the body?
11:49:24 A. No.

11:49:27 Q. And after you conduct this
11:49:30 examination, what do you do next?
11:49:33 A. I would go back to the
11:49:34 nursing station to review the chart and the
11:49:37 death register and the other documentation
11:49:39 that they would have ready.
11:49:40 Q. Okay. And in terms of the
11:49:43 documentation you would review in the chart,
11:49:45 what documentation would you look at?
11:49:47 A. I would be looking at the
11:49:49 Progress Notes for, you know, the last
11:49:51 period of the illness, if that's in
11:49:54 question. I would be looking at the
11:49:55 medication profile. I would be looking at,
11:49:58 you know, when the patient was admitted to
11:50:00 the long-term care facility, reading some of
11:50:06 the nursing notes to find out if there are
11:50:07 any concerns. If family is present, I would
11:50:11 have a discussion with the family and see if
11:50:14 they had any concerns or...
11:50:18 Q. Okay. So we'll get to the
11:50:20 family discussion in a moment, but in terms
11:50:22 of the medical records, you've mentioned the
11:50:24 Progress Notes for the last period of the
11:50:24 illness, the medication profile, information
11:50:29 from when the patient was admitted. Is
11:50:32 there anything else?
11:50:34 A. To find out what their
11:50:35 general level of functioning was before this
11:50:38 happened. If there were consultation
11:50:40 reports on the chart, I would usually review
11:50:43 those because they're usually a good

summary.

Q. Okay. Would you look at the -- what some people refer to as the face sheet at the front of the chart with the contact information?

A. Right. That's the demographic sheet.

Q. That's the demographic sheet. Okay.

And you've testified that you do this review of the medical records after you examine the body. Is there a particular reason for that order?

A. I think that my usual practice of doing that is so that if, you know, the body needs to be removed and that kind of stuff, then they can, you know, proceed with that.

Q. Is it ever the case, though, that you review something in the medical records which you didn't know when you were examining the body and wish to return to examine the body?

A. I may go back and look at the body. There's nothing that says that you can't.

Q. And then you referred to if the family is present, speaking to the family?

A. Or representative or power of attorney, you know, to find out additional information or find out if they have any

11:51:49 concerns.
11:51:49 Q. Okay. So do you have
11:51:50 particular questions you ask of family
11:51:52 members?
11:51:53 A. I usually start by expressing
11:51:54 my condolences and meeting under those kind
11:51:58 of circumstances, and then I try and find
11:52:01 out a little bit of medical information from
11:52:04 them and find out if they had any kind of
11:52:07 concerns or if there were any problems going
11:52:09 on and that type of thing.
11:52:10 Q. And why is that important, to
11:52:12 find out if there's concerns or problems?
11:52:14 A. I think you can glean a lot
11:52:16 of information from the family. They often
11:52:19 provide a lot of very useful information
11:52:22 that sometimes we miss in our medical
11:52:24 documentation and that kind of stuff.
11:52:26 Q. And so you referred to if the
11:52:27 family is present. What if the family is
11:52:30 not present?
11:52:31 A. I would try and call. You
11:52:33 know, on the face sheet or the demographic
11:52:36 sheet, there's usually listed, you know, a
11:52:39 contact person, and I would make an attempt
11:52:40 to contact them.
11:52:41 Q. Okay. And when you say "make
11:52:44 an attempt," if you didn't reach someone,
11:52:47 what was your practice then?
11:52:48 A. I would try and call the
11:52:49 second number or second person on the list.
11:52:51 Q. Okay. And would you continue

11:52:53 1 to contact people until you reached a family
11:52:57 2 member?
11:52:57 3 A. Yes, or I may make -- try and
11:52:59 4 call them later or, you know, sometimes
11:53:02 5 people have come to the nursing home, and
11:53:04 6 they've left, and they've gone to the
11:53:06 7 funeral home to make arrangements, and then
11:53:08 8 I try and catch up with them.
11:53:10 9 I mean, people are distraught when
11:53:13 10 dealing with, you know, the death of a loved
11:53:16 11 one, so I try and time it so that I can call
11:53:17 12 them and have a short discussion without
11:53:21 13 interfering too much.
11:53:21 14 Q. And when you speak to a
11:53:23 15 member of the family, do you record anywhere
11:53:27 16 on your Form 3, your coroners investigation
11:53:32 17 statement -- do you record who you spoke to?
11:53:34 18 A. No, I don't.
11:53:34 19 Q. Okay. Why not?
11:53:36 20 A. We don't name people in the
11:53:38 21 narrative.
11:53:41 22 Q. Why don't you do that?
11:53:44 23 A. I don't think it would be
11:53:44 24 appropriate, and it's not good practice.
11:53:47 25 It's written in the third person.
11:53:50 26 Q. And can you assist me a bit
11:53:51 27 more with that? Why would it not be
11:53:53 28 appropriate or good practice to say, "I
11:53:55 29 spoke to this patient's sister"?
11:54:00 30 A. Well, that would be
11:54:01 31 appropriate. I'm -- I thought you meant
11:54:04 32 actually naming the person.

11:54:06 Q. I did. So fair enough.
11:54:08 A. Yes.
11:54:08 Q. So providing the name, in your view, would not be appropriate?
11:54:12 A. Right, but I will -- it has been my practice to more recently in the last six or seven years to be writing I spoke with, you know, the spouse or the sister or the power of attorney regarding so-and-so, and postmortem examination was discussed, cause of death was discussed, or we had several discussions and that kind of thing.
11:54:34 Q. Okay. And why did you move towards that practice six or seven years ago?
11:54:40 A. I thought it was just better than saying that, you know, there were no concerns raised or that kind of thing. I -- because as time went on, we -- I improved on the way that I write my narratives.
11:54:59 And we had a session with Dr. Mann that was very helpful on how to write a more appropriate narrative, a more informative narrative.
11:55:01 Q. Thank you. And then when you speak to the family, we heard earlier from Dr. Mann that there's a pamphlet that the regional office has.
11:55:11 If the family is present in the hospital, do you provide the family with the pamphlet or any other information?
11:55:21
11:55:23
11:55:26

11:55:27 A. I usually provide them with
11:55:29 my card with my telephone number on it.
11:55:31 Q. Okay. And if you speak to
11:55:34 someone over the telephone, do you provide
11:55:36 them with any information, contact
11:55:38 information, for you?
11:55:39 A. Yes.
11:55:40 Q. And do you ever, then,
11:55:42 receive calls from family members?
11:55:44 A. Quite often.
11:55:46 Q. Okay. And when you receive a
11:55:48 call from a family member later on, do you
11:55:52 maintain notes of those calls?
11:55:55 A. If I haven't written the Form
11:55:57 3, I will write in the Form 3 that I have,
11:56:01 you know, discussed, you know, the cause of
11:56:04 death or the postmortem findings or the case
11:56:08 with the family on several occasions rather
11:56:10 than on just one occasion.
11:56:11 Q. And if you've already written
11:56:13 the Form 3, then do you maintain notes of
11:56:15 those discussions?
11:56:17 A. Not usually.
11:56:18 Q. So we've now reviewed you
11:56:26 attend at the home. You do an examination
11:56:29 of the body. You review medical records.
11:56:34 You speak to a member of the family or
11:56:35 attempt to speak to a member of the family.
11:56:39 Do you speak to anyone else?
11:56:40 A. I would, again, speak to the
11:56:41 nursing staff to see if there was any more
11:56:46 information that they were able to provide.

11:56:48 Q. What about physicians?
11:56:50 A. Or the attending physician.
11:56:53 Q. And do you have a particular practice as between nursing staff or physicians, or does it vary?
11:56:59 A. Usually if the nursing staff is there. The in-house physician is usually not there all of the time. I think he's there, you know, just for several times a week, if I'm not mistaken.
11:57:11 Q. And do you as a sort of standard practice request incident reports, if there had been any incident reports relating to the patient?
11:57:22 A. If there was a fall or something or if there was something unexplained, I would ask about that.
11:57:30 Q. You would ask to see an Incident Report?
11:57:33 A. To see the nursing -- the nursing notes on that.
11:57:36 Q. To see the nursing notes. Okay.
11:57:38 A. Right.
11:57:38 Q. And what about incident reports that are submitted perhaps to the Ministry? Do you ask to see those?
11:57:44 A. No, I haven't -- I haven't seen those.
11:57:48 Q. Now, how often in a long-term care home context would you, as part of your death investigation, order an autopsy?

11:58:00 A. Rarely.
11:58:00 Q. Why is that?
11:58:02 A. It's usually not indicated,
11:58:07 and most of the time, the cause of death,
11:58:13 you know, bearing in mind, you know, the
11:58:16 circumstances, is you can reasonably
11:58:19 ascertain.
11:58:19 Q. Okay. And can you recall
11:58:22 ever asking for a postmortem examination or
11:58:25 autopsy in the context of a death in a
11:58:28 long-term care home?
11:58:29 A. I can't.
11:58:29 Q. Okay.
11:58:30 THE COMMISSIONER: You cannot?
11:58:34 THE WITNESS: I cannot. Sorry.
11:58:37 THE COMMISSIONER: Not at all.
11:58:40 BY MS. JONES:
11:58:40 Q. When you say that normally
11:58:41 in the long-term care home context you can
11:58:42 discern the cause of death, can you assist
11:58:45 us with the standard or the test on which
11:58:49 you determine a cause of death?
11:58:53 A. Well, looking at a patient's
11:58:57 comorbid conditions, you can make a
11:59:00 reasonable assumption as to the -- as to the
11:59:02 cause of death.
11:59:03 Q. And how much certainty do you
11:59:05 need to have as to your assumption about the
11:59:07 cause of death?
11:59:08 A. A reasonable amount of
11:59:09 certainty.
11:59:10 Q. What does that mean, a

reasonable amount of certainty?
A. I think it would be fairly obvious what the cause of death was in most cases.
Q. Okay. And Dr. Huyer gave evidence about a balance of probabilities test. Is that a test you use?
A. That would be -- that would be -- that would be the same thing.
Q. Okay. And so what does the balance of probabilities test mean to you?
A. That it is -- it would be very likely, you know, that would be the cause of death that I was considering.
Q. Very likely?
A. Very likely. If I can backtrack for a minute.
Q. Yes.
A. I may have ordered a postmortem examination on a patient that may have been transferred from a nursing home to a hospital and passed away in the hospital.
Q. Okay. Are you thinking of an example in which that --
A. I might have done that a few years ago --
Q. Okay. Thank you.
A. -- but not recently.
Q. Thank you. While you're conducting your investigation -- and, again, let's ground this in a long-term care home context -- are you maintaining notes?

12:00:30 A. Yes.
12:00:31 Q. And I'm going to ask you to
12:00:37 turn now -- it's Document 72838. And it's
12:00:44 Tab 6, Dr. George.
12:00:47 A. Tab 6. Okay.
12:01:00 Q. I apologize. The number, I'm
12:01:04 being told, is 72832.
12:01:07 A. Mine doesn't have a number on
12:01:09 it, but it's Tab 6.
12:01:11 Q. That's fine. What is this
12:01:13 document we're looking at?
12:01:14 A. This is the Coroner
12:01:14 Investigation Worksheet that I think was in
12:01:17 the briefcase that we were all presented
12:01:22 with back in 2004 when we took the course.
12:01:26 And it may be something that Dr. Mann also
12:01:30 used, but I've made a habit of using this
12:01:32 over the years.
12:01:34 Q. Okay.
12:01:36 A. And if I didn't use this and
12:01:37 I had my laptop, I would be directly
12:01:41 entering things into Form 3 while I was
12:01:43 sitting there.
12:01:44 Q. I see. So is it fair to say
12:01:45 that when conducting an investigation --
12:01:47 and, again, let's ground this in a long-term
12:01:49 care home context -- you're maintaining
12:01:51 notes either on your Coroner Investigation
12:01:51 Worksheet or on your Form 3?
12:01:55 A. That's right.
12:01:55 Q. And after you do your notes
12:01:57 on your Coroner Investigation Worksheet, if

12:01:59 1 you do it that way, do you then take this
12:02:03 2 information and put it into your Form 3?
12:02:05 3 A. That's correct.
12:02:06 4 Q. And then what happens to the
12:02:07 5 Coroner Investigation Worksheet?
12:02:09 6 A. That -- that's kept in a file
12:02:12 7 folder along with the paper copy of Form 3.
12:02:15 8 Q. Okay. And you then maintain
12:02:18 9 that in your file then?
12:02:21 10 A. That's correct.
12:02:21 11 Q. Okay. And so just jumping to
12:02:24 12 Mr. Silcox for a moment where you conducted
12:02:26 13 the investigation, have you looked to see if
12:02:29 14 you had a Coroner's Investigation Worksheet
12:02:33 15 in that case?
12:02:34 16 A. No, I didn't. I had -- I had
12:02:35 17 a laptop.
12:02:35 18 Q. A laptop. Okay. So does
12:02:37 19 that tell you you put the information
12:02:38 20 directly into your laptop?
12:02:39 21 A. Yes.
12:02:40 22 Q. Okay.
12:02:45 23 A. And there are things on
12:02:47 24 Form 3 -- there's a box on Form 3 where it
12:02:50 25 talks about the scene, but you can't see
12:02:54 26 that on the -- on the printed out copy.
12:02:58 27 Q. I see. So if you don't put
12:02:59 28 any information into that box, does it
12:03:02 29 collapse, and you don't see it on the
12:03:04 30 printout?
12:03:05 31 A. You don't see it on the
12:03:05 32 printout. And that's the box where you say,

you know, is supine on a stretcher in the emergency department. There were no marks of external violence. There was evidence of therapeutic intervention. And underneath that, there are boxes for rigor and lividity.

Q. So if you insert any information into that section of the Form 3, does it show up on the printout so that the Form 3s that we look at today would look different than the Form 3s on the Coroners Investigation --

A. I don't think -- I think that that's there for our purposes, but I don't think -- that's why that needs to be included in the narrative.

Q. Oh, I see. And then you put that information into the narrative?

A. That's right.

MS. JONES: Commissioner, this document, the Coroners Investigation Worksheet has not yet been marked as an exhibit, so if we can please make it the next exhibit.

THE COMMISSIONER: Yes. Thank you. So is that Exhibit 108 then, Madam Clerk?

THE REGISTRAR: Yes, that's right.

THE COMMISSIONER: Thank you. So 108 then, the Coroner

12:04:17 1 Investigation Workshop (sic),
12:04:20 2 Document 72832.
12:04:25 3 MS. JONES: Yes, the Coroner
12:04:25 4 Investigation Worksheet.
12:04:28 5 EXHIBIT NO. 108: Coroner
12:04:28 6 Investigation Worksheet, Document
12:04:20 7 72832.
12:04:29 8 BY MS. JONES:
12:04:29 9 Q. And, Dr. George, then so
12:04:36 10 you've testified that in some occasions, you
12:04:40 11 would put your information directly into the
12:04:43 12 Form 3?
12:04:43 13 A. That's right.
12:04:43 14 Q. And then in other occasions,
12:04:44 15 would you take your worksheet and
12:04:45 16 subsequently complete your Form 3?
12:04:45 17 A. And do it later, yes.
12:04:47 18 Q. Okay. And then is the
12:04:48 19 submission of your Form 3, then, the
12:04:50 20 conclusion of your death investigation?
12:04:52 21 A. Yes.
12:04:58 22 Q. Dr. George, before learning
12:05:00 23 of Elizabeth Wettlaufer's offences, when
12:05:06 24 reaching conclusions about causes of death
12:05:08 25 in a long-term care home context, did you
12:05:12 26 consider the possibility that a caregiver
12:05:16 27 might be intentionally harming a resident?
12:05:18 28 A. No.
12:05:18 29 Q. And can you help us with
12:05:20 30 that, with why you don't believe you were
12:05:22 31 considering that possibility?
12:05:24 32 A. I've lived there for almost

12:05:26 1 25 years, and I've had patients there on a
12:05:29 2 regular basis and never had any concerns,
12:05:32 3 and I was always pleased with the nursing
12:05:35 4 staff.
12:05:35 5 Q. And are you referring to
12:05:37 6 Caressant Care, in particular?
12:05:38 7 A. Yes, I am.
12:05:38 8 Q. Okay. But my question is
12:05:41 9 more general than that. In the long-term
12:05:44 10 care sector as a whole, regardless of which
12:05:47 11 home your patients were at, were you
12:05:50 12 looking -- did it occur to you that it could
12:05:52 13 be intentional harm?
12:05:53 14 A. No. There was nothing to
12:05:59 15 suggest that.
12:06:03 16 Q. Dr. George, I'm going to now
12:06:05 17 ask you some questions about your
12:06:08 18 investigation of the death of Mr. Silcox.
12:06:10 19 So if I can ask you to turn to Tab 9, and
12:06:16 20 this is Document 65227.
12:06:23 21 A. Yeah. Okay.
12:06:27 22 Q. And is this your Form 3,
12:06:30 23 Dr. George?
12:06:31 24 A. Yes, it is.
12:06:31 25 Q. And you were the coroner that
12:06:33 26 investigated Mr. Silcox's death?
12:06:35 27 A. I was.
12:06:36 28 Q. Do you have, sitting here
12:06:38 29 today, any memory of that investigation?
12:06:40 30 A. No, other than what my notes
12:06:47 31 provide.
12:06:47 32 Q. Okay. So you'll be relying

on your notes when giving your evidence about the investigation.

Now, if we look at this form, we see on the right-hand side towards the top, the death pronounced. And that would tell us that Mr. Silcox's death was pronounced on August 12th, 2007?

A. That's correct.

Q. And if we look just at the very beginning of your narrative, at the bottom of the page, it says you were notified of the case at 05:15. So that's 5:15 in the morning; correct?

A. That's correct.

Q. And you were on the scene at 6:45 a.m.?

A. That's correct.

Q. And because you were on the scene, does that tell us that you had made a determination that an investigation was warranted under the Coroners Act in this case?

A. Yes.

Q. And can you assist us now with why you would have determined that this case warranted an investigation?

A. This -- this gentleman unfortunately experienced a fall in the nursing home and subsequently had a right hip fracture.

Q. Okay. So would this fall into the category of an accident?

12:08:07 1 A. An accidental death.
12:08:09 2 Q. So you determined, then, that
12:08:12 3 it was a coroners case by virtue of the fact
12:08:15 4 it was an accident, and you arrived on the
12:08:16 5 scene at 6:45?
12:08:18 6 A. That's correct.
12:08:24 7 Q. And if we actually turn up
12:08:28 8 the Institutional Patient Death Record,
12:08:30 9 which is Tab 8. It's Document 65226, page
12:08:38 10 123.
12:08:57 11 And you've testified that you
12:08:58 12 didn't have the Institutional Patient Death
12:09:00 13 Record at the time that you would be making
12:09:03 14 your assessment about whether or not a case
12:09:05 15 was a coroners case. Would you have it as
12:09:07 16 part of your death investigation in a
12:09:09 17 long-term care home?
12:09:11 18 A. No, I wouldn't. I wouldn't
12:09:12 19 have a copy of this.
12:09:13 20 Q. And could you have asked for
12:09:14 21 a copy of this?
12:09:16 22 A. I'm not sure if they would
12:09:17 23 have provided it, but I certainly could have
12:09:20 24 had a look at it.
12:09:21 25 Q. Okay. But it just wasn't
12:09:22 26 your practice?
12:09:22 27 A. No.
12:09:23 28 Q. Because in this case, it
12:09:24 29 looks like Ms. Wettlaufer completed both
12:09:27 30 accidental death and sudden and unexpected,
12:09:31 31 but you -- would you have been aware of the
12:09:34 32 fact that she completed those two boxes?

12:09:37 A. No.
12:09:37 Q. Okay. So we can now turn back to 65227 or Tab 9 and back down in the narrative. And can you assist us, looking at your narrative, with the physical examination that you conducted of Mr. Silcox and any findings from that physical examination?
12:10:12 A. It's fairly straightforward. The gentleman was supine in bed. There wasn't any evidence that he'd been harmed or there was external violence by -- I noted that he was last seen alive at 02:00 hours by a nursing staff on rounds and then was found with vital signs absent at 3:55 in the morning.
12:10:35 Q. And if you keep reading, I believe there are more physical findings, Dr. George.
12:10:41 A. Right. The lividity, there was blanching, and rigor was absent.
12:10:47 Q. And you testified that you would typically look at Progress Notes in considering in a death investigation. So I'm going to ask you to turn to Tab 12A, and it will be Document 4711, and if you can please go to page 6 of this document, at the bottom of the page, please.
12:11:35 And we see that this note type is described as an admission note. And you testified earlier that you would look at the information on admission.

12:11:46 So is this the information that
12:11:49 you believe you would have looked at in
12:11:50 doing this investigation?
12:11:51 A. Yes.
12:11:52 Q. Okay. And taking your time
12:11:56 to review this admission note, can you tell
12:12:01 us what, from this note, would have been
12:12:03 significant to you in doing your death
12:12:05 investigation?
12:12:07 A. This gentleman was a recent
12:12:10 admission to the long-term care facility.
12:12:14 He had a history of insulin-dependent
12:12:19 diabetes. He was hypertensive. He had a
12:12:21 history of thyroid disease. He had a
12:12:24 history of Alzheimer's disease and a history
12:12:27 of diverticulosis. He'd been previously in
12:12:29 hospital for quite some time as he'd had a
12:12:32 stroke, and it was affecting his right side.
12:12:34 And so this gentleman was
12:12:37 obviously awaiting admission to a nursing
12:12:40 home somewhere, and so he was admitted to
12:12:44 this long-term care facility, and it sounds
12:12:50 like he had, you know, quite a few problems
12:12:53 with mobility making him prone to falls.
12:12:56 Q. Okay. And was there any
12:12:57 significance to you of the fact that he was
12:13:00 prone to falls?
12:13:02 A. Unfortunately, this is a very
12:13:04 common occurrence in long-term care
12:13:06 facilities.
12:13:08 Q. And towards the bottom, it
12:13:12 refers to the fact that the family had

12:13:15 1 stated that Mr. Silcox had lost about 20
12:13:17 2 pounds in the last few months. His appetite
12:13:22 3 had varied. Is that information you would
12:13:24 4 consider?
12:13:25 5 A. Yes, to some degree. I mean,
12:13:28 6 this is not uncommon for patients with
12:13:32 7 dementia to stop eating, or, you know, they
12:13:34 8 go through cycles.
12:13:36 9 Q. And if we now go to -- back
12:13:46 10 to the Form 3, so 65 -- no, actually, let's
12:13:50 11 do that in a moment. Let's stay where we
12:13:52 12 are --
12:13:53 13 A. Okay.
12:13:53 14 Q. -- in these Progress Notes,
12:13:55 15 and let's move our way forward.
12:14:00 16 Would you have reviewed -- and we
12:14:04 17 don't need to pull up all of this
12:14:06 18 gentleman's notes, but would you have
12:14:09 19 reviewed his Progress Notes from the
12:14:10 20 admission note going forward?
12:14:12 21 A. Yes.
12:14:12 22 Q. Okay. And Mr. Silcox was not
12:14:14 23 in the home for a very long period of time?
12:14:16 24 A. No, no, he was several weeks
12:14:18 25 only.
12:14:18 26 Q. Okay. So would it -- in all
12:14:20 27 cases, would you read all of the Progress
12:14:22 28 Notes or --
12:14:23 29 A. Mostly relating to the last
12:14:24 30 illness.
12:14:25 31 Q. Okay.
12:14:25 32 A. I mean, there are patients

that have been in long-term care facilities for years, and it would be very difficult to review everything, but the most recent notes for the preceding several weeks would be, you know, most adequate in most cases.

Q. And if we turn to page 3, then, of the Progress Notes, we see at 17:00, there's a note referencing a fall. And you testified a moment ago that you would have looked at the Progress Notes about the event surrounding any incident.

And so is that the type of Progress Note that you would looked at?

A. That's right. And there was -- I think this gentleman probably had several falls, and it was kind of uncertain as to, you know, which fall caused the fracture.

Q. And now if you go to page 2 of this document at 22:18. Would you have understood from --

A. I'm sorry, page 2 --

Q. At 22:18.

A. I don't have a -- oh, there it is. Okay. On the 4th of August?

Q. That's right. What would you have understood from this note?

A. That the patient had hip surgery, had a Moore prothesis put in, and they said that the surgery went well. He was restless postoperatively, and they gave something to settle him.

12:16:19 Q. And now, from this point
12:16:21 forward, would you have reviewed the rest of
12:16:23 the Progress Notes up to the time of
12:16:26 Mr. Silcox's passing?
12:16:27 A. Yes.
12:16:31 Q. And if you go now to the
12:16:33 first page, page 1 of this document, can you
12:16:42 tell us what, if anything, you believe you
12:16:45 concluded in relation to Mr. Silcox's death
12:16:47 from these notes immediately preceding his
12:16:52 passing and his passing?
12:17:00 A. The patient had been
12:17:01 transferred back to the long-term care
12:17:07 facility. The patient had been transferred
12:17:09 on one occasion back to the hospital to have
12:17:16 sutures removed and then transferred back.
12:17:27 And it doesn't sound like he was doing very
12:17:31 well postoperatively.
12:17:32 Q. And there's a note on page 1
12:17:36 at 21:37, BS at 16:30, 1.8.
12:17:45 A. That's correct.
12:17:46 Q. What does that mean?
12:17:48 A. Blood sugar was 1.8 at 4:30
12:17:50 just before supper.
12:17:52 Q. And is 1.8 high or low?
12:17:54 A. Is low.
12:17:55 Q. It's low. Would you have
12:17:56 taken anything from that note in this
12:17:59 gentleman?
12:18:01 A. It's a solitary number
12:18:03 that -- where his blood sugar was low. This
12:18:06 man was an insulin-dependent diabetic, and

12:18:10 1 he was on Novolin 3070, which is a mix of
12:18:15 2 rapid and longer-acting insulin. So this
12:18:18 3 type of thing wouldn't be unusual. And in
12:18:21 4 somebody that wasn't eating very well...
12:18:26 5 Q. And then we see the note at
12:18:28 6 07:55, and that describes when it was
12:18:33 7 identified that Mr. Silcox had passed away;
12:18:36 8 correct?
12:18:36 9 A. That's correct.
12:18:38 10 Q. Okay. Now, if we now go back
12:18:41 11 again to your Form 3, which is
12:18:45 12 Document 65227, Tab 9. So you've described
12:19:06 13 your physical examination, and you've now
12:19:11 14 described your review of the Progress Notes.
12:19:14 15 I see here the reference to past
12:19:16 16 medical history a little bit below the
12:19:20 17 middle of your narrative. Where would you
12:19:22 18 have obtained the information about Mr.
12:19:23 19 Silcox's past medical history?
12:19:25 20 A. From the nursing home record
12:19:27 21 and from the hospital records as well.
12:19:30 22 Q. Okay. So what hospital
12:19:32 23 records would you have reviewed?
12:19:34 24 A. His admission history and
12:19:37 25 physical to the hospital.
12:19:38 26 Q. Okay. From his fall?
12:19:40 27 A. From his fall.
12:19:41 28 Q. Okay. And from our review of
12:19:43 29 the records, we've been able to identify one
12:19:48 30 document that describes this, which is a
12:19:52 31 hospital document, which is Document 4770.
12:19:59 32 And that is, Dr. George and Madam

12:20:04 1 Commissioner, at Tab 12B behind the first
12:20:10 2 blue sheet.
12:20:10 3 THE COMMISSIONER: Thank you.
12:20:11 4 THE WITNESS: 12B?
12:20:14 5 BY MS. JONES:
12:20:14 6 Q. Behind the blue sheet,
12:20:15 7 Dr. George.
12:20:16 8 A. Okay. Okay.
12:20:21 9 Q. And is this the type of
12:20:23 10 hospital record that you would have
12:20:24 11 reviewed?
12:20:25 12 A. Yes.
12:20:25 13 Q. Okay.
12:20:25 14 MS. JONES: And perhaps we can
12:20:27 15 mark that, Commissioner, as the
12:20:29 16 next exhibit.
12:20:33 17 THE COMMISSIONER: Were there
12:20:36 18 copies?
12:20:37 19 MS. JONES: We do.
12:20:39 20 THE COMMISSIONER: Thank you.
12:20:43 21 So Document 4770, Preliminary
12:20:49 22 Report History and Physical on
12:20:51 23 Mr. James Silcox, becomes
12:20:56 24 Exhibit 109.
12:20:58 25 EXHIBIT NO. 109: Preliminary
12:20:49 26 Report History and Physical on
12:20:51 27 Mr. James Silcox, Document 4770
12:20:58 28 BY MS. JONES:
12:20:58 29 Q. And reviewing this document
12:21:04 30 now, Dr. George, can you assist us with
12:21:08 31 what, if anything, of significance you would
12:21:09 32 have taken from this document?

12:21:11 A. That he was admitted to
12:21:12 hospital with a right surgical neck fracture
12:21:18 and that it needed to be fixed.
12:21:21 Q. Okay. What's a surgical neck
12:21:24 fracture?
12:21:25 A. Well, it's a hip fracture.
12:21:26 Q. Okay.
12:21:26 A. And so these are really quite
12:21:30 serious, and they're usually as a result of
12:21:35 trauma, as a result of a fall.
12:21:36 Q. Okay. And actually, there's
12:21:37 one more document we should mark in relation
12:21:38 to Mr. Silcox based on your practice, and
12:21:39 that's what we've referred to as the face
12:21:42 sheet or the demographic sheet.
12:21:45 A. Right.
12:21:45 Q. If you can turn to Tab 12B,
12:21:47 and that's Document 65226, please, page 3.
12:21:56 And is this the document you were referring
12:22:12 to?
12:22:12 A. Yes.
12:22:13 Q. Okay. And if you scroll down
12:22:14 one more page, it looks like it continues
12:22:19 with a --
12:22:20 A. They're cards. It's on two
12:22:22 sides.
12:22:21 Q. It's on two sides. Okay.
12:22:22 Fair enough. And would you have reviewed
12:22:24 both sides?
12:22:25 A. Yes.
12:22:25 Q. Okay.
12:22:25 MS. JONES: So if we can mark,

12:22:27 1 Commissioner, the demographic
12:22:29 2 sheet, two pages, as the next
12:22:33 3 exhibit.
12:22:33 4 THE COMMISSIONER: Yes.
12:22:36 5 Thank you. So Document 65226, the
12:22:46 6 Caressant Care Resident
12:22:47 7 Information Form for
12:22:49 8 Mr. James Silcox, two-page
12:22:52 9 document, and that would be
12:22:55 10 Exhibit 110.
12:22:56 11 MS. JONES: Thank you. And
12:23:00 12 that's pages 3 and 4 of that
12:23:03 13 document only.
12:23:03 14 THE COMMISSIONER: Thank you.
12:23:03 15 EXHIBIT NO. 110: The
12:22:46 16 Caressant Care Resident Information
12:22:47 17 Form for Mr. James Silcox, two-page
12:22:52 18 document, Document 65226, pages 3
12:23:02 19 and 4.
12:22:57 20 BY MS. JONES:
12:22:57 21 Q. Okay. So now, Dr. George,
12:23:09 22 going back to your Form 3 at Tab 9,
12:23:13 23 Document 65227, you've described now where
12:23:23 24 you would have obtained the past medical
12:23:27 25 history. We see that you obtained details
12:23:29 26 of Mr. Silcox's medications; is that
12:23:32 27 correct?
12:23:32 28 A. That's correct.
12:23:33 29 Q. And why is that important, or
12:23:35 30 why do you do that?
12:23:37 31 A. It's very important because
12:23:39 32 most of these patients are on polypharmacy,

and there can be lots of interactions, and many of these medications are really quite -- you know, can have some side effects and may have some implications.

Q. And then if you look the third line down under "narrative," it says: [AS READ]

"His death was discussed with his family; they had no concerns."

So I take it because you have no recollection of Mr. Silcox's death investigation, you're not in a position to assist us with recalling the family?

A. No.

Q. Okay. And we do anticipate that there will be evidence at the inquiry from Mr. Silcox's daughter, Diane Crawford, and we anticipate that her evidence will be that at no time, did she or her mother or any other members of her family have a discussion with you, with the coroner, about her father's death.

What do you say about that anticipated evidence? Can you help us with that?

A. I don't recall. It's my usual practice to speak with the family.

Q. Okay. And are there ever instances where you might ask a caregiver -- instead of speaking to the family, ask a nurse or a doctor, "Does the family have any concerns?"

12:25:10 A. It might happen.
12:25:11 Q. Okay. Are there any concerns
12:25:17 about obtaining that sort of information,
12:25:18 family concern information, from one of the
12:25:20 caregivers?
12:25:22 A. Potentially there could be.
12:25:23 Q. Okay. And what kinds of
12:25:25 concerns should we have about that?
12:25:27 A. They may not give you the
12:25:28 accurate picture, or the family may have an
12:25:31 entirely different perspective on things.
12:25:33 Q. Now, would it be best
12:25:40 practice, in your view, to make sure you
12:25:41 speak to a family member themselves as
12:25:45 opposed to getting this information
12:25:47 secondhand?
12:25:48 A. Absolutely. Always make an
12:25:49 attempt to speak to the family.
12:25:51 Q. When identifying which family
12:25:53 member to contact, how do you -- how do you
12:25:55 do that?
12:25:56 A. Usually I choose the person
12:26:01 who's designated on the -- on the
12:26:04 demographic sheet.
12:26:05 Q. Okay. And if there are a few
12:26:08 people --
12:26:09 A. Usually start at the top, or
12:26:10 sometimes the nursing home will have a --
12:26:14 put an asterisk next to the one to contact.
12:26:17 Q. Thank you. And I anticipate
12:26:18 that Ms. Crawford's evidence will also be
12:26:22 that she then called the coroner four to six

12:26:26 1 weeks later to discuss the circumstances of
12:26:29 2 the death and that she felt that the coroner
12:26:32 3 was dismissive and that the coroner felt
12:26:32 4 that this call was unwarranted as her father
12:26:35 5 was elderly, and there was nothing unusual
12:26:39 6 about his death.
12:26:40 7 A. I don't recall ever receiving
12:26:41 8 a call like that, and I would've never been
12:26:45 9 dismissive. I have great respect for the
12:26:47 10 dead and their family, so...
12:26:51 11 Q. Now, turning back to the
12:26:52 12 Form 3, which we have in front of us, at the
12:26:56 13 very bottom of the page and going over to
12:27:00 14 the second page, we see his death was as a
12:27:05 15 result of complications following a fall in
12:27:09 16 which he sustained a right hip fracture?
12:27:12 17 A. That's correct.
12:27:13 18 Q. Okay. And how did you reach
12:27:15 19 that conclusion as the cause of death for
12:27:18 20 Mr. Silcox?
12:27:19 21 A. His -- his death was as a
12:27:20 22 result of -- the primary event was a fall,
12:27:24 23 and in that fall, he sustained a right hip
12:27:27 24 fracture. And that, in turn, triggered, you
12:27:30 25 know, a spiralling down of other things.
12:27:33 26 The surgery, I'm sure, went well,
12:27:35 27 but this gentleman was deconditioned. He
12:27:40 28 had a history of dementia, previous history
12:27:45 29 of stroke, and any kind of, you know, blow
12:27:47 30 to the head or anywhere else on the body has
12:27:49 31 serious consequences. And they're sitting
12:27:53 32 ducks for complications afterwards.

12:27:56 Q. Okay. We do know -- just
12:28:00 assist us who don't do death investigations.
12:28:03 We can see from the Progress Notes that
12:28:03 there was a fall. And we can see that he
12:28:06 had surgery. Mr. Silcox had surgery, and we
12:28:07 can see that he passed away after that
12:28:09 surgery.
12:28:10 Is there anything else to assist
12:28:13 us with the fact that the cause of death
12:28:15 itself was the surgery as opposed to any
12:28:17 other reason?
12:28:19 A. I don't think so.
12:28:21 Q. Okay. So when you reach that
12:28:24 cause of death as your conclusion, how do
12:28:28 you do that?
12:28:30 A. I've reviewed his chart, and
12:28:34 it's really quite obvious --
12:28:36 Q. Okay.
12:28:36 A. -- the situation.
12:28:38 Q. Okay. So you were satisfied,
12:28:39 based on the test that you had provided
12:28:41 earlier, that it was --
12:28:42 A. That's right.
12:28:43 Q. I believe you used the
12:28:44 language "very likely"?
12:28:47 A. Very likely, yes.
12:28:48 Q. Okay. Thank you. Would you
12:28:53 have considered a postmortem for Mr. Silcox?
12:28:57 A. No.
12:28:57 Q. Why not?
12:28:58 A. I don't think anything would
12:28:59 have been gained by it.

12:29:02 Q. And if you turn now to Tab
12:29:05 10, which is Document 65226. This is
12:29:25 Mr. Silcox's Medical Certificate of Death?
12:29:26 A. That's correct.
12:29:27 Q. Okay. And did you complete
12:29:28 this document?
12:29:30 A. That's my handwriting from
12:29:31 the cause of death below.
12:29:34 Q. If we start at cause of death
12:29:36 and we go downwards, we see your
12:29:37 handwriting?
12:29:37 A. Onwards, that's all my
12:29:40 handwriting.
12:29:40 Q. Okay. And so is it the
12:29:41 practice for a local coroner to complete the
12:29:43 Medical Certificate of Death where there is
12:29:45 a death investigation?
12:29:46 A. Yes.
12:29:47 Q. And who completes it
12:29:49 otherwise?
12:29:49 A. A family doctor. If it's not
12:29:51 a coroners case, then it would be another
12:29:54 physician.
12:29:56 Q. And then if we turn to
12:29:58 Tab 11, which is Document 65226, and we're
12:30:10 looking at the Resident Death Form. If you
12:30:14 could assist us with whether your
12:30:16 handwriting appears on this document.
12:30:18 A. My handwriting is at the top
12:30:20 down as far as the serrated, the double line
12:30:26 that goes across the page.
12:30:28 Q. Okay. And is this a standard

12:30:29 1 death investigation document, or this is the
12:30:31 2 document particular to Caressant Care?
12:30:32 3 A. This is the document
12:30:34 4 particular to Caressant Care.
12:30:34 5 MS. JONES: Oh, and I apologize.
12:30:38 6 For the record, I should mention
12:30:40 7 that's at 65226, page 122.
12:30:44 8 THE COMMISSIONER: Thank you.
12:30:53 9 BY MS. JONES:
12:30:53 10 Q. Dr. George, looking at your
12:30:54 11 Form 3 now and the information that you
12:30:57 12 would have had before you at the time of
12:31:00 13 Mr. Silcox's death, do you think that you
12:31:03 14 missed anything that you ought to have
12:31:06 15 discovered when doing this death
12:31:08 16 investigation?
12:31:08 17 A. No.
12:31:14 18 Q. I'm going to turn now to the
12:31:17 19 passing of Ms. Maureen Pickering.
12:31:25 20 Dr. George, do you have any memory of
12:31:27 21 receiving a call about the death of
12:31:29 22 Ms. Pickering?
12:31:29 23 A. No.
12:31:31 24 Q. And do you have any memory of
12:31:34 25 receiving a call about a patient who had
12:31:38 26 extremely low blood sugar and that a
12:31:41 27 coroner -- there had been some suggestion
12:31:43 28 that a coroner should be involved?
12:31:45 29 A. After reviewing the records,
12:31:47 30 I'm familiar with it now.
12:31:49 31 Q. Pardon me?
12:31:49 32 A. After reviewing the records,

12:31:50 I'm familiar with it now.
12:31:51 Q. Right. Okay. But you have
12:31:52 no independent recollection outside?
12:31:54 A. No, outside of that not.
12:31:56 Q. And do you have any notes
12:31:59 relating to receiving this call?
12:32:01 A. No, I do not.
12:32:04 Q. But you've now had an
12:32:05 opportunity to review some of the records?
12:32:06 A. Yes.
12:32:07 Q. And does that include the
12:32:09 I/CAD or the Provincial Dispatch Record?
12:32:11 A. Yes.
12:32:15 Q. And does that include the
12:32:18 emergency room record from when
12:32:21 Ms. Pickering was seen in the emergency
12:32:23 room?
12:32:23 A. 23rd of March, yes.
12:32:25 Q. Thank you. And does that
12:32:26 include Ms. Pickering's Progress Notes in
12:32:29 the period -- let's say the two-week period?
12:32:32 A. That were provided, yes.
12:32:32 Q. Yes. Okay. I'm going to ask
12:32:37 that you refer now to Exhibit 97, which is
12:32:43 the Affidavit of Noelle Kelly. And that is
12:32:49 on the database as AFF18. I'm going to ask
12:33:11 you to turn to page 2, Dr. George, of the
12:33:12 document.
12:33:12 From my review of the records and
12:33:30 Ms. Kelly's Affidavit, it appears that the
12:33:33 first contact you had in relation to
12:33:36 Ms. Pickering's death was at 8:37 on

12:33:39 March 28th, 2014.
12:33:42 Is that consistent with what
12:33:45 you've been able --
12:33:46 A. Yes.
12:33:46 Q. -- to discern from your
12:33:48 review?
12:33:49 A. Yes.
12:33:49 Q. Okay. And Ms. Kelly's
12:33:50 Affidavit states that she contacted you,
12:33:56 that she does not have a note of her
12:33:58 discussion with you at this time, but that
12:34:00 it's her general practice to provide the
12:34:02 investigating coroner with all the
12:34:06 information that she is provided regarding
12:34:09 the circumstances of a death that have been
12:34:11 reported to her.
12:34:12 And if you look up at B and C of
12:34:20 Ms. Kelly's Affidavit, you see reference to
12:34:23 Ms. Kelly having information at B from a
12:34:26 nurse at Caressant Care, Karen Routledge,
12:34:31 that Ms. Pickering had gone to the hospital,
12:34:36 found to have low blood sugar. There's a
12:34:39 question mark there.
12:34:40 "Dr. Urbantke, one of our coroners,
12:34:42 advised the nursing home to call
12:34:44 the case in once she dies. Not
12:34:47 sure if there's more to it or not."
12:34:50 And at C, it appears that
12:34:53 Ms. Kelly spoke to Dr. Urbantke. And
12:34:57 Dr. Urbantke is who? Who's Dr. Urbantke?
12:35:01 A. Dr. Urbantke is another
12:35:03 coroner, but she also works in our emergency

department.

Q. Okay. And is it your understanding she had been involved in Ms. Pickering's treatment at the hospital?

A. Yes.

Q. Okay. And so it appears that Ms. Kelly called Dr. Urbantke to assign her as the investigating coroner. And we see that Dr. Urbantke declined that on the basis that it would be a conflict because she was also a treating physician; correct?

A. Correct.

Q. Okay. And that the information is -- from Dr. Urbantke was that the blood sugar was less than 1 and was unexplained. She can't take the case because she saw her in the ER but will speak to the coroner to give more background information.

Okay. So in relation to this information that Ms. Pickering was found to have low blood sugar and that Dr. Urbantke felt that a coroner should be called, do you have any reason to believe that you did not receive that information on March 28th?

A. No.

Q. Okay. So do you accept that you would have received that information? Okay.

THE COURT REPORTER: Excuse me, I didn't get an answer.

MS. JONES: Yes.

12:36:10 BY MS. JONES:
12:36:10 Q. If we then -- and actually, before we leave that document, at Tab D, it says -- I apologize. At paragraph 5D, it says:
12:36:20 "Dr. George accepted the case."
12:36:23 And then Ms. Kelly has clarified:
12:36:26 "I.e., agreed to look into the matter."
12:36:29 So what does "accepted the case" in this context mean?
12:36:31 A. She provided me with a synopsis of the situation and a contact telephone and told me what had gone on. And then I made phone calls and, you know, investigated into -- into her death.
12:36:32 Q. And does "accepted the case" in this context mean accepted it as a death investigation or accepted that you would do an assessment of whether or not --
12:36:47 A. Accepted you would do an assessment.
12:36:48 Q. Okay. So you accepted meaning you would now undertake a consideration of whether or not it met the criteria for a death investigation?
12:36:52 A. That's right.
12:36:53 Q. Okay.
12:36:55 A. If I can comment that it's -- in a hospital two days ago, that's not accurate. It was five days prior to that.
12:36:55 Q. That's correct. Thank you.
12:36:58
12:36:59
12:37:02
12:37:04
12:37:06
12:37:07
12:37:08
12:37:10
12:37:12
12:37:14

12:37:14 1 And that evidence has been clarified earlier
12:37:18 2 in the proceeding.
12:37:19 3 So if you now turn to Tab 28, and
12:37:26 4 this is Document 65222. These are
12:37:41 5 Ms. Pickering's Progress Notes. If you look
12:37:51 6 at the entry at 09:23, Dr. George.
12:37:56 7 A. Yes.
12:37:57 8 Q. And this entry -- our
12:38:03 9 understanding is that from Ms. Routledge's
12:38:05 10 evidence, that she would have started this
12:38:07 11 entry at 9:23 and then added to it over
12:38:10 12 time.
12:38:12 13 And you'll see that you're
12:38:12 14 referenced within this 09:23 entry at 09:50;
12:38:19 15 correct?
12:38:19 16 A. That's correct.
12:38:22 17 Q. Okay. And it says:
12:38:24 18 "Dr. George called back and did not
12:38:27 19 feel this was a coroners case."
12:38:30 20 Ms. Routledge also gave evidence
12:38:32 21 that when she spoke to you, she would have
12:38:39 22 discussed with you the fact that
12:38:42 23 Ms. Pickering had been in the hospital with
12:38:44 24 extremely low blood sugar and that you would
12:38:47 25 have talked amongst the two of you about
12:38:50 26 Ms. Pickering's comorbidities, the
12:38:59 27 possibility that she may have had a stroke,
12:38:59 28 and that you would have reviewed Ms.
12:38:59 29 Pickering's medical history?
12:39:00 30 A. Yes.
12:39:01 31 Q. Okay. And does that sound
12:39:03 32 consistent with what your practice would

12:39:05 1 have been?
12:39:05 2 A. Absolutely.
12:39:06 3 Q. Okay. Now, if we look at the
12:39:08 4 09:50 note, do you have any reason -- or any
12:39:16 5 evidence to provide about whether or not
12:39:18 6 09:50 was your first conversation with
12:39:23 7 Ms. Routledge? Your only conversation with
12:39:26 8 Ms. Routledge? Can you assist us with that?
12:39:28 9 A. What tab are we at again?
12:39:31 10 Q. At Tab 28, the first page,
12:39:34 11 Dr. George.
12:39:38 12 THE COMMISSIONER: The 9:50 is
12:39:41 13 in the middle of the 9:23 note.
12:39:43 14 THE WITNESS: Yes. Okay.
12:39:47 15 Thanks. It would -- it would have
12:39:50 16 been my usual practice to call
12:39:53 17 almost immediately after I had
12:39:54 18 hung up with dispatch.
12:39:56 19 BY MS. JONES:
12:39:56 20 Q. Okay. And so does that lead
12:39:59 21 you to have a belief about whether or not
12:40:01 22 this was the first time you spoke to
12:40:03 23 Ms. Routledge?
12:40:04 24 A. It may not have been.
12:40:05 25 Q. It may not have been. You
12:40:07 26 can't tell us either way?
12:40:09 27 A. It's my practice to call
12:40:10 28 immediately after, and then it's likely that
12:40:12 29 I was gathering more information from her
12:40:15 30 visit from the hospital.
12:40:16 31 Q. Okay. And so what would
12:40:19 32 gathering more information from her visit to

12:40:21 1 the hospital have looked like? Would you
12:40:23 2 have looked at medical records?
12:40:25 3 A. I may have called. I may
12:40:27 4 have gotten something faxed over.
12:40:29 5 Q. And if you called, who would
12:40:31 6 you have called?
12:40:34 7 A. Probably somebody in medical
12:40:35 8 records or in emerg.
12:40:37 9 Q. Okay. And we've seen that
12:40:43 10 Dr. Urbantke had indicated to Ms. Kelly that
12:40:47 11 she would be prepared to speak to the
12:40:49 12 coroner. Do you know whether you spoke to
12:40:52 13 Dr. Urbantke on that day?
12:40:53 14 A. I don't remember.
12:40:54 15 Q. Sorry?
12:40:55 16 A. I don't recall.
12:40:55 17 Q. You don't recall. Okay.
12:40:56 18 So is it fair to say that you
12:41:00 19 don't recall, in particular, whether you
12:41:02 20 looked at medical records or spoke to
12:41:04 21 anyone, but you believe it's possible that
12:41:06 22 you did, or do you believe it's likely that
12:41:08 23 you did?
12:41:09 24 A. It's likely that I did.
12:41:21 25 Q. Now, can you assist us, then,
12:41:25 26 with again accepting that you received the
12:41:29 27 information from Ms. Kelly and from
12:41:33 28 Ms. Routledge that you received, why you did
12:41:36 29 not feel this was a coroners case?
12:41:40 30 A. Based on the information that
12:41:41 31 she provided me, this lady was palliative
12:41:45 32 care and had experienced a pontine infarct,

12:41:52 1 a stroke, that was evidenced on the CT scan
12:41:55 2 that she had when she went to the emergency
12:41:57 3 department.
12:41:58 4 Q. Okay. So if we just break
12:41:59 5 that down, Mr. George, in terms of
12:42:02 6 Ms. Pickering being in palliative care, are
12:42:05 7 you aware of the fact that she was only in
12:42:07 8 palliative care after she returned to the
12:42:09 9 home after the hypoglycemic episode?
12:42:14 10 A. That's correct.
12:42:14 11 Q. Okay. And so would that have
12:42:16 12 played any part in your determination when
12:42:18 13 you were considering the fact that she was
12:42:20 14 in palliative care?
12:42:22 15 A. She was in palliative care,
12:42:24 16 and the case had been discussed with her
12:42:27 17 power of attorney that had requested comfort
12:42:29 18 measures. Her low blood sugar was, you
12:42:33 19 know, a single low blood sugar. There
12:42:38 20 didn't appear to be a succession of them.
12:42:41 21 And her CT scan revealed that she'd had a
12:42:45 22 stroke which was new compared to her
12:42:47 23 previous CT.
12:42:48 24 Q. Okay. And in terms of her CT
12:42:50 25 scan revealing that she had a stroke, were
12:42:53 26 you familiar at the time with the fact that
12:42:55 27 hypoglycemic encephalopathy, so brain injury
12:42:55 28 caused by low blood sugar -- is that right?
12:42:55 29 Okay -- can mimic a stroke on imaging?
12:43:05 30 A. Yes. I'm not an expert, but
12:43:07 31 it's my understanding that the hypoglycemia
12:43:10 32 would have to be low and prolonged for quite

12:43:14 a long time in order to precipitate that.
12:43:19 Q. Okay. Your understanding was
12:43:19 in order to precipitate hypoglycemic
12:43:23 encephalopathy which would show up as a
12:43:25 stroke, you would need a prolonged period of
12:43:27 low blood sugar?
12:43:29 A. I'm not sure that it would
12:43:31 show up as a stroke, but the encephalopathy
12:43:32 would be -- there would be different changes
12:43:38 on the CT scan. And she already had some
12:43:42 changes on her CT as a result of her
12:43:45 dementia.
12:43:47 Q. As a result of her dementia?
12:43:48 A. Yes.
12:43:48 Q. Okay.
12:43:49 THE COMMISSIONER: Okay. I
12:43:49 don't think I understood fully
12:43:51 your answers to all those
12:43:52 questions.
12:43:53 THE WITNESS: Okay.
12:43:54 MS. JONES: We can break it down a
12:43:56 little bit more, Commissioner.
12:43:59 THE COMMISSIONER: Thank you.
12:44:00 Start with the question of what he
12:44:01 understood hypoglycemia could do
12:44:03 to the brain.
12:44:07 BY MS. JONES:
12:44:07 Q. Okay. So were you familiar
12:44:10 with the condition of hypoglycemic
12:44:11 encephalopathy?
12:44:11 A. Yes.
12:44:12 Q. Okay. And what is that

12:44:13 1 condition?
12:44:13 2 A. So if somebody has a very low
12:44:18 3 blood sugar for a prolonged period of time,
12:44:21 4 that can cause encephalopathy, which is
12:44:24 5 damage to the -- to brain tissue.
12:44:26 6 Q. Okay. And is it a particular
12:44:26 7 type of damage to the brain tissue?
12:44:29 8 A. Well, the brain starts to
12:44:33 9 waste away.
12:44:34 10 Q. Okay.
12:44:34 11 MS. JONES: And we will be
12:44:36 12 hearing evidence, Commissioner,
12:44:36 13 from Dr. Pollanen about the
12:44:38 14 details of that particular injury.
12:44:40 15 BY MS. JONES:
12:44:40 16 Q. But for the purposes of
12:44:41 17 today, you understood that -- you understood
12:44:42 18 that condition?
12:44:42 19 A. Right. And a patient
12:44:43 20 presenting with a solitary low blood sugar,
12:44:46 21 most of those people respond, you know, to
12:44:49 22 the administration of glucose without any
12:44:53 23 untoward effects.
12:44:54 24 Q. And in Ms. Pickering's case,
12:44:56 25 her blood sugar was very low; is that fair?
12:44:59 26 A. That's true.
12:45:00 27 Q. And does that -- in terms of
12:45:01 28 being able to respond to glucose, does that
12:45:04 29 make any difference how low the blood sugar
12:45:08 30 was?
12:45:09 31 A. No, but it was -- it was
12:45:10 32 significantly low.

12:45:11 Q. Okay. And then going back to
12:45:13 make sure we go through it little bit more
12:45:16 slowly, I asked you -- your evidence was
12:45:18 that you were satisfied based -- or you
12:45:21 believe now you would have been satisfied
12:45:23 that she had a stroke because there was
12:45:25 imaging which suggested a stroke?
12:45:27 A. A new stroke.
12:45:28 Q. A new stroke. Okay.
12:45:29 And my question to you was in
12:45:32 imaging, when looking at a CT scan, is it
12:45:35 possible to mistake a stroke with
12:45:40 hypoglycemic encephalopathy?
12:45:41 A. I'm not sure, but I doubt it.
12:45:45 This -- it appeared to be a pontine infarct,
12:45:49 which means that there was some sort of
12:45:51 thrombotic event or some sort of a, you
12:45:53 know, blood clot that would have caused
12:45:59 that.
12:45:59 Q. Okay. So do you believe you
12:46:00 would have been concerned that the stroke
12:46:00 was, in fact, hypoglycemic encephalopathy,
12:46:01 or that would not have been a concern?
12:46:03 A. No, it wasn't my concern.
12:46:06 Q. And would you have, in
12:46:13 considering this case, attempted to come up
12:46:16 with a reason for Ms. Pickering's extremely
12:46:21 low blood sugar? Would that have been part
12:46:23 of your consideration?
12:46:24 A. Yes.
12:46:24 Q. Okay. And what do you
12:46:26 believe you would have considered when

12:46:28 1 determining or considering why her blood
12:46:30 2 sugar had been extremely low on that day?
12:46:33 3 A. I would be considering a
12:46:34 4 medication error as well as her medications.
12:46:40 5 And she was on numerous antipsychotics,
12:46:43 6 which can accentuate hypoglycemia.
12:46:52 7 Q. But a medication error would
12:46:56 8 have been one of your considerations for
12:46:58 9 this blood sugar?
12:46:59 10 A. Would have been one of them,
12:47:00 11 yes.
12:47:03 12 Q. If there's the possibility of
12:47:05 13 a medication error in the patient's time --
12:47:07 14 immediately preceding the patient's death,
12:47:15 15 is that not a reason for a coroners
12:47:18 16 investigation?
12:47:18 17 A. If the medication
12:47:21 18 precipitated the death, that would be reason
12:47:22 19 for a coroners investigation.
12:47:24 20 Q. Okay. So from that answer,
12:47:26 21 would you have reached a conclusion about
12:47:28 22 whether or not, if there had been a
12:47:30 23 medication error, it had resulted in the
12:47:32 24 patient's death?
12:47:34 25 A. That's right.
12:47:36 26 Q. You would have considered
12:47:36 27 that?
12:47:37 28 A. Yes.
12:47:37 29 Q. Okay. And based on your
12:47:41 30 answer, what would you your conclusion have
12:47:43 31 been?
12:47:44 32 A. In this particular situation?

12:47:46 Q. Yes.
12:47:47 A. That there was probably a
12:47:48 medication error and that it was a solitary
12:47:51 event.
12:47:51 Q. Okay. And what relationship
12:47:53 would you have concluded there was between
12:47:56 the medication error and Ms. Pickering's
12:47:58 death?
12:47:58 A. I didn't think it was related
12:47:59 to her death.
12:48:14 Q. Dr. George, looking back at
12:48:17 these circumstances now and attempting to
12:48:19 take out of your mind what we now know about
12:48:23 Ms. Wettlaufer's offences, do you think you
12:48:24 should have investigated this death?
12:48:27 A. No.
12:48:27 Q. Why not?
12:48:29 A. Because the death was
12:48:31 foreseeable and expected.
12:48:34 Q. And that was based on, as
12:48:36 you've testified, Ms. Pickering's palliative
12:48:38 status and the fact that you understood
12:48:40 she'd had a stroke?
12:48:41 A. That's correct.
12:48:49 MS. JONES: Thank you, Dr. George.
12:48:51 I have no further questions.
12:48:52 So, Commissioner, I will ask now counsel
12:48:56 to the province if they have any questions
12:49:00 in-chief.
12:49:03 THE COMMISSIONER: Thank you,
12:49:04 Ms. Jones.
12:49:07 MS. BAMBERS: Can I just have a

12:49:08 moment?
12:49:09 THE COMMISSIONER: Yes, you may.
12:49:36 MS. BAMBERS: Thank you,
12:49:37 Commissioner.
12:49:37 EXAMINATION IN-CHIEF BY MS. BAMBERS:
12:49:38 Q. Just a couple questions,
12:49:41 Dr. George. When you said that if the
12:49:44 family contacted you to get more information
12:49:49 about your decision, your conclusions on
12:49:58 investigating the death of Mr. Silcox, that
12:50:01 you would not have been dismissive. What is
12:50:05 your practice if a family contacts you?
12:50:06 A. I'm more than happy to speak
12:50:08 with them, and we've even had people come
12:50:10 into the office and -- because they had more
12:50:12 than one family member that wanted to
12:50:14 discuss this, and that's been quite a common
12:50:16 event.
12:50:18 Q. All right. And regarding the
12:50:24 information -- you said that you had no
12:50:27 information to contradict what Noelle Kelly
12:50:33 indicated was her usual practice of
12:50:35 providing information to coroners when she's
12:50:41 contacting a coroner, but you don't have any
12:50:43 recollection of exactly what she told you?
12:50:46 A. No. And I'm not sure that it
12:50:48 would be verbatim what she documented in her
12:50:52 record.
12:50:52 Q. All right. And you believe
12:50:56 that you would have reviewed certain things
12:51:01 from the time that you were called until
12:51:08 9:50 when Karen Routledge indicates you

12:51:11 1 called back, but at this time, you can't be
12:51:13 2 certain what you reviewed?
12:51:15 3 A. No, I can't.
12:51:17 4 Q. And you don't know whether
12:51:19 5 that would have included the hospital record
12:51:21 6 or not?
12:51:23 7 A. It likely would have.
12:51:25 8 MS. FRAZER: Sorry, I didn't
12:51:27 9 hear that.
12:51:28 10 THE WITNESS: It likely would
12:51:29 11 have.
12:51:31 12 MS. FRAZER: Would have?
12:51:31 13 THE WITNESS: Yes.
12:51:32 14 BY MS. BAMBERS:
12:51:33 15 Q. And why do you say that?
12:51:34 16 A. That would have been my --
12:51:36 17 you know, if they -- she had had a visit
12:51:36 18 there, then I would have attempted to -- you
12:51:36 19 know, got some information from that.
12:51:42 20 Q. How would you get that
12:51:45 21 record?
12:51:45 22 A. I would have called the
12:51:46 23 hospital.
12:51:47 24 MS. BAMBERS: Okay. Thank you.
12:51:51 25 MS. JONES: Commissioner, this
12:51:58 26 may be a good time for the lunch
12:52:01 27 recess before Mr. Van Kralingen
12:52:04 28 begins his cross-examination.
12:52:05 29 THE COMMISSIONER: All right.
12:52:05 30 Thank you very much.
12:52:17 31 THE REGISTRAR: This Public
12:52:17 32 Inquiry is now on lunch for an

12:52:19 hour and 15 minutes.
12:52:22 -- RECESSED AT 12:52 P.M.
12:52:22 -- RESUMED AT 2:13 P.M.
12:52:22 CROSS-EXAMINATION BY MR. VAN KRALINGEN:
12:52:22 Q. I've placed before you, and,
02:13:37 Madam Commissioner, hopefully you'll have a
02:13:40 copy, of a small group of documents that I
02:13:42 plan to reference in today's examination.
02:13:44 In the usual course I tend to go
02:13:47 sequentially but given some of your answers
02:13:49 we might bounce around in the document just a
02:13:51 little bit, just so you know.
02:13:52 A. Okay.
02:13:54 Q. Ms. Jones asked a little bit
02:13:55 about your background and your practice.
02:13:57 What I was unclear about after her
02:14:00 conversation with you is what percentage of
02:14:01 your practice is doing coroner's work?
02:14:08 A. Probably like 5 percent.
02:14:10 Q. And has that percentage
02:14:11 materially changed since 2007?
02:14:13 A. Not really, no.
02:14:14 Q. Has it ever changed during
02:14:15 the course of your career?
02:14:17 A. As I said before, sometimes
02:14:18 it's busier than other times but it's a
02:14:22 small portion of my practice.
02:14:24 Q. As you discussed with
02:14:24 Ms. Jones, you're aware from time-to-time
02:14:26 the Office of the Chief Coroner or the
02:14:29 Regional Senior Coroner will circulate
02:14:31 memorandum dealing with a variety of topics,

02:14:33 1 including best practices. Is it your
02:14:37 2 general practice to review those documents?
02:14:40 3 A. Yes.
02:14:40 4 Q. And to the extent that those
02:14:42 5 memoranda or circulars include best
02:14:45 6 practices is it your normal course of action
02:14:47 7 to incorporate them into your work as a
02:14:50 8 local coroner?
02:14:51 9 A. Normally yes.
02:14:52 10 Q. Before being appointed as a
02:14:53 11 coroner you took a 3-day course?
02:14:55 12 A. Yes.
02:14:55 13 Q. You were appointed in 2004.
02:14:57 14 We've learned today, from your discussion
02:14:59 15 with Ms. Jones, about a 6-month period of
02:15:01 16 mentoring with the Regional Senior Coroner,
02:15:04 17 is that correct?
02:15:05 18 A. One of the region -- she
02:15:06 19 was -- we had a Guelph office at that time
02:15:10 20 so Dr. Acheson was the regional coroner for
02:15:13 21 Guelph.
02:15:14 22 Q. Fair enough, a Regional
02:15:15 23 Senior Coroner?
02:15:16 24 A. A Regional Senior Coroner,
02:15:17 25 that's right.
02:15:19 26 Q. And it was a 6-month period
02:15:21 27 and was that a timed down period that was
02:15:21 28 significant or was there a certain number of
02:15:23 29 investigations that needed to occur before
02:15:25 30 you could stop being mentored?
02:15:27 31 A. That's what she had set out
02:15:29 32 and she had said, For the next six months I

02:15:32 1 want you to call me for each case that
02:15:34 2 you're called out for.
02:15:35 3 Q. Since then have you had
02:15:36 4 occasion to speak with the Regional Senior
02:15:39 5 Corner to assist with any cases you've had?
02:15:42 6 A. Yes.
02:15:42 7 Q. Since 2004 when you were
02:15:43 8 appointed can you approximate how many cases
02:15:46 9 you would have called the Regional Senior
02:15:48 10 Coroner for the purposes of consulting?
02:15:51 11 A. Probably about once a month.
02:15:52 12 Q. Okay.
02:15:53 13 A. Once every two months.
02:15:56 14 Q. Similarly we've heard in
02:15:57 15 previous testimony that in some
02:15:58 16 circumstances the Regional Senior Coroner
02:16:01 17 will follow-up with a local coroner after
02:16:04 18 reviewing either a Form 3 or a Case
02:16:06 19 Selection Data Form looking for further
02:16:09 20 information. During your conversation
02:16:12 21 Ms. Jones you spoke about the fact that in
02:16:14 22 certain circumstances you would be contacted
02:16:16 23 about your Form 3.
02:16:18 24 And of course you could never have
02:16:20 25 been contacted with respect to a Case
02:16:21 26 Selection Data Form because you don't submit
02:16:23 27 them, is that fair to say?
02:16:25 28 A. That's correct.
02:16:27 29 Q. My understanding is that your
02:16:28 30 process regarding death investigations you
02:16:30 31 decline is not to keep notes except for the
02:16:33 32 first few weeks after you have taken those

notes, is that right?
A. That's correct.
Q. I just don't understand why you would keep them for a few weeks and then discard them? What is the logic there?
A. They would probably be on my desk and in the coroner's -- I have a file on my desk that, a plastic file where I file stuff. And so if it's not a coroners case I didn't see any reason to keep it further.
Q. I understand that, but you're not saying that the choice to keep your notes for a few weeks is out of any reason connected to your role as a coroner?
A. No.
Q. It's just the way you administrate your notes?
A. It's just the way I was administering.
Q. Can I better understand the reason why you've chosen not to retain your notes relating to a death investigation that was declined?
A. I didn't think it was necessarily, and when it was implemented I thought it was more for monetary reasons.
Q. Can you explain that?
A. Well, up until when that form came in we had another form and we weren't paid for taking calls, and there was no requirement at that time. And so we had a different type of a form that was submitted

for a while that we weren't reimbursed for. And this was voiced at some of the coroner conferences that some of the coroners in bigger cities that were receiving a lot of calls for noncoroner cases wanted to be reimbursed for them. And that's how that came about.

Q. Is it fair to say that your usual practice was not to inform the Regional Senior Coroners office when you chose to decline a death investigation?

A. That's correct. There would be occasion when I would call him and ask him about a certain case whether, you know, this would be appropriate as a coroners case or not?

Q. But those would be few and far between, is that fair to say?

A. They would, you know, every several months. We have missed cases that often come up because as my role as a coroner I also issue death -- issue cremation certificate. So a cremation certificate has to come across a coroner's desk. And so if there's something on the cremation certificate that raises concerns, such as an accidental fall, or a head injury, or that kind of stuff and it's already been signed off as a non-coroners death that becomes a missed case and someone would have to investigate that, usually just doing a chart review.

02:19:04 Q. How frequent is that?
02:19:05 A. It happens with -- still
02:19:07 happens with some frequency in the province.
02:19:09 Q. In the course of your work
02:19:10 have you spoken with other local coroners
02:19:13 about their practices regarding keeping
02:19:16 notes or completing the death selection form
02:19:19 when they decline a death investigation?
02:19:21 A. Yes.
02:19:21 Q. Can you tell me about those
02:19:22 conversations?
02:19:23 A. At the recent coroners
02:19:24 conference last November there were numerous
02:19:28 other coroners that didn't submit the form
02:19:30 either.
02:19:31 Q. But did they tell you why
02:19:32 they weren't submitting it?
02:19:33 A. They didn't think it was
02:19:35 necessary.
02:19:39 Q. And that's not just for the
02:19:39 London region that's from coroners across
02:19:41 the Province?
02:19:42 A. That's from coroners across
02:19:43 the Province, yes.
02:19:46 Q. And the reason they weren't
02:19:48 submitting those forms is that they didn't
02:19:49 see them to be of any value?
02:19:51 A. That's correct.
02:19:52 Q. I assume that you understand
02:19:53 that the Regional Senior Coroners office has
02:19:57 various oversight responsibilities in
02:19:59 connection with its local coroners?

02:20:01 A. That's correct.
02:20:01 Q. One of those oversight
02:20:03 responsibilities is with respect to
02:20:04 evaluating the work of local coroners,
02:20:07 including the decision not to conduct a
02:20:08 death investigation, is that your
02:20:10 understanding?
02:20:10 A. That's correct.
02:20:12 Q. To your mind if a local
02:20:14 coroner chooses not to file a Case Selection
02:20:16 Data Form, or keep any notes of their
02:20:19 decision not to accept a death
02:20:20 investigation, does that hinder the ability
02:20:23 of the Regional Senior Coroner to provide
02:20:26 input on to whether that refusal was a
02:20:29 reasonable decision?
02:20:30 A. I don't think so.
02:20:31 Q. How would they learn about
02:20:32 the fact that the decision occurred?
02:20:34 A. Well, from the numbers that I
02:20:35 saw earlier it didn't appear that a lot of
02:20:38 those forms were being submitted.
02:20:41 Q. That's not the question. I
02:20:43 think you're answering a different question.
02:20:45 A. Sorry.
02:20:45 Q. It's all right. I'll restate
02:20:45 my question?
02:20:47 A. Can you rephrase it?
02:20:48 Q. No, no, for sure I will.
02:20:49 If you don't hand in a Case
02:20:51 Selection Data Form and you don't keep any
02:20:53 notes the Regional Senior Coroner doesn't

02:20:55 1 know that you've declined a death
02:20:57 2 investigation, is that fair?
02:20:59 3 A. That's correct.
02:21:00 4 Q. So how could they possibly
02:21:02 5 have any oversight of your decision to
02:21:04 6 decline a death investigation?
02:21:06 7 A. They would know from the
02:21:07 8 number of cases that were seen -- that were
02:21:10 9 called in to central dispatch.
02:21:12 10 Q. And your belief is that the
02:21:13 11 Regional Senior Coroner reviews the cases
02:21:16 12 that are sent to central dispatch?
02:21:18 13 A. They know the number of cases
02:21:19 14 that we each accept and decline.
02:21:29 15 Q. Can you go to tab 1 of the
02:21:30 16 documents that I've given you in the yellow
02:21:32 17 binder? This is the document 71383. This
02:21:39 18 document is called "Chapter 5 Apparently
02:21:42 19 Natural Deaths" and it's taken from the
02:21:45 20 Coroners Investigation Manual. Are you
02:21:47 21 familiar with this document?
02:21:48 22 A. Yes.
02:21:52 23 Q. In your personal practice my
02:21:53 24 understanding is that you access your
02:21:55 25 coroners Manual electronically?
02:21:57 26 A. That's correct.
02:21:58 27 Q. Do you keep it with you when
02:21:59 28 you go to conduct death investigations?
02:22:01 29 A. Yes.
02:22:02 30 Q. And do you have it with you
02:22:03 31 when you make decisions as to whether to
02:22:05 32 conduct a death investigation or not?

02:22:07 A. I almost always have my
02:22:09 laptop with me.
02:22:13 Q. Third paragraph here says:
02:22:13 "When an apparently natural death
02:22:17 is reported to the coroner, the
02:22:20 first responsibility is to assess
02:22:22 as fully as possible whether this
02:22:25 death requires a coroner
02:22:26 investigation. This will require
02:22:28 the coroner to obtain adequate
02:22:30 information from the reporting
02:22:32 person involved in the case."
02:22:34 Do you agree that this is an
02:22:36 appropriate explanation of your obligation?
02:22:38 To obtain information relating to -- adequate
02:22:45 information from the reporting person?
02:22:47 A. Yes.
02:22:49 Q. And below section A it says
02:22:51 that the coroner should obtain as much
02:22:53 information as possible to make an informed
02:22:56 decision. I suppose my question is this,
02:23:00 because I don't have any notes, your
02:23:03 contemporaneous notes from your decision
02:23:06 with respect to Ms. Pickering, and I don't
02:23:07 actually have a sense of what your process
02:23:10 is, despite your discussion with Ms. Jones,
02:23:12 I'd like to know how long does your process
02:23:14 typically take to determine whether a death
02:23:17 investigation is appropriate in any given
02:23:19 circumstance?
02:23:19 A. It would vary on the
02:23:21 information that I'm provided.

02:23:24 Q. Does the length of your
02:23:25 process typically change when you're dealing
02:23:27 with a death in a long-term care home?
02:23:31 A. No, it's about the same.
02:23:33 Q. How often are you called with
02:23:34 respect to a death in a long-term care home?
02:23:37 A. Not very often. I can't
02:23:39 recall the last time I've been to a
02:23:40 long-term care facility.
02:23:43 Q. In fact my understanding is
02:23:44 that it has been approximately four to five
02:23:47 years since you've conducted any death
02:23:48 investigation in a long-term care home, is
02:23:50 that fair to say?
02:23:51 A. I think so.
02:23:54 Q. Why is that?
02:23:56 A. At one time we were being
02:23:58 called for threshold cases and that stopped
02:24:01 in 2013. And, as I said, recently sometimes
02:24:06 when patients are transferred to the
02:24:08 hospital that would be a coroners
02:24:11 investigation where the primary site would
02:24:13 have -- primary injury site would have been
02:24:16 in the nursing home.
02:24:18 But I haven't been to the nursing
02:24:20 home for a coroners case in a number of
02:24:22 years.
02:24:27 Q. My understanding, from your
02:24:29 conversation with Ms. Jones, is that your
02:24:32 position is that deaths at a long-term care
02:24:33 home can truly never be unexpected, is that
02:24:37 fair to say?

02:24:38 A. I would never say never but
02:24:42 highly unlikely.
02:24:43 Q. Highly unlikely. And do you
02:24:46 think it's a useful criterion to have on the
02:24:49 Institutional Patient Death Record given
02:24:52 what you've just suggested?
02:24:53 A. I don't think it's useful.
02:24:56 Q. Nevertheless it is a criteria
02:24:57 on the Institution Patient Death Record, you
02:24:59 would agree?
02:25:00 A. Yes.
02:25:05 Q. Can you go to page 3 of the
02:25:08 same document please? In the middle of the
02:25:15 page, and if you could -- that's perfect.
02:25:17 Thank you.
02:25:18 It says:
02:25:19 "The investigation should be
02:25:20 conducted with an open mind
02:25:22 considering all manners of death as
02:25:24 an initial possibility and, ruling
02:25:26 manners of death out based on the
02:25:28 evidence collected."
02:25:31 You'll agree with me that that
02:25:33 direction would include nefarious actors?
02:25:36 A. That's right.
02:25:44 Q. Can you go to tab 2 of the
02:25:46 documents you have?
02:25:49 A. It's document 71449.
02:26:06 Q. This is a circular or
02:26:08 memorandum circulated on September 20th,
02:26:10 2010, from the then Chief Coroner of Ontario
02:26:15 Mr. McCallum. Is this something that you

02:26:19 1 believe you would have read in the normal
02:26:21 2 course?
02:26:21 3 A. Yes.
02:26:21 4 Q. It deals with the best
02:26:22 5 practice guidelines in the Coroners
02:26:24 6 Investigation Manual with respect to case
02:26:28 7 selection decisions regarding natural
02:26:30 8 deaths. The second paragraph there says:
02:26:35 9 "Discussion with callers reporting
02:26:36 10 a natural death to determine the
02:26:38 11 need for investigation involves a
02:26:40 12 time commitment by a coroner."
02:26:42 13 Would you agree with that
02:26:44 14 proposition?
02:26:44 15 A. Yes.
02:26:45 16 Q. Go to page 2 of this
02:26:47 17 document. Page 2 of the document in the
02:26:54 18 middle says:
02:26:54 19 "Documentation of natural deaths
02:26:56 20 declined for investigation will be
02:26:59 21 submitted to the respective
02:27:00 22 Regional Supervising Coroners
02:27:02 23 office for tracking and
02:27:04 24 identification of any trends or
02:27:05 25 patterns."
02:27:07 26 After 2010 was your choice not to
02:27:09 27 keep notes or submit a Case Selection Data
02:27:11 28 Form in any way affected by reading this
02:27:15 29 memo?
02:27:17 30 A. No. I didn't collect -- I
02:27:18 31 didn't submit these forms, in retrospect I
02:27:23 32 should have and going forward I will.

02:27:33 Q. Go to tab 3 of the documents
02:27:35 you have.
02:27:36 Madam Commissioner, tab 3 of your
02:27:39 document is a different copy of the one
02:27:40 that's in evidence so I'm going to ask that
02:27:42 the one in evidence be pulled up, it's 71435.
02:27:52 THE COMMISSIONER: Thank you.
02:27:52 BY MR. VAN KRALINGEN:
02:27:52 Q. This is the best practice
02:27:54 guidelines of "Investigating Coroners
02:27:56 Acceptance of Natural Deaths for
02:27:59 Investigation". I assume that you've
02:28:00 reviewed this before?
02:28:02 A. Yes.
02:28:02 Q. And I assume that you use
02:28:04 this in the course of your coroner's
02:28:06 practice?
02:28:07 A. Yes.
02:28:07 Q. Can we go to page 2 please?
02:28:09 Page 2 is a decision tool, and I assume that
02:28:13 this decision tool is something that you
02:28:16 would regularly use in your practice?
02:28:18 A. Regularly.
02:28:20 Q. If a nondiabetic patient had
02:28:22 unexplained, severe hypoglycemia before
02:28:26 their death to your mind would that affect
02:28:27 the answers to any of the questions in this
02:28:29 decision tool?
02:28:30 A. No.
02:28:31 Q. Similarly, if a doctor
02:28:32 specifically raised a concern relating to
02:28:34 that same severe hypoglycemia to your mind

02:28:39 1 would that affect any of the answers in this
02:28:41 2 decision tool?
02:28:42 3 A. No.
02:28:43 4 Q. Can you look at number 4
02:28:44 5 please? Number 4 says:
02:28:45 6 "Is the case free of significant
02:28:47 7 care related concerns from either
02:28:50 8 family or care providers?"
02:28:54 9 Do you believe that Dr. Urbantke's
02:28:58 10 note that it might be a good idea to call the
02:29:00 11 coroner on this one could have related to the
02:29:03 12 question at number 4?
02:29:04 13 A. It could have. The blood
02:29:06 14 sugar was a solitary event, it was an
02:29:09 15 isolated event.
02:29:12 16 Q. But that could have been
02:29:13 17 related to a significant care-related
02:29:15 18 concern?
02:29:16 19 A. But she responded immediately
02:29:18 20 to administration with D50W.
02:29:26 21 Q. And of course you're thinking
02:29:26 22 about this after the fact because you have
02:29:29 23 no contemporaneous recollection?
02:29:32 24 A. No. The -- on the emergency
02:29:35 25 report her blood sugars are --
02:29:39 26 Q. What I'm suggesting is with
02:29:40 27 respect to Ms. Pickering when you went
02:29:42 28 through this decision tool you don't
02:29:44 29 remember what you did when you --
02:29:45 30 A. No, I didn't.
02:29:46 31 Q. So the conversation you're
02:29:47 32 having with us today about various documents

02:29:49 you've looked at, and I'm going to speak
02:29:50 about that later, is essentially you
02:29:51 refreshing your recollections in advance of
02:29:54 this Inquiry by looking at the medical
02:29:57 documents?
02:29:58 A. That's correct.
02:30:00 Q. Go to page 4 of this document
02:30:01 please. Page 4 of this document excerpts
02:30:07 certain portions of the Coroners Act. Under
02:30:09 the section that says, "Decision to Accept a
02:30:12 Natural Death for Investigation", if you can
02:30:14 bring it up a little bit? Perfect.
02:30:17 It says:
02:30:21 "Common scenarios where a natural
02:30:24 death may not necessarily be
02:30:25 accepted for investigation would
02:30:27 fall under section 10.1(d) suddenly
02:30:31 and unexpectedly, or section
02:30:33 10.1(g) under such circumstances as
02:30:37 may require investigation."
02:30:39 To your mind if a treating doctor
02:30:42 says it might be a good idea to call the
02:30:45 coroner on this one would that constitute
02:30:48 such circumstances as may require
02:30:49 investigation?
02:30:50 A. It may, yes.
02:30:51 Q. It may?
02:30:51 A. Yes.
02:30:54 Q. Can you go to the next tab
02:30:56 please? Tab 4.
02:30:57 Tab 4 is again, Commissioner, I'm
02:31:05 going to give the right number, 71436, which

02:31:09 is the Case Selection Data Form.
02:31:12 THE COMMISSIONER: Thank you.
02:31:25 BY MR. VAN KRALINGEN:
02:31:25 Q. I want to take you back sort
02:31:27 of in advance of Ms. Wettlaufer's crimes
02:31:30 coming to light. At that time did you feel
02:31:32 that this was a particularly onerous form to
02:31:35 complete?
02:31:35 A. It's not onerous, no.
02:31:37 Q. So it's not a question of it
02:31:38 being hard or time consuming to complete it
02:31:41 you just saw no value in the form being
02:31:44 completed, is that fair to say?
02:31:46 A. Well, I used the decision
02:31:47 criteria on the form each time I was
02:31:50 speaking to somebody on the phone.
02:31:52 Q. I'll be more precise with my
02:31:53 question.
02:31:53 Then you saw no value in completing
02:31:56 the form but you had a use for the form?
02:31:58 A. Yes, I had a use for the
02:31:59 form.
02:32:00 Q. But you saw no value in
02:32:02 completing it?
02:32:02 A. I didn't complete it.
02:32:09 Q. Can we go to next document
02:32:11 please? Tab 5. It's document 69309.
02:32:17 This is the section of the Coroners
02:32:26 Investigation Manual, chapter 11, dealing
02:32:29 with institutional deaths. Again I assume
02:32:33 you're familiar with this chapter?
02:32:35 A. Yes.

02:32:36 Q. In your conversation with
02:32:37 Ms. Jones earlier today you indicated that
02:32:38 it didn't occur to you that a healthcare
02:32:42 provider would be intentionally harming
02:32:44 their patients when you were conducting
02:32:45 death investigations, is that fair to say?
02:32:48 A. Not in this situation.
02:32:49 Q. In any situation?
02:32:50 A. Well, I can't think of a case
02:32:51 in a long-term care facility that I've been
02:32:53 involved in.
02:32:54 Q. And again just to be precise
02:32:56 with my question, I'm not just speaking
02:32:58 about death investigations I'm also posing
02:33:00 my question with respect to the decision to
02:33:02 conduct a death investigation. I assume
02:33:04 your answers are the same?
02:33:06 A. Yes.
02:33:07 Q. Can we go to the third
02:33:08 paragraph here:
02:33:09 "From an investigative perspective
02:33:12 the elderly living in a long-term
02:33:14 care home should be thought of as a
02:33:18 vulnerable population. While the
02:33:20 vast majority of their deaths are
02:33:22 uncomplicated the coroner needs to
02:33:24 be open to the possibility of
02:33:26 injury, abuse and neglect in the
02:33:28 same way as one would when
02:33:30 investigating the death of a child
02:33:31 or other vulnerable member of our
02:33:33 society."

02:33:33 So I assume you'll agree with me,
02:33:35 based on what I've read, that the Manual
02:33:37 expressly calls long-term care residents
02:33:40 "vulnerable"?
02:33:41 A. Yes.
02:33:42 Q. The Corners Manual here
02:33:44 expressly asks local corners to contemplate
02:33:47 the possibility of abuse, you would agree
02:33:49 with that?
02:33:50 A. Yes.
02:33:50 Q. And it doesn't differentiate
02:33:53 between abuse of healthcare providers and
02:33:56 abuse of anybody else, would you agree with
02:33:58 that.
02:33:59 A. Agreed.
02:34:01 Q. So I assume as part of your
02:34:02 training you were asked to review this
02:34:04 manual, is that fair to say?
02:34:06 A. That's correct, it was an
02:34:07 earlier version.
02:34:08 Q. Did you ever have any
02:34:09 training specifically contemplating the
02:34:12 possibility of resident abuse and that being
02:34:14 a reason for death?
02:34:17 A. Not specifically.
02:34:18 Q. Okay. I'm going to ask you
02:34:21 to look at a document that you don't have in
02:34:23 your package there and it's been entered in
02:34:26 before.
02:34:26 Hopefully we can just deal with it
02:34:28 on the screen, Madam Commissioner.
02:34:31 It's document 71434. This is a

02:34:38 PowerPoint presentation in 2013 put on by
02:34:42 Dr. Skinner, who is the Deputy Chief Coroner
02:34:43 for investigations. It is an educational
02:34:47 session for other coroners. It's called
02:34:49 "Death Investigations in Long-Term Homes, An
02:34:53 Approach", and if you can kindly turn to page
02:34:57 12 please?
02:34:57 A. Do I have this?
02:34:59 Q. It will be on the screen in
02:35:01 front of you. The question is, "What's
02:35:24 different about this population?" Answer 1,
02:35:26 "Nothing". "Deserving of the same degree of
02:35:28 death investigation as anyone else." Answer
02:35:32 2:
02:35:32 "Everything. Vulnerable
02:35:33 population, similar potential
02:35:35 issues as in pediatric death
02:35:38 investigations"
02:35:38 And the third one is important for
02:35:39 my purposes for my question:
02:35:41 "Caregivers may conceal evidence of
02:35:43 abuse/neglect by staff, family or
02:35:47 other residents."
02:35:48 So my question to you is, in any of
02:35:49 the continuing education you obtained was it
02:35:52 ever discussed with you that those
02:35:54 responsible for caring for residents in
02:35:56 long-term care homes might try and conceal
02:35:59 their evidence of abuse?
02:36:00 A. Not to any of the conferences
02:36:02 that I've been.
02:36:04 Q. Has that come up in any other

02:36:05 educational format, in particular a circular
02:36:09 that you may have received?
02:36:11 A. Yes, and at the last corner's
02:36:14 conference some of the abuse was discussed
02:36:17 in long-term care facilities.
02:36:19 Q. The last coroners conference
02:36:22 in November of last year?
02:36:23 A. November of 2017.
02:36:25 Q. Before then though, because I
02:36:26 was obviously post-dating Ms. Wettlaufer's
02:36:29 confession. Before then do you remember
02:36:31 receiving any education on these issues?
02:36:34 A. No.
02:36:35 Q. Could you go to tab 6 of the
02:36:36 documents you have in front of you? It's
02:36:38 document 61287. Have you heard of the
02:36:51 geriatric and long-term care review
02:36:51 committee?
02:36:54 A. Yes.
02:36:55 Q. Broadly do you know what
02:36:56 their function is?
02:36:56 A. They're to investigate deaths
02:36:58 in long-term care facilities.
02:37:01 Q. And also to provide best
02:37:02 practices on a going-forward basis for those
02:37:05 who work in those facilities?
02:37:07 A. Yes.
02:37:08 Q. If you could go please to --
02:37:10 just after the blue page in your excerpt,
02:37:12 and for the benefit of everyone else it's
02:37:14 page 10.
02:37:17 Do you ever read these reports when

they come out?
A. Yes.
Q. And paragraph 1 here, this is a -- to be clear this is an April 2002 report. Paragraph 1 here says:
"Healthcare professionals should be reminded that disease presentation in the elderly is frequently atypical and may vary greatly from patient to patient. A subtle change in a patient's status may well indicate that something serious is going on which may not be readily apparent."
So my question to you is this, I know this is directed towards those who work in the facilities, but to what extent is this a consideration for you when you're getting calls relating to deaths in long-term care homes and whether to investigate them or not.
A. I agree with the statement and it's very well worded that these people are vulnerable; and the changes in health status in these people is frequently atypical and can be quite subtle, or it can be quite dramatic and profound.
Q. But these values could they inform your decision to conduct or not conduct a death investigation?
A. In what way do you mean?
Q. Well, the idea that a review of a patient's condition, a subtle change in

02:38:48 a patient's condition may well indicate that
02:38:51 something very serious is going on?
02:38:53 A. Absolutely.
02:38:54 Q. And so those values would
02:38:56 inform your decision to either choose to
02:38:58 conduct or not choose to conduct a death
02:39:00 investigation?
02:39:01 A. That's correct.
02:39:03 Q. Can you go to the next tab
02:39:09 please? Tab 7, document 69322. This is a
02:39:19 best practice guideline with respect to
02:39:23 providing guidance with respect to
02:39:24 investigating coroners ordering post-mortem
02:39:29 examinations. Is this a document that
02:39:31 you've seen before?
02:39:32 A. Yes.
02:39:32 Q. In the introduction they talk
02:39:33 about the purpose of a post-mortem
02:39:36 investigation. And they lay out one of the
02:39:41 purposes at number 4 as, "To address
02:39:44 relevant medico-legal issues." I suppose
02:39:49 my first question is as a local corner what
02:39:51 is your understanding of a relevant
02:39:53 medico-legal issue.
02:39:56 A. If there are family concerns,
02:39:58 if there's some sort of suspicion, or if
02:39:59 there's foul play suspected, or if it's a
02:40:01 work-related accident or something of that
02:40:04 nature.
02:40:04 Q. But that -- to your mind that
02:40:05 would have to be something expressly
02:40:08 concerning -- something that someone is

02:40:10 1 expressly concerned about at the time you
02:40:13 2 arrive to determine whether a post-mortem --
02:40:16 3 at the time that you determine whether a
02:40:18 4 post-mortem is necessary?
02:40:20 5 A. That's correct.
02:40:21 6 Q. Do you believe that an
02:40:22 7 unexplained, severe hypoglycemia in a
02:40:26 8 resident could constitute a relevant
02:40:28 9 medico-legal issue?
02:40:30 10 A. I don't think so.
02:40:31 11 Q. Particularly where that
02:40:32 12 resident is nondiabetic?
02:40:34 13 A. I don't think so.
02:40:36 14 Q. What would the source of
02:40:38 15 exogenous insulin be?
02:40:40 16 A. There may have been a
02:40:41 17 medication error, the lady's state of
02:40:44 18 nutrition --
02:40:46 19 MS. BAMBERS: I don't know that we
02:40:47 20 have any evidence that there was
02:40:50 21 exogenous insulin. The question
02:40:53 22 was what is the source of
02:40:54 23 exogenous insulin?
02:40:56 24 THE COMMISSIONER: I'm sorry, so
02:40:56 25 "exogenous" it has been used and
02:41:00 26 nobody has defined the term. Is
02:41:02 27 that your concern?
02:41:04 28 MS. BAMBERS: My concern is --
02:41:06 29 MR. VAN KRALINGEN: My
02:41:06 30 understanding of exogenous is that
02:41:07 31 it's any sort of insulin that is
02:41:09 32 not created by the body.

02:41:11 MS. BAMBERS: So there was, the
02:41:12 records show, hypoglycemia but
02:41:14 he's making an assumption that the
02:41:16 source was exogenous insulin. The
02:41:18 person investigating wouldn't know
02:41:20 what the cause of the hypoglycemia
02:41:23 is.
02:41:24 Your question was?
02:41:27 MR. VAN KRALINGEN: Quite frankly
02:41:28 I can't remember my question. I'm
02:41:29 going to try again and avoid any
02:41:31 concern.
02:41:32 THE COMMISSIONER: Okay. Thank
02:41:32 you.
02:41:33 BY MR. VAN KRALINGEN:
02:41:33 Q. I'll go back to my earlier
02:41:36 question and we'll build from there if
02:41:37 that's all right.
02:41:37 Could an unexplained, severe
02:41:38 hypoglycemia in a resident who is nondiabetic
02:41:44 constitute a relevant medico-legal issue at
02:41:47 the time of death?
02:41:49 A. It could.
02:41:50 Q. It could?
02:41:50 A. Yes.
02:41:51 Q. Do you think it's important
02:41:52 for an investigating local coroner to
02:41:55 determine the source of that unexplained,
02:41:57 severe hypoglycemia?
02:42:00 A. So I think we need to qualify
02:42:02 that. So is the -- is the hypoglycemia
02:42:06 prolonged? Repeated? Or just solitary?

02:42:11 Q. That's a fair question. My
02:42:12 question is does it bear investigation I
02:42:15 suppose as a first --
02:42:15 A. If it's solitary and it's
02:42:16 corrected I don't think so.
02:42:20 Q. Can you go to the next tab,
02:42:26 second page within this -- no. The second
02:42:35 page within this tab, yes.
02:42:37 There's reference within this best
02:42:48 practice guideline to a post-mortem
02:42:54 examination ordering decision tool. Have you
02:42:56 seen that before?
02:42:57 A. Yes.
02:42:58 Q. And what's your best
02:42:59 understanding of the purpose of that
02:43:00 decision tool?
02:43:01 A. The post-mortem examination
02:43:05 is at the discretion of the attending
02:43:08 coroner provided, you know, there's no
02:43:11 obvious cause or you're at a loss for a
02:43:14 reasonable cause of death in a patient.
02:43:16 Q. All right. Can you go to tab
02:43:18 9 of the document you have? It's document
02:43:21 69319. This is actually a copy of the
02:43:26 examination ordering decision tool itself?
02:43:29 A. Uhm hmm.
02:43:36 Q. And, again, you've seen this
02:43:38 document before and you've used the document
02:43:40 in your coroners practice?
02:43:42 A. Yes.
02:43:42 Q. Could you cycle down to page
02:43:44 2 please at the bottom? Page 2 has a

02:43:47 1 category there -- well, first of all, my
02:43:49 2 first question is, to what extent does a
02:43:51 3 family member's request for an autopsy
02:43:52 4 affect your decision as to whether to
02:43:55 5 conduct a post-mortem examination or not?
02:43:57 6 A. I take it into consideration.
02:43:59 7 Q. Page 2, the bottom left-hand
02:44:01 8 corner has a category called "Undetermined".
02:44:08 9 It says:
02:44:08 10 "Circumstances of apparently
02:44:10 11 natural death where there is a need
02:44:12 12 to exclude other potential manners
02:44:13 13 of death."
02:44:14 14 Have you ever ordered a post-mortem
02:44:20 15 examination in the context of an undetermined
02:44:22 16 death before?
02:44:23 17 A. Yes.
02:44:23 18 Q. In the case of Ms. Pickering,
02:44:25 19 and the unexplained severe hypoglycemic
02:44:30 20 episode, did you believe that it's possible
02:44:32 21 that her death could have fallen within the
02:44:35 22 undetermined category here?
02:44:37 23 A. No.
02:44:37 24 Q. Why not?
02:44:38 25 A. Because her CT scan revealed
02:44:40 26 a pontine infarct which was new.
02:44:52 27 Q. That's not how she died, is
02:44:55 28 it?
02:44:55 29 A. Yes.
02:44:59 30 Q. Didn't she die because
02:45:01 31 Ms. Wettlaufer injected her with a
02:45:03 32 significant dose of insulin?

02:45:05 MR. HUBBARD: Commissioner, I'm
02:45:07 sorry but I rise. This is not an
02:45:10 appropriate line of questioning.
02:45:11 He can certainly, as my friend was
02:45:13 doing, ask what Dr. George
02:45:14 understood and believed at the
02:45:16 time, but in terms of what the
02:45:17 actual cause of death was in this
02:45:19 particular case that's for someone
02:45:20 else, not Dr. George looking back.
02:45:23 There'll be experts during another
02:45:26 phase of this Inquiry. I don't
02:45:27 know that it's particularly in
02:45:29 dispute but we're now wandering
02:45:31 outside of this witness' area of
02:45:32 involvement and expertise.
02:45:34 BY MR. VAN KRALINGEN:
02:45:34 Q. That's fine, let's go to tab
02:45:36 10 of the documents you have in front of
02:45:36 you. This is the Institution Patient Death
02:45:37 Record, 65223. My first question is -- page
02:45:52 7.
02:45:59 My first question is, I'm unclear
02:46:00 as to how often you encounter this form or
02:46:04 what facility you have with this form?
02:46:07 A. The Institutional Patient
02:46:07 Death Record?
02:46:08 Q. Yes. Do you ever see it?
02:46:11 A. Yes, I've seen it before.
02:46:13 Q. Okay.
02:46:20 A. I'll see it at the same
02:46:21 time -- when I'm going to a nursing home to

02:46:22 do a death investigation I usually see this
02:46:25 form.
02:46:25 Q. I see.
02:46:25 You'll see that Ms. Routledge
02:46:27 completes it. This is the form with respect
02:46:29 to Ms. Pickering and Ms. Routledge completes
02:46:31 it?
02:46:31 A. Yes.
02:46:32 Q. And she completes all
02:46:33 "no's", do you see that?
02:46:36 A. Yes.
02:46:36 Q. My question is, if she's
02:46:38 completed these as all as "no's" do you
02:46:41 know why you were called?
02:46:42 A. Central dispatch put through
02:46:45 the call as there was some concern.
02:46:47 Q. And do you know why central
02:46:49 dispatch was called if Ms. Routledge
02:46:52 completed this as all "no"? You don't?
02:46:56 A. I don't.
02:46:59 Q. Do you know if you talked
02:47:01 with Ms. Routledge before she completed the
02:47:04 Institutional Patient Death Record?
02:47:05 A. I don't recall.
02:47:06 Q. If a local coroner doesn't
02:47:15 keep notes and doesn't send in a Case
02:47:16 Selection Data Form, and the long-term care
02:47:19 home only answers "no" on the Institutional
02:47:21 Patient Death Record, you'll agree with me
02:47:25 that there's nobody from either the Regional
02:47:26 Senior Coroners Office, or the Office of the
02:47:28 Chief Coroner who would ever know that there

was ever a consideration of investigating a particular death?

A. The family physician -- the attending physician would have been aware of that as well.

Q. Can you go to tab 11 of the document you have before you? I apologize, can you go to tab 14. I said we would bounce around a little bit.

This is document 71986. This is the record from Ms. Kelly's dispatch. And what you'll see is over the next three pages the box in the middle there is actually where the narrative is captured, and because the narrative is larger than the box we've printed out a number of pages to capture the full narrative.

The narrative from Ms. Kelly says:

"Went to the hospital, found to have had low blood sugar.

Dr. Urbantke, one of our coroners, advised the nursing home to call this case in once she dies. Not sure if there is more to it or not."

Let's go to the next page.

"Hospital two days ago, spoke to Dr. Urbantke, the coroner, and she said that the blood sugar was less than 1 and was unexplained. She can't take the case because she saw her in the ER but will speak to the

coroner to give more background information."

To be fair to you my understanding is you don't have an independent recollection of a conversation with dispatch about this case, is that fair to say?

A. That's fair to say.

Q. Sitting here today though you don't dispute that this information was conveyed to you, is that fair to say?

A. That's fair to say.

Q. Go back to the first page please. It says:

"Dr. Urbantke advised the nursing home to call this case in once she dies."

It doesn't speak to the timeframe between when she was in the hospital and when she dies, you'll agree with that?

A. That's correct, but it does on the second page. It says "two days earlier" but that's incorrect.

Q. That's fair but my comment was about what Dr. Urbantke had advised?

A. That's right.

Q. And you'll agree with me that she didn't speak to a time limitation for when the coroner should be called?

I'm sorry, you have to verbalize your answer.

A. Okay.

Q. My read of this note is that

02:49:59 Dr. Urbantke would have taken the call if
02:50:03 she did not have a conflict as the treating
02:50:05 doctor, is that your read of it?
02:50:07 A. I can't say -- speak for
02:50:10 Dr. Urbantke.
02:50:22 Q. Go to tab 16 of the documents
02:50:23 you have before you. I apologize, document
02:50:33 71446. This document is called "A Narrative
02:50:44 Template for Corners", and my understanding
02:50:46 is that its purpose is to assist a coroner
02:50:48 in completing a Form 3, is that accurate?
02:50:51 A. That's correct.
02:50:51 Q. Have you seen this document
02:50:53 before?
02:50:53 A. Yes.
02:50:54 Q. And do you use this document
02:50:55 in the course of your usual practice?
02:50:57 A. Yes.
02:50:59 Q. You've indicated today that
02:51:00 you will speak with family members when
02:51:02 those family members are available, is that
02:51:04 fair to say?
02:51:05 A. That's fair to say.
02:51:07 Q. And Dr. Mann discussed a best
02:51:09 practice to provide a pamphlet or perhaps
02:51:13 contact details, and you've indicated that
02:51:14 you provide contact details to family
02:51:17 members at least, is that right?
02:51:20 A. That's correct.
02:51:20 Q. Are you authorized -- let's
02:51:22 go to the third page as a starting point.
02:51:25 At the top of the third page please.

02:51:27 1 There's a discussion with
02:51:30 2 communication of next of kin or legal
02:51:32 3 representatives and under the "Necessary
02:51:33 4 Elements" it says:
02:51:35 5 "It is mandatory to speak to the
02:51:37 6 next of kin, legal representative
02:51:38 7 or substitute decision maker
02:51:41 8 regarding the death."
02:51:41 9 My question to you is, do you deem
02:51:46 10 it to be mandatory to speak to the next of
02:51:49 11 kin, legal representative or substitute
02:51:51 12 decision maker assuming that they are
02:51:53 13 reasonably available?
02:51:54 14 A. Yes.
02:51:54 15 Q. And are you authorized in any
02:51:55 16 way to delegate that authority to another
02:51:57 17 healthcare practitioner?
02:52:00 18 A. No.
02:52:01 19 Q. So you have to be the one who
02:52:02 20 speaks to the family member?
02:52:04 21 A. That's correct.
02:52:04 22 Q. And if you didn't speak to a
02:52:06 23 family member at any given point it would be
02:52:08 24 a breach of your obligations?
02:52:11 25 A. It may have occurred, I don't
02:52:13 26 recall.
02:52:25 27 Q. Can you go to tab 18 of the
02:52:27 28 document you have before you? This is
02:52:29 29 document 65227.
02:52:31 30 This is the coroners investigation
02:52:45 31 Form 3 relating to Mr. Silcox. If you can
02:52:48 32 cycle down to the narrative on the bottom?

02:52:50 So you've just indicated to me that
02:52:52 you're not really supposed to delegate the
02:52:54 authority to speak to a family member to
02:52:56 another healthcare practitioner?
02:52:58 A. That's correct.
02:52:59 Q. But you don't have an
02:53:00 independent recollection of any conversation
02:53:02 with Mr. Silcox's family?
02:53:04 A. I don't recall.
02:53:06 Q. And so what is your response
02:53:07 to Mr. Silcox's family, and in particular
02:53:11 his power of attorney who says that she
02:53:14 never spoke with you and no member of her
02:53:17 family who was present at the home that day
02:53:19 spoke with you?
02:53:20 A. I don't recall.
02:53:31 Q. Can you go to tab 11 of the
02:53:33 documents you have? And this is the section
02:53:43 of the transcript, June 13, 2018, I'm going
02:53:49 to ask you to look past two of the blue
02:53:53 pages.
02:53:54 Could you cycle down starting at
02:54:21 question 19 -- line 19? To give you some
02:54:30 context, Dr. George, there was a
02:54:32 cross-examination of Karen Routledge earlier
02:54:34 in these proceedings.
02:54:38 Starting at line 19 the question
02:54:40 was:
02:54:41 "QUESTION: My understanding is
02:54:41 that upon Ms. Pickering's death you
02:54:43 had a conversation with Dr. George?
02:54:45 "ANSWER: Yes.

"QUESTION: Specifically because Dr. Urbantke, as documented in the progress notes, suggested a call to the coroner?
"ANSWER: Yes."
I ask her to recall everything she can about that conversation with Dr. George, and I intentionally sort of asked an open question, just so you know.
Her answer starts at the bottom of that page. It says:
"ANSWER: I called the coroners office the 1-800 number and he called back. And I passed on the information that this lady had been seen yesterday in emerg regarding concerns I had about her condition and that they had discovered an unexplained extremely low blood sugar"
"QUESTION: Okay. Dr. George, in the face of that -- did Dr. George talk to you about the reason why he was not going to attend?
"ANSWER: No. I also talked about co-morbidities and the possibility that she may have had a stroke and we reviewed her medical history."
I assume sitting here today you have nothing to dispute that recollection?
A. No.
Q. I'm sorry?

02:55:44 A. Yes.
02:55:45 Q. You've got nothing to dispute
02:55:46 that recollection?
02:55:47 A. Nothing to dispute that.
02:55:52 Q. And so we're very comfortable
02:55:54 that you knew about the extremely low blood
02:55:57 sugar that Dr. Urbantke was concerned about
02:55:59 as of the date you were called with respect
02:55:59 to this possible death investigation?
02:56:03 A. That's correct.
02:56:04 Q. Can we go to next document
02:56:05 which is --
02:56:06 A. However it wasn't the day
02:56:07 before, the low blood sugar.
02:56:10 Q. I didn't say it was the day
02:56:11 before?
02:56:11 A. On the transcript it is.
02:56:13 Q. I understand.
02:56:25 MS. FRAZER: It's getting very
02:56:27 difficult to hear back here.
02:56:29 THE COMMISSIONER: I do think we
02:56:30 should just clarify this point
02:56:31 because it's come up several times
02:56:33 in the examination.
02:56:34 So, Dr. George, you're saying it
02:56:41 wasn't the day before?
02:56:44 THE WITNESS: It wasn't.
02:56:45 THE COURT: So you are disputing
02:56:47 what -- because counsel just put
02:56:50 to you, do you have any reason to
02:56:52 dispute what Karen Routledge said
02:56:54 to you?

02:56:59 BY MR. VAN KRALINGEN:
02:56:59 Q. Well, let's be clear. That
02:57:00 Karen Routledge said this to you. That
02:57:04 Karen Routledge said this to you. What the
02:57:05 actual fact of the events were is a separate
02:57:09 question.
02:57:10 THE COMMISSIONER: Okay. So were
02:57:10 you answering his question?
02:57:12 THE WITNESS: Okay. I understand
02:57:14 that.
02:57:14 THE COMMISSIONER: And you are
02:57:15 answering his question?
02:57:17 THE WITNESS: Differently.
02:57:18 THE COMMISSIONER: You're saying
02:57:18 that if Karen Routledge testified
02:57:20 here in the Inquiry that she told
02:57:22 you this thing you have no reason
02:57:23 to --
02:57:24 THE WITNESS: No reason not to
02:57:26 believe that.
02:57:27 THE COMMISSIONER: Okay.
02:57:27 BY MR. VAN KRALINGEN:
02:57:27 Q. And you have no reason to
02:57:29 dispute it because you have no independent
02:57:31 recollection of the evidence.
02:57:31 A. No.
02:57:31 MR. HUBBARD: Sorry, I just need
02:57:33 clarification then. Is it just
02:57:33 the message that there was a
02:57:34 concern raised and what they may
02:57:35 have discussed as opposed to the
02:57:37 issue of whether it was one day

post-visit to the ER, or five-days post-visit to the ER?

MR. VAN KRALINGEN: It is absolutely the former not the latter.

MR. HUBBARD: I think we're all agreed but it's important.

THE COMMISSIONER: I do think it's important and that's why we're clear. This is what I understand, I understand that Karen Routledge testified before us that she told Dr. George about the concerns she had about her and said that it related to the day before; and Dr. George responded that he had no reason to dispute that statement because he has no independent recollection, but he added that factually the statement sin correct. That's what I understand.

THE WITNESS: Yes.

MR. VAN KRALINGEN: That's also my understanding of the evidence as welt.

MR. HUBBARD: Thank you very much.

BY MR. VAN KRALINGEN:

Q. Because you have no independent recollection of these events you can't tell us how long you took to come to your decision not to conduct a death

02:58:38 1 investigation, is that fair to say?
02:58:40 2 A. Um....
02:58:40 3 Q. You can't tell us if it was
02:58:46 4 one of those shorter decision or one of
02:58:48 5 those decisions that took a longer period of
02:58:50 6 time?
02:58:51 7 A. No, I can't tell you.
02:58:53 8 Q. Tab 12 is document 65222.
02:58:56 9 These are progress notes for Ms. Pickering.
02:58:59 10 In your conversation earlier today with one
02:59:12 11 of the counsel, I believe it was Ms. Jones,
02:59:15 12 you referred to a series of documents you
02:59:17 13 allegedly would have reviewed in advance of
02:59:20 14 making your decision. And of course you
02:59:22 15 don't know exactly what you reviewed because
02:59:24 16 you don't have contemporaneous notes and you
02:59:26 17 don't have a clear recollection, is that
02:59:29 18 fair to say?
02:59:30 19 THE COMMISSIONER: Can you hear?
02:59:30 20 THE COURT REPORTER: I'm not
02:59:30 21 hearing a verbal answer.
02:59:30 22 THE COMMISSIONER: That's why I
02:59:30 23 asked. I think that situation was
02:59:30 24 you were starting your answer as
02:59:30 25 he was finishing his question.
02:59:30 26 THE WITNESS: I'll be more
02:59:52 27 careful.
02:59:52 28 BY MR. VAN KRALINGEN:
02:59:53 29 Q. And I'll ask my question
02:59:53 30 again so we have a clear record. You've
02:59:56 31 talked today about documents that you think
02:59:58 32 you would have reviewed in coming to your

decision not to conduct a death investigation with respect to Ms. Pickering, correct?

A. That's correct.

Q. But you don't know what you did review, and we don't know what you did review for two reasons. First of all you had no contemporaneous notes, is that fair to say?

A. That's correct.

Q. And, second, you don't have an independent recollection?

A. No, I don't recall.

Q. Okay. Yesterday we heard from the chief -- but those documents that you're referring to that you would have reviewed are essentially the equivalent of medical records, is that fair to say?

A. That's correct.

Q. Yesterday we heard from the Chief Coroner of the Province that coroners are not legally allowed to look at medical records before choosing to undertake a death investigation, i.e., during the time when they're figuring out whether to conduct an investigation or not. It's actually something that he wants to fix.

So my question to you is, where would you have obtained the authority to review medical records in advance of deciding whether to conduct a death investigation for Ms. Pickering?

03:01:01 A. Through an electronic system,
03:01:04 or through medical records from the
03:01:06 hospital, or through a phone call to emerg.
03:01:09 Q. Well, you're talking to me
03:01:10 about the process by which you would have
03:01:12 got those documents. I'm asking you for
03:01:14 your authority to obtain those documents in
03:01:16 the circumstance?
03:01:18 A. I guess we're doing it and
03:01:20 we're probably not supposed to be.
03:01:28 Q. You can't tell me today if
03:01:29 you spoke to Dr. Urbantke or not can you?
03:01:34 A. I don't recall.
03:01:35 THE COMMISSIONER: Counsel, we'll
03:01:35 take a brief pause for the Court
03:01:35 Reporters to switch the audio.
03:01:35 MR. VAN KRALINGEN: Certainly.
03:01:35 -- RECESSED AT 3:01 P.M.
03:01:35 -- RESUMED AT 3:01 P.M.
03:02:05 MR. VAN KRALINGEN: Ms. Jones
03:02:05 has actually just helped me with a
03:02:05 clarification of Ms. Routledge's
03:02:05 evidence with respect to the one
03:02:05 day versus five day that -- just
03:02:21 in the public interest, I think
03:02:22 it's actually important to put on
03:02:24 the record.
03:02:24 THE COMMISSIONER: Yes.
03:02:25 MR. VAN KRALINGEN: Looking at
03:02:26 page 1407 of that same transcript.
03:02:28 THE COMMISSIONER: Do you want
03:02:32 to pull it up?

MR. VAN KRALINGEN: If don't mind. This comes out of you her time, not my time; right?
THE COMMISSIONER: Right.
MR. VAN KRALINGEN: You don't have the full transcript. Go to 1407, please. [AS READ]
"I note that this conversation that you had with Dr. George was over four years ago or four years ago, and I think you were giving evidence today to my friend today that you told Dr. George that she had gone to the hospital yesterday?
A. Yes.
Q. So I think from the documents we're seeing, that was about five days earlier?
A. Yes.
Q. And I think it's understandable given the passage of time, you were just mistaken about exactly what you told Dr. George on the point that it was five days earlier, not yesterday?
A. Correct.
THE COMMISSIONER: Thank you.
MR. VAN KRALINGEN: Thanks.
BY MR. VAN KRALINGEN:
Q. Can we go back to Tab 12 of the documents you have, and that's Document 65222. Thanks.
On the bottom of the page, there

is a -- there's a note from Ms. Wettlaufer at 17:21. Do you see that?

A. Yes.

Q. So it's Dr. Urbantke mentioned that Maureen's blood sugar was extremely low when she arrived at the hospital, and the cause is unknown. She stated that if Maureen passes, it might be a good idea to call the coroner on this one.

Again, you'll agree with me that Dr. Urbantke, through the note that Ms. Wettlaufer documented, doesn't seem to put a time frame in terms of how long you should wait to call the coroner if Ms. Pickering dies? You'll agree with me on that?

A. But Ms. Pickering was palliative care. She was returned to the long-term care facility with -- you know, she was receiving hydromorphone on a regular basis.

Q. That's my very point. When she leaves, she's palliative, and we don't know how long she's going to live; correct?

A. That's correct. And that -- you know, the word "if," if Maureen passes. So the implication of the word "palliative" means somebody is going to pass.

Q. In your experience as a local coroner, have you seen a note like this before where somebody who's a treating physician who also happens to be a coroner

provides a note to a long-term care home or other health facility that it might be a good idea to call a coroner if the patient dies?

A. We've had differences of opinion on occasions where one coroner may thing something is a coroners case and another coroner thinks that it's not.

Q. That's not the question I asked you, but I appreciate the contribution. The question I asked you is have you ever seen a note like this before in a medical record of any sort?

A. No.

Q. Would you agree with me it's an unusual note?

A. It's an unusual note.

Q. We talked earlier today about your views that you did not believe a long-term care -- a caregiver at a long-term care facility would intentionally harm a resident?

A. I didn't think so.

Q. Do you think that that affected your approach with respect to the decisions, investigate or not investigate any given death in a long-term care home?

A. I didn't suspect foul play.

Q. That's not the question I asked you, though. The question I asked you was do you think the fact that you didn't suspect foul play affected your

decision-making process when considering whether to conduct or not conduct a death investigation of a long-term care resident?

A. No.

MR. VAN KRALINGEN: Thank you kindly for your time today. Those are my questions.

THE COMMISSIONER: Thank you, Mr. Van Kralingen.

MR. SCOTT: We have no additional questions.

THE COMMISSIONER: Thank you, Mr. Scott.

MS. JONES: Commissioner, I just canvassed the room, and I believe the only counsel currently who has questions in cross-examination is Ms. Fraser on behalf of the Ontario Association of Residents' Councils.

THE COMMISSIONER: Thank you very much.

MS. FRAZER: Thank you.

THE COMMISSIONER: Ms. Frazer.

CROSS-EXAMINATION BY MS. FRAZER:

Q. Sir, my name is Suzan Fraser. I'm here on the behalf of the Ontario Association of Residents' Councils. Do you know what a Residents' Council is?

A. Yes.

Q. Okay. So you understand that each long-term care home has a mandated

Residents' Council?
A. Yes. I see advertising for it in the -- in the elevators and the hallways.
Q. All right. And did I understand your evidence correctly that you had patients at Caressant Care Woodstock?
A. I still have.
Q. You still have. So did you know Elizabeth Wettlaufer during the period of time that she worked at Caressant Care Woodstock?
A. I honestly didn't recognize her.
Q. Okay. Did she care for any of your patients?
A. She may have.
Q. You don't know that?
A. I don't know that for a fact.
Q. Okay. You weren't interested in reviewing that after her offences became known?
A. I did have patients in that -- in that part of Caressant Care, I believe.
Q. I see. Okay. And in terms of the local community of Woodstock, would you know Dr. Reddick because he had privileges at Woodstock General Hospital?
A. Yes.
Q. Okay. You'd know Dr. Urbantke?

03:08:59 A. I don't think.
03:08:59 Q. You would know Dr. Fernando
03:09:01 who was a psychiatrist?
03:09:02 A. Yes.
03:09:03 Q. I understand he was
03:09:05 Ms. Wettlaufer's psychiatrist, among other
03:09:06 people?
03:09:06 A. I didn't know that.
03:09:07 Q. You did not know that.
03:09:08 And Dr. Brio we've heard of?
03:09:15 A. Yes.
03:09:16 Q. You knew him. Okay.
03:09:17 And so when somebody died in a
03:09:21 long-term care home and you were familiar
03:09:21 with the person professionally from your
03:09:21 work sharing privileges at the hospital, did
03:09:29 you ever decline a case by view of it being
03:09:34 a conflict?
03:09:35 A. I can't recall. I may have.
03:09:36 Q. Okay. You can't think of a
03:09:38 specific example?
03:09:38 A. No.
03:09:39 Q. Okay. And certainly, you
03:09:43 didn't think Dr. Urbantke in the case
03:09:46 involving Ms. Pickering thought that she had
03:09:49 a conflict, but you didn't think it was a
03:09:51 conflict to perform -- decide whether it was
03:09:55 a coroners investigation or not?
03:09:56 A. That's correct.
03:09:56 Q. Okay. Just turning, then, to
03:10:04 your jurisdiction and your legislative
03:10:08 authority, you understand that when you are

03:10:11 acting as a coroner dispatched to a
03:10:16 long-term care home, that you're performing
03:10:19 a statutory function?
03:10:20 A. Yes.
03:10:21 Q. Okay. And that your work is
03:10:22 guided by statute?
03:10:23 A. That's right.
03:10:24 Q. All right. That you can only
03:10:25 do what the statute tells you to do?
03:10:28 A. That's correct.
03:10:29 Q. Or gives you -- what --
03:10:30 authorizes you to do?
03:10:33 A. What the authority is, yes.
03:10:34 Q. Right. Okay. And you
03:10:36 understand that -- you've talked about the
03:10:44 process in which you're forming an opinion
03:10:46 about whether you're going to investigate or
03:10:48 not; right?
03:10:48 A. That's correct.
03:10:49 Q. And you understand that in
03:10:51 cases of long-term care, that you have broad
03:10:54 authority to investigate?
03:10:56 A. That's correct.
03:10:56 Q. Right. That you're guided by
03:10:59 Subsection 2.1 of Section 10 of the Coroners
03:11:03 Act?
03:11:05 A. The Coroners Act, yes.
03:11:06 Q. Okay. So you're not limited
03:11:09 to whether there's a sudden or unexpected
03:11:11 death in terms of deciding to investigate?
03:11:14 A. That's correct.
03:11:14 Q. Okay. So how do you, as a

03:11:16 coroner, decide to exercise your discretion?
03:11:19 What are the special considerations that you
03:11:21 use in 2.1?
03:11:24 A. There would have to be some
03:11:26 sort of extenuating circumstances where I
03:11:28 would, you know, investigate it and turn it
03:11:31 into a coroners case.
03:11:32 Q. Okay. And so in terms of
03:11:36 examining those extenuating circumstances,
03:11:37 do you ever look towards what particular
03:11:39 policy issues or whether manuals have been
03:11:42 complied with, anything like that?
03:11:44 A. Not specifically.
03:11:46 Q. Okay. You don't look to
03:11:47 patient management guides or protocols?
03:11:51 A. Not at the nursing home.
03:11:52 Q. Okay. What about safety
03:11:56 procedures or staff training? Do you ever
03:12:00 look at those circumstances?
03:12:01 A. No.
03:12:01 Q. No?
03:12:01 A. Not unless they were brought
03:12:03 to my attention.
03:12:03 Q. Right. And the only time in
03:12:05 that period of time where you're forming an
03:12:07 opinion about whether to investigate, you
03:12:09 wouldn't actually have access to all those
03:12:12 things?
03:12:12 A. No, I wouldn't.
03:12:12 Q. Okay. So you're limited in
03:12:13 forming that opinion to the information that
03:12:17 is readily and legally available to you?

03:12:20 A. That's correct.
03:12:20 Q. And you'll agree with me that
03:12:22 that -- in terms of what the Coroners Act
03:12:26 provides, you have much greater powers once
03:12:30 you issue a warrant to seize information; is
03:12:34 that fair?
03:12:34 A. Or warrant to take possession
03:12:36 of the remains.
03:12:37 Q. Right. So you have two
03:12:38 things that you can do: You can issue your
03:12:40 warrant for a postmortem examination. You
03:12:44 can also issue warrants to seize records;
03:12:44 right?
03:12:46 A. Warrant to take possession,
03:12:47 not warrant for postmortem examination.
03:12:49 Q. Warrant to take possession of
03:12:50 the body?
03:12:51 A. That's right.
03:12:51 Q. Okay. So in the
03:13:03 consideration of extenuating circumstances
03:13:06 in long-term care, you've already told us
03:13:09 that you did not at the time believe that a
03:13:16 caregiver would intentionally harm -- a
03:13:20 health practitioner would intentionally harm
03:13:23 a patient?
03:13:24 A. I had no reason to believe
03:13:26 that.
03:13:26 Q. Okay. And would you agree
03:13:27 with me that -- well, it's not a no reason
03:13:31 to believe, but you actually did not believe
03:13:35 that health care practitioners would harm
03:13:39 patients?

03:13:41 A. That's correct.
03:13:42 Q. Right. And so I'm going to
03:13:45 suggest to you that your mind was closed to
03:13:47 the possibility --
03:13:49 A. On the contrary.
03:13:51 Q. Okay. Let me just finish my
03:13:52 question.
03:13:53 I'm suggesting to you that your
03:13:54 mind was closed to the possibility that
03:13:58 health care practitioners would harm a
03:14:01 patient because of your personal beliefs?
03:14:05 A. I didn't suspect that a
03:14:08 health care practitioner in a long-term care
03:14:10 facility would harm a patient.
03:14:14 Q. Okay. Now, you understand
03:14:14 that; right? That's possible?
03:14:20 A. That is possible.
03:14:22 Q. Okay. But during the period
03:14:23 of time between you were acting as a coroner
03:14:25 from 2004 to the disclosure of
03:14:27 Ms. Wettlaufer's offences in 2016, did you
03:14:29 not ever hear a story of a caregiver working
03:14:32 in long-term care harming a resident?
03:14:37 A. I think there were some in
03:14:38 the news where patients were being abused by
03:14:41 staff.
03:14:41 Q. Yes, but that didn't affect
03:14:43 your view?
03:14:45 A. No, it didn't.
03:14:46 Q. All right. So in the period
03:15:09 of time following the elimination of the one
03:15:14 in ten deaths, have you ever been called to

give an opinion about whether it ought to become a coroners investigation under Section 2.1 of the Coroners Act?

A. I can't recall recently.

Q. So you can't remember whether you were called, and we know that you haven't done an investigation?

A. I haven't been to -- I haven't done a nursing -- a long-term care facility coroners case in quite some time, and I don't recall receiving a phone call asking me.

Q. Okay. I have some questions about the conference that you went to in November, the coroners conference.

A. That's right.

Q. Was that a coroners conference organized by the Office of the Chief Coroner, or was that conference organized by the Ontario Coroners Association?

A. No, by the Office of the Chief Coroner.

Q. Okay. And are you a member of the Ontario Coroners Association?

A. No.

Q. No. Are you familiar with the Ontario Coroners Association?

A. Yes.

Q. Okay. Have you had any familiarization with any other death investigation model? Because I know you did

some training overseas.

A. Right.

Q. So a medical examiner model, other models of death investigation?

A. I lived in B.C., and in British Columbia, you didn't have to be a physician in order to be a coroner.

Q. Okay. Can you tell us just briefly about your experience with that model?

A. I was on a military base, and a civilian had died on military property, so it created some concern.

The coroner ran a delicatessen somewhere about 50 miles away, and it took him several hours to get there, and the elderly lady passed away. She was in our morgue.

The bag was taped up, and then she was transferred down to Campbell River on Vancouver island for a further assessment by a physician coroner.

Q. I see. Okay. So in that -- just the way that you said ran a delicatessen, I didn't think that you thought highly of that particular model.

A. No, it's not that I didn't think highly. I was just rather shocked. That's the first time I'd heard that, you know, a nonphysician, a nonmedical person was that.

But he was actually quite

knowledgeable, and, you know, he was there to investigate a death, and she had died on Crown property.

Q. All right. So he actually did have some knowledge about how to conduct an investigation?

A. Right. He had been doing it for a number of years.

Q. Right. Okay.

MS. FRAZER: Sir, those are my questions for today. Thank you very much.

THE COMMISSIONER: Thank you, Ms. Fraser.

MS. JONES: Commissioner, if we can take the afternoon recess now just so that my friends can determine whether or not there will be a reexamination. I think that would be helpful.

THE COMMISSIONER: Yes, I don't have any problem with that. May I invite all of you to consider carefully whether there needs to be any reexamination on that one-day, five-day, two-day business?

MS. JONES: Okay. Thank you.

THE REGISTRAR: This Public Inquiry is in recess for 15 minutes.

-- RECESSED AT 3:19 P.M.

03:19:29 1 -- RESUMED AT 3:39 P.M.
03:19:29 2 THE COMMISSIONER:
03:19:29 3 MS. JONES: Madam Commissioner,
03:19:29 4 counsel for the Province and
03:39:40 5 Dr. George do not have any
03:39:42 6 questions in reexamination, and I
03:39:44 7 will be brief in reexamination.
03:39:46 8 THE COMMISSIONER: Thank you.
03:39:46 9 RE-EXAMINATION BY MS. JONES:
03:39:47 10 Q. Dr. George, you were asked
03:39:49 11 questions in cross-examination by my friend,
03:39:54 12 Mr. Van Kralingen, about what information
03:39:56 13 you received from Karen Routledge about the
03:40:00 14 timing of Ms. Pickering's low blood sugar
03:40:05 15 relative to the date of her death. Do you
03:40:06 16 remember those questions?
03:40:08 17 A. Yes.
03:40:08 18 Q. And then you were shown
03:40:10 19 different transcripts that contained
03:40:14 20 different information; correct?
03:40:15 21 A. That's correct.
03:40:16 22 Q. I'm going to ask you to
03:40:17 23 assume that you were advised that
03:40:19 24 Ms. Pickering had been hospitalized with low
03:40:22 25 blood sugar. And in that scenario, when
03:40:26 26 assessing a death, would it have been your
03:40:29 27 practice to determine the timing or the date
03:40:30 28 of that low blood sugar relative to the date
03:40:34 29 of death?
03:40:35 30 A. Absolutely.
03:40:35 31 Q. Okay. Why would that have
03:40:37 32 been your practice?

03:40:38 A. It would have different
03:40:40 implications. I mean, her blood sugar was
03:40:42 -- the low blood sugar was five days
03:40:44 earlier, and it would have been different if
03:40:49 she had had a low blood sugar and then
03:40:52 passed away very suddenly as a result of,
03:40:55 you know, persistently low blood sugar.
03:40:58 This was a solitary event, as far
03:41:01 as I can see, and she responded to several
03:41:06 intravenous injections of some glucose.
03:41:09 Q. So is it your belief today
03:41:11 that you would have known that it was five
03:41:13 days previously that Ms. Pickering had had
03:41:15 low blood sugar?
03:41:16 A. Yes.
03:41:17 MS. JONES: Thank you. I have no
03:41:19 further questions, Commissioner.
03:41:21 THE COMMISSIONER: Thank you
03:41:21 very much. That's helpful. So
03:41:23 that's everything for Dr. George?
03:41:27 Yes. Thank you very much.
03:41:29 Sorry, I almost called you by the wrong
03:41:31 doctor's name. Thank you so much for coming
03:41:33 in. We know that testifying at inquiries is
03:41:34 not the most pleasant experience for
03:41:37 everybody, but we appreciate your help very
03:41:40 much.
03:41:41 THE WITNESS: It's necessary.
03:41:41 THE COMMISSIONER: It is.
03:41:42 Thank you, Dr. George.
03:41:46 MS. JONES: Thank you,
03:41:47 Commissioner. We don't have

03:41:49 1 another witness for today.
03:41:51 2 Dr. Urbantke will be here in the
03:41:53 3 morning, and she will be
03:41:55 4 testifying.
03:41:55 5 THE COMMISSIONER: Okay. And we
03:41:56 6 expect that she will be finished
03:41:59 7 her testimony in one day?
03:42:01 8 MS. JONES: We expect she will be
03:42:01 9 quite brief actually,
03:42:01 10 Commissioner. We expect she'll be
03:42:01 11 finished her testimony probably by
03:42:02 12 lunch.
03:42:03 13 THE COMMISSIONER: All right.
03:42:03 14 And if that is the case, we will
03:42:07 15 then pass 2?
03:42:10 16 MS. JONES: We will pass over to
03:42:12 17 Monday with Dr. Pollanen.
03:42:15 18 THE COMMISSIONER: Okay. So we
03:42:15 19 won't have anybody except
03:42:15 20 Dr. Urbantke tomorrow?
03:42:15 21 MS. JONES: That's right, because
03:42:16 22 Dr. Pollanen will be more than a
03:42:18 23 day, so instead of having -- or at
03:42:21 24 least a day, so instead of having
03:42:23 25 Dr. Pollanen's evidence split, we
03:42:24 26 thought we'd call him on Monday.
03:42:27 27 THE COMMISSIONER: Yeah, no,
03:42:27 28 that makes good sense. I just --
03:42:32 29 yeah, I just wasn't exactly sure
03:42:34 30 when Diane Crawford was going to
03:42:38 31 be called in relation to the other
03:42:40 32 evidence.

03:42:41 MR. VAN KRALINGEN: Neither am I
03:42:42 right now. We'll figure it out,
03:42:44 though.
03:42:44 THE COMMISSIONER: Oh, okay.
03:42:44 All right. That was --
03:42:45 MS. JONES: If Ms. Crawford is
03:42:47 called, it would most likely be on
03:42:49 Monday, and we can do that, I
03:42:51 expect, relatively quickly, but we
03:42:53 should have an update for you,
03:42:56 Commissioner, and perhaps as early
03:42:57 as tomorrow.
03:42:58 THE COMMISSIONER: All right.
03:42:59 That's fine. I'm not pressing you
03:43:01 on that. That was my bit of
03:43:03 confusion about the lineup and
03:43:05 where we were going with that.
03:43:06 Thank you very much.
03:43:08 MS. JONES: Thank you.
03:43:31 THE REGISTRAR: This Public
03:43:32 Inquiry is adjourned until
03:44:22 tomorrow at 9:30 a.m.
03:44:35 --- Adjourned at 3:44 p.m.

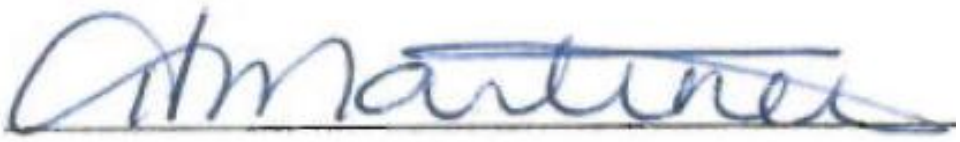
REPORTERS' CERTIFICATE

We, HELEN MARTINEAU, CSR, and CARISSA STABBLER, CSR, RPR, certify;

That the foregoing proceedings were taken before us at the time and place therein set forth;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by us and were thereafter transcribed;

That the foregoing is a true and accurate transcript of our shorthand notes so taken. Dated this 18th day of July, 2018.



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